ID link

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Measles and Vaccination Uptake

No further reports of measles in the MWHB were recorded during the summer and autumn. It remains to be seen what course measles epidemiology will take as children return to school and colleges re-start. In Ireland the incidence of measles fell dramatically after March 2003 and dwindled to a couple of cases per week after August. Nevertheless, the 565 cases reported up to October, make 2003 the worst year since the major measles outbreaks in 2002 and 1993-4.

Childhood vaccination under the Primary Childhood Immunisation Programme (PCIP) remains the best and safest means of protecting children from these serious childhood diseases.

Uptake of Mumps Measles Rubella (MMR) vaccine fell in recent months. Reasons for this are unclear. The fall was quite pronounced in the Clare area.

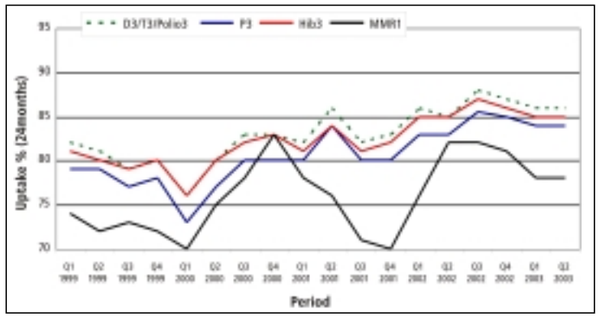

Figure 2: Percentage vaccination uptake of PCIP in the MWHB 2000 - 2003, by quarter.

SIMPLE HANDWASHING CAN PREVENT FOODBORNE DISEASE

Wash after changing babies and always before food preparation!

Tuberculosis

In 2002, 32 notifications of tuberculosis were received (provisional data).

Twenty-three were male and nine were female. Cases were resident in

Clare (10), Limerick (21) and Tipperary North (1).

In the first nine months of 2003, 33 notifications of tuberculosis have been received (preliminary data). Twenty were male and 13 were female. Cases were resident in Clare (6), Limerick (26) and Tipperary North (1).

About one third of cases in 2002 were detected in foreign-born individuals compared to just 10% in 2003. Fifteen cases were diagnosed as pulmonary TB in 2002 but 26 have been reported in 2003 (to October). There were ten isolates of *M. tuberculosis* in 2002 and eleven so far in 2003, one isolate of *M. bovis* was notified in 2002 in a non-national; two were notified in 2003 - both in Irish nationals.

The trend in TB in the MWHB over the last three years has been slowly rising. A full report will be published shortly.

German Measles

Rubella (German measles) is a highly contagious viral illness that poses a serious threat to an unborn child if the mother contracts the illness in pregnancy. Miscarriage, stillbirth and birth defects (congenital rubella syndrome) may result from infection at this time, depending on the stage of pregnancy. Major outbreaks no longer occur in Ireland as the majority of children are vaccinated and most women are routinely screened during pregnancy for immunity to rubella. Symptoms of infection include rash, slight fever, swollen glands and joint pains in adults. Many cases can occur without symptoms or rash. It is spread by direct contact with infected individuals (nasal and throat secretions). Persons are infectious for seven days prior to onset of rash and for seven days after onset.

Symptoms often appear 16-18 days after contact but incubation period may be from 12-23 days. Immunity acquired after contracting disease is usually permanent. The virus which causes regular measles is different and immunity to one is not conferred by the other.

The rash (small pink spots which remain distinct, unlike regular measles) appear on the face first and then spread from head to body, lasting about three days. Exclusion from school or crèche may be needed and medical advice should be sought in relation to female contacts. It is important to confirm clinically suspicious illness associated with rash in pregnancy by laboratory tests. Vaccination of all children with Mumps, Measles Rubella vaccine (MMR) will reduce the risk of serious rubella infection.

