

Public Health News

Quarterly newsletter from the CDC Teams of Brisbane Northside and Moreton Bay

health • care • people

JUNE 2011

The Temperature Drops but our Work Doesn't Stop!

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2011 started off as an eventful year and things look set to continue.

As winter sets in, it's not just the freezing temperatures we have to watch out for. Winter brings its own unique challenges for the Public Health Units and our wider medical community.

Before we even thought to dig out the snuggies and bed socks, the Flu season was upon us. It began several months earlier than usual and notifications have been four times higher than previous years.

To help minimise spread, please encourage your patients to have the flu vaccine this year and advise anyone who develops the flu to stay home until they are no longer infectious.

Our public health units have also been battling increasing numbers of outbreaks of viral gastroenteritis in Child Care Centres as we reach peak season for these illnesses.

This season is also typically the peak season for meningococcal disease, so take care to look out

for the signs in your patients. See page 2 for more details.

It's not all bad news though. This year, the Brisbane North Public Health Unit warmed up to winter by hosting a successful Australia's Biggest Morning Tea to help raise much needed funds for Cancer Council Qld.



We would like to thank all of our Brisbane North and Moreton Bay staff for their valuable contribution to this issue of Public Health News.

We would also like to thank you, our professional colleagues for helping us deliver quality public health outcomes in the Brisbane Northside and Moreton Bay regions.

Calendar

July 3—NAIDOC Week
 July 28—World Hepatitis Day
 August 19—World Humanitarian Day
 August 20—40 Hr Famine
 September 23—World Rabies Day

Alert: Meningococcal Disease

Meningococcal disease is an acute bacterial infection that can lead to serious illness.

It is uncommon in Queensland but occurs more often around late winter and early spring.

Meningococcal disease usually causes meningococcal meningitis and/or meningococcal septicaemia.

The symptoms of meningococcal disease are non-specific but may include fever, headache, neck stiffness, joint pain, petechiae and purpura¹, photophobia, drowsiness, nausea and vomiting. The rash is often a late sign.

Young children may have less specific symptoms including irritability, difficulty walking, high pitched crying, refusal to eat, pale blotchy complexion and cold extremities.

Early diagnosis of meningococcal disease can be difficult, but where the clinical presentation of the condition is suggestive, early treatment is vital to prevent serious complications. If you suspect a patient has meningococcal disease they should be given an appropriate antibiotic (see table below) immediately and admitted to hospital. Public Health should also be notified.

Confirmation of the diagnosis involves taking samples of blood and/or cerebrospinal fluid for PCR and culture.

Treatment should not be delayed while awaiting confirmation of the diagnosis.

¹A rash of red-purple spots or bruises may be assessed using the glass test. Simply press a clear glass firmly against the rash. A rash that does not fade under pressure may be a sign of meningococcal septicaemia. However, be aware that this test is not 100% reliable, especially in the early stages.



(Picture sourced from www.meningitis-trust.org)

Antibiotic	Dosage
Benzylpenicillin	Child <1year: 300mg IV or IM single dose Child 1-9years: 600mg IV or IM single dose Adult of child >10years: 1.2g IV or IM single dose
Ceftriaxone	50mg/kg (up to 2g) IV or IM single dose

Empirical therapy prior to hospitalisation.

The meningococcal rash can take the following forms:



Blister



Spot



Major Haemorrhage

(Pictures sourced from www.stephensfoundation.org.au)

Acute Rheumatic Fever & Rheumatic Heart Disease

Acute Rheumatic Fever (ARF) is an auto-immune response to bacterial infection with group A streptococcus (GAS). People with ARF often suffer severe pain and require hospitalisation.

After an acute episode of ARF, a person may suffer damage to their heart valves (Rheumatic Heart Disease—RHD) and are much more likely to suffer from subsequent episodes of ARF.

Recurrent episodes of ARF can lead to further valve damage and worsening of RHD, so it is important to diagnose (see table below) and manage ARF appropriately.

Several factors currently contribute to inadequate diagnosis and management of ARF and RHD in Australia. This includes limited clinical awareness of, and experience in managing the disease; variability in the management of the disease; and limited access to health care services for high risk groups.

