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PHPU Newsletter

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Increase in cases of pertussis in Scotland

During the first half of 2012 there has been an increase in both the number of notifications and laboratory - confirmed cases of pertussis reported in NHS GG&C. This is consistent with a general rise in pertussis across the rest of Scotland and the [wider UK](#). It is also consistent with the three or four year cyclical nature of pertussis in the community.

Epidemiological investigations are being undertaken to understand more fully this marked increase in cases, but one factor is believed to be waning immunity in individuals who have previously been vaccinated, and therefore cases will present among those with a complete history of vaccination.

Pertussis can affect individuals of all ages but young infants are at highest risk of severe complications, hospitalisation and death. Although adolescents and adults tend to display milder symptoms, they can be an important source of infection for very young infants.

The incubation period of pertussis is on average 7-10 days (range 5-21 days). The usual clinical presentation is an initial catarrhal stage with a cough that becomes paroxysmal. Paroxysms of cough usually increase in frequency and severity as the illness progresses and persist for 2-6 weeks. These paroxysms may end in vomiting, cyanosis and/or a characteristic inspiratory whoop. Patients with pertussis are most infectious in the initial catarrhal stage and during the first three weeks after the onset of cough. Symptoms slowly improve in the convalescent phase, which generally lasts 2-6 weeks but can persist for months.

Pertussis is a notifiable infection. The identification of cases should be based on clinical suspicion and not delayed pending laboratory confirmation. The PHPU has recently written to all GPs on [identification and management of suspected cases](#).

Vaccination is the most effective way to prevent spread of the disease. Health professionals are asked to continue working to maintain the high vaccine coverage of the childhood immunisation programme in Scotland and take the opportunity to offer vaccination to those who have missed doses and are not appropriately vaccinated for their age.

Flu vaccine-uptake

The [Chief Medical Officer letter of July 2011](#) set an uptake target of **75%** for both those aged 65 years and over and the 6 months to 64 years 'at risk' flu cohorts, respectively.

Provisional surveillance data provided by Health Protection Scotland as at 31st March 2012 reports an overall **75.8%** uptake across the NHS GGC Board area for those in the 'aged 65 and over' cohort, compared to **76.2%** nationally, and **57.5%** for those 'aged 6 months to 64 at risk', compared to **56.4%** nationally. *Final* uptake figures based on practice returns will be published in July.

Where the NHS GGC headline for those 65 yrs and over is favourable, the uptake for this cohort across the 266 practices ranged from **37.2% - 92.7%**, with 110 practices (43%) falling below the GGC average. For those 'at risk' where the overall GGC uptake fell significantly below the national target, uptake ranged from **18.9% - 83.6%**, with 117 practices (45%) falling below the GGC average.

On analysis across the 266 NHS GGC GP practices, flu vaccination uptake did not correlate with practice list size, location or deprivation factors.

Clearly then, with the 2012/2013 flu season commencing 1st October, there is opportunity for localities to explore why there is such a significant variation in uptake between neighbouring practices. The PHPU would urge those practices falling below the average GGC uptake to look at key areas such as: flu cohort identification; call/recall approach; advertising; clinic/vaccination approach; appointment/clinic reminders, and to discuss with their locality Clinical Director best-approach sharing with the GP practices that are achieving the national targets or significantly above national/GGC average uptake (uptake data broken down by practice per CH(C)P area will be provided to Clinical Directors).

From a recent NHS GGC GP Practice survey on call/recall approach, it was found that those practices which send a 'call' letter to those aged 65 yrs and over, on average, achieved a **6%** higher uptake than those practices that rely solely on the national letter. It was also found that those practices that subsequently 'recalled' those aged 65 and over achieved a **2%** higher uptake than those that did not.

Practices may also be interested in the variation in overall uptake between the individual 'at risk' clinical groups. This information may inform patient identification, call/recall, advertising, and clinic approach strategies.

Note: The relative risk of death across Scotland from flu last winter in individuals in the various clinical risk groups. was highest in those with chronic liver disease. Although numbers were small similar results were obtained on death data analysis in England.

Hep C: testing, referral and treatment

At the end of 2011 12,743 people had been diagnosed as *ever having been infected* with hepatitis C (HCV) in NHS GGC, representing 40% of all diagnoses in Scotland. Where route of infection is known, 91% of cases were acquired through Injecting Drug Use (IDU). HPS estimates the majority of infected individuals remain undiagnosed.

