Influenza

Auckland experienced two peaks in influenza-like illness (ILI) this year (Figure 1). The first began during the week of the 17th June: a second more diffuse peak occurred during August and September.

The average consultation rate for the Auckland region over the entire surveillance period this year was approximately 90 per 100,000 practice population per week. This is far greater than the rates recorded last year. However influenza activity in 2000 was the lowest since the surveillance system began in 1991. ILI was more frequently reported by GPs in South and West Auckland, with consultation rates approximately 1.5 times those in North and Central Auckland. This is consistent with the pattern observed in the 1999 epidemic.

Rates of ILI consultations varied by age with the lowest rate among adults aged 65 years and over (33 per 100,000 per week). This was observed in 1999 and has not changed with improved uptake of immunisation since then. Rates of ILI consultations in all other age groups were similar (90-98 per 100,000 per week).

As in previous years, Influenza A predominated in the early stages, and Influenza B in the latter part of the epidemic (Figure 2). 88/102 (86%) of positive swabs obtained in the earlier peak were identified as Influenza A, and 38/41 (93%) in the later peak were Influenza B. Of these isolates, 83 were subtyped as A/New Caledonia/20/99 (H1N1), and 45 were B/Johannesburg/5/99. Both of these strains were contained in this year’s influenza vaccination.

New Zealand has an active influenza surveillance system that operates from May to early October each year. Public Health Protection co-ordinates the Auckland Influenza Surveillance Network (FLUNET) in the Auckland region as part of the national system. Its aim is to provide an early warning of the onset of the annual increase in ILI as well as to allow comparison with previous years. We are grateful to the network of general practitioners (GPs) who voluntarily provide weekly reports to Public Health Protection on the number of patients presenting each week with symptoms of ILI. Sentinel influenza surveillance this year included 45 GPs across Auckland. In addition to reporting ILI numbers, participating GPs collect swabs for virological testing by the Auckland Virology laboratory. The New Zealand influenza surveillance system in turn contributes to global influenza surveillance co-ordinated by the World Health Organisation (WHO). The results of virological testing are used to assist WHO to determine the most appropriate strains for inclusion in influenza vaccines. WHO has recommended that vaccines used in the 2002 Southern Hemisphere winter contain the following strains:

- an A/New Caledonia/20/99(H1N1)-like virus
- an A/Moscow/10/99(H3N2)-like virus
- a B/Sichuan/379/99-like virus
- B/Johannesburg/5/99 (the predominant Influenza B subtype in Auckland this year) is a B/Sichuan/379/ 99-like virus

Data from the vaccine supplier suggests that uptake of the influenza vaccination in Auckland was lower than last year, with 15,000 fewer vaccine doses given to the end of June. An explanation for less than optimal immunisation rates against influenza is being sought in a Ministry of Health-funded survey into
what people think about immunisation. The survey will target doctors, practice nurses and people aged 65 years and over from Northland, Bay of Plenty, Waikato and Canterbury. It aims to identify the attitudes and beliefs that influence immunisation rates.

While vaccination is the most important strategy for disease control, antiviral therapy also has a role in minimising the impact of influenza. Two major classes of antivirals are available for treatment: the adamantanes and the neuraminidase inhibitors. The adamantanes (amantadine and rimantadine) have been in use for many years, but are limited by their lack of activity against influenza B, toxicity (especially in the elderly), and the rapid development of resistance. The neuraminidase inhibitors (zanamivir and oseltamivir) are a new class of anti-influenza drugs, and can significantly reduce the severity and duration of the illness when treatment is started within two days of the onset of symptoms. A standard course of these medications can cost upwards of $65, and they are not subsidised.

**Gonorrhoea resistance to ciprofloxacin on the increase**

The number of laboratory confirmed cases of gonorrhoea and chlamydia seen at Auckland DHB’s sexual health clinics throughout the Auckland region are increasing (see figure 3). The number of gonorrhoea cases reported by Auckland DHB’s laboratory follow a similar pattern to the sexual health clinics. This lab retests all specimens taken in the Auckland region for WHO surveillance purposes.

