November 2nd 2022
Volume 1, Issue 1

Health Protection Newsletter

NHS Grampian Health Protection Team: Working to protect the people in Grampian from harmful infections and environmental hazards

MEET THE TEAM

Welcome to our first newsletter since before the pandemic!

Over the last two years several established, key members of the team retired or moved on to pastures new. However, we have welcomed all three of our consultants, two of our Health Protection Nurse Specialists as well as our Advanced Health Protection Nurse during the pandemic and how glad we are to have them! We have also been lucky enough to secure our Health Protection Manager, Rachel. This is a post that has been on the team's wish list for many years!

Over the course of the pandemic the HPT continued to work with existing colleagues and has forged stronger links with all partners across Grampian, from care homes to schools to partnerships and workplaces. This has resulted in the appointment (albeit fixed term) of our three Health Protection Nurses who all provide vital support the care homes and our three Health Protection Officers who have been invaluable in helping the whole team manage our data/information, interview patients with enteric illness and helping support the team with various projects/audits that previously we have not had the time to undertake. We are so glad to have them all!

INSIDE THIS ISSUE

Consultants

Chris Littlejohn	Consultant in Public Health & Head of Health Protection
Dr William Moore	Consultant in Public Health Medicine
Dr Shantini Paranjothy	Consultant in Public Health Medicine

Manager Rachel Soplantila Lead Public Health Manager – Health Protection

Health Protection Nurse Specialists

Fiona Browning
Helen Corrigan
Rhona Kirkham
Jenni Strachan

Lead TB Specialist Nurse

Susan Duthie

TB Specialist Nurses

Fiona Aitken
Dawn Sineath

Advanced Health Protection Nurse

Sarah Brown

Health Protection Nurses (Care Homes): Audrey Collie; Lisa Cormack; Jackie Donald

Health Protection Officers: Christian Nicholson; Dammy Fasan; Saba Savul

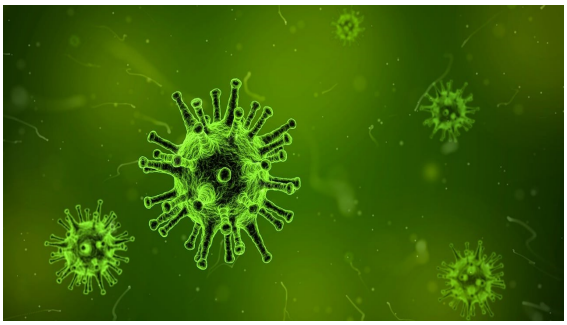
Health Protection Admin: Beverley Miller; Fiona Anderson; Pam Craig

PREPARING FOR COVID-19 AND INFLUENZA IN CARE HOME SETTINGS

Hopefully all care home residents' anticipatory care plans will have been updated in advance of winter. Ideally, plans will identify treatment intentions for any resident who would be eligible for treatment for covid-19 or influenza, informed by the clinical appropriateness of treatment and resident/power of attorney preferences regarding treatment. This should preferably also include consideration of the preventive use of antivirals in the event of the resident being exposed to influenza during an outbreak. Current guidance is to target post-exposure antivirals as far as possible, rather than to use 'blanket' prescribing, and exposed residents' GPs will be asked to make the final determination as to post-exposure prophylaxis.

Eligibility criteria and NHS Board pathways for assessment for COVID-19 treatment are set out at https://www.nhsinform.scot/illnesses-and-conditions/infections-and-poisoning/coronavirus-covid-19/coronavirus-covid-19-treatments

Guidance on the use of influenza antivirals is available at https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents



INCREASE IN GROUP A STREPTOCOCCAL INFECTIONS

Many of you will have already seen the alert letter from Public Health Scotland regarding the unseasonal increase in cases of invasive group A streptococcal (iGAS) infections in Scotland. This increase is also being seen locally in the Grampian area.

Group A Streptococcus (GAS), can commonly colonise the throat, skin and anogenital tract with the potential to cause a diverse range of skin, soft tissue and respiratory tract infections. Invasive Group A Streptococcal infections are diagnosed from laboratory confirmed samples from normally sterile sites, such as blood or cerebrospinal fluid. Non-invasive presentations of these infections include scarlet fever, pharyngitis and impetigo. More serious, invasive disease include streptococcal toxic shock syndrome, necrotising fasciitis, and septicaemia. National-level evidence-based guidance identifies Chickenpox (varicella infection) as the most common risk factor for invasive GAS (iGAS) disease in children, including streptococcal toxic shock syndrome, necrotising fasciitis, and septicaemia.

