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# Weekly Notification of Infectious Diseases

Nationally, the increase in acute viral meningitis experienced in 2001 has abated in 2002, total notifications dropping from 161 in 2001 to 30 in 2002.

EPI-INSIGHT, the monthly publication of the National Disease Surveillance Centre, in its first issue of 2003, highlighted the importance of malaria surveillance.

Another striking feature of the annual notification data has been the rise in notifications of viral hepatitis B. Several factors may be responsible for this increase (sexual transmission, new entrants to the country) and there is a pressing need to instigate enhanced surveillance.

Additional information will be used to assist current knowledge and recommendations on routine antenatal testing as well as control and prevention of disease. Viral hepatitis B chronic infection may have serious consequences in the long term (hepatic carcinoma). A small percentage of infected individuals become infectious carriers. Cases reported in 2002, in Ireland, totalled 447, an increase of 105 cases on 2001.

## Clean the air of tobacco smoke - create a healthier environment for all!



### Influenza surveillance

In early January the first laboratory confirmed cases of influenza were detected in Ireland in the national influenza surveillance system operated by the NDSC and the NVRL with Sentinel GP practices throughout Ireland. To date, in mid-February, nine cases of influenza were reported, mostly type B. Several cases of influenza B were reported in the MWHB region, mostly in younger adults. Influenza B tends to occur mostly in the younger age groups. Sporadic activity of influenza-like illness has been reported in some regions. There were several notifications of respiratory syncytial virus infection and respiratory infections due to chlamydia and mycoplasma over the winter.



### Tuberculosis

Based on preliminary data, the number of cases of tuberculosis reported in 2002 is likely to exceed the low levels of 2001 (27 cases). Thirty-eight cases have been reported in 2002. Ten cases reported were in patients not born in Ireland.



### Brucella surveillance

Human brucellosis is an uncommon zoonosis (disease transmitted from animals), inextricably linked to animal health. The illness is serious and debilitating in humans. It is a treatable and preventable illness. Suspected and confirmed cases of brucellosis are statutorily notifiable in Ireland by the attending physician.

Since 1988, 76 of the 238 cases notified in Ireland have been reported from the MWHB (32%). Since 1997, 29 of the seventy cases were from the MWHB (41%). About 6 cases per year are seen in the MWHB. Little research has been done on the epidemiology of human brucellosis in recent years. The Department of Public Health and the Microbiology Department (MWRH) are seeking the co-operation of all clinicians in the MWHB to gather more detailed information on this illness.

All rates calculated using 1996 Census data.



**BORD SLÁINTE**  
 AN MHEÁN-IARTHAIR

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## Vaccination uptake:

Uptake of the primary childhood immunisation schedule vaccines for diphtheria, tetanus, pertussis (DTP), polio and *H. influenzae b* continues to show improvement, rising to 86% in quarter 3 of 2002. While this rate is better than some Boards it is lower than the 92% uptake achieved by the North Eastern and North Western Health Boards. MMR uptake in quarter 3, 2002 has levelled at 82% recovering from a previous low of 70%. This uptake rate for MMR is one of the highest in the country. Within the MWHB the uptake rates show some variation. In Clare MMR uptake at 24 months is 85%, in Limerick 80% and in Tipperary 82%. For diphtheria/tetanus the uptake in Clare is highest reaching 91%, while Limerick and Tipperary show rates of 86%. Nationally, uptake of primary childhood vaccines (DTP) is 82% and MMR uptake is 72%. Uptake rates still fall short of the desired 95% threshold that is needed to prevent spread of disease. Uptake rates in Ireland have not improved to the same extent as in the United Kingdom. Over the same period, DTP uptake in England was 93%, Wales was 94%, Northern Ireland was 96% and Scotland was over 97%. MMR uptake ranged from 82% in Wales to 88.5% in Northern Ireland. What is clear from analysis of MWHB data in the last year is that the late return of immunisation information is creating the appearance of lower uptake. Immunisation uptake can only be accurately gauged when all the data is returned complete and in a timely manner. Vaccines have become increasing more expensive. Vaccines for the Primary Childhood Immunisation Programme and Booster Four-in-one/2nd dose MMR now cost the Mid Western Health Board in excess of €800,000 per year.

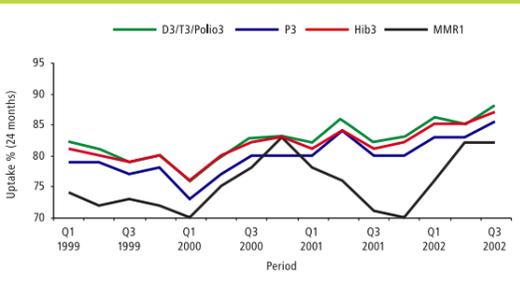


Figure 1: Uptake rates for the primary childhood immunisation panel at 24 months in MWHB, 1999-2002.

