

# In.CONTROL



*The Newsletter of the NSW Infection Control Resource Centre  
An initiative of the NSW Health Department*

**Volume 6, Number 4,  
December 2002**

## **INFECTION CONTROL CONFERENCE – A GREAT SUCCESS**

The 25<sup>th</sup> Annual Conference of the Infection Control Association NSW Inc was held Wednesday 30<sup>th</sup> October – Friday 1<sup>st</sup> 2002 in Gosford on the Central Coast. Participants came from all over NSW and it was a great success.

The key note speaker was Teresa Horan, Chief Performance Measurement Section, Health Outcomes Branch, Division of Healthcare Quality Promotion, National Centre for Infectious Diseases, CDC, Atlanta USA. Her topics were *Prevention of Surgical Site Infection* and *National Healthcare Safety Network: Is There Life After NNIS?*



*Tereas Horan, and Koala, at the ICA NSW Conference*

Other interesting and topical presentations included sterilization issues, waste management, multi-resistant organisms, strategic planning issues and some fascinating infectious diseases case studies that included health risks on cruise ships, an outbreak of shigellosis and the perils of pertussis. In conjunction with the NSW Health Department, the NSW Infection Control Resource Centre had a display stand in the exhibition hall. It was great to

meet with people we have only had contact with over the phone or by e-mail and nice to be able to put a face to their names. Thank you to all those who called by the stand to say hello.

We welcome Cate Quolye as the new Acting Policy Analyst in Infection Control at NSW Health. Cate brings a wealth of Infection Control experience from her previous position at the Royal Prince Alfred Hospital in Sydney.

Regular readers would be aware that our newsletter frequently features a guest writer. If any budding writers would be interesting in submitting an article for inclusion in a future edition, please let us know. **In.Control** is distributed to over 2500 people and read by many more. Please contact the NSW Infection Control Resource Centre on (02) 9332 9712 or email [albicr@sesahs.nsw.gov.au](mailto:albicr@sesahs.nsw.gov.au)

I would like to take this opportunity to thank all our readers for your ongoing support of the NSW ICRC and the great feedback we receive for our resources and services. I would also like to wish each and everyone a very happy and safe Christmas and New Year. Best wishes from Sue, Philip and Laura.

*Sue Resnik - Editor*

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# NSW HEALTH DEPARTMENT CIRCULARS & INFORMATION BULLETINS

The following are the latest Circulars and Information Bulletins, from October 2001 to going to print, relating to Infection Control issues have been released by the NSW Health Department

- 2001/101** HEPATITIS B VACCINATION POLICY (This Circular should be read in conjunction with the current edition of the National Health and Medical Research Council (NHMRC) The Australian Immunisation Handbook.  
*(supersedes: Circulars 97/51, 99/48 and 00/43)*
- 2002/7** AUTHORITY FOR REGISTERED NURSES TO PROVIDE IMMUNISATION SERVICES  
*(supersedes Circular 2000/87 Authority for Registered Nurses to Provide Immunisation Services)*
- 2002/10** REQUIREMENTS FOR THE PROVISION OF COLD AND HEATED WATER  
*(replaces Circular 2000/10)*
- 2002/19** EFFECTIVE INCIDENT RESPONSE: A FRAMEWORK FOR PREVENTION AND MANAGEMENT IN THE HEALTH WORKPLACE *(rescinds 97/97)*
- 2002/26** MANAGING YOUNG CHILDREN AND INFANTS WITH GASTROENTERITIS IN HOSPITALS
- 2002/28** MINIMISATION OF NEONATAL EARLY ONSET OF GROUP B STREPTOCOCCAL (EOGBS) INFECTION
- 2002/45** INFECTION CONTROL POLICY  
*(supersedes Circulars 86/7, 97/95,99/87,IB2000/13)*
- 2002/77** CLINICAL PRACTICES – PRESSURE ULCER PREVENTION
- 2002/80** INFECTION CONTROL GUIDELINES FOR ORAL HEALTH CARE SETTINGS
- 2002/84** MANAGEMENT OF PEOPLE WITH HIV INFECTION WHO RISK INFECTING OTHERS  
*(supersedes Circular 2001/104)*
- 2002/92** MANAGEMENT OF FRESH BLOOD COMPONENTS  
*(supersedes Circulars 82/319, 84/130, 85/230, 86/177, 86/234, 89/90, 90/29, 91/9, 91/64, 97/128)*
- 2002/93** COMMUNITY SHARPS DISPOSAL BY PUBLIC HOSPITALS AND AUTHORISED OUTLETS OF THE NSW NEEDLE AND SYRINGE PROGRAM
- 2002/97** OCCUPATIONAL SCREENING AND VACCINATION AGAINST INFECTIOUS DISEASES  
*(supersedes Circular 2001/91)*
- 2002/98** TECHNICAL SERIES (TS) 10, STANDARD PROCEDURES FOR HANDLING OF ACCOUNTABLE ITEMS 5<sup>th</sup> EDITION
- 2002/104** INFECTION CONTROL PROGRAM QUALITY MONITORING

**Copies of NSW Health Department Circulars and Information Bulletins can be obtained from the**

**NSW Health Department Health Web site:**

**<http://www.health.nsw.gov.au>**

*or*

**phoning Central Records at the  
NSW Health Department on (02) 9391 9000**

**A list of NSW Health Department Circulars and Information Bulletins relating to Infection Control issues can be obtained from  
THE NSW INFECTION CONTROL RESOURCE CENTRE  
(02) 9332 9712**

# MEDIA WATCH AUSTRALIA

In September, the *Sydney Morning Herald* printed an interesting article on the controversial anti-**malaria** drug mefloquine, which is sold in Australia as Lariam. Mefloquine was developed by the US Army because some strains of **malaria** were becoming resistant to chloroquine in the late 1970s. The drug has come under attack because of the serious, but rare, neuropsychiatric side effects it causes. One in every 10,000 people who take mefloquine to avoid developing **malaria** while in areas where mosquitoes are rife experiences severe neuropsychiatric disorders. That rises to one in 1000 to 2000 when it is used as a treatment for **malaria** because it is used in higher doses, experts say. Mefloquine is mainly prescribed for people traveling or living in Africa and South America. In South-East Asia and the Pacific, **malaria** has become resistant to the drug, so doxycycline, another anti-**malaria** drug, is usually prescribed. **Malaria** is endemic in more than 100 countries visited by more than 125 million travelers every year. It causes at least 30 million acute illnesses and 1 million deaths a year. It causes fever, vomiting, headache and other flu-like symptoms. Mefloquine side effects can include anxiety, psychotic syndromes including mania, schizophrenia, hallucinations, delusions, personality disorders and neurosis, depression, sleep disorders, dizziness, convulsions and headaches.

In a scientific assault on **malaria**, the genetic code of the parasite that causes the deadliest form of the disease and the mosquito that carries it have been deciphered. The genome of the parasite *Plasmodium falciparum* was published in *Nature* and the genome of the mosquito, *Anopheles gambiae* was published in *Science*, both in October. It took a consortium of more than 150 scientists six years to work out the order of the 24 million "letters", or chemical building blocks, of the parasite's DNA in a technical tour de force. The genes could now be targets for much-needed new drugs and vaccines. **Malaria** is one of the most devastating infectious illnesses in the world. 40% of the world's population live in countries where **malaria** is endemic. Up to 2.5 million die of **malaria** each year, mostly Africans under five. About 500 million people develop **malaria** each year. Case numbers could double in 20 years without new control measures. All four **malaria** parasites that affect humans have developed resistance to the drug chloroquine.

