



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Infectious Disease News

HSE – South (Cork & Kerry)

Volume 7, Issue 1, March 2009



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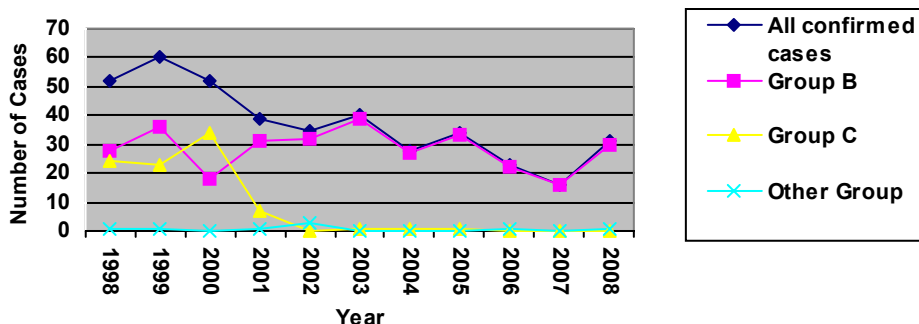
** If you would like any particular topics covered in this bulletin, please let us know at dph@hse.ie*

Meningococcal Disease: Cork & Kerry 2008

2008 saw an increase in notifications of meningococcal disease in Cork and Kerry. A total of 33 notifications (31 confirmed cases) were received, compared to 22 notifications (16 confirmed cases) in 2007. Tragically two children died last year. There had been no deaths in the previous three years.

We have now seen the full and dramatic effect of the Men C campaign (which ran from 2000 to 2002) on meningococcal disease, with no cases of Group C disease in the last three years, compared to 58 cases in 1999-2000. Figure 1 shows the number of confirmed cases for the last 11 years and the breakdown of the meningococcal group of those cases. The decrease in Group C cases is dramatically seen in this graph. While there have been some fluctuations in Group B cases, these continue to occur, with an average of 28 cases per year over the 11 year period. We are unlikely to see any further dramatic reductions in meningococcal disease until a vaccine against the Group B strain is available.

Figure 1. Confirmed meningococcal diseases cases, Cork & Kerry, 1998 to 2008



Cases tend to occur more frequently in the winter and spring months and this pattern was evident in 2008, see Figure 2. Those most at risk are children under 5 years, particularly infants under 1 year, see Figure 3. In total 65% of cases occurred in the under 5 year olds. Of the 31 confirmed cases, 30 were Group B and 1 Group W135.

Figure 2. Seasonal distribution of confirmed cases 2008

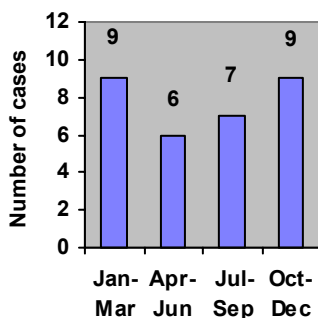
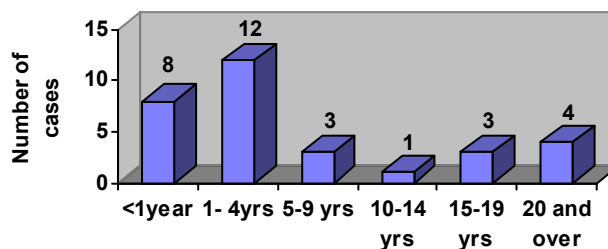


Figure 3. Age distribution of confirmed cases 2008



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Summary

There was an increase in the incidence of meningococcal disease in 2008, with an incidence of 5.0 per 100,000 compared to 2.6 in 2007. The incidence in 2007 was the lowest recorded in recent years. The dramatic effect of Men C immunisation continues, with no cases of Group C meningococcal disease occurring in 2008 for the third consecutive year.

Tuberculosis—An ongoing problem

Global

Worldwide, TB accounts for over 9 million new cases every year, mainly in Asia and Africa. In 2006, nearly 8% of new cases were co-infected with HIV. About 2 million deaths due to TB occur annually¹.

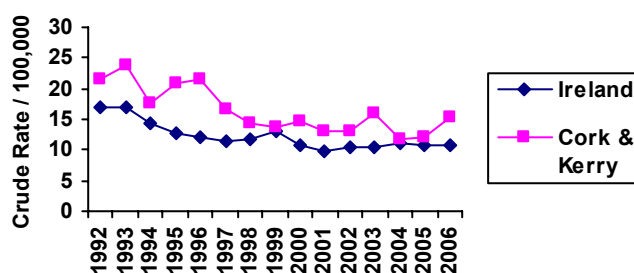
Europe

Rates in Europe rose steadily over the last decade. The Eastern European region (comprising most of the states of the former Soviet Union) reported rates in excess of 110 cases/100,000 population in 2006. Former Soviet Union countries have the greatest burden of disease (72% of notifications in Europe in 2006), the highest rates of multi-drug resistant TB and the highest mortality rates².

Ireland

Ireland had 465 TB notifications in 2006 (11 cases/100,000). Provisional data for 2007 reports little change at 478 cases³. National trends over the last decade are shown (Figure 1), along with rates from the Cork/Kerry region.

**Figure 1. Notified Cases of Tuberculosis
Ireland & HSE-South (Cork & Kerry) 1992-2006**



HSE-South (Cork & Kerry)

In 2006, this region had 95 new TB cases. Data for 2007 and 2008 are as yet provisional (2007 = 110 cases; 2008 = 96 cases). Twenty-one cases were linked to the large crèche associated outbreak in Cork in 2007.

**Table 1. TB Cases 2006
HSE-South (Cork & Kerry)**

Area	TB Cases
North Lee	47
South Lee	29
North Cork	7
West Cork	3
Kerry	9
HSE-South (Total)	95

Key features 2006:

- +Highest rates North Lee
- +Irish born 75% ; Foreign-born 25%
- +Age-group 25-34 yrs most common
- +61% pulmonary disease alone; 28% extrapulmonary alone; 11% both
- +One multi-drug resistant case
- +68% of cases culture positive.
- +All *M. tuberculosis* apart from one *M. bovis*.

TB Control

The cornerstones of an effective TB control programme are (1) prompt and accurate diagnosis, (2) effective treatment and (3) identification and appropriate management of contacts.

All persons with an otherwise unexplained productive cough lasting three or more weeks with at least one additional symptom, including fever, night sweats, weight loss or haemoptysis should be evaluated for tuberculosis.⁴

TB cases in this region are treated by hospital-based clinicians. TB treatment is lengthy. Problems with compliance can arise. In recent years, about 10-16% of cases in this region started on directly observed therapy (DOT). DOT demands intensive cooperation over extended periods between public health professionals in the community and the patient, family members, treating clinician and family doctor. Public health systems ensure the follow up of TB contacts by a process of identification and screening. Following screening, any newly identified cases are referred for specialist attention. For other contacts, preventive antibiotic treatment (prophylaxis) is prescribed, where indicated, and chest x-ray follow up is arranged as appropriate.

New National Guidelines

The National TB Advisory Committee is currently reviewing Irish guidelines on the prevention and control of TB in Ireland. It is expected that these guidelines will be finalised and available later this year.

Useful Website Links

- Health Protection Surveillance Centre (Ireland) <http://www.ndsc.ie/hpsc/A-Z/VaccinePreventable/TuberculosisTB/>
- Health Protection Surveillance Centre (UK) <http://www.hpa.org.uk/> (Under Topics A-Z)
- Centers for Disease Control (USA) <http://www.cdc.gov/tb/>

References available on request.

