

Nexus



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with the Health Care Community

New Canadian Guidelines on Sexually Transmitted Infections: Changes in First Line Treatment

—Barbara Vander Meer, BScN, RN, Public Health Nurse

An Expert Working Group, comprised of STI experts from medical, nursing, laboratory, public health and research fields from across Canada was brought together by the Public Health Agency of Canada (Community Acquired Infections Division) to revise the 1998 Canadian STD guidelines in order to provide evidence-based recommendations for the prevention, diagnosis, treatment and management of STI's in Canada. The recommendations in the Canadian Guidelines on Sexually Transmitted Infections edition 2006 cover a diverse patient population and are based on the best currently available scientific knowledge and medical practices. ⁽¹⁾

This new edition reflects emerging issues and necessary changes in first line treatment; an example is the resistance rate of *Neisseria gonorrhoeae* to ciprofloxacin that has risen from less than 1% in the early 1960's to 2.4% in 2003 and 15.7% in 2005. In 2005, the *N. gonorrhoeae* resistance rate to quinolones in Ontario exceeded the 3% - 5% threshold for dropping a recommended treatment according to data collected by the National Microbiology Lab. ⁽²⁾

Therefore ciprofloxacin and ofloxacin are no longer recommended as treatment when the case is linked epidemiologically or by residence to areas with a resistance rate higher than 3 - 5% (including all of Ontario). Cefixime 400mg in a single dose is now the recommended treatment of urethral, endocervical, rectal and pharyngeal infection in youth and adults (except in pregnant and nursing mothers). Single dosing helps eliminate treatment failure often encountered with multi-dose regimens. Further details regarding effective prevention, treatment and management of this and other populations can be found on pages 174 through 188 of the 2006 STI Guidelines. ⁽¹⁾

The 2006 edition of the Canadian Guidelines on Sexually Transmitted Infections as well as the Quick Reference have been distributed to all practitioners in the Leeds Grenville and Lanark District Health Unit area and is the guideline used by the Health Unit for all STI follow-up in Leeds Grenville and Lanark. The guidelines can also be found online at: www.phac-aspc.gc.ca/std-mts/sti_2006/pdf_2006_e.html. ❁



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nexus ('nek-sus) noun,
Latin: bond, tie; from
nectere - to bind : a
connection or link between things,
persons, or events esp. that is or is
part of a chain of causation

Source: Merriam-Webster's
Dictionary of Law, © 1996
Merriam-Webster, Inc.

Sources

1. Public Health Agency of Canada. Canadian guidelines on sexually transmitted infections, 2006 edition. Ottawa: Public Works and Government Services Canada: 2006.
2. Public Health Agency of Canada. Epi update: Ciprofloxacin resistance to Neisseria gonorrhoeae in Canada, 2006 [Online]. 2006 [cited 2007 Sept 14]; Available from: URL: http://www.phac-aspc.gc.ca/sti-its-surv-epi/ciprofloxacin_e.html.



SYNOPSIS

ADVISORY: Finger-prick Devices

In April 2007, 22 patients in the London, Ontario area were identified as at risk for possible exposure to blood-borne illnesses. A common finger stick device was used for these patients. Although the actual lancets were disposed of after each use, the lancet device itself, including the cap was reused.

The manufacturer's recommendation clearly states that this device is NOT to be shared between individuals.

The Public Health Agency of Canada has confirmed that there is sufficient evidence to conclude that blood-borne illnesses can be transmitted by this route. For a list of articles documenting outbreaks of blood-borne pathogens associated with finger-prick devices please contact the health unit at 613-345-5685 or log onto the PHAC for the most recent advisory at : http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/2007/2007_94_e.html



Mass Immunization Exercise

The Leeds, Grenville and Lanark District Health Unit, in partnership with the Ministry of Health and Long Term Care, has been chosen to participate in a mass immunization exercise for Influenza. The municipality chosen for this exercise is Smiths Falls. We will be providing flu shots to the population of Smiths Falls on Friday, November 30th from 9:00 a.m. until 9:00 p.m. at the County Fair Mall.

The goal of this exercise will be to test our Health Unit's internal mass immunization plan as a part of pandemic preparedness.

The ultimate purpose of this day will be to immunize as many of the residents of the municipality as possible on one day. We will be working with our community partners to assist us in achieving this goal. In support of this initiative, we ask that Smiths Falls health care practitioners consider holding their regular flu clinics on this date or direct their clients to the clinic at the mall on November 30th, 2007.

