Northern Health Physicians
Partners in Wellness
Public Health Newsletter for Northern Health Physician
Tuesday, January 5th, 2016 Page 1 of 1

BULLETIN

Hepatitis A Virus Health Alert

Chiefs of Staff, COOs and HSAs are requested to bring this to the attention of Northern Health's GPs in the Northeast HSDA.

Dear Colleagues:

In the past month there have been five (5) confirmed hepatitis A cases in the Dawson Creek area diagnosed among three (3) seemingly unconnected groups of people. At this time there is no clear exposure source uniting the three groups. As cases are continuing to present, we are seeking your assistance in identifying current or past cases.

Background: Hepatitis A is a viral infection of the liver spread through fecal oral contact. The incubation period for hepatitis A is approximately 28 days (range 15-50 days). The virus is ingested by mouth from fecal-contaminated food or drink, or through close personal contact with an infected person. Those with the hepatitis A virus are most infectious two (2) weeks prior to symptom onset. Symptoms include fever, fatigue, loss of appetite, nausea, vomiting, abdominal discomfort, dark urine, clay-colored bowel movements, joint pain, and jaundice. Symptoms can last for several weeks and typically do not last more than two (2) months. Children under six (6) years of age with hepatitis A are often asymptomatic. Thorough hand washing after visits to the restroom, before touching food or drink, and after changing a baby's diaper can assist in mitigating spread.

Lab Confirmation: Serological testing is required to confirm the diagnosis of hepatitis A. **The confirmatory test for hepatitis A is IgM anti-HAV. Please label the specimen as STAT to BCCDC Rule out Acute Hepatitis A.**

Disease Reporting Requirements: Hepatitis A is a reportable disease under the *Public Health Act*. **If you are caring for, or have cared for, someone that meets the clinical picture for Hepatitis A, we ask that you contact your local health unit and notify Public Health of the case:**

Dawson Creek Health Unit
1001-110 Avenue, Dawson Creek
Phone 250-719-6500.

We are carefully investigating the cases as we attempt to stop transmission and every case brings more information forward.

Treatment and Postexposure Prophylaxis (PEP) Recommendations:

- There is no specific treatment for hepatitis A, only supportive treatment and management of the infection.
- Prompt notification of cases to Public Health will enable us to quickly identify household close contacts to offer post exposure prophylaxis with either immune globulin (IG) or vaccine. It will also enable us to exclude cases from high risk occupation (e.g. food handlers) to prevent further spread of disease.

We sincerely appreciate your assistance in helping to control this hepatitis A outbreak.

Sincerely,

Dr. Sandra Allison, MPH CCFP FRCPC
Chief MHO and Interim NE MHO

References:

1. HealthLinkBC: http://www.healthlinkbc.ca/healthtopics/content.asp?hwid=hw124783
2. BCCDC – CD Control Manual: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/HepA_August_2008.pdf

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OVERDOSE ALERT

Chiefs of Staff, COOs and HSAs are requested to bring this to the attention of ALL Northern Health's GPs and post in Emergency Rooms.

Date posted: February 4, 2016
(please remove by February 11, 2016)

In Prince George, several overdoses have been reported this week of people who thought they were taking heroin.
We anticipate there could be more throughout the region.

FOR YOUR SAFETY:

- Avoid using this drug where possible
- Do not use alone and know how to respond to overdose
- Test by using small amounts first
- If you inject, reduce the amount and inject slowly
- Do not use with alcohol or other drugs
- Take naloxone training to get a kit
- Call 911 immediately if something doesn't feel right
- If someone is unconscious, **GIVE BREATHS** until help arrives

TO RESPOND TO SOMEONE WHO IS NOT RESPONSIVE:

CALL 911 immediately and PROVIDE BREATHS until naloxone is administered and/or they are breathing on their own.

Resources: OD Awareness brochures: http://towardtheheart.com/news/oad2015

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BULLETIN

Haemophilus Influenza Type B

For the attention of Northern Health Physicians in the Fort St. John area

Dear Colleagues:

Increase of Haemophilus Influenza Type B in your region

In the past three months, there have been two cases of invasive ***Haemophilus influenzae*** **type b** (Hib) in young children from the community of Wonowon. Both cases were unvaccinated. For context, in the entire province last year there was not a single case of Hib. We are bringing this to your attention, given the high rates of vaccine hesitancy and the presentation of two cases in such a short time period. The occurrence of these cases illustrates the importance of achieving and maintaining high rates of immunization among infants and toddlers.

Haemophilus influenzae type b (Hib) is vaccine preventable through routine immunization beginning at 2 months of age. The vaccine is highly effective and results in reduced carriage of the organism in the nasopharynx, providing 'herd immunity' at a community level.

Prior to introduction of vaccines in the early 1990s, Hib was the most common cause of bacterial meningitis and a leading cause of other serious invasive infections in young children. About 55% to 65% of affected children had meningitis, the remainder suffering from epiglottitis, bacteremia, cellulitis, pneumonia, or septic arthritis. The case fatality rate for meningitis is about 5%. Severe neurologic sequelae occur in 10% to 15% of survivors and deafness in 15% to 20% (severe 3% to 7%). Disease onset can be sub-acute but is usually sudden, with fever, vomiting, lethargy, and meningeal irritation, bulging fontanel in infants, or stiff neck and back in older children. Progressive stupor or coma is common. Hib epiglottitis is a medical emergency and requires intubation by an experienced practitioner in order to avoid airway obstruction.

Hib is spread by direct contact or by respiratory droplets. The incubation period is uncertain but is probably short (2 to 4 days). Communicability ends within 24-48 hours after starting effective antibiotic therapy. The standard empiric antimicrobial therapy regimens provide adequate coverage for Hib. Examples of such regimens can be found on the BC Children's Hospital web site at https://cme.bccher.ca/wp-content/uploads/2015/11/2015-BCCH-Empiric-Antimicrobial-Guide.pdf.

Cases of invasive Hib disease are reportable to public health. Public health staff will assess the age and immunization status of household members and may recommend antibiotic prophylaxis to prevent secondary cases. Vaccination is not effective as post-exposure prophylaxis for contacts, but this situation represents an opportunity to ensure our young patients' vaccination status is up to date in case of future exposure.

If you have any questions or concerns please feel free to call Dr. Fumerton at 250-641-1758.
If calling after hours please call the MHO on call at 250-565-2000.

Thank you for your assistance in decreasing morbidity and mortality related to infectious diseases, specifically Haemophilus influenza type b at present.

Yours sincerely,

Dr. Raina Fumerton, MPH, FRCPC
Northwest Medical Health Officer and acting Northeast Medical Health Officer
Northern Health

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Public Health Newsletter for Northern Health Physicians

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from Northern Health's MHOs:

Dr. Sandra Allison
Dr. Raina Fumerton
Dr. Ronald Chapman

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2015: Year in review...

Volume 11: Month	Issue	Article/Bulletin Topic
January		No regular issue *Bulletin: NE Pertussis*
February	1	Canada Winter Games Public Health Info; 2014 Year in Review; Influenza Update; Influenza Fast Facts; National Outbreak Summary-Outbreaks in LTC Facilities; Measles in California; N7N9 in British Columbia
March	2	HPV Vaccine: One Physician's Experience with prescribing the HPV vaccine; Influenza update; Parotitis and Influenza H3N2 *Bulletin: Increasing Respiratory Illness Incidence: Quesnel, and Influenza B Skin Rash Reminder*
April	3	Pertussis cases on the rise; CMHO Report on Health Status – Child Health Consultation; Public Health 101; Stop Smoking before surgery Update; Influenza – Influenza Update, Influenza B, and Concomitant Rash
May	4	Curing Hepatitis C Infection: Curing a Silent Killer; Retirement–Dr. William Osei; Pertussis Update in the Northwest
June	5	Salmonella Outbreak; Bat Bit in Northwest BC; Best Advice–Social Determinants of Health; Changes to 4th Generation HIV Testing; Radon Accredited e-Learning *Bulletin: Update on MERS-COV*
July	6	MHOs in Northern Health – who are we and what do we do?; Approved but not publicly-funded vaccines – the role of the health care provider
August		No regular issue
September	7	Northeast Medical Health Officer; Antimicrobials–Handle with Care; Vaccine Storage and Handling Course; Energy Drinks–Kids on Caffeine; Question Corner: Immunization and Serology FAQs *Bulletins: Pertussis Cluster in Prince George; Urgent Chief MHO Request re Pertussis Cluster in Prince George*
October	8	Special Issue on Influenza: 2015-16 Season–What you need to Know, including: *Immunization Campaign Start Date; Vaccine Ordering Reminders; Eligibility; Vaccines and Recommended Usage; Recommended Influenza Vaccine Dosage by Age; Polysaccharide Pneumococcal Vaccine; Adverse reactions following Immunization (AEFI); Reporting Vaccine Administered; Egg Allergies/Oculo-Respiratory Syndrome (ORS); Influenza Education; References; Additional Resources; and Influenza Control Program Policy for Health Care Workers* *Bulletin: Pertussis Update*
November	9	Antimicrobials—Handle with Care; Influenza Update; Influenza - the next "Great Imitator"? and It's not just syphilis that can have frequent atypical presentations!; Doula Initiative enables access for First Nations and Aboriginal Women; Interactive Electronic Immunization Infographic now available for Health care providers; What about the Boys?...Vaccinating Boys and other common HPV questions
December	10	Question Corner: Serologic Testing and Hepatitis B; Influenza update; confident Parents, Thriving Kids; Antimicrobials–Handle with care; Sentinel Physicians needed!; Child Health Consultation Input

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Opioid Overdose Prevention and Response

32 people have died of opioid overdose in Northern BC so far this year, largely due to illicit fentanyl and related high-potency opioids. Overdoses are occurring in both long-term users and first-time users.

Physicians have key roles to play in preventing further unnecessary deaths. Please consult https://northernhealth.ca/YourHealth/OverdosePrevention.aspx for up-to-date information on how you can help prevent opioid overdose among your patients.

Take-home naloxone (THN)

Physicians are asked to **ensure any patient who is at risk for an opioid overdose receives a THN kit**, along with appropriate training on responding to an overdose. Key opportunities for offering THN include:

- On discharge from emergency or acute care, following a suspected or confirmed overdose;
- On discharge from withdrawal management (detox) or addiction treatment programs;
- On release from correctional facilities.

Naloxone can now be legally sold without a prescription, and can be legally administered by anyone outside of a hospital setting when opioid overdose is suspected. THN programs, which offer free THN kits and training to people at risk of overdose, are now available in many Northern BC communities. Visit www.towardtheheart.com for the most up-to-date information on where to access naloxone and other harm reduction supplies across BC.

Other treatment options

To learn more about:

- **managing opioid addiction,** please see guidelines developed by Vancouver Coastal Health at http://www.vch.ca/media/Opioid-%20Addiction-Guidelines_Nov6_1330.pdf.
- **specialized addiction treatment services** in Northern BC, please consult https://northernhealth.ca/YourHealth/MentalHealthAddictions.aspx.

Report overdoses

We would like to remind physicians that all cases of *suspected or confirmed* opioid overdose that present to emergency departments must be reported to Northern Health. This information is vital for Northern Health to be able to focus prevention efforts where they are most needed, and to be able to assess the effectiveness of these efforts. A graphic summary of the current situation is presented on the following page.

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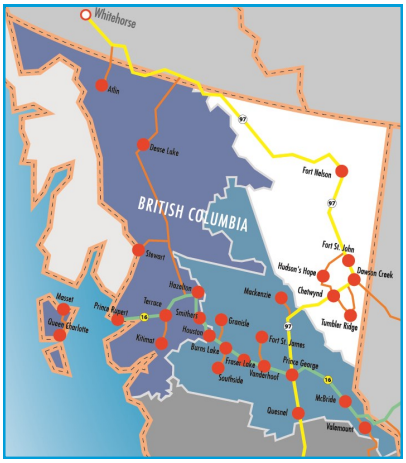
Notable Quotable:



Northwest

Atlin, Dease Lake, Houston, Hazelton, Masset, Kitimat, Port Clements, Prince Rupert, Smithers, Stewart, Terrace, the Village of Queen Charlotte

Northern Interior

Burns Lake, Fort St. James, Fraser Lake, Granisle, Mackenzie, McBride, Prince George, Quesnel, Valemount, Vanderhoof

Northeast

Chetwynd, Dawson Creek, Pouce Coupe, Hudson's Hope, Fort Nelson, Fort St. John, Tumbler Ridge

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Opioid Overdose Prevention and Response, Cont'd.

(Continued from page 1)

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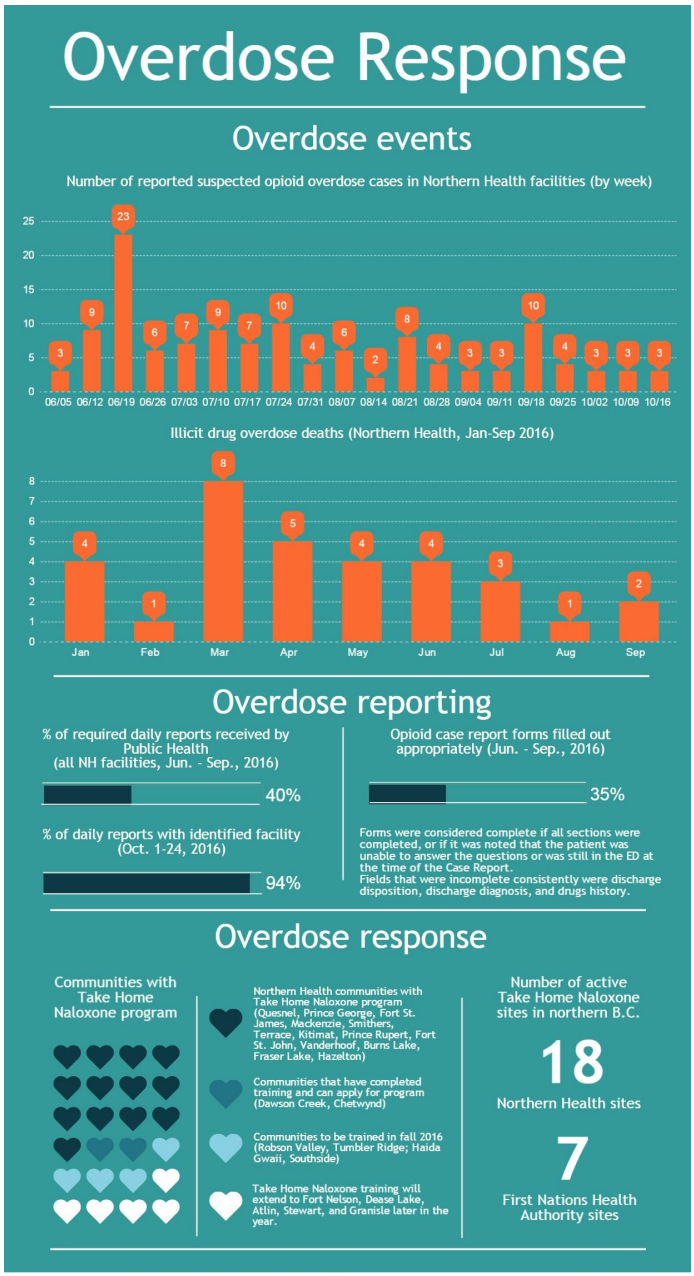


powered by Piktochart

Submitted by:
Dr. Andrew Gray Northern Interior MHO

Refugee/New Immigrant Health—Resources for Clinicians

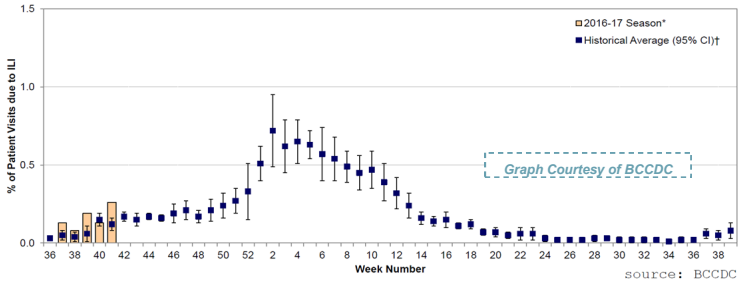
As is the case elsewhere in the province, Northern BC is home to a significant refugee and immigrant population. As such we wanted to share a useful resource that supports local clinicians caring for new immigrants and refugees: http://refugeehealth.ca/.

The website is very comprehensive, up to date, and easy for clinicians to navigate. It includes medical guidelines (including preventive care checklists) as well as cultural and health insurance coverage issues.

Submitted by: Shannon King, UBC Student and
Dr. Raina Fumerton, Northwest MHO and Acting Northeast MHO

Influenza Update

Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2016-17



* Data are subject to change as reporting becomes more complete.
† 10-year historical average for 2016-17 season based on 2004-05 to 2015-2016 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

During weeks 39-41, 578 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 71 (12%) tested positive for influenza, including 69 (97%) influenza A [57 A(H3N2) and 12 with subtype pending] and 2 (3%) influenza B. Overall influenza positivity decreased slightly from 13% in week 39 to 11% in week 41 but remained above 10% during this period.

So far during the 2016-17 season, influenza A(H3N2) has been the dominant subtype among influenza detections, with multiple detections among early season outbreaks in long-term care facilities (LTCFs). Entero/rhinoviruses were the most commonly detected respiratory virus during this period.

Source: BC Centre for Disease Control Influenza Surveillance Reports: Report No. 1, Sept.25-Oct.15, 2016 *(weeks 39-41)*
http://www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

NH staff influenza vaccination clinics are now scheduled. To find a clinic near you and to report your immunization status, visit the OurNH flu page:
https://ournh.northernhealth.ca/AboutMe/HealthSafetyWork/Pages/InfluenzaProtection.aspx

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Regional Opioid Overdose Response Background and Update

- **Sept. to December 2015:**
  Increased overdoses in PG triggered multiple drug alerts, extended hours of service at the Needle Exchange urgently over Christmas, as well as heightened education and distribution of Take Home Naloxone (THN) amongst users.
- **April 2016:**
  PHO declares a PH emergency to require overdoses be reportable. In June, an NH enhanced OD reporting system was established.
- **June-Sept. 2016:**
  Interim response committee coordinates emergency room THN and community THN programs in "hot spots".
- **July-Aug. 2016:**
  Provincial Overdose response work plan established for core interventions of:
  - THN, Reporting, Treatment, SCS, Education/Awareness.
- **Sep.-Nov. 2016:**
  Refined reporting, intensified spread of THN, built expansion plans; established regional overdose oversight committee and three HSDA planning and implementation committees; hired a lead Physician for NH Addictions and Harm Reduction; supported provincial communication campaigns. Connected with School District Superintendents, RCMP, BCAS, BC Coroner's Service.
- **Dec. 2016:**
  HSDA implementation teams set target for a trained THN educator in all Emergency Departments and work to begin in having all appropriate staff trained.
- **Upcoming activities:**
  - Detailing of all applicable HC settings, community provider programs and partners, identification of interventions and priorities.
  - Expansion of THN to all EDs, community healthcare settings, working with community partners to meet community context.
  - CQI focus to comprehensive overdose surveillance and reporting.
  - Consideration for other harm reduction interventions such as supervised consumption, that are contextually and culturally appropriate for northern BC.
  - Enhanced universal and targeted education and awareness campaigns.

