

# Public Health Information Quarterly

## COMMUNICABLE DISEASES

For general practitioners and practice nurses

### Measles Globally And In New Zealand

Measles is one of the leading causes globally of death among young children even though a safe and cost-effective vaccine is available. The disease is still common in many developing countries, particularly in parts of Africa and Asia. The overwhelming majority (more than 95%) of measles deaths occur in countries with low per capita incomes and weak health infrastructures, typically parts of Africa and India. In 2014, there were 114,900 measles deaths globally; 315 deaths every day.

The World Health Organisation has implemented a strategy to eliminate measles globally. Countries are regarded as being measles free if they have interrupted measles transmission in the population for at least three years. In the Western Pacific Region of which New Zealand is part only Australia, Mongolia and the Republic of Korea are measles free. New Zealand has not gained this status because of the all too frequent outbreaks that originate from imported cases (Fig. 1).

The most recent outbreak began in April in Waikato and by the end of June there had been 87 notifications in six DHBs including Nelson Marlborough, but none in the C&PH region.

Since 2010, there have been 24 confirmed measles notifications in Canterbury, one in South Canterbury and two in West Coast.

## July 2016

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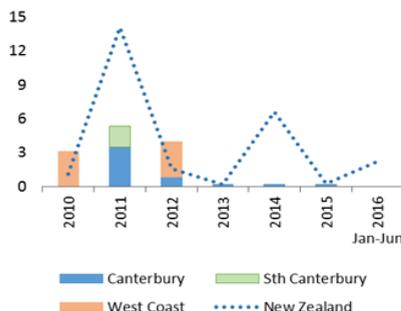
## Community and Public Health

Canterbury  
District Health Board  
Te Poari Hauora o Waitaha

### Practice Point

MMR vaccination is the only prevention for measles. A person intending to travel should ensure they have had 2 MMR at some stage of their life.

Figure 1. Rates of measles (per 100,000 pop.) in the C&PH DHBs and New Zealand, 2010–June 2016



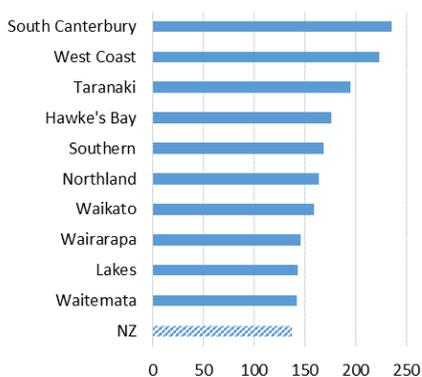
### Community & Public Health

## Gastroenteritis In South Canterbury And West Coast

Compared with other DHBs, South Canterbury had the highest rate of campylobacteriosis for the 12 months ending 30 June with 236 per 100,000 population (Fig. 2). The illnesses were likely to be attributable to the high number of people living or working with animals that carried the organism. West Coast had a similarly high rate (223).

Many cases could be prevented with good personal hygiene including washing hands thoroughly, wearing protective clothing when working or in physical contact with farm animals, changing clothes before going home, and avoiding drinking raw milk unless it has been heated first.

Figure 2. The 10 DHBs with the highest campylobacteriosis rates (per 100,000 pop.) for the 12 months to June 2016



## Potentially Infectious Gastroenteritis

Most cases of gastroenteritis don't require a specimen to be provided (see Health-Pathways [Infectious gastroenteritis control, Gastroenteritis testing guide and Gastroenteritis in children, for the exceptions]). However, the principles of managing a potentially infectious situation still apply, particularly if it is a child who is affected.

## Practice Point

The management of potentially infectious gastroenteritis should include the following advice:

- wash and dry hands thoroughly after toileting, maintain clean towels and clean the toilet, taps and door handles
- ensure isolation from social activities (including swimming pools), preschool, play groups and school until asymptomatic
- avoid sharing bath water
- return if there is deterioration or no improvement.

## Faecal Clearances

Sometimes C&PH ask medical practices to assist with faecal clearances of certain cases<sup>1</sup> with notified enteric disease because either they live in the country or the case's preference is to have their GP manage the process. In either case a letter is sent to the practice explaining the situation, requesting assistance with the clearance and providing details of what is required.

<sup>1</sup> Those requiring a clearance are deemed at high risk of spreading the disease if there is a breakdown in hygiene. In this category are:

- Food or food product handlers
- Staff of health care or early childhood facilities
- Children under 5 attending an early childhood centre
- Adult or child at risk due to an underlying illness or disability.

## Testing of contacts also

Symptomatic and/or high risk close contacts e.g. household and travel contacts, may also need to be tested. If any attend your practice and if distance is prohibitive for screening from Christchurch we would be grateful if you would test these persons also. A list of these contacts would also be provided

along with their clearance requirements.

### Discuss the following with the MOH:

- ◊ If the case is slow to clear
- ◊ If in the occupational situation, there is a need for the case to return to work (provided the case is asymptomatic but prior to a clearance)
- ◊ If symptoms reoccur.