Sydney researchers have discovered two previously unknown routes **HIV** uses to enter the body, sparking hope that new ways to block the disease can now be found, the *Sydney Morning Herald* reported in September. Scientists at Westmead Hospital's flagship research program, the Millennium Institute, announced that they had found two more receptor molecules on dendritic cells, through which

**HIV** enters the body. They believe drugs could soon be developed to block these entry points. Scientists previously thought there was only one molecule receptor on the cells. Dendritic cells are key to the immune system, alerting immune system cells around them when the body is under attack.

Preventing **asthma** in children may be as simple as eating more yogurt while breastfeeding or adding fish to the menu, according to a study conducted by Westmead Hospital and Liverpool Hospital. In September, the *Sydney Morning Herald* reported that studies had determined mothers who eat lacto-bacillus yogurt in the later stages of pregnancy and while breastfeeding appeared to protect children against **asthma**. The study also suggested omega-3 fatty acid capsules (omega-3 is found in fish oils) could also ward off **asthma**. "We have data that shows children who regularly have fish meals have half the rate of **asthma** that kids who don't" said Professor Craig Mellis, head of Paediatrics and Child Health at Westmead Children's Hospital. **Asthma** affects more than two million Australians and one in four children. According to **Asthma NSW** it is the most frequent cause for childhood admission to hospital and school absenteeism.

There is no medical reason for boys to be circumcised, according to scientific research. In September the *Daily Telegraph* reported that the Royal Australasian College of Physicians had issued a statement on routine circumcision. A spokesperson for Circumcision Information Australia said: "the statement sends a clear message to doctors that they should warn parents against choosing circumcision for their sons. After a review of the medical literature, including claims that circumcision is protective against **STDs, AIDS, urinary tract infections, and cervical cancer** in female partners, the working party concluded there is no evidence of a benefit outweighing harm for circumcision as a routine procedure."

Joanne Clarke, of Macquarie University, told the Australian Society for Microbiology conference in Melbourne in September that she had harvested antibiotics from the surface of flies at different stages of their life-cycle, the *Sydney Morning Herald* reported. More work is needed to identify the compounds, but they have been shown to be active against a number of bacteria, including **MRSA** and **E-coli**. The antibiotics were produced by the flies during the larval and adult stages, when they lived and ate in dirty environments. But they were not produced during the middle stage when, as pupae, they had a protective casing. It was hoped bacterial resistance would be less of a problem with antibiotics produced by insects, because they would have very different chemical structures to most medical antibiotics now in use. The CSIRO has recently established a new company, Entocosym, to produce drugs from insects. Its chief executive, Dr Geoff Garret, said the four million species of insects were a "virtually untouched" potential source of antibiotics, anti-cancer agents, blood thinners and other therapeutic substances.

In October, the Canberra Raiders rugby team contacted 80 players who had tried out for the club following a **meningococcal** scare. The *Sydney Morning Herald* reported that an 18-year-old player from Perth had shown signs of contracting the disease just days after taking part in the trials at Seiffert Oval in Queanbeyan and was treated with antibiotics at Sutherland Hospital. Although it was unlikely any of the other trial players would have contracted the disease, the Raiders were warning them to be alert. A club spokesman said the attempt to contact the players was “just a precaution, given that players may have shared water bottles or something like that”. Several days later a friend of the footballer was also diagnosed with the condition. Health authorities believe the two friends came into contact with the disease – probably while sharing drinks – as they socialized in Sydney the previous weekend.

According to a paper published in the journal *Sexually Transmitted Infections* in October, researchers discovered the prevalence of the **herpes virus HSV-1** was strongly tied to the age at which the person first had sex. Someone who had sex for the first time at 20 was 60% less likely to have **herpes** than someone who did so at 15. The paper said “It appears that people who start having sex at an early age are particularly vulnerable to infection with **HSV-1**, more likely because of their sexual behaviour than any biological precondition”. **HSV-1**, primarily associated with cold sores on the mouth, can be passed by kissing and oral sex. The researchers studied 869 clients of a sexual health clinic in London and 1494 blood donors. One of the study’s authors, Professor Adrian Mindel, the director of the sexually transmitted infection research center at Westmead, said **HSV-1** was a major issue for young Australian adults, who, like their British counterparts, tended to have oral sex before having vaginal or anal sex.

Set up in the mid-1980s, needle and syringe program (NSP) initiatives have done a first-rate job in preventing an explosion of **HIV/AIDS** among the estimated 200,000 Australians who inject illicit drugs, *The Hep C Review* reported in September. NSPs have had less success with **hepatitis C** virus because this virus was well established in Australia a decade before the arrival of **HIV/AIDS** and the introduction of NSP. The \$10 million spent on NSP in 1991 prevented an estimated 3000 cases of **HIV** which saved \$266 million in health care costs in that year alone.

**AIDS** deaths are declining in NSW, according to the latest figures released in October, the *Daily Telegraph* reported. According to figures, 36 people died from **AIDS** last year compared with a record high of 405 in 1994. So far this year there have been 14 deaths. The numbers of people being diagnosed with **AIDS** also has declined. Last year, 69 cases were diagnosed compared with 552 cases in 1994. This year, 26 people have been diagnosed.

Fears of bio-terrorism have prompted the Government to start stockpiling 50,000 doses of **smallpox** vaccine, according to a report in the *Sydney Morning Herald* in

October. The federal Health Department is finalized contracts with the vaccine’s manufacturer in France, and is also buying vaccine from another supplier that should be available next year. The stockpile will be kept in a secure location, able to be deployed to any city within hours. The Commonwealth Chief Medical Officer, Richard Smallwood, said: “The initial shipment and the additional stock we will get mean Australia will have an adequate supply of vaccine to effectively manage a **smallpox** outbreak anywhere in Australia.” He said that while the **smallpox** bioterrorism threat was very low, the vaccine was a “prudent step in our preparations to respond to threats to human health from biological agents.” The acquisition of the vaccine is part of an \$11.4 million budget commitment to acquire a range of antibiotics, vaccines and antiviral drugs.

In November, *The Washington Post* and *The New York Times* reported that a United States intelligence review has concluded that four nations – Iraq, North Korea, Russia and France – possess covert stocks of the **smallpox** pathogen. Records and operations manuals captured this year also showed that Osama bin Laden devoted money and personnel to pursue **smallpox**, among other biological weapons including **anthrax**, the nerve agent ricin and **botulinum** toxin.

Also in November, the *Sydney Morning Herald* wrote a large interesting article about who should receive the **smallpox** vaccine in the event of a bio-terrorist attack of **smallpox**. The **smallpox** vaccine is considered “the worse of all vaccines” that can produce complications such as a painful injection site, swollen glands and encephalitis. People who suffer eczema develop lesions all over, and there are other complications for those with immune deficiencies and for children under 10. The United States and Britain are well advanced in developing **smallpox** vaccination policies, spurred on by September 11, the American **anthrax** attacks and fears that Iraq has biological weapons. In Australia, the Federal Government has set up the Infectious Diseases Emergency Response Group to develop a **smallpox** vaccination policy.

An **HIV**-positive man was found guilty of infecting an unsuspecting woman, the *Daily Telegraph* reported in October. The 35-year-old man was convicted of causing grievous bodily harm after deliberately not telling her he had the disease before the couple had unprotected sex. The man is the first person to be convicted in WA for grievous bodily harm relating to **HIV**. The man was diagnosed with **HIV** in 1990 and said his friends deserted him when told about the disease.

