

Physicians' Newsletter



Leeds, Grenville & Lanark District

HEALTH UNIT

From the
Medical Officer
of Health

Mar. 2004 - June. 2004

Report on the Year 2003 by the Medical Officer of Health

Taken from a speech made on January 15, 2004 at the Annual General Meeting of the Board of Health, by Dr. Charles Gardner, Medical Officer of Health

The new millennium has been most eventful for those of us in public health, and certainly the year 2003 was no exception. Beginning with the Walkerton water disaster in 2000 we have witnessed a series of emerging, high profile public health issues that have given us plenty of opportunity to prove our metal; issues such as the anthrax scares following the 9/11 disaster, West Nile virus, and in the spring of last year SARS. In addition there have been in varying locations throughout the province meningitis outbreaks, high-profile meat recalls, large-scale hepatitis A exposures from food retailers, and this winter influenza outbreaks.

These crises have served to raise the profile of public health – to remind people that public health is all about taking care of the basics, and that the basics will always be critically important. From SARS we learned that the world is indeed small and that the spread of new diseases is only an international flight away. The incubation time for most communicable diseases is longer than the time required to fly anywhere in the world; thus the hospital emergency department has become the frontier for the detection of new diseases, and basic infection control is our protective shield. SARS was not beaten by high-tech medications or sophisticated diagnostic imagery but by the tried and true, old fashioned public health methods of case and contact identification, isolation and quarantine - and the prevention of future incidents of SARS-like diseases will require stronger ties and effective collaboration between public health and health care facilities.

As the health unit for Leeds, Grenville and Lanark we have prided ourselves on our broad, long-range approach to planning. Thus we have maintained an active strategic plan to keep us focused on our mandate, and long range multiyear resource plans to better ensure that we have the resources and the capacity to respond. Since 2001 we have had a pandemic influenza plan to prepare us and the health care facilities of our district for large scale infectious disease outbreaks. This helped us to work well together when SARS arrived in the province. Thus by being prepared we were in a position to provide other health units and the province with assistance during SARS.

The public is presently focused on the need for protection from communicable diseases – and this is warranted given the inherent potential for disease spread if these are not managed well. However the major burden of illness on our society is from chronic diseases such as heart disease, and cancer, and from preventable injuries. Our mandate as the health unit for Leeds Grenville and Lanark is to “work with the community to protect, promote and enhance health through the identification of issues and the development of quality preventative health programs and services”. Thus we must be ever mindful of the broad determinants of health – to step back periodically to see beyond the crises of the moment to better anticipate the issues to come and to ensure that we address the other health needs of our communities.

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These broad determinants of health include:

- our lifestyles - physical activity, diet, substance use, physical and sexual risk-taking,
- our socioeconomic environments - education, income, occupation, and social supports,
- our childhood experience - love, nurturing, stimulation, positive parenting and the sufficiency of physical resources,
- our physical environments - the safety of our food, water, air, disease vector organisms and climate conditions
- and our health care services –vaccines, health condition screening, infection control and communicable disease response

In 2003 we had notable successes on these fronts, as well as challenges. With regard to West Nile virus (WNV) we continued to work with our WNV Stakeholders Advisory Committee to do public education and surveillance, and we conducted mosquito larviciding in keeping with legislation changes passed by the province in May. We also continued our work with municipalities to develop smoke-free bylaws, with a number of municipalities choosing to enhance their legislation; most notably Brockville should be commended on this front and is now on the provincial “Go for the Gold” map as having a silver-level bylaw coming into full force this summer. In the throne speech late in the year the province pledged to create smoke-free provincial legislation within three years. We will work with the Association of Local Public Health Agencies to encourage the province to fulfill this promise.

With regard to child health we have continued to work hard to ensure good public health programming, including the Healthy Babies Healthy Children program. It takes a village to raise a child, and so we work in partnership with many other agencies to improve conditions for our children. And it is with this in mind that we have invited our guest speaker for today, namely Dr. Fraser Mustard the founding president of the Canadian Institute for Advanced Research, to provide us with insights.

Socioeconomics (our education, income and occupation) is the most potent determinant of health. It is also inherently the most challenging to address, requiring efforts from the entire community. We supported the work of the Lanark Leeds and Grenville Health Forum in its efforts to document, educate and advocate on poverty issues in our district. Unfortunately this group had to suspend its activities last fall due to a lack of

funding. The South Eastern Ontario District Health Council has shown an interest in taking up these issues in its review of primary care needs. We will continue to pursue opportunities to address socioeconomic issues.

The Board of Health has demonstrated forward thinking by pursuing the fulfillment of a long range resource plan since 1999. This has allowed us to increase our staffing level to better meet the program requirements of the Ministry of Health and Long-Term Care. Of course there have been challenges along the way including difficulties in filling Public Health Inspector positions due to a provincial shortage of trained personnel. Such shortages, as well as the increased work responding to the emerging public health issues that could not have been foreseen in 1999 with our long range resource planning, have made it difficult to meet the requirements of the Mandatory Core Programs. The provincial auditor’s report raised concerns regarding food safety and the adequacy of resources for health units to fulfill their programs – concerns that were reviewed on a local level in our media in December. The Naylor and the Walker reports on SARS also have included recommendations for substantial increases in public health resources.

