

Immunisation project checking on 'decliners'

A project will be starting within the MidCentral DHB area shortly that focuses on the group of children recorded as 'decliner' on the National Immunisation Register (NIR). Each quarter approximately 5% of MidCentral's two year olds are labelled as decliner on the NIR. However, a project conducted in Hawkes Bay DHB indicated that a proportion of children listed as 'decliner' on NIR were not true decliners in that their caregivers were happy for the children to receive some vaccinations. Thus, Hawkes Bay has been successful in improving their two year old vaccination coverage through a programme of checking on the decliner status of these children and facilitating vaccination when desired. Hawkes Bay DHB is the only DHB that usually achieves 95% fully vaccinated levels amongst two year olds.

The proposed project in MidCentral DHB will follow a similar methodology to that used in the Hawkes Bay DHB.

Table. Notifications to Whanganui and MidCentral Public Health Services June-August 2011: Confirmed and probable cases

(Statistically significant decline in 2011 compared with 2010;

statistically significant increase in 2011 compared with 2010).

Disease	Cases (Annualised rate per 100,000), June-August 2011			Statistical significance (DHB vs NZ)	
	MidCentral	Whanganui	NZ	MCDHB	WDHB
Campylobacter	61 (152)	15 (95)	1442 (139)	n/s	n/s
Cryptosporidiosis	3 (7)	1 (6)	93 (10)	n/s	n/s
Giardiasis	10 (25)	3 (19)	448 (43)	n/s	n/s
Hepatitis A	0 (0)	0 (0)	5 (0.5)	n/s	n/s
Hepatitis B	1 (2)	0 (0)	17 (2)	n/s	n/s
Invasive Pneumo	7 (17)	2 (13)	190 (18)	n/s	n/s
Lead Poisoning	1 (2)	0 (0)	34 (3)	n/s	n/s
Legionellosis	0 (0)	0 (0)	18 (2)	n/s	n/s
Leptospirosis	2 (5)	0 (0)	21 (2)	n/s	n/s
Listeriosis	0 (0)	0 (0)	5 (0.5)	n/s	n/s
Measles	0 (0)	0 (0)	149 (14)	p<0.01	n/s
Meningococcal	3 (7)	1 (6)	47 (5)	n/s	n/s
Pertussis	6 (15)	2 (13)	225 (22)	n/s	n/s
Rheumatic Fever	4* (10)	0 (0)	39 (4)	n/s	n/s
Salmonellosis	4 (10)	3 (19)	193 (19)	n/s	n/s
TB - New	3 (7)	0 (0)	64 (6)	n/s	n/s
Yersiniosis	1 (2)	2 (6)	166 (16)	p<0.05	n/s

*one of these was a transfer from another DHB

Key points from the notifications for June to August 2011 inclusive were:

- The rate of measles was significantly lower in MidCentral DHB compared with New Zealand as a whole. This was in the context of significantly more national cases in 2011 compared with 2010.
- The rate of yersiniosis was significantly lower in MidCentral DHB compared with New Zealand as a whole. This was in the context of significantly more national cases in 2011 compared with 2010.

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Public Health Update

Key Points

- Appropriate treatment of sore throats is vital in preventing the occurrence of acute rheumatic fever.
- A case of typhoid fever was notified to the MidCentral Public Health Service in a person with no recent overseas travel. It is suspected this patient had a prolonged carriage state.
- If you suspect English measles please notify the public health unit early and collect specimens to confirm the diagnosis.
- With the Rugby World Cup approaching there will be increased tourist numbers. The timely notification on suspicion of any notifiable disease will enable efficient follow up by public health.
- MidCentral DHB will shortly be starting a project on 'vaccination decliners' following the success of a similar project in Hawkes Bay.
- Laboratory surveillance from 2010 indicates similar rates of chlamydia and gonorrhoea in MidCentral and Whanganui to national rates.
- Influenza B has been the predominant influenza strain isolated in NZ this year.

Current local activity: Acute rheumatic fever

There have been three new cases of acute rheumatic fever in the MidCentral area since the start of June. This is a reminder that, while our rates of rheumatic fever are not as high in MidCentral and Whanganui DHBs as other parts of New Zealand it is still an issue. Enclosed is the Heart Foundation guide for sore throat management. The appropriate management of a sore throat is a key method of primary prevention of rheumatic fever along with strategies that address the wider determinants of health, such as housing. The enclosed guide helps with the decision regarding what management strategy will provide the best outcome for the patient in front of you. First line therapy (when required) is oral Penicillin V or amoxicillin for 10 days.

