Health New Zealand
Te Whatu Ora

Waikato Public Health Bulletin

Public Health Waikato

October 2024 | Oketopa 2024

Tēnā koutou katoa. We hope you enjoy this edition of the Waikato Public Health Bulletin and we welcome your feedback.

The bulletin is written for GPs and colleagues in primary and community care.

In this month's bulletin:

The lowdown on *Legionella*

As we head into the warmer months and enjoy more gardening, it is timely to consider the potential health risks involved. *Legionella* is a species of bacteria which exist in soil and aquatic environments and cause legionellosis.

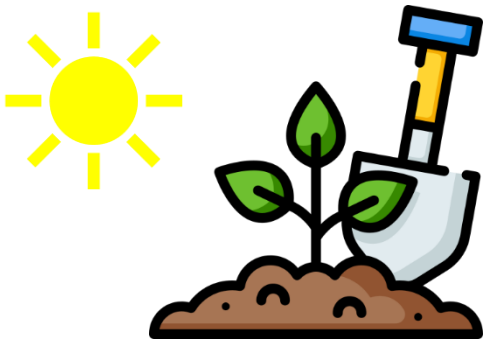
Aside from being an important cause of community-acquired pneumonia (Legionnaires' disease), *Legionella* can also affect multiple other organ systems, including the skin and joints. Pontiac fever is a mild form of legionellosis with flu-like symptoms, including muscle aches and fevers, and which usually resolves without treatment.

Legionellosis is more common in older people, people who smoke, people with chronic disease, and people with immunocompromise. Person-to-person spread has not been reported; transmission is through inhaling (not ingesting) aerosols of water or dust particles carrying *Legionella* bacteria.

Practice points: Legionellosis

- The incubation period ranges from 2 to 14 days (typically 2 to 10). In patients with suspected community-acquired pneumonia, ask about the places visited and any at-risk activities done within the 2 weeks before symptoms began.

- Activities and sources at risk of exposing patients to *Legionella* include:
  - Handling soil and any soil product (compost, mulches, potting mix).



  - Note that *Legionella* can be found in commercially prepared products, even those that have been sterilised, due to reinfection. A common exposure is bags or bulk loads of potting mix and compost.

Practice points: Legionellosis

- Apart from handling soil, droplets and spray from sources such as spa pools, cooling towers, and warm-water systems may also contain Legionella.

- Lab tests for diagnosis:

  - Sputum for PCR and culture
    - PCR will be performed on sputum if:
      - there is a specific request for *Legionella* testing
      - clinical details on the request form indicate pneumonia or an immunocompromised patient

For more info on investigations, refer to:

- "Laboratory test for diagnosis" in the Communicable Disease Control Manual chapter on Legionellosis

- The "Legionnaires' Disease" sections of the "Community-acquired Pneumonia (CAP) in Adults" page on Community HealthPathways.

Advise patients to prevent legionellosis by:

- Working with soil or soil-related products in a well-ventilated area, preferably outside.
- Dampening potting mixes before use.
- Wearing a well-fitting face mask to avoid inhaling dust.
- Opening bags of soil products with scissors slowly and away from the face.
- Wearing gloves when handling soil.
- Avoiding touching the face when handling soil.
- Practicing thorough handwashing with soap after handling soil-related products, even if gloves were worn.

Click here for information on garden safety in general and here for a patient-friendly resource on legionellosis.

Pertussis alert

Nationally, there has been a significant increase in pertussis cases. Pertussis epidemics tend to occur every 3 to 5 years, with the previous beginning in late 2017 and continuing through to 2018.

Currently, ESR has assessed the risk of a national pertusiss outbreak to be high. In September, the notification rate (3.4/100,000, or 187 confirmed, probable and suspected cases) was equal to the national outbreak threshold. Case numbers are among the highest since early 2019 and are exacerbated by low vaccination rates.

The ESR dashboard shows that case numbers are increasing in all regions at different times in recent weeks. Cases have been spread across age groups and ethnicites.