Work in public health is never easy – it is in fact a calling. As such, work on the Board of Health is also a calling. At this, the Annual General Meeting of the Board of Health we have a new Board, with five new members. To those of the Board who have just left us, I thank you for the challenging public service that you have provided. In particular, if I may, I would like to thank Bill Widenmaier for serving as the Board Chair for the past four years. The chair is frequently called upon to attend numerous additional meetings, and to speak publicly on difficult and contentious health issues. Bill did this well, and with wit and wisdom. His support has been very much appreciated and will not be soon forgotten.

To the new members of the Board I bid you welcome and I thank you for your willingness to take on the mantle of public health. As you know we are presently at a crossroads with regard to our resource base. We have communicated publicly and thoroughly over the years on this, including with our long range planning needs report last June and with further reports to the Board in the fall. Very soon you will be called upon to make tough decisions that will affect how well we can continue to protect, promote and enhance the health of our citizens.

The health of the public has always been determined by the actions of all its members. Thus I commend the excellent work and the dedication of our staff, in collaboration with our community partners. I would like to close as I always do on these occasions by saying that I look forward to working with all of you in the year 2004, with all its anticipated and unforeseen challenges and opportunities. Thank you.

Conducting Cold Chain Inspections

Submitted by Dr. Charles Gardner and by Jane Futcher, Director of Clinical Services

Over the past three years the Leeds, Grenville & Lanark District Health Unit has not consistently carried out the cold chain inspections of physicians' offices and other premises storing publicly funded vaccine. The importance of these inspections was highlighted in November 2003, when a hospital in Toronto was required to recall several thousand clients who had received Td vaccine in the previous year. The temperature log of the emergency department's vaccine fridge had not been kept up to date, thus there was no way to verify that the vaccine had NOT undergone a break in the cold chain. The local Medical Officer of Health decided that it was necessary to revaccinate these patients.

We are now facing a global shortage of the polysaccharide pneumococcal vaccine. Ontario has a limited quantity remaining and the next shipment of vaccine is expected in July 2004. We have to ensure that the supply of vaccine, currently distributed to physicians' offices is being stored according to the Ministry of Health *Vaccine Storage and Handling Protocol (January 1, 1998)*. We are asking for your help in maintaining the integrity of the vaccine supply in the tri-county.

We have inspected nearly all the vaccine fridges in facilities and physicians' offices over the last several months and have found that the recording of min-max temperatures has not been consistent. The power failure in August 2003, also illustrated the need to have well documented records and well maintained refrigerators.

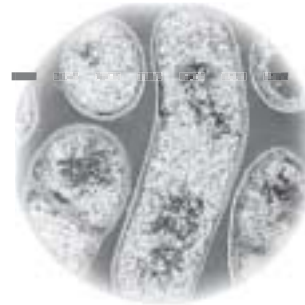
The Mandatory Health Programs and Services Guidelines (December 1997), states that

the Board of Health shall ensure that provincially-funded vaccines are available to physicians practicing within the health unit and that the Board of Health shall optimize vaccine use by ensuring cold chain maintenance in premises where vaccine is stored by inspecting at least once annually, all such premises for adherence to the minimum requirements.

Inspections will be carried out on a random basis over the next year. Public Health Inspectors have the mandate from the Medical officer of Health to enter premises where publicly funded vaccines are stored to conduct the required cold chain inspections.

The Leeds, Grenville and Lanark Health Unit relies on the physicians in the tri-county to ensure the safety and efficacy of the government funded vaccines and we thank you for your vigilance in this matter.

If you have any question, do not hesitate to call Dr. Gardner or Jane Futcher, Director of Clinical Services at 345-5685 or 1-800-660- 5853



Laboratory Diagnostic Tests For Botulism Now Performed In Ottawa

Submitted by Joan Mays, Public Health Inspector

As of October 1, 2003 the laboratory diagnosis of Clostridium Botulinum will be performed at the Botulism Reference Service for Canada in Ottawa. Previously, the Central Public Health Laboratory in Toronto performed Botulism testing.

There is a new updated Botulism Fact Sheet which can be accessed through our internet site www.healthunit.org or by calling the Health Unit and speaking with the Health Protection Department. Accompanying the Fact Sheet are instructions on "How to Request the Botulinum Antitoxin" and "How to Send in a Specimen for Testing".

The ABC's of Respiratory Outbreak Control

Submitted by Bonnie Erwin, Public Health Nurse

Now that the season of influenza and other respiratory infections is upon us many people are inquiring "What is an outbreak, how are they determined and who decides how they are handled?"

What is an Outbreak?

Respiratory outbreaks and influenza may occur year round in long-term care facilities, but are more common from early fall to early spring. This year the influenza season arrived earlier than expected and is more widespread than in the past few years. Outbreaks may lead to substantial sickness & death. Occasionally two or more infectious agents are involved in a respiratory outbreak. Outbreak prevention, (i.e. influenza vaccine, handwashing) preparation and early detection are vital to effective outbreak management.