Colorectal Project Report

— Bonnie Schnittker, RN, PHN

The Health Unit staff would like to thank all physicians for their support during the Ontario FOBT Colorectal Pilot Project that we participated in from March 2004 - May 2005. Our Health Unit was one of 12 regions that participated. The primary objective of the project was to inform colorectal cancer screening policy by comparing the effectiveness of two methods of promotion and recruitment for opportunistic screening - one through primary care providers and one through local public health units. Over the 15 month intervention period, our Health Unit was heavily involved in connecting with health care providers, implementing media campaigns, providing displays at flu clinics, and delivering many community presentations - to name a few of the activities.

The Final Report of this project has been released and we wish to share some of the findings and recommendations with you.

The project clearly indicated that an organized colorectal screening program for Ontario, with population-based promotion, recruitment, follow-up and monitoring is required to reduce colorectal cancer mortality.

Some of the of key findings:

- The uptake of colorectal screening was very low in both arms (primary care provider and public health unit) of the project.
 - Recruitment in the Public Health Unit arm was slightly higher at 1% compared to the Primary Care Provider arm at 0.7%.
 - There is great need for awareness raising and education about FOBT and colorectal screening in the community.
- 65% of the age-eligible population participate in the biennial program
 - 75% of participants testing positive undergo diagnostic colonoscopy within 12 weeks from the test date
 - 60% of invasive cancers detected be stage I
 - 95% of advanced non-invasive neoplasms be resected by polypectomy
 - The rates of serious complication from colonoscopy be lower than 3/1000 for bleeding, 1/1000 for perforation, and 1/15,000 for death¹

Summary of Recommendations:

It is recommended that:

- the Ontario MOHLTC establish a provincial population-based organized Colorectal Cancer Screening Program.
- the program be phased-in over 4 or more years.
- Cancer Care Ontario with MOHLTC implement a major mass media

awareness campaign for both primary care providers and for age-eligible residents of Ontario (age 50 or older).

- a central program office at Cancer Care Ontario be established to plan and implement the regional phase-in program.
- a population-based list of persons eligible for biennial screening invitation be created and automatically updated.
- Cancer Care Ontario with MOHLTC and other stakeholders, consult with primary care providers during the planning and implementation phases of the program.
- the MOHLTC solicit bids from laboratories to provide comprehensive services (refer to report for list of services).
- regional offices of the Colorectal Cancer Screening Program be established to provide toll-free telephone assistance and information/direction for completing the FOBT kit.
- critical success factors be established and monitored. These should include:

For the complete report, along with the executive summary, please visit: <http://cancercare.on.ca/documents/OntarioFOBTProject-FinalReport.pdf>



Sources

¹ Cancer Care Ontario. Ontario FOBT Project: Final Report, March 2006. [Online]. 2006 [Cited 2007 Oct 2] Available from: <http://cancercare.on.ca/documents/OntarioFOBTProject-FinalReport.pdf>

HPV Vaccine Program for Grade 8 Girls Began September 2007

— Julie Rogers, BScN, RN, Public Health Nurse and
Rebecca Kavanagh, BScN, RN, Manager, Department of Clinical Services

On August 2, 2007, Ontario's Premier Dalton McGuinty announced the introduction of the Human Papilloma Virus (HPV) vaccine into the publicly funded provincial immunization program for grade 8 girls. The primary goal of this new vaccine program is to reduce cervical cancer in women in Ontario.⁽¹⁾

Beginning this fall, the three-dose HPV vaccine will be offered to about 1000 young women in Grade eight across Leeds, Grenville & Lanark. This school-based vaccination program will be administered by public health nurses. The vaccination will be voluntary. Educational materials on HPV and the vaccination program have

been developed and are provided to young women and their families, along with consent forms before the scheduled vaccination clinic. Consent to receive the vaccination will be addressed in the same manner as other voluntary school-based vaccine programs.



This initiative represents an investment of \$117 million over three years. The funding for the program is being provided through a recent federal budget initiative.⁽¹⁾

The HPV vaccine, Gardasil, protects young women from developing certain types of HPV. There are over 100 different types of HPV. Some of them can cause cervical cancer, genital warts and other cancers.⁽²⁾ HPV is spread through close skin-to-skin contact. HPV does not always cause symptoms and the infection can unknowingly be spread to sexual partners⁽²⁾.