The Pharmacy Guild is planning to train pharmacists to give injections, but the move has angered the medical profession, according to a report in the *Daily Telegraph* in October. The Pharmacy Guild believes the current vaccination system is often highly inconvenient and expensive for the patient. For example, those under 65 who want a **flu** vaccination, and parents who want to

immunize their children against **chicken pox**, must first visit a doctor to get a prescription. The pharmacist fills the prescription and the patient then takes the vaccine back to the doctor who administers it. "The system of two visits to the doctor is not only expensive but can often deter would-be vaccination recipients who find it too time-consuming," Pharmacy Guild executive director Stephen Greenwood said.

In November, the *Daily Telegraph* reported that a working party is proposing changes to the childhood immunisation schedule. The changes being proposed include a new **pneumococcal** vaccine recommended for babies that could prevent deafness, middle ear infections and surgery to insert grommets to drain the ear canal. Other changes could see children receiving a dose of **chicken pox** vaccine at 18 months and another between the ages of 10 and 13 years. Also, for the first time, adolescents between 15 and 17 may be immunised against **whooping cough** to stop the spread of the disease, which is dangerous to babies. Finally, the oral **polio** vaccine may be placed by an injection to prevent rare side effects.

## MEDIA WATCH THE WORLD

In September a food poisoning outbreak at a fast food restaurant killed 49 people and left hundreds needing hospital treatment in the eastern Chinese city of Nanjing. Several days later the *China Daily* reported a business rival had confessed to spiking the meals with rat poison. Most of the 49 customers who died were children.

Also in September, the *Boston Globe* reported that patients infected with the mosquito-borne **West Nile virus** are suffering from the deformed limbs, impaired breathing, and fevers that are the hallmark of **polio**. The strain of **polio** that was so widely feared in the 20<sup>th</sup> Century, and now prevented by vaccines, comes from a different family of viruses to **West Nile**. However, the devastating effects are the same. In **polio**, the virus attacks the grey matter of the patients spinal cord, which contains the neurons responsible for carrying information to the muscles. As the attack frays the neuron fibres, muscles turn limp, often producing uneven results – a leg gone weak on the right side, an arm on the left. It also results in bladder and bowel dysfunction, and respiratory complications that can leave patients tethered to breathing machines. The Centers for Disease Control say the **West Nile virus** has killed 94 people in America this year and sickened 1963, by far the largest outbreak since it was first reported in the US three years ago. Although other viral illnesses kill more people – the **flu** is blamed for 20,000 deaths in the US annually – public-health authorities are concerned about **West Nile** because it has spread from coast to coast so quickly and produced unexpected symptoms, with **polio** being the most

recent example. *The New England Journal of Medicine* released the articles on the **polio** link nearly a month before their scheduled publication, a step reserved for reports of urgent importance.

*The British Journal of Neurology, Neurosurgery and Psychiatry* in September published a controversial theory that **multiple sclerosis (MS)** may actually be a sexually transmitted disease, transmitted by an as yet unidentified virus. **MS** bears a striking similarity to the sexually transmitted infection **tropical spastic paraplegia** and **MS** is typically acquired around the same age as STDs. There was an increase of **MS** among women following the 1960s sexual revolution. Clusters of **MS** have known to occur after large groups of young men entered areas where the incidence was previously low – for example, an unexplained epidemic of **MS** occurred in the Faroe Islands following their occupation by British troops during World War II.

The former NBA star Magic Johnson's latest check-up has confirmed he is free of **AIDS** symptoms, more than a decade after he first tested positive for **HIV**, the *Associated Press* and *Reuters* reported in September. Johnson, who won five NBA titles with the Los Angeles Lakers in the 1980s, first retired at 32 after testing positive for **HIV** while being examined for an insurance policy. Johnson has kept the disease at bay by working out regularly and taking his medication.

The *Los Angeles Times* reported that Dr Wan Yanhai, the Chinese **AIDS** activist whose detention for nearly a month sparked concern and protest around the world, was released by Chinese authorities in late September. Dr Wan had confessed to obtaining classified documents illegally, including an official report about the growing **AIDS** crisis, a scandal involving illegal blood donations that the local government had tried hard to cover up. Dr Wan said he intended to continue his work in China fighting **AIDS**, "but I need to learn a lesson from this, that I must do the work more conscientiously in the future."

New research published in the September issue of *Nature Medicine* found the 1997 **Hong Kong influenza virus** had developed the ability to bypass the human body's immune system, raising the prospect of a deadly global outbreak. Robert Webster, who led the study at St Jude Children's Research Hospital in Memphis, Tennessee, said "It is the first time this mechanism has shown up and we wonder if it was not a similar mechanism that made the 1918 **influenza virus** so enormously pathogenic." The 1918 virus killed 50 million people. Dr Klaus Stohr, the leader of the World Health Organisation's global flu program, called the 1997 outbreak "the last warning from nature" that the world faces a pandemic similar to 1918. The new research found the **Hong Kong influenza virus**, which killed six people, was able to avoid interferons and other vital chemical factors that are released as a response to infection. The **Hong Kong virus** did not transmit easily from person to person. Dr Stohr said "Imagine if the **Hong**

**Kong virus** had obtained a little additional capacity to be freely transmitted in humans – a large proportion of the population of the world would presumably have died.”

*Reuters* news agency reported that doctors had confirmed that a 25-year-old woman is the first person in Italy to suffer from **variant Creutzfeldt-Jakob (vCJD)** disease, the human form of mad-cow disease, and called for greater surveillance programs in the country.

In October the *The Independent* newspaper reported that Britain will follow Australia and Switzerland by opening a heroin shooting gallery, where addicts can inject drugs safely.

The *New York Times* reported that the National Intelligence Council, a group that advises the CIA, believe that rates of infection from **HIV** in China, India, Russia, Nigeria and Ethiopia – five of the world’s most populous countries – are rising so fast that they pose potential security threats by harming the economic, social, political and military structure in each of the states.

In October, the *New York Times* also reported that more than 50 people at a hospital in Norman, Oklahoma, have been infected with **hepatitis C** after a nurse repeatedly used the same needle and syringe to administer medication. Investigators believe that the infections occurred because the nurse-anaesthetist drew enough medication into one syringe to treat multiple patients seen in the pain treatment clinic on the same day. The nurse then used that syringe with the same needle to inject a small dose of medication into the port of an intravenous line that had been inserted into the arm of each patient. Since a patient’s blood can easily back up into intravenous line ports, nurses and doctors are supposed to use needles and syringes only once to avoid the risk of transmitting diseases through re-use. The nurse’s actions were apparently the result of misunderstanding proper procedure. A spokeswoman said 300 patients treated at the clinic this year had been tested and 52 of them had shown positive for **hepatitis C**. The hospital had advised another 500 people treated at the clinic since it began operating in 1999 to seek testing. A number of those infected have filed lawsuits against the anaesthetist, the nurse and the hospital. More than 4 million people in the United States are infected with **hepatitis C**.

A study published in the October issue of *Archives of Pediatrics and Adolescent Medicine* reported that researches found over-the-counter duct tape was a more effective, less painful alternative to liquid nitrogen used to freeze warts. Patients wore duct tape over their warts for six days. Then they removed it, soaked the area in water and used an emery board or pumice stone to scrape the spot, reapplying the tape the next morning. The treatment continued for up to two months. The duct tape irritated the warts, apparently causing an immune system reaction that attacked the growths.

Also in November, *The New York Times* reported that nearly 800 people had sought help at hospitals in four south-west Russian provinces after sanitation problems at a regional milk processing factory apparently set off an outbreak of bacterial **dysentery**. Epidemiologists said they believed that the outbreak had been traced to two women in the factory, both of whom tested positive for **dysentery**. The women washed milk cans and packaged dairy products. The disease outbreak appeared to be linked not to sterilised milk, but to sour cream, yogurt and other fresh-milk products produced at the Kropotkinsky Dairy Factory.