Key vaccination messages:

- Pertussis can be severe for babies, who may require hospitalisation. Advise pregnant people of the national increase in pertussis and **recommend the free Boostrix vaccination from 16 weeks in every pregnancy.**

- Encourage pertussis vaccination for the extended whānau of pregnant people, new babies, and infants. However, not everyone is eligible for a funded vaccine. Boostrix is free for:

  - People from 45 years old, if they have received fewer than 4 tetanus doses in their life-time.
  - Everyone from 65 years old (if it has been more than 10 years since the previous dose).

Key vaccination messages:

- Boostrix is not free for people aged over 65 years who have already had a free Boostrix vaccine from age 65.
- Encourage all staff in healthcare settings to be protected from pertussis as well as influenza and measles.
- Continue to prioritise on time immunisation for all babies at 6 weeks, 3 months, and 5 months.

Whānau Āwhina Plunket: New pilot child immunisation programme

Te Whatu Ora and Whānau Āwhina Plunket have announced a new pilot programme to increase access and boost childhood immunisation rates at selected sites across the motu.

Whānau Āwhina Plunket will offer immunisation alongside Well Child visits in clinic, at dedicated immunisation clinics and community events, and eventually in the home.

The Well Child Tamariki Ora is a programme that provides health visits and support free to all families for tamariki from around 6 weeks up to 5 years of age. Whānau Āwhina Plunket is one of multiple organisations delivering this programme, including many other predominantly Māori and Pacific NGOs that also deliver childhood immunisation.

iGAS now notifiable

Invasive Group A Streptococcal (iGAS) infection became a notifiable disease under the Health Act 1956 from 1 October 2024.

GAS infections of the throat and superficial skin (impetigo) are not notifiable. GAS-positive skin, throat, and genital swabs do not need notification. GAS is only notifiable when it causes infection in a normally sterile site, which includes:

- Bloodstream infections
- Skin and soft tissue infections (cellulitis, necrotising fasciitis)
- Bone and joint infections (osteomyelitis, septic arthritis)
- Lower respiratory tract infections (pneumonia, empyema)
- Central nervous system infections (meningitis)

Notify the local MOoH of iGAS cases that meet the case definition for a confirmed or probable case. Refer to the new iGAS chapter added to the Communicable Disease Control Manual.

- **Confirmed cases** have evidence of GAS either by culture or nucleic acid testing in a specimen from a normally sterile site.
- A **probable case** has a clinical presentation consistent with iGAS as a cause of peripartum infection or neonatal sepsis, with evidence of GAS (by culture or nucleic acid testing) in a site that is not normally sterile.

Notifying probable cases will help identify and support close contacts to receive preventative antibiotic therapy (chemoprophylaxis) within a birthing-person–neonate pair.

Please note that **chemoprophylaxis is recommended routinely only within a birthing-person–neonate pair** in the context of iGAS causing peripartum infection or neonatal sepsis.

Outside of this situation, MOoH's may consider chemoprophylaxis for close contacts with additional risk factors on a case-by-case basis.

Preventative antibiotics should be given as soon as possible, preferably within 48 hours of exposure to the index case, or at least within 48 hours of notification.

The purpose for making iGAS notifiable is to improve and support case and outbreak detection, surveillance, the breadth and quality of data, and chemoprophylaxis of high-risk close contacts.

Enhanced surveillance will also support the development of effective interventions and policies to reduce the impact of iGAS on people's health. These policies may include access to environmental housing support.

Previously, surveillance of iGAS was based on voluntary laboratory referral of isolates to ESR. Along with other high-income countries, there has been a recent increase in the incidence rate of **reported** iGAS in Aotearoa.

The incidence of reported infections in 2023 was 10.9 cases per 100,000 population (568 cases), compared with 4.8 per 100,000 (244 cases) in 2022, and 8.3 per 100,000 (414 cases) in 2019. The increasing incidence in Aotearoa is most prominent in children aged 1 to 9 years. Rates are higher in Pacific Peoples and Māori. Rates also increase with increasing socioeconomic deprivation, as GAS thrives in poor housing and overcrowded conditions.