## Meningitis C Vaccine

The Meningococcal group C conjugate (MenC) vaccine was introduced in Ireland in October 2000 as part of the Primary Childhood Immunisation schedule at 2, 4 and 6 months. A catch-up programme was also launched, offering the vaccine to all young adults under 23 years of age, the entire catch-up programme being completed by March 2002. Nationally, by August 2002, the overall MenC uptake was 70% in the 1-22 year olds. This ranged from 89% in 5-12 year olds, to 81% in 13-17 year olds, to 77% in 1-4 year olds but down to 30% in 18-22 year olds (NDSC).

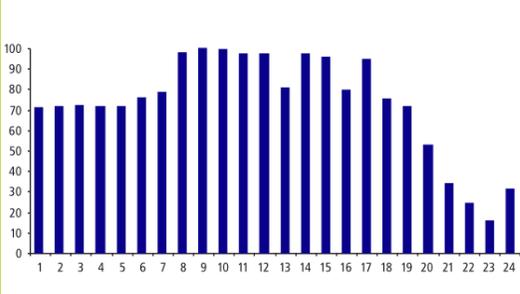


Figure 2: MWHB Men C uptake rates ages 1 (born during 2001) to 24 (born during 1978)

In the MWHB region the overall uptake was 78% with highest uptake in those aged 6-18 years.) The highest uptake levels in 5-17 years age group, represents children and young adults in primary and secondary school who would have largely been targeted by immunisation teams visiting the schools. The poor uptake in over 18 year olds reflects the difficulty in targeting young adults. Since the MenC vaccine has been introduced, there has been an 89% decrease in group C disease in Ireland, highlighting the positive impact that the MenC vaccine has had in reducing group C disease in Ireland.

## Gastroenteritis

Since November 2002 there has been only two recorded outbreaks of SRSV (winter vomiting disease) in an institutional setting in Nenagh and 1 in St Josephs Hospital, Limerick. Efforts will continue into the future to try and identify these events quickly and institute appropriate procedures to reduce the risk of transmission, control further spread and prevent more illness. The incidence of rotaviral illness (viral gastroenteritis) in young children increased in December and January following its usual seasonal pattern. There were a total of 23 salmonella notified by clinicians in 2002. Information on a further nine isolates was provided through voluntary laboratory reporting. The trend in the frequency of salmonellosis is shown in Figure 3, with cases peaking over summer/autumn. Most of the cases were detected in the Limerick and Tipperary North areas, with Clare recording a low incidence. A more detailed analysis of the risk factors in these cases revealed travel to another country to be the greatest risk and parts of Spain in particular. Salmonella in Ireland, on an annual basis, was down 65 cases to 363 in 2002 (preliminary data). The incidence of campylobacter infection in each of the counties was similar but the pattern of infection in 2002 showed two peaks - one in June and one in November. Even more unusual is the seasonal trend in cryptosporidium in the MWHB region. Instead of the well-defined peak demonstrated in April/May (illustrated in *INFOSCAN* for the Southern Health Board and *Westfile* for the Western Health Board), a peak in autumn shown in Figure 3 will be examined in future years. The numbers are small and the event may not be repeated, alternatively there may be some changes to the epidemiology of the pathogen. Fewer cryptosporidium were reported in the Tipperary area, though this might reflect GP sampling practice or awareness.

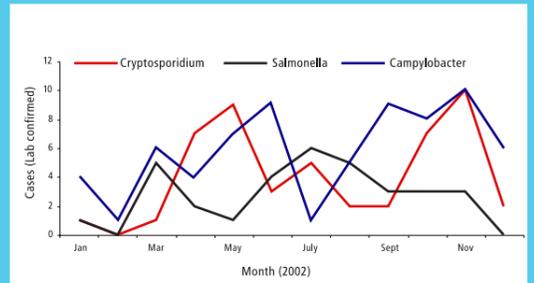


Figure 3: Monthly reports of salmonella, campylobacter and cryptosporidium in MWHB, 2002.

Very little has been seen of *Shigella spp.* (or bacillary dysentery) in the region. This pathogen is confined to humans and has no animal or environmental reservoir. Once eradicated from an area, there can follow periods free from infection. Re-introduction is likely to result from infected persons returning from abroad. It must be stressed that antimicrobial therapy is not indicated for uncomplicated self-limiting gastrointestinal infections. There were 4 cases of hepatitis A in the MWHB region in 2002. Hepatitis A, nationally, fell from 112 in 2001 to 25 in 2002. Total gastroenteritis notifications continue to fall in Ireland.