The elderly in long-term care facilities often have chronic illnesses, which weakens their immune system, making them more vulnerable to respiratory infections. These viral infections may then lead to bacterial infections such as pneumonia.

The Ministry of Health and Long-Term Care has very clear guidelines on how to define a respiratory case, a potential outbreak and an outbreak.

Respiratory Case

Resident must have 2 or more of the following symptoms – cough, stuffy nose, sore throat, dry cough, fever, and swollen glands in the neck.

Potential Outbreak

One laboratory confirmed case of influenza

or

Two cases of acute respiratory tract infection occurring within 48 hours in a geographic area – unit, floor

or

More than one unit having a case of acute respiratory illness within 48 hours.

Outbreak

Any further progression of the "potential outbreak" The outbreak would be considered an influenza outbreak only if there is at least one laboratory confirmed case of influenza in the facility.

Recent headlines have been somewhat misleading. In any one institution there may be only 1 lab confirmed case – the person had a swab taken, which grew the influenza virus, but there may be many more with influenza like illness or who have respiratory tract infections. Swabs are not taken on every sick person. It is important to remember that only bacterial infections can be treated with antibiotics.

How is an outbreak handled?

Again very clear guidelines come from the Ministry of Health and Long-Term Care. If the influenza virus is identified all residents will be treated with an antiviral medication which may help to prevent others from becoming ill or will lessen symptoms for a case.

The institution will also implement control measures in consultation with the Health Unit. These will include, use of gloves & masks when providing care to ill residents reinforcing hand washing precautions, keeping ill residents in their rooms and may include visiting restrictions.

When is an outbreak over?

It depends on the cause of the illness. If influenza has been the culprit the outbreak will be declared "over" when 8 days have passed from the onset of symptoms of the last resident case (5 days of communicability plus 3 days incubation).

Healthcare workers can do their part in helping to prevent respiratory outbreaks in long-term care institutions by getting an influenza vaccination, not attending healthcare facilities when they have experienced respiratory symptoms in the previous 5 days and frequent hand washing.

For more information you may visit the Health Unit web site at www.healthunit.org





Spring Forward, Don't Fall Back ... It's Time To Prevent A Fall

Submitted by Tawnya Boileau, Public Health Nurse

Falls are a serious health and safety issue among older adults. They account for more than half of all injuries and are the 6th leading cause of death in this age group (Active Independent Aging Website, 2003). Not only do falls significantly impact the lives of older adults, by jeopardizing their independence and quality of life, they also impact health care costs. "Canadians spend about \$3 billion a year on medical care for fall related injuries to seniors" (Ministry of Health Planning, Health File #78, 2001).

Falls by older adults are often the result of environmental factors and/or an individual's health status. Fortunately, studies show that health promotion strategies can reduce or eliminate these factors contributing to falls. Although some falls prevention knowledge exists, there is still little public awareness of the seriousness of this issue (Health Canada/Veterans Affairs Canada Falls Prevention Initiative, Fact Sheet No.8).

In order to broaden awareness and address the risk factors of falls, the Leeds Grenville and Lanark District Health Unit is launching a Falls Prevention Campaign in April 2004. This campaign will consist of media awareness targeted at the general population. In addition, we plan to offer presentations to established senior's groups, such as diner's clubs in Leeds Grenville and Lanark. We have also developed a Campaign Poster and Home Safety Checklist that may be useful in increasing awareness amongst your clients.

For a copy of these resources or for more information, please contact Julie Ingleby, Public Health Nurse, at (613) 283-2740.

The debate over childhood vaccination and autism

The study on thimerosal and the flu vaccine referred to on Canada AM, February 5, 2004 adds nothing relevant to the issue of infant vaccination and autism. What the reported study does show is that low concentrations of thimerosal can alter a biochemical pathway in undifferentiated cancer cells in tissue culture. It is well known that mercury can damage the brain, but ONLY if sufficient amounts of mercury reach the brain cells. However, the study provides no information on how much, if any, thimerosal in vaccines actually reaches the brain in a child. The results are therefore of no help whatsoever in determining whether there is any relationship between vaccination and autism.

The conclusions of the article published in Molecular Psychiatry are an overinterpretation of the results of a study on an abnormal cell line in a laboratory setting. Further study is needed to see if the same results can be replicated under conditions using normal cell lines before jumping to any conclusions that this additive is harmful.

Unfortunately, this article will create unwarranted fear in parents and increased risk of serious disease by children who are not vaccinated because of this fear. With the exception of the influenza vaccine, routine vaccinations for children in Canada do not contain thimerosal. Given the lack of evidence that thimerosal causes autism, we would still encourage parents to follow their physician's recommendations for the influenza and other routine childhood vaccine.

Article from the Canadian Paediatric Society
Ronald Gold, MD, Author *Your Child's Best Shot*
and
Joanne Embree, MD
Chair, Infectious Diseases
Immunization Committee

An excellent web-site to refer your patients:
<http://www.immunize.org/mmr/autism/>