Influenza vaccine now recommended for all aged 50+

This year, the annual influenza vaccine is recommended for all people aged 50 years and over by the National Immunisation Advisory Committee. Influenza vaccine is provided free of charge for all those aged 50 years and over, those in at-risk groups and healthcare staff as outlined below. Those that do not have a medical card or GP visit card will be liable for a consultation fee.

- All people aged 50 years and over.
- Adults and children over six months of age with any of the following chronic illnesses requiring regular follow-up (e.g. chronic respiratory disease, including cystic fibrosis, moderate or severe asthma, chronic heart disease, diabetes mellitus, etc.).
- Persons whose immune system is suppressed due to disease or treatment, including those with missing or non-functioning spleens.
- Children and teenagers on long-term aspirin therapy.
- Residents of nursing homes, old peoples’ homes and other long-stay facilities.
- Healthcare staff.
- Carers who have direct patient contact.
- Poultry workers, veterinary inspectors, park rangers and those with likely contact with water fowl (as this puts them at risk of co-infection with avian influenza).

As highlighted above, healthcare workers are recommended to get the influenza vaccine, both for their own protection and for the protection of their families and colleagues/patients. With growing concern that an influenza pandemic is imminent, it is important that all HSE staff, whether hospital, community or office based, avail of the vaccine. For the 2006/2007 influenza season only 11% of HSE staff availed of the vaccine. This year, we hope to improve our uptake rates. We ask all HSE staff to avail of the opportunity to get vaccinated and encourage their colleagues to do likewise. This vaccine is available free of charge from the Occupational Health Department.

From October to December 2008, the Occupational Health team plan to hold vaccination clinics at various workplaces in the region. Details of dates and times of clinics in your area are enclosed and will also be available on noticeboards in your place of work. Alternatively, you may contact the Occupational Health Department on 057 93 59137/8/9.

Should you have any concerns or queries regarding the vaccine, please contact Ms Catherine Samuels, Occupational Health Manager, on 086 8157401, who will be happy to be of assistance.
New Childhood Immunisation Schedule 2008

A new schedule for the Primary Childhood Immunisation Programme will begin in September 2008 for all children born on or after July 1st 2008. Two new vaccines are being introduced into the schedule – Hepatitis B and the Pneumococcal Conjugate Vaccine (PCV). In addition, a pneumococcal catch-up campaign will begin in September for all children under two years of age, i.e. born between 2nd September 2006 and 30th June 2008.

The new Hepatitis B vaccine will be incorporated into a new 6 in 1 vaccine with Diphtheria, Tetanus, Pertussis, Polio and Haemophilus influenzae. The PCV will be a separate vaccine given at 2, 6 and 12 months of age. It can be given at the same time as other vaccines. Both the UK and US childhood immunisation schedules allow for the administration of three injections at the same time without any additional adverse effects. The 6 in 1 and Men C should be given in one thigh (at least 2.5 cm apart) and the PCV in the other. To help determine any local side-effects of the different vaccines the vaccination sites should be recorded.

As a result of the new vaccines, there are some changes to the timing of the Men C vaccine and the Hib booster in this new schedule. The Men C will be given at 4, 6 and 13 months (instead of 2, 4 and 6 months). The Hib Booster dose is to be given at 13 months of age instead of 12 months.

As mentioned above, the catch-up campaign with PCV for children under two will start in September. The number of doses to be given will depend on the age of the child:

Table 1. PCV catch-up campaign for those aged under 2 years on 30th June 2008.

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>No. of Doses Required</th>
<th>When to Vaccinate</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/09/06 – 31/07/07</td>
<td>1</td>
<td>Before 31st January 2009</td>
</tr>
<tr>
<td>01/08/07 – 29/02/08</td>
<td>1</td>
<td>13 months of age</td>
</tr>
<tr>
<td>01/03/08 – 30/06/08</td>
<td>2</td>
<td>6 months and 13 months</td>
</tr>
</tbody>
</table>

All children born before July 1st 2008 should continue with the old primary childhood immunisation schedule.

Table 2. Early childhood immunisation programme, current and new.

<table>
<thead>
<tr>
<th>Age</th>
<th>Changes in Primary Childhood Immunisation Programme (by age)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current Schedule (up to 31st August 2008)</td>
</tr>
<tr>
<td>2 months</td>
<td>5 in 1 + Men C</td>
</tr>
<tr>
<td>4 months</td>
<td>5 in 1 + Men C</td>
</tr>
<tr>
<td>6 months</td>
<td>5 in 1 + Men C</td>
</tr>
<tr>
<td>12 months</td>
<td>MMR + Hib</td>
</tr>
<tr>
<td>13 months</td>
<td>-</td>
</tr>
</tbody>
</table>

The Midlands Region has the highest immunisation uptake rates in the country.