We have seen an increase in cases of scarlet fever among children throughout Grampian in line with the national increase. Although not a notifiable disease in Scotland, it is important at this time to maintain a high index of suspicion. If an outbreak occurs in a school/nursery, parents and guardians may receive communication from the HPT advising that if they suspect their child may have acquired scarlet fever, they should contact their GP practice for medical advice. In outbreak situations, the HPT may request laboratory confirmation is sought for those with symptoms consistent with scarlet fever.

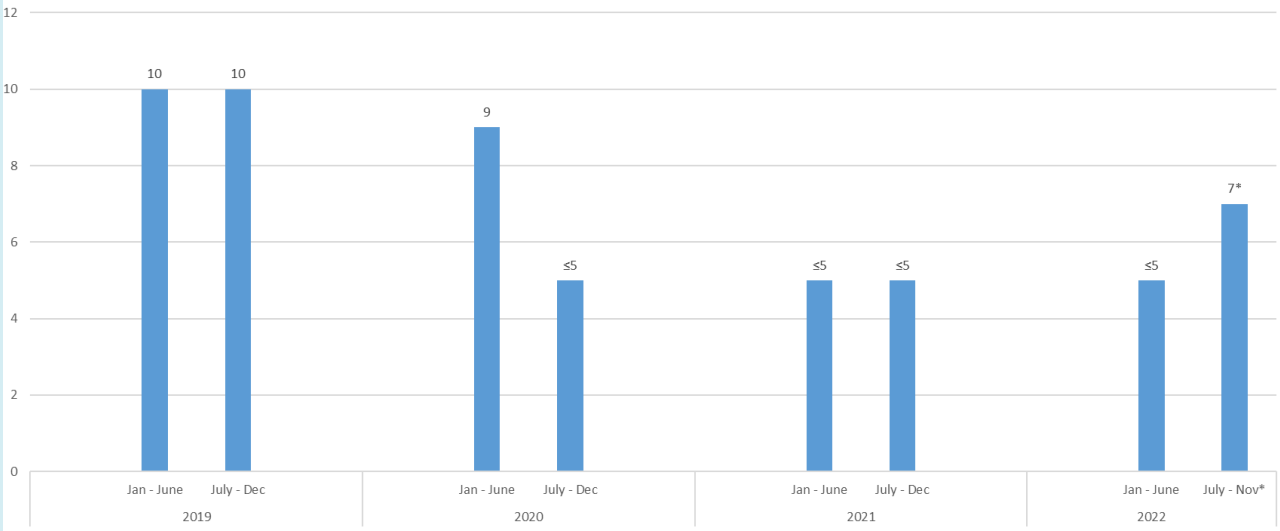
Child with scarlet fever and strawberry tongue

Scarlet fever symptoms are non-specific in early illness and may include sore throat, headache, fever, nausea and vomiting. After 12 to 48 hours the characteristic red, generalised pinhead rash develops, typically first appearing on the chest and stomach, rapidly spreading to other parts of the body, giving the skin a sandpaper-like texture. On more darkly-pigmented skin, the scarlet rash may be harder to spot, although the 'sandpaper' feel should be present. Patients typically have flushed cheeks and pallor around the mouth. This may be accompanied by a ‘strawberry tongue’. During convalescence the skin at the tips of fingers and toes can peel.

Suspected scarlet fever can be confirmed by taking a throat swab for culture of Group A streptococcus, although a negative throat swab does not exclude the diagnosis. Guidance recommends prescription of antibiotics on clinical suspicion without waiting for the culture result. Patients should not attend nursery/school/work until they are well and have completed 24 hours

of appropriate antibiotic treatment.

LOCAL IGAS DATA 2019 - OCTOBER 2022



Data for 2022 was collected up to October 31st 2022. *October saw a striking increase in cases making up the majority of the cases in the July to November period.

CHICKENPOX

Chickenpox is caused by the Varicella zoster virus, and is one of the most common viral exanthems of childhood. Following a typical incubation period of 14-16 days, there is often a prodromal illness of fever, headache and malaise. The rash typically begins on the trunk and progresses from papules, to fluid-filled vesicles, to pustules which then dry to crusts. Cases are infectious up to five days before the onset of the rash.

