

COMMUNICABLE DISEASES for general practitioners and practice nurses

July 2008
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Public Health
Canterbury
District Health Board
Te Pōari Hauora o Waitaha

Enteric Diseases From Nepal

A tour group that had been trekking in Nepal returned to New Zealand with an unusually high incidence of enteric disease. Five different organisms were identified: *Giardia*, *Shigella*, *Cryptosporidium*, *Blastocystis hominis* and *Dientamoeba fragilis*. Of the 15 persons in the group, seven had one or more of the above organisms identified on faecal testing and another seven were regarded as probable cases, having had significant diarrhoea, some with vomiting, at some stage. On the trek precautions had been taken including ensuring safe food, filtering the water and treating it with iodine, and being strict with hand washing. Once back in Kathmandu however, standards appear to have slipped with illness resulting.

Measles In A Preschool

In May-June there was an unusual association in a Christchurch preschool of a case of measles with a possible case. The first case was a 16 month old boy who developed a maculopapular rash, conjunctivitis and coryza along with positive measles IgM and IgG three and a half weeks after receiving an MMR vaccination. A non-communicable fever and rash is occasionally seen 1-4 weeks after MMR, but in this instance, an unimmunised 13 month old boy who attended the same sessions developed a fever, maculopapular rash, coryza, cough and conjunctivitis 12 days later. Serology was positive for measles IgM.

Specimens have been sent to Melbourne to try and establish if the post-MMR symptoms were due to the vaccine strain or wild measles and if the cases were related. There have been no further cases following intervention as outlined in Management (below).

Investigations for measles

1. Serological Confirmation

Blood for serology should be collected. Specimen required: 5 ml plain blood or serum.

2. Other Investigations

Other samples for virological investigation should be collected in consultation with the laboratory. Timing and choice of sample is important for accurate diagnosis.

- i. Combined nasopharyngeal and throat swab in virus transport media
- ii. Blood in EDTA/ACD tube
- iii. Urine: First passed morning specimen preferred, collected as soon as possible after rash onset and at least within 5 days of rash onset.

Primary diagnostic testing is treated as a routine request. Confirmatory serological testing and virus detection is a National Measles Laboratory reference function and is not charged for. Rubella and parvovirus should be considered amongst the differential diagnoses.

Management of contacts

Public health management of measles is directed to preventing spread and providing prophylaxis for those who are susceptible. Unimmunised contacts are excluded from preschools, schools, community gatherings etc. for 14 days after exposure.

The following prophylactic measures are guidelines for management of susceptible contacts of sporadic cases.

Age	Recommendation
>15 months	If person has not had 2 doses of MMR give dose as soon as possible and preferably within 72 hours of contact with the case. A further MMR can be given if required after four weeks.
Between 9-15 months	Give a dose of MMR. If under 12 months of age, should have two further doses when aged over 12 months as seroconversion is low under 12 months of age.
Between 6-9 months	Give immunoglobulin ¹ instead of vaccine. The child should subsequently be offered an MMR vaccination but this should be administered no earlier than five months after the immunoglobulin and provided that the child is older than 12 months.
<6 months	Where the mother does not have immunity to measles eg., the mother is the case, the infant will be susceptible and should be given immunoglobulin.

¹ Immunoglobulin

Should be given to those for whom MMR is contraindicated and it is within 7 days of exposure.

Influenza Surveillance

Surveillance of influenza-like illness this year (Fig. 1) shows a similar level of activity compared with the national average and with last year. Influenza virus has been isolated from Canterbury and South Canterbury sentinel practices but not West Coast at the time of writing (Fig. 2).

