Canterbury District Health Board
MEDICAL OFFICERS OF HEALTH

Public Health Information Quarterly

COMMUNICABLE DISEASES

For general practitioners and practice nurses

October 2014

Contents

Community and Public Health
Canterbury
District Health Board
Te Poari Hauora o Waitaha

Ebola Preparations in Primary Care

For the Ministry of Health's recommendations for primary care refer to;
www.health.govt.nz/ebolaguidance
This site includes the following documents:

- Patient management guideline for primary care—Ebola virus disease
- Guidelines for environmental cleaning of primary care facilities following suspected case of EVD
- Updated information for health professionals: Ebola virus disease

The document 'Patient Management Guideline For Primary Care—Ebola Virus Disease' includes a case definition and flow diagram for managing a suspected case. The following is key information from the document:

- ◊ If EVD is suspected, the person should be placed in a single room.
- ◊ Where possible, the room should be cleared of removable items to reduce cleaning requirements.
- ◊ Staff should put on the appropriate PPE* (surgical facemask and visor, gloves, single use gown) and perform hand hygiene.
- ◊ The Medical Office of Health is to be contacted as soon as possible.

If the suspected case phones the practice they should be advised not to attend. The doctor is to contact the Medical Officer of Health and arrangements for transfer to an appropriate health care facility will be made.

Reception staff should be made aware of these instructions.

Any people that identify themselves to reception staff as being unwell and have visited an EVD affected country in the previous 21 days should be isolated in a single room as soon as possible. They should not sit in the general waiting room once EVD is considered a possibility.

* For correct putting on and removal of PPE, refer to the Infection Protection and Control section of the Ministry's Updated information for health professionals: Ebola Virus Disease (EVD) - see link above.

'Updated Information For Health Professionals: Ebola Virus Disease', contains more detailed information about management of suspected and confirmed cases, the current international situation and infection

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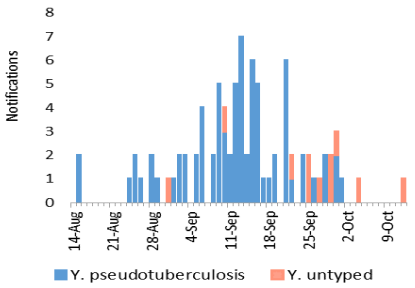
prevention and control guidelines. This last section includes a summary of PPE recommendations with diagrams for putting on and removing PPE.

Yersinia Pseudotuberculosis Outbreak

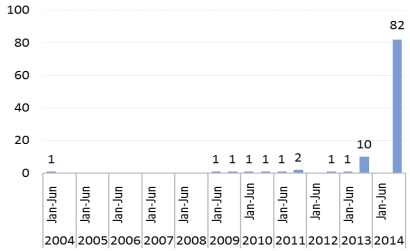
A national outbreak of *Yersinia pseudotuberculosis* (320 cases as of 21 Oct.) with most cases in Canterbury (82) began in August with the first notifications in mid-September (Fig.1). Infection with this biotype of *Yersinia* is uncommon with usually 0-2 cases per year. In 2013 however, there were 10 cases in Canterbury (Fig. 2).

Figure 1. Canterbury *Y. pseudotuberculosis* and *Yersinia* untyped notifications by date of onset: 14 August - 21 October 2014



A case-control study indicated that bagged lettuce and carrots were likely sources and a national investigation was instigated with the Ministry of Primary Industries (MPI) as the lead agency. By the second week in October the outbreak had waned. As of 21 October 217 cases had been confirmed nationally and 64 hospitalised. MPI has been following up certain food producers to review distribution regions, food safety programmes and processes to identify the likely source and how contamination occurred.

Figure 2. Canterbury *Y. pseudotuberculosis* notifications by six-monthly reporting: 2004 - 21 October 2014



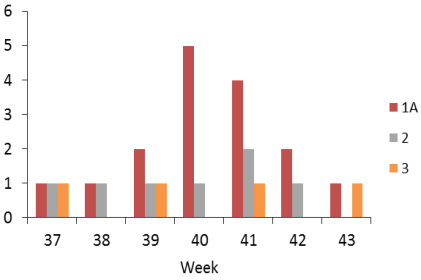
Key points

- Presentation of fever and abdominal pain can mimic appendicitis
- Reactive arthritis and erythema nodosum are late signs
- Diarrhoea is uncommon
- Incubation period is 3-10 days
- Person-to-person transmission is uncommon
- The bacteria thrives in the fridge
- Main vehicle – fresh vegetables
- There are many animal reservoirs.

Yersinia Enterocolitica Increase

In mid-September an increase in *Yersinia enterocolitica* notifications particularly 1A, was noted in Canterbury at the same time as the pseudotuberculosis outbreak and may be associated with it.