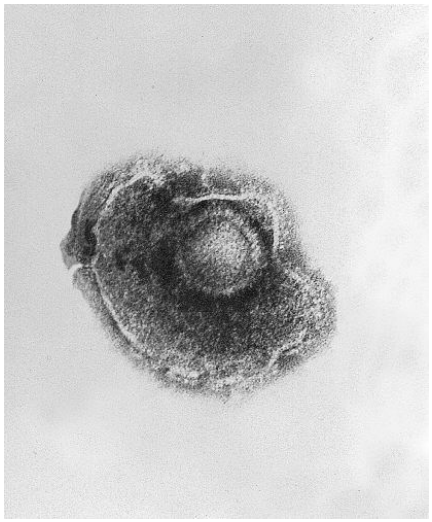
Chickenpox rash in child

Chickenpox infections in Scotland typically peak in the spring and summer months, between February and August each year. Highly infectious but usually self-limiting, chickenpox can be complicated by secondary infection by bacteria (due to the usual skin barrier being broken by the chickenpox blisters). Secondary bacterial infections are typically caused by bacteria such as group A Streptococcus (GAS) or Staphylococcus aureus. Other complications can include pneumonia, hepatitis and encephalitis. Some groups are at greater risk of complications from chickenpox; in particular, the elderly, the immunocompromised, neonates and pregnant women (where the varicella virus can cause both severe chickenpox in the mother, and congenital varicella syndrome in the fetus).

Chickenpox is a vaccine-preventable disease, although this isn't currently included in routine childhood

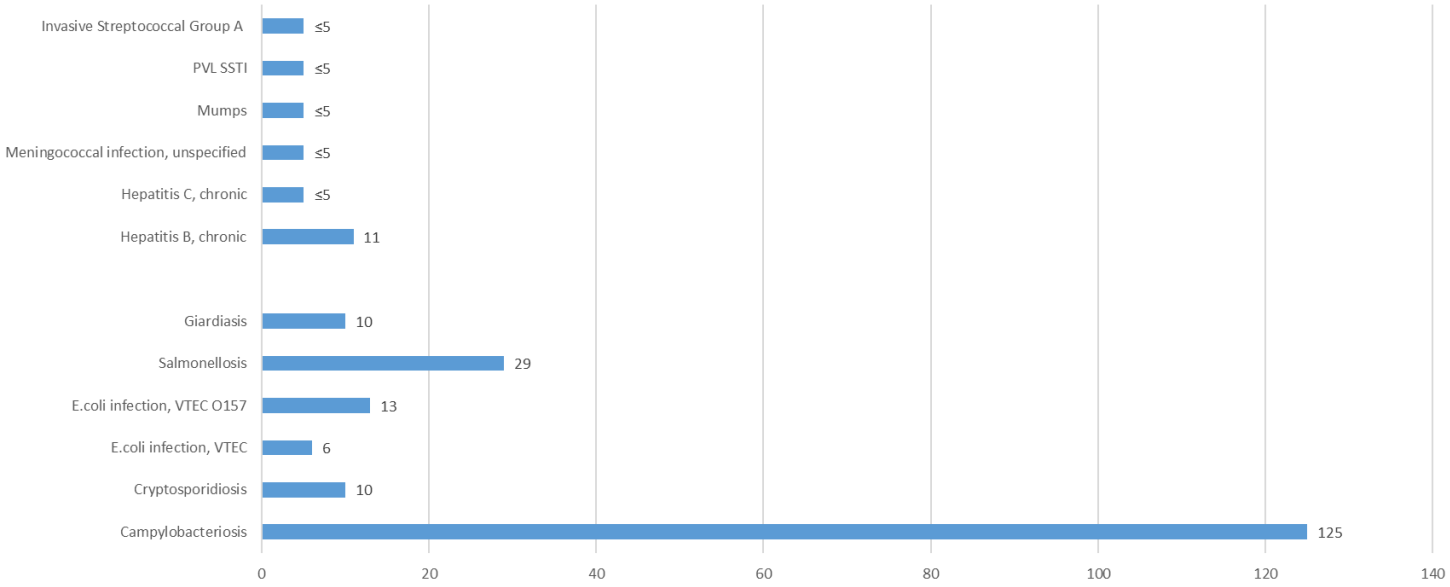
immunisation in the UK. Over 90% of adults in Scotland have immunity following infection in childhood. Passive protection can be achieved using human varicella-zoster immunoglobulin. Chickenpox isn't a notifiable disease, either in the UK or in Scotland. The vast majority of cases are diagnosed clinically, with no laboratory confirmation.

In October, Public Health Scotland issued an alert regarding unseasonal patterns of invasive group A Streptococcus (iGAS) in Scotland. Health Protection teams should remain vigilant of the risk of chickenpox in this context, as chickenpox is the most common risk factor for iGAS in children.



Electron Micrograph of varicella virus

LOCAL SURVEILLANCE SNAPSHOT



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Look forward to our holiday special issue with important tips for the winter and all its festivities as well as a Holiday Health Protection Quiz!

If you have something you would like to add to a upcoming feature of our newsletter please feel free to get in touch via email or phone listed above!