Closing the Loop

June 2004

Communicable Disease Bulletin for the Eastern Regional Health Authority

Contents Issue 2:

Editorial Board

Contact details

Department of Public Health
Eastern Regional Health Authority
Dr Steevens' Hospital
Dublin 8

Tel: 01 679 0700
Fax: 01 635 2103
E-mail: public.health@erha.ie

Introduction

Welcome to the second issue of Closing the Loop. Thank you for your comments and suggestions about the first issue. Contact details for community care areas now include fax numbers.
The notification of infectious diseases is a dynamic and ongoing process and therefore the data presented in this document are provisional unless otherwise stated. The first issue was distributed in paper format by post. We are in the process of setting up an electronic distribution list for further issues, in addition to the postal list. Please send us your email address if you would like to be added to our electronic distribution list. **We also need your email address for urgent communication about infectious diseases. Let us know at: public.health@erha.ie**

New Infectious Diseases Legislation

On January 1st 2004 an amendment to the Infectious Diseases Regulations 1981 (Infectious Diseases (Amendment) (No. 3) Regulations 2003, S.I. No. 707 of 2003) came into effect. A number of changes have been introduced which include:

- A revised list of notifiable diseases, along with standardised case definitions
- Laboratory directors are now legally required to report infectious diseases.

The most notable changes to the list of notifiable diseases are:

- The number of notifiable diseases increases from 50 to 68.
- Some diseases are no longer notifiable, as they do not require public health action: (Candidiasis, pediculosis pubis, molluscum contagiosum, infectious mononucleosis and ornithosis).
- "Food poisoning" has been removed as a category; food- and water-borne illnesses are now specified individually (e.g. campylobacteriosis, cryptosporidiosis, listeriosis and staphylococcal food poisoning).
- The age cut-off for gastroenteritis has been removed and all individual causes of gastroenteritis are now notifiable. Where there is no known infectious cause the illness should be notified as acute infectious gastroenteritis.
- Possible biological threat agents such as botulism and tularemia have been added.
- Hepatitis C is now specified.
- Hepatitis B must be notified as either acute or chronic infection.
- Several pathogens that are important in the monitoring of antimicrobial resistance are notifiable: *Enterococcus spp, Staphlococcus spp.*
- Listing both diseases and pathogens also reflects the fact that laboratories are now notifiers.
- Outbreaks are now included in the new schedule. An outbreak of infection or food-borne infection is defined as: two or more linked cases of the same illness, or where the number of observed cases exceeds the expected number or a single case of disease caused by a significant pathogen (e.g. diphtheria or viral haemorrhagic fever).
- Unusual clusters or changing patterns of illness that may be of public health concern must also be reported.
- Registrars of Births, and Deaths are required to notify deaths due to infectious diseases.

All notifiable diseases are defined by a set of clinical and microbiological characteristics. A number of general principles underlie the use of these case definitions:

- Unless specifically stated, only symptomatic cases are to be reported.
- If the infection has therapeutic or public health implications, asymptomatic infections are to be regarded as cases,
- A "case with an epidemiological link" is a case that has either been exposed to a confirmed case, or has had the same exposure as a confirmed case (eaten the same food, stayed in the same hotel etc).
- 3-tiered classification is now in use:
- **Confirmed case:** verified by laboratory analysis.
- **Probable case:** clear clinical picture, or linked epidemiologically to a confirmed case.
- **Possible case:** indicative clinical picture without being a confirmed or probable case.

The clinical symptoms listed provide a general outline of the disease.
For most diseases several "criteria for laboratory diagnosis" are listed; however, unless otherwise stated, only one of these is needed to confirm a case.

A complete list of case definitions along with notification forms is being distributed to all potential notifiers by the Department of Public Health; a list is currently available on the NDSC website: www.ndsc.ie. In each issue of Closing the Loop, where individual diseases are discussed in detail the case definitions will be included.

Topical Disease

Tuberculosis

Tuberculosis (TB) is a curable infectious disease caused by the tubercle bacillus – also known as *Mycobacterium tuberculosis or M. tuberculosis*. It is transmitted from person to person via the respiratory tract. A patient with infectious TB coughs, sneezes or speaks and disseminates small droplets containing tubercle bacilli into the air. These tiny droplets float in air; the fluid evaporates, and the living tubercle bacillus may remain air-borne for long periods. Another individual who inhales the organism may then become infected. The risk of transmission depends upon the amount of bacilli in the sputum, the nature of the cough and duration of the interaction and the susceptibility of the contact.