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## AN INTERVIEW WITH PAMELA ANDERSON!

Pamela Anderson has just started a new project, writing a column for *Jane* magazine called “Pam, Honestly”. Her first column appeared in the August issue. Pamela was also diagnosed with hepatitis C last year. The following is an abridged version of a recent interview on CNN’s “Larry King Live” that appeared in *The Hep C Review*, edition 38, September 2002, and is reprinted here with permission.

**LARRY KING:** OK, hepatitis C. When were you diagnosed? How do you deal with it?

**PAMELA ANDERSON:** How do you deal with it? Well, when I first was diagnosed, I thought obviously I was dying. My doctor told me, “You know this little glitch in your blood work? You have hepatitis C.” And I said, “OK, how do I get rid of it?” And he said, “You can’t.”

**KING:** How long ago was this?

**ANDERSON:** Just over a year ago.

**KING:** What symptoms did you have?

**ANDERSON:** I didn’t really have any symptoms. That’s the whole problem. It was just a checkup. I started reading about it and realized there’s no cure and that, you know, there’s liver transplants, liver cancer, cirrhosis, all this kind of stuff going on and it just scared me. You start facing your own mortality, you start realizing that you might die. Now I realize that there’s actually a treatment for it.

**KING:** Which is?

**ANDERSON:** Interferon with another drug called ribavirin.

**KING:** They're tough drugs, though. What about the side effects?

**ANDERSON:** There's lots of side effects. And I'm thinking of doing it in December. It's going to be a year of basically having the flu. It's a bit like chemotherapy. I did have a liver biopsy. And liver damage is rated from zero to four. Four is cirrhosis, cancer, you know, and liver transplant. My liver is a healthy zero. I'm a one.

They said it's a miracle that my liver is as healthy as it is. They said keep doing what you're doing, you're taking good care of yourself. I'm a vegetarian and I look after myself. I don't drink that much. And definitely now my doctor said, "No drinking at all, as your doctor. But as your friend, you can have a glass of red wine every once in a while."

**KING:** Are you writing about this in your new column?

**ANDERSON:** Yes, we're writing all about this.

You know who I actually saw on your show was Naomi Judd [US country and western singer]. And I called Naomi and I talked to her, and she's a wonderful mentor for me, and she's been wonderful.

She's a great lady. She's got a great heart, and she's been really helpful, and she's like, I can fight this now, and I'll win and I won't have it anymore, and then I'll think of other children. But I really do believe that it's not going to take me down. I'm too healthy.

**KING:** Are you a role model for hepatitis C?

**ANDERSON:** Well, I feel like I can be a good role model as a mother because I love being a mom and I have great advice for everybody when it comes to mothering. I have terrible advice for relationships. I can't follow that myself.

But being a role model in that I'm a free spirit, and that I've done what I've wanted. I'm self-made. I've created my own career in my life, and I've had a lot of fun doing it. I think that's good.

**The Hep C Review is published by  
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## hetero-Vancomycin-Intermediate *Staphylococcus Aureus* (hVISA)

### THE FACTS

#### What is hVISA?

hetero-Vancomycin-intermediate *Staphylococcus aureus* (hVISA) is a vancomycin and teicoplanin resistant type of MRSA (Methicillin-resistant *Staphylococcus aureus*). The organism is so recently discovered that the nomenclature is not yet agreed. It has also been called: heteroresistant Vancomycin-intermediate *Staphylococcus aureus*, heterogeneous Vancomycin-intermediate *Staphylococcus aureus*, Vancomycin-intermediate **Staphylococcus aureus** (VISA), Glycopeptide intermediate *Staphylococcus aureus* (GISA) and Vancomycin-resistant *Staphylococcus aureus* (VRSA).

Methicillin-resistant *Staphylococcus aureus* (MRSA) will be familiar to you as the multi-resistant form of *Staphylococcus aureus* responsible for many difficult-to-treat hospital-acquired infections.

Vancomycin and teicoplanin (the glycopeptide antibiotics) are the antibiotics most often used to treat MRSA. The development of resistance to vancomycin (and teicoplanin) is a significant evolution in MRSA. Thankfully, hVISA infections are rare. However, they are increasing in frequency around the world. The first case was found in Japan in 1997, and later that year other cases were found in the USA. A case was detected in Melbourne in 2001 (Ward PB, et al. Med J Aust 2001;175:480-483).

#### The consequences of Vancomycin resistance

Because Vancomycin is one of the few drugs that can be reliably treat MRSA, development of resistance to Vancomycin is a significant problem. Patients infected with hVISA strains fail Vancomycin treatment.

#### When to suspect hVISA infection

hVISA infection may be suspected when a patient is being treated for MRSA infection with vancomycin or teicoplanin and the treatment is failing. The typical patient with hVISA has been in hospital for a long time and has been treated for MRSA infection with Vancomycin or teicoplanin – sometimes several courses. Dialysis patients, cardiothoracic surgical and intensive care patients have been the most commonly infected patients.

#### Diagnosis of hVISA infection

Diagnosis is made by isolation of a hVISA strain from a single patient sample.

#### What to do if you suspect one of your patients has hVISA infection

Ensure appropriate specimens for microbiological investigation are collected from patients failing treatment for MRSA. If you suspect hVISA infection you should

inform your microbiology department because identifying these organisms require special testing (the change in Vancomycin susceptibility does not always show up in routine antibiotic sensitivity testing).

#### Treatment of hVISA infection

The advice of an Infectious Diseases Physician should be sought. The appropriate antibiotics have only recently been developed and there is still much to learn about their use.

#### Transmission of hVISA strains

hVISA strains easily spread in the same way that MRSA spreads, including transfer between patients on health care workers hands.

#### Prevention of transmission

The Infection Control Nurse must be notified immediately to coordinate infection control procedures and monitor compliance with infection control practice. Patients identified as colonised or infected with a hVISA strain must be nursed in isolation. All staff must comply with the infection control procedures, including strict adherence to Contact Precautions and hand washing immediately after attending to the patient. The number of persons accessing the patient must be minimised during the patient's in-patient stay. All staff are responsible for alerting other relevant staff to their responsibility to follow the recommended infection control procedures. Refer to the NSW Health Infection Control Policy 2002/45 for information on Contact Precautions, the policy is available online at:

<http://www.health.nsw.gov.au>

#### Reporting hVISA colonisation and infection

The detection of a patient colonised with or infected with a hVISA strain is a significant infection control event. Immediately alert your Infection Control Officer or that officer's manager if you detect a patient with hVISA colonisation or infection.

#### Promote prudent use of antibiotics

Because hVISA strains are resistant to so many antibiotics, the use of almost any antibiotic selects for their survival on patients. Therefore, any antibiotic, but particularly Vancomycin and teicoplanin should be used only when indicated. Please consult Therapeutic Antibiotic Guidelines 11<sup>th</sup> Edition for advice on appropriate antibiotic usage (also available on the Internet at:

[http://www.hcn.net.au/nswhealth/dbase\\_ref.htm](http://www.hcn.net.au/nswhealth/dbase_ref.htm))

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*South Western Sydney Area Health Service*

*Public Health Unit – A Unit of the Division of Population Health*

# SPOTLIGHT ON SMALLPOX

Smallpox was globally eradicated in 1980. However, because of the current climate of terrorism there is a real fear that smallpox may be used by terrorist groups as a biological weapon. Here is a quick look at smallpox.

