

COMMUNICABLE DISEASES
for general practitioners and practice nurses

VTEC From Drinking Raw Milk

Two persons in Timaru developed enterocolitis due to verotoxic E. coli 0157 last month with one becoming seriously ill requiring admission to hospital. Both had drunk raw milk in the week prior to becoming ill from a dairy farm on the outskirts of Timaru. The dairy owner indicated that in general customers purchased the milk for two main reasons: it was cheap and some thought that there were health benefits from consuming raw milk.

A recall of milk was considered but sales were self-service and the sellers didn't know who had bought the milk recently. The sale of raw milk is legal under the Food Act subject to no more than 5 litres per sale and provided it is only for personal or family consumption. The NZ Food Safety Authority Compliance Investigation Group who are responsible for dairy production under the Animal Products Act became involved and assisted with proceedings. The farmer stopped selling milk to the public and indicated that in future all his supply would be going to the dairy company.

VTEC is usually acquired through ingestion of food or drink contaminated by cattle faeces. Unpasteurised milk has been well documented as a vehicle for infection. People of all ages can be affected with diarrhoea that varies from mild to frank bleeding. Children are at greatest risk of developing a haemolytic uraemic syndrome. The elderly are also at increased risk of complications.

Other enteric pathogens that have been transmitted in unpasteurised milk include campylobacter, salmonella, yersinia and listeria. Raw milk can also transmit tuberculosis or be contaminated through handling with other bacteria such as streptococcus. A pamphlet on home pasteurisation is available from C&PH.

Unpasteurised milk should not be consumed by anyone and especially not by the young, elderly, pregnant or immune-compromised.

October 2008

Contents

- VTEC from drinking raw milk
- Management of a bite from a hepatitis B carrier
- Influenza surveillance summary
- Invasive pneumococcal disease notifiable by laboratories
- HPV and vaccinator authorisation
- Campylobacteriosis notifications remain low
- Follow up of contacts of TB
- Case Report Forms
- Avian influenza update
- Summary of notifiable diseases Jul-Sep '08 and '07

**Public Health
Canterbury**
District Health Board
Te Pōari Hauora o Waitaha

Management Of A Bite From A Hepatitis B Carrier

Human bites have been shown to transmit hepatitis B, hepatitis C, herpes simplex virus, syphilis, tuberculosis, actinomycosis, and tetanus. Although evidence suggests that it is biologically possible to transmit HIV through human bites, this is unlikely. There are up to 100 million organisms/ml in saliva consisting of over 150 different species and meticulous wound care and management is necessary to prevent infection and complications.

Following the development of fulminant hepatitis B in a healthcare worker with no documented seroconversion to hepatitis B vaccination, who was inadvertently bitten by a chronic carrier, Gane and Calder (*NZMJ 15 February 2008, Vol 121 No 1269*) have provided post-exposure prophylaxis advice because the current NZ guidelines are not specific for such situations.

For a person who is hepatitis B susceptible post exposure prophylaxis must include a combination of hepatitis B immunoglobulin 400 iu IM within 72 hours of exposure and hepatitis B vaccine within 7 days, repeated after 1 and 6 months. They also recommend that all New Zealand adults at risk for HBV exposure such as healthcare workers, new sexual partners and injecting drug users have their HBV status checked [if they have never demonstrated immunity], and if non-immune, receive vaccination.

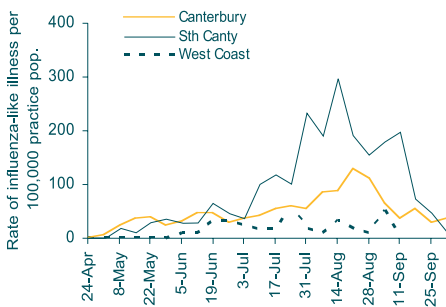
Influenza Surveillance Summary

Incidence

2008 was another relatively quiet year for influenza-like illness in Canterbury and West Coast but South Canterbury recorded high rates of illness for seven of the 23 weeks (Fig. 1). The national rates overall were similar to those of Canterbury.