In Ireland, in recent years, 30 - 100 cases are clinically notified each year (600 in 1996). Peaks in rubella notifications accompanied or preceded peaks in measles prior to 1990 but since 1990 there have been two major measles outbreaks without concurrent rubella peaks. Outbreaks of measles have been linked to poor uptake of MMR primary childhood immunisation. In the MWHB, 3 – 15 cases are reported annually and no notifications of congenital rubella syndrome in recent years. We would ask all clinicians to notify suspected measles and rubella cases. The Department of Public Health recommends that parents ensure that children are fully protected from both these infections with MMR vaccination, thereby reducing the risk to expectant mothers.

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

Clarification: We regret that due to an error in the processing of the previous issue of "ID-Link", the title and logo and issue number did not appear on the cover.

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All rates calculated using 1996 Census data.

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BORD SLÁINTE
AN MHEÁN-IARTHAIR




Gastroenteritis

Tummy upsets were no strangers this summer. With the exception of salmonella present rates of cryptosporidium and campylobacter in all three areas are in excess of those received for the entirety of 2002. Reports of salmonellae detected have not increased beyond levels seen in 2002.

This summer highlighted the potential of the protozoal pathogen cryptosporidium to cause outbreaks of disease. Events of transmission of this organism were recently associated with swimming pools. A pool in Majorca was reported responsible for illness in a large number of people from the UK. Several reports in Ireland and in this region were also linked to travel to Majorca. Pools in Scotland and the US were also implicated in cryptosporidiosis during the summer. The infection is usually self-limiting.

A report on the epidemiology of human salmonellosis, cryptosporidiosis and campylobacteriosis in the MWHB is available to download:

http://www.mwhb.ie/healthservices/publichealth/pub_hea14.htm

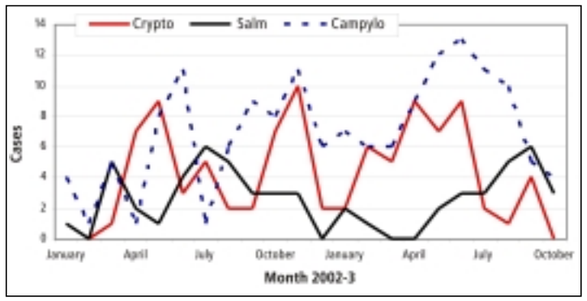

Figure 1: Laboratory reports of cryptosporidium, campylobacter and salmonella in MWHB 2002-3.

In a more serious development there was a large increase in the number of verotoxigenic *E. coli* O157 (VTEC O157). Nine confirmed cases were recorded in 2003 (up to October) compared to 1 in 2002 and 3 in 2001. Three cases (two phage type (PT) 21/28 and one PT8) were in individuals from outside the MWHB area and were followed up by agencies within the relevant jurisdictions once informed by public health authorities here. Two of these cases were linked to an investigation of an outbreak in the Eastern region. Of the six cases from the Mid-West, three cases (a family cluster, PT2) reported travel to Spain as a risk factor. Two other isolates were PT32 and one was PT21/28. VTEC O157 can cause serious and potentially fatal illness. Bloody diarrhoea is a feature in most cases but not all. The successful detection of these organisms is likely due to a good clinical index of suspicion and the expertise in the laboratory isolation and identification of the pathogen.

Table 1: Cases of VTEC reported in Ireland and MWHB 1997 – 2003 (to October 2003)

Cases of VTEC	MWHB	Ireland
1997	-	31
1998	-	76
1999	12	51
2000	3	37
2001	3	50
2002	1	68
2003	6	-

A report from a multidisciplinary group on a survey of gastroenteritis North and South was launched in September and copies are available from *Safe*food. Electronic copies can be downloaded at:

http://www.safefoodonline.com/

HIV

The National Disease Surveillance Centre published the latest statistics on HIV and AIDS infection in Ireland (2002 summary).