Although ARF is rare in industrialised countries, Aboriginal and Torres Strait Islander Australians living in rural or remote settings are known to be at high risk, particularly children aged between five and 14 years. Some of these children may

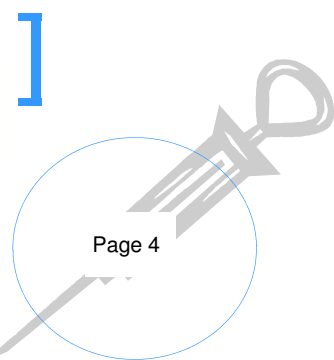
travel or move to south-east Queensland and may present to your practice.

If you suspect one of your patients may have ARF it is important to conduct an echocardiography to confirm or refute the diagnosis of rheumatic carditis. It is also recommended that you conduct the following investigations for all suspected cases:

- White blood cell count
- Erythrocyte sedimentation rate
- C-reactive protein
- Blood cultures if febrile
- Electrocardiogram
- Chest x-ray if clinical or echocardiographic evidence of carditis
- Throat swab culture for GAS
- Anti-streptococcal serology: both anti-streptolysin O and anti-DNase B titres, if available.

For further information on ARF or RHD see www.rhdaustralia.org.au or www.heartfoundation.com.au

	High Risk Groups	All Other Groups
Initial episode of ARF	2 major or 1 major and 2 minor manifestations plus evidence of a preceding GAS infection	
Recurrent attack of ARF with known past ARF or RHD	2 major or 1 major and 2 minor or 3 minor manifestations plus evidence of preceding GAS infection	
Major Manifestations	-Carditis (including subclinical evidence of rheumatic valve disease on echocardiogram) -Polyarthritis, aseptic monoarthritis or polyarthralgia -Chorea -Erythema marginatum -Subcutaneous nodules	-Carditis (including subclinical evidence of rheumatic valve disease on echocardiogram) -Polyarthritis -Chorea -Erythema marginatum -Subcutaneous nodules
Minor Manifestations	-Fever -ESR>30mm/hr or CRP>30mg/L -Prolonged P-R interval on ECG	-Fever -Polyarthralgia or aseptic monoarthritis -ESR>30mm/hr or CRP>30mg/L -Prolonged P-R interval on ECG



Just for Jabbers

Changes to the National Immunisation Schedule (NIP):

Prevenar 13® will be added in the National Immunisation Program

From 1 July 2011 the seven valent pneumococcal conjugate vaccine, Prevenar® will be replaced with the thirteen valent pneumococcal conjugate vaccine, Prevenar 13® in Queensland and all states and territories except the Northern Territory. Prevenar 13® will replace:

- Prevenar® at 2, 4 and 6 months of age for all children
- Prevenar® at 12 months of age for children with underlying medical conditions associated with greater risk or severity of invasive pneumococcal disease; and
- Prevenar® at 2 years of age for Aboriginal and Torres Strait Islander children living in high risk areas including Queensland.

A time limited program providing a supplementary dose of Prevenar 13® for children aged between 12 and 35 months who have completed primary vaccination with 3 doses of Prevenar® will commence on 1 October 2011.

Suspension of Pneumovax 23 for 2nd and subsequent doses of the vaccine

In March this year, NSW were experiencing a larger than normal number of Adverse Events Following Immunisation (AEFI) to Pneumovax23, related to a particular batch. Recall of the implemented batch commenced on 25 March 2011.

Analysis of these adverse reactions suggests that the largest number of reactions is occurring in people receiving their second five yearly dose of Pneumovax23.

Further detailed analysis of case reports, adverse reaction databases and clinical trial data is required and will be undertaken by the TGA and the Australian Technical Advisory Group on Immunisation (ATAGI).

On 18 April 2011 the Therapeutic Goods Administration (TGA) advised Health practitioners **not** to administer Pneumovax 23 vaccine to patients who have previously received a dose of Pneumovax 23 pending completion of an investigation into an increased rate of adverse events in people receiving the vaccine for the second time.

This suspension does not apply to the use of 7-valent pneumococcal vaccine (Prevenar) for children, or for any person receiving the first dose of Pneumovax23®.