Figure 1

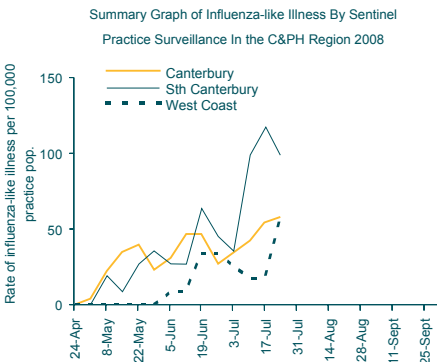
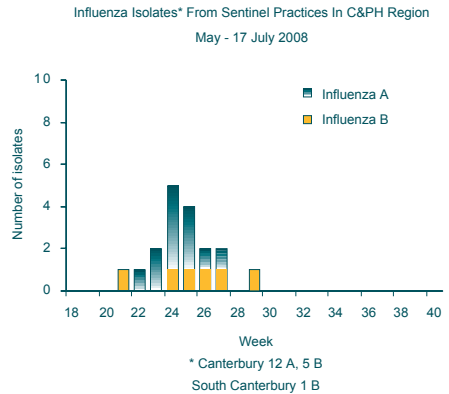


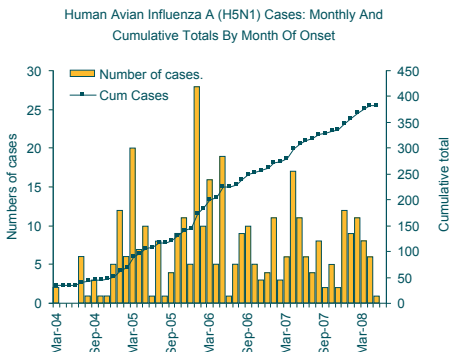
Figure 2



Avian Influenza Update

Concerning H5N1, the World Organisation for Animal Health reported in June, that there were no records of an epizootic having lasted so long and having covered such a wide geographical area in such a short period of time. In June also, at a conference in Malaysia the director of the US Centers for Disease Control and Prevention (CDC), said, "We do not have a vaccine that will provide universal protection, we do not have surveillance in every country, we do not have control of the virus in animal reservoirs and we have huge gaps in our basic understanding of influenza." She warned against complacency stemming from either misplaced confidence that a solution is at hand or a belief that nothing can be done to stop a pandemic. As of 19 June (latest figures) there had been 383 cases and 245 deaths (Fig. 3).

Figure 3



A Case Of Leprosy

The first case of leprosy in the region for over 10 years was notified in May. He was a middle aged European who was in Papua New Guinea 20 years ago. The only contact had no evidence of disease. Nationally in the past eight years there have been 36 cases of whom 55% were males and 75% of Pacific Peoples ethnicity.

Notifications From Smaller Local Authorities

The significance of communicable diseases in the smaller local authorities can be overlooked because of the fewer cases notified. However when the rates of diseases, particularly enteric diseases, are compared, the less populated rural areas can have higher rates than might otherwise be expected. Figures 4-7 show the rates of cryptosporidiosis, giardiasis, yersiniosis and VTEC in the C&PH region in the past 12 months, by local authority.

Regional reviews of cryptosporidiosis, giardiasis and yersiniosis in 2001-02 noted that children under 10 years of age in rural areas had higher notification levels compared with their urban counterparts. Doctors should be vigilant for the spring increase in enteric diseases, especially cryptosporidiosis, associated with calving and lambing.

Figure 4 Cryptosporidiosis Notification Rate By Local Authority July 07 - June 08