There has been a marked increase in the proportion of cases of ciprofloxacin resistant gonorrhoea notified in 2001 (see table 1). The recommended treatment for patients with ciprofloxacin resistance is ceftriaxone 250mg IM stat. Ceftriaxone is a specialist only prescription medication. Any general practitioners requiring a prescription for this medication are advised to contact the Auckland DHB sexual health registrar on call (025-883703).

Co-infection with Chlamydia trachomatis. Refer to the October 1999 issue of Public Health Advice. We recommend treating gonorrhoea patients for chlamydia at the same time. Use tetracycline antibiotics e.g. doxycycline 100mg BD for 7 days if this is appropriate, or single dose therapy with azithromycin 1g stat.

**Notification of suspected environmental poisonings**

With several large scale environmental and health programmes possible within the region over the next few months (for example the spray programme for the Painted Apple Moth in West Auckland, and spraying against the Southern Saltmarsh Mosquito in the Kaipara), general practitioners may receive enquiries from patients who think they may have been affected by sprays or chemicals in some way. It is also not infrequent for patients to consider their illnesses to be due to exposure to pesticides or other chemicals that they may have come in contact with in their day to day lives. Under schedule 2 of the Health Act 1956 general practitioners should notify to the Medical Officer of Health any cases they believe are likely to be related to such exposures. Notifications should be made to the usual number (09) 262 1855 either to the Notifiable Diseases Clerk or the Environmental Health Duty Medical Officer of Health who will arrange for an environmental investigation.

In making such a notification, the general practitioner should generally, other than in circumstances of sudden or extreme illness, provide a clear clinical diagnosis so that the environmental investigation can proceed. Lack of a clear diagnosis may hamper our ability to identify an environmental cause of illness.

**Food borne Illness Patient Pamphlets Available**

Public Health Protection would like to remind medical practitioners and practices nurses that patient pamphlets on four important food borne illnesses are available. The pamphlets provide information on the illness, measures to prevent transmission and advice concerning return to work among high-risk occupational groups.

Resources can be requested by contacting Hannah and requesting supplies by quoting the following:

- Campylobacter infection - CC2494
- Shigella infection - CC3258
- Salmonella infection - CC3254
- Yersinia infection - CC3255
- Norwalk-like Virus - CC3383
### Commentary on Disease Surveillance Summaries

There was a sharp increase in **dengue fever** notifications. 8/42 were hospitalised. Nineteen were Pacific Islands people; 17 European; 5 ethnicity unknown. Samoa was the source of infection for 32/42 (76%) of the notifications. This reflects the relative popularity of Samoa as a destination rather than the intensity of the outbreak. (Tahiti also reported a large outbreak but only five Auckland cases reported travelling there). 37/42 (88%) were NZ residents travelling for short-term holidays. Mosquito vectors for dengue fever are daytime biters, especially at dawn and dusk. Protection against mosquito bites is important for all travellers to tropical areas, including the Pacific - see *Health Advice for Overseas Travellers* pp 41-2.

A few confirmed cases of **pertussis** are still being reported. There is a need to remain on alert for **meningococcal disease** cases because they can deteriorate rapidly without early treatment. The increase in **gastroenteritis** is due to a single outbreak in a school camp with 147 cases. The increase in **salmonellosis** reflects national outbreaks of two serotypes - *Salmonella typhimurium* (Phage type 160) and *Salmonella heidelberg*. The increase in **shigellosis** is due to an increase in sporadic disease without an identified common source.

### Refugee Handbook

This detailed compendium of clinical advice and social services etc (based on a successful Australian handbook) has been produced by the Ministry of Health for those caring for refugees and asylum seekers. It will be launched at the Fickling Centre, 546 Mt Albert Rd, Three Kings, 15th Nov 1030 - 1200. The Minister of Health will speak. All welcome. If attending please RSVP to amortensen@adhb.govt.nz.

Copies will be available at the launch and from Folio Communications ph 04 499 7922 PO Box 12 102 Thorndon, Wellington, foliocom@clear.net.nz. It will be placed on the Ministry of Health website (www.moh.govt.nz) at a future date.