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Options for sexual health (OPT) ---------- p.4
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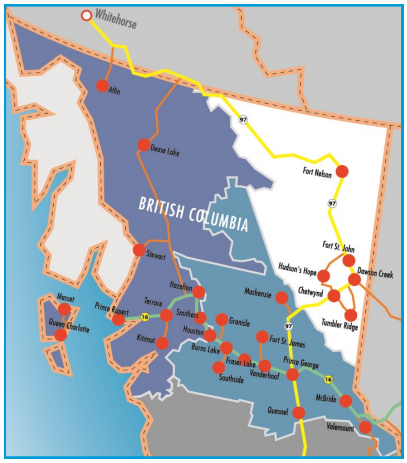
Notable Quotable:



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Regional Opioid Overdose Response Background and Update, Cont'd.

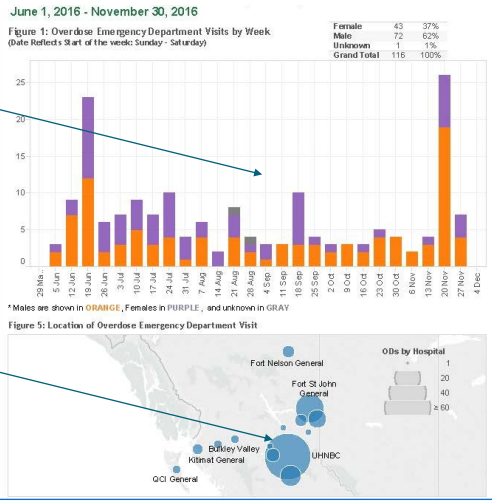
(Continued from page 1)

Average individual presenting in ED with an overdose is:

- Using illicit opioids, or opioids not prescribed to them
- Using in private residences with some using in public spaces
- Using frequently or daily

UHNBC is reporting the great majority of overdose presentations.

Recent spike in November was almost entirely overdoses reported at UHNBC.



OPIOD Education Partnership:
The Opioid Education Partnership is a Health Canada –funded pilot education program consisting of 8 interactive modules to help physicians, pharmacists and students enhance understanding of prescription opioid use and promote collaborative management. The program has been accredited by the College of Family Physicians of Canada for 8 Mainpro-M1 credits: https://opioidpartnership.org

Source:
Opioid Education Partnership web site:
https://opioidpartnership.org

Submitted by:
Dr. Sandra Allison, Chief MHO

Public health wants to hear from you!
Reportable Communicable Diseases

Most reportable communicable diseases (RCDs) are routinely reported to public health by laboratories. However, some RCDs are best reported by clinicians on an urgent basis, **before** laboratory confirmation is available, and ideally while the patient is still in care. Rapid reporting at the "suspect" stage allows Public Health to act quickly to protect contacts and limit further transmission of these potentially severe infections. We rely upon physicians to report these conditions, and we thank you for your assistance in protecting the health of the population.

To report a suspected case of an urgent RCD, or any other situation that you feel requires urgent public health follow-up:

- During office hours (8:30 a.m. to 4:30 p.m., Monday to Friday), call the NH Centralized Communicable Disease unit at 1-855-565-2990.
- After hours (evenings, weekends, holidays), call the MHO on call at 250-565-2000.

We ask that **all physicians** report by phone at **suspect stage** (based on history, physical, and preliminary lab results where available):

	Disease/condition	*Clinical presentation*	*Exposure history/risk factors*
Endemic in BC (and elsewhere)	**Invasive meningococcal disease***	Clinical meningitis or sepsis Petechial rash Gram-negative diplococci in CSF or blood	
	Necrotizing fasciitis*	Clinical diagnosis or diagnosis based on histopathology	
	Gastroenteritis outbreak in a health care facility or unit*	3 or more cases of gastroenteritis (diarrhea and/or vomiting) among patients/staff within 4 days	
	Influenza-like illness outbreak in a health care facility or unit*	2 or more cases of influenza-like illness (fever, cough, sore throat, arthralgia, myalgia, prostration) among patients/staff within 1 week	
	Botulism	Visual disturbance; cranial nerve involvement; paralysis/weakness; +/- diarrhea, vomiting	Consumption of home-canned food or other unusual food
	Rabies	Fever, flu-like symptoms Paresis/paralysis, muscle spasm, hydrophobia	Exposure to bats, or to other mammals outside BC
Primarily travel-associated	**Measles**	Fever, cough, coryza, conjunctivitis Koplik spots on buccal mucosa Generalized red rash	Recent travel Unvaccinated Born after 1956
	Severe acute respiratory infection (SARI)*	Fever, cough, shortness of breath Rapid progression Severe (ICU admission or mechanical ventilation)	Recent travel, or occupational exposure to pigs or birds
	Diphtheria	Fever, severe sore throat, Adherent grayish-white membrane in pharynx	Recent travel Unvaccinated or elderly
	Polio	Acute flaccid paralysis (focal or generalized) Flu-like symptoms, paresthesia, meningitis	Recent travel Unvaccinated
	Viral hemorrhagic fevers (Ebola, Lassa, Marburg)	Fever; +/- hemorrhagic rash; +/- vomiting and diarrhea; hemorrhagic symptoms	Recent travel to Africa
Possible bioterrorism agents	Anthrax	Respiratory distress Widened mediastinum on CXR Vesicular skin lesion with black eschar	Known exposure to anthrax

The most common conditions encountered in BC are highlighted in **bold text.*
For the complete list of reportable diseases in BC, please see: http://www.bccdc.ca/health-info/disease-system-statistics/list-of-reportable-diseases.

We would like to take this opportunity to also remind physicians to report any adverse events following immunizations (AEFIs) by completing the AEFI reporting form at: http://www.bccdc.ca/health-professionals/professional-resources/surveillance-forms and faxing it to the Northern Health's Centralized Communicable Disease Unit at 250-649-7071.

Submitted by:
Dr. Andrew Gray, Northern Interior MHO

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Varicella (chicken pox) refresher

Northern Health received more reports of varicella (chicken pox) cases than usual in November 2016, particularly in Prince George. Varicella is not a reportable disease, so exact data is not available, but we do know that varicella continues to circulate in our communities, especially among unvaccinated children. Now is a good time to review the presentation and management of varicella.

Clinical presentation: Varicella often begins with a prodrome of fever, headache, and sore throat. The characteristic vesicular rash, which appears in several successive waves or "crops", usually appears about 1 or 2 days after the first symptoms start. The prodrome may also be absent.

Complications: While varicella is often a mild disease, severe complications do occur, including secondary bacterial infections, hepatitis, thrombocytopenia, cerebellar ataxia, and encephalitis. Complications are more frequent in pregnant women, newborns, teens and adults, and people who are immune compromised. The case fatality rates for varicella are highest among adults (30 deaths/100,000 cases), followed by infants (7 deaths/100,000 cases), and lowest among children 1 to 19 years of age (1 – 1.5 deaths/100,000 cases). Finally, the varicella virus can be reactivated later in life as shingles, which may be complicated by post-herpetic neuralgia.

Transmission: Varicella is transmitted by the airborne route, or by direct contact with fluid from vesicles. Varicella is most easily spread from 1 to 2 days before the rash appears – at which point the patient may still be asymptomatic – until all the blisters have crusted over. It usually takes 14 to 16 days to show symptoms of varicella after exposure to the virus (range: 8 to 21 days).
Case management: Treatment is supportive for uncomplicated cases. Cases should be advised to stay home from daycare, school, or work, until 5 days after the start of the rash, or until all blisters have crusted over, whichever is later.

Contact management: The priority with varicella is to quickly provide post-exposure prophylaxis to contacts who are both ***high -risk*** **and** ***susceptible***:

- ***High-risk*** contacts include pregnant women, people with immune deficiency, and infants born prematurely who are in their first weeks of life.
- *Contacts* are considered ***susceptible*** if they have no history of varicella disease, and no history of complete immunization.
  - *Note* that most adults have had varicella disease in childhood, though it may have been sub-clinical. A history of infection can be determined by serological testing (VZV IgG).
  - *Immunization* is considered complete if someone has had two documented doses of vaccine, at least 12 months apart (or just one dose, for those 12 years old and younger).

Varicella zoster immune globulin (VZIG) should be given to most high-risk susceptible contacts within 96 hours of exposure. VZIG is available from Canadian Blood Services by calling 604-876-7219.

In the minority of high-risk susceptible contacts for whom varicella vaccine (which is a live vaccine) is not contraindicated, varicella vaccine is preferred, and should be given within 3 to 5 days of exposure.

Prevention: Regardless of contact status or risk level, all varicella-susceptible individuals should be advised to complete their varicella vaccination series (2 doses, at least 12 months apart). Varicella vaccine, like all vaccines, is very safe for most people, though as a live vaccine it is contraindicated for pregnant women and people with severe immune deficiency.

Varicella vaccine is offered as part of the routine BC immunization schedule. Two doses are given to children, at 12 months of age and at school entry (4 to 6 years of age). Catch-up schedules are also available for older children who have not received 2 doses of the vaccine.

People 13 years of age and older who have not had varicella (or are unsure), and who do not have a documented vaccination history, should have serological testing (VZV IgG) to verify susceptibility prior to vaccination. This is particularly important for health care workers.

For additional information on the management and control of varicella, please see BCCDC's Communicable Disease Manual at: http://www.bccdc.ca/NR/rdonlyres/0065F4AD-0EEC-430F-B1B5-9634115528D4/0/Epid_GF_VaricellaZoster_July04.pdf.

Information about the varicella vaccine can be found at: http://www.immunizebc.ca/diseases-vaccinations/chickenpox.

Submitted by:
Dr. Andrew Gray Northern Interior MHO

Options for Sexual Health (Opt) in Northern BC

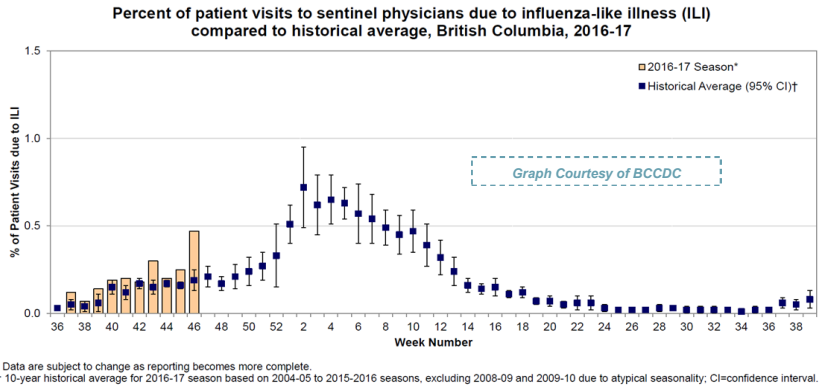
Ensuring patients leave their clinician appointment with all their questions answered is particularly challenging in sexual health. Opt Clinics and The Sex Sense Line are two excellent resources, dedicated to sexual health, that complement the care provided by local clinicians in Northern BC and alleviate primary care providers. There are 14 Opt Clinics in Northern BC offering low-cost contraception, STI testing and treatment, sexual health counselling, and more. The Sex Sense Line, Opt's free and anonymous sexual health information and referral service, is open Monday to Friday 9am-9pm, and serves clients and clinicians alike.

For more information and Opt Clinics near you, call 1-800-SEX-SENSE
or go to www.optionsforsexualhealth.org.

Source:
Helena Palmqvist De Felice,
Clinic Operations Manager (Provincial)
Options for Sexual Health
3550 East Hastings Street, Vancouver, BC V5K 2A7
www.optionsforsexualhealth.org

Physicians can direct patients to an educational website: ***SEX & U… Your trusted resource for sexual and reproductive health***:
http://www.sexandu.ca/
Sponsored by Society of Obstetricians and Gynaecologists of Canada

Influenza Update



* Data are subject to change as reporting becomes more complete.
† 10-year historical average for 2016-17 season based on 2004-05 to 2015-2016 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

During weeks 45-46, 545 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 57 (10%) tested positive for influenza, including 51 (86%) influenza A [35 A (H3N2) and 16 with subtype pending] and 6 (11%) influenza B. Although the majority of influenza detections remained A(H3N2) during this period, a slight increase in the number of influenza B detections was observed, concurrent with the first report this season of an influenza B outbreak in a long-term care facility (LTCF). Overall influenza positivity decreased slightly from 15% in week 44 to 12% in week 45 and 9% in week 46 but remained elevated.

Entero/rhinoviruses remained the most commonly detected respiratory virus during this period; however, the number of respiratory syncytial virus (RSV) positive specimens increased slightly in week 46.

Cumulatively since week 40 (starting October 2, 2016), 194 (12%) patients tested positive for influenza at the BCCDC PHL, including 186 (96%) with influenza A [170 A(H3N2) and 16 subtype pending] and 8 (4%) with influenza B. No patients have tested positive for influenza A(H1N1) pdm09 so far this season.

So far during the 2016-17 season, influenza A(H3N2) has been the dominant subtype among influenza detections. The majority of influenza detections have been in elderly adults ≥65 years old, consistent with early season outbreak reports from LTCFs and dominant circulation of A (H3N2) subtype viruses so far this season. However, a greater proportion of influenza A(H3N2) detections during the 2016-17 season are in non-elderly individuals <64 years old compared to the same period of the last early dominant A (H3N2) season in 2014-15 (50% vs. 34%, respectively).

Source: BC Centre for Disease Control Influenza Surveillance Reports:
Report No. 4, Nov. 6-9, 2016 *(weeks 45-46)*
http://www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

Physicians are encouraged to self-report their immunization, or their decision to mask while working within Northern Health facilities, at: https://medicalstaffhealth.phsa.ca/.

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Public Health Newsletter for Northern Health Physicians

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Hepatitis A Outbreak Dawson Creek and Alberta

To date there have been six (6) lab confirmed hepatitis A cases in the Dawson Creek area and an additional four (4) cases have been identified in Alberta. The last case of hepatitis A in Dawson Creek became symptomatic early January. Eight (8) lab specimens have been isolated to date and all have been identified as a strain of genotype 1b unique to this outbreak.

The source of the outbreak continues to be investigated. At this time there is no clear exposure source uniting the primary cases. We have been extremely appreciative of the assistance from the physicians in Dawson Creek in identifying cases.

We are collaborating on this outbreak investigation with our public health partners at the BC Centre for Disease Control as well our public health counter parts in Alberta and at the Public Health Agency of Canada and First Nations Inuit Health Branch of Health Canada.

Given the recent ongoing outbreak involving Northern BC, we thought it would be of interest to provide information to clinicians across the North surrounding hepatitis A.

Background:
Hepatitis A is a viral infection of the liver spread through fecal oral contact. The incubation period for hepatitis A is approximately 28 days (range 15-50 days). The virus is ingested by mouth from fecal-contaminated food or drink, or through close personal contact with an infected person. Those with the hepatitis A virus are most infectious two (2) weeks prior to symptom onset. Symptoms include fever, fatigue, loss of appetite, nausea, vomiting, abdominal discomfort, dark urine, clay-colored bowel movements, joint pain, and jaundice. Symptoms can last for several weeks and typically do not last more than two (2) months. Children under six (6) years of age with hepatitis A are often asymptomatic.
Thorough hand washing after visits to the restroom, before touching food or drink, and after changing a baby's diaper can assist in mitigating spread.

(Continued on page 2)

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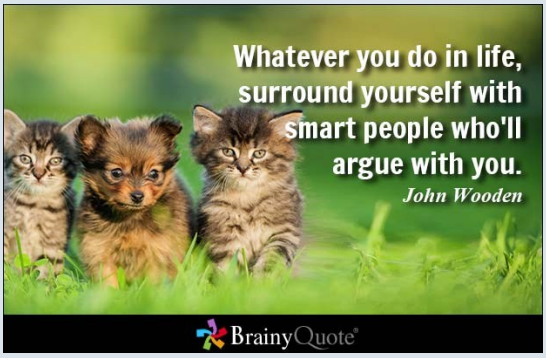
Notable Quotable:



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raina.fumerton@northernhealth.ca

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ronald.chapman@northernhealth.ca

Hepatitis A Outbreak Cont'd.

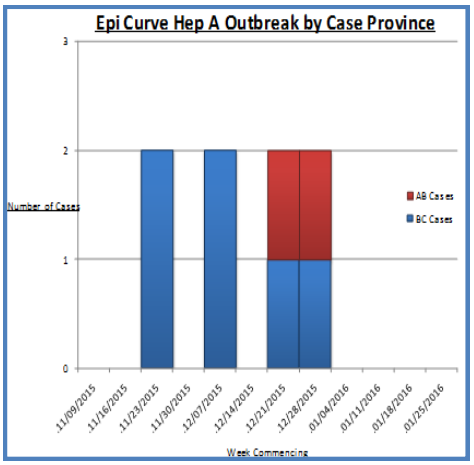
(Continued from page 1)

Lab Confirmation:
Serological testing is required to confirm the diagnosis of hepatitis A. The confirmatory test for hepatitis A is IgM anti-HAV. Please label the specimen as STAT to BCCDC Rule out Acute Hepatitis A.

Disease Reporting Requirements:
Hepatitis A is a reportable disease under the *Public Health Act*. If you are caring for, or have cared for, someone that meets the clinical picture for Hepatitis A, we ask that you notify the MHO on call 250-565-2000.

Treatment and Post-exposure Prophylaxis (PEP) Recommendations:

- There is no specific treatment for hepatitis A, only supportive treatment and management of the infection.
- Prompt notification of cases to Public Health will enable us to quickly identify household close contacts to offer post exposure prophylaxis with either immune globulin (IG) or vaccine. It will also enable us to exclude cases from high risk occupation (e.g. food handlers) to prevent further spread of disease.



Acknowledgements:

- BCCDC, Dr. Sean Wachtel

Submitted by: **Dr. Raina Fumerton,** MHO—NW HSDA and Acting MHO—NI HSDA

Reporting Communicable Diseases

While most reportable diseases are reported by laboratories, we ask that physicians report some communicable diseases urgently, by telephone, and if possible, while the patient is still in the clinic or hospital. These are infections for which timely public health follow-up can prevent infection in contacts or reduce further transmission.

We ask that these diseases be reported at the "suspect" stage, prior to laboratory confirmation, because of they can be severe and effective prevention is time sensitive. We rely upon physician reporting to provide prompt public health follow up of communicable diseases and we thank you for your assistance.

No list can be exhaustive; if you encounter any infection that you feel requires urgent public health follow up, please call Public Health at 250-565-2000 and ask for the Medical Health Officer for your area (or the on-call MHO after hours) to discuss it.

