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EPI-LOG

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Vaccine Campaign

The Seattle-King County Department of Public Health (SKCDPH) plans to begin its influenza vaccine campaign on October 12. October through mid-November is the optimal time for vaccination to provide protection throughout the typical influenza season. The vaccine may be administered earlier for high-risk patients who will not be able to return to the clinic after the start date, or for those who are traveling to geographic regions with earlier influenza seasons.

As we reported in the August Epi-log, reports of febrile respiratory illnesses and associated pneumonia among summer land and sea travelers to Alaska and the Yukon Territory have been under investigation since July 26, 1998. Epidemiologic and laboratory evidence has implicated influenza A virus as the etiologic agent of the outbreak. Of the 26 influenza A isolates identified so far, five have been characterized at the Centers for Disease Control and Prevention (CDC); all have been identified as influenza A/Sydney/5/97 (H3N2)-like viruses, a strain included in the 1998–99 influenza vaccine. As of August 22, active surveillance has identified few (n=46) cases and no outbreaks of influenza among residents in Alaska or the Yukon Territory. Therefore, no special prevention measures are recommended for travelers to this area who are aged <65 years and in good health. Travelers at high risk of influenza-related complications should be immunized as normally recommended during flu season. These persons should also receive information about the signs and symptoms of influenza and about the advisability of carrying rimantadine or amantadine, antivral medications that can be used for the treatment or prophylaxis of influenza A (but not B). Both medications can reduce the duration of influenza A illness and viral shedding if administered within 48 hours of onset of symptoms, but they may also lead to CNS or GI side effects and may require dosage adjustments in patients with underlying renal or hepatic disease.

Groups at highest risk for influenza-related complications that should receive the vaccine include persons aged 65 years or older, those older than 6 months of age who have a chronic illness, children and teenagers receiving long-term aspirin therapy, residents and staff of long-term care facilities, pregnant women who will be at least 14 weeks gestation *during the flu season*, and HIV-infected persons without AIDS as well as HIV-infected persons with minimal AIDS-related symptoms. Flu vaccine should also be given to persons likely to transmit influenza to susceptibles.

[For detailed information on administration of influenza vaccine, refer to Centers for Disease Control and Prevention. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 1998; 47 (No. RR-6).]

Rabies Prophylaxis

Health care providers with patients needing rabies post exposure prophylaxis (PEP) can administer rabies immune globulin (RIG) and the Human Rabies Diploid Cell Vaccine (HDCV) in their office. Although some providers have referred patients to SKCDPH clinics, these clinics do not keep RIG in stock. In addition, only a few of the many hospitals in the county have RIG on hand. With recent changes in health care plans, insurance coverage for rabies PEP is limited; referrals to hospital emergency rooms or the Health Department clinics for this service may not be covered. As a result, most health care providers now are ordering the biologics and administering them in the office. RIG and HDCV can be ordered directly from Connaught (1-800-VACCINE) or through the pharmacy covered under the patient's insurance plan.

Although the SKCDPH does not keep RIG in stock, it does have HDCV on hand. If the primary health care provider can not vaccinate the patient, the patient may be referred to a Health Department clinic for the HDCV doses. If this is necessary, the health care provider should call the Communicable Disease Epidemiology Unit (206-296-4774) to make arrangements to obtain the vaccinations. The Health Department clinics will not administer the vaccine for post exposure purposes unless the Epidemiology Unit approves the use and notifies the clinic of this approval. The Unit can assist with the evaluation of exposure situations, treatment plans and advice on how to obtain treatment. The Unit also has a document for health care providers on pre- and post-exposure uses of rabies vaccine and the use of RIG.

Body Piercing

Body piercing has become part of mainstream culture in the U.S. and is increasingly popular among adolescents. Piercings may be obtained at tattoo or body-art salons, concert tours, and impromptu "piercing stations" at dance locations. Piercings may also be self-inflicted or performed by friends. There are no nationwide training requirements for piercers. The risk of infectious complications of piercing will vary with the circumstances under which the procedure is performed. Infections following piercing are infrequently reported. An organism may be introduced to the piercing site at two points in time. The first is when the piercing is done with poor technique and unsterile instruments. The second is during the aftercare of the piercing site

when the wound is not kept clean or is handled by the client.