Of the 364 new HIV cases diagnosed in 2002

54%	female
45%	male

During 2002

63.5%	of infections were acquired heterosexually (231/364)
13%	of the cases were among men who have sex with men (MSM)
14%	were among injecting drug users (IDUs)

HIV infection rose overall by 22%. Within this figure, infection rose in heterosexuals (33%) and injecting drug users (32%) but fell in men who have sex with men (37%). In the heterosexual category, 77% of the cases during 2002 were born in sub-Saharan Africa and 10% were born in Ireland.

Eight children were diagnosed with HIV infection in 2002 and 119 babies were born to a HIV infected mother during 2002 (infection status indeterminate). Almost 42% of HIV cases diagnosed were resident outside the ERHA at the time of diagnosis.

Percentages should be interpreted with caution as numbers that are small can fluctuate widely over time.

The full report is available to download:

http://www.ndsc.ie

Influenza Activity Increases

Annual surveillance of influenza began in September 2003. The system uses sentinel general practices, consultations for influenza-like illness, hospital admission data, school absenteeism data and laboratory testing for influenza virus to determine the level of influenza across the country. A preliminary report from the Health Protection Agency (HPA) in the UK indicates recent fatalities in children associated with influenza A. Seven children, aged from 22 months to 12 years, have died in the past two months. Five of these have been confirmed as influenza A infections – 4 of which are the H3N2 Fujian like strain.

In Ireland, GP consultations rates for influenza-like illness increased during week 44. Influenza activity levels are higher than previously recorded for this time of year (the influenza surveillance scheme began in October 2000). Influenza A is now circulating in Ireland. Influenza activity has started earlier this season than previous seasons.

Since surveillance for the 2003-2004 season commenced in week 40 (week commencing 29/09/03) the National Virus Reference Laboratory has tested 80 swabs from sentinel general practices. Thirty seven were positive, 15 were influenza A H3N2 and 22 were influenza A unsubtyped. There have been 6 positive specimens from the Mid Western region.

Since early September there have been three outbreaks of influenza reported in schools. Two outbreaks occurred in the Eastern Regional Health Authority region. Influenza A (H3N2) has been found on PCR test and serology on a number of cases. In total over 240 people mostly students were reported ill. Positive specimens from the second school outbreak in mid-September have been characterized as A/Fujian/411/2002. An influenza outbreak also occurred in a school for children with special needs in the South Eastern Health Board area.

The current vaccine should still offer some protection, particularly against severe disease. Vaccination is strongly recommended for those over 65, younger people who have chronic illness, such as lung or heart disease, diabetes or a suppressed immune system and also for key healthcare staff and carers. Further efforts must be made to maximize uptake of influenza vaccine among frontline healthcare workers.

The Director of Public Health has written to all clinicians with advice about the current influenza pattern and treatment options. A&E Department staff should be made aware that influenza is in circulation so that patients presenting with respiratory illness are treated (within reason) as quickly as possible and with minimum exposure to other patients.

Bacterial Meningitis

Evidence from the surveillance of bacterial meningitis indicates that pneumococcal and meningococcal disease is more common over the winter months. A pneumococcal vaccine is available to those with increased risk of infection.

Cases of meningococcal disease due to group C are now rare. However, vigilance is still needed to act quickly when invasive meningococcal disease is suspected – group B disease is still a major cause for concern. While the non-blanching rash and neck-stiffness are classic signs of disease, they can be late indicators. Signs in babies can be non-specific – irritability, floppiness and off feed.

While much emphasis is placed on these two pathogens as causes of meningitis it should be remembered that several other pathogens can cause bacterial meningitis on rare occasions. Notably cases of bacterial meningitis caused by *M. tuberculosis* and Group B Streptococci have been reported in the region recently. *Salmonella species* and *E. coli* can also cause this disease. Quite often the burden of disease is greatest in infancy but all can be treated.

Cases of viral meningitis occur and have been reported occasionally. These episodes are usually self-limiting and seldom as serious as bacterial disease. Antibacterial therapy has no effect on viral infection