#### HISTORY

- **1000 BC** Smallpox is thought to have originated in Egypt or India.
- **1798** Inoculation with cowpox the first protection against smallpox.
- **1950s** 50 million cases a year worldwide.
- **1967** 10-15 million cases a year, World Health Organisation (WHO) launches a campaign to eradicate smallpox.
- **1977** Somalia last known natural case.
- **1978** Britain: laboratory accident kills one and leads to limited outbreak.
- **1980** Global eradication of smallpox is certified. Stocks of the virus are held in secure laboratories in the US and Russia.
- **2002** Four countries, including Iraq and North Korea, are identified as holding covert stocks of smallpox. Terrorist groups are believed to be developing smallpox to be used as a biological weapon.

#### SYMPTOMS

- Incubation period of 7-17 days during which the person feels healthy and is not infectious.
- Severe influenza -like symptoms for two to three days.
- Rashes then develop on the face and forearms, progressively spreading to the torso.
- Lesions develop in the nose and mouth, releasing large amounts of virus into the mouth and throat.
- Rashes develop into pustules that form scabs which fall off 8-14 days after onset of symptoms, signaling the end of the disease.

#### INFECTION

Person-to-person contact and saliva droplets in an infected person's breath.

**TREATMENT**

There is no cure but vaccine is effective up to four days after exposure

**DISPENSING THE VACCINE**

The smallpox vaccine is administered to the skin over the deltoid muscle using a cool and sterile bifurcated needle.

A very small volume of vaccine is held between the fork of the needle and then released on to the skin. The needle is held perpendicular to the arm, then 15 strokes are rapidly made within an area about 5mm in diameter. The strokes should be vigorous enough for a trace of blood to appear on the skin

*Source:*  
*WHO/The New York Times/The Sydney Morning Herald*

**HAND WASHING ALERT**

There have been a number of gastroenteritis outbreaks recently reported in NSW health care facilities. The findings of the investigations indicate that the likely cause of transmission is person to person contact. The most important infection control measure to prevent transmission of gastroenteritis is hand washing. Health care workers must wash their hands before and after any direct patient care. Gloves should be used in situations where there is a potential exposure to blood and/or body fluids. Hands should be washed or cleaned after removal and disposal of gloves.

The NSW Infection Control Policy Circular 2002/45 outlines the Contact Precautions that should be instigated if patients in health care facilities have gastroenteritis. Staff should also notify the local Public Health Unit of any clusters of cases of gastroenteritis to facilitate investigation.

**HAND WASHING POSTERS**

The NSW Infection Control Resource Centre, with funding from NSW Health, has developed a series of six hand washing posters. The aim of the posters is to promote hand washing and improve compliance across the State to minimise transmission of healthcare associated infections. The colour posters are A3 in size (297mm x 420mm) with a matt finish printed on 200gsm art board. The posters can be viewed on the NSW Infection Control Resource Centre website:

<http://www.sesahs.nsw.gov.au/albionstcentre>

To order posters, contact the NSW Infection Control Resource Centre by phone (02) 9332 9712 or e-mail:

[albicr@sesahs.nsw.gov.au](mailto:albicr@sesahs.nsw.gov.au)

**VIDEO & CD-ROM LIBRARY**

The NSW Infection Control Resource Centre has a Video and CD-ROM Library containing sixty-four videos and one CD-ROM relating to infection control. A catalogue, providing a short description of the contents and running time of all the videos is available. The catalogue will assist you in deciding which videos are suitable for your target inservice or education session audience.

To borrow videos or the CD-ROM free-of-charge, or to obtain your copy of the *Video and CD-ROM Library Catalogue*, contact:

The NSW Infection Control Resource Centre  
Monday to Friday, 8am-5pm  
(02) 9332 9712

**INFECTION CONTROL CONFERENCES**

**HOSPITAL INFECTION SOCIETY/PHLS  
LABORATORY OF HOSPITAL INFECTION –  
COURSE ON HOSPITAL INFECTION CONTROL**  
24-28 February 2003

Public Health Laboratory Service, London, England  
For further information and an application form, please write to:

Greta Howell  
Laboratory of Hospital Infection  
PHLS Central Public Health Laboratory  
61 Colindale Avenue  
London NW9 5HT  
e-mail: [ghowell@phls.org.uk](mailto:ghowell@phls.org.uk)

**APICS's 30<sup>th</sup> ANNUAL EDUCATIONAL  
CONFERENCE**

8-12 June 2003  
San Antonio, Texas, USA  
<http://www.apic.org/apic2003/>

**AUSTRALIAN  
INFECTION CONTROL ASSOCIATION (AICA)  
NATIONAL CONFERENCE**

9-11 June 2004  
Wrest Point Casino, Hobart

**APSIC  
2<sup>ND</sup> INTERNATIONAL CONGRESS OF THE ASIA  
PACIFIC SOCIETY OF INFECTION CONTROL**  
Singapore 20-23 July 2003

# QUESTIONS AND ANSWERS

In.Control invites readers to write in with questions that they want answered. Names and organisations will **NOT** be included in the newsletter.

**Q.** I am attempting to gather some resource material that would be relevant to the child care industry. Of particular interest is the recommended procedure for cleaning spills of bodily fluids, especially urine and faeces. I would like to be able to provide some information to child care providers in “plain English” that pertains to their circumstances.

**A.** The National Health and Medical Research Council (NHMRC) has produced several documents that should be a great resource for you. *Staying Healthy in Child Care: Preventing Infectious Diseases in Child Care* (2001) is the third edition of this publication and aims to assist child care workers, parents and health professionals in controlling the spread of childhood infections.

Infections with or without illness are common in children. When children spend time in child care or other facilities they are exposed to a large number of children, increasing the opportunity for the spread of infectious diseases. *Staying Healthy in Child Care* describes simple but effective methods for minimising the spread of infections for many common childhood diseases which are encountered in child care and the home. Chapters include:

- Handwashing
- Nappy changing and toileting
- Cleaning toys, clothing and the centre
- Food safety
- Animals
- Dealing with spills of blood and other body fluids
- Children’s wading pools
- Immunisation
- Watching for and recording infections in children
- Exclusion of sick children and staff
- Occupational risks for child care workers
- Specific Diseases

The publication also includes the *NHMRC Recommended Minimum Exclusion Periods for School, Preschool and*

*Child Care Centres for Cases of and Contact With Infectious Diseases.*

*Staying Healthy in Child Care: Preventing Infectious Diseases in Child Care* (third edition), June 2001, is available from your nearest Government Info Bookshop, Price: \$37.50. It can be downloaded free-of-charge from the NHMRC website:

[www.health.gov.au/nhmrc/publications/](http://www.health.gov.au/nhmrc/publications/)

**From the same website the following documents can be downloaded:**

- *New NHMRC Australian Standard Vaccination Schedule*

**Posters:**

- *Changing Nappies Without Spreading Germs*
- *When To Wash Hands*
- *NHMRC Recommended Childhood Vaccination Schedule*
- *Table: Recommended Minimum Periods of Exclusion From School, Pre-School and Child Care Centres for Cases of and Contact With Infectious Diseases.*

**Q.** Our company has a number of Occupational Health Nurses who carry out “office-based” occupational health nursing functions. We are encouraging the nurses to dispense with their uniforms but first would like to know if there are any infection control guidelines that state that nurses must wear a uniform while performing their duties.

**A.** The abandonment of prescribed nurses’ uniform frequently generates debate focusing on many issues including infection control. There are, however, many areas in the health industry, such as sexual health clinics, community health centres, haemodialysis units, birthing centres and non-clinical settings, where nurses have elected to abandon the traditional nurses uniform, mainly because a uniform is often seen as an overt display of authority and the antithesis of the nurse-patient relationship.

