From the Director’s desk

The control of communicable diseases has been under intense media scrutiny over the past few weeks. Investigations into potential transmission of tuberculosis within a high school, the tragic occurrence of three childhood deaths in a short period of time linked to co-infection with influenza and probably group B streptococcus, and a highlighting of indigenous sexual health transmission in remote areas have all been prominent. The urgent public warnings with regard to childhood influenza deaths placed significant strain on acute care facilities and while a tragedy for the families concerned, will provide CDCD with opportunities to assess the effectiveness of communication strategies and potential ramifications of the arrival of pandemic influenza in the future. In the midst of high profile investigations, an influenza outbreak occurred in a nursing home, large gastroenteritis outbreaks occurred in nursing homes, new vaccines became available for rotavirus and human papillomavirus in general practice settings and new guidelines were produced for antenatal care. The latter are covered in this Disease Watch bulletin. CDCD staff continue to be gratified by the operational support received from primary care physicians across Western Australia.

Paul Van Buynder
July 2007

Viral Gastroenteritis

Since the beginning of June 2007, there has been a marked increase in viral gastroenteritis in Western Australia in aged care facilities, hospitals and the community.

Most cases have been due to norovirus, a common viral infection that is highly transmissible from person-to-person through the faecal-oral route and through the aerosolisation of vomitus that results in droplets contaminating surfaces or entering the mouth/nose and being swallowed. Symptoms usually start 24 – 48 hours after transmission, and last 1 – 3 days. Symptoms include nausea, vomiting, diarrhoea, abdominal pain, headaches and fever.

“Remain at home at least 24 hours after gastroenteritis symptoms cease”

Patient with gastroenteritis symptoms should be advised to follow these simple hygiene steps to prevent transmission:

- Always wash hands after going to the toilet and before and after eating
- Don’t share food and drinks
- Don’t touch your face with unwashed hands
- Use gloves when cleaning up vomit or faecal accidents
- Cleaning surfaces with diluted bleach and washing contaminated linen will decrease transmission.
- Remain at home at least 24 hours after symptoms cease. This is especially important for high transmission risk patients (i.e., food handlers, children in daycare, health care workers, child care workers)
- Avoid visiting hospitals or residential care facilities at least 24 hours after symptoms cease, to protect those in care

If patients in residential care facilities or hospital develop gastroenteritis symptoms, they should be nursed with enteric precautions, preferably in a single room with private bathroom.
Chlamydia Testing now recommended for all Pregnant Women.

New recommendations about antenatal testing for sexually transmissible infections (STIs) and blood-borne viruses (BBVs) have been published by the Department of Health WA in the Women and Newborn Health Service’s Antenatal Shared Care Guidelines for General Practitioners (May 2007). The main change from previous guidelines is that Chlamydia testing is now recommended for all women at their first antenatal visit.

Tests for pregnant women at their first antenatal visit:

- Chlamydia - Offer Chlamydia testing to all women - first void urine and self-obtained lower vaginal swab (SOLVS) or practitioner-obtained endocervical swab (see accompanying SOLVS diagram)
- Hepatitis B - Undertake hepatitis B serology testing for all women
- Hepatitis C - Offer hepatitis C serology testing to women at high risk for Hepatitis C infection
- HIV - Offer HIV serology testing to all women
- Syphilis - Undertake Syphilis serology testing for all women.

Tests at subsequent antenatal visits

Women, who are believed to be at high risk of acquiring Syphilis, hepatitis B, hepatitis C, HIV and Chlamydia or who have put themselves at risk of infection since their first test, should be re-tested in the third trimester (28 – 36 weeks).

In addition:

- Women who have positive syphilis serology in the first trimester should be re-tested in the third trimester (28 – 36 weeks) or at delivery
- Women with clinical Hepatitis B should be re-tested at the time of admission to the hospital for delivery.

Additional tests for women living in STI-endemic areas

All women living in STI endemic regions of WA, i.e., the Kimberley, Pilbara and Goldfields, should be offered the following additional tests:

- At the first antenatal visit request specimens collected for Chlamydia to also be tested for Gonorrhoea
- Between 28 and 36 weeks re-test HIV and Syphilis serology
- At 36 weeks re-test for Chlamydia and Gonorrhoea.

Late presenters

Women who present for the first time either late in pregnancy or during labour and who have not received any antenatal care may be at increased risk of STI/BBV infection. Testing may need to be performed urgently in these situations to ensure that appropriate therapy can be commenced to benefit both the mother and baby.

These recommendations are in the spirit of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Antenatal screening tests, Statement number C–Obs 3, November 2006 and are also about to be published in a new Operational Directive, Antenatal testing for sexually transmissible infections and blood-borne viruses.

