PHPU Newsletter

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MEASLES

Suspected case

▼

Notify PHPU 0141 201 4917

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Non-charcoal flocked throat swab*

▼

Insert in viral PCR solution (VPS)

▼

Virus Lab Gartnavel 0141 211 0080

**Swabs can be taken from prodromal to 14 days after onset of rash*

Measles outbreak in England

Measles incidence in Western Europe has seen a five-fold increase in the last five years. This situation increases the risk of Scottish travellers coming into contact with measles cases abroad, becoming infected and importing the disease to Scotland.

While there are no substantive current outbreaks of measles in Scotland, there is a current outbreak in Merseyside, where the latest cumulative results have recorded 85 laboratory confirmed cases, 44 probable cases and many possible cases being followed up. See HPA news site

During an outbreak situation it is more likely that clinically suspected cases will be laboratory confirmed. A probable case would be defined as a person with fever, a generalised maculopapular rash and either cough, coryza or conjunctivitis and an epidemiological link to a laboratory-confirmed case. The infectious exposure period to a confirmed case is 5 days before to 4 days after rash onset. The incubation period of measles ranges from 7-21 days.

In the situation where no known outbreaks of measles exist, a clinical diagnosis of measles should be considered if the patient has a fever (38º or higher), a generalised maculopapular rash lasting 3 days or longer and either a cough, coryza or conjunctivitis. Immunity against measles is highly likely if there is evidence of 2 doses of MMR being given previously.

GPs who suspect measles are asked to notify the PHPU. Diagnostic testing for measles consists of a throat swab for PCR (the detection of viral nucleic acids). A sterile non-charcoal swab (flocked preferable) should be used, wiping along the back of the throat. The swab should then be placed in a vial of viral transport medium and sent to the West of Scotland Virus lab at Gartnavel Hospital.

The swab can be taken from the 5 days before the rash up to 14 days post onset of the rash, however the virus is more likely to be detectable pre-rash and in the first week of the rash appearing. The PHPU will be made aware of the result from the lab and, if positive, will undertake all the necessary public health action required. See HPS Guidance on link below.

http://www.documents.hps.scot.nhs.uk/about-hps/hpn/measles-guidelines.pdf

Travel vaccines and storage

The PHPU recently received an enquiry from Practice staff about a travel vaccine which a patient had kept at home (out of the fridge) for 23 hours prior to their returning to the surgery. This incident raises the issue of maintaining the cold chain for vaccines prescribed on the GP10 form for patients to uplift from community pharmacies.

Please note that all vaccines require to be stored at 2-8°C. Ideally, arrangements should be made in advance with the community pharmacy to ensure that the product can be stored in either the pharmacy or GP surgery and so avoid the patient storing it at home.

Vaccine update

Rabies – drug alert

Novartis has advised that there is a potential problem with syringes included with batches of Rabipur (490011C and 49311A). Healthcare professionals are advised to inspect the outer packaging for signs of yellow discolouration or mould prior to use. If no signs are identified the syringes may be used as normal. Full information is available on the MHRA website.

Typhoid - supplies

Supply of Sanofi typhoid vaccine is expected to resume by end of March but GSK vaccines are likely to remain unavailable until the end of 2013. In cases of supply problems, however, a combined hepatitis A and typhoid vaccine is preferred to oral typhoid vaccine (live), and Sanofi combined hep A/typhoid ***is*** available. GPs who encounter a problem with supply should contact Pharmaceutical Public Health on 0141 201 4424.

Pneumovax II ®- supplies

Problems with Pneumovax II supply are expected to be resolved by mid April.

Local mumps outbreak

Cases continue to be reported as part of the mumps outbreak at University of Glasgow and the majority of the illnesses have been mild and self limiting. While GPs should continue to report cases to public health there is no enhanced surveillance of this group and therefore any patients presenting at community pharmacy for self management do not need to be reported.