The initial entry of tubercle bacilli into the lungs of a previously uninfected individual causes a non-specific acute inflammatory response, which is rarely noted and is usually accompanied by few or no symptoms. This is called tuberculous infection and the individual:

- Has no symptoms
- Cannot spread TB to others
- Usually has a positive skin test reaction
- Can develop TB disease later in life or may never develop TB disease
- Hilar lymph node enlargement is usually seen on a chest x-ray.

In the minority who do not successfully contain their primary TB infection, tuberculosis – **the clinical disease** – develops. This is usually due to reactivation of a previous infection or reinfection in a person whose health status has declined. When "acid-fast bacilli" are seen in sputum a person is said to have sputum smear-positive tuberculosis, which is sometimes called "open" or infectious TB.

While tuberculosis can affect any part of the body, it usually affects the lungs and when it does the most common symptoms are:

- Cough – lasting for more than two weeks and sometimes with blood stained sputum
- Shortness of breath
- Loss of appetite and weight loss
- Fever and sweating – particularly at night
- Extreme fatigue and tiredness
- Symptoms of active TB involving areas other than the lungs vary depending on the organ affected.

Key Points

- The incidence of TB has decreased over the past decade both nationally and in the ERHA region. Figure 1 shows the number of cases in each area health board for the period 1998 to 2002, while Figure 2 shows the crude rates per 100,000 population.
- There were 163 cases of TB in 2002 in the region. Sixty-three cases were female (39%) and one hundred were male (61%).
- Table 1 provides a summary of some of the epidemiological features of TB between 1998 and 2002.
- Figure 3 shows the number of cases in each community care area in 2002; the highest numbers of cases were seen in CCAs 3, 6, 7 and 5; these areas, which cover the north and south inner city and West Dublin, are areas of poverty, unemployment, social disadvantage and high rates of illicit drug use.
- Ninety-four cases (58%) were aged between 15 and 44 years, while 34 (21%) were aged over 65 years.
- The majority of cases (64%) were born in Ireland and 59 (36%) were of foreign nationality, reflecting an increase in notifications in non-nationals compared to the 2000 figure of just over 18%. Twenty of these patients came from countries where the incidence of TB is high.
- There were 14 cases of HIV associated TB, compared to five cases in 2001.
- One hundred and fifteen cases were pulmonary TB.
- Drug resistance is becoming a problem in the region. Resistance to one or more antibiotics was seen in eight people with TB.
- Eleven people died following a diagnosis of TB; TB was considered to be the cause of death in two of the cases.

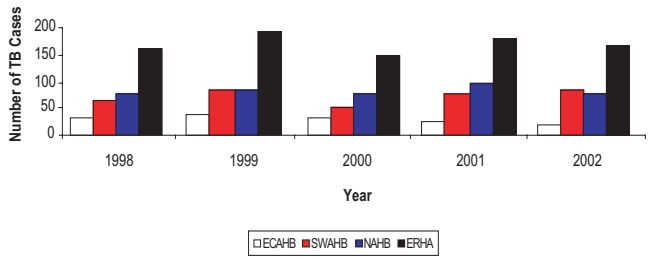

Figure 1 Cases of TB in area health boards

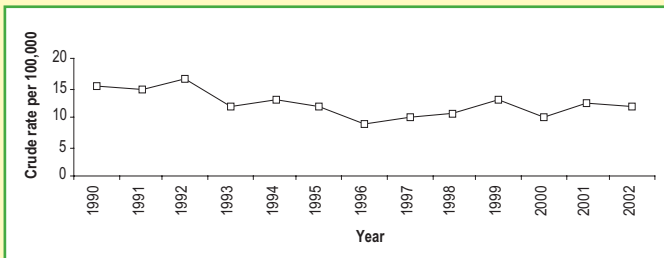

Figure 2 Crude rates per 100,000 population

	1998	1999	2000	2001	2002
Total number of cases	152	185	143	173	163
Indigenous population	129	140	118	136	104
Non-nationals	23	45	23	47	59
Culture positive TB cases	106	111	106	122	83
Smear positive pulmonary disease	53	51	54	61	49
Drug resistance	1	2	2	8	8
TB Meningitis	2	4	1	0	2

