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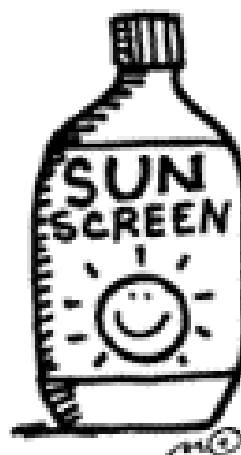
Travel Advice

The risks associated with travel abroad are influenced not only by features of the individual (age, sex and general health status) but also by the destination, the purpose of the trip and the route and duration of the trip.

A pre-travel consultation is an opportunity to ensure that all primary immunisations have been given and that those recommended for travel are appropriate.

The important features of travel advice to travellers on how to best protect their health when away from home are:

- Avoid ingesting any potentially contaminated (i.e. unfiltered) drinking-water or recreational water
- In malaria endemic areas cover arms and legs and use insect repellent in evenings
- Beware of risks on roads – driving “on the other side”, roadworthiness of vehicles
- Non-nationals who have been resident



here for over six months will have lost all natural immunity to diseases such as malaria and will require chemoprophylaxis when returning to their home country.

- Infants and young children are particularly sensitive to ultraviolet radiation and become more easily dehydrated than adults
- Travellers need to be aware of the increased risk of sexually transmitted diseases from unprotected sex
- Gastrointestinal infections may result in contraceptive failure and result in unplanned pregnancies
- Travel insurance, including air
- ambulance insurance when travelling to areas where medical care may be restricted.
- Dental check-up before travelling so as to avoid dental treatment in countries where sterilisation may be inadequate.
- Gradual exposure to sun; Protect skin with high factor sun cream and loose clothing and avoid sun during middle of day,
- The Sun Protection Factor (SPF) refers to UVB protection only. A cream with SPF value of 15 or above should be used.
- UVA protection is indicated by a voluntary star system on sunscreen products; more stars indicate greater protection.
- To avoid travellers' diarrhoea, *boil it, cook it, peel it* yourself or forget it.....
- Avoid tattooing, body piercing, acupuncture, manicuring and shaving with open razors, unless absolutely certain that the equipment is sterile



Useful Websites

The World Health Organisation provides a comprehensive guide on international health. It offers guidance on the full range of health risks likely to be encountered at specific destinations and associated with different types of travel – from business, humanitarian and leisure travel to backpacking and adventure tours. The 2004 Guidelines are only available on the WHO website, www.who.int/ith, while the 2003 edition may be purchased in hard copy.

The National Disease Surveillance Centre provides general advice for international travellers: www.ndsc.ie/DiseaseTopicsA-Z/TravelAdviceforInternationalTravellers/

The Health Protection Agency in the United Kingdom provides information on individual diseases, www.hpa.org.uk/infections/topics_az

The National Travel Health Network and Centre provides guidance for both health professionals and the public: www.NaTHNAC.org

The Travel Medicine Division (TRAVAX) of the Scottish Centre for Infection and Environmental

Health (SCIEH) is a resource provided by the National Health Service for Health Care Professionals primarily within the United Kingdom. Irish professionals can register to access this site for an annual fee. www.travax.scot.nhs.uk

SCIEH also provides a site accessible to the general public, which gives advice consistent with the more detailed advice designed for health care professionals. www.fitfortravel.nhs.uk

The travel health section of the Centres for Disease Control and Prevention (CDC), Atlanta provides advice for different types of travellers and contains comprehensive fact sheets on the diseases that can be contracted abroad: www.cdc.gov/travel

A new report published by the British Medical Association titled The Impact of Flying on Passenger Health: a Guide for Health Care Professionals is available online at www.bma.org.uk/ap.nsf/content/flying. This report provides an up-to-date summary of how commercial flying can impact on health of passengers and offers guidance on advising travellers about their health and well-being during a flight.

Travel vaccines

The Immunisation Guidelines for Ireland contains a chapter on travel health issues. Up-to-date information regarding emerging diseases and new vaccines is available on a number of web sites (some of which are listed above). While vaccination offers the possibility of avoiding a number of dangerous infections, the traveller must be made aware that additional precautions should be followed carefully regardless of what vaccines he/she has received.

