IMMUNISATION ISSUES

COMING EVENTS

To register, contact Marg Dalton, Immunisation Coordinator Phone 8341815 Ext 4228

Vaccinators Training Course; Tuesday 26 & Wednesday 27 February 2008

Update for authorised vaccinators. Monday 17 March 2008

Vaccines not on the National Immunisation Schedule

Some vaccines that would be beneficial at a population level are not yet funded on the National Immunisation Schedule. Prevenar PCV7 will be included in the schedule from 1 June 2008.

Varilrix: GSK

Varicella vaccine has been available in New Zealand since 1996 but uptake has been low.Whilst for most children chicken pox remains a benign though troublesome childhood infection, for the immunocompromised and for a few normal hosts it can result in severe complications and even death. Varilrix vaccine costs approx $56.00 per dose. Children aged 9 months to 12 yrs only need one dose, people 13 years and over need 2 doses at least 6 weeks apart. Introduction of varicella vaccination to the funded schedule has not been a high priority in New Zealand but is more likely to be accepted with the arrival of combined (MMRV) vaccine.

Rotarix: GSK

Rotavirus is one of the leading causes of paediatric gastroenteritis and may lead to hospitalisation of young children due to dehydration secondary to vomiting and diarrhoea.GSK has recently introduced the first commercially available rotavirus vaccine to the New Zealand market. The first dose should be given after 6 weeks of age, with dose 2 between 10 & 24 weeks of age. The vaccination course should be completed by 24 weeks of age. Cost is approx $90.00 per vaccine.

Gardasil: CSL.

The primary reason for the development of the HPV vaccine is the prevention of HPV related malignancy. Gardasil is recommended for all females aged between 11 and 26 years but can start as early as 9yrs. It is a 3 dose programme with the 2nd dose given 2 months and the 3rd dose given 6 months after the 1st dose. Cost of vaccine is approx $128.50.

Post-exposure prophylaxis for hepatitis B

We have been recently notified of a case of liver failure requiring transplantation following percutaneous hepatitis B innoculation from a carrier. When there has been recent sexual or percutaneous exposure to hepatitis B, it is important to

- get urgent serology to elucidate the status of the source and exposed contacts
- arrange post-exposure prophylaxis (PEP) following all such incidents - a combination of hepatitis B immunoglobulin 400iu IM within 72 hours of exposure and hepatitis B vaccine within 7 days, repeated after one and 6 months
- follow the advice in the *Immunisation Handbook*

Medical Officer of Health
Public Health
ADVICE

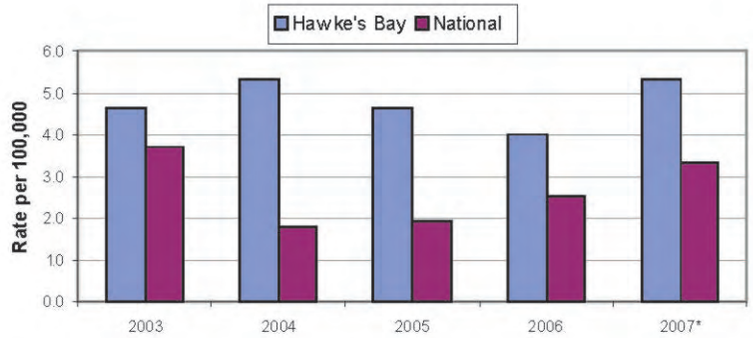
Inside

Public Health Report *November 2007* *Vol. 4, Issue 3*

RHEUMATIC FEVER IN HAWKE'S BAY

The rate of rheumatic fever in Hawke's Bay is higher than the national rate per 100,000 population. (Figure1). There have been 37 cases of rheumatic fever notified in Hawke's Bay during the last five years, including two recurrent attacks.

Figure 1. Rheumatic fever initial attack rates by year, 2003 - 2007



*2007 rate is based on the cumulative total for the 12 months ending Oct 2007.

Swabbing and treatment of sore throats is the most practical primary prevention measure. It is the General Practitioner's clinical decision whether or not to swab. However, given the high rheumatic fever rates and the fact that, by the time the child is seen, the sore throat is likely to be several days old, a throat swab will often be appropriate.

It is important that parents, teachers and care-givers are aware that children with sore throats should see a doctor for swabbing and treatment without delay. We do not have funding for a permanent swabbing programme run by community health or public health nurses in schools.

