# Hunter New England and Central Coast Public Health Units
# Communicable Diseases Report
# Sept 2017

Meningococcal W increase
NSW Hepatitis A outbreak – locally acquired

**Meningococcal W:** An increase in invasive meningococcal disease caused by serogroup W (MenW) in New South Wales has prompted a state-funded school-based immunisation program for Year 11-12s. These trends have also been observed in HNELHD, with the proportion of meningococcal cases caused by MenW increasing from 4% in 2013 to 30% in 2015. In HNELHD in 2015-2016, there were 7 cases of MenW. CCLHD (2015-16 calendar years) had 2 MenW cases notified. Clinically, MenW may manifest as classical meningococcal disease (meningitis or septicaemia), or with less typical features, with many cases presenting with focal gastrointestinal symptoms such as vomiting, diarrhoea, abdominal pain, nausea and headaches. MenW causes more frequent sudden deterioration and death compared to other serogroups.

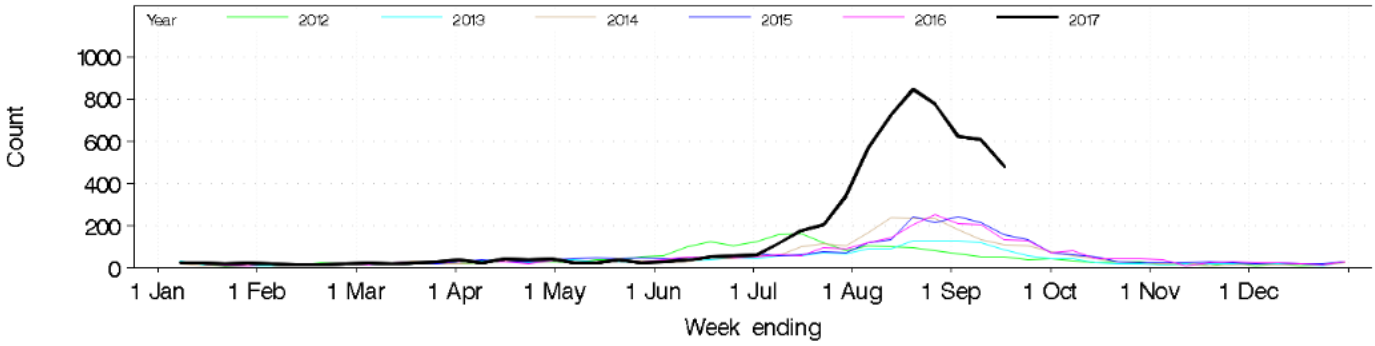
- Invasive meningococcal disease usually peaks in late winter and early spring.
- Early signs of sepsis may be subtle – a thorough history and examination, including a full set of vital signs is recommended for all febrile children. Compare with NSW Health Standard Paediatric Observation Charts for easy reference ranges.
- Aboriginal and Torres Strait Islander people experience a 3-4 times higher incidence of invasive meningococcal disease than non-Aboriginal people. Consider additional strategies such as longer observation periods or more frequent review in patients from these populations.
- Quadrivalent 4vMenCV (covering serogroups A,C,W,Y) vaccination is available for free to those in year 11 and 12 through the school program, or to adolescents aged 16-18 who are not attending school through GPs. The vaccine can also be accessed on private prescription for any patient >2 months of age

**Hepatitis A:** There have been 21 cases of locally acquired Hep A (as of Sept 20) in NSW since late July. Of these, 9 are in men who have sex with men (MSM). Molecular typing has been completed on 11 of the 21 cases, and all 11 are a 100% match to each other (and highly related to a large outbreak occurring in Europe, predominantly among MSM). Hunter New England and Central Coast LHDs have had three cases (illness onsets of 18/7, 29/8 and 6/9); none are MSM. The two HNELHD cases reported travel to Sydney doing their exposure period. It is suspected that transmission is occurring through two concurrent pathways; person-person (MSM) and foodborne.

- If patients present with symptoms of hepatitis, investigate as usual, including hepatitis A IgM
- If acute viral hepatitis is suspected, ask about international travel, travel to Sydney, MSM activity and food handling during exposure period (15-50 days prior to illness onset), and notify public health immediately
- Advise symptomatic patients not to have sex, prepare food or drink or share utensils, provide personal care to others, share linen or towels or donate blood until infection is excluded, or if infection is confirmed, until they are no longer infectious (usually 2 weeks after symptom onset – please seek PHU advice)
- Infection can be prevented in contacts of cases if hepatitis A vaccine (or in special situations immunoglobulin) is administered as soon as possible, and within 2 weeks of first contact – please

**Influenza and respiratory infection:** High flu activity continues in several parts of the world, especially in Australia, as well as some countries in southern Asia and south-east Asia. In Australia, the national flu levels seem to have plateaued but intensity varies by region, with H3N2 as the predominant strain, followed by influenza B. At the global level, influenza A made up 87.5% of the specimens that tested positive for flu, and of the subtyped influenza A viruses, 84.3% were H3N2.

**Figure 1**: Total weekly counts of NSW emergency department presentations for influenza-like illness, for 2017 (black line), compared with each of the five previous years (coloured lines), persons of all ages, for 60 NSW hospitals.




## Communicable disease notifications:

**Table 1.** Summary of selected notifiable conditions (YTD* by year), 2013 – 12 Sept 2017

| | **Hunter New England** (YTD* by year) | | | | | **Central Coast** (YTD* by year) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **2017** | **2016** | **2015** | **2014** | **2013** | **2017** | **2016** | **2015** | **2014** | **2013** |
| **Cryptosporidiosis** | 116 | 74 | 91 | 38 | 117 | 34 | 58 | 21 | 10 | 26 |
| **Gonorrhoea** | 276 | 288 | 186 | 203 | 147 | 131 | 85 | 69 | 50 | 76 |
| **Syphilis** | 33 | 41 | 43 | 28 | 27 | 9 | 28 | 28 | 31 | 22 |
| **Chlamydial Infection** | 2012 | 2158 | 1949 | 2040 | 2091 | 723 | 771 | 650 | 765 | 583 |
| **Influenza** | 8892 | 2189 | 2007 | 2359 | 269 | 3264 | 895 | 631 | 350 | 55 |
| **Meningococcal Disease** | 9 | 6 | 3 | 6 | 9 | 1 | 3 | 2 | 3 | 2 |
| **Pertussis** | 556 | 833 | 608 | 230 | 162 | 71 | 310 | 219 | 14 | 28 |
| **Ross River Virus** | 296 | 75 | 313 | 150 | 93 | 43 | 10 | 68 | 16 | 16 |
| **Salmonellosis** | 296 | 308 | 306 | 358 | 300 | 177 | 122 | 100 | 128 | 92 |

*YTD, Year to date for each year (reporting delays may result in changes to 2017 figures)

**Population Health contact details (note, 1300 066 055 will find your local PHU)**

Hunter New England: Wallsend Office 4924 6477 - Tamworth Office 6764 8000

Central Coast Public Health Unit: Gosford Office 4320 9730

This Communicable Disease Report and previous editions are available on the internet

Public Health contact HNELHD-PHEnquiries@hnehealth.nsw.gov.au