Clinical notifications Quarter 1 2008

There were 40 clinical notifications of disease made to the Medical Officer of Health for Clare, Limerick and Tipperary North from the 1st January -31st March 2008, see table 2.

Disease	Notifications
Acute infectious gastroenteritis	4
Bacterial meningitis (not otherwise specified)	1
Campylobacter infection	7
Cryptosporidiosis	3
Hepatitis B (acute and chronic)	1
Influenza	1
Listeriosis	1
Malaria	1
Meningococcal disease	5
Mumps	10
Noroviral infection	2
Shigellosis	1
Staphlococcus aureus bacteraemia	1
Tuberculosis	2
Total	**40**

Revised Primary Childhood Immunisation Programme

The National Immunisation Advisory Committee (NIAC) has recommended a revised Primary Childhood Immunisation Programme (PCIP) as follows:

Age	Vaccine(s)
Birth	BCG
2 months	DTaP/Hib/IPV/HepB (6 in 1) + PCV
4 months	DTaP/Hib/IPV/HepB (6 in 1) + MenC
6 months	DTaP/Hib/IPV/HepB (6 in 1) + PCV + MenC
12 months	MMR + PCV
13 months	MenC + Hib

The changes from the current programme are:

- The addition of Hepatitis B (HepB) as part of a 6 in 1 vaccine (along with Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio and Haemophilus Influenzae B) to be given at 2, 4 and 6 months.
- The addition of pneumococcal conjugate vaccine (PCV) to be given at 2, 6 and 12 months
- Changes to the timing of 4th Haemophilus influenza type B (Hib) vaccine from 12 to 13 months
- Changes to the timing of Meningococcal C (MenC) vaccine from 2, 4 and 6 months to 4, 6 and 13 months.
- Plans are underway to implement the revised programme in September 2008, for children born from July 1st 2008.

Pneumococcal Catch-Up

In addition there will be a Pneumococcal Catch-Up vaccination campaign for children aged 2 months to 24 months. Children aged 2 to 6 months are to get 2 doses of pneumococcal conjugate vaccine at 6 and 13 months, while those over 6 months are to get 1 dose at 13 months. RF

Vaccination Uptake

The uptake of Bacillus Calmette-Guerin (BCG) vaccine in children aged 12 months in the first quarter of 2008 is just over 97%. Uptake of BCG vaccine has remained at this level since quarter four 2006. There has been a slight decline in the uptake of the '5-in-1' vaccine in the cohort aged 24 months in quarter one 2008 to just under 93% from 94% in quarter four 2007. This vaccine protects children from diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae b. According to the recommendations of the National Immunisation Advisory Committee, Hepatitis B vaccine will be added from September 2008 to create a 6-in-1 vaccine to be given at 2, 4 and 6 months as part of the Primary Childhood Immunisation Programme.
Uptake of the Measles Mumps Rubella vaccination in Clare, Limerick and Tipperary is just under 92%. OH

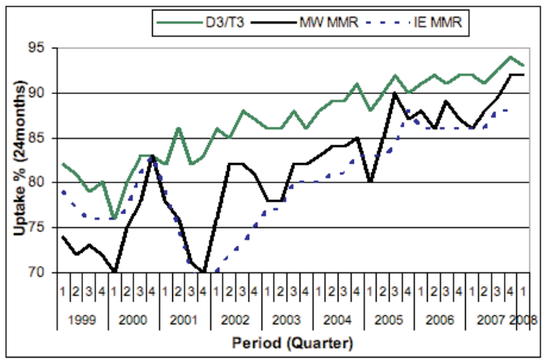

Figure 3: Percentage uptake of DT and MMR at 24mths in HSE MWA and MMR in Ireland. (D3-Diphtheria T3-Tetanus MMR=Mumps Measles Rubella)

Wear sunscreen - slogan to go here

Notice: We would encourage general practitioners to make a copy of ID-Link available in the surgery waiting area.

If your contact details have changed, please let the Department of Public Health know **(061-483337)** and this will ensure timely delivery of your copy.

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

Some data are provisional and are subject to amendment.

ISSN No. 1649-1912. All rates calculated using 2002 or 2006 Census data where appropriate.

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Department of Public Health,
HSE West,
31-33 Catherine St., Limerick
www.mwhb.ie

Clostridium difficile associated disease (CDAD) is notifiable from May 4th

The Department of Health and Children has instructed the HSE to include *Clostridium difficile* (toxin producing) as an organism notifiable under the category of "Acute Infectious Gastroenteritis (AIG)".
Notification under AIG is an interim measure until the disease and the related organism *Clostridium difficile* (toxin producing) are specified on the Infectious Diseases Regulations schedule of notifiable diseases in the near future.