From an infection control perspective, there is nothing in State or National infection control directives that states that nurses must wear a uniform while performing their work. Nor is there anything in the literature to suggest that there is an increase in the transmission of infections between patients, or between patients and nursing staff, when other clothing is worn instead of a uniform.

Nurses’ uniforms are no cleaner than other clothing or less likely to contribute to cross infection. Home laundering is as effective as hospital laundering and renders clothes equally clean. The organisms that can be cultured from uniforms can also be cultured from personal clothing and

are not usually responsible for cross-infection. The principal culprits in the spread of infection are hands, not clothing. Frequent hand washing and the use of gloves are the best preventive measures. Indeed, one study in the literature found that nurses who were not wearing a uniform became much more aware of the need for cleanliness, washing their hands and wearing plastic aprons more frequently than when they wore a uniform. If the study's findings are accepted, this 'out of uniform' behaviour would have the effect of reducing nosocomial or health-care acquired infections.

Regardless of whether nurses wear a uniform or other clothing, basic hygiene principles should be followed, such as the wearing of clean attire at the start of every shift and changing the clothing should it become visibly soiled. A fluid-resistant gown or apron made of impervious material must be worn during any procedure where there is the likelihood of splashes or contamination with blood or other body substances, regardless of whether the nurse is wearing a uniform or other clothing. The wearing of 'loose weave' clothing, such as wool jumpers or sweaters, should be discouraged when performing procedures, whether part of the uniform or not, as microorganisms can lodge in the weave of such fabrics.

**Q.** I have heard that alginate bags are no longer recommended for soiled linen. Is this correct and what do you recommend in their place?

**A.** The information you have heard is correct. Alginate bags are not cost effective and often disintegrated long before they reach the laundry service if they come into contact with moisture.

The current recommendations are outlined in the Australian/New Zealand Standard *Laundry Practice 4146:2000*. The Standard states in Section 2.4.1 (page 17) "In addition to being placed in suitable laundry bags, linen which is heavily soiled with blood or other body fluids, or other fluids which could leak and further contaminate other linen, shall be also contained within suitable impermeable bags which are to be securely closed." Alginate bags are not impermeable. In other words, place the soiled linen in a plain plastic bag (*not* a clinical waste bag) and securely tie it before placing it in a laundry bag.

At the laundry, workers wearing protective apparel will open the bag and the soiled linen is washed and dried with all the other laundry, it is not treated any differently. The combination of detergents, water and hot temperatures ensure that the linen is safe to handle on completion of the wash cycle.

The Australian/New Zealand Standard *Laundry Practice As 4146:2000* can be obtained by contacting Standards Australia:

Tel: 1300 65 46 46 Fax: 1300 65 49 49

E-mail: [sales@standards.com.au](mailto:sales@standards.com.au)

Internet: [www.standards.com.au](http://www.standards.com.au)

**Q.** Are there any infection control guidelines specifically for dentistry?

**A.** Your question could not be more timely. NSW Health recently released *Infection Control Guidelines for Oral Health Care Settings, Circular 2002/80*. The 27-page document contains sections on Standard and Additional Precautions; Personal and Patient Protection; Procedure for Dental and Clinical Practice; Safe Handling and Disposal of Sharps; Processing of Instruments and Equipment; Clinical Practice Environment; Waste Management; Prosthetics/Laboratory; Radiology; Staff Health Issues; Education; and Creutzfeldt-Jakob Disease.

A full copy of this document can be downloaded from the NSW HealthWeb site: [www.health.nsw.gov.au](http://www.health.nsw.gov.au)

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# CURRENT JOURNAL AWARENESS

The following selected articles appeared in recent journals and may be of interest to our readers. Copies of the articles can be obtained by contacting the NSW Infection Resource Centre.

1. **Research in Infection Control Practice: A Proposed Collaborative Model**, Creedy, D. et al, *Australian Infection Control*, vol. 7, no.3, September 2002.
2. **Relative Efficacy and Activity of Medical Instrument Cleaning Agents**, Cheetham, N. & Berentsveig, V., *Australian Infection Control*, vol. 7, no.3, September 2002.

The website address for the  
**Australian Infection Control Association**

<http://www.aica.org.au>

For discussion of infection prevention and control issues,  
 contact the **Australian Infection Control Association**

listserv:

[hunter.infconlist@hunter.health.nsw.gov.au](mailto:hunter.infconlist@hunter.health.nsw.gov.au)

3. **Sharps Injury Recordkeeping Activities and Safety Product Use in California Health Care Facilities: Pilot Study Results From the Sharps Injury Control Program**, Gillen, M. et al, *American Journal of Infection Control*, vol. 30, no.5, August 2002.
4. **Risk of Medical Sharp Injuries Among Chinese Nurses**, Phipps, W. et al, *American Journal of Infection Control*, vol. 30, no.5, August 2002.
5. **Willingness to Pay to Avoid Sharps-Related Injuries: A Study in Injured Health Care Workers**, Fisman, D. et al, *American Journal of Infection Control*, vol. 30, no.5, August 2002.
6. **Handling of Surgical Instruments in a Presymptomatic Familial Carrier of Creutzfeldt-Jakob Disease**, Fishman, M. et al, *American Journal of Infection Control*, vol. 30, no.5, August 2002.
7. **Tuberculosis Exposure of Patients and Staff in an Outpatient Hemodialysis Unit**, Linqvist, J. et al, *American Journal of Infection Control*, vol. 30, no.5, August 2002.
8. **Use of Evidence Based Data to Drive Your Patient Safety Program**, Meyer, G. & Rall, C., *American Journal of Infection Control*, vol. 30, no.5, August 2002.
9. **Assessment of Handwashing Practices With Chemical and Microbiologic Methods: Preliminary Results From a Prospective Crossover Study**, Marena, C. et al, *American Journal of Infection Control*, vol. 30, no.6, October 2002.
10. **Hygienic Hand Antiseptics: Should They Not Have Activity and Label Claims Against Viruses?**, Sattar, S. et al, *American Journal of Infection Control*, vol. 30, no.6, October 2002.
11. **The Importance of Evaluating Product Dispensers When Selecting Alcohol-Based Handrubs**, Kohan, C. et al, *American Journal of Infection Control*, vol. 30, no.6, October 2002.
12. **Understanding and Controlling Methicillin-Resistant Staphylococcus aureus Infections** (editorial), Boyce, J., *Infection Control and Hospital Epidemiology*, vol. 23, no.19, September 2002.
13. **Is Methicillin-Resistant Staphylococcus aureus More Contagious Than Methicillin-Susceptible S. aureus in a Surgical Intensive Care Unit?** Vriens, M. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.19, September 2002.
14. **Staphylococcus aureus Rectal Carriage and Its Association With Infections in Patients in a Surgical Intensive Care Unit and a Liver Transplant Unit**, Squier, C. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.19, September 2002.
15. **Risk Factors for Methicillin-Resistant Staphylococcus aureus Carriage in Residents of German Nursing Homes**, Von Baum, H. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.19, September 2002.
16. **Routine Screening for Methicillin-Resistant Staphylococcus aureus Among Patients Newly Admitted to an Acute Rehabilitation Unit**, Manian, F. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.19, September 2002.
17. **Outbreak of Hemodialysis Vascular Access Site Infections Related to Malfunctioning Permanent Tunneled Catheters: Making the Case for Active Infection Surveillance**, Hannah, E. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.19, September 2002.
18. **Influenza Outbreaks in Long-Term-Care Facilities: How Can We Do Better?** (editorial), Simor, A., *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.
19. **Tuberculosis Among Adult Visitors of Children With Suspected Tuberculosis and Employees at a Children's Hospital**, Munoz, F. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.
20. **Congenital Tuberculosis and Management of Exposures in a Neonatal Intensive Care Unit**, Laartz, B. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.
21. **Failure to Implement Respiratory Isolation: Why Does It Happen?** Iwata, K. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.
22. **Delays in the Application of Outbreak Control Prophylaxis for Influenza A in a Nursing Home**,

Visit the *American Journal of Infection Control* online at:  
[www.mosby.com/ajic](http://www.mosby.com/ajic)

Drinka, P. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.