Figure 1

Summary Graph of Influenza-like Illness By Sentinel Practice Surveillance In the C&PH Region 2008



Analysis By Age

A review of the age distribution of incidence (age specific rates per 100,000 practice population) for Canterbury and South Canterbury showed relatively high rates of illness in the youngest age group but low levels in the elderly. The low incidence in the elderly was also seen in West Coast (Figs.2-4). This may have been related to the persons over 65 years of age taking advantage of the free influenza immunisation.

Figure 2

Average Weekly Age Specific Rates of Influenza-like Illness In Canterbury, May-September 2008

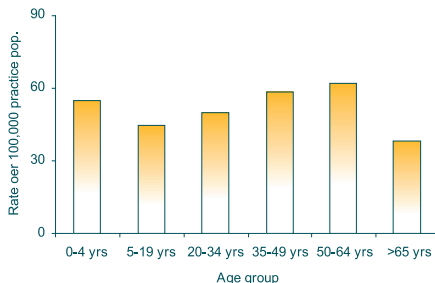


Figure 3

Average Weekly Age Specific Rates of Influenza-like Illness In South Canterbury, May-September 2008

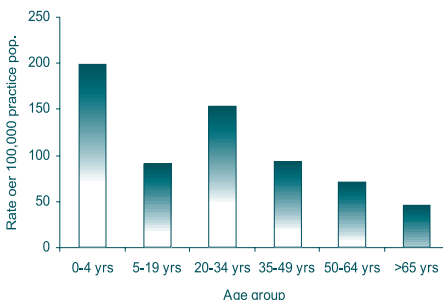
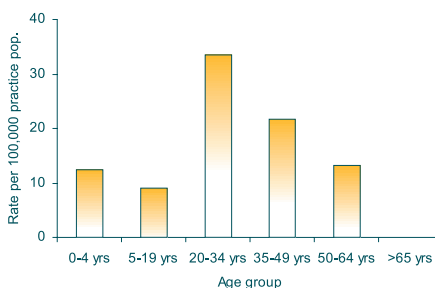


Figure 4

Average Weekly Age Specific Rates of Influenza-like Illness In West Coast, May-September 2008



Isolates

Swabs were taken from certain patients meeting the case definition throughout the five months programme and a number of isolates of both influenza A and B were identified (Figs. 5 and 6) in Canterbury and South Canterbury.

Figure 5

Influenza Isolates From Sentinel Practices In Canterbury Weeks 18-40 (May-September) 2008

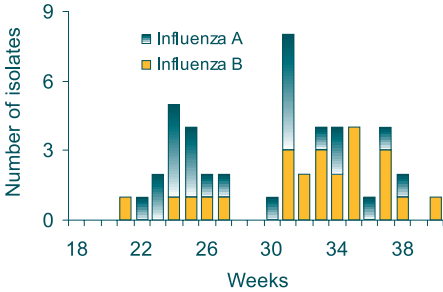
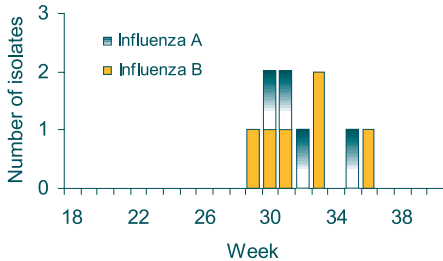


Figure 6

Influenza Isolates From Sentinel Practices In South Canterbury Weeks 18-40 (May-September) 2008



If any medical practice in the region would be interested in participating in the annual influenza surveillance programme please contact your local C&PH office as an increase in the number of participants would result in a more accurate representation of the actual incidence of influenza-like illness in that community.

Invasive Pneumococcal Disease Now Notifiable By Laboratories

Invasive pneumococcal disease became notifiable by laboratories from the 17th of October in order to monitor its incidence following the introduction of Prevenar, to the immunisation schedule in June.

HPV And Vaccinator Authorisation

Nurses who may be involved in the HPV

programme in schools need to be authorised as independent vaccinators if they are unaccompanied by a doctor. For further information contact the Immunisation Co-ordinator for your area.