Figure 3. Canterbury Y. enterocolitica notifications weeks 37- 43 to 21 October 2014 (week 43)



Test Suspected Measles Cases

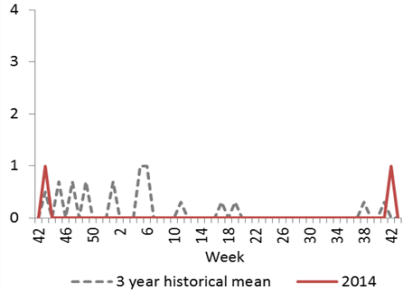
A suspected measles case is a cause for concern because of the potential severity of the disease in the individual and contacts. Every suspected case requires to be tested (serology and/or nasopharyngeal swab, or buccal swab if less than 5 years of age and other diagnostic tests are unlikely to be done. Buccal swabs are available to be done at the three after hours centres (24 Hour Surgery, Moorhouse Medical and Riccarton Clinic).

The most recent case acquired the illness in South East Asia but because of the atypical presentation, she was not diagnosed until admitted to hospital. Forty contacts were followed up to determine their susceptibility and whether or not they required prophylaxis. That was the only confirmed measles case in Canterbury (Fig.4), South Canterbury and West Coast in the past 12 months; an unusual situation given that the North Island had 282 cases during that time.

Practice Point

Two doses of MMR are recommended and funded for any adolescent or adult who are known to be susceptible.

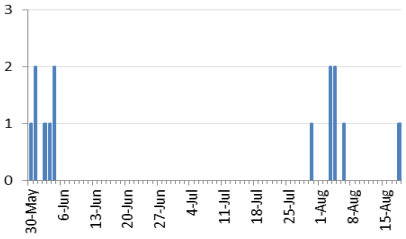
Figure 4. Canterbury measles notifications for the 12 months to week 43 (24 October) 2014



Recurrent Outbreak Of Group A Streptococcal infection in A Long Term Care Facility

An outbreak of an erythromycin-resistant group A streptococcal infection has recurred in a Christchurch rest home one month after it was thought to have been controlled. As previously reported that outbreak resulted in five deaths. In late July and early August seven cases were diagnosed of whom five were admitted including a staff member in her 60s in a serious condition with pharyngitis. Others had leg wounds, cellulitis or sepsis. Fortunately there were no deaths.

Figure 5. Cases of group A streptococcal infection associated with a Christchurch rest home, May—August 2014



Due to the widespread distribution of cases and the lack of evidence for direct person-to-person spread the source was considered to be environmental. A comprehensive review of the facility was again undertaken from an infection prevention and control perspective and further recommendations made. They included:

- monitoring the temperatures of any resident with a skin wound to identify cases early, and admit and treat with antibiotics as soon as possible, and
- using disposable dressing trays and removing the dressing trolley from use.

Referred Contacts Of Hepatitis A Or Meningococcal Disease Cases

Contacts are now referred from public health to their GPs for prophylactic vaccination. If further details are required about how to provide these vaccinations please contact your Immunisation Co-ordinator.

Summary Of Selected Notifiable Diseases By District Health Board July - September 2014 And 2013

	Canterbury		South Canterbury		West Coast		TOTALS	
	Cases Jul-Sep 2014	Cases Jul-Sep 2013	Cases Jul-Sep 2014	Cases Jul-Sep 2013	Cases Jul-Sep 2014	Cases Jul-Sep 2013	Cases Jul-Sep 2014	Cases Jul-Sep 2013
Enteric Diseases								
Campylobacteriosis	135	185	13	40	14	16	162	241
Cryptosporidiosis	17	61	5	12	3	3	25	76
Gastroenteritis	3	6			2	8	5	14
Giardiasis	38	47	3	2	2	1	43	50
Hepatitis A	1	19		1			1	20
Paratyphoid								
Salmonellosis	33	38	2	2	2	5	37	45
Shigellosis	1	1					1	1
Typhoid								
VTEC	4	9		1			4	10
Yersiniosis	90	36	5	1			95	37
Other Diseases								
Dengue Fever	6	2					6	2
Haemophilus influenzae b								
Hepatitis B	2					1	2	1
Hepatitis C	5	3					5	3
Hydatid		1						1
Lead absorption	1	2	2	1	1	1	4	4
Legionellosis	7	11				1	7	12
Leptospirosis	2	1		1			2	2
Malaria	5	2					5	2
Measles		2						2
Meningococcal Disease	7	2		1			7	1
Mumps	4			1			4	1
Pertussis	22	143		8		30	22	181
Pneumococcal Invasive Dis	13	14	1	2		3	14	19
Rheumatic fever (initial attack)	1	2					1	2
Rheumatic fever (recurrent)								
Rubella								
Tuberculosis (new case)	10	5				1	10	6