Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Infectious Disease News

HSE – South (Cork & Kerry)

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In this Issue:

New Healthcare Associated Infection and MRSA Leaflets

New Healthcare Associated Infection and MRSA leaflets, aimed at patients and the public, are now available.

MRSA: Information for Patients and Visitors 2006 and *Healthcare Associated Infection: Information for Public and Patients* leaflets are designed by the Health Protection Surveillance Centre for use in the hospital setting. These are being distributed to all hospitals and further copies can be obtained from the infection control services in the hospitals or directly from the National Hospitals Office (grace.rothwell@maila.hse.ie)

MRSA: An information leaflet for patients and their families is designed by the HSE South (Cork and Kerry) for use in the community and includes practical advice for households where a family member has MRSA. We are enclosing a copy of this leaflet, with this ID Bulletin, for all GPs. Further copies can be obtained from the Primary Care Unit, contact details (021) 4965511.

Influenza Surveillance

In the Northern Hemisphere, influenza season commences in October and continues through to May. In general influenza outbreaks last between 6 – 8 weeks and can affect all ages, in particular the extremes of age. Influenza surveillance can provide information that may help in the management of such an outbreak.

Influenza surveillance involves collection of both clinical and virological data. Clinical surveillance monitors the impact of the illness on the health service and the community, while virological surveillance confirms that influenza is circulating and also identifies the current strain.

The Health Protection Surveillance Centre in partnership with the Irish College of General Practitioners and the National Virus Reference Laboratory (NVRL) have established a network of forty-six computerised sentinel general practices who report on a weekly basis the number of patients seen with influenza-like illness. Influenza-like illness is characterised by the sudden onset of symptoms with a temperature of 38°C or more, in the absence of any other disease, with at least two of the following: dry cough, headache, sore muscles and a sore throat.

As there is little difference in the presenting symptoms of a number of respiratory infections, virological confirmation is required to identify that influenza is the causative agent. The NVRL can detect and identify if influenza A and/or B viruses are circulating. Further identification of subtypes of influenza A isolates is also carried out. Samples received at the NVRL undergo polymerase chain reaction studies, cell culture and virus isolation.

Following collection of the data a weekly influenza report is compiled throughout the influenza season, which runs from October to May. Both graphs and tables are used to display the clinical and virological data from the sentinel practices and the NVRL. Reports of influenza activity in Europe and Worldwide are also provided as part of the overall monitoring of influenza activity.

These weekly influenza reports can be accessed on the internet at www.hpsc.ie , click on *Topics A-Z* from the menu, click on *flu* and then on *publications*.

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Communicable Disease Screening in Asylum Seekers in Cork City 2002-2004

Asylum seekers may come from countries where certain communicable diseases are more prevalent than in Ireland and where vaccination programmes are less well developed. Asylum seekers are encouraged to avail of voluntary comunicable disease screening (HIV, Hepatitis B, Rubella, Varicella and TB) and vaccination services. A data review showed that the uptake of voluntary screening was high. Screening identified significant levels of infection requiring specialist referral and non-immunity to vaccine preventable disease in a high-risk population. The prevalence rates of infectious disease reflect those of the country of origin

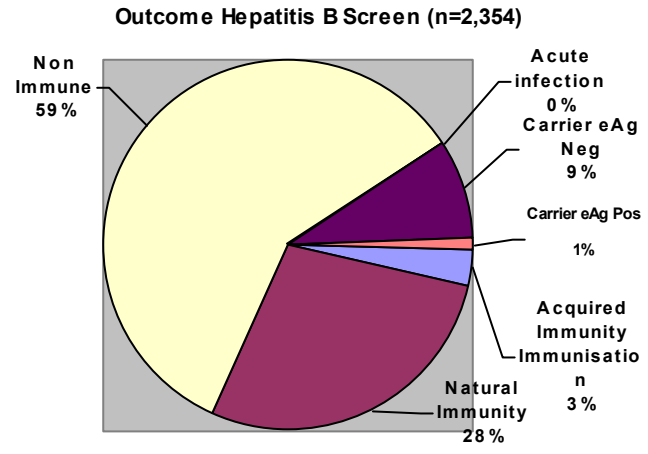
Data on all asylum seekers (n = 4,780) attending communicable disease screening services in Cork and Kerry was collated prospectively for a three-year period from 2002-4. The vast majority (96%) were under the age of 40 years of age, a quarter were in the 25-29 year age group and 29% were under 19 years of age. Overall 49% were male and 51% female. Asylum seekers originated from 76 countries, Nigeria (30%) was the most common country of origin. Thirty principal languages were identified of which English (28%) Russian (12%), French (9%) and Yoruba (8%) were the most common. Interpretive services were used in 2% of consultations.