<http://www.tga.gov.au/newsroom/media-2011-pneumovax-110417.htm>

Reminder—ATAGI Recommendations for the use of 2011 Trivalent seasonal influenza vaccines

Age Group	Fluvax	Influvac	Vaxigrip	Fluarix*	Agrippal*	Intanza
> 6 months to 5 years	X			X	X	X
> 5 years to < 10 years	Note 1			X	X	X
> 10 years to < 18 years						X

Note 1: The use of *Influvac* or *Vaxigrip* in children aged 5 years to less than 10 years is strongly preferred, however, *Fluvax* may be used when no timely alternative vaccine is available and parents are informed of the potential increased risk of fever.

* *Fluarix*® (GSK) and *Agrippal*® (Novartis) are approved for use in anyone aged 6 months and above, however, the TGA does not recommend that *Fluarix* and *Agrippal* be used in children aged less than 9 years at this stage. Neither of these vaccines was used in Australia in 2010 and there is no experience of their use in Australian children.

Viral Gastroenteritis in Child Care Centres

Gastroenteritis is one of the most common causes of morbidity in young children.

While the causes of gastroenteritis vary, viruses are currently the most common pathogens leading to illness. Of these viruses, Norovirus and Sapovirus are the most common.

At present, Queensland Health are receiving an increasing amount of notifications of Norovirus in child care centres. The virus is very contagious and can spread rapidly in such environments.

In young children, the symptoms of Norovirus infection include acute onset of vomiting, watery non-bloody diarrhea with abdominal cramps, and nausea. Fever also occurs occasionally.

Young children are also particularly prone to dehydration as a result of infection.

If you suspect a patient may have Norovirus it is important to submit clinical specimens for testing. Faecal specimens should be collected as soon as possible after symptoms begin, preferably during the symptomatic phase of illness.

It is also important to conduct viral studies if you have two or more related cases.

In recent years the diagnosis of Norovirus out-

breaks has improved with advances in available diagnostic tests.

RT-PCR is regarded as the preferred diagnostic method and can be used to test stool and emesis samples. EM and ELISA tests can also be performed but are less sensitive.

There is currently no antiviral medication for Norovirus infection and treatment is symptomatic focusing on replacing fluid losses and correcting electrolyte disturbances.

The illness is, however, usually brief in healthy individuals.

Sapovirus is usually a milder illness but has similar symptoms to Norovirus. Studies suggest that almost all children are infected with Sapovirus by the age of 5 years. The illness is usually brief and self-limiting. Treatment is symptomatic.

Following standard infection control precautions can help minimise the spread of disease. This includes environmental cleaning and disinfection, regular hand-washing, and exclusion of ill people.

For further information please contact your local Public Health Unit.

Introducing...

The VIVAS team welcomes two new Data Officers to Central Regional Services. Lucinda Norris and Carley Gray join Jennifer Medley to form our new and expanded VIVAS team.

Once the new staff have settled into their new roles there will be a greater capacity for them to offer hands on support to practices having issues with their immunisation data.

We encourage you to get to know the Data Officer who looks after your area and contact them should you have any questions or concerns. Their contact details are listed below.

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VIVAS

NEWS
FLASH!

Australian Childhood Immunisation Register (ACIR) Forms

What form do I use to get an exemption from immunisation for a child, or to update their Immunisation History?

Completion of the correct ACIR form will ensure that parent/guardians still receive Family Assistance Office payments linked to immunisation (Child Care Benefit, Maternity Immunisation Allowance).

Medical Contraindication Form

This form should be used when a child cannot be immunised due to a medical condition such as:

- Unstable neurological disease or encephalopathy within seven days after previous vaccination
- Immediate severe acute allergic or anaphylactic reaction after any previous vaccination
- Malignant disease and/or immunosuppressive therapy and/or immunosuppression (e.g. child receiving chemotherapy, radiotherapy, high-dose steroid therapy etc)
- Allergy to preservative or antibiotic contained in vaccine/s

Conscientious Objection Form

This form should be used when a parent/guardian has a personal, philosophical, religious or medical belief that vaccination should not take place.