Table 1 Summary of TB epidemiology from 1998 to 2002

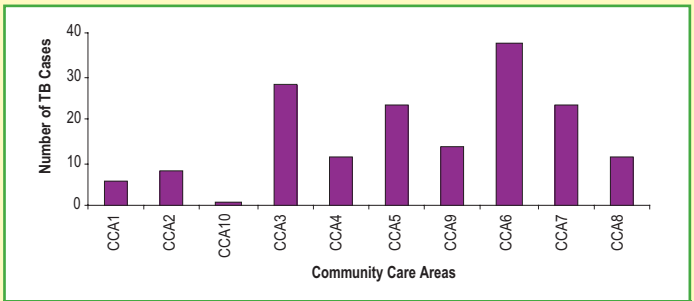

Figure 3 TB Cases in CCAs in 2002

Control of TB

Tuberculosis is controlled in the ERHA through a number of measures:

- Early identification and prompt and effective treatment of persons infected with *M.tuberculosis*
- Examination of close contacts of cases, i.e. contact tracing
- Screening of asylum seekers and refugees
- A BCG immunisation programme.

TB Contact Tracing in ERHA

The notification of TB initiates the contact tracing process, the aim of which is the identification of undiagnosed tuberculosis infection and the follow-up of latent TB. Public health doctors and nurses working in the Community Care Areas have responsibility for the contact tracing process. Contacts are screened using screening questionnaires and a Mantoux test, recommended by the WHO as the gold standard.

Contact tracing clinics are provided at three hospital clinics attached to TB/Respiratory Units, in the Mater Hospital, St.Vincents's Hospital and St.James's Hospital. A Consultant Respiratory Physician is available at these clinics to give advice. Contact tracing is also provided locally in Kildare and Wicklow.

Family contacts are referred to one of the TB clinics for screening. Contacts in a workplace, school or other institution are screened on-site by a team comprising an Area Medical Officer, a Public Health Nurse and administrative support and are referred to one of the TB contact tracing clinics if follow-up is required. Asylum seekers are offered screening by health questionnaire and by chest x-ray if they are not dispersed before this can be carried out. Cases of TB are referred to Consultant Physicians and they and their contacts are followed up in the normal way.

BCG Vaccination

The Bacillus Calmette-Guerin (BCG) vaccine is a strain of *Mycobacterium Bovis* that causes TB in cattle. It has been modified so that it produces immunity against TB without causing the disease. It is a live vaccine, but does not cause disease and does not contain any bovine tissue.

It is policy in the eastern region to provide neonatal BCG vaccination in the maternity hospitals and in BCG clinics in community care areas as a back up service.

Response to BCG vaccine

Following intradermal administration of BCG, a local reaction (a small red spot) normally develops at the injection site within 2-6 weeks. This increases in size for a few weeks, widening into a circular area up to 7mm in diameter with scaling, crusting and occasional bruising. Occasionally, a shallow ulcer up to 10mm in diameter develops. The lesions slowly subside over several months and eventually heal leaving only small flat scars.

Severe injection site reactions, large ulcers and abscesses are most commonly caused where some or the entire dose is administered too deeply (subcutaneously instead of intradermally). People with severe reactions should be referred to a physician familiar with the treatment of such complications.
A minor degree of adenitis may occur in the weeks following immunisation and should not be regarded as a complication. Occasionally the lymph node process becomes suppurative followed by adhesion to the skin and fistula formation usually three to six months after vaccination. The process is benign and heals spontaneously.

Remember, treating TB takes a long time, preventing it is much easier.

Contact details for notification of infectious diseases.

Points to remember:
Please return notification forms to the Director of Public Health, Eastern Regional Health Authority, Dr Steevens' Hospital, Dublin 8.
Where immediate action may be required in order to identify and advise contacts, please notify the Senior Area Medical Officer in your CCA.

C.C.A	Contact number		Address
1	Tel: 284 3579	Fax: 280 8785	Tivoli Road, Dun Laoghaire, Co. Dublin.
2	Tel: 269 8222	Fax: 283 0002	Vergemount Hall, Clonskeagh, Dublin 6.
3	Tel: 648 6500	Fax: 648 6600	1-25 Lord Edward Street, Dublin 2.
4	Tel: 415 4700	Fax: 415 4804	Old County Road, Crumlin, Dublin 12.
5	Tel: 620 6300	Fax: 620 6358	Cherry Orchard Hospital, Ballyfermot, Dublin 10.
6	Tel: 868 0444	Fax: 868 0394	Rathdown Road, Dublin 7.
7	Tel: 857 5400	Fax: 857 5449	193 Richmond Road, Dublin 3.
8	Tel: 816 4200	Fax: 847 9944	Cromcastle Road, Coolock, Dublin 5.
9	Tel: 045 981 800	Fax: 045 981870	Beech House, Dublin Roads, Naas, Co Kildare
10	Tel: 0404 68 400	Fax: 0404 69044	Glenside Road, Co. Wicklow.