For a full list of reportable diseases in BC, please see: (http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/Other/Epid_Guidelines_reportable_diseases_British_Columbia_July2009.pdf)

Disease	Clues for Identification
Anthrax	Known exposure to anthrax; Respiratory: Resp. distress, widened mediastinum on CXR; Cutaneous: Vesicular lesion with black eschar
Botulism	Visual disturbance; cranial nerve involvement; paralysis/weakness; +/- diarrhea, vomiting; +/- consumption of unusual or home-canned food
Respiratory Diphtheria	Unvaccinated or elderly; aderent grayish-white membrane in pharynx
Emerging Infections	Suspect Ebola, MERS-CoV
Measles	Unvaccinated; born after 1956; recent travel; fever, cough, coryza, conjunctivitis; Koplik spots on buccal mucosa; generalized red rash
GI Outbreak	3 or more cases of gastroenteritis (diarrhea and/or vomiting) among patients/staff within the same setting within a 4-day period. **We ask laboratory physician to phone w/ all outbreak related lab results.**
ILI Outbreak	2 or more cases of influenza-like illness (fever, cough, sore throat, arthralgia, myalgia, prostration) among patients/staff within 1 week in a ward/facility. **We ask laboratory physician to phone w/ all outbreak related lab results.**
Invasive Meningococcal Disease	Fever; meningitis, petechial rash; coma; gram-negative diplococci in CSF or blood
Necrotizing fasciitis	Clinical diagnosis or diagnosis based on histopathology.
Rabies	Known bat exposure (or other animal outside BC); fever; flu-like symptoms; paresis/paralysis; muscle spasm, hydrophobia
Viral Hemorrhagic Fevers (Ebola, Lassa, Marburg)	Recent travel to Africa; fever; +/- hemorrhagic rash; +/- vomiting and diarrhea; hemorrhagic symptoms
Yellow Fever	Recent travel to Africa/Latin America; fever; flu-like symptoms; jaundice; hemorrhagic symptoms; no history of vaccination

Submitted by: **Dr. Raina Fumerton,** MHO—NW HSDA and Acting MHO—NI HSDA

Changes to BC's Smoking Cessation program

Now it's easier to have a conversation about tobacco with your patients!

As of Jan. 1, 2016, smokers who want to quit no longer need to call HealthLink BC at 8-1-1 to join the British Columbia Smoking Cessation Program. Instead, they can join the program and access 12 weeks of free nicotine replacement therapy products just by visiting any community pharmacy in the Province. Encourage your patients to talk to their pharmacist about quitting smoking.

The products are now being provided by Johnson and Johnson and smokers have the option of choosing Nicotine and Nicoderm –brand products. **Nicotine lozenges or nicotine inhalers are also now available**, as well as nicotine gum and the nicotine skin patch previously paid for by the program.

If your patients have met their PharmaCare deductible, they are eligible for coverage for prescription smoking cessation drugs, Champix (varenicline) and Zyban (bupropion).

Since it began in 2011, the Province has invested more than $38 million into the program and more than 187,000 have used the program to try to quit. That's 25% of British Columbians who smoke! Recent evaluation of the program's nicotine replacement therapy shows it helps people attempt to quit, and to be successful.

Your patients can also access free counselling by phone, text or email by enrolling with Quit Now Services at quitnow.ca or by calling HealthLinkBC at 8-1-1.

Each year, more than 6,000 British Columbians die from the effects of tobacco use. Tobacco use is the single most-preventable cause of disease and death in British Columbia. Take a minute and save a life!

Resources:

- Link your patients to the British Columbia Smoking Cessation Program at: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/bc-smoking-cessation-program and Quit Now services.
- Free booklets and pamphlets can be ordered on the Quit Now website: https://www.quitnow.ca, or by emailing: tobaccofree@northernhealth.ca.
- Dec. 30/15 press release announcing changes to the BC Smoking Cessation Program by Health Minister Terry Lake.

Submitted by:
Nancy Viney, RN, BScN
Population Health—Tobacco Reduction Lead

Pearls for Immunization Practice—self learning course

Are you interested in:

- Refreshing your essential immunization knowledge?
- Ensuring you are up to date on immunization resources?
- Being better prepared to answer clinical-related vaccine questions?
- Learning tips that will improve your vaccination technique and efficiency?
- Learning about the Immunization Infographic for Health Professionals, a centralized clinical resource to make accessing vaccine information easier?

"Pearls for Immunization Practice" is an online self-learning course for all interested immunization providers that takes approximately one hour to complete. This course is suitable as a refresher course for health providers who already have a theoretical and clinical understanding of immunization practice and would like to update their knowledge. It is especially useful for those physicians and providers new to immunization practice in BC.

The course was developed by the BC Immunization Committee Professional Education Working Group.

For further information and to enroll in the course, please see: http://www.bccdc.ca/health-professionals/education-development/immunization-

Submitted by:
Jill Walker, Interim Regional Manager, Communicable Disease Control

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Antimicrobial Stewardship Program Update

Happy New Year from your Antimicrobial Stewardship (AMS) program!

With the New Year comes the season of resolutions! Make 2016 the year of improved antimicrobial use; our team is here to help. Northern Health's AMS program has recently acquired a permanent full time pharmacist lead (AMS Program Coordinator) based out of UHNBC. Even though the coordinator currently works at UHNBC, an AMS program can exist anywhere because AMS practices can be carried out on any ward at any facility.

All clinical tools/supports or policies that are created and provided by the AMS program are going to be made available to all acute care facilities and clinicians across Northern Health. The program coordinator will be working with site leadership outside UHNBC to identify site specific antimicrobial stewardship needs. In addition to the lead pharmacist there will continue to be an interdisciplinary regional working group with Dr. Hamour as the current infectious disease expert.

There is a new career opportunity for an Infectious Diseases Physician/Medical Lead Antimicrobial Stewardship (AMS) and Infection Prevention and Control (IPAC) – this individual will provide ID consultation service (fee for service) as well as medical support for the AMS and IPAC programs (contracted).

Any interested parties are encouraged to contact either the program coordinator (see below) for more information or email: physicians@northernhealth.ca.

If you have been working on converting your patients from IV to oral antimicrobials there is more information available to assist you! The AMS program has developed an *Intravenous to Oral Conversion for Antimicrobials* clinical practice standard which is now available on OurNH under Policies and Standards; keyword(s): antimicrobial stewardship, intravenous, antimicrobial, IV to PO. Transitioning patients to oral therapy when a highly bioavailable option exists and their clinical condition allows can decrease the length of hospital stay and overall health care costs. Another newly available reference for Northern Health clinicians is an Empiric Treatment Guideline for Infections in **pediatric** patients. These guidelines were created by BC Children's hospital's Antimicrobial Stewardship Program with input from all health authorities across BC. They are currently available on the perinatal page on OurNH and, if used electronically, this guide will link you to the BCCH dosing handbook for guidance with antimicrobial dosing. Another useful reference created by BCCH is www.pedmed.org, which gives access to medication information including dosing.

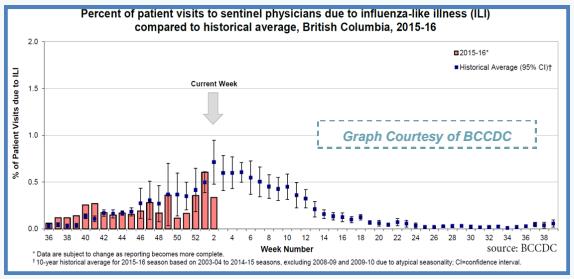
Keep a look out for more information and new items over the next few months, including a NEW regional order set for management of community acquired pneumonia in adults.
For more information about Northern Health's Antimicrobial Stewardship program, contact Alicia Ridgewell the program coordinator/lead pharmacist at 250-565-5956 or via email to: alicia.ridgewell@northernhealth.ca.

Submitted by:
Alicia Ridgewell
Antimicrobial Stewardship Program

Influenza Update

In weeks 1-2, 608 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory. Of these, 144 (24%) tested positive for influenza, including 57 (40%) influenza A [10 A (H3N2), 5 A(H1N1)pdm09, and 42 subtype pending], 86 (60%) influenza B and one adult patient with an A(H1N1)pdm09 and influenza B co-infection. Influenza positivity increased from 18% in week 1 to 30% in week 2. As seen in other recent weeks, influenza B detections continued to outnumber influenza A detections in weeks 1-2 at a ratio of 1.5:1.

Cumulatively since week 40 (starting October 4, 2015), 338 patients have tested positive for influenza at the BCCDC Public Health Laboratory, including 179 (53%) with influenza A [111 A(H3N2), 26 A (H1N1)pdm09 and 42 subtype pending], 158 (47%) with influenza B, and one patient with an A(H1N1)pdm09 and influenza B co-infection. So far during the 2015-16 season, influenza A(H3N2) viruses have predominated, comprising more than two-thirds of influenza detections with known type/subtype until week 48. However, in recent weeks, an increasing proportion of influenza B viruses has been detected (comprising 60% of influenza detections in weeks 1-2), with influenza B/Victoria lineage viruses predominating over B/Yamagata lineage viruses at a ratio of 3:1 so far this season. An increasing number of A (H1N1)pdm09 viruses have also been detected since week 51.



Just over one-third of influenza detections so far during the 2015-16 season have been in elderly adults aged ≥65 years, driven by the predominance of Az(H3N2) activity earlier this season. However, in recent weeks, a greater proportion of detections has been in younger, working-aged adults 20-64 years (representing 45% of influenza detections so far this season) and to a lesser extent children <20 years (20% of detections), due to increased circulation of A (H1N1)pdm09 and influenza B viruses.

Source: BC Centre for Disease Control Influenza Surveillance Reports: Report No. 7, Jan. 3-16, 2016 *(weeks 1-2)*
http://www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

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NOTE: For **Updated** Zika information and recommendations, please see May 2016 issue &/or http://www.bccdc.ca/health-info/diseases-conditions/zika-virus/information-for-health-professionals

Zika Virus Update
for Health Care Professionals

What is Zika virus?

Zika virus is a flavivirus transmitted by *Aedes* mosquitoes found in South America, Latin America and the Caribbean. Originally found only in Africa and Asia, the virus was first reported in the Western Hemisphere in 2015. Zika is from the same family of viruses as Dengue and West Nile Virus that are also transmitted by *Aedes* mosquitoes. Mosquito-borne transmission is overwhelmingly the dominant mechanism of Zika transmission. There have been reports, outside of Canada, of both sexual transmission and transmission of Zika virus through the blood supply. The overriding concern about Zika infection relates to the association between Zika virus infection in pregnancy and microcephaly. The nature of this association is being investigated, as causality has not been established.

Who is at risk of acquiring Zika virus?

1. People from British Columbia who travel to regions where Zika is circulating. More than 30 countries in South America, Latin America and the Caribbean have reported Zika cases. Due to differences in testing and reporting, the risk of acquiring Zika infection when travelling to countries in the region not currently reporting Zika cases is unknown and likely to change. The absolute risk to a traveller for each particular destination is unknown at this time. For a list of affected countries go here: http://www.cdc.gov/zika/geo/index.html
2. Possibly sexual partners of men who have recently visited areas where the Zika virus is circulating.
3. A fetus exposed through either of the mechanisms above.

What are the symptoms and complications of Zika virus infection?

Up to 80% of those infected are asymptomatic. Symptomatic illness is generally mild, with acute onset of low-grade fever, maculopapular rash, arthralgia, or non-purulent conjunctivitis, lasting from several days to one week. Headache and myalgias are also reported. Severe disease is uncommon, and death is rare. Guillain-Barré syndrome has been reported following Zika virus infection, and an association between Zika virus infection in pregnant women and microcephaly in the infant is being further investigated. There is currently no specific treatment for, or vaccine against, Zika virus infection.

Are cases expected in Canada?

Cases of Zika virus have been confirmed in Canada **only among travellers** who have been to areas where Zika virus is circulating. The risk of vector-borne Zika transmission in Canada is very low as the mosquitoes known to transmit the virus are not established in Canada. Cases of Zika virus are reportable to the medical health officer.

Prevention

There are no vaccines or medications currently available to prevent Zika virus infection. **It is advised that**

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Zika Virus Update ---------- pp.1-3

Pharmacy Awareness Month ---------- p.4

Antimicrobials update ---------- p.4

Influenza update ---------- p.4

Notable Quotable:

Back issues of *NH Physicians, Partners in Wellness* newsletters and bulletins are located on the NH Physicians website:
http://physicians.northernhealth.ca/physicianResources/PublicHealth.aspx

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Zika Virus Update, Cont'd.

(Continued from page 1)

pregnant women and women trying to get pregnant during their travels or immediately afterwards, consider postponing travel to areas where Zika is being transmitted. There are no specific recommendations for others to avoid travel. If pregnant women, and those trying to conceive are unable to avoid travel they should follow travel advice recommended for all travellers including seeking travel medicine advice prior to departing.

All travellers should take precautions to avoid mosquito bites throughout the day and night, both indoors and outdoors, and be advised to:

- wear long-sleeved shirts and long pants,
- use a recommended insect repellent according to instructions on the product label; those containing **DEET (20%)** or **icaridin (20%)** are effective and safe for pregnant women,
- use permethrin-treated clothing and gear,
- stay and sleep in screened-in or air-conditioned rooms,
- if staying outside, sleep under a mosquito bed net

Management of returning travellers

All returning symptomatic travellers **should be assessed for infections in a returning traveller.** All symptomatic travellers **who have visited an area where Zika virus is circulating and become ill up to 15 days of returning can be offered Zika testing as component of the work-up for infection in a returning traveller (see Table 1 for Laboratory Testing Guidelines).**

Zika virus testing is not routinely indicated for **asymptomatic** returning travellers **unless the traveller was pregnant during or within two months of returning from travel to a Zika virus affected area.**

Testing for other travellers can be considered on a case-by-case basis, in consultation with the Medical Microbiologist at the BCCDC Public Health Laboratory :

- 1-877-747-2522
- or page 604-661-7033 for urgent consults only.

(Continued on page 3)

Pregnancy and sexual transmission

Information on this topic is changing rapidly with some of the current recommendations based on expert opinion only. This guidance will be updated frequently as new data become available. As most infections are asymptomatic, the advice is provided in the context of an exposed and potentially infected traveller.

Women as travellers

a. It is recommended that women be advised of the **risks of conceiving a child in a region where Zika is circulating,** postpone travel if possible, and be provided with information on how to prevent both mosquito bites and pregnancy.

b. It is recommended that health care providers of women **returning from an area where Zika virus is circulating, discuss delaying conceiving** a child for at least 2 months. This recommendation is based upon the sum of incubation period, duration of illness and time required to clear virus. Note: Once the virus has cleared, there is no evidence to suggest that previous Zika virus infection will have any effect on subsequent pregnancies.

Men as travellers

a. It is recommended that men who have returned from an area where Zika is circulating and who have a **pregnant partner** should consider abstaining from sexual activity or, consistently and correctly using a condom, for at least two months and possibly the duration of the pregnancy. This advice is being offered in an environment of uncertainty about the duration of time in which special barrier precautions should be in place during pregnancy. Guidance will be updated as evidence becomes available. (The role of Zika virus testing in this setting remains to be determined. You may wish to consult with a BCCDC Public Health Laboratory Medical Microbiologist for specific circumstances at 1-877-747-2522 or page 604-661-7033 for urgent consults only).

b. It is recommended that health care providers discuss the possibility of sexual transmission of Zika virus with men who have returned from an area where Zika virus is circulating, and who have a **non-pregnant partner**.

- If effective birth control is being used, the guidance relates to transmission of the virus, and the associated illness in the female partner, in the absence of foetal considerations. For asymptomatic men, interventions to prevent sexual transmission of Zika include abstinence or avoiding unprotected sexual activity for at least 2 months. As data accumulates, more precise recommendations may be communicated.
- If pregnancy is desired, at minimum, attempts at conception should be delayed for at least 2 months. Abstinence or the use of condoms with sexual activity is recommended for this period of time. It is unclear what the risks of Zika virus transmission are associated with conception beyond the 2 months. Guidance from the UK- RCOG has suggested a 6 month delay for men who are symptomatic with Zika virus infection. The CDC guidance on sexual transmission of Zika has not placed time limits on the risk of sexual transmission associated with sexual activity.

Zika Virus Update, Cont'd.

(Continued from page 2)

Current recommendations for the management of returning pregnant travellers to BC

Updates to these recommendations will be shared as soon as available.

At this time, we recommend that **all pregnant women returning from a Zika affected area be offered Zika virus testing** (please see Table 1 below for details), and a detailed ultrasound at 19-20 weeks gestational age. Those with negative or unknown Zika virus serology and a normal detailed or baseline ultrasound, may be offered monthly ultrasounds for reassurance.

Assistance with interpreting results and determining follow-up can be obtained from the Reproductive Infectious Diseases Clinic at BC Women's Hospital:

- Tel: 604-875-2424 ext. 5212
- Fax 604-875-2871

Referral to the Reproductive Infectious Diseases Clinic at BC Women's Hospital is recommended for pregnant women that meet the following criteria:

1. Have a positive test for Zika virus infection OR
2. Have an abnormality on ultrasound consistent with congenital viral infection.

Interpretation of serologic laboratory test results among returning pregnant travellers who did not have symptoms consistent with Zika virus during or within 2 weeks of their travel is challenging as the sensitivity and specificity of Zika virus antibody testing among those who are asymptomatic is not known. Laboratory tests for Zika virus are not yet fully validated and cross-reactivity with related flaviviruses (e.g. Dengue) is common. Results need to be interpreted in consultation with the BCCDC-PHL medical microbiologist:

- 1-877-747-2522
- or page 604-661-7033 for urgent consults only.

Please contact the MHO for your region at the numbers listed on page 1 of this newsletter. Or, call the UHNBC switchboard at 250-565-2000 and ask for the Medical Health Officer for your area (or the on-call MHO after hours).

References:

1. Government of Canada – Zika Virus Website: http://healthycanadians.gc.ca/diseases-conditions-maladies-affections/disease-maladie/zika-virus/index-eng.php?utm_source=zika_virus_16&utm_medium=banner_en&utm_campaign=phacfeaturebox
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7. Committee to Advise on Tropical Medicine and Travel Recommendations http://www.healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/committee-statement-treatment-prevention-zika-declaration-comite-traitement-prevention/index-eng.php
8. BCCDC Zika Virus Website: http://www.bccdc.ca/health-info/diseases-conditions/zika-virus

Submitted by: Dr. Raina Fumerton, Northwest MHO

Source: BC Centre for Disease Control
http://www.bccdc.ca

Acknowledgements: Diana George, Epidemiologist
BC Centre for Disease Control

Table 1. Laboratory Guidance for Zika Virus Testing

Clinical presentation	Recommended Tests	
Acutely ill: • *Patient reports **two or more symptoms consistent with Zika virus disease** (acute onset of fever, maculopapular rash, arthralgia, or conjunctivitis) with onset during or within 2 weeks of travel; **AND*** • *Is **currently symptomatic** or had **symptom onset** within the previous 10 days.*	1. 5ml EDTA purple top blood tube for Zika virus RNA detection. 2. 5 ml gold top serum separator tube for Zika virus serology. 3. Urine for Zika virus RNA detection. 4. Nasopharyngeal swab for Zika virus RNA detection.	**Please provide the travel and clinical history (including the date of onset of symptoms), information on pregnancy and indicate that samples are to be forwarded to the BCCDC Public Health Laboratory.**
Recovered: • *Reported symptoms consistent with Zika virus disease with onset during or within 2 weeks of travel.* • *No longer symptomatic, **and** symptom onset was more than 10 days ago.*	5 ml gold top serum separator tube for Zika virus serology, collected one month after symptom resolution.	
Asymptomatic: • *No symptoms consistent with Zika virus disease during or within 2 weeks of travel.*	5 ml gold top serum separator tube for Zika virus serology, collected one month after return from Zika affected area.	