This form must be completed by a doctor or immunisation provider AND the parent/guardian of the child, after discussing the risks and benefits of immunisation, the potential dangers if the child is not immunised, and the parent/guardian has been given the opportunity to discuss any concerns about immunisation with the doctor or immunisation provider.

It is NOT possible to lodge a Conscientious Objection form for a single antigen/vaccine. The Medical Contraindication form SHOULD NOT be used for this purpose.

If a parent/guardian has lodged a Conscientious Objection form, it covers all antigens/vaccines on the National Immunisation Program (NIP). The parent/guardian can still choose to vaccinate their child with some or all of the vaccines on the NIP and does not need to withdraw their Conscientious Objection to do so.

Natural immunity to a disease

When a child has a natural immunity to a disease, the doctor or immunisation provider should send a letter to ACIR on their practice letterhead stationery with the following details:

- Medicare provider number or ACIR registration number
- Child's details – Medicare number, date of birth, sex, name and address, Reason for requesting Natural Immunity exemption (e.g. Varicella vaccine exemption for a child who has already had chickenpox disease)

Immunisation history form

This form should be used for reporting immunisation details to ACIR when another doctor or immunisation provider performed the vaccination service (e.g. child vaccinated overseas, update missing vaccination details).

Forms are available from Medicare offices, and are also available online at <http://www.medicareaustralia.gov.au/provider/pubs/forms/acir.jsp>

Send completed and signed forms/letters to:

Medicare Australia, GPO Box 295, Hobart TAS 7001

Or fax to: 03 6281 0555

For further ACIR information, phone the enquiry line on 1800 653 809

Notifiable Conditions Report

Notifications and quarterly rates per 100,000 of selected notifiable conditions for Local Governments by date of onset, 1st Quarter 2011 and average 2006-10, Full year 2010 and average 2005-09.