ALL DIAGNOSING MEDICAL PRACTITIONERS TO REPORT INJURIES CAUSED BY HAZARDOUS SUBSTANCES

In December 2005, an amendment was made to section 143 of the Hazardous Substances and New Organisms (HSNO) Act (1996). The HSNO Act now requires all diagnosing medical practitioners, in addition to hospitals, to notify injuries

caused by hazardous substances. We are then required to supply information about the notified injury (excluding person identifiable data) to the Ministry of Health for reporting to the Minister of Health.
Notifications should be made in the normal way to the PHU. We will then collect information about place of exposure, date, length of exposure, injury resulting, the substance, lab results and clinical course.

DIRECT LABORATORY NOTIFICATION

Included in the amendments to the Health Act in December 2006 was a section on laboratory notification of diseases on the schedule. This commences on 18 December 2007. It requires the labs to notify the MOH (via the Public Health Unit) and the requesting health practitioner *immediately* of any lab result indicating a notifiable condition. This will enhance surveillance and public health managment of notifiable disease but is not intended to replace notification by doctors.

The responsible health practitioner is still required to notify the condition to the MOH in the usual way.

In Hawke's Bay we are well placed to comply with this law, given that both labs currently report most notifiable conditions to the PHU. This may also mean we are contacting health practitioners for details of cases we need to follow up urgently...

The Ministry of Health and labs are working to define both the lab criteria necessary to identify a notifiable condition so that there is national consistency, and also a national system for secure electronic notification that satisfies the "immediately" criteria.

LEAD NOTIFICATION LEVEL DECREASED

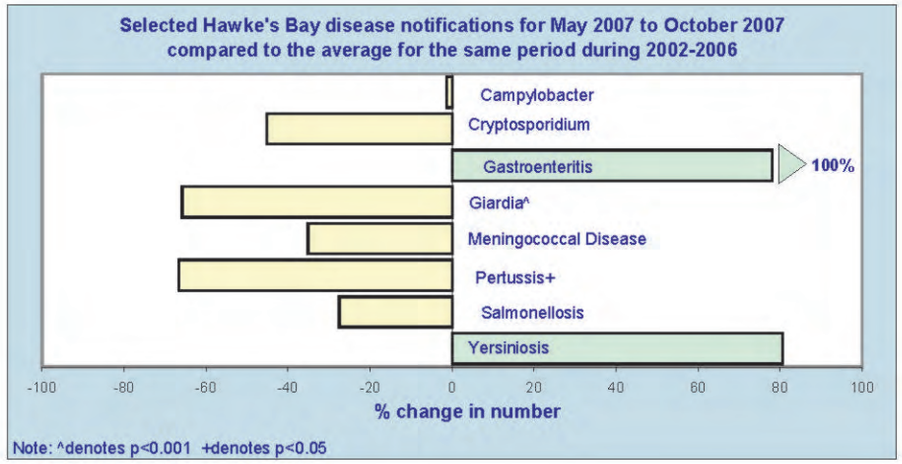
The lead poisoning notification level has reduced to 10µg/dL (0.48µmol/L), down from 15µg/dL, effective from 3 September 2007. The µmol/L is now the way labs report blood lead levels, so watch out for that 0.48 figure (was 0.72).

Lead paint (renovations and flaking) is a common source of lead poisoning, including dust and soil contamination, but also consider hobbies such as lead lighting, smelting sinkers/bullets, and water contamination.

Occupational exposure is also notifiable to Dept of Labour, but at much higher levels than for public health action (2.6µmol/L for notification and suspension from work at 3.2µmol/L)!
For more information see:
http://www.moh.govt.nz/moh.nsf/indexmh/environmental-case-management-lead-exposed-persons?Open

PH ADVICE

DISEASE SURVEILLANCE SUMMARIES



Selected notifications November 2006 to October 2007

	Hawke's Bay		New Zealand	
Disease	Cases	rate*	Cases	rate*
Campylobacter	491	332.4	13905	335.9
Cryptosporidium	34	23.0	945	22.8
Gastroenteritis	13	8.8	604	14.5
Giardia	37	25.1	1366	33.0
Hepatitis A	4	2.7	44	1.1
Hepatitis B	6	4.1	74	1.8
Lead Absorption	3	2.0	64	1.5
Leptospirosis	6	4.1	73	1.8
Meningococcal disease	10	6.8	122	2.9
Paratyphoid	1	0.7	21	0.5
Pertussis	11	7.4	387	9.3
Rheumatic fever	9	6.1	146	3.5
Salmonellosis	42	28.4	1244	30.1
Shigellosis	2	1.4	130	3.1
Tuberculosis	14	9.5	299	7.2
VTEC/STEC Infection	2	1.4	100	2.4
Yersinia	23	15.6	524	12.7

* Annualised crude rate per 100,000 population calculated from 2006 census usually resident population.