23. **Health Behavior Associated With Influenza Vaccination Among Healthcare Workers in Long-Term-Care Facilities**, Manuel, D. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.
24. **Disruption of Services in an Internal Medicine Unit Due to a Nosocomial Influenza Outbreak**, Sartor, C. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.
25. **Isoniazid-Resistant Cavitory Tuberculosis in a Physician Following Isoniazid Prophylaxis**, Karchmer, T. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.
26. **Factors Influencing Decisions Regarding Influenza Vaccination and Treatment: A Survey of Healthcare Workers**, Steiner, M. et al, *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.
27. **Nosocomial Influenza at a Canadian Pediatric Hospital From 1995 to 1999: Opportunities for Prevention**, Slinger, R. & Dennis, P., *Infection Control and Hospital Epidemiology*, vol. 23, no.10, October 2002.

*Abstracts from articles in  
Infection Control and Hospital Epidemiology  
can be viewed on the Internet at:  
<http://www.slackinc.com/general/iche>*

## INFORMATION SHEETS AVAILABLE

The NSW Infection Control Resource Centre has developed five Information Sheets on the following topics:

- Cleaning Health Care Facilities
- Infection Control in Health Care Facilities
- MRSA – Information Sheet for Patients
- MRSA – Information Sheet for Staff
- Needlestick Injuries and Other Occupational Exposures

These double-sided A4 sheets are ideal for orientation or inservice. Copies of these Information Sheets can be obtained by contacting the NSW Infection Control Resource Centre (02) 9332 9712.

## “Summertime and the living is .....MOSQUITOES!”

Mosquitoes are a health hazard. Mosquitoes spread human disease, such as Murray Valley encephalitis and Ross River Virus. During this summer holiday season around dusk each day, make sure you take special care to protect yourself, your clients or patients, your family and friends.

### USE A REPELLANT

Most mosquitoes become active around dusk although some species are active also during the day. The key time to take special care against mosquito bites is just prior to and for two hours after dusk, the time of day when many of us go outside. Your chances of being bitten at this time are extremely high, particularly if you are unprotected and exposed.

### COVER UP AND TAKE CARE

It only takes common sense to reduce your chances of picking up a serious mosquito borne infection.

- Use an effective repellent on exposed skin areas. Re-apply within a few hours, as protection wears off from perspiration, particularly on hot nights.
- The best mosquito repellents contain DIETHYL TOLUAMIDE (DEET less than 20%) check the label. **NOTE: Prolonged or excessive use of repellents can be dangerous, particularly on babies and young children. Avoid putting repellent near eyes and mouth, spread sparingly over the skin and rinse off once indoors.**
- Provide mosquito netting, outdoors, where necessary.
- Cover up as much as possible with loose fitting clothing and sensible footwear. Avoid tight clothes.
- Cover your clothes with repellent as mosquitoes can bite through material. **BE CAREFUL**, some repellents stain clothes.
- Light mosquito coils or use vapourising mats. **NOTE: Devices using light as an attractant to electrocute insects have not been shown to effectively reduce overall mosquito numbers.**
- Ensure you cover all windows, doors, chimneys, vents and other entrances with insect screens that are in **GOOD CONDITION**.

### CREATING A LOW RISK ZONE

Mosquitoes breed in stagnant ground water. Their breeding sites include swamps, ground pools and containers. It only takes two to three weeks to produce large numbers of mature mosquitoes. They then travel as far as 10km from

their breeding place in search of food, resting and breeding along the way.

During the day mosquitoes will rest and hide in cool shady areas away from direct heat before emerging at dusk to feed.

Your work facility or home could be a potential site for mosquitoes, so take steps to reduce mosquito numbers and exposure to mosquito borne disease. Keep yards well maintained and regularly mow lawns and clear vegetation areas of moist tangled undergrowth. Don't grow your own mosquitoes. Clean up yards and remove all water-holding rubbish, regularly flush out pot plant bases, keep guttering clear and make sure openings of septic tanks/water tanks are covered/screened securely.

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## **AND LET'S NOT FORGET ABOUT TICKS!**

Ticks can be a health hazard too. Ticks are bloodsucking parasites found in many parts of Australia. There are many species of ticks in Australia though the most common tick along the NSW coast is the paralysis tick, *Ixodes Holocyclus*. This tick is mostly found along the coastal strip of eastern Australia inland for about 30 kilometres. As the majority of the population also lives along the coast encounters with this tick can be frequent.

Ticks have four distinct stages of development – from eggs, to larve, to nymph, to adults. Between each stage ticks must have a bloodmeal. The whole cycle, from egg to adult, usually takes about a year. It is easy to confuse the different stages of a tick's development for different species of tick.

Ticks inject a toxin that may cause local irritation or a mild allergic reaction, however most tick bites cause little or no symptoms. However, in some cases ticks can pose a serious threat to human health.

### **ALLERGIC REACTIONS TO TICKS**

Mild allergic reactions and itching can be treated with antihistamine creams and lotions. In some susceptible people tick bite may cause a severe allergic reaction or anaphylactic shock, which can be life threatening. If swelling of the face and throat causes breathing difficulties, seek urgent medical attention.

### **TICK BORNE DISEASES**

There are several tick borne diseases in Australia including tick typhus and tick paralysis.

Australian Tick Typhus or Spotted Fever occurs along the coastal strip of eastern Australia from North Queensland to Victoria. Flinders Island Spotted Fever occurs in Victoria, Tasmania and Flinders Island in Bass Strait. Early

symptoms of tick paralysis can include rashes, headache, fever, flu-like symptoms, tenderness of lymph nodes, unsteady gait, intolerance to bright light, increased weakness of the limbs and partial facial paralysis. At the site of the bite there may be a black scab or eschar. As the tick engorges on more human blood the tick paralysis symptoms may intensify including after the tick has been removed.

Clinical diagnosis is conformed by specific blood tests. Tick typhus is treatable with antibiotics, although fatalities have been know to occur.

Lyme Disease is caused by a bacterium and has become the most common tick-borne disease in the world. It has been reported from every continent, though there is no conclusive evidence that it is found in Australia.

Lyme Disease causes a range of non-specific symptoms including fever, fatigue, headaches, myalgia, arthralgia, muscle and joint pain and sore and swollen lymph glands. These symptoms can occur within days, weeks or months of being bitten. A characteristic skin lesion, erythema migrans, may also appear within 3 to 30 days at the site of the tick bite. Lyme Disease can be treated with antibiotics.

### **TO REMOVE A TICK**

Remove a tick as soon as possible after locating it. Use fine pointed tweezers and grasp the tick as close to the skin as possible. Gently pull the tick straight out with steady pressure. If you have difficulty seek medical attention.

**DO NOT** try to kill the tick with methylated spirits or any other chemicals. This will cause the tick to inject more toxins. If you have severe infestation by larval ticks (often referred to as grass ticks) take a bath for 30 minutes with 1 cup of bicarbonate of soda.