Report Date: 22/06/2011

Notifiable Condition		Quarter 1 (1 Jan - 31 Mar)						Year to Date (1 Jan - 31 Dec)					
		Brisbane North-side		Moreton Bay		Queensland		Brisbane North		Moreton Bay		Queensland	
		2011	06-10 average	2011	06-10 average	2011	06-10 average	2010	05-09 average	2010	05-09 average	2010	05-09 average
Bloodborne Diseases													
Hepatitis B (acute)	Notifications	3	2	1	11	15	9	8	6	2	57	54	
	Rate/100000	0.7	0.4	0.3	0.3	0.4	2	1.7	1.8	0.6	1.4	1.3	
Hepatitis B (other)	Notifications	31	37	10	7	254	242	159	130	40	29	1047	913
	Rate/100000	6.7	8	3	2.1	6.2	5.9	34.6	28.3	12	8.7	25.6	22.3
Hepatitis C*	Notifications	65	72	42	44	579	714	298	267	169	160	2689	2669
	Rate/100000	14.1	15.7	12.6	13.2	14.2	17.5	65	58.3	50.8	48.1	65.7	65.2
Gastrointestinal Diseases													
Campylobacter	Notifications	162	138	142	100	1386	1219	530	528	340	374	4790	4435
	Rate/100000	35.3	30.1	42.7	30.1	33.9	29.8	115.6	115.1	102.2	112.4	117.1	108.4
Cryptosporidiosis	Notifications	9	39	2	31	115	373	43	106	15	69	302	928
	Rate/100000	2	8.5	0.6	9.3	2.8	9.1	9.4	23.1	4.5	20.7	7.4	22.7
Hepatitis A	Notifications		2			3	13	7	5	2	1	40	47
	Rate/100000		0.4			0.1	0.3	1.5	1.1	0.6	0.3	1	1.1
Listeriosis	Notifications		1	1	1	3	3	1	1	1	1	9	9
	Rate/100000		0.2	0.3	0.3	0.1	0.1	0.2	0.2	0.3	0.3	0.2	0.2
Salmonellosis (all)	Notifications	98	81	87	61	1114	959	275	217	194	153	2846	2401
	Rate/100000	21.4	17.6	26.1	18.3	27.3	23.4	60	47.3	58.3	46	69.5	58.7
Shigellosis	Notifications	3	3			19	30	7	11	4	2	91	91
	Rate/100000	0.6	0.6			0.4	0.7	1.5	2.4	1.2	0.6	2.2	2.2
Yersiniosis	Notifications	1	1		1	19	22	9	7	9	4	81	72
	Rate/100000	0.2	0.2		0.3	0.5	0.5	2	1.5	2.7	1.2	2	1.8
Invasive Diseases													
Meningococcal (all)	Notifications	3	1	1		13	14	6	6	7	8	56	74
	Rate/100000	0.6	0.2	0.3		0.3	0.3	1.3	1.2	2.1	2.4	1.4	1.7
Pneumococcal	Notifications	4	5	4	3	30	35	35	35	24	24	272	295
	Rate/100000	0.9	1.1	1.2	0.9	0.7	0.9	7.6	7.6	7.2	7.2	6.6	7.2
Vaccine Preventable Diseases													
Influenza (lab confirmed)	Notifications	144	24	67	8	1233	141	386	819	220	506	3206	6005
	Rate/100000	31.4	5.2	20.1	2.4	30.1	3.4	84.2	178.6	66.1	152.1	78.4	146.8
Measles	Notifications	3		4	1	10	8			1	1	14	10
	Rate/100000	0.7		1.2	0.3	0.2	0.2			0.3	0.3	0.3	0.2
Pertussis	Notifications	227	108	302	79	2385	792	993	350	937	284	8200	2793
	Rate/100000	49.5	23.6	90.8	23.7	58.3	19.4	216.5	76.3	281.6	85.4	200.4	68.3
Rotavirus**	Notifications	36	17	35	18	243	141	87	122	95	148	813	1134
	Rate/100000	7.9	3.7	10.5	5.4	5.9	3.4	19	26.6	28.6	44.5	19.9	27.7
Rubella	Notifications	2				5	2	1	1			5	8
	Rate/100000	0.4				0.1		0.2	0.2			0.1	0.2
Sexually Transmitted Infections													
Chlamydia	Notifications	579	510	291	208	4907	3938	2373	1708	1034	671	19373	13357
	Rate/100000	126.4	111.2	87.5	62.5	119.9	96.2	517.5	372.5	310.7	201.6	473.4	326.5
Gonorrhoea	Notifications	99	70	22	10	721	416	321	258	75	31	2069	1500
	Rate/100000	21.5	15.3	6.6	3	17.7	10.2	70	56.3	22.5	9.3	50.6	36.7
Syphilis <2yrs (STI)	Notifications	37	14	5	2	108	53	66	52	7	5	228	194
	Rate/100000	8	3.1	1.5	0.6	2.6	1.2	14.4	11.4	2.1	1.5	5.4	4.6
Syphilis >2yrs (STI)	Notifications	7	5	2	2	52	65	20	23	6	7	195	279
	Rate/100000	1.5	1.1	0.6	0.6	1.2	1.5	4.4	5	1.8	2.1	4.7	6.9
Vector-borne Diseases													
Barmah Forest Virus	Notifications	22	15	29	22	329	310	41	48	75	79	911	896
	Rate/100000	4.8	3.3	8.7	6.6	8	7.6	8.9	10.5	22.5	23.7	22.3	21.9
Ross River Virus	Notifications	27	73	32	78	452	1048	169	149	187	173	2398	2181
	Rate/100000	5.9	15.9	9.6	23.4	11	25.6	36.9	32.5	56.2	52	58.6	53.3
Zoonotic Diseases													
Leptospirosis (all)	Notifications	3	1	1		116	35	2	1		1	85	90
	Rate/100000	0.6	0.2	0.3		2.9	0.8	0.4	0.2		0.3	2.1	2.2
Q Fever (excl chronic)	Notifications		1	2	2	48	46	1	2	7	5	148	159
	Rate/100000		0.2	0.6	0.6	1.2	1.1	0.2	0.4	2.1	1.5	3.6	3.9
Other Diseases													
Legionellosis	Notifications			1	1	15	9	7	2	4	4	42	44
	Rate/100000			0.3	0.3	0.3	0.1	1.5	0.4	1.2	1.2	1	1.1

*Inaccuracies in hepatitis C data may occur due to incorrect patient addresses and thus attribution to incorrect LGAs
 **Notifiable since December 2005

For more information contact: Brett Eichmann Ph 3624 1106
 No information in a box indicates zero notifications in the period.
 Notifications with an "unsure" validity status are not included in this report.