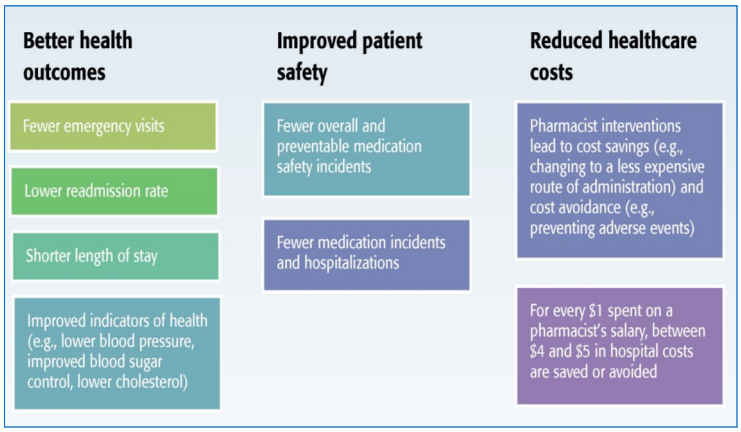
Pharmacy Awareness Month—March 2016

Your Hospital Pharmacy Team: Your Trusted Medication Experts

March 2016 is Pharmacy Awareness Month in Canada, a month long period to celebrate the many ways your pharmacy team contributes to the care, health and wellness of patients and their families.

The Pharmacy team consists of: clinical pharmacists, dispensary and medication management pharmacists, pharmacy technicians and assistants.

With their expanded scope of practice, regulated pharmacy technicians are performing essential technical duties allowing the Clinical Pharmacists to devote more time for patient care.



Pharmacists – trusted and valued members of the healthcare team – work closely with patients, physicians, nurses, and other health professionals to ensure that medication use is safe and effective, by:

- partnering with patients to help them achieve their desired health goals and outcomes
- contributing to the development of treatment plans through participation in patient care rounds
- liaising with other healthcare providers to enable smooth transitions of care as patients move from one place of care to another, such as from hospital to home
- working with the patient and others (e.g., healthcare providers, insurance companies) to help patients obtain medications after discharge
- recommending alternative therapies and dosage forms for patients
- educating pharmacy students and other healthcare professionals
- conducting and supporting research

Join your Pharmacy Team in March

Join the celebration and get to know your pharmacy team better. Various activities will be taking place over the month of March at our various sites, so stay tuned and don't be shy to join.

Enter our Twitter campaign; tell us about your interactions with the Pharmacy Team or the impact that they on patient care by using the **#PAM2016** hash tag.

Submitted by:
Jennifer Hawkes BSP, ACPR, AAHIVP
Canadian Society of Hospital Pharmacists (CSHP) - BC Northern Branch Chapter Chair
Northern Health Clinical Pharmacy Specialist Phone: 250-645-6495

Antimicrobials—Handle with Care:

A note from the Antimicrobial Stewardship Program

Pneumonia is the 2nd most common reason why patients were admitted to Northern Health facilities in the 2014/15 fiscal year and one of the top 10 reasons patients were re-admitted at 30 days.

Community acquired pneumonia (CAP) is a common infectious disease seen in our adult population therefore we need to ensure we are providing these patients with appropriate antibiotics for a reasonable length of time. Improvements in prescribing practices will lead to timely resolution of our patient's symptoms, reduced length of hospital stays and minimize development of pathogen resistance. CAP is often treated using an empirical regimen since organism identification is often difficult or not possible.

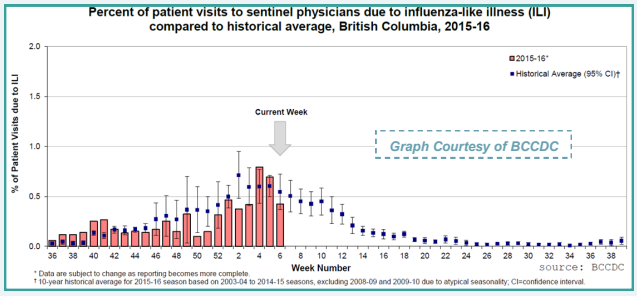
Previously UHNBC and Stuart Lake Hospital provided clinicians with order sets for CAP, no other official order set existed in Northern Health. The AMS working group has created a NEW order set for management of CAP in adults that can be used at all facilities in Northern Health. This order set has been reviewed by an extensive group of stakeholders – thank you to everyone who has contributed. Information you will find in this order set includes:

- Antibiotic regimens for patients requiring admission to medical wards
- Antibiotic regimens for patients requiring admission to ICU
- CURB-65 criteria
- Options for oral step down regimens and recommended durations

For more information about this order set or Northern Health's Antimicrobial Stewardship program, contact Alicia Ridgewell the program coordinator/lead pharmacist at 250-565-5956 or via email: alicia.ridgewell@northernhealth.ca

Submitted by: Alicia Ridgewell Antimicrobial Stewardship Program Coordinator

Influenza Update



In week 6, 453 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 196 (43%) tested positive for influenza, including 106 (54%) with influenza A [14 A(H3N2), 25 A(H1N1)pdm09, and 67 subtype pending] and 90 (46%) with influenza B. Influenza positivity has remained elevated above 30% since week 2 at the BCCDC PHL and increased to over 40% in week 6.

While influenza B viruses comprised the majority of influenza detections from week 50 to week 5, influenza A viruses, predominately A(H1N1)pdm09 among those with known subtype, comprised slightly more than half (54%) of all influenza detections in week 6. This trend is consistent with influenza activity observed in other provinces, where influenza A(H1N1)pdm09 viruses have predominated so far this season. Respiratory syncytial viruses (RSV) were also commonly detected during this period.

Source: **BC Centre for Disease Control** Influenza Surveillance Reports: Report No. 11, Feb.7-13, 2016 *(week 6)*

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Mumps

Confirmed cases of mumps in adults have been recently identified in several communities in the Vancouver Lower Mainland. We have two lab-confirmed cases in the Northwest. TWO doses of measles-mumps-rubella (MMR) vaccine are recommended for any susceptible person* born in 1970 or later (1957 for health care workers). It is notable that both of these Mumps cases in the Northwest were fully immunized. Mumps vaccine effectiveness has been estimated at 62% to 91% (for one dose) and 76% to 95% (for two doses).

Background:

Mumps is an acute infectious disease characterized by swelling of one or more salivary glands, most commonly the parotid glands, which may be unilateral but is more commonly bilateral; sometimes the sublingual or submaxillary glands are involved. Only 20-30% of those infected develop acute parotitis. Parotitis may be preceded by a non-specific prodrome lasting 3 to 5 days with fever, headache, malaise, myalgia and anorexia. Although complications are relatively frequent, permanent sequelae are rare. Before the widespread use of mumps vaccine, mumps was a major cause of viral meningitis. Other complications include orchitis, mastitis, oophoritis.

- Individuals presenting with the signs and symptoms of mumps should be tested for mumps and advised to practice good hand hygiene, avoid sharing drinking glasses or utensils and cover coughs and sneezes with a tissue or forearm.
- Individuals should be advised to stay home for 5 days after onset of salivary gland swelling.
- Public Health should be notified immediately of suspected cases of mumps to enable follow-up and identification of susceptible[2] contacts[1] .

[1] ***Definition of "contacts"***

- *household contacts;*
- *persons who share sleeping arrangements with the case, including shared rooms;*
- *direct contact with the oral/nasal secretions of an infectious case (e.g., sharing cigarettes, drinking glasses, food, cosmetics like lip gloss; kissing on the mouth);*
- *children and staff in child care and school facilities (as deemed necessary by the epidemiology of the outbreak).*

[2] ***"Susceptible persons"*** *are those who do not have a history of lab-confirmed mumps infection, or documentation of 2 doses of a live mumps-containing vaccine at 12 months of age or older and given at least 4 weeks apart.*

Laboratory Testing:

- Diagnostic work-up of suspected cases should include **both viral detection and serology.** (although please note that serology can be difficult to interpret in previously vaccinated individuals) **Requisitions should be labeled as "suspected mumps case" and sent STAT to BCCDC.**

Viral Detection

- If patient is **within 5 days of onset of symptoms** obtain **buccal swab** using a BCCDC Public Health Microbiology and Reference Laboratory (BCPHMRL) blue topped virus isolation swab
- If patient is **greater than 5 days post symptom** onset **collect urine** in a sterile container.

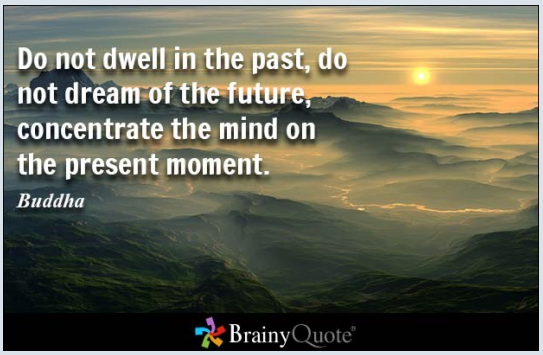
(Continued on page 2)

Inside this Issue:

Mumps ---------- pp.1-2

Zika virus update ---------- p. 2

Notable Quotable:



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Mumps Cont'd.

(Continued from page 1)

Serology

- Acute (at patient presentation) and convalescent (10 days to 3 weeks after first serum collection) serology should be done to supplement the diagnosis.

If you see suspected mumps cases during regular office hours, please call your local Health Unit or your HSDA MHO at the numbers listed on page 1 of this newsletter. After hours, the MHO on-call can be reached via the switchboard at UHNBC: 250-565-2000.

For more detailed information, the full BCCDC guidelines for Mumps can be found at: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/MumpsSeptember2014.pdf

Submitted by: **Dr. Raina Fumerton,**
NW MHO and Acting MHO, NI HSDA

Zika virus update for Health Care Professionals

We last updated you regarding Zika in the March issue of the Physicians Bulletin. Information on this topic is changing rapidly with some of the current recommendations based on expert opinion only. Please refer to BCCDC for comprehensive and continually updated clinical guidance at http://www.bccdc.ca/health-info/diseases-conditions/zika-virus/information-for-health-professionals

The purpose of this article is to briefly outline important changes since the March update that need to be particularly highlighted to physicians, nurse practitioners and midwives.

Pregnancy and sexual transmission: (Note: Most Infections are ASYMPTOMATIC)

Women as travellers

Advise women returning from an area where Zika virus is circulating to consider delaying conceiving for at least **2 months** (based on timing of expected serological viral clearance).

Men as travellers

There remains much uncertainty about the duration of time the Zika virus can live in sperm.

Men who have returned from an area where Zika virus is circulating and who have a pregnant partner consider **abstaining from sexual activity or consistently and correctly use a condom for the duration of the pregnancy.**

For men with non-pregnant partners, interventions to prevent sexual transmission of Zika virus include abstinence or avoiding unprotected sexual activity for **at least 6 months** (previous recommendation was 2 months). Men should not attempt to conceive with their partners for **at least 6 months** after returning from travel.

Management of returning travellers and those with possible exposure through sexual contact with a returning traveller:

Zika virus testing indications:

- All pregnant women returning from a Zika virus affected area.
- Women who have become pregnant within 2 months of travelling to a Zika virus affected area.
- All pregnant women who have had unprotected sexual contact with a man who has travelled to a Zika virus affected area within the past 6 months.
- All patients who become acutely ill within 14 days of return from a Zika virus affected area.
- Patients presenting with Guillain-Barré, acute disseminated encephalomyelitis, or myelitis may have been exposed through travel or unprotected sexual contact with a returning traveller.
- Can be considered for: products of conception in cases of stillbirth/congenital anomaly if appropriate travel or exposure history (Call BCCDC Med Micro to discuss 1-877-747-2522).

Referral pathway for pregnant women being offered Zika virus testing:

- Offer obstetrical US to women being evaluated for possible Zika virus infection at the time of presentation and again at 19-20 weeks gestational age (see Table 1 for testing details).
- Refer to Reproductive Infectious Diseases Clinic (Tel: 604-875-2424 ext. 5212) for all positive Zika tests (preliminary or confirmed) **or** abnormal US consistent with congenital viral infection.
- If negative or unknown Zika virus serology and a normal detailed or baseline ultrasound—consider offering monthly ultrasounds for reassurance (assistance with interpreting results and determining follow-up can be obtained from the Reproductive Infectious Diseases Clinic).

Additional (easy to understand) information for patients is available on the **Vancouver Coastal Health Travel Clinic** webpage: http://www.vch.ca/about-us/news/what-travellers-need-to-know-about-the-zika-virus

Table 1. Laboratory Guidance for Zika Virus Testing

Clinical presentation	Recommended Tests
Pregnant Women	*Submit specimens as described below for the Acutely Ill patient, regardless of the presence or absence of symptoms.*
Acutely Ill: • Patient reports **two or more symptoms consistent with Zika virus disease** (acute onset of fever, maculopapular rash, arthralgia, or conjunctivitis) with onset during or within 2 weeks of travel **AND** • Is **currently symptomatic** or had **symptom onset** within the previous 10 days.	1. *5ml EDTA purple top blood tube for Zika virus RNA detection* 2. *5 ml gold top serum separator tube for Zika virus serology* ***Please provide the travel and clinical history (including the date of onset of symptoms), information on pregnancy and indicate that samples are to be forwarded to the BCCDC Public Health Laboratory.*** ***After consultation with the BCCDC microbiologist, urine and nasopharyngeal swabs can be sent for RNA detection** (1-877-747-2522 or page 604-661-7033 for urgent consults only).*
Recovered: • Reported symptoms consistent with Zika virus disease with onset during or within 2 weeks of travel • No longer symptomatic, **and** symptom onset was more than 10 days ago	1. 5 ml gold top serum separator tube for Zika virus serology, collected one month after symptom resolution **Please provide the travel and clinical history (including the date of onset of symptoms), information on pregnancy and indicate that samples are to be forwarded to the BCCDC Public Health Laboratory.**
Asymptomatic: • No symptoms consistent with Zika virus disease during or within 2 weeks of travel	1. 5 ml gold top serum separator tube for Zika virus serology, collected one month after return from Zika affected area **Please provide the travel and clinical history (including the date of onset of symptoms), information on pregnancy and indicate that samples are to be forwarded to the BCCDC Public Health Laboratory.**

Submitted by: **Dr. Raina Fumerton,**
NW MHO and Acting MHO, NI HSDA

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"Growing up Healthy in Northern BC" Consultation Process/Child Health Report

The Chief Medical Health Officer issued a report on Child Health in Northern BC in April 2016: https://northernhealth.ca/Portals/0/About/Community_Accountability/documents/Northern-Health-CMHO.pdf. This report provides a review of the status of health of northern children, from conception to five years of age. A set of 24 life course indicators was identified and data was obtained, analyzed, interpreted and shared in the detailed technical report at: https://northernhealth.ca/Portals/0/About/Community_Accountability/documents/CMHO-Child-Health-Status-Technical-Report.pdf

Key findings - How healthy are most pregnancies in the North?

Compared to the rest of the province, Northern BC reports higher rates of the following conditions, all of which can lead to complications later in the child's life:

- teen pregnancies;
- exposure to alcohol, tobacco, and stress related to mental health concerns;
- overweight and obesity in mothers and high birth weights of newborns

Key findings - How healthy are children in the North?

Newborns are generally welcomed safely in Northern BC, but higher rates of infant mortality are reported in the region in the first year of life. Statistics also indicate that:

- Women in Northern BC have the lowest rates of exclusive breastfeeding to six months of age.
- About one-third of children are not emotionally, nor physically, ready for the transition to enter school.
- The region has higher rates of poor oral health in comparison to the rest of the province, including the highest rate of dental surgeries.
- The rates of injury hospitalization are among the highest in the province.
- Rates of child abuse, neglect, and children in need of protection are also among the highest in the province.
- One in five children in the North live in low income families.

Key recommendations for how we can work together to improve the health of our children Communities and families can seek to strengthen protective factors for optimal child wellness and reduce or prevent risk factors. Children's health happens in families and communities, in the settings in which children live, learn and play.

1. Within Northern Health, develop a program focused on children, youth and families within Northern BC.
2. Encourage, promote and highlight collaboration in communities.
3. Strive to achieve high levels of collaboration across sectors.
4. Strengthen the partnership between Northern Health and the First Nations Health Authority.
5. Support communities and families to provide the foundations for early childhood development.
6. Commit to ongoing monitoring of child health data and indicators.

Do you have any stories, ideas, concerns or opportunities about improving the health of children in the north?
You can participate in community consultations in your community, weigh in on ThoughtExchange, or submit a story to childhealthconsultation@northernhealth.ca

Submitted by: Chief MHO Dr. Sandra Allison

Inside this Issue:

"Growing up Healthy in Northern BC" Consultation Process/Child Health Report ----------p.1

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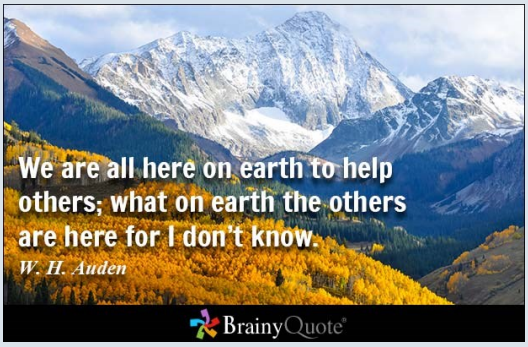
Notable Quotable:



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Interim Syphilis Treatment Guidelines during the Benzathine Penicillin Shortage

Background

- The Public Health Agency of Canada (PHAC) has been recently informed of a national shortage of benzathine penicillin G (Bicillin L-A) which is estimated to last until July 2016.
- Pfizer is the only Canadian supplier of Bicillin L-A at present and the shortage is due to a manufacturing issue.
- PHAC recommends conserving available stock of Bicillin L-A and using alternative treatments wherever feasible or possible. Ideally, treatment and follow-up of syphilis should be done in consultation with an STI/Infectious disease specialist or a colleague experienced in syphilis management.
- PHAC is working closely with Health Canada regulators to develop options to mitigate the shortage.
- The following interim treatment recommendations have been developed by PHAC, in collaboration with the Expert Working Group for the Canadian Guidelines on Sexually Transmitted Infections.

These recommendations are intended for use during the Bicillin shortage only and until further notice. They may differ from the preferred and alternative treatment recommendations in the Syphilis chapter of the Canadian Guidelines on Sexually Transmitted Infections. Close clinical and/or serologic follow-up is especially important when non-penicillin regimens are used for treatment. Refer to tables 6 and 7 in the Syphilis Chapter.