For more information about this program, contact the Leeds, Grenville & Lanark District Health Unit at 613-345-5685 or 1-800-660-5853. ❁

Sources

1. Ministry of Health and Long Term Care. Human Papilloma Virus Immunization Program [Online]. 2007 Sept 2 [cited 2007 Oct 2]; Available from: URL: http://www.health.gov.on.ca/english/media/news_releases/archives/nr_07/aug/bg_20070802.html
2. National Advisory Committee on Immunization. Statement On Human Papillomavirus Vaccine. Can Commun Dis Rep 2007 Feb 15;33(DCC-2):1-32.

Influenza Vaccination for Health Care Workers

— Melinda L. Billett, BScH, BScN, RN

During the 2006-2007 influenza season, there were 2,892 confirmed influenza cases in Ontario. In the Leeds, Grenville and Lanark area, there were 26 confirmed cases of influenza and one confirmed institutional outbreak. All the cases in Leeds, Grenville and Lanark area were Influenza A⁽¹⁾. Confirmed cases represent only cases with laboratory evidence of influenza and therefore, the true incidence, although unknown, is likely much higher.

The National Advisory Committee (NACI) on Immunization⁽²⁾ states, "people at greatest risk for serious infections, complications, hospitalization and/or death are children aged 6-23 months, those with chronic medical conditions (especially cardiopulmonary diseases) and the elderly.... Influenza virus is usually the predominant cause of serious [viral] respiratory infections in a community."

Studies have shown that health care workers (HCW) who are ill with influenza frequently continue to work, potentially transmitting the virus to both patients and co-workers. Some HCWs experience subclinical infection and also continue to work, oblivious of their potential to act as a vector of influenza virus to those at greater risk of developing disease.⁽³⁾ The Ontario Hospital Association and the Ontario Medical Association⁽⁴⁾ state, "influenza vaccine has been shown to prevent illness in approximately 70% of healthy children and adults." Therefore, it is particularly important for HCWs to receive annual influenza vaccination to prevent transmission of influenza to those at high risk of influenza-related complications.⁽²⁾

"NACI considers the provision of influenza vaccination for these HCWs to be an essential component of the standard of care for influenza prevention for the protection of their patients. HCWs who have direct patient contact should consider it their responsibility to provide the highest standard of care, which includes undergoing annual influenza vaccination. In the absence of contraindications, refusal of HCWs to be immunized against influenza implies failure in their duty of care to patients."⁽²⁾

The Leeds, Grenville and Lanark District Health Unit supplies influenza vaccine to family doctors and workplaces for immunization of patients and health care workers. The Health Unit also provides numerous community clinics where health care providers can be vaccinated against influenza. For further information, please call the Health Unit at 613-345-5685 or 1-800-660-5853 or visit the Health Unit's website at www.healthunit.org. ❁

Sources

1. Ontario Ministry of Health and Long-Term Care. Ontario influenza bulletin 2006-2007 season: surveillance week 34-35 (August 19-31) 2007 [bulletin on the Internet]. 2007 Sep [cited 2007 Sep 21]. Available from: http://www.health.gov.on.ca/english/providers/program/pubhealth/flu/flu_06/bulletins/flu_bul_01_20070831.pdf
2. National Advisory Committee on Immunization. Canadian immunization guide. 7th ed. Ottawa (Canada): Public Health Agency of Canada; 2006: 209-220.
3. Champlain Infection Control Network. Champlain Infection Control Network regional recommendations for influenza immunization in healthcare providers. Ottawa: Regional Infection Control Networks; 2007.
4. Ontario Hospital Association and Ontario Medical Association. Influenza surveillance protocol for Ontario hospitals. Ontario: Ontario Hospital Association; 2005 Oct. Publication No: 306

GUEST ARTICLE

**Early Childhood
Tooth Decay**

— Dr. Robert Bowes, DDS, MPH,
Dental Consultant

Early Childhood Tooth Decay (ECTD), also known as Early Childhood Caries or Baby Bottle Tooth Decay is a preventable disease seen mainly as cavities in the upper front teeth of infants and toddlers.

These cavities may be seen shortly after the baby teeth erupt and they first appear on the enamel along the gum line. Lifting the lip to look is a simple method of observing the lesion. Depending on the child's age and extent of the decay, dental treatment can be expensive, often needing general anesthetic. Treatment may include extractions, baby teeth root canals and stainless steel crowns.

ECTD can have a severe impact on children and parents. In addition to pain and infection, ECTD can lead to problems with sleeping, eating and speech. It can also interfere with learning and impair the growth and development of children^{1,2}.