Immunisations related to travel can be divided into three general categories: those that are considered routine (part of the primary series of immunisations), those required by international law (yellow fever), and those recommended for maintenance of health while travelling. The immunisations recommended for travel will vary according to the traveller's age, existing medical conditions, the nature of travel (whether the traveller is staying in urban hotels or visiting remote rural areas), the legal requirements for entry into countries being visited and the duration of travel.

Tetanus and Diphtheria

The aim of primary immunisation is that each child should receive five doses of diphtheria and tetanus toxoid. For those ten years and older who have not previously been immunised three doses of Td with intervals of at least

one month between doses are recommended. A booster of Td should be given ten years after the primary course and again ten years later.

Poliomyelitis

The WHO recommends polio immunisation for travellers to developing countries where poliomyelitis is still transmitted. At the end of 2003, six countries were polio endemic: Nigeria, Pakistan, India, Niger, Afghanistan and Egypt. All children should receive four doses of IPV at two, four and six months and four to five years of age. Unimmunised adults should receive three doses, the second dose one to two months after the first dose, and the third dose six to twelve months later. If protection is needed more rapidly, doses can be given at four weekly intervals. If protection is needed in less than four weeks, OPV can be used as one dose of OPV results in enhanced mucosal immunity when compared with one dose of IPV. The course should be completed with IPV.

Measles, Mumps and Rubella

Measles, mumps and rubella are endemic in many countries and travel in densely populated areas may favour transmission. Transmission increases during the late winter and early spring in temperate climates, and after the rainy season in tropical climates. The WHO recommends that all travellers from six months of age who have not been

immunised should be offered MMR. Two doses of MMR are recommended for adult travellers who were born after 1978, who are on route to a measles endemic area, unless there is serological proof of immunity or physician documentation of prior measles infection.

Hepatitis A

Hepatitis A is the most common vaccine-preventable disease in travellers. It is usually a self-limiting, acute viral disease of the liver that is typically spread by eating or drinking contaminated food and water. Vaccination should be considered for all travellers to developing countries, especially to rural areas or places with inadequate sanitary facilities in countries where the disease is endemic. A combined Hepatitis A/Typhoid vaccine has recently become available. The vaccine is administered as a single dose at least two weeks before departure and confers high levels of protection against both diseases. A second dose of hepatitis A vaccine is required 6-12 months later and boosters of typhoid vaccine at 3-yearly intervals if required.

Hepatitis B

Infection due to Hepatitis B virus is one of the commonest causes of morbidity and mortality in the world. It is an important cause of serious liver disease including acute and chronic hepatitis, cirrhosis, and primary hepatocellular carcinoma. Hepatitis B is believed to be second only

to tobacco among human carcinogens.

While only certain categories of traveller are clearly at risk because of their planned activities, any traveller may be involved in an accident or medical emergency that requires surgery. Hepatitis B vaccine should be considered for all travellers to highly endemic areas. It can be administered to infants from birth. It can be given either singly or as a combined hepatitis A/hepatitis B preparation. Hepatitis B infection in pregnant women may result in severe disease in the mother and chronic infection in the newborn. Immunisation should not be withheld from a pregnant woman if she is travelling to highly endemic areas.

Typhoid and paratyphoid fever

Typhoid is an enteric fever caused by the bacterium *Salmonella enterica serovar Typhi* and paratyphoid fever by *Salmonella enterica serovar paratyphi*. These organisms only affect humans and can be acquired from either cases or carriers. Typhoid is rare in resource-rich countries; it is endemic in countries with poor hygiene and sanitation. Typhoid vaccine is available either alone or in combination with Hepatitis A vaccine discussed above.

If patients present with infectious diseases following foreign travel please let us know when you submit a notification.

Travelling with Young Children

- Ensure all age appropriate vaccinations have been administered
- Falciparum malaria in a young child is a medical emergency --- it may be rapidly fatal.
- Advise parents not to take babies or young children to areas with transmission of chloroquine-resistant *P.falciparum*. If travel cannot be avoided, children must be very carefully protected against mosquito bites and be given appropriate chemoprophylactic drugs. Babies should be kept under insecticide-treated mosquito nets as much as possible between dusk and dawn.
- Ensure adequate supplies of any regular medication.
- Advice to parents on how to treat minor ailments and when to seek medical attention.
- Antimalarial medication for children is administered on the basis of the child's weight.