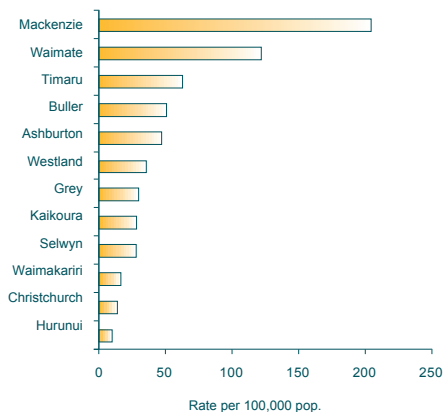


Figure 5 Giardiasis Notification Rate By Local Authority July 07 - June 08

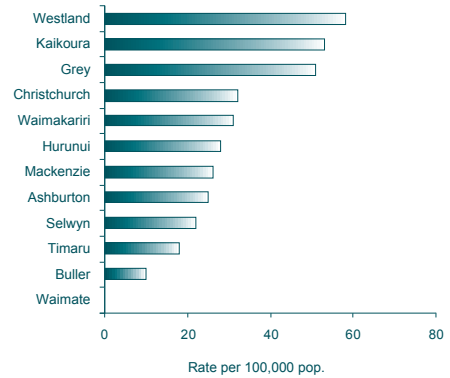


Figure 6 VTEC Notification Rate By Local Authority July 07 - June 08

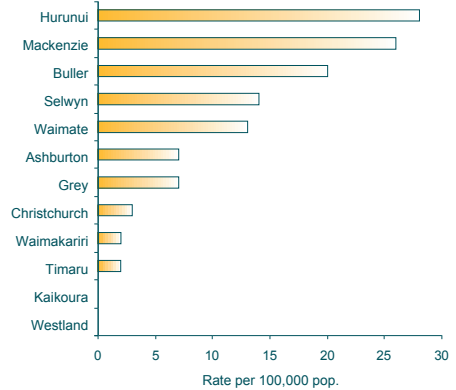
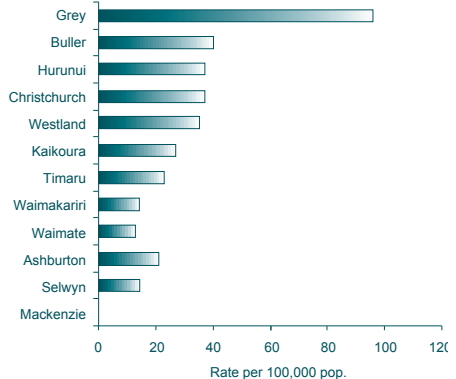


Figure 7 Yersiniosis Notification Rate By Local Authority July 07 - June 08



Correction

Vaccination schedule changes

The following information corrects comments in the April edition of the PHIQ.

Can children who have started the MeNZB course finish it?

Yes, a child may complete a course of MeNZB vaccine. Parents and children should be encouraged to complete the course before 31 December 2008, although the vaccine will still be available after this date

Is the MeNZB vaccine still available if parents request it for their child?

Yes, if the parents of a child or young person up to 19 years of age, requests that the child receives a course of MeNZB vaccine, and the doctor thinks the child is at risk, the MeNZB course will still be available and funded. A GP may start the child's course of MeNZB without further authorisation, and the immunisation benefit may be claimed.

STIs – Contact Tracing

Sexually transmitted infections diseases are not currently notifiable but if there is a need for assistance with contact tracing, please contact Chris Woods, Christchurch office telephone (03) 3786 806.

Summary Of Selected Notifiable Diseases April - June 2008 and 2007

	Canterbury		South Canterbury		West Coast		TOTAL
	Cases Apr-Jun 2008	Cases Apr-Jun 2007	Cases Apr-Jun 2008	Cases Apr-Jun 2007	Cases Apr-Jun 2008	Cases Apr-Jun 2007	Cases Apr-Jun 2008
ENTERIC DISEASES							
Campylobacteriosis	119	284	41	63	10	11	170
Cryptosporidiosis	22	12	4	1	-	-	26
Gastroenteritis	19	25	-	2	1	-	20
Giardiasis	49	30	3	5	5	2	57
Hepatitis A	1	1	-	-	-	-	1
Listeriosis	-	-	-	-	-	-	-
Paratyphoid	-	-	-	-	-	-	-
Salmonellosis	43	45	11	2	-	4	54
Shigellosis	2	6	-	1	-	-	2
Typhoid	-	-	-	-	-	-	-
VTEC	4	4	-	1	1	-	5
Yersiniosis	23	23	4	9	3	3	30
OTHER DISEASES							
AIDS	-	-	-	-	-	-	-
Dengue Fever	1	1	-	-	-	-	1
Haemophilus influenzae b	1	-	-	-	-	-	1
Hepatitis B	1	4	-	-	-	-	1
Hepatitis C	1	5	-	-	-	-	1
Lead absorption	4	-	2	-	-	-	6
Legionellosis	3	3	-	-	-	1	3
Leprosy	1	-	-	-	-	-	1
Leptospirosis	3	-	-	2	1	3	4
Malaria	1	-	-	-	-	-	1
Measles	4	-	-	-	1	3*	5
Meningococcal infection	3	2	1	-	-	-	4
Mumps	4	2	1	-	-	-	5
Pertussis	10	19	2	7	2	-	14
Rubella	-	-	-	-	-	1*	-
Tuberculosis (new case)	8	5	4	2	-	1	12

* Suspected