## Zika Virus Disease (ZVD)

### Travel destinations

As of 19 July, 92% of cases of ZVD notified this year in New Zealand acquired the disease in the Pacific Islands. Fifty-three cases had visited Tonga, 22 had been to Samoa and 9 to Fiji. There is no breakdown by DHB as ZVD is only reported nationally (ESR Zika virus infection weekly report, 20 July 2016.).

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### Practice Points

- Women who are pregnant or plan to become pregnant in the near term should defer travel to areas with Zika virus (advice is evolving regarding areas of risk).
- If travel is essential, delay pregnancy if possible.
- If travelling in Zika-infected areas, women who are pregnant or could become pregnant should consult their doctor.
- All travellers should take all precautions to avoid mosquito bites.
- For details on bite avoidance and prevention of sexual transmission of Zika virus refer to the Ministry of Health website, [www.health.govt.nz/ur-work/diseases-and-conditions/zika-virus](http://www.health.govt.nz/ur-work/diseases-and-conditions/zika-virus)

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### Zika infection in third trimester

An article entitled, Zika Virus Disease in Colombia — Preliminary Report, was published in the New England Journal of

Medicine, June 15, 2016 ([www.nejm.org/doi/full/10.1056/NEJMoa1604037](http://www.nejm.org/doi/full/10.1056/NEJMoa1604037)).

It documents a study that was conducted on ZVD between August 2015 and April 2016 that involved a total of 11,944 pregnant women with ZVD. In a subgroup of 1850 women of whom 90% were reportedly infected during the third trimester and who had given birth, no infants with apparent abnormalities, including microcephaly were identified.

### Testing Of Infectious Patients

Doctors are reminded not to send a suspected case of measles, mumps or rubella to either a hospital or community laboratory for testing because of the risk of transmission to others, particularly other persons in the waiting room who may be vulnerable.

It is vital however, that suspected cases be tested but this is best done at the time the patient attends the surgery, in an isolated situation.

#### Measles tests<sup>1</sup>

Both of the following tests are advised because their different sensitivities vary on the stage of the illness:

- nasopharyngeal swab<sup>2</sup> (placed in viral transport media and transported via the SCL courier to Canterbury Health Laboratories, and
- serology (whole blood sample).

#### Mumps test

- A buccal swab specimen (saliva) during the acute illness.

#### Rubella test

- Serology (whole blood sample).

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<sup>1</sup> There has been a change in advice since the withdrawal of the oral swab recently.

<sup>2</sup> Regardless of age a nasopharyngeal swab is advised (throat swabs are suboptimal especially if dry). Contact the on-call Health Protection Officer at C&PH if the practice has no nasopharyngeal swab.

**Practice Points**

- Laboratory testing is essential for confirming a diagnosis of measles, mumps or rubella.
- Test the patient in the surgery and don't send them to a laboratory.
- See HealthPathways for advice on the management of suspected measles.

### Summary Of Selected Notifiable Diseases By District Health Board April—June 2016 And 2015

	Canterbury		South Canterbury		West Coast		TOTALS	
	Cases	Cases	Cases	Cases	Cases	Cases	Cases	Cases
	Apr-Jun 2016	Apr-Jun 2015	Apr-Jun 2016	Apr-Jun 2015	Apr-Jun 2016	Apr-Jun 2015	Apr-Jun 2016	Apr-Jun 2015
<b>Enteric Diseases</b>								
Campylobacteriosis	123	138	17	19	9	11	149	168
Cryptosporidiosis	21	9	1	1	-	-	22	10
Gastroenteritis	3	5	-	-	-	-	3	5
Giardiasis	35	30	4	2	-	3	40	35
Hepatitis A	2	-	-	-	-	-	2	-
Listeriosis	1	-	-	-	-	-	1	-
Paratyphoid	1	-	-	-	-	-	1	-
Salmonellosis	29	31	10	5	1	1	40	37
Shigellosis	4	5	-	-	-	-	4	5
Typhoid	-	-	-	-	-	-	-	-
VTEC	3	3	-	3	1	1	4	7
Yersiniosis	32	37	6	1	1	1	39	39
<b>Other Diseases</b>								
Dengue Fever	9	-	-	1	-	-	9	-
Haemophilus influenzae b	-	-	-	-	-	2	-	2
Hepatitis B	1	1	-	-	-	-	1	1
Hepatitis C	4	3	-	-	-	-	4	3
Invasive Pneumococcal dis.	11	8	4	-	-	1	15	9
Lead absorption	-	-	-	-	-	-	-	-
Legionellosis	8	16	1	1	1	1	10	18
Leptospirosis	1	1	1	-	-	-	2	1
Malaria	-	1	-	-	-	-	-	1
Measles	-	-	-	-	-	-	-	-
Meningococcal Disease	-	1	-	-	-	-	-	1
Mumps	-	-	-	-	-	-	-	-
Pertussis	83	27	1	1	-	-	84	28
Rheumatic fever (initial attack)	1	1	-	-	-	-	1	1
Rubella	1	-	-	-	-	-	1	-
Tuberculosis (new case)	9	8	-	-	-	-	9	8