Advice for Elderly Travellers

- Pre-travel assessment may reveal need for special advice on the mode of travel, choice of destination and route.
- Ensure traveller has supplies of medications to cover trip.
- Check immunisation history to confirm adequate protection. Age alone is not a contraindication for any vaccine. If vaccines have been given in the past boosters may be necessary.
- Vaccinate according to destination.
- Influenza vaccination especially if going on a cruise and long haul flights. Remember that the 'flu season' in the southern hemisphere is from April to November.
- Pneumococcal vaccine every five years if an underlying condition is present that predisposes to infection.

Malaria

Malaria is a common and often life-threatening disease. It occurs in many tropical and subtropical countries. It is caused by four different species of the Plasmodium parasite: *Plasmodium falciparum*, *P.vivax*, *P.ovale* and *P.Malariae*. The parasite is transmitted by various species of Anopheles mosquitoes, which bite mainly between sunset and sunrise. The parasites multiply in the liver, are released into the circulation and then invade the red blood cells. The parasites develop further in the red blood cells, which then rupture and release large numbers of parasites into the circulation. Clinical symptoms coincide with this release of parasites.

P.falciparum is the only one of the four species of malaria parasite that poses a substantial risk of life-threatening illness and death. All cases of falciparum malaria have the potential to be severe and even fatal if untreated. It is important that patients are made aware of the life threatening nature of malaria and why compliance with prophylaxis is so important. It is also important that clinicians have a high index of suspicion when a returned traveller presents with an unexplained illness. *P.falciparum* is the predominant parasite in hotter and more tropical areas, particularly Africa. It is also the main species that has become resistant to chloroquine and, lately, other drugs.

Malaria Prophylaxis

The aim of malaria prophylaxis is to prevent illness and death in people who travel to areas where malaria is transmitted.

ABC of Prevention

- Awareness about risk of malaria, the incubation period and the main symptoms
- Bites by mosquitoes: Prevent or avoid. Avoid being outdoors and close windows when mosquitoes are most active; wear protective clothing and use insect repellents and nets.
- Compliance with appropriate chemoprophylaxis correctly
- Immediately seek Diagnosis and treatment if a fever develops one week or more after entering an area where there is a malaria risk and up to three months after departure.

In advising travellers about antimalarial medication, it is important to point out that the risk of contracting malaria is roughly proportional to the duration of stay in a malarious area. It is therefore important that chemoprophylaxis is maintained during a long visit.

The Advisory Committee on Malaria Prevention in the UK has published guidelines for healthcare workers who advise travellers. These may be accessed at www.hpa.org.uk/infections/topics_az/malaria/menu.htm These guidelines are mainly concerned with the prevention of falciparum malaria. The guidelines include detailed information on the currently available drugs for chemoprophylaxis, emergency standby treatment, advice for long-term travellers, country specific advice and prophylaxis for people with other clinical conditions or pregnancy. If patients present with malaria please include travel history when notifying the Department of Public Health.

Sexually transmitted and Blood borne Infections

Potential travellers need advice on precautions to take to avoid contracting sexually transmitted diseases and blood

borne infections. Some of the most serious sexually transmitted infections, including syphilis, gonorrhoea, and HIV/AIDS, are endemic in many parts of the developing world especially in sub-Saharan Africa.

Advice on the following should be given to travellers:

- Use of condoms with casual partners
- In many developing countries where the re-use of medical supplies, such as needles and syringes is common, travellers should be advised to bring with them an emergency travel kit, available from some chemists and travel clinics, which contain sterile equipment for use in an emergency.
- In developing countries, where blood available for transfusion may not have been screened for HIV, the risk of infection associated with blood transfusion is high. Accidents are the commonest reason for a traveller to need a transfusion. Avoiding situations where transfusion may be required is probably the best advice to give, e.g. extra caution when driving in foreign countries and participating in new recreational activities.
- Knowledge of blood group and of travelling companions will be useful.