Exposure to blood and body fluid

Occupational exposure to blood and bodily fluids can put people at risk of hepatitis B virus (HBV), hepatitis C virus (HCV), and/or human immunodeficiency virus (HIV).

In addition to blood, body fluids such as respiratory secretions, saliva, and faecal matter and contact with a patient's contaminated skin or mucous membranes can also potentially pose an infection risk.

We have received queries about managing these exposures. As a reminder, here is a quick summary of management.

Managing exposures to blood and body fluid:

1. First aid
   - Wash exposed area with soap and water for 3 minutes
2. History
   - Time of exposure, source of fluid, exposure site
   - Recipient risk: vaccination status, previous testing or exposure, infection status of source
3. Investigations
   - Arrange HBsAg, HBsAb, HCV serology, and HIV serology for the source and exposed individual with consent ideally within 24 hours and marked as urgent
4. Asses risk and provide prophylaxis when appropriate
   - HIV: If high risk of HIV exposure, seek infectious diseases advice for prophylaxis preferably within 2 to 4 hours, or up to 72 hours following exposure
   - HBC: Arrange serology follow-up at 3 and 6 months. Currently there is no effective post-exposure prophylaxis for HCV
5. Advice for patients
   - Advise the recipient to notify the workplace Health and Safety officer of the BBFE, and of any subsequent infection as a result
   - If an accident has occurred submit an ACC claim
   - Due to risk of HIV, HBV, and HCV infection, provide advice regarding sexual contact and not donating blood until results return
6. Follow up testing in 6 months

Staff news

This month we farewell our wonderful house officer **Dr Connie Alarcon**. Her research on the health status of former refugees in the Waikato region has shaped the direction and content of health promotion intiatives at the Settlement Centre Waikato. We wish you all the best with your next hospital run in Plastics!

L to R: Drs Richard Vipond (MOoH), Connie Alarcon, and Liz Becker (MOoH).

We are very excited to have **Dr Kato McDonald** join us for her house officer attachment. Welcome!

We also extend a warm welcome to **Lizzy Kepa-Henry**, our new Manager of Community & Whānau Wellbeing for Waikato and Taupō.

Ko Tarawera, ko Ruawāhia rātou ko Wāhanga ōku maunga
Ko Te Awa o Te Atua raua ko Tarawera ōku awa
Ko Te Arawa tōku waka
Ngā Pūmanawa e waru o Te Arawa
Ko Ngāti Mahi raua ko Ngāti Tīonga ōku hapu
Ko Rangiaohia tōku Whare Tūpuna
Ko Rakauheketara tōku Wharekai
Ko Rangitihi te Tangata
Ko Rangitihi tōku Marae
Te Arawa Mangai Nui
Tapa tahi ngā Whakāro
E kore e nuku
E kore e neke
Ko Te Arawa tōku Iwi
Ko Lizzy Kepa-Henry tōku ingoā

I was able to determine the most effective way to provide tāngata-focused primary health care to disadvantaged populations receiving benefits due to my experience working as a Regional Public Health Nurse for the Ministry of Social Development across all of their regional sites in the capacity of Work and Income Nurse.

When COVID disrupted all our worlds, I was seconded into the Māori and Pacifica Clinical Team Lead role to implement our public health approach named Tiakina te Ira Tangata – Not one life lost.

Utilising my work and income nursing skills and strategies during this pandemic, I was able to positively support COVID positive patients across Aotearoa to access health care and support in a timely manner.

Navigating gangs, mental health, transient communities, Kuia and Kaumatua working 10-16hr days and weekends to ensure ambulances, Dr's, kai, housing, telephone communication had arrived taught great lessons and the lengths nursing went to, to provide safe care.

Subsequently, I assumed the position of Regional Clinical Manager for Access Community Health for Green Doctors and Life Pharmacies which deepened my knowledge and helped me to highlight the actual scope of underserved areas in particular rural communities with an appreciation of their struggles.