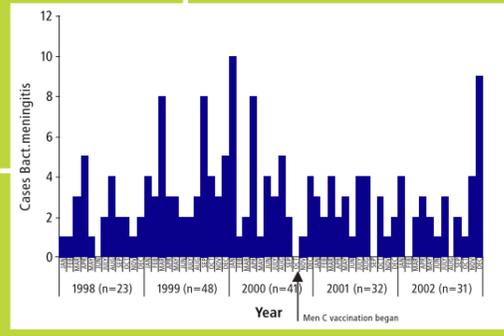


Figure 4: Cases of bacterial meningitis in MWHB, 1998 to 2002.

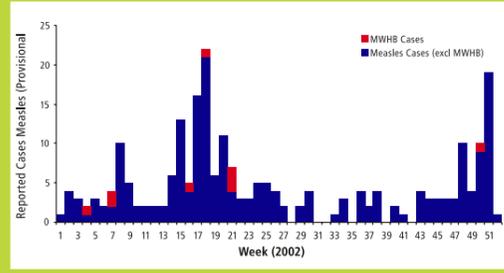


Figure 5: Cases of measles notified in Ireland and the MWHB, 2002.

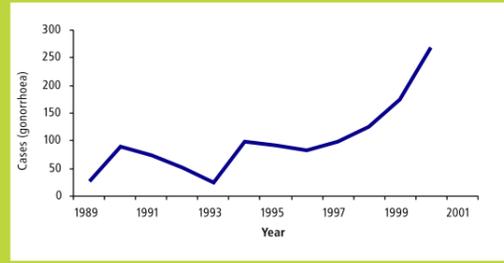


Figure 6: Cases of gonorrhoea notified in Ireland 1989 - 2000. (Source NDSC)

This report is produced with the assistance of the Area Medical Officers, Senior Area Medical Officers and the Mid-Western Regional Hospital Laboratory.

## Bacterial Meningitis

Winter is the peak period for meningococcal disease (Figure 4). In December 2002, the Department advised doctors and parents through the media, of a rise in confirmed meningococcal disease. Ten cases were seen during the month, compared to four usually. Six were detected in Limerick, three in Tipperary North and one in Clare. All cases that were tested and could be identified were type B.

The PCR test for meningococcal types B and C has played an important role in the confirmation of cases where bacterial isolates were not available - this test, requiring a sample of EDTA blood, can be performed on all suspected cases of bacterial meningitis or invasive meningococcal disease - adults or children. Throat and nasal swabs from all suspect cases of meningococcal disease can help in isolating the bacteria. In Ireland, there has been a decrease in bacterial meningitis across the year of 89 cases to 310 in 2002, most likely due to the meningococcal C vaccine campaign. However, the trend in *N. meningitidis* type B in the MWHB is upward. One case of bacterial meningitis caused by *S. pneumoniae* was reported in November.

## Measles

There were 245 cases of measles notified in Ireland throughout 2002 compared to 241 in 2001. Many of these were reported from the ERHA, WHB and NEHB. The WHB had an outbreak in May/June of 2002 and another outbreak occurred in the Athenry area in December 2002. Worryingly there has been no great fall in cases of measles in Ireland following the major outbreak in the Eastern region two years ago. The MWHB reported ten cases of measles in 2002, less than half the national rate for 2002. Data from the weekly notifications of disease show a continued high level of measles in the eastern region and a growing number of cases in the midlands region in early 2003.

## STIs - Gonorrhoea

*Neisseria gonorrhoeae* causes one of the more common sexually transmitted infections (STIs) in Ireland – gonorrhoea. It affects both males and females but can be harder to detect in females. It is an infection confined to the human species and there is no animal or environmental reservoir. In males there is usually a purulent discharge and pain passing urine, whereas in females the infection can be asymptomatic or present as cervicitis. Infection at other sites is possible (eyes, throat and rectum).

There can be more serious long-term consequences from untreated infection (infertility). Treatment is usually simple but resistance is a growing concern in this species and isolates are monitored for resistance to penicillin, tetracycline and quinolones.

The rate of gonorrhoea in Ireland had levelled prior to 1997, possibly amid concern at the progress of the HIV epidemic and the precautions taken by sexually active people to avoid the more serious viral infection. However, in recent years the rate of gonorrhoea has accelerated (see Figure 6), especially in men under 30 years. In 2000, of the 290 cases of gonorrhoea notified, 228 were men (a large proportion of this group was under 30 years).

Data from the STI services in the MWHB reflect this trend in gonorrhoea. The number of cases in 1998 and 1999 in the region, doubled to 24 and 31 cases respectively in 2000 and 2001. There is grave concern that this trend indicates a slippage in precautions against STIs and that there will be a concomitant rise in other STIs – as is occurring with syphilis and may be occurring with HIV. Sexually active men and women should seek advice on how to minimise their risk of catching STIs.