Illness associated with foreign travel

In recent months a number of travel related notifications were received in the ERHA region. While the infectious diseases notification form does not specify travel history, its inclusion nonetheless would be of great value in the surveillance of travel related illness. This would not only assist in the follow-up of such cases but would also assist in the targeting of travel advice. The following table shows the illness and the causative pathogen (where known) and the country of infection (where known).

Illness / pathogen	Number of cases	Country of infection
Campylobacter infection	3	Mexico, Peru
Cryptosporidiosis	18	Unknown
E.coli 0157	1	Minorca
Giardiasis	2	Nepal, China
Legionellosis	1	USA
Malaria	1	Nigeria
West Nile Virus	2	Portugal
Paratyphoid	1	Nepal
Salmonella species (not typed)	7	Spain, USA
Salmonella Typhimurium	1	Nigeria,
Salmonella Typhi	2	Pakistan, Philippines
Acute infectious diarrhoea	1	Spain

The Travax website mentioned above provides information on travel related disease outbreaks on a quarterly basis on its website www.travax.scot.nhs.uk.

The NDSC also provides updates on disease outbreaks on its website at www.ndsc.ie

West Nile Virus

The National Disease Surveillance Centre (NDSC) has advised people intending to travel to countries where mosquitoes are prevalent to take routine preventive measures against insect bites, following confirmation of West Nile Virus (WNV) in two Irish travellers who returned from the Algarve, Portugal in July.

West Nile Virus (WNV) belongs to a group of viruses, which are generally transmitted by insects. Infection with WNV is a zoonosis, a disease that can be passed from animals to humans. Birds are the normal host for the virus, which circulates in the bird's blood and is transmitted from one bird to another by bites from infected mosquitoes. The virus multiplies during the course of transmission between the birds and transmission is increased where there are large numbers of mosquitoes are close to suitable bird populations. Animals and humans rarely develop high enough levels of virus in their bloodstream necessary to infect mosquitoes.

The NDSC provides detailed information on clinical symptoms, diagnosis and treatment of West Nile Fever.

Key points on West Nile Fever

- West Nile fever is generally described as a febrile illness of sudden onset often accompanied by malaise, headache, muscle pain, rash and gastrointestinal symptoms.
- Incubation period is between 3 to 14 days.
- Symptoms generally last 3 to 6 days.
- About 80% have no symptoms
- Approximately 20% develop a mild illness.
- West Nile Fever should be strongly considered in adults over 50 years who develop unexplained encephalitis or meningitis in summer or early autumn within 14 days of returning from areas where there is known WNV activity.
- Year round transmission is possible in some parts of the US.
- Any suspected case should be reported to the Director of Public Health.
- West Nile Fever is generally a self limiting illness, requiring simple measures only.

Further information can be found at:

CDC Clinical Guidance:

www.cdc.gov/ncidod/dvbid/westnile/clinical_guidance.htm

A list of Frequently Asked Questions on West Nile Virus can be found on the National Disease Surveillance Centre's website at <http://www.ndsc.ie/DiseaseTopicsA-Z/WestNileVirusWNV/>

Immunisation Update

Pertussis

While the incidences of pertussis is well controlled by the primary immunisation programme cases still occur in vulnerable young infants.

Seventeen notifications were received in the first six months of 2004. A number of these relate to very young infants.

Infants under the age of 1 year have the highest mortality rate and also are more likely to be hospitalised and suffer complications such as pneumonia and cerebral complications. We rely on herd immunity to protect young infants before they can be protected directly by vaccination. Therefore, optimal immunisation rates are necessary to protect these vulnerable children. Erythromycin chemoprophylaxis has been advocated for use in the prevention of secondary transmission and should be considered (up to 21 days after onset of illness) for young unimmunised or partially immunised infants (including neonates) in households where an older sibling or adult develops pertussis.

Guidelines on the use of erythromycin chemoprophylaxis are available on www.hpa.org.uk/infections/topics_az/whoopingcough.htm

Influenza

The influenza season is fast approaching. The following should receive annual influenza vaccination.