SARS

Although the level of risk of SARS in Ireland is very low, there is a need for continuing vigilance. The WHO provides updated information on its website: www.who.int. The SARS Department of Health and Children Expert Group has produced a number of documents, which have been issued to all GPs in the region and which are also available along with any updates on the NDSC website: www.ndsc.ie

1. Severe Acute Respiratory Syndrome (SARS): Interim Guidelines for Health Care Professionals

2. Interim Guidance for General Practitioners on the investigation and management of severe acute respiratory syndrome.

The following are important from a GP perspective:

SARS case definitions:

The case definition depends on whether there is currently person-to-person SARS transmission activity anywhere in the world. To fulfil the clinical definition of SARS a patient should have:

- One or more symptoms of lower respiratory tract illness and
- A fever >= 38°C and
- Radiographic findings consistent with pneumonia or respiratory distress syndrome and
- No alternative diagnosis to fully explain the illness.

A detailed travel history from patients with symptoms and signs consistent with SARS should be taken in order to determine if other family members and/or close contacts have had a similar illness within 10 days prior to the patient's onset of illness.

Infection control precautions:

- Patients should be assessed at home initially, if possible.
- If a patient presents at the GP surgery with a SARS-like history they should be isolated immediately. Other practice staff should be aware of this advice.
- Appropriate precautions should be taken when examining, or taking samples from a potential SARS case to prevent the spread of infection. These include hand hygiene, use of personal protective equipment (gloves, gowns, eye protection and a mask/respirator) and correct donning and removal of personal protective equipment.
- Hand hygiene is the most important measure in preventing the spread of infection with SARS.

Notification

- Potential cases of SARS should be notified to the Director of Public Health immediately by telephone and followed by written notification.

Hospital referral

- Patients meeting the possible case definition should be referred to hospital for further investigation
- Hospital and ambulance staff should be informed in advance that a potential SARS case is being transferred and the patient should wear a surgical mask on transfer.

Packs of personal protective equipment (PPE) are currently being prepared and will be distributed to GPs in the event of changes in the level of risk from SARS. Ireland is presently a low risk area for SARS but in the event of this situation changing the Director of Public Health will advise GPs without delay. **In order to communicate quickly with you we would like to have your contact details: email address or alternatively fax number please.**

Varicella Zoster Infections

Not a trivial illness

Infection with the varicella zoster virus (VZV) causes two distinct clinical syndromes: chickenpox and shingles (herpes zoster). Primary infection results in chickenpox, which is an acute highly infectious disease that is transmitted directly by personal contact or droplet spread and indirectly by fomites. Herpes zoster is caused by reactivation of the patient's varicella virus. People with shingles are contagious to those who have not had chickenpox. However, it is not possible to catch shingles from a person who has chickenpox.

The incubation period for chickenpox is 14 to 21 days. There is sometimes a prodromal illness of fever, headache and myalgia. Crops of vesicular spots usually starting on the trunk follow this. The virus is plentiful in the nasopharynx in the first few days and in the vesicles before they dry; the infectious period is therefore from 1 to 2 days before the rash appears until the vesicles dry. The severity of the infection varies and it is possible to be infected but show no symptoms.

However, it can be more serious in neonates, adults, in particular pregnant women and those who are compromised due to illness or treatments such as chemotherapy or high dose steroids. Complications in these groups may include viral pneumonia, secondary bacterial infections and encephalitis.

Risks to the foetus and neonate from maternal chickenpox are related to the time of infection in the mother:

- In the first 20 weeks of pregnancy: congenital varicella syndrome, which includes limb hypoplasia, microencephaly, cataracts, growth retardation

and skin scarring. The mortality rate is high. The incidence is estimated at 1% in the first 12 weeks and around 2% between weeks 13 and 20.
- In the second and third trimesters of pregnancy: herpes zoster in an otherwise healthy infant.
- A week before or after delivery: severe and even fatal disease in the neonate.

