Gonorrhoea cases increase in the Midlands

**Background**
This year has seen an increase in the number of cases of gonorrhoea (21 to date) reported to the Department of Public Health (Midlands), compared to 12 cases, in total, for 2012. This coincides with a large increase in cases (particularly among MSMs) noted in the HSE East region.

**Symptoms**
Symptoms may be mild or absent in up to 86% of women and 55% of men. If present, symptoms in women include: yellow or bloody vaginal discharge, postcoital bleeding, intermenstrual bleeding and dysuria. Men may experience urethral discharge, dysuria, and epididymo-orchitis.

If the infection is transmitted via anal sex, it can cause pruritus ani, soreness, discharge, pain during anal sex, bleeding or painful bowel movements.

Gonorrhoea transmitted during oral sex is usually asymptomatic but may cause a sore throat.

If symptoms do occur, they usually appear within 2-10 days of infection. They can persist or they may only last for a few days. A small number of people may be infected for over 30 days before they experience symptoms.

**Treatment**
Current guidelines advise that gonorrhoea is treated with Ceftriaxone 500mg intramuscularly as a single dose with azithromycin 1g oral as a single dose.

**Test of Cure**
Due to an increase in antibiotic-resistant strains of gonorrhoea a test of cure is recommended for all and especially for:
- Persisting symptoms or signs
- Pharyngeal infection (all treatments are less effective at eradicating pharyngeal infections)
- Treatment with anything other than the first-line recommendations
- Pregnant women

**Timing of Test of Cure**
- **Persisting symptoms or signs** – test with culture, performed at least 72 hours after completion of therapy
- **If asymptomatic** – test with Aptima swab followed by culture if NAAT positive
  Test two weeks after completion of antibiotic therapy

**Partner notification**
As even asymptomatic infection can cause pelvic inflammatory disease in women and epididymitis in men, both of which can result in infertility, partner notification is advised in all patients diagnosed with gonococcal infection:
- All partners in past 2 weeks if: Male with symptomatic urethral infection:
- All partners in past 3 months if: Male & female patients with infections at other sites/asymptomatic infections

**Midlands STI Clinic**
Many people diagnosed with gonorrhoea are co-infected with another STI.

If you wish to refer patients to the HSE Midlands STI Clinics for a full STI screen and partner notification please contact
- Portlaoise STI Clinic on 086-8591273
- Mullingar STI Clinic on 086-4169830.

(Please forward copy of laboratory result to the clinic as sometimes patients give incorrect information re the diagnosis)
Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

What are human coronaviruses?
Human coronaviruses were first identified in the mid-1960s. There are three main subgroups: alpha, beta and gamma. Coronaviruses can cause a range of symptoms varying from mild symptoms such as the common cold to more serious respiratory illnesses.

What is the new human coronavirus – MERS-CoV?
The new virus is a beta coronavirus. It is different from other coronaviruses that have been isolated in humans to date. This novel coronavirus (NCoV) probably came from an animal. This subtype/strain of NCoV was first identified by the Netherlands in September 2012 in a patient from the Middle East who died from a severe respiratory infection in June 2012.

Epidemiology
Globally, from September 2012 to 25th June 2013, WHO has been informed of a total of 70 laboratory-confirmed cases of infection with MERS-CoV, including 39 deaths.

Several countries in the Arabian Peninsula and neighbouring countries (Bahrain, Iraq, Israel, Jordan, Kingdom of Saudi Arabia, Kuwait, Lebanon, Occupied Palestinian Territories, Oman, Qatar, Syria, UAE and Yemen) have been affected. Cases have also been reported by France, Germany, Italy, Tunisia and the United Kingdom. These cases were either transferred for care of the disease or returned from the Arabian Peninsula and subsequently became ill.

In France, Italy, Tunisia and the United Kingdom, there has also been limited local transmission among patients who had not been to the Arabian Peninsula but who had been in close contact with laboratory-confirmed or probable cases.

Could this patient have MERS-CoV?
MERS-CoV should be considered in patients with unexplained pneumonias, or in patients with unexplained severe, progressive illness not responding to treatment, and who have recently returned from the Arabian Peninsula or neighbouring countries.