According to a recently published report by the Institute of Public Health in Ireland, “Irish Health Poverty Index (interim release),” childhood immunisation uptake in the Republic of Ireland was variable, with the highest average uptake in the Midlands (Laois 98%, Offaly 98%, Longford 97%, Westmeath 97%). The counties with the lowest average immunisation uptake were Waterford (83%), Kildare (86%), Wicklow (86%), Dublin (87%) and Westport (88%).

Outbreak of Legionnaires’ disease in a Dublin workplace

Public Health colleagues in Dublin are currently investigating an outbreak of Legionnaires’ in a Dublin company after two staff members were diagnosed with the disease. The company suspects that a cooling tower was part of the company’s air-conditioning system may be the source of the outbreak.

Legionnaires’ disease (LD) is a rare form of pneumonia caused by the Legionella pneumophila. It was first identified at an American Legion convention in 1976 in Philadelphia, USA. Early symptoms include a dry cough, fever and muscle aching. Diarrhoea and confusion may occur. The illness eventually progresses to a severe debilitating pneumonia which has a 10-20% mortality rate. The diagnosis is most commonly made by rapid urinary antigen testing. LD can be treated effectively with erythromycin, ciprofloxacin or ceftriaxone. A milder form of the disease – Pontiac fever – is a self-limiting flu-like illness which lasts 2 to 5 days and does not require treatment.

Epidemiology

Legionnaires’ disease is a statutorily notifiable disease. In Ireland, in 2007, 16 cases of LD were notified to the Health Protection Surveillance Centre (HPSC), giving a crude incidence rate of 3.6 per million. This is an increase on previous years but well below an expected rate of 20 per million. This underestimation of the true likely incidence is thought to be due to successful clinical treatment of the pneumonia without a definitive diagnosis and failure to notify all cases.

Cases can be sporadic, i.e. not associated with any other case, or they can present in clusters or outbreaks where more than one case is associated with a single source within a six-month time period. The incubation period for LD is between two and 10 days, although cases with incubation periods of up to 19 days have been documented.

Approximately 60% of cases in Ireland over the last decade have been travel-acquired, 31.3% were community-acquired and 7.5% were nosocomial (acquired in a healthcare facility). Anyone can get LD but it is more common in older age groups (≥50 years), men, smokers, and those with a chronic underlying disease and/or an associated immunodeficiency. The likelihood of a person developing LD is based on their individual susceptibility, the quantity of Legionella they are exposed to and the duration of exposure.

Source of infection

People become infected when they inhale Legionella bacteria which have been released into the air in aerosolised form from a contaminated source. Any mechanical action that causes the surface of a contaminated liquid to break up may cause this to happen. Recognised sources of aerosols include showers, fountains, humidifiers, spa pools, whirlpool baths, car washes and some respiratory therapy equipment. Legionnaires’ disease is not normally transmitted by drinking water, but infection can occur as a result of aspiration of contaminated water in people with swallowing disorders. Person to person transmission has not been documented.

Legionella bacteria is widely distributed in the environment and can be found in both natural and artificial water sources. Legionella is commonly found in water towers associated with cooling systems, hot and cold water systems and spa pools. It does not multiply under 20°C and does not survive over 60°C but thrives in water between these two temperatures. Conditions leading to stagnation within water systems, such as unused capacity and blind-ending pipework (dead legs), in addition to the presence of sediment, sludge, scale and biofilm (complex aggregation of microorganisms marked by the excretion of a protective and adhesive matrix), allow Legionella to survive and multiply. While chlorine kills Legionella bacteria, it is generally present at levels and in conditions that may not kill Legionella living in biofilm, and chlorine may not reach distal sites in a water distribution system.

Prevention

Control of LD is through planned organised design, maintenance and treatment of water systems which are or may be a source of Legionella bacteria. Guidelines for maintenance are provided by the UK Health and Safety Commission. The principles of maintenance include disinfection and treatment of water systems; cleaning and replacement of tanks, pipes and boilers; maintenance of cold water temperatures below 20°C and hot water above 50°C; prevention of water stagnation by reducing unnecessary capacity, unused outlets and regular flushing of infrequently used taps and showers. For further information, please see the documents below.