The estimated prevalence of ECTD in urban areas is 6-8% and can be as high as 79% in some native communities³. The disease is completely preventable. The education of mothers or caregivers to promote healthy dietary habits, cleaning the mouth after feeding and putting only water in the bottle at night is the main strategy used for the prevention of ECTD. Education should be promoted especially in high risk communities and population groups, but it should not be the only preventive strategy. Early screening for signs of caries, starting from the first year of life, could identify infants and toddlers at risk. High risk children include those with poor oral hygiene, limited exposure to fluorides, and frequent exposure to sugary snacks and drinks. These children should be targeted with a professional preventive program that includes fluoride varnish application, fluoride toothpastes, fluoride supplements, oral hygiene instruction and diet counseling. ❁

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1. Ayham H, Suskan E, Yildirim S. The effect of nursing or rampant caries on height, body weight and head circumference. *Journal of Clinical Paediatric Dentistry* 1996;20:209-212.
2. Acs G, Shulman R, Ng MW, Chussid S. The effect of dental rehabilitation on the body weight of children with early childhood caries. *Paediatric Dentistry* 1999;21:109-113.
3. Leake presentation to National Oral Health Strategy, Toronto May 2004.
4. Ismail AI. Prevention of early childhood caries. *Community Dent Oral Epidemiol* 1998;26(1 Suppl).

Nutrition Myths about Breastfeeding

— Dianne Oickle, MSc, RD, Public Health Nutritionist

Myth #1:

Breastmilk alone is not sufficient for infant nutrition in the first 6 months of life.

The Canadian Paediatric Society recommends exclusive breastfeeding for the first six months of life for healthy, term infants⁽¹⁾. Breast milk is the optimal food for infants, and breastfeeding may continue for up to two years and beyond. This recommendation, proposed by the CPS Nutrition Committee and adopted by the CPS Board of Directors in March 2005, extends the duration of exclusive breastfeeding from the former range of four to six months. It is consistent with recently published recommendations from Health Canada⁽²⁾ and the American Academy of Pediatrics Section on Breastfeeding.⁽³⁾ These changes follow the WHO 2001 recommendation that exclusive breastfeeding continue for six months⁽⁴⁾.

The WHO defines exclusive breastfeeding as the practice of feeding only breast milk (including expressed breast milk) and allows the baby to receive vitamins, minerals or medicine. Water, breast milk substitutes, other liquids and solid foods are excluded.⁽⁵⁾ Nutrient-rich complementary foods, with particular attention to iron, should be introduced at six months. Breastfed babies should receive a daily vitamin D supplement until their diet provides a reliable source or until they reach one year of age^(6,7). Complementary foods also include infant cereal or "pablum", which should be delayed until 6 months. Promoting exclusive breastfeeding to six months has the potential to improve health for infants who are economically and socially disadvantaged. *(Adapted from the Canadian Pediatric Society, 2007).*

Sources

1. Canadian Paediatric Society, Dietitians of Canada and Health Canada. Nutrition for Healthy Term Infants. Ottawa: Public Works and Government Services Canada; 1998.
2. Health Canada. Exclusive Breastfeeding Duration. Health Canada Recommendation. Ottawa: Public Works and Government Services Canada; 2004.
3. American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the Use of Human Milk. *Pediatrics* 2005; 115(2): 496-506.
4. World Health Organization. Global Strategy for Infant and Young Child Feeding, The Optimal Duration of Exclusive Breastfeeding. Geneva: World Health Organization; 2001.

Myth #2:

A breastfeeding mother needs to follow a specific diet.

A woman who is breastfeeding should consume foods without restriction. Although many foods will change the taste of breastmilk, this is acceptable to infants who are exclusively breastfed and may help in their later acceptance of complementary foods after the age of 6 months. Many strongly flavoured foods, such as spices, cabbage, garlic, kidney beans, broccoli, and caffeine can be consumed and not bother an infant's gastrointestinal tract. In addition, a breastfeeding mother does not need to consume special foods in order to make breastmilk. A mother's own energy and health may be affected if she does not eat well, but an infant will get enough breastmilk and the breastmilk will be of good quality⁽⁸⁾.

Myth #3:

A number of foods need to be avoided during breastfeeding in order to prevent food allergies in infants.

Food allergy risk is determined by genetic history, not by exposure to foods in utero or during breastfeeding. Although there is lack of consensus on this issue, research does show that there is no need to avoid certain foods during breastfeeding in order to prevent food allergies, even in high risk infants. The best protection against development of food allergy in high risk infants is exclusive breastfeeding for the first 6 months of life, and delay of complementary foods until 6 months of age⁽⁹⁾.