Effective immediately it is recommended that the use of Bicillin L-A be restricted to:

Pregnant patients (all stages) Primary, secondary, early latent syphilis

Benzathine penicillin G 2.4 m.u. IM as a single dose

Late latent, latent of unknown duration, tertiary syphilis (not involving the central nervous system)

Benzathine penicillin G 2.4 m.u. IM weekly x 3 doses

Notes:

- There is no satisfactory alternative to penicillin in pregnancy; strongly consider penicillin desensitization in patients reporting anaphylactic reactions to penicillin.
- Given the complexity of accurately staging early syphilis, some experts recommend that primary, secondary and early latent cases in pregnancy be treated with two doses of benzathine penicillin G 2.4 m.u. 1 week apart; the efficacy of this regimen in preventing fetal syphilis is not known.

Infectious cases (primary, secondary and early latent syphilis), regardless of HIV status, if adherence to treatment and follow-up is uncertain

Benzathine penicillin G 2.4 m.u. IM as a single dose

Note:

- A single dose of Benzathine penicillin G long-acting is adequate for HIV positive patients with early syphilis.

Sexual contacts (within 90 days) of infectious cases of syphilis if pregnant OR adherence to treatment and follow-up is uncertain

Benzathine penicillin G 2.4 m.u. IM as a single dose

Note:
There is no satisfactory alternative to penicillin in pregnancy; strongly consider penicillin desensitization in patients reporting anaphylactic reactions to penicillin.

The following patients (including HIV infected) should be preferentially treated with oral doxycycline if adherence to treatment AND follow-up is expected.

Primary, secondary and early latent syphilis cases and their sexual contacts (non-pregnant adults)

Doxycycline 100 mg PO BID x 14 days

Late latent, latent of unknown duration, tertiary syphilis (not involving the central nervous system) in non-pregnant adults

Doxycycline 100 mg PO BID x 28 days

Notes:

- In the case of late latent syphilis, if there is uncertainty regarding the staging, (i.e., there is a possibility that it could be an infectious case of syphilis), some experts would recommend the use of Bicillin 2.4 m.u. IM in a single dose followed by the routine doxycycline regimen.
- If there is no uncertainty regarding staging of late latent syphilis, clinicians may opt to defer treatment until the supply of Bicillin is re-established.

In the event that no Bicillin L-A is available, the following treatment guidelines are recommended (including HIV infected)

Pregnant patients (all stages)

Penicillin G 4 m.u. IV q 4 h x 10 days

Note:

- There is no satisfactory alternative to penicillin in pregnancy; strongly consider penicillin desensitization in patients reporting anaphylactic reactions to penicillin.

Primary, secondary, early latent syphilis cases and their sexual contacts (non-pregnant adults)

Doxycycline 100 mg PO BID x **14** days

Notes:

- If suboptimal adherence is suspected some experts would recommend the addition of azithromycin 2 g PO in a single dose followed by the routine doxycycline regimen.
- Treatment failures have been reported following the use of azithromycin to treat early syphilis, and resistance has been observed in Canada. As such, close clinical follow-up is especially important if early or incubating syphilis is suspected. Monotherapy with azithromycin is not recommended for the treatment of syphilis.

Alternative treatments

Penicillin-G 4 m.u. IV q 4 h x 10 days OR
Ceftriaxone 1 g IV q 24 h x 10 days

Late latent, latent of unknown duration, tertiary syphilis (not involving the central nervous system) in non-pregnant adults

Doxycycline 100 mg PO BID x 28 days

Alternative treatments

Penicillin-G 4 m.u. IV q 4 h x 10 days
OR Ceftriaxone 1 g IV q 24 h x 10 days

Continued-Interim Syphilis Treatment Guidelines

(Continued from page 2)

Notes:

- If there is no uncertainty regarding staging of late latent syphilis, clinicians may opt to defer treatment until the supply of Bicillin L-A is re-established.
- In the case of late latent syphilis, if there is uncertainty regarding the staging, (i.e., there is a possibility that it could be an infectious case of syphilis), some experts would recommend the addition of azithromycin 2 g PO in a single dose followed by the routine doxycycline regimen.
- Treatment failures have been reported following the use of azithromycin to treat early syphilis, and resistance has been observed in Canada. As such, close clinical follow-up is especially important if early or incubating syphilis is suspected. Monotherapy with azithromycin is not recommended for the treatment of syphilis.

Source:
Troy Grennan
Physician Lead, HIV/STI Program

June is Brain Injury Awareness month and concussions are one of the most common forms of brain injury. BC's Injury Research and Prevention Unit has recently released concussion statistics for children and youth across BC. The Concussion Among Children & Youth: Northern Health report and Injury Insight identifies:

- Northern Health with the highest rate of concussion hospitalizations among all Health Authorities
- Concussion hospitalizations from off-road vehicles are most common in rural areas
- Cycling as the main cause of sport-related concussion hospitalizations
- Transport-related concussion hospitalizations were highest among 15-19 years olds
- Falls-related concussion hospitalizations were highest among 0-4 year olds

Standardized concussions prevention, diagnosis and management is crucial to addressing this brain injury. During Brain Injury Awareness month, check out and encourage staff and clients to visit the Concussion Awareness Training Tool at www.cattonline.com , providing free, online and up-to-date education, tools and resources for:

For further information:
Brenda Matsen
Regional Team Lead, Healthy Living & Chronic Diseases
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Public Health Emergency Declared: Unintended Opioid Overdose Deaths

In recent years, there has been a significant increase in the number of overdose deaths in British Columbia, rising from an annual total of 274 deaths in 2012 to 480 in 2015. At the current rate, a total of over 750 overdose deaths can be expected to occur in the province by the end of this year. The presence of illicit fentanyl and related compounds such as W-18, opioid analgesics that can be up to 1000-fold more powerful than morphine, are believed to be driving the current epidemic. A majority of people who use drugs in BC (73%) are not aware that they are using these compounds. The BC Coroners Service has detected fentanyl in increasing proportions of illicit drug deaths. In 2012, the drug was identified in 5% of these cases. The proportion thus far in 2016 is 49%.

The Provincial Health Officer, Dr. Perry Kendall, declared the overdose situation in BC a Public Health Emergency on April 14, 2016. The declaration allows the PHO or Minister of Health additional powers, including powers regarding reporting, making regulations and implementing emergency measures, including overdose report-ability and greater access to more detailed Coroner's data for health authorities.

Local physicians play a key role in surveillance efforts and in preventing overdose deaths due to fentanyl/fentanyl analogues; prevention efforts include Take Home Naloxone (THN) programs, advocating for local Safe Injection Services (SIS), screening for substance use disorders or predisposition towards one, providing Opioid replacement therapy, and optimizing safe prescribing practices.

Naloxone: The Take Home Naloxone program provides training in overdose recognition, response and naloxone injection. THN kits are available for those that use opioids or for friends and family of users.

Supervised injection services (SIS): SIS have demonstrated benefit in terms of improved health, stability, access to social services and addictions treatment, as well as the prevention of overdose mortality and a reduction of impact on the health, enforcement and legal sectors. SIS decreases the risk of overdose; provide stabilization and referrals which can be the first step on the road to recovery. Local physicians can play a role in advocating for this gap in harm reduction services to increase awareness that these services be expanded to meet the needs of our northern communities.

Opioid Replacement Therapy (ORT): ORT involves the use of pharmaceutical-grade long-acting prescription opioids as a treatment for patients with opioid use disorder. Vancouver Coastal Health Opioid Addiction Guidelines released in November 2015 recommend Suboxone (buprenorphine/naloxone) over methadone as first-line treatment. Risk of overdose on Suboxone is six-fold lower than on methadone. Currently in BC, permission to prescribe Suboxone requires a methadone exemption. However, it is expected that the College of Physicians and Surgeons of BC will be changing this requirement to increase access to this treatment option. Information

(Continued on page 4)

Continued-Public Health Emergency Declared

(Continued from page 3)
on how to safely prescribe Suboxone can be found at http://www.suboxonecme.ca

Safe Prescribing Practices: Avoid prescribing sedative medications to patients who use illicit or prescribed opioids. A recent study of people who use drugs in Vancouver found that people who used benzodiazepines were twice as likely to die as those that did not use them. Always use resources such as Pharmanet, when prescribing opioids or benzodiazepines, in order to avoid prescriptions from multiple providers and reduce the risk of diversion and overdose. Also remember that sudden restriction or reduction of prescribed medication can result in illicit drug use and consequently increase the risk of overdose. Consider options for tapering and/or addiction treatment with patients in these situations.

Screening: It is advised that you screen for the risk of opioid use disorder before and during treatment with opioid analgesics. The Opioid Risk Tool is a validated, self-administered pre-screen that is currently recommended before starting opioid prescriptions by the U.S. National Institute on Drug Abuse. For those patients in whom you suspect an active opioid use disorder, the DAST-10 is a brief clinician-administered validated tool which identifies the DSM-V criteria for substance use disorder. For patients that either screen positive or request access to treatment, it is important to know your local resources to which you may refer.

Given the current trends of overdose in our northern communities, it is vital for physicians to make every effort to address the risk to patients by reducing harm and providing evidence-based treatment.

Submitted by:
Dr. Raina Fumerton,
NW MHO and Acting MHO, NI HSDA
Acknowledgements:
Dr. Mark Lysychyn,
MHO Vancouver Coastal Health

A Treatment Option for the Opioid Dependent Patient
Speaker: Dr. Mandy Manak

- Understand and appreciate the chronic relapsing disease state of opioid dependency
- Recognize the options available in treating opioid dependencies with medically-assisted therapies
- Identify patients who may be appropriate candidates for opioid replacement therapy
- Complete accreditation process to offer opiate replacement therapy with Suboxone

Saturday, June 4, 2016
8:30am – 3:00pm
Delta Vancouver Suites,
Thompson Room, 2nd Floor,
550 West Hastings St, Vancouver

Please contact Kathleen MacDonald (Kathleen.macdonald@indivior.com) for more information.

Antimicrobials—Handle with Care:
A note from the Antimicrobial Stewardship Program

Prescribing antimicrobials without culture results can be difficult, especially in situations where cultures are not possible or useful (e.g. cellulitis). Choosing an antimicrobial with empiric sensitivity to the most likely pathogens is integral to successful management of these infections. There are resources and references which can help point prescribers in the right direction (e.g. The Sanford guide to Antimicrobial Therapy) but there is also data from the local health region which may help to further refine treatment options. This local data is referred to as an Antibiogram or an annual antimicrobial susceptibility report, and is created based on culture results produced by NH's microbiology lab. The Antibiogram is created using a cumulative summary of antimicrobial susceptibility testing data collected during the previous calendar year. This year's NH Antibiogram contains data collected between January 1, 2015 and December 31, 2015. The data is organised into 3 separate reports, based on the 3 health services delivery areas within Northern Health, in order to capture any regional differences. You can find these documents on ourNH → Clinical & Patient Care → Medications → Quick Reference Guide. There will soon be a pocket-card available from docuSource.

Duration of therapy is another area of focus for an antimicrobial stewardship program. Prolonged duration of therapy puts patients at risk for adverse effects and should only be used if clinically necessary. One method used by many facilities to prevent inappropriately prolonged therapies is the Automatic Stop Order policy. This policy has been in existence in Northern Health since 2008 but was recently been revised to include more information regarding the Stop Order Report and its role in prompting reassessment of medications. The Regional Medication Safety Officer and Antimicrobial Stewardship pharmacist will be presenting this updated policy at the September 14th Policy Rounds.

For more information about Northern Health's Antimicrobial Stewardship program, contact Alicia Ridgewell the program coordinator/lead pharmacist at 250-565-5956 or via email: alicia.ridgewell@northernhealth.ca

Submitted by:
Alicia Ridgewell
Antimicrobial Stewardship Program

Northern Health Physicians
Partners in Wellness

Public Health Newsletter for Northern Health Physicians

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Overdose Public Health Emergency

On April 14th, a public health emergency was declared in BC in response to a significant increase in illicit drug overdose deaths. In the Northern Health region alone, illicit drug overdose deaths increased from 19 deaths in 2012 to 29 deaths in 2015. In the first five months of this year, 25 deaths have already occurred in the North.

The BC Coroners Service has detected fentanyl in increasing proportions of illicit drug overdose deaths. In 2012, fentanyl was identified in 5% of illicit drug overdose deaths in BC, rising each subsequent year to 32% of overdose deaths in 2015 and 56% of overdose deaths in the first quarter of 2016.

The emergency declaration under the *Public Health Act* has allowed for improved access to information that is crucial to guide the overdose crisis. Northern Health has established an Overdose Response Team to provide direction and coordinate our response. The team's priorities include:

- Implementing enhanced surveillance of overdoses among individuals who present to emergency departments and in the community. To date, from our emergency room surveillance which commenced June 13, 2016, there have been 65 suspected Opioid Overdose cases reported.
- Expanding access to Take Home Naloxone from emergency departments, public health units, and Mental Health and Substance Use (MHSU) services.
- Removing barriers to accessing MHSU services (e.g., opioid substitution therapy).
- As well, the Northern Health Overdose Response Team is exploring the feasibility of safe consumption services through consultation with stakeholders.

Additional suggested resources:

1. BC Drug Overdose and Alert Partnership (www.bccdc.ca/health-professionals/clinicalresources/harm-reduction/bc-drug-overdose-alert-partnership-doap) – Provincial Harm Reduction Committee
2. BC Coroners Reports (http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf) – Recent illicit drug overdose statistics in BC
3. Overdose prevention (www.interiorhealth.ca/YourEnvironment/CommunicableDiseaseControl/Documents/OD%20Prevention.pdf) – signs of an overdose and overdose prevention
4. Know Your Source (www.knowyoursource.ca) – Information on Fentanyl
5. Toward the Heart (www.towardtheheart.com) – A project of the provincial harm reduction program

Submitted by: **Dr. Raina Fumerton,**
NW MHO and Acting MHO, NI HSDA

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BCCDC Update: Sexually Transmitted Infections
Benzathine penicillin (Bicillin L-A) is once again available in Canada

Pfizer Canada has confirmed that their production of Bicillin L-A is back to normal. **Physicians should resume use of Bicillin L-A for the treatment of syphilis.** Please disregard the interim treatment guidelines for syphilis and resume using the British Columbia Treatment Guidelines: Sexually Transmitted Infections in Adolescents and Adults (2014) available at: http://www.bccdc.ca/resource-gallery/Documents/Communicable-Disease-Manual/Chapter%205%20-%20STI/CPS_BC_STI_Treatment_Guidelines_20112014.pdf

Provincial increase in all STIs
BC saw a particularly marked increase in bacterial STIs in 2015 compared to 2014. We are continuing to see additional in-creases in many infections in 2016. Some of the trends noted in 2015 include:

- a 75% increase in cases of **gonorrhea**;
- a 40% increase in **syphilis**, representing the highest rates we have seen in 30 years;
- cases of **lymphogranuloma venereum** (LGV) were the highest ever recorded in BC, with over 40 cases.

For more information, please see:

- BC Update on Sexually Transmitted Infections: June 2016 available at: http:// smartsexresource.com/health-providers/blog/201606/update-sexually-transmitted-infections-bc-june-2016.
- BCCDC Smart Sex Resource webpage: www.smartsexresource.com

Source:
Dr. Troy Grennan
Physician Lead, BCCDC HIV/STI Program

Do your patients who smoke want to quit?

70% of your patients who smoke want to quit.

Most tobacco users want to quit. Maybe not today but more than 70% of tobacco users *do* want to quit.

Helping them is as simple as 1 – 2 – 3.

Ask: *"Have you used any tobacco products in the last 6 months?"*

Advise: *Link* tobacco reduction to their personal health situation to personalize your advice.

Act: *Connect* your patients with:

QuitNow services: https://www.quitnow.ca/, and

BC Smoking Cessation Program: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/bc-smoking-cessation-program.

It can take less than a minute to have a short conversation that has been shown to increase quit rates. Great resources are available to easily connect your patients with cessation services at https://www.quitnow.ca/helping-others-quit/healthcare-providers/order-materials.

This systematic approach (previously 5A's) helps you identify patients who smoke, encourage them to quit and allows you to provide resources to support them for success. Your EMR can potentially remind you to address tobacco with your patients and follow-up on their next visits.

Check out this video, "*Emily's Story, Ask Advise Act*" at https://www.youtube.com/watch?v=6ggvECsMnqw).

A few minutes can save a life.

Submitted by:
Nancy Viney, Regional Nursing Lead - Tobacco Reduction

Quadrivalent Meningococcal Vaccine Available for Adolescents

BC is introducing a quadrivalent meningococcal vaccine (Men-C-ACYW-135) program for adolescents to offer protection against meningococcal serotypes A, C, Y and W-135. The attached Q & A provides answers to frequently asked questions for health care providers who are responsible for implementing this program.

This Q & A can also be found on the Health Professionals Section of the BCCDC website:
http://www.bccdc.ca/health-professionals/clinical-resources/immunization.

Chelsea Taylor RN MPH
Vaccine Educator
Immunization Programs and Vaccine Preventable Diseases Service
BC Centre for Disease Control

The Role of Serological Testing:
Immunization of those with no or Inadequate Immunization Records

Physicians often see patients who have no immunization records or whose records are incomplete. These may include immigrants, refugees, and sometimes health care workers. It may be possible to retrieve these records from a previous health care provider or public health unit in another province, but if records cannot be obtained the generally recommended approach is to offer the routinely recommended vaccines appropriate for the patient's age group, as one would for an unvaccinated individual. The reasons for this are threefold: a large portion of undocumented individuals are unimmunized or inadequately immunized, vaccination of immune individuals is safe, and serologic proof of immunity may be unavailable or unreliable.

This article focuses on serological testing in association with vaccination decisions.

There are only a few situations in which routine testing for immunity following completion of a vaccine series among healthy individuals is indicated. These include:

- Hepatitis B immunity testing of health care workers, infants of carrier mothers, and household members and ongoing sexual partners of hepatitis B carriers.
- Varicella testing for some immunocompromised individuals following a dose of varicella vaccine.
- Rabies serology for animal handlers following a pre-exposure series of rabies vaccine.

Laboratory testing services are also available for testing select individuals (e.g., pediatric oncology) for select diseases for which there are available antibody assays and known correlates of serological protection. Practically, these include only hepatitis B, measles, and rubella. There are no established serological correlates of protection for pertussis, mumps, and human papillomavirus. Testing for immunity against poliovirus is not necessary given the global epidemiology of this disease, which is approaching eradication, nor are these assays readily available. Commercially available varicella antibody assays are insufficiently sensitive to reliably detect varicella–vaccine induced immunity, and the assays used in clinical trials that have been correlated to clinical protection are not available outside of research laboratories. Therefore, varicella immunity testing following immunization of select immunocompromised individuals is informative only if antibody is detected, and a negative serology result in a vaccinated individual does not imply susceptibility. Finally, only research laboratories have the ability to test for multiple serogroup serological protection conferred by meningococcal and pneumococcal vaccines, and *Haemophilus influenzae* type B titres.