The Immunisation Advisory Committee of the Royal College of Physicians of Ireland, Immunisation Guidelines recommends passive immunisation with varicella-zoster immunoglobulin (VZIG) for individuals who fulfil the following criteria:

- **Significant exposure to**
  - Chickenpox **or**
  - Disseminated zoster **or** extensive exposed lesions in immunocompetent individuals **or**
  - Localised or disseminated zoster in immunocompromised **plus**
- **A clinical condition which increases the risk of severe varicella (neonates, pregnant women and immunosuppressed patients) plus**
- **No antibodies to varicella-zoster virus**

Health care workers without a definite history of chickenpox, particularly those working with haematology, oncology, obstetrical, general paediatric or neonatal patients should be routinely screened for VZV antibody. Vaccination should be offered to non-immune staff. Non-immune workers, who have had a significant exposure to varicella zoster, should, wherever possible, be excluded from contact with high-risk patients from eight to 21 days after exposure.

Hepatitis B Immunisation

Since 1996, the Immunisation Guidelines for Ireland have recommended hepatitis B vaccine for those in high-risk groups who are not already immune. Ideally, immunisation should be carried out before the risk of exposure to hepatitis B, but it may also follow exposure (post exposure prophylaxis). The following groups should be immunised if non immune:

1. Health care personnel

2. Patients and family contacts:
   - Spouses, sexual partners, family and household contacts of acute cases and carriers of hepatitis B
   - Families adopting children from countries with a high prevalence of hepatitis B
   - Babies born to mothers who are chronic carriers of hepatitis B or who had acute hepatitis during pregnancy – Vaccinate within 24 hours of birth
   - People with haemophilia and those receiving regular transfusions
   - Patients and carers in institutions for those with intellectual disability (including day care facilities and school service)
   - Patients with chronic renal failure

3. Security and emergency services personnel

4. Susceptible members of high risk groups
   - Individuals who change sexual partner frequently, particularly homosexual and bisexual men, and men and women who are sex workers
   - Intravenous drug users
   - Prisoners
   - Tattoo artists
   - Immigrants from, or travellers to, areas with a high prevalence of hepatitis B
   - Homeless people

Hepatitis B vaccine is available from CCA headquarters. The Immunisation Guidelines contain details of post exposure prophylaxis. These guidelines and further information on Hepatitis B may be found on: www.ndsc.ie.

Preventing Spread of Infection: Standard Precautions

Remember all blood and body fluids are potentially infectious. Standard precautions are simple actions, which decrease the risk of transmission of blood-borne diseases by needle-stick accidents or fluid contact with an open wound, non-intact skin or mucous membrane. Hand hygiene, is critical not only in the control of infectious intestinal diseases but also in the prevention of health-care associated infection by reducing the incidence of cross infection. It is the single most important part of infection control.

Summary of standard precautions

Hand washing
- Wash hands between patient contacts.
- Wash hands after touching blood, body fluids, secretions, excretions and contaminated items
- Wash hands immediately after removing gloves

Gloves
- Wear gloves when touching blood, body fluids, secretions, excretions and contaminated items
- Change gloves between patients

Mask, eye protection, face shield & apron/gown
- Wear a mask and eye protection or face shield to protect mucous membranes of the eyes, nose and mouth in any situation where splashes of blood or body fluids may occur.
- Wear a gown to protect skin and prevent soiling of clothing.

Equipment

- Soiled equipment and clothing should be safely removed and decontaminated.
- Reusable equipment must be cleaned and reprocessed appropriately before being used for another patient

Environmental control

Develop procedures for routine care, cleaning and disinfection of furniture and the environment.

Linen

Soiled linen should be handled in a manner to prevent skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other patients and to the environment.

Sharps

- Take sharps bin to site of use and dispose of sharps directly into sharps bin immediately after use.
- Dispose of sharps bin immediately when it reaches full mark (indicated by arrow).
- **NEVER** recap needles.
- Do **NOT** handle syringes without gloves.
- Do **NOT** use clinical bins for sharps disposal.
- Do **NOT** use general-purpose bins for sharps disposal.

Immunisation Update

The immunisation target in Ireland is for 95% of children to have completed the immunisation schedule by two years of age. If this is achieved and maintained it is possible to eradicate and control vaccine-preventable diseases and future outbreaks can be avoided.

The immunisation uptake rates for children born between 01/01/2002 and 31/12/2002 and who had received three doses of DTaP, IPV, Hib and MenC by the time they were 12 months old are presented in table 2 for each of the area health boards. Rates for each quarter refer to the cohort of children born in the corresponding quarter the previous year.

