Health
Western Sydney
Local Health District

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Bug Bulletin

THE LATEST INFORMATION ABOUT HEALTH PROTECTION IN WESTERN SYDNEY LOCAL HEALTH DISTRICT

THE BUG BULLETIN IS NOW AVAILABLE AS A DIGITAL NEWSLETTER AND WILL NO LONGER BE AVAILABLE IN HARDCOPY.

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Immunisation

NSW SCHOOL VACCINATION PROGRAM 2017

The school-based vaccination program offers the vaccines recommended by the National Health and Medical Research Council (NHMRC) for students in high school.

Students in high schools in 2017 will be offered the following vaccines:

Program change 2017 – NSW Meningococcal W Response Program

On Monday 6 February the NSW Minister of Health announced the funding of a new school-based meningococcal vaccination program targeting Year 11 & 12 students, (17 and 18 year olds), in 2017. This is in response to the rise in cases of invasive meningococcal disease caused by serotype W to almost triple the numbers in NSW in 2015. Serogroup W is known to have a fatality rate up to 10% even with appropriate antibiotic treatment.

GP access to the vaccine:

The vaccine is being prioritised for the School Vaccination Program and GPs will be supplied with the vaccine later in the year, once more supplies become available. NSW Health will notify GPs of vaccine ordering arrangements for the Year 11 & 12 equivalent who do not attend secondary school or miss vaccination at school.

YEAR 7 STUDENTS

Vaccine	Number of Doses	More Information
Diphtheria-Tetanus-Pertussis (dTpa)	1 dose	Term 1
Human Papillomavirus (HPV)	2 doses (in 2017)	Term 1 first dose & terms 3 & 4 second dose. (dose 2 has been deferred to allow for administering Meningococcal ACWY Program for Years 11 & 12 in term 2)
Varicella (chicken pox)	1 dose	Terms 3 & 4

YEAR 11 & 12 STUDENTS - NEW FOR 2017

Vaccine	Number of Doses	More Information
Meningococcal ACWY (ACWY – conjugate vaccine)	1 dose	The program will commence on 1 May (Term 2)

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If you have any suggestions or stories to share please contact the ID team on **02 9840 3603**

Communicable diseases

MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS (MERS-COV)

Situation Update - February 2017

WHO have received notification of 1905 laboratory confirmed cases of MERS-CoV and 677 related deaths globally since September 2012. Disease is still occurring as of 3 February 2017. The disease starts with fever, cough with other common symptoms including myalgia, chills, sore throat, arthralgia, dyspnoea, nausea. Gastrointestinal symptoms are less common. The illness may progress to severe pneumonia with acute respiratory distress syndrome and multi-organ failure.

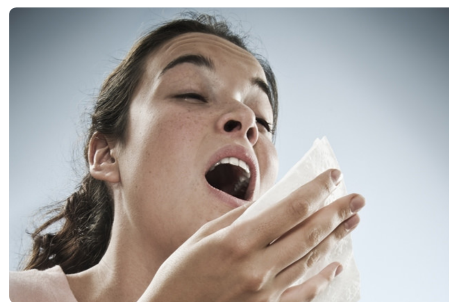
Travellers should avoid drinking raw camel milk or camel urine, or eating meat that has not been properly cooked. General hygiene measures, such as regular hand washing before and after touching animals and eating should be observed.

GET READY FOR WINTER

Pneumococcal Disease

A single dose of pneumococcal vaccine is recommended for adults at 65 years of age. Adults who have not received a dose at 65 years of age should have a single catch-up dose as soon as possible.

Children and adults who have a medical condition (for example, cardiac, liver and congenital diseases) are at risk of catching this disease and may require additional vaccinations. Further details of the conditions associated with an increased risk of invasive pneumococcal disease is listed in the Australian Immunisation Handbook 10th Edition.



Influenza

Annual influenza vaccination is recommended for any person ≥6 months of age for whom it is desired to reduce the likelihood of becoming ill with influenza. Certain high risk groups are more likely to be impacted by seasonal influenza flu than others and should be vaccinated.

The following groups are eligible for free seasonal influenza vaccine:

- ✔ All pregnant women
- ✔ Aboriginal and Torres Strait Islander people aged six months to less than 5 years
- ✔ Aboriginal and Torres Strait Islander people aged 15 years and over
- ✔ People aged 65 years or older
- ✔ People aged 6 months and over with medical conditions predisposing to severe influenza
  (Refer to the Australian Immunisation Handbook, 10th edition)

NEISSERIA GONORRHOEAE INFECTION

Written by the WS Sexual Health Clinic.

Since 2011, gonorrhoea notifications have increased in non-indigenous Australians by nearly 100% and the rates in Aboriginal and Torres Strait Islanders are 10 times that of their non-indigenous counterparts. Closer to home, notification rates in Nepean Blue Mountains Local Health District (NBMLHD) and Western Sydney Local Health District (WSLHD) have also increased, 13% and nearly 18% respectively in the last 12 months. Mirroring national trends, males <30 years bear the burden of infection, however the rate in females continues to gradually rise.

Neisseria gonorrhoeae is mostly asymptomatic at cervical, pharyngeal and rectal sites of infection, unlike urethral infection in men which typically presents with dysuria and urethral discharge within 2-5 days of infection. Urethral infections in women generally produces only mild symptoms, typically dysuria alone.

Symptoms may only present when complications such as pelvic inflammatory disease (PID) or epididymoorchitis occur. These observations underscore the importance of routine screening and early diagnosis. Unfortunately complications such as subfertility and chronic pelvic pain can develop with little symptomatology hence the need for a low threshold for testing and routine screening.

Increasing resistance to current first line treatment is a global concern and as a result the World Health Organisation has listed N. gonorrhoeae as a critical antibiotic-resistant “priority pathogen” which poses a great threat to human health. First line treatment with dual therapy (ceftriaxone + azithromycin) remains effective in Australia; however, the taking of an N. gonorrhoeae culture for all NAAT-confirmed gonorrhoea cases is essential for antibiotic sensitivity and surveillance purposes. Further, contact tracing and, where required, test of cure test and test of reinfection and are necessary key components of management.

SNAPSHOT

PATHOGEN: Neisseria gonorrhoeae (NG)

PRESENTATION: Asymptomatic in rectum, throat and cervix. Urethral discharge and dysuria in urethra.

TESTING WITH A NG NAAT:

Men (as per risk): throat swab, ano-rectal swab, first pass urine (if symptomatic)

Women (as per risk): throat swab, ano-rectal swab, endocervical swab (if symptomatic) or self-collected vulvo-vaginal swab (if asymptomatic)

NG CULTURE: perform culture from all NG NAAT positive sites

TREATMENT:

Ceftriaxone 500mg IMI in 2mls 1% lignocaine + Azithromycin 1gm stat

MANAGEMENT:

1. Contact tracing: sexual partners last 2 months
2. Test of reinfection with NG NAAT at 2-4 weeks
3. Test of cure with NG NAAT at 3 months