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HUNTER NEW ENGLAND NSW HEALTH

Communicable Diseases Bulletin

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Index

- **Hepatitis C Update from the Viral Hepatitis Clinical Group**
- **Hepatitis A Alert for your Patients Travelling to Latvia and Czech Republic**
- **Simple and Effective Steps To Enhance Respiratory Outbreak Management**
- **Correct anti-malarial advice for travellers to malarious areas. Therapeutic Guidelines - Antibiotic (v 13) gives most current advice for malaria prophylaxis**
- **Young men at risk of mumps**
- **Safe re-use of greywater to minimise risk to people and the environment**
- **GP notifications**
- **YTD number of diseases notified to Population Health for residents of Hunter New England Area – September 2008**
- **To the Point**

24 hour contact numbers for Hunter New England Population Health

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Hunter New England Health Service

Hepatitis C Update from the Viral Hepatitis Clinical Group

World Hepatitis Day - 19 May 2008

World Hepatitis Day was held on Monday 19th May with the following week being the National Hepatitis Awareness Week. During the months prior to the awareness week a teaser campaign was conducted asking the question "Are You Number 12?" The inference being that one in 12 people worldwide are infected with either hepatitis B or hepatitis C. A good response to this campaign was reported by the Hepatitis C Council of NSW and can be accessed on www.hepatitisc.org.au

Viral Hepatitis Clinical Group

Over the past two years there have been a number of changes to the Hepatitis Service that have resulted in the development of a Viral Hepatitis Clinical Group. The group consists of various medical specialities including Gastroenterologists, Hepatologists and Infectious Diseases Physicians. It also includes nursing, allied health and administrative support staff. One of the nurses is Tracey Jones, the Hepatology Nurse Practitioner (HNP), whose clinical practice guidelines have recently been approved for use within the Hunter New England Health Service. The position is the first of its kind in the state and is a significant bonus for the area and the affected community. A significant part of the clinical practice guideline is the inclusion of the HNP prescribing formulary. The HNP will be initiating medications from the approved formulary when required for the patients reviewed by the Viral Hepatitis Clinical Group.

Treatment clinics within Hunter New England

Whilst the main treating centre for Hunter New England Health is the Viral Hepatitis Clinical Group located at John Hunter Hospital, there are two other centres, Taree and Tamworth that offer a range of services to the Viral Hepatitis community.

For information on the referral process for the three centres please contact:

John Hunter Hospital:
Tracey Jones - Ph: (02) 49214789

Taree Community Health:
Julie Elmes - Ph: (02) 65929432

Tamworth Hospital:
Rosemary Goodman - Ph: (02) 67678216

Recently the clinics have been experiencing an increase in the number of patients being referred for viral hepatitis assessment that have complex including mental health disorders. Whilst a mental health disorder is not an exclusion criteria for accessing therapy, it is an issue that must be assessed and often requires the development of a multidisciplinary service support plan. The patients' general practitioner will be included as part of the team.

Hepatitis A Alert for your Patients Travelling to Latvia and Czech Republic

Two reports in a recent Eurosurveillance Bulletin (Vol 13 issue 40; 2 October 2008) (www.eurosurveillance.org) highlighted ongoing outbreaks of hepatitis A in both Latvia and the Czech Republic. There is no link between the two outbreaks.

Whilst the majority of cases occurred in intravenous drug users and lower socio-economic groups, both countries report cases from all levels of their communities.

As Eastern Europe is now a popular winter holiday spot (for cheaper skiing and snowboarding holidays), and a number of community members may want to visit families in Latvia and the Czech Republic for Christmas, it is important to advise about maintaining high hygiene standards.

For non-immune people, hepatitis A vaccine is a good option; however the 1st dose will need to be given at least two weeks before departure.

Simple and Effective Steps to Enhance Respiratory Outbreak Management

HNEPH would like to commend a facility managed by Uniting Care Ageing in the Hunter New England area on their management of an outbreak of respiratory illness recently. Because the facility had implemented additional processes, the impact on the residents was minimal (6/100 affected). In addition to the recommendations in: *Practical Guide for the Management of Influenza Outbreaks in Residential Care Facilities in Australia July 2008* (Communicable Disease Network Australia), the facility also implemented the following steps:

1. Staff education program implemented at the time of outbreak – staff viewed the DVD “Infection Control and PPE in Respiratory Disease” produced by the Commonwealth Department of Health and Ageing.
2. Cohorted staff in all areas of the facility.
3. Strategies to ensure resident safety due to ward closure
4. 98% of staff had attended mandatory infection control training for 2007-2008
5. Extra staff rostered for night duty due to the division of areas during the outbreak, to promote safety and security amongst residents.

Correct Anti-Malarial Advice for Travellers to Malarious Areas. Therapeutic Guidelines - Antibiotic (v 13) gives most current advice for malaria prophylaxis

Now is a popular time for people to travel to Papua New Guinea and travel the Kokoda Track. It is important that travellers are given the correct anti-malarials for the recommended time.