Immunity testing requested most frequently in BC is for measles, mumps, and rubella. Such testing is neither recommended nor necessary either before or after vaccination, including for health care workers. The exception is rubella immunity testing in pregnancy, which is part of the routine prenatal screen, with MMR vaccine administered as a single dose for rubella protection postpartum in those whose serology indicates rubella nonimmunity. Rubella immunity testing in pregnancy is not required if previous laboratory results indicate immunity or if there is written documentation of a dated receipt of rubella vaccine. For measles and rubella, although there are serologic correlates of protection, immunity is robust and very high levels of protection are achieved in individuals who have received the recommended two doses of measles and one dose of rubella vaccine for those born in 1970 and later. Those fully immunized and tested many years following immunization may have titres below the protective threshold but remain protected if exposed due to a solid anamnestic response. Furthermore, immunized individuals with low antibody titres may be adequately protected through cell-mediated immunity, which cannot be measured by serologic tests and is assessed only in research laboratories.

Finally, immune individuals may be safely reimmunized as receiving MMR when already immune is associated with fewer adverse events than immunizing those who are susceptible; in such people, pre-existing immunity will interfere with replication of the live attenuated virus and systemic reactions such as rash and fever generally do not occur.

Source:

Issue: BCMJ, Vol. 58, No. 4, May 2016, page(s) 232, 238 BC Centre for Disease Control

Monika Naus, MD, MHSc, FRCPC, FACPM
Medical Director, Immunization Programs and Vaccine Preventable Diseases Services, BCCDC

Back issues of *NH Physicians, Partners in Wellness* newsletters and bulletins are located on the NH Physicians website:
http://physicians.northernhealth.ca/physicianResources/PublicHealth.aspx

Cervical Cancer Screening Policy Change

Effective June 21, 2016, British Columbia's updated Cervical Cancer Screening Policy will be in effect. This policy reflects the latest evidence and the province's commitment to reducing cervical cancer incidence and mortality.

Updated Protocols for Cervical Cancer Screening

Screening aims to identify high-grade pre-cancerous lesions which can be treated to prevent the development of cervical cancer. High grade lesions may be treated with ablative and excisional therapies, including laser ablation, loop electrosurgical excision procedure (LEEP) and cold knife conization. Cervical cancer may be treated with surgery (hysterectomy) and/or radiation +/- chemotherapy.

Benefits and Harms of Cervical Cancer Screening

While cervical cancer screening has proven very effective in decreasing the incidence of pre-cancer and cervical cancer, like any screening test, it isn't perfect. Women should be aware of the benefits and harms of cervical cancer screening and make an informed decision to screen.

		Recommendation	Screening Test	Screening Interval	Balance of Screening Harms and Benefits
Average Risk	Age 25-69	Screen	Cytology	3 years	Benefits outweigh harms
	Never had sexual contact*	Do not screen	No test	N/A	Harms outweigh benefits
	Have received the HPV vaccine	Screen	Cytology	3 years	Benefits outweigh harms
	In same sex relationship	Screen	Cytology	3 years	Benefits outweigh harms
	Transgender with a cervix	Screen	Cytology	3 years	Benefits outweigh harms
	After total hysterectomy†	Do not screen	No test	N/A	Harms outweigh benefits
	Age < 25	Do not screen	No test	N/A	Harms outweigh benefits
	Age > 69‡	Do not screen	No test	N/A	Harms outweigh benefits
Higher than Average Risk	Immunocompromised women§	Screen	Cytology	Annual	Benefits outweigh harms
	History of pre-cancerous lesions or cervical cancer	Screen	Cytology	Annual - until 25 years after diagnosis with at least 5 negative cytology in last 10 years.	Benefits outweigh harms

** Sexual contact includes intercourse as well as digital or oral sexual contact involving the genital area of a partner of either gender.*

† Including removal of cervix, with no history of pre-cancerous lesions or cervical cancer.

‡ Provided there are 3 negative tests in preceding 10 years and no high risk criteria.

§ Immunocompromised includes those diagnosed with human immunodeficiency virus (HIV/AIDS), lymphoproliferative disorders, an organ transplant, and those under long-term immunosuppression therapy.

Benefits of Screening

- Screening where practiced effectively, has resulted in decreased cervical cancer incidence and mortality in women[1,2].
- Cervical cancer is one of the most preventable cancers. Cervical cancer begins as an infection of the uterine cervix with high risk human papillomavirus (hr-HPV) that needs to persist for many years. The transition from initial HPV infection to invasive cancer seems to take decades in most cases, with a minimal latency period of approximately 7 years[3,4].
- Cervical cancer screening saves lives. Most cervical cancer cases occur among women who have not undergone screening or who have had a long interval between Pap tests. In BC, about 58% of the 178 patients diagnosed with invasive cervical cancer in 2014 were five years or more overdue for screening[5]. The majority of cases are diagnosed in the 30-39 and 40-49 age groups[5].
- Women between the ages of 25-69 stand to benefit the most from screening.

Harms of Screening

- Most HPV infections and pre-cancerous lesions resolve spontaneously, particularly among younger women who are of childbearing age[6,7].
- Over-diagnosis and treatment of these transient cervical intraepithelial neoplasia (CIN) is associated with substantial harms, including heightened psychosocial consequences in the women treated[8], increased risk of pre-term and low-birth weight babies (especially for women treated with excisional approaches)[9,10] and unneccesary utilization of health care resources.
- A 2008 study concluded that in the treatment of CIN, all excisional procedures seem to be associated with adverse obstetric morbidity, but among these, only cold knife conisation is associated with a significantly increased rate of severe outcomes[11].
- Initiating screening in women under 25 can produce more harm than benefit, as cervical cancer is not common in women under age 25.

References

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3 Hildesheim A, Hadjmichael O, Schwartz P, et al.: Risk factors for rapid onset cervical cancer. Am J Obstet Gynecol 1999;180:571-577.

4 Liebrich C, Brummer O, Von WR, et al.: Primary cervical cancer truly negative for high-risk human papillomavirus is a rare but distinct entity that can affect virgins and young adolescents. Eur J Gynaecol Oncol 2009;30:45-48.

5 2016 Cervical Cancer Screening Program Annual Report, BC Cancer Agency, www.screeningbc.ca.

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Source: BC Cancer Agency

Cervical Cancer Screening Program
801-686 West Broadway
Vancouver, BC V5Z1G1

Website: www.screeningbc.ca/cervix
Email: screening@bccancer.bc.ca

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Partners in Wellness

Public Health Newsletter for Northern Health Physicians

Volume 12 . Number 8, September 2016 ● Page 1 of 4

Introducing:
New Northern Interior Medical Health Officer, Dr. Andrew Gray

We are very pleased to advise that Dr. Andrew Gray assumed the role of Northern Interior Medical Health Officer on Monday, August 29th, 2016.

Dr. Gray grew up in Vancouver. He completed a B.Sc. in mathematics and computer science, followed by a medical degree, at the University of British Columbia. He is passionate about promoting health equity and ensuring that health policy reflects the voices and needs of everyone in the community.

Dr. Gray worked for two months with the Public Health program in Northern Health in late 2015 as part of his residency training. We are very happy to welcome him back to Northern Health!

Dr. Gray can be reached at andrew.gray@northernhealth.ca or **250-565-7461.**

Northern Health's Medical Health Officers:

- Dr. Sandra Allison, Chief MHO
- Dr. Raina Fumerton, MHO **NORTHWEST HSDA**
- Dr. Andrew Gray, MHO **NORTHERN INTERIOR HSDA**
- Dr. Raina Fumerton, Acting MHO **NORTHEAST HSDA**
- Dr. Ronald Chapman will continue to work as an on-call MHO as needed.

**** all after hours calls are to the Switchboard at UHNBC—250-565-2000** (5 p.m. to 8 a.m. weekdays, and 24 hours on weekends and Stat holidays), and ask for the "MHO on-call".*

Fig. 1: Northern Health HSDAs

Submitted by: Dr. Sandra Allison, Chief Medical Health Officer

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HPV 9 valent vaccine to replace HPV 4 in grade 6 program in BC
starting September 2016

Dear colleagues:
At the June Communicable Disease Policy Advisory Committee meeting, there was support for securing approvals and other required changes to allow for introduction of HPV 9 valent vaccine (Gardasil® 9) for the routine female program in grade 6 in BC, in a two dose schedule, beginning the 2016/7 school year. We have received approvals along with making supply changes effective today, and I'm writing to let you know so that you can plan as appropriate to introduce this product in place of HPV 4 (Gardasil®) for the coming school year.

The recommended immunization schedule will be the same as for Gardasil®. While the current product monograph and current NACI statement contain recommendations only for a 3 dose schedule, these are expected to be updated in the near future.

The current NACI statement for HPV 9 vaccine is available here: http://www.healthycanadians.gc.ca/publications/healthy-living-vie-saine/human-papillomavirus-9-valent-vaccine-update-recommendation-mises-a-jour-recommandations-papillome-humain-vaccin-nonavalent/index-eng.php

The grade 6 consent form prepared for the coming school year does not specify the product, and will not require adjustment.

The grade 6 HealthFile, the Immunization Manual pages, accompanying Q & As, and web site information (BCCDC and Immunizebc.ca) will be updated as required, as will other components required for this product change. These resources will be distributed as soon as they are completed.

HPV 4 valent vaccine will continue to be used for the high risk male program for the foreseeable future. Please ensure that all remaining inventory in your health authority is allocated to the high risk male program. Remaining HPV 4 vaccine in inventory with community vaccine providers should be used for completing the series of girls in progress of their HPV 4 series, and for immunization of high risk males. Age-eligible girls older than grade 6 wishing to complete or initiate a series of HPV vaccine may also be immunized with available HPV 4 vaccine.

We are very pleased to be able to make this product change.

Source:
Monika Naus, MD FRCPC
Medical Director—Immunization Programs & Vaccine Preventable Diseases Service BC
Centre for Disease Control
Tel 604-707-2540

Northern Health Smoke-free Grounds Policy

It's their home! It's the last pleasure they can enjoy!
How do we protect others at Long Term Care Residences from second hand smoke when some residents smoke?

Northern Health is a Smoke-Free Organization and smoking tobacco is prohibited on all Northern Health owned and operated premises, facilities, and grounds. You can review Northern Health's Clinical Practice Standard - Smoke Free Grounds.[1]

Some seniors have used tobacco throughout their lives and have difficulty complying with the Smoke Free Grounds Policy when admitted to long term care. It is a challenge for the staff at facilities to help their residents maintain their autonomy and enjoy their life.

A case study was submitted to the Centre for Addiction and Mental Health (CAMH) by Nancy Viney of Northern Health's Tobacco Reduction Population Health program. It was chosen to be reviewed by an expert panel and discussed at TEACH[2] Educational Rounds to assist in developing positive approaches and systems to support smoke free long term care facilities while respecting the people who live there.

You can listen to the recording of this webinar[3] to hear what the experts have to say. For more information please contact Nancy at: nancy.viney@northernhealth.ca

Please note that the changes to the *Tobacco Control Act* will take place as of September 1, 2016. Stay tuned for more information on how the changes support tobacco reduction efforts in the North.

[1] Smoke Free Grounds Policy https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-8-030.pdf

[2] TEACH Educational Rounds: http://www.camh.ca/en/education/about/AZCourses/Pages/Sample-Course_9.aspx

[3] Webinar link: http://camh.adobeconnect.com/p3ckexocqg2/

Submitted by:
Nancy Viney, Regional Nursing Lead - Tobacco Reduction

Rare but Risky… Autonomonic Dysreflexia

Northern Health is home to an estimated 200 individuals living with a spinal cord injury (SCI). Autonomic Dysreflexia (AD), is a **potentially life-threatening condition** common in patients with a SCI; up to 90% of people with a cervical or high thoracic SCI develop AD.

Primary Care Physicians play two pivotal roles in the care and management of AD:

1. **Prevention** of AD through education (of the patient and other health care providers) and incorporation of strategies such as appropriate bladder, bowel, and skin care practices, in addition to warnings and management plans in the patient's chart, and
2. **Recognition** and, if necessary, **acute management** of AD.

AD is most often found in people with spinal cord injuries above the T6 level. **The most common symptoms are: increased BP as above; a pounding headache; bradycardia; flushing of the face; profuse sweating above the level of the lesion; goosebumps below the lesion; blurred vision; shortness of breath; anxiety and naso-congestion.**

AD is defined as a sudden 20 to 40 mmHg increase in blood pressure **above the patient's baseline**, in response to a noxious or non-noxious stimulus below the level of SCI. NOTE: resting blood pressure is often low in SCI. **AD can lead to stroke and Cardiovascular Arrest (CVA).** The condition develops when the brain is unable to receive signals of distress from the nervous system, such as a full bladder or bowel, pain or infection. As a result, the body must resort to other methods of sending the information, which can be life-threatening. (See link below: Cragg and Krassioukov 2012)

Conservative management includes removing the noxious stimuli (catheter kinks, constipation, skin breakdown or pressure, tight clothing, ingrown toenails, etc.) which will often resolve symptoms. Monitor their HR and BP every five minutes. If these do not resolve symptoms, medical management is reviewed in Milligan et al. (2012) (See link below).

Primary Care Physician resources for AD:

1. http://www.cmaj.ca/content/184/1/66: Cragg, J. and Krassioukov, A. Five things to know about Autonomic Dysreflexia, CMAJ 2012:, 184, 66.
2. https://abcofad.jibc.ca/resources/references/: An in depth course in AD for primary and emergency care providers, with patient interviews
3. http://www.cfp.ca/content/58/8/831.full.pdf+html Milligan et al. Autonomic dysreflexia: Recognizing a common serious condition in patients with spinal cord injury. Can Fam Physician 2012;58:831-5.
4. http://www.pva.org/atf/cf/%7BCA2A0FFB-6859-4BC1-BC96-6B57F57F0391%7D/Autonomic%20Dysreflexia__24x36_final.pdf Paralyzed Veterans of America's poster on AD

Patient resources:

1. Patient Wallet Card: http://scspinalcord.org/sites/default/files/PDF/AD%20Card%20Personal.pdf

Additional resources:

1. https://www.scireproject.com/: The Spinal Cord Injury Research Evidence (SCIRE) reviews and rates the research on SCI, eliminating the need to search and screen individual databases and allowing health care providers to access acute and rehabilitation evidence and download outcome measures for their practice.

Submitted by:

The Clinical Team at the Rick Hansen Institute 30/Aug/2016

The Rick Hansen Institute is a Canadian-based not-for-profit organization committed to accelerating the translation of discoveries and best practices into improved treatments for people with spinal cord injuries. It does this by leading the collaboration of researchers, health care professionals, individuals with SCI and like-minded organizations across Canada and internationally. To learn more visit www.rickhanseninstitute.org

Rick Hansen Institute
Institut Rick Hansen

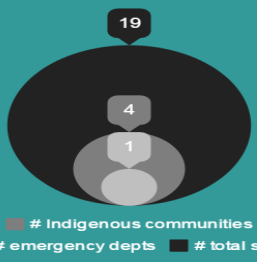
Back issues of *NH Physicians, Partners in Wellness* newsletters and bulletins are located on the NH Physicians website:
http://physicians.northernhealth.ca/physicianResources/PublicHealth.aspx

Overdose Response

Communities with Take Home Naloxone program

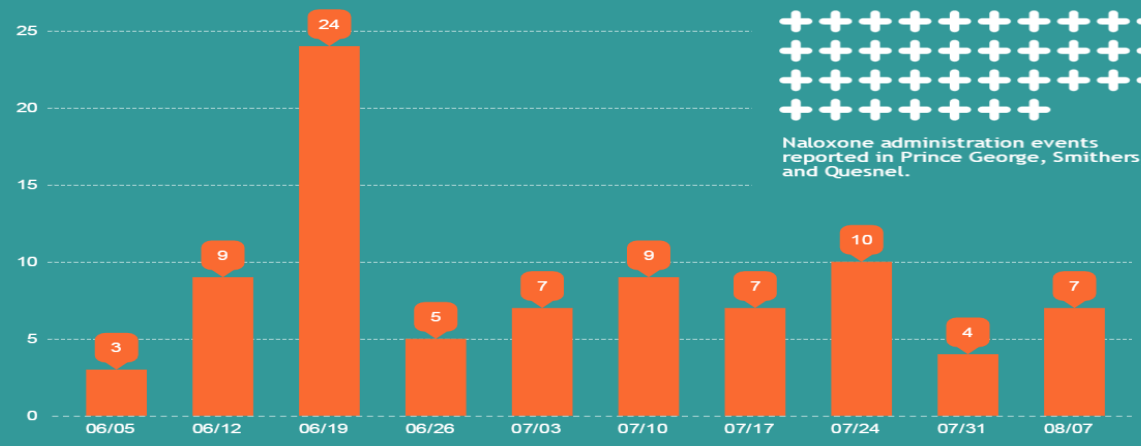
- Northern Health communities with Take Home Naloxone program (Quesnel, Prince George, Fort St. James, Smithers, Terrace, Kitimat, Prince Rupert, Fort St. John)
- Communities that have completed training and can apply for program (Vanderhoof, Burns Lake, Fraser Lake)
- Communities to be trained in fall 2016 (Robson Valley, Dawson Creek, Chetwynd, Tumbler Ridge; additional sites in Fort St. John)
- Take Home Naloxone training will extend to Fort Nelson, Dease Lake, Atlin, Stewart, and Haida Gwaii later in the year.

Number of active Take Home Naloxone sites [1]



Overdose events and response [1]

Suspected opioid overdoses in Northern Health emergency departments (weekly)



Naloxone administration events January 2015 - July 2016 (37)

Naloxone administration events reported in Prince George, Smithers, and Quesnel.

Overdose reporting

% of required daily reports received by Public Health (average across all NH facilities, June 13 - July 31, 2016)

Number of daily reports without identified facility (Aug. 1-14, 2016)

Opioid case report forms filled out properly (Aug. 1-14, 2016)

Forms were considered complete if all sections were completed, or if it was noted that the patient was unable to answer the questions or was still in the ED at the time of the Case Report.
Fields that were incomplete consistently were discharge disposition, discharge diagnosis, and drugs history.

[1] Klassen, D. & Buxton, JA. (2016). Overdose Recognition and Response in the BC Take Home Naloxone Program. Review of data to July 2016. Vancouver, BC. BC Centre for Disease Control.

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Public Health Newsletter for Northern Health Physicians

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Special Issue on Influenza 2016-17 Season

HIGHLIGHTS

Vaccine roll-out:

- Week of **October 24**: first shipments of vaccine to be available for pick-up by community and workplace providers.
- Week of **November 7**: Northern Health community clinics start, provincial campaign launches.
- Order your vaccines now!

Indications for specific influenza vaccines are unchanged since 2015-16, EXCEPT that the intranasal vaccine (FLUMIST®) is **no longer considered superior** to the injectable quadrivalent vaccine (Flulaval Tetra Quadrivalent®) for children aged 2-17. Either vaccine may be given to this group.

Eligibility for free/publicly covered vaccination is the same as 2015-16:

- Seasonal influenza vaccination is covered for people at high risk, their close contacts, and people who live or work in high-risk settings (see p.3).
- One-time polysaccharide pneumococcal vaccine for people 65 or older or otherwise at high risk, plus one booster for certain very high-risk groups (see p.5).