HCV treatment is increasingly effective and the virus can be cleared in the majority of patients who complete a course of therapy. This year has seen the launch of new drugs that increase the cure rate to over 80% in patients with a suitable genotype. The Viral Hepatitis MCN is keen to increase the number of chronic cases diagnosed and referred to hospital for clinical assessment and treatment.

Current and recent Injecting Drug Users (IDU)

In 2010, the prevalence of HCV antibodies among clients attending needle exchanges in GGC was 68%. IDU are more likely to have damaged peripheral veins, which makes venepuncture more difficult for healthcare providers and patients. To support diagnostic activity Dried Blood Spot testing kits are being made available to GPs who work with addiction patients. This technology is validated by the Specialist Virology Laboratory for confirmation of hepatitis C antibody and PCR status. The kits can also be used to check for HBV and HIV infection, where indicated.

All GPs working to the addiction LES will be sent an initial supply of kits and details on how to order more. It's recommended that all current and recent IDU should be offered testing for hepatitis C. HIV testing should also be offered where indicated. Uninfected IDU who are at ongoing risk should be offered annual testing.

Former Injecting Drug Users

HCV is a slowly progressive disease which is often asymptomatic in chronically infected cases. It is likely that many former injectors have been infected and living with the virus for a number of years. People who have moved away from injecting are likely to be less chaotic and ideal candidates for treatment. NHSGGC is keen to reduce the level of undiagnosed infection amongst this population.

Public Health and the GP IT team are developing a case-finding tool that will identify patients with a history of HCV risk so that they can be offered a discussion and testing. When ready, this service will be promoted to GPs. In the meantime, GPs are encouraged to offer HCV testing to patients who are former injectors.

For further information

See the Viral Hepatitis MCN website for local information and links: www.hepnet.scot.nhs.uk

In 2011, there were 1677* cases of malaria reported in the UK (see table below).

Persons diagnosed HCV antibody positive in GGC		
Year	Annual	Cumulative
2006	560	9,102
2007	604	9,706
2008	617	10,323
2009	848	11,171
2010	853	12,024
2011	719	12,743

Source: [HPS \(2012\)](#)

Malaria - advice for travellers to endemic areas

In 2011, there were 1677 case of malaria reported to the HPA Malaria Reporting Laboratory (MRL).

This is slightly less than the 1761 cases of malaria in 2010, but 12% more than the 1495 in 2009, and a 22% increase compared to 1370 reported in 2008. This trend is against a background of falling malaria incidence globally over the last five years, and probably reflects greater travel to malaria-endemic areas.

Of the malaria cases in 2011, 69% (compared with 72% in 2010) were caused by (the potentially fatal) *Plasmodium falciparum* and this high proportion of falciparum malaria reflects the fact most malaria imported to the UK is acquired in Africa. The proportion due to vivax malaria has however also risen in recent years, mainly as a result of increased vivax cases acquired in Pakistan (182 reported in 2011 compared to 73 in 2010 and 46 in 2009).

Eight deaths from malaria in 2011 have been reported to date; 6 from falciparum malaria acquired in Africa and 2 from vivax malaria acquired in India.

Some groups are at particular risk of acquiring malaria and are not being reached by health messages about the importance of antimalarial prophylaxis. Of those who had malaria diagnosed in the UK, where ethnicity was known, 136 were reported as white British, compared with 938 who were reported as African or of African descent and 395 reported as Asian or of Asian descent. The burden of falciparum malaria in particular falls heavily on those of African ethnicity, and this group is important to target in pre-travel advice.

An [analysis](#) of malaria deaths over 20 years in the UK and published in the BMJ March 2012 has shown the following.

Risk of acquisition is higher in:-

- those of African/Asian ethnicity travelling to endemic areas to visit friends/relatives
- those who fail to take prophylaxis

Risk of death is higher in:-

- holiday travellers (tourists)
- elderly travellers, and in particular, tourists - mortality from malaria increases steadily with age in the UK
- those who are treated in UK regions where fewer malarial cases are seen
- those who present in the month of December

Practice staff who provide pre-travel advice are reminded to target those travelling to endemic countries, *especially* elderly tourists and those of African/Asian ethnicity travelling to visit relatives/friends, on the importance of malarial prophylaxis, prevention measures and the need to seek medical attention if unwell on return. GPs should contact the Brownlee Centre for advice if a traveller returns from an endemic country with a febrile illness.

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

Year	Cases of malaria
2011	1677
2010	1761
2009	1495
2008	1370