% Uptake at 12 months
Cohort born 01/01/2002 – 31/12/2002

Health Board		%DT	%P	%Polio	%Hib	% Men C
NAHB	Q1-2003	77.1	76.9	77.0	77.0	79.6
	Q2-2003	76.3	76.1	76.1	76.3	77.9
	Q3-2003	76.7	76.7	77.0	76.9	75.9
	Q4-2003	78.0	78.0	78.0	78.0	77.0
		%DT	%P	%Polio	%Hib	% Men C
SWAHB	Q1-2003	71.6	71.4	71.4	71.7	74.7
	Q2-2003	70.8	70.8	70.7	70.7	72.4
	Q3-2003	71.1	71.1	71.1	71.1	70.3
	Q4-2003	74.7	74.6	74.7	74.7	73.7
		%DT	%P	%Polio	%Hib	% Men C
ECAHB	Q1-2003	79.4	79.2	78.9	79.1	83.6
	Q2-2003	79.4	78.8	79.2	79.2	81.9
	Q3-2003	78.1	77.6	78.0	77.9	77.6
	Q4-2003	78.0	77.2	77.6	77.6	76.9

Table 2: % uptake at 12 months

% Uptake at 24 months
Cohort born 01/01/2001 – 31/12/2001

Health Board		%DT	%P	%Polio	%Hib	% Men C	%MMR
NAHB	Q1-2003	79.0	78.6	78.2	78.8	71.7	68.2
	Q2-2003	82.6	82.5	82.4	82.3	77.8	74.0
	Q3-2003	82.0	81.5	81.8	81.7	78.9	72.8
	Q4-2003	76.0	75.4	75.9	76.0	73.8	69.4
		%DT	%P	%Polio	%Hib	% Men C	%MMR
SWAHB	Q1-2003	82.7	81.8	79.2	82.3	79.0	71.4
	Q2-2003	82.9	82.4	82.4	82.5	79.2	72.0
	Q3-2003	82.7	82.3	82.4	82.4	79.8	73.6
	Q4-2003	85.2	84.8	84.8	84.8	82.8	76.3
		%DT	%P	%Polio	%Hib	%Men C	%MMR
ECAHB	Q1-2003	85.3	83.8	84.7	84.8	81.9	75.8
	Q2-2003	85.1	83.6	84.4	84.3	82.5	76.6
	Q3-2003	87.0	86.2	86.5	86.5	84.7	79.2
	Q4-2003	85.5	84.6	84.5	85.0	84.1	78.2

Table 3: % uptake at 24 months

The immunisation uptake rates for children born between 01/01/2001 and 31/12/2001 and who had received three doses of DTaP, IPV, Hib and MenC and one dose of MMR by the time they were 24 months old are presented in Table 3 for each of the area health boards. Rates for each quarter refer to the cohort of children born in the corresponding quarter two years previously.

Immunisation Rate Update at 12 months of Age in ERHA by Year and by Quarter

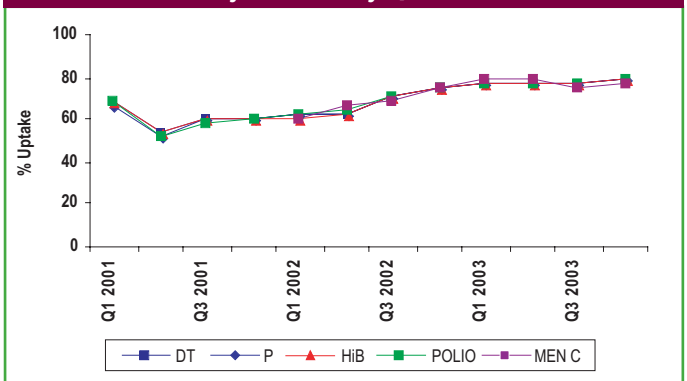

Figure 6: Quarterly immunisation uptake rates AT 12 months in ERHA

Immunisation Rate Update at 12 months of Age in ERHA by Year and by Quarter

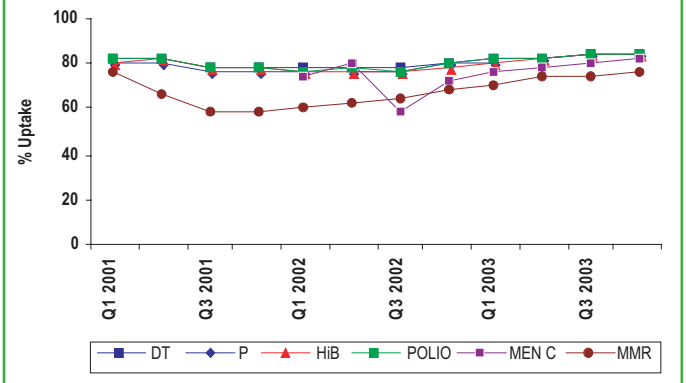

Figure 7 Quarterly immunisation uptake rates at 24 months in ERHA

Figures 6 and 7 show the uptake rates for individual vaccines over the last three years. While there has been some improvement we are still below the desired target rate.