### **PREVENTION OF TICK BITE**

Ticks, like many insects, occur in humid, moist bushy areas. Eggs are typically layed in leaf matter or mulch. Ticks are not very mobile but rely on passing animals to both feed on and transport them. Ticks may appear to drop onto clothing after brushing past bushes or trees or may fall from overhanging branches, especially around clothes lines.

### **HOW TO PREVENT THE LIKELIHOOD OF BEING BITTEN**

- Wear appropriate clothing when outdoors in tick areas including long sleeved shirts, long pants tucked into socks and a wide brimmed hat. Ticks are more easily detected on light coloured clothing.
- Spray clothes and hats with an insect repellent and wear a repellent that contains DEET or Picaridin. All clothing should be removed on return from a known tick area and the body searched for ticks especially behind the ears, on the back of the head, groin, armpits and back of knees. Be careful where clothes

- are placed as they may introduce ticks to inside the house.
- Don't forget to inspect children and pets. Many dogs are infested each year and can often die from tick paralysis.
- Mow grass in the backyard and keep mulch and leaf litter away from the main entrance to the house. Trim shrubs overhanging paths and play areas.

The above information was taken from the NSW Health brochures *Warning: Mosquitoes are a health hazard* and *Tick Alert*. Both brochures can be downloaded from the NSW Health web-site: [www.health.nsw.gov.au](http://www.health.nsw.gov.au) or can be ordered free-of-charge from:

The Better Health Centre  
 Victoria Road  
 Locked Mail Bag 5003  
 GLADESVILLE NSW 2111  
 Tel: (02) 9816 0452 fax: (02) 9816 0492



ALBION STREET CENTRE

## INFECTION CONTROL FOR CLEANERS OF HEALTH CARE FACILITIES 10<sup>th</sup> April (morning)

This half-day (morning) workshop is for cleaners of health care facilities. It provides an overview of current Infection Control procedures related to cleaning

### TOPICS

- Standard Precautions
- Preventing Transmission of Blood-Borne Infections (in particular Hepatitis B & C and HIV)
- Waste Management
- Cleaning Blood Spills
- Disposing of Incorrectly Discarded Sharps

*All information will be delivered at a basic and easy to understand level*

### VENUE

The Albion Street Centre  
 150 Albion Street, SURRY HILLS NSW 2010

### COURSE DETAILS:

\$77 (including GST)  
 Tel: (02) 9332 9720 Fax: (02) 9360 4387  
 E-mail: [albeducation@sesahs.nsw.gov.au](mailto:albeducation@sesahs.nsw.gov.au)



ALBION STREET CENTRE

## HIV PRE & POST TEST COUNSELLING 17<sup>th</sup>-20<sup>th</sup> March 2003

This four-day workshop is designed specifically for counselors and health care professionals who will be providing pre and post HIV test counseling. This is a skills-based workshop focusing on the immediate emotional and psychosocial responses to HIV testing. Other issues to be addressed will include hepatitis C, occupational exposures and suicide risk assessment.

The workshop includes didactic presentations, case discussions and micro skills practice in small groups.

### PREREQUISITE:

Basic counseling skills and an introduction to HIV/AIDS course or equivalent knowledge level.

Conditionally registered psychologists: this course has been assessed as suitable for workshop supervision hours for the NSW Psychologists' Registration Board

### VENUE

The Albion Street Centre  
 150 Albion Street, SURRY HILLS NSW 2010

### COURSE DETAILS:

\$385 (including GST)  
 Tel: (02) 9332 9720 Fax: (02) 9360 4387  
 E-mail: [albeducation@sesahs.nsw.gov.au](mailto:albeducation@sesahs.nsw.gov.au)



ALBION STREET CENTRE

## MANAGEMENT OF NEEDLESTICK INJURIES AND OTHER BLOOD BORNE PATHOGENS 25<sup>th</sup>-26<sup>th</sup> March 2003

This two-day workshop is designed specifically for counselors and health care professionals who will be providing pre and post HIV test counseling. This is a skills-based workshop focusing on the immediate emotional and psychosocial responses to HIV testing. Other issues to be addressed will include hepatitis C, occupational exposures and suicide risk assessment.

The workshop includes didactic presentations, case discussions and micro skills practice in small groups.

### PREREQUISITE:

Basic counseling skills and an introduction to HIV/AIDS course or equivalent knowledge level

Conditionally registered psychologists: this course has been assessed as suitable for workshop supervision hours for the NSW Psychologists' Registration Board

### VENUE

The Albion Street Centre  
 150 Albion Street, SURRY HILLS NSW 2010

### COURSE DETAILS:

\$220 (including GST)  
 Tel: (02) 9332 9720 Fax: (02) 9360 4387  
 E-mail: [albeducation@sesahs.nsw.gov.au](mailto:albeducation@sesahs.nsw.gov.au)



### INTRODUCTION TO INFECTION CONTROL NURSING

12<sup>th</sup> February 2003

7<sup>th</sup> May 2003

This one-day course is designed for Nurses who are beginning practitioners in the field of Infection Control, or who are required to take some Infection Control responsibilities in the course of their work.

#### TOPICS

The Principles of Infection Control  
The Role of the Infection Control Nurse  
Staff Health  
Waste Management  
Policy and Programs  
Networking and Resources

#### VENUE

The Albion Street Centre  
150 Albion Street  
SURRY HILLS NSW 2010

#### COURSE DETAILS:

\$137.50 (including GST)

Tel: (02) 9332 9720

Fax: (02) 9360 4387

E-mail: [albeducation@sesahs.nsw.gov.au](mailto:albeducation@sesahs.nsw.gov.au)



### INTRODUCTION TO INFECTION CONTROL FOR DENTAL ASSISTANTS

26<sup>th</sup> February 2003

31 March 2003

This one-day workshop is designed for Dental Assistants. It provides an overview of current infection control procedures.

#### TOPICS COVERED INCLUDE:

The Principles of Infection Control  
Introductory Microbiology and Immunology  
Processing Instruments and Equipment  
Staff Health  
Management of Sharps Injuries

#### VENUE

The Albion Street Centre  
150 Albion Street  
SURRY HILLS NSW 2010

#### COURSE DETAILS:

\$137.50 (including GST)

Tel: (02) 9332 9720

Fax: (02) 9360 4387

E-mail: [albeducation@sesahs.nsw.gov.au](mailto:albeducation@sesahs.nsw.gov.au)

## INFECTION CONTROL RESOURCE PACKAGE

The NSW Infection Control Resource Centre has developed the Infection Control Resource Package containing current Infection Control topics, issues and selected diseases. Each topic contains a short historical overview, recent developments and future trends. Mode of transmission, incubation period and preventative measures are also included in the applicable packages. Each topic contains a reference list for further reading as well as suggested videos and relevant websites.

The Resource Package is in easy-to-understand English and ideal for gaining brief background information on a particular infection control related topic. It is written for health care worker reference and not for patients or clients.

Further topics will be developed and suggestions for future topics are welcome.

Current topics include:

- Standard and Transmission Based Precautions
- Hand Washing
- Safe Handling, Usage and Disposal of Sharp Objects
- Latex Allergies
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV/AIDS
- Tuberculosis
- Methicillin-Resistant Staphylococcus Aureus (MRSA)
- Vancomycin-Resistant Enterococcus (VRE)
- Measles
- Rubella (German Measles)
- Pertussis (Whooping Cough)
- Respiratory Syncytial Virus
- Varicella (Chicken Pox)
- Herpes Zoster (Shingles)
- Meningococcal Disease
- Legionellosis
- Head Lice (Pediculosis Capitis)
- Scabies

To order your copy of the bound Infection Control Resource Package please contact the NSW Infection Control Resource Centre on (02) 9332 9712.