HNEPH recommends using the Therapeutic Guidelines Antibiotic (v 13), which provides the most current recommendations for malaria chemoprophylaxis.

It needs to be stressed that malaria chemoprophylaxis is not necessarily 100% effective and any signs and symptoms of disease should be investigated.

Recommendations for chemoprophylaxis are based on the area of travel, as drug resistance is prevalent in some areas.

The World Health Organisation and Centers for Disease Control websites have information for specific geographical areas.

<http://www.who.int/malaria/malariaandtravellers.html>
<http://www.cdc.gov/travel/diseases.htm>

Recommendations for duration of chemoprophylaxis

When prescribing doxycycline (not to be used for children <8 yrs)

Commence 2 days before entering and continue **until 4 weeks** after leaving malarious area.

When prescribing atovaquane + proguanil

Commence 1-2 days before entering and continue **until 7 days** after leaving malarious area.

When prescribing mefloquine

Commence 3 weeks before entering and continue **until 4 weeks** after leaving malarious area.

When prescribing chloroquine

Commence 1 week before entering and continue **until 4 weeks** after leaving malarious area (there are few areas where malaria is chloroquine-sensitive).

Reference: Antibiotic Reference Group (2006) *Therapeutic Guidelines (Antibiotic) version 13 p150*

Young Men at Risk of Mumps

It is possible that a number of young men in the 20-30 year age group are not fully immunised against mumps, as a second dose of mumps-containing vaccine for Year 7 males was only introduced in 1994.

GPs are advised to give an MMR vaccine to their male and female patients in this age group unless there is a good history of 2 doses of a mumps containing vaccine (MMR) or immunity is confirmed.

Mumps is now a relatively rare infection in Australia because of the high rate of immunisation with the MMR Vaccine which is given at 12 months and 4 years; however in 2007 there was an outbreak in young people, predominantly males, in Sydney. Eurosurveillance continues to report mumps cases in the UK.

Symptoms - an acute viral illness characterized by fever, headache, malaise, and swelling and tenderness of one or more salivary glands, usually the parotid and sometimes the sublingual or sub-maxillary glands. Thirty percent of cases have no swelling of the parotid glands.

Infectious period - 6 days before parotid swelling to 9 days after, with maximum infectiousness 2 days before and 4 days after.

Other reasons for parotitis to consider include:

- Bacterial Infection, usually in elderly, patients on medications causing a dry mouth.
- Salivary stone in the parotid gland.
- Mucus plugs in salivary ducts.
- Sjogrens Syndrome - chronic autoimmune salivary disease.
- AIDS - 5% of patients have enlarged parotid glands.
- Tumour
- Certain medical conditions such as diabetes, alcoholism and bulimia.

Mumps is a notifiable condition under the *Public Health Act 1991* by hospitals, child care centre directors, school principals and medical practitioners.

In Australia, only confirmed Mumps are included in disease figures. To date there have been **no** confirmed cases of Mumps in HNEAHS during 2008.

Safe Re-use of Greywater to Minimise Risk to People and the Environment

More and more families are using greywater systems for both ecological and economical reasons. Health concerns have been raised about its use.

The NSW government has developed best practice guidelines for households wanting to re-use their grey water. The guidelines can be accessed at:

http://www.waterforlife.nsw.gov.au/data/assets/pdf_file/0017/11771/Greywater_guidelinesSep2007.pdf

GP Notifications

HNEPH staff wish to thank the following GPs for reporting presumptive cases of notifiable diseases during August 2008.

Lise Burgess	Isobel Lang
Clinton Clunas	Nigel Pain
Catherine Eve	B Zhang
Colin Fair	

**Year to date (YTD) number of diseases notified to Population Health for residents of
Hunter New England Area – September 2008**