For more information, refer to
Antenatal Shared Care Guidelines for General Practitioners
The commonest groups of pathogens that cause respiratory illness in Residential Care Facilities (RCF) are viruses and of these, influenza is by far the most significant in terms of health impact.¹ The occurrence of respiratory illness in RCF is often a challenge for GPs as many elderly people have complex health problems which are frequently accompanied by varying degrees of dementia making it very difficult to identify early signs and symptoms of illness. Estimates of the rates of influenza in residents in RCF vary considerably and the majority of studies have examined influenza-like illnesses rather than influenza. For those studies that have examined laboratory confirmed influenza in residents in RCF seasonal rates of influenza are reported to vary from 2 to 16% of residents. Moreover, the attack rates during an outbreak of influenza are reported to be as high as 40%. Hence, RCF are considered to be high risk environments for influenza given their communal living arrangements, close proximity to one another, complex chronic conditions, dementia and high numbers of untrained staff who are not skilled to identify changes in the resident’s physical health.

There are now proven interventions to assist doctors and health care professionals to prevent and control influenza outbreaks in RCF. The Communicable Diseases Network Australia (CDNA) released guidelines for the prevention and control of influenza outbreaks in residential care facilities in Australia in September 2005. These guidelines are comprehensive and provide RCF and GPs with best practice information that includes outlining strategies for staff to take to prevent and control influenza outbreaks in RCF.

### Key points outlined in the guidelines which need to be promoted include:

- promoting immunisation uptake for residents and staff annually
- educating staff about the importance of being proactive in early detection of illness (residents with respiratory symptoms)
- taking throat and nasal swabs to test for viruses promptly
- promoting use of standard/additional precautions
- prompt reporting of influenza cases to the Department of Health or local Public Health Unit
- recommended method of taking a throat/nasal swab, and use of corrective transport mediums, and
- early use of anti-virals to contain the transmission of illness.

### Reference

1. CDNA Guidelines for the prevention and control of Influenza outbreaks in residential care facilities in Australia. Commonwealth publishing

For further information see: [http://www.health.gov.au/internet/wcms/publishing.nsf/content/1BE0BC4755ED5D66CA25710F000FA32C/$File/fluguide.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/content/1BE0BC4755ED5D66CA25710F000FA32C/$File/fluguide.pdf)

2. Ibid.
**Rotavirus**

Rotavirus is the most common cause of severe gastroenteritis in infants and young children, causing around half of all hospitalised cases of gastroenteritis in children less than 5 years. Two oral live attenuated rotavirus vaccines are available in Australia. They are Rotarix® (given in a 2 dose schedule at 2 and 4 months of age) and RotaTeq® (given in a 3 dose schedule at 2, 4 and 6 months of age).

Western Australia has opted for Rotarix® which will be available on the routine vaccination schedule as of the 1st July 2007. All babies born from 1st May 2007 will be eligible for the free vaccine.

Rotavirus vaccine can be administered at the same time as the other vaccines on the routine vaccination schedule. The interval separating the doses should be no less than 4 weeks. The first dose of Rotarix® should be administered between 6 and 14 weeks of age and the second dose between 10 and 24 weeks of age. Immunisation of older infants or children is not recommended. Late or catch up doses are not to be given.

Vaccination will reduce the risk of developing severe rotavirus gastroenteritis (by 85 — 100%) and any rotavirus gastroenteritis (by 70%).

Given the restricted time period, GPs are encouraged to explain to parents the importance of getting the vaccine at the recommended dates.

---

**Introducing The WA Endemic Regions STI/HIV Control Supplement**

In the Kimberley, Pilbara and Goldfields regions rates of infection for Syphilis, Gonorrhoea, Chlamydia and Donovanosis are well above the State average, particularly in the 15 to 30 year old age group. Prevention and control of these treatable diseases is important in its own right and helps to reduce the spread of HIV. In order to address these high STI rates, the WA Endemic Regions STI/HIV Control supplement was developed.

The Supplement has been developed in partnership with WA Country Health Services, Regional Population Health Units (PHU) and the Communicable Disease Control Directorate’s (CDCD) Sexual Health and Blood-borne Virus Program.

It is a public health tool that will assist in providing the best, evidence-based sexual health practice appropriate to high STI prevalence. The supplement describes useful STI/HIV control strategies for public health and primary health care settings. The WA Endemic Regions STI/HIV Control Supplement does not replace the *Guidelines for Managing Sexually Transmitted Infections (2006)* but provides supplementary information which is important in areas of endemic disease.

Clinical management pro formas for sexual health clinical consultations and a standard stamp for ordering pathology are available. These can be obtained free of charge from the Kimberley, Pilbara and Goldfields Population Health Units.

If you require further information please contact your local Population Health Unit (PHU) or direct your inquiries to Disease Control Staff.

<table>
<thead>
<tr>
<th>Population Health Unit</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimberley Population Health Unit</td>
<td>08 9194 1630</td>
</tr>
<tr>
<td>Pilbara Population Health Unit</td>
<td>08 9172 8333</td>
</tr>
<tr>
<td>Goldfields Population Health Unit</td>
<td>08 9080 8200</td>
</tr>
</tbody>
</table>