HIV Screen

Of those tested for HIV, 98% were HIV negative and 2% were HIV positive, 1% of males, 3% of females and 3% of pregnant women were HIV positive. The vast majority (92%) of HIV cases originated in Africa. Three quarters of the 48 HIV cases identified were female and 36% of female HIV cases were pregnant. All HIV positive cases were referred to an ID consultant for assessment and treatment. There was no vertical (mother-to-infant) transmission of HIV infection for 2002-4.

Hepatitis B Screen

Of those screened for Hepatitis B infection, 59% were non-immune, 28% had evidence of past infection, 3% were immune due to past immunisation, 9% were e Ag negative carriers, 1% was e Ag positive carriers. **Overall 10% of pregnant women were Hepatitis B virus (HBV) carriers.** All non-immune are offered HBV vaccine, using the normal schedule with doses at 0,1, and 6 months and with post vaccination testing at 8 months.



Rubella & Varicella

90% of women were immune to rubella and 10% were non-immune. 85% of babies born to women infected with rubella in the first trimester will develop Congenital Rubella Syndrome. 83% of women were immune to varicella, 17% were non-immune. While the majority of women who contract varicella in pregnancy do not suffer any lasting harm to mother or baby, varicella can cause severe illness in mother, fetus and neonate.

TB Screen

The vast majority (97%) were not infected with TB. Overall 4% had a history of TB and 83% had a BCG scar. One percent of those screened for TB were cases. There were 3 infectious Pulmonary TB cases (0.2%), 6 non-infectious pulmonary cases (0.3%) one extra pulmonary case (0.1%) and 4 latent TB infections (0.3%). Information was not recorded in the other 2%.

It is important to remember that:

In the absence of intervention an estimated 15-30% of mothers with HIV will transmit infection during pregnancy and delivery and 10-20% through breast milk. **All HIV cases should be referred to an ID consultant, particularly when pregnant.**

Perinatal transmission of HBV occurs vertically from an infected mother to her infant. It is a highly efficient mode of transmission, the risk ranging from 20% - 90% depending on the infectivity of the mother. The administration of Hepatitis B immunoglobulin (HBIG) and HBV vaccine in hospital and 2 shots of HBV vaccine at 1 and 6 months by the GP result in a 90% reduction in the risk of vertical transmission. An anti-Hepatitis B surface antigen (anti -HBsAg) serology test should be done 2 months after the third vaccine to check the response and an HBsAg test to check if vertical transmission has occurred.

The risk of Chronic Hepatitis B Infection is 90% for infants infected at birth, 20-50% for children infected aged 1-5 and 1-10% in older children and adults. **All household contacts of HBV carriers, particularly children should be screened and receive HBV vaccine if non-immune**.

Women who are non-immune to rubella should receive two MMR vaccines one month apart (after delivery or non-pregnant women).

Varicella is highly infectious and there have been a number of outbreaks of varicella in accommodation centres where pregnant asylum seekers and children are housed. **GPs are advised to notify Public Health when they become aware of a case of varicella residing in accommodation centre as pregnant non-immune women can be followed up and if exposed can be admitted to maternity hospitals for Varicella Zoster immunoglobulin (VZIG).**

The WHO indicates that more than 85% of refugees originate in regions of the world with high TB rates. **It is important that professionals remember TB as a differential diagnosis in a patient originating in a high endemic country. Babies born to asylum seekers/ refugees should receive BCG.**

Department of Public Health, HSE-South (Cork & Kerry), December 2006