Immunisation Co-ordinators

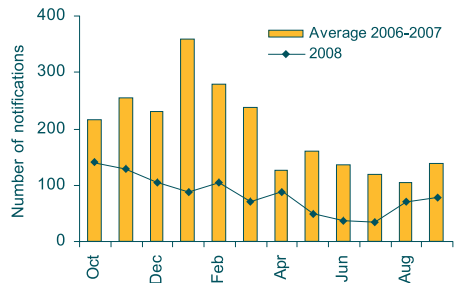
Area	Name	Telephone
Canterbury (Chch PHO, Partnership Hlth)	Ann Fraser	353 9854
	Di Bos	353 9857
Canterbury (All other)	Bernadette	
	Heaphy	386 2773
	Jayne Thomas	021 02259795
Sth Canty or	Sarah Patrick	03 684 1545
		027 200 9494
West Coast	Betty Gilsenan	03 732 8098

Campylobacteriosis Notifications Remain Low

A comparison of campylobacteriosis notifications in the C&PH region in 2008 with the monthly averages for 2006-2007 showed that the low levels evident last year were maintained throughout the first nine months of 2008 despite the additional laboratory notifications (Fig.7). This may be due to recent changes in poultry processing.

Figure 7

A Comparison of Campylobacteriosis Notifications In the C&PH Region October 2007-September 2008



Follow Up Of Contacts Of TB

On occasions a general practitioner has arranged for a Mantoux test and chest x-ray on a patient who was a contact of a case of tuberculosis, before involving or informing

the Communicable Disease nurse at C&PH. This makes it difficult to keep track of the infection status of contacts and to maintain a comprehensive overview of a case.

If you are consulted by a patient who has had contact with a tuberculosis case, please telephone C&PH for advice.

Case Report Forms

Follow up of a notified case requires information about the clinical symptoms, the date of onset, exposure to possible sources and immunisation history, details that can only be provided by the doctor (and not a laboratory) looking after the person. This information is used locally to evaluate the risk

to others from either the case or a common environment and nationally to guide policy and evaluate interventions. This necessary information is sought on the Case Report Forms and their completion is very much appreciated.

Avian Influenza Update

The latest numbers from the WHO (10 September) indicate that so far this year there have been 38 cases with 26 deaths. Annualised this would give 6 fewer cases than last year but four more deaths. Indonesia continues to have the most cases this year (20), followed Egypt (7), Vietnam (5), China (3) and Bangladesh (1).

Summary Of Selected Notifiable Diseases July - September 2008 and 2007

	Canterbury		South Canterbury		West Coast		TOTAL
	Cases Jul-Sep 2008	Cases Jul-Sep 2007	Cases Jul-Sep 2008	Cases Jul-Sep 2007	Cases Jul-Sep 2008	Cases Jul-Sep 2007	Cases Jul-Sep 2008
ENTERIC DISEASES							
Campylobacteriosis	112	252	54	64	11	20	177
Cryptosporidiosis	34	14	43	22	5	6	82
Gastroenteritis	20	31	1	2	5	1	26
Giardiasis	49	25	6	2	6	1	61
Hepatitis A	1	-	-	-	-	-	1
Listeriosis	-	-	-	-	-	-	-
Paratyphoid	-	1	-	-	-	-	-
Salmonellosis	23	25	9	4	1	3	33
Shigellosis	2	5	-	-	-	-	2
Typhoid	-	1	-	-	-	-	-
VTEC/STEC	1	4	4	4	-	-	5
Yersiniosis	28	33	7	5	4	5	39
OTHER DISEASES							
AIDS	-	-	-	-	-	-	-
Dengue Fever	3	1	-	-	-	-	3
Haemophilus influenzae b	-	-	-	-	-	-	-
Hepatitis B	1	1	-	-	-	-	1
Hepatitis C	1	-	-	-	-	2	1
Lead absorption	2	-	1	-	-	-	3
Legionellosis	-	-	1	-	-	-	1
Leptospirosis	1	1	3	1	1	1	5
Malaria	1	-	-	-	-	-	1
Measles	1	1	-	-	-	-	1
Meningococcal infection	2	4	1	-	1	-	4
Mumps	5	4	-	-	-	-	5
Pertussis	25	22	2	5	1	-	28
Rheumatic Fever	1	-	-	-	-	-	1
Rubella	-	-	-	-	-	-	-
Tuberculosis (new case)	2	5	2	2	-	-	4