Case classification
A confirmed *Clostridium difficile* associated disease case is a patient, two years or older, to whom one or more of the following criteria applies:
Diarrhoeal stools or toxic megacolon, with either a positive laboratory assay for *C. difficile* toxin A (TcdA) and/or toxin B (TcdB) in stools or a toxin-producing *C. difficile* organism detected in stool via culture or other means
Pseudomembranous colitis (PMC) revealed by lower gastrointestinal endoscopy
Colonic histopathology characteristic of *C. difficile* infection (with or without diarrhoea) on a specimen obtained during endoscopy, colectomy or autopsy
An additional positive result of a laboratory test performed on a specimen collected more than eight weeks after the last specimen that tested positive represents a new *C. difficile* case.

Notifications from clinicians
All clinicians diagnosing CDAD should notify cases by completing an Infectious Disease Notification form as "Acute infectious gastroenteritis - CDAD" and sending it to the Department of Public Health.

Reporting of CDAD
All clinical notifications will be entered into the national Computerised Infectious Disease Reporting system (CIDR) each week. Reports of CDAD will be produced and distributed each week by the Health Protection Surveillance Centre as for other infectious disease notifications.

Information re *C. difficile* is available on the HPSC website, including a Patient Information leaflet, see http://www.hpsc.ie/hpsc/A-Z/Gastroenteric/Clostridiumdifficile/ RF.



Influenza Surveillance

Data from sentinel GP reporting influenza like illness (ILI) shows that there is still influenza activity in the area up to the end of April. The peak of ILI reported through sentinel GP practises occurred in the first week of the New Year followed by a slightly lower peak in the 3rd and 4th week of January. The 2007-2008 influenza surveillance season ends on the 18th of May 2008 but the HPSC will continue to receive data from sentinel GP practises throughout the summer period and report same on a monthly basis.
There was little difference in the total number of laboratory notifications of Influenza from January to April 2008 and the same period last year. However there was a variation in the type of influenza circulating. Data from the MWRH laboratory shows that 51.2% of laboratory confirmed cases of influenza in January to April 2008 were Type B. This is a significant increase from 9% in the same period for 2007. Also data from the National Virus Reference Laboratory shows that Type A (H1) is circulating in the area this year as opposed to A (H3) last year, see table 1. OH

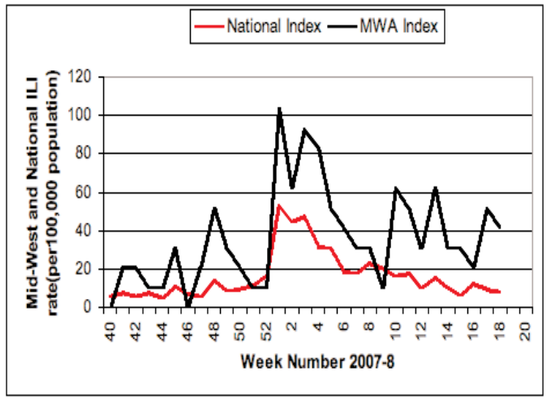


Figure 1: Weekly index of influenza like illness (ILI) (MWA and national) based on sentinel GP practises October 2007- May 2008.

	Total	Specimen type			Influenza A	Influenza B
		Serum	Swab	NP Aspirate		
MWRH Laboratory						
2007	84	49	35	0	76	8
2008	78	65	12	1	38	40
National Virus Reference Laboratory						
2007	12	0	12	0	12 (H3)	0
2008	16	0	16	0	7 (H1)	9

Table 1: Laboratory confirmed cases of influenza in Clare, Limerick and Tipperary North from January to April 2007 and 2008

Mumps Alert issued to Students on University of Limerick Campus

Since the beginning of the year, the Department of Public Health in Limerick has been notified of 18 cases of mumps across the Mid-West area with over half of these cases being students at the University of Limerick. Close contacts of the cases in UL who were not immune have been offered immunisation through the Student Health Service and GPs were alerted about this rise in the incidence of mumps in the region. Students on the UL campus were advised to ensure that they were fully protected against mumps by having had two doses of the MMR vaccine.

Like measles, mumps is caused by a virus from the paramyxovirus family, but it is from genus Paromyxovirus, which is antigenically related to the parainfluenza viruses. The virus is spread person-to-person by close contact between people who are not immune to the disease. It can be spread by coughing or sneezing and by direct contact with saliva or discharges from the nose and throat of infected individuals. People who are infected with mumps may spread the infection to others even when they do not have any symptoms. Mumps is contagious seven days prior to and nine days after the onset of symptoms. Those with the infection are most contagious two days before to four days after the onset of symptoms.