Remember to report to your local health unit:

- influenza vaccine administration to children up to 8 years old, and
- all pneumococcal vaccine administration,
- any adverse events following immunization.

Order forms, reporting forms, and many more resources are available at: https://northernhealth.ca/Professionals/ImmunizationResourcesTools.aspx.

Read on for more details!

Inside this Issue:

2016–17 Seasonal Influenza: What you Need to Know:

Highlights ---------- *p.1*

Immunization Campaign Start Date ---------- *p.2*

Vaccine Ordering, Distribution, Storage ---------- *p.2*

- *Eligibility* ---------- *p.3*
- *Recommended Influenza Vaccine Dosage by Age* ---------- *p.3*
- *Vaccines and Recommended Usage* ---------- *p.4*
- *Egg Allergies/Oculo-Respiratory Syndrome* ---------- *p.5*

Pneumococcal Vaccine ---------- *p.5*

Reporting Requirements

- *Adverse reactions following Immunization* ---------- *p.5*
- *Vaccine Administered* ---------- *p.5*

References ---------- *p.5*

Additional Resources ---------- *p.5-6*

Enterovirus D-68 (EV-D68) circulating in BC ---------- *p.6*

Influenza Control Program Policy for Health Care Workers ---------- *p.6*

Also included:

Community Vaccine Provider Influenza Vaccine Order Form ---------- *p.7-8*

Notable Quotable:

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2016-17 Seasonal Influenza: What You Need to Know

Introduction

The following pages contain information on influenza and pneumococcal vaccines to guide physicians, health care workers, and community vaccine providers on their use during the upcoming influenza season. For more information please see the references and resources at the end of this newsletter.

Immunization Campaign Start Date:

The official provincial campaign launch date for this season's influenza community campaign is **the week of November 7th, 2016**; however we plan on redistributing the vaccine as soon as we have sufficient quantity.

Vaccine Ordering, Distribution, Storage:

The Northeast will not be receiving any Fluviral® - Agriflu® has been ordered in replacement.

Vaccine Ordering:

Physicians and all other community vaccine providers (pharmacists, nurses in First Nation Communities, acute and residential care facilities and Workplace Health & Safety, and others) are requested to fill out the Influenza Vaccine Order form Influenza Vaccine Order Form when ordering Influenza and Pneumococcal vaccine this flu season. Your order for pneumococcal vaccine can be placed at the same time.

Please use the Influenza Vaccine Order Form which can also be found at the following link: https://northernhealth.ca/Professionals/ImmunizationResourcesandTools.aspx

Please fax your order to the local Health Unit at the number identified on the form. After receipt of your vaccine order, influenza vaccines will be available for pick up starting the week October 24th (date dependent on vaccine delivery to local health units). If sufficient supplies arrive earlier, you will be notified of an earlier pick up date. We expect to have a majority of our influenza vaccine by mid-October.

Please note that due to the incremental arrival of vaccines, we may not be able to fill all orders completely at the onset. We will endeavor to ensure fair and equitable distribution to all community partners and fill your complete order in as few installments as possible.

Reminders about Vaccine Distribution and Storage:

- Call the Biological Product Monitor (BPM) at your local health unit to arrange your vaccine order pick up date.
- Agriflu® & Fluad® packaging both require more storage space as it is single dose pre filled syringes. Please bring additional coolers to accommodate the extra storage needs when you pick up your order.
- Keep your biological fridge between 2-8 degrees.
- Notify the local BPM of any cold chain break incidents and report accordingly.
- Return all unused and partially used vials of publically funded vaccines to your BPM. Do not dispose.
- Influenza vaccine can continue to be offered until the Health unit sends out a request for annual influenza vaccine return.

(Continued on page 3)

2016-17 Seasonal Influenza: What You Need to Know

(Continued from page 2)

Eligibility:

Influenza vaccine is recommended for everybody ≥ 6 months of age. It is provided free to:

Demographic Groups (and contacts where applicable)	People with higher risk health conditions (and contacts)	People residing in particular settings (and contacts)	People in higher-risk Jobs/workplaces/other settings (and contacts)
People 65 years and older and their caregivers/ household contacts	Children and adults with chronic health conditions and their household contacts	People of any age in residential care facilities	Health care and other care providers in facilities and community settings who are capable of transmitting influenza disease to those at high risk of influenza complications.
All healthy children 6-59 months of age.	Children and adolescents (6 months to 18 years) with conditions treated for long periods of time with Acetylsalicylic Acid (ASA) and their household contacts	Inmates of provincial correctional institutions	Individuals who provide care or service in potential outbreak settings housing high risk persons (e.g., crew on ships).
Aboriginal people (on and off reserve)	Children & adults who are morbidly obese (adult BMI>40; child BMI assessed as >95th percentile adjusted for age and sex)	Visitors to health care facilities and other patient care locations	People who provide essential community services (first responders, corrections officers)
Household contacts and caregivers of infants and children 0-59 months of age			People who work with live poultry.
Pregnant women at any stage of pregnancy during the influenza season and their household contacts			

Recommended Dosage of Injectable Influenza Vaccine by Age:

Age	Dosage (mL)	No. of doses
6 months to 8 years	0.5 IM	1 or 2[1]
≥ 9 years	0.5 IM	1

[1] Eligible children < 9 years of age receive two doses of vaccine 4 weeks apart ONLY if they are previously unvaccinated or if influenza vaccination history is uncertain. If one or more doses have been received in any preceding season, only one dose will be given.

For children requiring 2 doses within the season, QIIV or TIIV may be given interchangeably with LAIV-Q with either product used for the 1st or 2nd dose if LAIV-Q is not available.

2016-17 Seasonal Influenza: What You Need to Know

Vaccines and Recommended Usage

Five publicly-funded vaccine products will be distributed in Northern Health this influenza season. These products reflect the following World Health Organization recommended composition of influenza virus vaccines for use in the northern hemisphere during the 2016-17 influenza season:

- A/California/7/2009 (H1N1)pdm09 like virus
- A/Hong Kong/4801/2014 (H3N2)-like virus
- B/Phuket/3073/2013-like virus (in quadrivalent vaccines only)
- B/Brisbane/60/2008-like virus

The A/Hong Kong/4801/2014 strain was not contained in the 2015/16 season vaccine; the B/Brisbane/60/2008-like strain was contained in the quadrivalent but not trivalent vaccines in the 2015/16 season.

Vaccine	FLUVIRAL®	FLUAD®	AGRIFLU®	FLUMIST®	Flulaval Tetra Quadrivalent®
Description	Inactivated Split Virion (IM) from GlaxoSmithKline Inc.	Inactivated Subunit (IM) Adjuvanted with MF59C.1 from Novartis	Inactivated Subunit (IM) from Novartis	Live, attenuated (Intranasal) from AstraZenaca	Inactivated Split Virion (IM) from GlaxoSmithKline Inc.
Presentation	10 doses per vial without syringes	Single dose syringe	Single dose syringe	Box with 10 applicators	10 doses per vial without syringes
Client Age Group	Intended for use in eligible individual 18 years of age and older	≥ 65 years	Intended for use in eligible individual 18 years of age and older	2-17 years	Intended for use in eligible children 6 months to 17 years of age
Storage temperature	2-8°C for all products				
Shelf-life, once opened	Multi dose vial Discard after 28 days of first entry	n/a single dose	n/a single dose	n/a single dose	Multi dose vial Discard after 28 days of first entry.
Other considerations	• may be used in children 6 months to 17 years of age if quadrivalent vaccine is unavailable • can be used for those ≥ 65 years of age if Fluad® is not an option	• Preferential for seniors ≥ 65 years • Requires nine times more storage space than the equivalent number of FLUVIRAL® doses	• Preferential for use in individuals with a known hypersensitivity to thimerosal • May be used for pregnant women who request a thimerosal vaccine • May be used for children 6 months to 17 years of age if a quadrivalent influenza vaccine is unavailable • Can be used for those ≥ 65 years of age if Fluad® is not an option • Requires nine times more storage space than the equivalent number of FLUVIRAL® doses	• Egg allergic individuals (including those who have experienced anaphylaxis following egg ingestion) CAN be immunized with inactivated or live attenuated influenza vaccine, • See product monograph for more details on other contraindications	• In the event of vaccine surplus in the providers inventory beyond that is required for those under 18 years old, this vaccine may be provided to those 18 years and older as part of the publicly funded program in BC.
	*contains thimerosal	*contains neomycin and kanamycin	*contains neomycin and kanamycin	*contains gentamicin	*contains thimerosal

Note:

Influenza vaccine is safe and well-tolerated and may be given to persons starting from six months of age (noting-specific age indications and contraindications).

Complete details on these vaccines are available in the BC Centre for Disease Control, Communicable Disease Control Manual, Chapter 2, Immunization Program, Section VII-Biological Products.

2016-17 Seasonal Influenza: What You Need to Know

Egg allergies/Oculo-Respiratory Syndrome (ORS)

Since the 2013/14 influenza season, British Columbia Guidelines have allowed for the immunization of egg allergic individuals with inactivated influenza vaccine. The live intranasal influenza vaccine (Flumist® Quadrivalent) is not contraindicated for egg allergic persons. It can be safely administered to egg allergic individuals, including those who have experienced anaphylaxis following egg ingestion, according to standard practices. This recommendation is supported by recent studies that assessed the safety of LAIV in egg allergic individuals.

For unresolved questions about egg allergies and severe Oculo-Respiratory Syndrome (ORS) you may contact your local health unit or MHO. For more information, please visit BCCDC Safety Issues Applicable to Influenza Vaccines for more details on egg allergies and ORS. Accessed at: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/SectionVII_BiologicalProducts.pdf

Pneumococcal Vaccine

Polysaccharide Pneumococcal Vaccine

Secondary pneumococcal infections add to the morbidity from seasonal influenza viruses. Polysaccharide pneumococcal vaccine is recommended and provided free for:

- adults 65 years of age and older
- residents of extended or intermediate care facilities
- individuals 2 years of age and older with:
  1. ***Anatomic or functional asplenia***
  2. ***Sickle cell disease***
  3. ***Immunosuppression related to disease or therapy***
  4. ***Chronic kidney or liver disease***
  5. ***Hematopoietic stem cell transplant (HSCT) recipients***
  6. *Solid organ or islet cell* transplant or cochlear implant (candidate or recipient)
  7. Diabetes
  8. Alcoholism/drug abuse problem
  9. Cystic fibrosis
  10. Chronic CSF leak
  11. Homelessness
  12. Chronic heart or lung disease

We encourage family physicians to identify patients who are eligible for pneumococcal vaccine, and administer pneumococcal vaccine if not already done.

Revaccination with pneumococcal vaccine is not routinely recommended. However, a **ONE TIME ONLY** booster dose of vaccine is recommended for people with one of the first five medical conditions listed above. This booster should be given five years after the first dose (with the exception of the HSCT recipients, who's post-transplant vaccination schedule is quite complex and is based on BC Centre for Disease Control Immunization for special populations guidelines).

Pneumococcal vaccine can be given at the same time as the seasonal influenza vaccine, using separate syringes/needles at separate sites.

Reporting Requirements

Adverse Reactions following Immunization (AEFI):

All significant and unexpected adverse events following immunization with any vaccine product are to be reported to the local health unit. Medical Health Officer recommendations for future immunizations will be sent to the immunizer.

The reporting form for AEFIs is available at: http://www.bccdc.ca/health-professionals/professional-resources/surveillance-forms

For more information on Adverse Events following immunization please visit http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/SectionIX_AdverseEventsFollowingImmunization.pdf

Reporting of Vaccine Administered

Community vaccine providers are required to report the following vaccines administered:

- All clients receiving the pneumococcal vaccine
- Children 8 years and younger who receive the influenza vaccine

This ensures Public Health records are up to date and avoids unnecessary doses of vaccine.

The Immunization Influenza Vaccine and Pneumococcal reporting form can be found at: https://northernhealth.ca/Professionals/ImmunizationResourcesandTools.aspx

References

1. BCCCDC Communicable Disease Guidelines at http://www.bccdc.ca/dis-cond/comm-manual/CDManualChap2.htm
2. Recommended composition of influenza virus vaccines for use in the 2015-2016 northern hemisphere influenza season: WHO | Recommended composition of influenza virus vaccines for use in the 2016-2017 northern hemisphere influenza season
3. FluWatch: http://www.phac-aspc.gc.ca/fluwatch/

Additional Resources

1. Northern Health Influenza information is available at: https://northernhealth.ca/YourHealth/PublicHealth/InfluenzaInformation.aspx
2. The National Advisory Committee on Immunization (NACI) "Statement on Seasonal Influenza vaccine for 2016-2017 available at http://www.phac-aspc.gc.ca/naci-ccni/index-eng.php
3. HealthLinkBC - Health Files: http://www.healthlinkbc.ca/servicesresources/healthlinkbcfiles/ or
   - Facts about Influenza (The Flu) (12b)
   - Inactivated Influenza Vaccine (12d)
   - Influenza (Flu) Immunization: Myths and Facts (12c)
   - Pneumococcal Polysaccharide Vaccine (62b)
   - Influenza (Flu) Season

(Continued on page 6)

2016-17 Seasonal Influenza: What You Need to Know

(Continued from page 5)

4. Immunize BC website at: http://www.immunizebc.ca/
5. BCCDC Immunization Manual: Section VII-Biological Products at: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/SectionVII_BiologicalProducts.pdf
6. BCCDC Immunization & Vaccines for Health Professionals at: http://www.bccdc.ca/health-professionals
7. Influenza Education BCCDC Influenza Courses. BCCDC Foundations of Influenza: Diseases and Vaccinations & Seasonal Influenza Update 2015/2016 please visit: BCCDC Influenza Courses. BCCDC Foundations of Influenza: Diseases and Vaccinations & Seasonal Influenza Update 2016/2017 please visit: Immunization Courses at http://www.bccdc.ca/health-professionals/education-development/immunization-courses

Submitted by:
Dr. Andrew Gray
Medical Health Officer
Northern Interior HSDA

Jill Walker
Interim Regional Manager
Communicable Disease Program

Enterovirus D-68 (EV-D68) Circulating in BC

Enterovirus D-68 (EV-D68) is circulating again in BC. So far, only one case has been detected in northern BC, but more can be expected during the fall season. Like most respiratory viruses, EV-D68 usually causes only mild respiratory disease, but may occasionally cause severe respiratory disease, particularly among children with asthma. It is preventable through routine infection control practices, including hand and respiratory hygiene.

Unlike most respiratory viruses, EV-D68 is suspected to cause **acute focal muscle weakness, flaccid paralysis,** or other neurological complications (similar to polio), in a small number of children. EV-D68 infection may be diagnosed by specific testing of respiratory specimens (nasopharyngeal/throat), stool, or CSF, which should be tested as clinically indicated. Please report to your local public health unit any cases of acute neurological illness possibly associated with EV-D68.

For more information, please see: http://www.bccdc.ca/health-info/diseases-conditions/enterovirus-d68

Submitted by: Dr. Andrew Gray MHO, NI HSDA
**adapted from Vancouver Coastal Health Physicians' Update*

Influenza Control Program for Health Care Workers

The Ministry of Health has confirmed the Influenza Prevention policy will be implemented throughout BC health care organizations this fall. Northern Health, together with all other health authorities, is in the process of implementing this policy for the 2016/17 flu season.

The Influenza Prevention policy requires all employees, physicians, students, volunteers, contractors, and visitors to be vaccinated annually against influenza or wear a procedure mask at all times when in patient care areas during the Policy Application Period, which begins this December.

During a declared influenza outbreak, the Influenza Prevention Policy is suspended and Northern Health's "Influenza Exclusion Criteria (Suspected and/or Confirmed Outbreak)" Policy is activated.

Physicians have access to influenza immunization from the following sources:

1. Workplace Health & Safety flu clinics: These dedicated flu clinics will be available at most Northern Health facilities during a four week period, beginning October 24th. Clinic schedules will be posted shortly on the OurNH Flu Page. (Clinics usually occur during business hours on weekdays).
2. Peer Nurse Immunizers (PNIs): PNIs will be available in a variety of sites and departments throughout Northern Health. They immunize within their departments, when they have time between regular duties. They may be available on evenings and weekends.
3. Public Health/Primary Care Nurses: Physicians may choose to access public flu clinics. Schedules for these clinics will be distributed by each community's Health Unit.
4. Participating pharmacies and physician's offices: Physicians may choose to receive their influenza immunization at participating pharmacies, or from a colleague.

Please note that in all cases, physicians are eligible for FREE influenza immunization, as per the criteria set out by the BC Center for Disease Control.

This year, physicians are encouraged to self-report their immunization, or their decision to mask while working within Northern Health facilities, at the following address: https://medicalstaffhealth.phsa.ca/.

Working collaboratively with MHOs and physicians is an important part of Northern Health's flu campaign and physicians' support is an important factor for success. If you have any questions regarding the flu campaign, please email: influenza@northernhealth.ca and we will be happy to connect with you. There will be further information provided as the flu campaign progresses.

Submitted by:
Courtenay Kelliher Occupational Health Nurse & Safety Advisor
Workplace Health & Safety

2016-17 Seasonal Influenza: What You Need to Know

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Community Vaccine Provider
Influenza Vaccine Order Form

Name of pharmacy/clinic/facility/other: _____

Contact person: _____ Date of order: _____

Address: _____ Phone #: _____ Fax #: _____

Vaccine		Doses requested	Doses remaining in fridge	Health Unit use only		
				Doses supplied	Date	Panorama req #
Pneumococcal polysaccharide						
See back of page for indications by age group	Flumist® (Unable to provide to pharmacists)					
	Fluad®					
	Agriflu®					
	Fluviral®					
	Flulaval®					

Community provider/designate: _____ Sign upon receiving biologicals **Pick-up date:** _____ **Health Unit staff signature:** _____

Community provider/designate: _____ Sign upon receiving biologicals **Pick-up date:** _____ **Health Unit staff signature:** _____

Community provider/designate: _____ Sign upon receiving biologicals **Pick-up date:** _____ **Health Unit staff signature:** _____

Health Unit will keep a copy of the order form.