Primary care staff please note that e - learning module on the cold chain is now live

HPV and GPs - clarification

In last month's newsletter it was pointed out that the HPV community catch-up programme had come to an end and that some girls - probably very few - who remain eligible for the HPV might attend their GPs seeking vaccination. *GPs are not contractually required to complete the course* but if a GP is happy to do so then the vaccine can be obtained centrally from the PDC (0141 347 8981). Otherwise the GP should refer to the PHPU and alternative arrangements will be made.

Making HIV testing easier in primary care

The availability of effective HIV treatment has transformed the outcome for people living with HIV and yet about 50% of all new diagnoses are still made at a late stage with associated poor outcome. Many of these late presenters will have been seen by a range of medical professionals, for a range of HIV-related conditions, on more than one occasion before a diagnosis of HIV is made.

Making HIV testing easier is crucial if the incidence of missed diagnosis/late presentation is to be reduced in the NHSGGC population. Testing for HIV is achievable in non-specialist settings - all that is required is informed consent, as for all investigations; lengthy pre-test counselling is no longer required. The following patients should be routinely offered an HIV test:

- Patients with specific indicator conditions (see indicator chart)
- Patients known to be from a country of high prevalence i.e. the estimated percentage prevalence is >1% [1]
- Patients whose personal behaviours and/or those of their contacts put them at increased risk of acquiring the infection

In response to requests from GP colleagues and in support of such action, the results of all virology tests undertaken with a CHI number (i.e not anonymised), will be available on SCI Store to all clinicians for their own patients (in both primary and secondary care) from the 5th March 2012.

While it is crucial that HIV testing is no longer perceived as being in the exclusive domain of the specialist arena, it is essential that those diagnosed HIV positive are linked into specialist services as quickly as possible. To facilitate this, a copy of all HIV-positive results will be sent to the multi-disciplinary clinical team based at the Brownlee Centre where all adult HIV patients are managed. In addition, support to give positive results and facilitate referral is available from Sexual Health Advisors on 0141 211 8634 and Brownlee Blood Borne Virus counsellors on 0141 211 1089.

NHSGGC offers a range of free BBV training to all staff including primary care staff. Training ranges from a basic e-learning module, through to scheduled half day sessions and bespoke training, to meet individual needs. For further details, please contact the BBV Training Team at the Sexual Health Advisors office on 0141 211 8634 or by email on GG-UHB.bbvtrainingteam@nhs.net.

[1] *UNAIDS Estimated Number of people living with HIV by country, 1990-2007*
http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/latestEpiData.asp

Norovirus in care homes and transfer of residents to hospital

During an outbreak of norovirus, care homes should, as far as is possible, avoid the need to transfer residents to hospitals as this can start another outbreak. Where a GP is recommending admission of a resident from an affected care home to hospital, *even where the resident has no diarrhoea/vomiting*, the following must be done before the transfer begins:

- The hospital's clinical team who will care for the resident must be informed if the resident has, or has had, symptoms, and if there are people in the care home with symptoms
- The transfer ambulance team must also be informed if the resident has symptoms

This allows the ambulance and hospital staff to take the necessary infection control precautions and so minimise the impact of an infectious, or potentially infectious resident, on staff and patients.

Care home managers are advised to report outbreaks of diarrhoea and vomiting to the PHPU and to liaise with the Health Protection Nurse regarding closure of the home to admissions and transfers. They are also advised to contact the GPs of affected residents. Where a care home is 'closed' the PHPU will notify the infection control team at the local hospital. The HPN will advise the care home on when to 're-open' which is usually when the last reported norovirus symptom has occurred more than 48 hours before.

Health Protection Scotland has produced a policy document on general information and infection control precautions for norovirus management in care homes. Transfer of residents to hospital is discussed in Section 3.3.

http://www.documents.hps.scot.nhs.uk/hai/infection-control/norovirus/norovirus-guidance-carehomes-2011-09.pdf

If you would like to comment on any aspect of this newsletter please contact Marie Laurie on 0141 201 4933 or at marie.laurie@ggc.scot.nhs.uk