If there is any clinical suspicion of MERS-CoV, immediately adopt infection control measures to protect yourself, other staff and patients.

Assessment*
1. Recent travel to Arabian Peninsula or neighbouring countries (MERS-CoV) or China (Influenza A(H7N9)) and
2. Fever or history of fever ≥38°C and
3. Clinical signs of pneumonia

*Taken from “Interim infection prevention and control (IPC) precautions for patients suspected to be infected with Middle East Respiratory Syndrome Coronavirus (MERS-CoV) or influenza A (H7N9) in primary care facilities - vs 1.0 - 23/05/13”

- HCW: Hand hygiene, surgical mask, eye protection, gloves & long sleeved fluid repellent gown
- Prevent contamination when removing personal protective equipment (PPE)
- Hand hygiene after removing PPE

- Placement: Single room

- Clean and disinfect all patient care equipment used, in accordance with the manufacturer’s instructions.
- Wipe surfaces in the examining room that have been in contact with the patient - use a general purpose detergent and water followed by wiping with a hypochlorite solution 1/10 dilution (1000ppm)
Guidelines for the Emergency Management of Injuries

The HPSC recently published “Guidelines for the Emergency Management of Injuries (including needlestick and sharps injuries, sexual exposure and human bites) where there is a risk of transmission of bloodborne viruses and other infectious diseases”.

These guidelines are relevant to injuries occurring to members of the public in a community setting and also to injuries sustained occupationally (such as to healthcare workers (HCW) or members of An Garda Síochána). A flowchart (right) outlines the required stages in the management of such exposures in general terms.

Specific algorithms are available by injury type and guidance is provided on when post-exposure prophylaxis is recommended. An online “toolkit” allows users to access individual algorithms and other appendices as appropriate to the situation they are managing.

Both the full version of the guidelines and the online toolkit are available at www.emitoolkit.ie

Guidelines for Vaccinations in General Practice

The HSE in conjunction with the ICGP and the IPNA have published new guidelines on best practice for vaccinations in general practice.

These guidelines are available for downloading from the National Immunisation Office website at www.immunisation.ie.
Rubella Outbreak in Poland

There is currently a nationwide epidemic of rubella infection in Poland. From Jan-April 2013 over 26,000 cases have been reported, mostly among young males (15-29 years).

This outbreak reflects the history of immunisation policies in Poland – selective vaccination of adolescent girls since 1989, then universal two-dose measles-mumps-rubella vaccination since 2004.

Two cases of congenital rubella syndrome have also been reported to date and more are expected due to high circulation of the rubella virus among adolescent and young adult populations.

Travellers to Poland should ensure they are up-to-date with their rubella vaccine.

Non-immune pregnant women should consider not travelling to Poland during this outbreak- this is especially important during the first 20 weeks of pregnancy.

List of Infectious Diseases notified in HSE- Midland Area - 01/01/2013 - 27/06/2013*

<table>
<thead>
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<th>Number</th>
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</thead>
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<tr>
<td>Campylobacter infection</td>
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<tr>
<td>Haemophilus influenzae disease (invasive)</td>
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<td>Shigellosis</td>
<td>3</td>
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<tr>
<td>Hepatitis B (acute and chronic)</td>
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<td>Streptococcus group A infection (invasive)</td>
<td>4</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>14</td>
<td>Streptococcus group B infection (invasive)</td>
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<tr>
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<td>Trichomoniasis</td>
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<tr>
<td>Malaria</td>
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<tr>
<td>Measles</td>
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<td>Verotoxigenic Escherichia coli infection</td>
<td>20</td>
</tr>
<tr>
<td>Meningococcal disease</td>
<td>3</td>
<td>Viral meningitis</td>
<td>2</td>
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</tbody>
</table>

* All data are provisional

Please contact the Department of Public Health on 057 9359891 or by e-mail if:
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❖ You would like to receive this newsletter electronically
❖ You would like to see a specific topic covered in a future issue of MIDAS

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