Key Points

- The uptake of childhood immunisation is still below the desired target.
- A team (medical, nursing and clerical) in the ECAHB is currently dealing with a backlog in the schools immunisation programme.
- A targeted focus on immunisation black spots is being undertaken in ERHA.

Feedback on immunisation uptake is sent to each CCA. This identifies the District Electoral Division (DED) where uptake rates fall below 70%.

- A new immunisation information booklet for parents has been developed: *Immunisation – A Guide For Parents*. This is being distributed throughout the area health boards and is also available on www.erha.ie
- Information leaflets in French, Portuguese and Romanian have also been developed and have been distributed to – They are also available on www.erha.ie

Recommended Immunisation Schedule

Age	Immunisation
Birth – 1 month	BCG
2 months	DTaP/IPV/Hib (5 in 1) and MenC
4 months	DTaP/IPV/Hib (5 in 1) and MenC
6 months	DTaP/IPV/Hib (5 in 1) and MenC
12-15 months	MMR, Hib*
4-5 years	DTaP/IPV/MMR
11-12 years	MMR (omit if 2 previous doses)
10-14 years	BCG ** (interval of 4 weeks post MMR)
12-14 Years	Td

**** A single dose of Hib vaccine is also recommended if the child presents after age 13 months and has had no previous Hib vaccine. ** Only for those who are known to be tuberculin negative and have had no previous BCG.***

Points to remember

- Adrenaline should be available at all times.
- Guidelines on the management of anaphylaxis are in the Immunisation Guidelines for Ireland 2002.
- If the immunisation schedule is interrupted, it is not necessary to repeat the course, just resume the schedule as soon as possible.
- Children who have missed out on all immunisations and are older than the recommended age range, should be immunised as soon as possible. DTaP, MMR, Hib and IPV may be given simultaneously. DTaP is not recommended for children over 12 years; Td is recommended for such children.
- Each child should receive five doses of tetanus and diphtheria and four doses of polio vaccine.

Measles Alert

There has been an increase in the notification of measles in the last two weeks. Please notify us early by telephone or fax.

MMR and egg allergy:

- Egg allergy is not a contraindication to MMR.
- If a child can tolerate egg-containing foods such as biscuits, cake and pasta, he/she can safely receive standard MMR.
- Most children with mild egg allergy can receive MMR in general practice.
- Egg-free MMR vaccine is no longer available.
- The only relevant contraindication to MMR vaccine is egg anaphylaxis.
- True egg anaphylaxis is a very rare, serious condition.
- The only children who ought to receive MMR in a hospital setting are "those with an allergy to eggs in whom previous exposure led to cardio-respiratory reactions".

ERHA infectious Disease Notifications 2004

Data on notifications presented below show the various methods of notification used in the first quarter of 2004.
(Clin = Clinical only; Lab = Laboratory only)
**These only reflect notifications received from laboratories by the end of March 2004.

Disease	Clin	Lab**	Clin & Lab**	Total
Acute infectious gastroenteritis	89	15	70	174
Bacterial meningitis	4	0	3	7
Campylobacter	14	57	26	97
Clostridium perfringens	1	0	0	1
Creutzfeldt Jakob disease sporadic	0	0	1	1
Cryptosporidiosis	0	1	0	1
Enterococcal bacteraemia	0	8	0	8
Enterohaemorrhagic E coli toxin producing	1	2	0	3
E coli infection (invasive)	0	19	0	19
Giardiasis	1	1	0	2
Haemophilus influenza disease (invasive)	0	6	0	6
Hepatitis A (acute)	9	0	0	9
Hepatitis B (acute & chronic)	24	18	4	46
Hepatitis C	29	63	0	92
Infectious parotitis (mumps)	5	0	0	5
Influenza A	1	1	2	4
Influenza B	1	0	0	1
Listeriosis	1	0	0	1
Malaria	0	2	0	2
Measles	14	0	0	14
Meningococcal disease	12	0	8	20
Noroviral infection (sporadic cases)	3	5	5	13
Pertussis	1	0	0	1
Rubella	4	0	0	4
Salmonellosis	0	14	6	20
Shigellosis	1	3	0	4
Staphylococcus aureus bacteraemia				
incl. MRSA	0	33	3	36
Streptococcus pneumonia invasive	2	11	3	16
Streptococcus pyogenes, group A				
infection (invasive)	1	6	1	8
Tuberculosis	27	14	13	54
Typhoid Salmonella Typhi	0	0	1	1
Viral meningitis	2	0	0	2
Total	**247**	**280**	**145**	**672**

The amended legislation in place since January 1 2004 may be causing some confusion about what to include in a number of disease entities. The following points may clarify some issues.