- People aged 65 years and over
- Nursing home / long stay unit residents
- People with chronic medical conditions including:
 - Chronic respiratory illness (cystic fibrosis, asthma)
 - Heart disease
 - Diabetes
 - Chronic renal disease
 - Immunosuppression through disease or treatment including asplenia / splenic dysfunction
 - Children and teenagers on long term aspirin therapy because of risk of Reyes Syndrome
- Health care workers who have contact with patients both in the community and in health care institutions such as hospitals and nursing homes, both for their own protection and that of their patients. Information on the influenza vaccine for health care workers is available on the NDSC website at www.ndsc.ie

There is overlap between many groups targeted for influenza and pneumococcal vaccination. While influenza vaccine must be given every year, pneumococcal vaccine is administered every 5 years only for those at highest risk of disease. Both may be given at the same time but at different sites.

Vaccine uptake in the 65 to 70 age group last year was not as good as in the over 70s. Many in this younger group may be caring for elderly or disabled relatives whose welfare may be at risk if the carer falls ill.

Enhanced Surveillance of Syphilis in the ERHA 2000 – 2003

Syphilis is caused by a bacterium *Treponema pallidum* and has emerged as an important public health infection in the ERHA region. Syphilis progresses in four stages: primary, secondary, latent (early and late), and tertiary. Early syphilis (primary, secondary and early latent) is infectious. Late syphilis (late latent and tertiary) is non-infectious. Diagnosis is made by serological tests usually of blood

Since early 2000 there has been a

dramatic increase in syphilis in the ERHA especially in Dublin. Most of the cases were in men who have sex with men (MSM). The rise was against a low level throughout the 1990s, which in 1999 reached its lowest level in 10 years. As a result of the increase of syphilis the Director of Public Health established an outbreak control team in October 2000. Interventions to control the outbreak were targeted primarily at MSM in Dublin.

An enhanced surveillance system was introduced by both the ERHA and the NDSC to capture data on all syphilis cases from January 2000. Epidemiological information on all syphilis cases reported (including those based on clinical notifications) to ERHA and the NDSC between January 2000 and December 2003 is presented below.

- The outbreak of syphilis which occurred among men who have

sex with men in Dublin, peaked in 2001 and has now entered an endemic phase

- There has been rise in infectious syphilis in the heterosexual community
- Cases of infectious and late syphilis cases in non-nationals especially from antenatal clinics have emerged
- There is a need for more information on congenital syphilis
- Enhanced surveillance allows information and trends to be monitored and supports intervention
- Continued enhanced surveillance is recommended
- Between January 2000 and December 2003, 803 cases were notified: 61% were early (infectious) syphilis and 29% were late syphilis (the remainder were of an unknown or other syphilis stage)
- 75% cases were male
- 463 (58%) cases were amongst MSM (413 were homosexual and 50 were bisexual)

Early (infectious) syphilis

- Four hundred and ninety-two notifications: 92% male.
- Four hundred and four (82%) were in MSM (73% were homosexual and 9% were bisexual).
- Two hundred and sixty nine (55%) were symptomatic.
- The average age for male cases was 34 years and 25 years for female cases.
- Three hundred and forty-three (70%) were born in Ireland; of these 89% were MSM, the remainder were heterosexual.
- In those cases born outside Ireland (77), 69% were MSM, and 24% were heterosexual.
- Sexual contact abroad was reported by 20% of cases, in particular London, Amsterdam and Manchester where syphilis outbreaks have also been reported.

Reporting Clinic	2000	2001	2002	2003	Total	% of Total
Genitourinary Medicine & Infectious Diseases Clinic, St James's Hospital	60	266	222	116	664	82.7 %
Rotunda Hospital	8	4	0	29	41	5.1 %
Private STD Physicians	6	14	8	7	35	4.4 %
Mater Hospital	6	8	10	10	34	4.2 %
GP	1	5	0	4	10	1.2 %
Coombe Hospital	0	0	2	5	7	0.9 %
St James's Hospital Laboratory	0	0	0	3	3	0.4 %
Beaumont Hospital	0	2	1	0	3	0.4 %
Irish Blood Transfusion Service	0	2	0	0	2	0.2 %
Gay Men's Health Project	1	0	0	0	1	0.1 %
Unknown	1	2	0	0	3	0.4 %
Total	83	303	243	174	803	100 %

Table 1 A breakdown of the notifications by reporting source

Two distinct groups have been associated with the increase in syphilis in the ERHA:

- An outbreak of early (infectious) syphilis mainly among MSMs in Dublin and
- Late syphilis cases particularly among heterosexual non-nationals.