Evidence-Based Practice for Public Health

A two-day professional development workshop

Presenters:

Dr Philip Baker – Director Epidemiology, CRS & Adjunct Professor QUT
Daniel Francis – Advanced Epidemiologist – EBP, CRS

15 & 16 September 2011

**Learning & Development Centre
Rockhampton Hospital**

Standard registration closes 9 September 2011

Price:

Early Bird* \$250
Early Bird QH Staff* \$195
Standard Registration \$400

*Includes lunch and refreshments on the day
Registration is limited and will fill up fast!*

3 & 4 November 2011

**Education Centre
The Prince Charles Hospital**

Standard registration closes 19 October 2011

**Early Bird Registration closes 26 August 2011
for the September workshop & 5 October 2011
for the November workshop.*

This two day course emphasises the *interpretation* and *application* of research to inform policy, planning and practice decisions.

- Are you certain you have the best evidence to address a health issue or support your claims?
- Are you using or planning the most appropriate interventions or practices?
- How do you know which interventions work the best?
- Do you know how to read research papers and interpret the findings?

This course will help you find and use the evidence to make the best decisions.
No prior knowledge is expected, though there will be some pre-reading.

Testimonials from previous EBP workshop participants:

“An excellent learning experience that is very helpful in the workplace.”

“Thanks for the effort and work you put in to this. It was well set out and flowed well. Resources to take away are really great and will support future use of this process”

“I really enjoyed the practical component using the computers, I feel confident now that I will be able to search for relevant information to assist me with implementing my strategies.”

“The course was very interactive so it was easy to follow along and understand the content.”

For registration & enquiries:

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Epidemiology Team
Central Regional Services
Division of Chief Health Officer
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Hendra Virus Infection

Hendra virus was discovered in 1994 following an outbreak of illness in a large racing stable in the suburb of Hendra, Brisbane.

The natural host of Hendra virus is the flying fox. The virus can spread from flying foxes to horses and, in rare circumstances, from horses to people. There is no evidence to date to suggest transmission from flying foxes to humans.

Since it was first discovered, there have been 14 outbreaks of Hendra virus in coastal Queensland and northern New South Wales.

Of the several hundred people exposed to horses with Hendra virus during these outbreaks, only seven have contracted Hendra.

Clinical features in humans have included:

- Self-limiting influenza-like illness (two cases)
- Influenza-like illness complicated by severe pneumonic illness contributing to death (one case)
- Aseptic meningitis with apparent recovery, then death from encephalitis 13 months later (one case)
- Acute influenza-like illness followed by encephalitis at seroconversion, followed by recovery (one case) and death (two cases).

The seven confirmed human cases all became infected following close contact with respiratory secretions and/or blood from an infectious horse.

Adherence to standard precautions and the use of personal protective equipment is recommended when in contact with sick horses. Further details can be found by referring to "Biosecurity Queensland, Guidelines for veterinarians handling potential Hendra virus infection in horses".

Human testing should be on the basis of exposure to confirmed equine cases and level of concern in contact, or for a compatible human illness in consultation with an infectious disease physician. Testing is not routinely recommended for contacts with nil or negligible exposures.

A request for Hendra virus testing is notifiable by laboratories to Public Health. When a doctor requests a Hendra test, the PHU will usually contact that doctor to discuss the case and determine the level of public health risk and intervention that might be required.

For further information contact your local Public Health Unit or go to www.dpi.qld.gov.au/4790_2900.htm OR www.qldhorsecouncil.com

The next newsletter will be published at the end of September 2011

We appreciate your feedback. Please send any comments or article suggestions to Dr Rod Davison or Dr Sonya Bennett: rod_davison@health.qld.gov.au, Sonya_Bennett@health.qld.gov.au.

If you are further interested by any issues raised in this newsletter, contact your relevant public health unit—Dr Rod Davison or Dr Sonya Bennett at Brisbane North or Dr Megan Young and Dr Susan Vlack at Moreton Bay.