In reporting notifiable infectious diseases due to Acute Infectious gastroenteritis, *Enterohaemorrhagic Escherichia coli* and *Hepatitis B* (acute and chronic), the following should be noted:

1. Acute infectious Gastroenteritis (AIG)
- The case definition for AIG has been updated and now includes Rotavirus but not Adenovirus
- Gastro-enteritis cause unspecified is notifiable
- AIG in all age groups, and not just those under 2 years, is notifiable

2. Enterohaemorrhagic Escherichia coli (EHEC)
The following are reported as EHEC:
- All verotoxin positive *E.coli*
- *E.coli* serotypes O157, O26, O111, O103, O145 regardless of whether verotoxin producers or not
- Excludes *E.coli* urinary tract infection

3. ***Hepatitis B*** (acute and chronic)
- When notifying cases of Hepatitis B please specify whether acute or chronic.

Outbreaks of all gastrointestinal illness

The notification of outbreaks is required under the amended Infectious Diseases Legislation. An outbreak is defined as two or more linked cases of the same illness, or where the number of observed cases exceeds the expected number or a single case of disease caused by a significant pathogen. While individual cases of a number of diseases are not notifiable outbreaks of chickenpox for example are notifiable. During the first quarter of 2004 sixteen outbreaks were reported; of these 14 were gastrointestinal in nature one was chickenpox and one was Hepatitis A. Table 4 shows outbreaks of gastroenteritis in terms of the type of location where it occurred, the numbers ill, the mode of transmission and the pathogen where known.

There were a number of outbreaks of SRSV or Noroviral infection. Many of these resulted in the curtailment of hospital activities for long periods of time. Ward closures, delayed transfer and discharge of patients and restricted visiting as well as staff sick leave were the most obvious features of these outbreaks. **National Guidelines on the Management of Norovirus Infection in Health Care Settings** are available at www.ndsc.ie/Publications/Norovirus

Key Message

- Immediate cleaning and environmental decontamination
- Scrupulous hand washing
- Segregation of those who are ill from those who are not
- Limitation of movement of staff and patients
- Exclusion of ill staff from work for 48 hours after their last episode of vomiting or diarrhoea
- Sensible management of visiting

Location	No. Ill	Illness	Transmission	Pathogen
Long Stay/Nursing home	26	Gastroenteritis	P-P	Suspected viral
Long Stay Hospital	5	Gastroenteritis	P-P	Suspected viral
Acute hospital	16	Gastroenteritis	P-P	Suspected viral
Acute Hospital	18	Gastroenteritis	P-P	Norovirus
Long stay	14	Gastroenteritis	P-P	Norovirus
Acute hospital	11	Gastroenteritis	P-P	Suspected viral
Acute Hospital	4	Gastroenteritis	P-P	Norovirus
Residential Unit	27	Gastroenteritis	P-P	Suspected viral
Long stay	28	Gastroenteritis	P-P	Suspected viral
Acute hospital	172	Gastroenteritis	P-P	Norovirus
Long stay	18	Gastroenteritis	P-P	Suspected viral
Nursing home	9	Gastroenteritis	P-P	Suspected viral
Nursing home	9	Gastroenteritis	P-P	Suspected viral
Long stay hospital	4	Gastroenteritis	P-P	Suspected viral

Table 4 Outbreaks of gastrointestinal illness Jan-Mar 2004

P-P = Person to person transmission

All Ireland Campylobacter Case Control Study

A campylobacter case-control study has recently commenced. The ERHA and the four Health and Social Services Boards in Northern Ireland along with the NDSC (Dublin) and the CDSC-NI (Belfast) are undertaking this study. The main aim is to identify and assess risk factors for sporadic cases of campylobacter on an all-Ireland basis.

A letter has been sent to all GPs explaining this study and encouraging timely notification. Response rate for cases to date is 38%. Your support in improving response rate in both cases and controls would be appreciated.