The symptoms of mumps include a low-grade fever, headache, malaise and swelling or tenderness of one or more of the salivary glands, most commonly the parotid but sometimes the sublingual or the submaxillary glands. Orchitis is most commonly unilateral and occurs in 20-30% of post-pubertal males with mumps. Mastitis occurs in up to 30% of females older than 15 years with the disease. Sterility is a rare sequel. Symptoms usually appear between the 12th and the 25th day after a person has been exposed to the virus that causes this disease. Between 20-30% of people with the disease do not show signs of infection but in a few people this may be quite a debilitating illness. Symptoms tend to decrease after one week and have usually resolved within 10 days of the onset of the disease.

Mumps infection usually occurs in school-aged children, teenagers or young adults who are not immune, although older people may contract the disease. Most infections in children less than two years are subclinical. Mumps is more common in winter and spring.

Cases of mumps are usually diagnosed clinically but there are other possible causes for acute parotitis and laboratory confirmation of a diagnosis of mumps infection is important with a blood or a salivary test. These tests detect the level of antibodies to the mumps virus that are present.

There is no specific treatment for mumps and treatment is based on relieving the symptoms.

Immunity to mumps will result from having either already had clinical mumps or from having received two doses of the MMR (measles, mumps, rubella) vaccine in the past – this vaccine gives 99% protection against mumps. Individuals who are already immune in one of these ways do not need to be vaccinated again.

In Ireland, MMR uptake rates among children remain below the target of 95% required to prevent the spread of mumps. Ensuring high coverage is important to prevent outbreaks occurring in non-immune individuals. The MMR vaccine was first introduced in Ireland in 1988 as a single dose vaccine at the age of 12-15 months and in 1992 a second dose of MMR was recommended for children aged 10-14 years. In 1999, the age of the second dose of MMR was lowered to children aged 4-5 years, i.e. pre-school. The introduction of the MMR vaccine has led to a significant decrease in the number of cases of mumps reported, but it is important that we achieve an adequate uptake rate to prevent outbreaks of the disease and provide herd immunity to those who are not vaccinated.

Most of those students born since 1988 will have been offered two doses of the MMR vaccine. However, if they are not certain that they are immune, the Department of Public Health has advised them to seek medical advice through their GP or Student Health Centre as to whether they need a further dose of the MMR vaccine to protect them. University Staff who think that they are not immune have also been advised to attend their own General Practitioner for this vaccine.

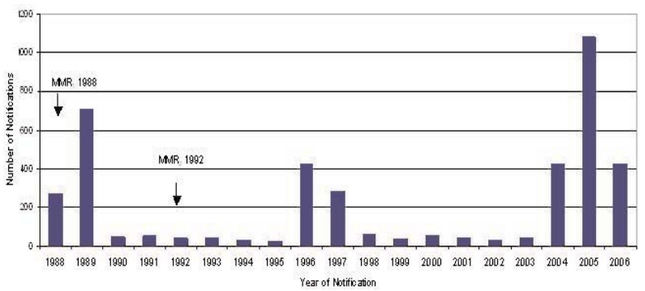
Individuals with mumps should not attend work, school, college, university or child-care during their infectious period (for 10 days from onset of parotid swelling) in view of the possibility of transmitting virus to non-immune individuals.

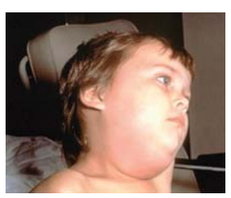
Infection with mumps during the first 12 weeks of pregnancy is associated with an increased risk of spontaneous abortion but malformations have not been found following mumps virus infection during pregnancy. However, pregnant women should not receive mumps vaccine (i.e. not receive MMR vaccine). Women who are not pregnant and receive MMR vaccine should be advised to avoid pregnancy for two months after vaccination.

Mumps was made a notifiable disease in Ireland in 1988 and there has been a dramatic decrease in the number of mumps cases reported since the MMR vaccine was introduced. However, in recent years outbreaks of mumps have occurred, particularly in student populations where non-immune individuals may be in close contact with each other.

The complications of mumps that may occur include meningitis (occurs in up to 15% of patients), orchitis (occurs in up to 40% of post pubertal males but sterility is rare) and oophoritis (occurs in approximately 5% of post pubertal females). Mastitis is also reported in female patients. More rarely, pancreatitis, encephalitis or deafness may occur and other complications may include mastitis, arthritis, nephritis, pancreatitis, or myocarditis. The mumps fatality rate is reported at between 1-3 deaths per 10,000 cases.

Hopefully, we can reduce the possibility that outbreaks of this disease will occur by improving the uptake rate for MMR vaccination, so that children and young adults are protected by having received two doses of this vaccine as part of their childhood immunization schedule. PO'S





This child is very swollen under the jaw and in the cheeks due to mumps.
Courtesy of Centers for Disease Control and Prevention, USA.

Figure 2: Number of Mumps Notifications in Ireland, 1988-2006 (courtesy Health Protection Surveillance Centre, Dublin.)