- Eighty-eight (18%) of cases were HIV positive; HIV was newly diagnosed in 27 of the HIV positive cases
- Thirteen cases were identified through antenatal screening; of these 4 were also HIV positive.
- Two congenital syphilis cases in infants were reported.

Late syphilis

- Two hundred and thirty-eight notifications: 46% male.
- One hundred and seventy-two (72%) were heterosexual, 44 were MSM and 24 were of unknown sexual orientation.
- The average age for male cases was 40 years and 31 years for female cases.
- Fifty-four (23%) were born in Ireland; of these 30 were MSM and 24 were heterosexual.
- Of the 92 cases born outside Ireland, 85% were heterosexual.

Key Messages

- "Safer sex" messages for sexually active population
- High index of suspicion in vulnerable groups especially MSM and sexually active patients with vague symptoms
- Refer patients with suspected syphilis to specialist genitourinary medicine services for investigation and treatment
- Serological test for MSM with vague symptoms should be considered

Further Information on syphilis

<http://www.ndsc.ie/DiseaseTopicsA-Z/Syphilis/>

Domegan L, Cronin M, Thornton L, Creamer E, O'Lorcain P, Hopkins S. Enhanced surveillance of syphilis. Epi-Insight, 2004; 3(7).

Hopkins S, Coleman C, Quinlan M, Cronin M. Interventions in a Syphilis Outbreak. Epi-Insight, 2002; 3(8).

Coleman C, Clarke, Fitzgerald M, Quinlan M. Syphilis Onsite Testing In Dublin. Epi-insight, 2004; 5(7). The above articles are available at <http://www.ndsc.ie/Publications/EPI-Insight/>

Doherty, L., et al. Syphilis: old problem, new strategy. BMJ, 2002. 325(7356): p. 153-156.

http://www.hpa.org.uk/infections/to_pics_az/topics.asp

ERHA infectious Disease Notifications 2004

Data on notifications presented below show the various methods of notification used in the second quarter of 2004. (Clin = Clinical only; Lab = Laboratory only) ** These

only reflect notifications received from laboratories by the end of June 2004.

There has been a marked increase in the number of laboratory notifications in

the last quarter. While acknowledging the response of the laboratories to the new Infectious Diseases Legislation, we would like also to acknowledge the

increased workload in both the Department of Public Health and in the community where individual cases and outbreaks are investigated and managed.

Disease	Clin	Lab **	Clin & Lab **	Total
Acute infectious gastroenteritis	75	22	72	169
Bacterial meningitis	3	0	0	3
Campylobacter	27	81	46	154
Enterococcal bacteraemia	0	9	0	9
Enterohaemorrhagic E coli toxin producing	0	1	1	2
E coli infection (invasive)	3	35	0	38
Giardiasis	1	1	0	2
Hepatitis A (acute)	1	0	1	2
Hepatitis B (acute & chronic)	43	20	42	105
Hepatitis C	36	93	5	134
Infectious parotitis (mumps)	8	0	1	9
Legionellosis	1	0	0	1
Leptospirosis	1	0	0	1
Malaria	0	1	0	1
Measles	60	14	22	96
Meningococcal disease	3	0	8	11
Noroviral infection (sporadic cases)	6	1	0	7
Paratyphoid	0	0	1	1
Pertussis	5	1	2	8
Rubella	6	0	0	6
Salmonellosis	4	17	10	31
Shigellosis	0	4	1	5
Staphylococcus aureus bacteraemia incl. MRSA	3	53	1	57
Staphylococcus aureus enterotoxigenic food poisoning	1	0	0	1
Streptococcus pneumonia invasive	2	19	7	28
Streptococcus pyogenes, group A infection (invasive)	1	4	1	6
Tuberculosis	12	24	11	47
Viral encephalitis	0	0	2	2
Viral meningitis	2	0	1	3
Total	304	401	235	940

C. C. A	Contact numbers	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 Tel: 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.