With a strong desire to support Māori nursing, I commenced work within Ara Poutama Corrections Aotearoa as National Lead - Māori Nursing Health Services. It is challenging to comprehend the differences between primary health care in the community and corrections, but there are some similarities in patient care, and safe staffing has well prepared me to work with you all to achieve improved public health outcomes by putting whānau at the centre in line with Pae Ora Health Futures.

Medical Officers of Health (MOoH)

Dr Felicity Dumble, Dr Richard Wall, Dr Richard Vipond, Dr Elizabeth Becker, Dr Kate Meerkerk

After Hours:

MOoH: 021 359 650 **HPO**: 021 999 521

If there is no answer, please contact Waikato Hospital's switchboard 07 839 8899 and ask for the on-call MOoH.

During Office Hours:

Public Health (MOoH or HPO): (07) 838 2569

Notifications outside Hamilton: 0800 800 977

Notifications: 07 838 2569 ext. 22041 or 22020

Fax: 07 838 2382

Email: notifiablediseases@waikatodhb.health.nz

Notifiable Diseases – Trends

Notifiable diseases (Waikato District) - period to: **October 2024**

*Stats NZ estimated 8.69% of the population resided in Waikato in 2021

Disease name	Waikato cases per month			Cases per month over the last year (mean)		
	August	September	Trend	Waikato	National	% Waikato*
Botulism	0	0	-	0.0	0.1	0
Brucellosis	0	0	-	0.0	0.0	-
Campylobacteriosis	32	57	▲	45.1	469.5	10
COVID-19	871	193	▼	1,451.8	18,371.8	8
Cryptosporidiosis	3	19	▲	7.9	107.0	7
Decompression sickness	0	0	-	0.0	0.1	0
Dengue fever	1	0	▼	0.8	9.6	8
Diphtheria	0	0	-	0.0	0.1	0
Gastroenteritis - unknown cause	1	0	▼	1.9	18.3	10
Gastroenteritis / foodborne intoxication	8	6	▼	5.8	16.7	35
Giardiasis	10	11	▲	9.7	73.0	13
Haemophilus influenzae type b	0	0	-	0.0	0.1	0
Hepatitis A	1	1	-	0.3	4.6	7
Hepatitis B	0	0	-	0.0	1.0	0
Hepatitis C	1	0	▼	0.1	2.2	5
Hepatitis NOS	0	0	-	0.3	0.5	60
Hydatid disease	0	0	-	0.0	0.3	0
Invasive pneumococcal disease	10	5	▼	4.0	60.9	7
Latent tuberculosis infection	1	5	▲	1.5	9.3	16
Legionellosis	0	1	▲	1.5	18.7	8
Leprosy	0	0	-	0.0	0.4	0
Leptospirosis	1	3	▲	2.7	9.1	30
Listeriosis	0	0	-	0.2	2.2	9
Listeriosis - perinatal	0	0	-	0.0	0.3	0
Malaria	0	0	-	0.2	3.1	6
Measles	0	0	-	0.2	0.8	25
Meningococcal disease	0	1	▲	0.4	3.8	11
Mumps	0	1	▲	0.1	2.7	4
Murine Typhus	0	0	-	0.0	0.1	0
Pertussis	1	0	▼	1.4	50.8	3
Q fever	0	0	-	0.0	0.2	0
Rheumatic fever - initial attack	2	0	▼	0.8	15.4	5
Rheumatic fever - recurrent attack	1	0	▼	0.2	1.7	12
Salmonellosis	4	3	▼	4.9	64.6	8
Shigellosis	1	1	-	0.4	14.0	3
Taeniasis	0	0	-	0.0	0.2	0
Tetanus	0	0	-	0.0	0.2	0
Tuberculosis disease - new case	2	3	▲	2.3	29.8	8
Tuberculosis disease - relapse or reactivation	0	0	-	0.0	1.3	0
Tuberculosis infection - on preventive treatment	0	0	-	0.0	0.2	0
Typhoid fever	1	0	▼	0.7	4.6	15
VTEC/STEC infection	5	20	▲	7.7	95.1	8
Yersiniosis	4	4	-	5.4	96.4	6