Disease	YTD: Number of notifications					Year Total: Number of notifications				NSW	
	Y2008	Y2007	Y2006	Y2005	Y2004	T2007	T2006	T2005	T2004	YTD	NSW2007
Blood Borne Virus											
Hepatitis B - newly acquired	4	7	5	3	5	8	8	3	9	28	55
Hepatitis B - unspecified	60	42	51	68	50	61	72	87	69	2147	2531
Hepatitis C - newly acquired	4	7	4	3	6	7	6	4	6	14	49
Hepatitis C - unspecified	391	318	312	306	326	416	428	404	454	3418	3572
Hepatitis D	0	0	0	2	0	0	0	2	0	9	11
Gastrointestinal Disease											
Cryptosporidiosis	32	32	78	58	24	106	109	146	51	379	544
Giardiasis	154	172	153	130	118	226	210	181	145	1376	1940
Haemolytic uraemic syndrome	0	3	0	1	0	6	1	2	1	9	12
Hepatitis A	1	0	2	6	7	1	2	6	8	46	65
Hepatitis E	0	0	0	0	0	0	0	0	1	8	8
Listeriosis	0	2	4	5	1	5	7	6	1	27	22
Salmonellosis	170	187	164	155	182	269	240	225	251	1587	2540
Shigellosis	1	4	0	6	10	4	3	8	12	61	70
Typhoid and paratyphoid	0	1	0	0	0	1	0	0	1	27	33
Verotoxin producing E. coli	2	3	1	4	2	13	3	10	2	9	23
Sexually Transmitted Infection											
Chlamydial infection - genital	1506	1270	1314	1220	1050	1750	1857	1670	1442	9989	12191
Chlamydial infection - congenital	7	1	7	4	6	2	10	5	9	25	30
Gonococcal infection	84	40	62	57	52	85	74	106	69	927	1354
Syphilis	23	25	17	29	21	33	24	38	30	812	1069
Vaccine Preventable Disease											
Adverse events following immunisation	15	18	7	19	11	19	8	22	14	208	233
H. influenzae (type b) infection	1	1	1	1	1	1	1	2	1	9	7
Influenza	172	288	86	73	27	298	93	88	75	1171	1909
Measles	0	1	1	0	0	1	1	0	0	38	4
Meningococcal disease - invasive	8	5	11	11	18	12	12	13	24	64	111
Mumps	0	3	3	4	2	6	3	4	3	64	318
Pertussis	180	191	454	394	353	264	537	561	524	3245	2096
Pneumococcal disease - invasive	51	64	65	65	105	82	86	88	129	401	520
Q fever	22	42	41	31	49	68	59	51	73	110	206
Rubella	0	1	1	2	0	1	1	3	0	11	9
Vectorborne Disease											
Arboviral infection	354	292	382	229	286	405	452	292	335	1489	1497
Barmah Forest virus disease	105	103	168	95	77	135	193	120	98	437	572
Dengue fever virus disease	9	2	1	1	4	3	2	3	5	91	80
Malaria	6	12	12	25	7	17	19	30	9	85	95
Ross River virus disease	240	187	213	133	202	266	257	169	228	958	842
Zoonoses											
Leptospirosis	3	2	9	8	13	2	10	11	20	12	9
Psittacosis	5	4	22	15	25	5	27	26	36	31	35
Other Conditions											
Creutzfeldt-Jakob disease	0	1	2	1	1	1	2	1	1	2	7
Elevated blood lead level	29	16	37	43	52	23	41	56	76	189	279
Legionnaires disease	5	7	5	3	3	9	10	4	3	55	105
Tetanus	0	0	0	0	0	0	0	0	0	1	2
Tuberculosis	8	15	11	12	8	19	12	15	13	243	454

To The Point

Pertussis alert

NSW Health recently issued a pertussis alert to the community following notification of over 3,000 cases to date in 2008. This is more than double the number of cases for the same period in 2007.

In the last 2 months we have received a substantial number of cases in the < 20 years of age group. All these cases are followed up to establish the onset of symptoms and immunisation status. For school age children, an awareness raising letter is sent to the child's school for distribution to the school community.

What to do?

Individuals of any age can receive pertussis-containing vaccine, even those who reacted adversely to the former pertussis whole cell (Pw) vaccine, which was used prior to 1997:

Especially advise diphtheria, tetanus and acellular pertussis (dTpa) for adults who are:

- Parents of young infants;
- Soon-to-be parents (even if pregnant if pertussis risk is high, or immediately after pregnancy)
- Grandparents; and
- those in contact with small children such as health care workers or childcare workers

General Practitioners can give free 15 year old booster adult dose dTpa opportunistically (Boostrix™) during this outbreak if 15 year olds attend for another reason; refer to their own GP if the child attends elsewhere (eg GP Access).

GPs can access free dTpa vaccine from HNE Population Health. 4924 6477 (Newcastle).

From 1st term 2009, a school-based dTpa vaccination program for Year 10 students will be offered.

Ensure vaccines are given on time at age 2, 4, 6 months and 4 years of age.

Do NOT delay vaccination unnecessarily. Coughs, colds, ear infection, URTIs, & fever <38.5°C are NOT valid contraindications.

Catch-up overdue children. Check every child's blue book immunisation page, even if they are seeing you for something else; have all due vaccines be given? Children 4 years and over should have received 4 doses of pertussis-containing vaccine. Check the number of doses rather than the age.

Immunise on-the-spot. If a child/adult is not up-to-date, discuss the risks of delays and prompt parent/client to immediately seek catch-up vaccination.

Pertussis fact sheet can be accessed at the NSW Health website:

<http://www.health.nsw.gov.au/factsheets/infectious/pertussis.html>

Hunter New England Health Population Health website with other immunisation-related links:

<http://www1.hnehealth.nsw.gov.au/hneph/Immunisation/Immunisation.htm>