Staphylococcus aureus is the organism most commonly reported bacterial cause of infected piercings. Complications of *S. aureus*-infected earlobe piercings have included hematogenous osteomyelitis, bacteremia, meningitis, and staphylococcal toxic shock syndrome. Piercings that traverse the auricular cartilage have been associated with *S. aureus* and *Pseudomonas aeruginosa* infections. Green discharge may be a clue to pseudomonas infection. Surgical I & D, debridement, or resection may be needed with pseudomonas infection. Group A β-hemolytic streptococcal infections can cause life-threatening infections including the streptococcal toxic shock syndrome and endocarditis after body piercing. Also of concern is the potential for inoculation with *Clostridium tetani*.

Body piercing has been associated with transmission of viruses in several epidemiologic studies. Transmission of hepatitis B virus (HBV) has been documented in cases in which needles and other equipment have been shared in body piercing as well as tattooing. A large retrospective Italian study found ear piercing significantly associated with hepatitis, even when intravenous drug use and multiple sexual partners were controlled for (Mele, A. Scand J Infect Dis 1995;27:441). A case-control study in Washington found that those with HBV were significantly more likely to have had their ears pierced than controls (Johnson CJ. JAMA 1974;227:1165). Another study from South Africa had similar findings. Body piercing and tattooing have been associated with hepatitis C virus infection. No cases of HIV have been reported to be linked to body piercing although this remains a possibility; acute HIV has been reported after acupuncture treatments (Vittecoz, D. NEJM 1989;320:250).

Prevention of infectious complications of body piercing should involve patient education to minimize risk from improper sterile technique or contamination. In addition, although piercing is not a significant contributor to overall HBV transmission in the U.S., the potential for transmission reinforces the current recommendations for hepatitis B immunization for all children and adolescents. Persons desiring piercing should avoid piercing themselves or friends and avoid inexperienced piercers. Piercing should be done in a clean environment and the piercer should be able to provide convincing information about the sterile technique used, including sterilizing equipment in autoclaves, and use of latex gloves and sterile instruments and jewelry.

Cervicitis and PID

Caring for Women: Management and Prevention of Cervicitis and Pelvic Inflammatory Disease, a live interactive satellite broadcast, will be presented at sites nationwide on October 7, 1998, from 9:30 a.m. to 12:30 p.m. Pacific standard time.

Co-sponsors are CDC and the Seattle and New England STD/HIV Prevention Training Centers. The program will address the etiology, diagnosis and management of cervicitis; choice of appropriate laboratory work-up, treatment and follow-up of pelvic inflammatory disease; the role of new diagnostic technologies for the detection of Chlamydia trachomatis in the management of cervicitis and PID, and identification of screening strategies for the prevention of cervicitis and PID.

Physicians, nurse practitioners, nurse midwives, physician assistants and registered nurses who provide care for women at risk of, or presenting with, cervicitis or PID should attend.

Information about registration, satellite coordinates, and Continuing Medical Education and Continuing Education Units is available by telephone from the Seattle STD/HIV Prevention and Training Center at (206) 685-9850, or on the internet at http://www.weber.u.washington.edu/~seaptc.

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Tuberculosis 296-4747
STDs..... 731-3954
Communicable Disease 296-4774
24-hr Report Line..... 296-4782
Disease Alert:
CD Hotline 296-4949
After hours 682-7321
http://www.metrokc.gov/health/

REPORTED CASES OF SELECTED DISEASES
SEATTLE-KING COUNTY 1998

	CASES REPORTED IN AUGUST		CASES REPORTED THROUGH AUGUST	
	1998	1997	1998	1997
VACCINE-PREVENTABLE DISEASES				
Mumps	1	0	2	4
Measles	0	0	0	1
Pertussis	11	10	107	138
Rubella	0	0	1	1
SEXUALLY TRANSMITTED DISEASES				
Syphilis	1	1	27	5
Gonorrhea	74	79	668	559
Chlamydial infections	289	210	2326	2013
Herpes, genital	51	60	462	441
Pelvic Inflammatory Disease	14	27	160	203
Syphilis, late	3	2	21	32
ENTERIC DISEASES				
Giardiasis	35	29	154	160
Salmonellosis	32	21	147	147
Shigellosis	17	9	63	71
Campylobacteriosis	26	43	169	227
E.coli O157:H7	6	10	20	27
HEPATITIS				
Hepatitis A	15	47	338	314
Hepatitis B	2	4	31	29
Hepatitis C/non-A, non-B	1	0	2	2
AIDS	5	12	170	210
TUBERCULOSIS	10	9	75	92
MENINGITIS/INVASIVE DISEASE				
Haemophilus influenzae	0	0	1	1
Meningococcal disease	0	1	11	15