Northwest	Northern Interior	Northeast
Atlin Health Centre T: 250-651-7677 F: 250-651-7687	**Burns Lake** T: 250-692-2460 F: 250-692-2469	**Chetwynd** T: 250-788-7300 F: 250-788-9877
Dease Lake T: 250-771-4444 F: 250-771-3911	**Fraser Lake** T: 250-699-8960 F: 250-699-6292	**Dawson Creek** T: 250-719-6500 F: 250-719-6513
Hazelton T: 250-842-4640 F: 250-842-4642	**Fort St. James** T: 250-996-7178 F: 250-996-2216	**Fort Nelson** T: 250-774-7092 F: 250-774-7096
Houston T: 250-845-2294 F: 250-845-7884	**Mackenzie** T: 250-997-8517 F: 250-997-3253	**Fort St John** T: 250-263-6000 F: 250-263-6086
Kitimat T: 250-632-3181 F: 250-632-7081	**McBride** T: 250-569-2251 ext 2026 F: 250-569-2232	**Hudson's Hope** T: 250-263-6000 F: 250-263-6086
Masset T: 250-626-4727 F: 250-626-5279	**Prince George** T: 250-565-7367 F: 250-565-7377	**Tumbler Ridge** T: 250-242-5271 F: 250-242-3889
Prince Rupert T: 250-622-6380 F: 250-622-6391	**Quesnel** T: 250-991-7571 F: 250-991-7577	
Queen Charlotte City T: 250-559-2350 F: 250-559-8525	**Valemount** T: 250-566-9138 ext 4228 F: 250-566-9756	
Sandspit T: 250-637-5403 F: 250-637-2496	**Vanderhoof** T: 250-567-6900 F: 250-567-6170	
Smithers T: 250-847-6400 F: 250-847-5908		
Stewart T: 250-636-2221 F: 250-636-2715		
Terrace T: 250-631-4200 F: 250-638-2264		

10-400-7012 (LC - Rev. - 09/16)

2016-17 Seasonal Influenza: What You Need to Know

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Community Vaccine Provider
Influenza Vaccine Order Form

Orders will be filled based upon:
- Vaccine shipments from BCCDC over a period of 3 to 4 weeks
- Historic dosage reporting
- Availability

Note: Depending on the local health unit's inventory, specific brands may not be available and an interchangeable product may be supplied.

Instructions for Community Vaccine Provider (CVP)
- Using this form, submit your order by **FAX** to your community Health Unit.
- Please keep a copy for your records
- The CVP or designate is required to sign for receipt of the influenza vaccine upon pick-up at the Health Unit.
- If only partial doses are supplied, the Health Unit Biological Product Monitor will contact CVP when remaining doses are available.
- If the remaining doses are declined by the CVP, the order is considered as complete.
- The CVP will need to submit a new order for subsequent orders.

Instructions for the Health Unit Biological Product Monitor/Designate

To fill the CVP's complete/partial order:
- Record the number of doses in the "doses supplied" column
- Record the date the vaccine is packaged and available for pick-up in the date column
- Record the Panorama Requisition Number
- Contact CVP for pick-up
- The health unit staff is required to sign when order is picked up

When vaccine doses are available to complete the partial order:
- Follow the steps above and document in the second row of the order
- If the CVP declines the remaining doses in the order, document 'declined' and the declined date in the applicable column. The order is considered as complete and the CVP will need to submit another order if further doses are requested.

Influenza vaccine accountability
- Publicly funded influenza vaccine must be accounted for. Return expired/unused vaccine back to the local Health Unit when requested.
- The Publicly Funded Influenza Vaccine Tally form is available on the Northern Health website.

Cold chain

Always maintain the cold chain (2° to 8°C) and contact the health unit immediately if you experience cold chain problems.

Age group	Vaccine (quadrivalent)	Comments
6 to 23 months	• Flulaval®	• For children 6 to 23 months, Flulaval® is the recommended product. If unavailable, Fluviral® or Agriflu® should be used.
2 to 17 years	• Flumist® • Flulaval®	• For children 2 to 17 years, Flumist® is the recommended product. If unavailable or contraindicated, Fluviral® or Agriflu® should be used.
18 to 64 years	• Fluviral® • Agriflu®	• Agriflu® may be used for individuals with a known thimerosal hypersensitivity or pregnant women who request a thimerosal-free vaccine.
65 years or older	• Fluad® • Fluviral® • Agriflu®	• Fluad® is approved for use only i n those 65 years and older and is used variably at the health authority level. Use the product as outlined in guidance from your regional health authority. • Fluviral® and Agriflu® are also intended for use in those 65 years and age and older. This is particularly so in Island and Interior Health Authorities.

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Practitioner Alert:
Increased Syphilis rates in BC

The rate of infectious syphilis in BC increased significantly from 11.9 per 100,000 in 2014, to 16.2 per 100,000 in 2015. Like many jurisdictions, BC has observed an increase in infectious syphilis rates since 2010. However, this recent increase was much greater than previous year-to-year increases.

- In 2015, there were 761 infectious syphilis cases – nearly 40% higher than 2014
- 80% of infectious syphilis cases were among gay, bisexual, and other men who have sex with men (MSM)
- About half of infectious syphilis cases among MSM were in HIV-positive individuals
- Though increases were seen across all age groups, the rate of increase was greatest among young men (i.e. 20-29 years).
- While there is a concern that this increase may lead to cases of congenital syphilis, only one congenital syphilis has been reported since 2010.

Pertinent facts about syphilis

- Syphilis is caused by the spirochete bacterium *Treponema pallidum*.
- Syphilis is transmitted sexually. Condoms *may* reduce the risk of transmission, but do not offer complete protection.
- The classic presentation of syphilis is a painless ulcer (primary stage) or generalized maculopapular rash and lymphadenopathy (secondary stage). Left untreated, it may also progress to tertiary syphilis, where involvement of the major organs may occur (e.g. heart, aorta, bones, joints, brain).
- Syphilis – even in its early stages – can also manifest in more complicated and serious ways, such as neurosyphilis or ocular syphilis. These more serious sequelae are more commonly seen in those who are HIV-positive.

Testing and treatment

- Syphilis testing is done via serology, or if available, via direct examination (e.g. darkfield microscopy) or nucleic acid amplification testing (i.e. PCR) of swabs taken from a lesion.
- Syphilis is curable with benzathine penicillin G (Bicillin) given intramuscularly.
- Serial serology (q3 months) is typically recommended after treatment to assess response

Populations of interest

While all sexually active individuals are at risk for syphilis, some populations are at increased risk for syphilis infection and re-infection and/or increased risk of morbidity due to syphilis.

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Notable Quotable:

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Syphilis Update, Cont'd.

(Continued from page 1)

These are:

- **Gay, bisexual, and other men who have sex with men (MSM)**: Increased risk for infection/re-infection
  - *Recommend STI screening every 3 months*
- **People living with HIV:** Increased risk for serious syphilis-related complications, and concomitant syphilis infection may contribute to onward HIV transmission
  - *Recommend STI screening every 3 months*
- **Prenatal patients and women of childbearing age:** Risk of vertical transmission and congenital syphilis
  - For *prenatal* patients, *routine screening in the first trimester is recommended*;
  - If *there* is *ongoing risk during pregnancy, repeat testing may be warranted* (i.e. third trimester screening and at delivery)
  - *All women should have at least one syphilis test documented prior to discharge after delivery*
- **Individuals with multiple sex partners**
  - *Recommend screening every 3 months.*

What is BCCDC doing about this?
The BCCDC, along with our partners within the regional health authorities as well as Perinatal Services BC, have developed an action plan to respond to this provincial increase in syphilis cases, in collaboration with clinicians, community-based organizations, laboratory personnel, and other key stakeholders. This plan is a long-term strategy with the aim to prevent and control syphilis, especially among key populations. Included in this plan are:

- The development of a provincial awareness campaign to be rolled out in mid- to late 2016
- The addition of resources to our nursing, physician and administrative staff effective December 2015.
- The development of several research projects examining the drivers of the epidemic and exploration of novel strategies to prevent syphilis infection (i.e. doxycycline pre-exposure prophylaxis). Already, these projects have received funding from the Vancouver Foundation and the BCCDC Foundation, and other peer-reviewed grant submissions have been completed.

If there are any questions surrounding the testing or treatment of syphilis, or other clinically-related questions, please call the **BCCDC STI Physician at 604-707-5610**. If you have questions about, or require assistance with partner notification or management, need information on a patient's previous syphilis treatments, or would like to order syphilis treatment, call the BCCDC Syphilis Nursing Team at 604-707-5607.

Source: Troy Grennan, MD MSc FRCPC DTM&H
Physician Lead, HIV/STI Program, Clinical Prevention Services
BC Centre for Disease Control

Antimicrobials—Handle with Care:
A note from the Antimicrobial Stewardship Program

Prospective audit and feedback of targeted antimicrobials is currently occurring at UHNBC. This process involves assessment of patient's on antimicrobial therapy evaluated against approved guidelines to ensure the optimal use of drug therapy. This strategy is employed after the drug has been initiated and the current goal at UHNBC is to assess within 48 - 72 hrs. Antimicrobials currently being targeted for review include:

Piperacillin-tazobactam	Cefuroxime IV	Metronidazole IV
Imipenem	Daptomycin	Clindamycin IV
Meropenem	Micafungin	Co-trimoxazole IV
Vancomycin	Linezolid IV & PO	Fluconazole IV
Ceftriaxone/ Cefotaxime	Tobramycin/ Gentamicin	Acyclovir IV
Ceftazidime	Ciprofloxacin IV	Ganciclovir IV
	Moxifloxacin IV	Oseltamivir

The Antimicrobial Stewardship lead pharmacist as well as other clinical pharmacists will be performing these reviews. As prescribers you can expect to be contacted or see chart notes regarding optimization of their antimicrobial therapy including changing of agents based on suspected infection or sensitivities, route of administration and duration of therapy. Physicians are also welcome to contact the AMS pharmacist or clinical pharmacist for advice regarding antimicrobial therapies.

For patients outside of UHNBC, site pharmacists and or physicians are able to contact the AMS lead pharmacist for assistance with reviewing patients on targeted antimicrobials.

For more information about Northern Health's Antimicrobial Stewardship program, contact Alicia Ridgewell the program coordinator/ lead pharmacist at 250-565-5956 or via email: alicia.ridgewell@northernhealth.ca

Submitted by:
Alicia Ridgewell
Antimicrobial Stewardship Program

North Coast First Nations video for health care providers

The North Coast Aboriginal Health Improvement Committee is pleased to launch a new video titled: Honouring Our Journey: https://www.youtube.com/watch?feature=player_embedded&v=IGc2gCU15Yg *(if you cannot open this link, please paste the link into Google Chrome).*

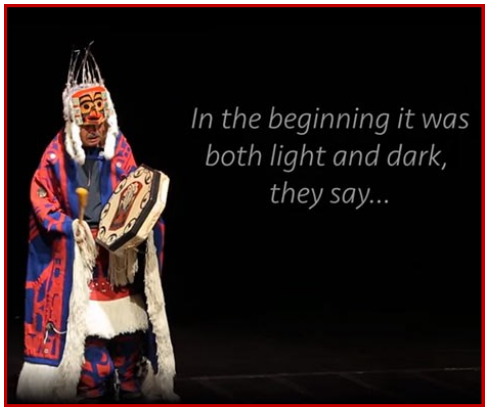
This 25 minute video provides information for health care providers about the Haida and Tsimshian Nations' culture and history, and how these impact their health care needs. "*If doctors and nurses come with an open mind and are genuine, lots will be returned to them as our people are kind and generous*," says Elizabeth Moore, an Elder in Old Masset.

In 2014-2015, Aboriginal Health provided financial support to each of the nine AHICs in the north to develop local cultural resources. These resources were guided by the question, "*If I were a new health care practitioner in your community, what would you want me to know*?"

In the video, Lauren Brown, the Health Director in Skidegate, encourages health care providers to consider "*the whole person, including their beliefs and traditions*." Cindy Ignas, the Health Director in Kitkatla advises,"*You have to really listen and be very careful to not make any judgements and to understand the cultural lens that you bring as a non-First Nations person … step back from your biases, assumptions, and judgements and try to really learn, be curious and ask lots of questions*."

This impactful video covers important and relevant topics such as:

- the present day impacts of Residential School experiences on health care interactions,
- the current role of traditional medicines and the importance of health care providers asking about their use to prevent possible negative interactions with prescribed medications,
- the importance of using plain language, including family and or translators in the appointment,
- and learning about the gathering and use of traditional foods in health and well-being.



This video is a beautiful gift from the North Coast First Nations in hopes that we all are inspired to continue our learning journeys towards a culturally safe health care system for all First Nations and Aboriginal people.

Another way to develop your understanding of First Nations and Aboriginal peoples is the San'yas Indigenous Cultural Safety Training offered by the Provincial Health Services Authority: http://www.sanyas.ca/.

This unique facilitated on-line course is designed to increase knowledge, enhance self-awareness and build on individual competencies leading to better access to services and health outcomes for Aboriginal people. The course takes 8-10 hours of learning over an 8-week period. Physicians can register without charge using an Northern Health email or physicians who practice in rural communities can register at: https://phsa.culturalcompetency.ca/register/phsa with the Rural Education Action Plan (REAP): http://www.sanyas.ca/training/british-columbia/rural-education-action-plan-reap) for reimbursement: http://www.sanyas.ca/training/british-columbia/rural-education-action-plan-reap. As a Northern Health physician, you can take it for free by signing in with your Northern Health email address.

For a summary of other cultural resources developed by First Nations in northern BC, check out this booklet from Aboriginal Health: https://northernhealth.ca/Portals/0/Your_Health/Programs/Aboriginal_Health/documents/Cultural_Resources_Booklet_web.pdf)

This article was first published on the NH Blog on February 11, 2016: https://blog.northernhealth.ca/health-care-services/a-video-from-north-coast-first-nations-for-health-care-providers/.

Submitted by: Hilary McGregor
Lead, Knowledge Translation & Community Engagement, Aboriginal Health 250-649-4812

Travel Health Advice

Vancouver Coastal Health Travel Clinic Services provide consultation to nurses and physicians that provide travel health advice to their clients. The challenges of rural clinicians is recognized and further supports are available to rural clinicians by completing the registration form.

At this time, only a paper registration form is available, attached, once the registration is submitted, you will gain access to the online policy manual and ability to access email consultations with Dr. Suni Boraston, the Travel Medicine Consultant at Vancouver Coastal Health. For more information, contact Eliza.Wong@vch.ca

Source: Eliza Wong
Project Coordinator, Travel Clinic
Vancouver Coastal Health

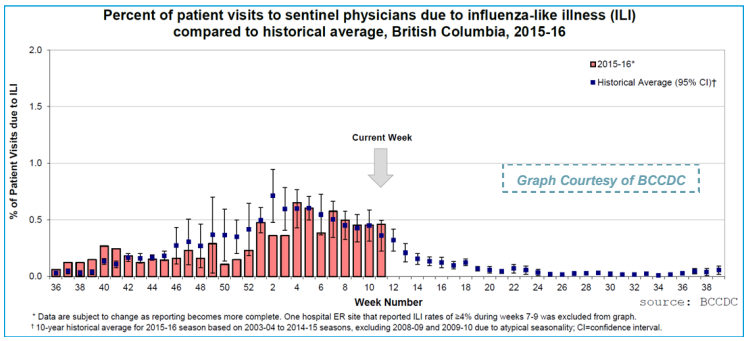
Late Spike in Influenza

Influenza activity is still high in northern BC; with Influenza A(H1N1) pdm09 being the predominant strain. Please keep influenza on your differential diagnosis and consider prompt (within 48 hours of symptom onset) administration of olseltamivir in high risk patients who present with influenza like illness (ILI). This year's flu shot is protective against Influenza H1N1 - given the late spike this season, the flu vaccine is still recommended for primary prevention of influenza.

Resources:

- AMMI Guidelines: https://www.ammi.ca/guidelines/

Submitted by:
Dr. Raina Fumerton, NW MHO and Acting MHO, NI HSDA



In week 11, 368 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 104 (28%) tested positive for influenza, including 72 (69%) with influenza A [53 A (H1N1)pdm09, 2 A(H3N2), and 17 subtype pending] and 32 (31%) with influenza B. Influenza positivity continued a decreasing trend from a peak of 45% in week 6 to 28% in week 11. Since week 9, influenza A(H1N1)pdm09 has been the predominant circulating influenza virus detected at the BCCDC PHL, comprising about 60% of influenza detections with known type/subtype in week 11. Respiratory syncytial viruses (RSV) and rhino/enteroviruses were also commonly detected during this period.

Cumulatively since week 40 (starting October 4, 2015), 1850 (27%) patients have tested positive for influenza at the BCCDC PHL, including 980 (53%) with influenza A [686 A(H1N1)pdm09, 273 A (H3N2), and 21 subtype pending], 866 (47%) with influenza B, and four adult patients with influenza A and B co-infections. The 2015-16 season to date has been characterized by mixed circulation of influenza A and B viruses, with A(H1N1) pdm09 subtype viruses predominating over A(H3N2) subtype viruses since week 2 among influenza A detections and B/ Victoria lineage viruses predominating over B/Yamagata lineage viruses among influenza B detections.

So far this season (cumulatively since week 40), just over one-half (52%) of influenza detections have been in non-elderly, working-aged adults 20-64 years, with a smaller proportion of detections in children <20 years (27%) and elderly adults ≥65 years (21%). However, this age distribution differs by influenza type/ subtype: adults 20-64 years, and to a lesser extent children <20 years, comprise a larger proportion of A(H1N1) pdm09 and influenza B cases, while elderly adults ≥65 years comprise a larger

Source: **BC Centre for Disease Control** Influenza Surveillance Reports: Report No. 16, March 13-19, 2016 *(week 11)*

Deactivation of Ebola Public Health follow-up

for returning travellers

At the last Provincial Ebola Task Force Meeting, we identified that Sierra Leone, Liberia and Guinea have all moved to a period of heightened surveillance for Ebola Virus Disease, with no sustained human to human transmission occurring. As a result of this, the Order in Council requirement for enhanced border measures has been repealed, and all public health follow up of travelers has ceased.

As a result of this, we are deactivating the Ebola Preparedness Task Force, and working to develop a sustainable structure for the health system to ensure ongoing preparedness work for new or novel pathogens is in place.

We are asking that you please ensure this message is communicated to your colleagues in the health system. While asking about travel to West Africa is no longer necessary given the diminishing threat of Ebola, assessing travel history continues to be important given other communicable diseases (such as Middle Eastern Respiratory Syndrome and Zika) continue to arise globally and can impact British Columbia.

We thank all people involved in the Ebola Preparedness work over the past 18 months for the significant work and time associated with ensuring British Columbians are protected from Ebola Virus Disease.
Thank you,

P.R.W. Kendall
Co-Chair, Provincial Ebola Task Force and Provincial Health Officer
Office of the Provincial Health Officer
Ministry of Health
and
Lynn Stevenson
Co-Chair, Provincial Ebola Task Force and Associate Deputy Minister, Health Services

Travel Clinic – Vancouver Coastal Health
L-5, 601 West Broadway
Vancouver, BC. V5Z 4C2
T: (604) 736-9244 F: (604) 736-3917
http://travelclinic.vch.ca

The Centre of Excellence in Travel Medicine for British Columbia (CofE)

Registration Form

Please complete this form if you are a nurse working in a Public Health travel clinic within British Columbia and would like access to the services of the CofE.

Name of Public Health Travel Clinic

Address of Clinic

City	Postal Code

Phone # Fax #

Names of nurses/doctors accessing the CofE web site

Last Name	*First Name*	*E-mail Address*

Main Contact to the CofE

Last Name	*First Name*	*E-mail Address*

Are you a Yellow Fever licensed centre? Yes ☐ No ☐

Who provides Malaria Prescriptions?

Approximately how many hours of travel clinics do you hold per week? ☐

Signature

Print Name:

**Note: Please print and fill this form out in full out by hand, then scan and email to eliza.wong@vch.ca*