For anybody with a history of acute rheumatic fever, a minimum of 10 years IM penicillin every 28 days is indicated to prevent further attacks and to reduce the risk of cardiac disease.

Typhoid

We were notified of a case of *S.typhi* infection recently. It is likely this is a case of long-term carriage rather than recent infection. It is estimated that 1-4% of typhoid infections result in long-term carriage, and the rate is higher for people with biliary tract abnormalities including gallstones.

On average there are about 30 notifications of typhoid per year in New Zealand. Nearly all cases have a history of travel outside NZ during the incubation period (3-60 days, usually 8-14 days). The local case moved to NZ from the Pacific over 30 years ago, and has been in this country since then.

Sexually Transmitted Infections

Laboratory surveillance information from 2010 indicates that MidCentral and Whanganui have rates of chlamydia and gonorrhoea identification which are about the same as the national rate. However, in Auckland and Waikato infection rates for gonorrhoea are falling whilst they remain static for the lower North Island. For both infections, rates are highest in the 15-24 year age group.

	Gonorrhoea		Chlamydia	
	+ve cases	Rate/1,000	+ve cases	Rate/1,000
MidCentral	115	0.69	1325	7.9
Whanganui	34	0.55	467	7.5
NZ		0.65		7.8

Across the country about 40% of gonorrhoea cases are diagnosed in sexual health, family planning, and youth health clinics. It is presumed that most of the other 60% are diagnosed in general practice.

In both MidCentral and Whanganui the rate for Chlamydia is three times higher among women than men. For gonorrhoea the gender rates are about equal in MidCentral, and about 2.5 times higher for males in Whanganui. Chlamydia infection is often asymptomatic as is gonorrhoea infection in women and in non-genital sites in men.

In New Zealand resistance of *N.gonorrhoeae* to ciprofloxacin has been steadily increasing. Last year resistance rates for penicillin and ciprofloxacin were 5% and 43% (MidCentral) and 7% and 33% (Whanganui). Standard treatment for presumptive gonorrhoea is ceftriaxone 500mg stat and azithromycin 1g stat or as per antibiotic sensitivities.

Rugby World Cup and notifiable diseases

Palmerston North will be hosting three teams (Argentina, Romania and Georgia) and Whanganui will be hosting one team (USA) during the Rugby World Cup (RWC). Two games are being played in Palmerston North (Georgia versus Romania on 28 September and Argentina versus Georgia on 2 October).

In relation to surveillance activities, the importance of prompt notification is emphasised for any of the notifiable diseases. If there is suspicion of a notifiable disease in the course of a GP consultation, it would be appreciated if this could be passed on to the public health service as soon as possible. Such actions will be particularly important during the RWC given the potential for spread and the mobile nature of visitors for the RWC.

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Measles

There has been significant measles activity in Auckland, Waikato and Hawkes Bay this year. While there have not been any cases of measles notified to MidCentral and Whanganui public health units this year, the risk remains.

Immunisation is recommended for all contacts 12 months of age and over who do not have documentation of immunisation or previous measles infection. Post exposure immunisation should be administered within 72 hours of exposure and is considered by Public Health Services in following up all notified cases of measles. Therefore, it is vital that any cases where you are suspicious of measles are notified to the public health service as soon as possible. As well as notifying on suspicion of measles we are also conscious that measles can be easily confused with other diseases so laboratory confirmation is also important.

A confirmed case of measles requires:

- A clinically compatible illness:**
 - Fever 38C or higher
 - Generalised maculopapular rash lasting three or more days
 - Cough or coryza or conjunctivitis or Koplik spots
- Laboratory confirmation:**
 - Demonstration of measles specific IgM antibody or
 - Significant rise in measles antibody titre or
 - Isolation of measles virus from a clinical specimen.

Due to the differential timing of laboratory tests being positive, it is recommended that at least two forms of diagnostic test be taken (eg throat swab plus measles serology) on presentation.

Influenza surveillance

Throughout New Zealand, influenza like illness consultations have been low this year compared with both 2009 and 2010. Overall, there have been few weeks where the proportion identified with influenza like illness from sentinel surveillance has exceeded baseline levels.

Influenza B has predominated in New Zealand this year. Figure 1 shows the proportion of all virological swabs collected in New Zealand that were positive for Influenza A and B.

Figure 1 Proportion of swabs positive for Influenza from New Zealand sentinel and non-sentinel surveillance, 2011

