VOLUME #34 SUMMER 2009

HALDIMAND-NORFOLK HEALTH UNIT

PHYSICIANS' NEWSLETTER

Step up to a *Healthier* you

First Stroke Primary Prevention Educational Series A Success!

Heart Disease and Stroke are still among the leading causes of death and disability in Ontario. More than 75% of adults have at least one risk factor for stroke[1], and Haldimand and Norfolk Counties are no exception. From the Canadian Community Health Survey (CCHS, 2005), it is evident that the following lifestyle factors play a significant role in the health of older adults in Haldimand and Norfolk counties. We know that:

- 51.5% consume less than 5 daily servings of fruits and vegetables
- 56.8% are inactive (leisure time physical activity)
- 15.9% smoke daily or occasionally
- 32.7% have high blood pressure
- 48.5% regularly drink alcohol
- 42.1% are overweight

However, with our new Stroke Primary Prevention Program, targeting adults 55 and older, the Haldimand-Norfolk Health Unit is hoping to lower these numbers.

The program, Step Up to a Healthier You, was first launched on April 20th, 2009 with a Stroke Awareness Evening at the Green's at Renton. That night all who attended had the opportunity to learn about stroke prevention from the various health displays that were set up and from two guest speakers: Walter Gretzky and Dr. Tim Bard, MD, FRCPC. Participants also had the chance to sign up for a four week educational series, to learn about the risk factors for stroke. The evening was a great success with over 170 people in attendance.

During the month of May, the first round of the Stroke Prevention Educational Series took place in Dunnville and Simcoe. Participants met once a week, for two hours for four weeks and had the opportunity to learn about, as well as make, healthy lifestyle changes. Some of the main topics that were of focus included: raising awareness about stroke, healthy eating, increasing physical activity levels, managing high blood pressure and high cholesterol, quitting smoking and stress management. The classes ended with great success and lots of positive feedback from participants.

With the first round of the educational series completed, Anna Glowala, Health Promoter for Stroke Prevention from the Haldimand-Norfolk Health Unit, is already in the process of organizing and accepting participants for the second round of the educational series. This time, they will be held during October 2009 in Delhi and Caledonia.

Flyers and more information will be distributed throughout the community closer to the start date of the classes but for anyone who would like more information or is interested in taking an active role in promoting the educational series, please contact Anna Glowala, at the Haldimand-Norfolk Health Unit at 519.426.6170 ext 3257 or e-mail: anna.glowala@hnhu.org.

-Anna Glowala

[1] Preventstroke.ca

INSIDE THIS ISSUE

Suicide Bereavement Support Group

There is now a support group for people who have lost friends and relatives to suicide in Haldimand – Norfolk.

The Suicide Prevention Network holds an annual community forum every year. Last Nov. 25, 2008 the focus was on the survivor (someone who has lost a loved one to suicide). Judge James Clarke visited Haldimand – Norfolk and spoke of his journey and his rediscovery of hope after he lost his wife to suicide. His presentation was well received by the audience. Many commented on how Judge Clarke's honest, frank sharing of his feelings, his thoughts and his beliefs helped them.

This forum was the impetus to forming a suicide bereavement support group for survivors in the Haldimand – Norfolk area. The first meeting took place on April 28, 2009. Several survivors attended and asked to continue meeting.

Survivors of the suicidal death of a loved one are an isolated and neglected group with unique problems and needs. The grief after suicide is one of the most stressful and difficult of all grief processes.

It can be so powerful to connect with other survivors and such a relief to be able to talk openly about suicide with people who understand.

For so many survivors a crucial part of their healing process is the support and sense of connection they feel through sharing their grief with other survivors. The most common way this sharing occurs is through survivor support groups.

If you have any patients in your practice that you think might benefit from attending the meetings please have them call Marilyn Antkiw PHN at 519 426-6170 ext. 3252 to find out when the group's is meeting again.

Keep a copy of the book mark at your desk for reference. Thanks for your support of this bereavement group.

Antibiotic Stewardship

Due to the growing number of resistant organisms, the need for effective antibiotic stewardship is growing. Antibiotic stewardship helps lower the development of resistance to various organisms, especially those responsible for causing Upper Respiratory Tract Infections (URTI's) . The objective of such a stewardship is to identify and quantify the determinants of antibiotic prescribing for URTI's for both physicians and patients in hospital and family practice.

In the past, the primary outcome of stewardships has been the cost savings, however, the focus now is on decreasing bacterial resistance and/ or reducing super-infection. Many benefits are clear when these programs are put into place and they will become an integral part in the in-patient healthcare setting.

In order to develop and maintain valuable antibiotic stewardship programmes in health care facilities, a multi-disciplinary approach is preferable. Ideally, this involves physicians, nurses, labs, pharmacies, and Infection Control Practitioners (ICP's) for hospitals and long term care homes (LTCH's). In family practices, patients would also be involved in surveys and education. With the multi-disciplinary approach, antibiograms can be developed to ensure first line antibiotics take presedence.

Patient age, co-morbidity, repeat visits and provision of pharmaceutical samples are just a few of the factors which influence antibiotic use. Patient pressure is also perceived as a major factor in inappropriate antibiotic use. Keeping this in mind, education for patients as well as physicians helps to ensure an effective stewardship programme.

It has been noted that patients who are recommended Over the Counter medications are less likely to return to their physicians for antibiotic prescriptions. When necessary, first line antibiotics outlined in

The antibiogram should be prescribed to eliminate the trial and error using other medications.

Literature indicates that physicians surveyed reported decreased costs with decreased use of antibiotics. Also, costs are decreasing with increased use of less expensive antibiotics such as TMP/SMX. These physicians have also noted fewer adverse effects and antibiotic drug interactions.

Submitted by CD Team, HNHU

References

Antibiotic Stewardship – all Good Things in Moderation; Dr. Dick Zoutman, Queen's University Faculty of Medicine

Antimicrobial Stewardship Programs: Interventions and Associated Outcomes; Patel D, Lawson W, Guglielmo BJ, University of California

Thimerosal in Vaccines and Autism

Thimerosal is a mercury-based preservative used in the manufacturing process of multidose vials of vaccine. Thimerosal helps to prevent the growth of bacteria and fungi in vaccines and stabilizes the vaccine so that it remains effective over time.

In large concentrations or over extended periods of exposure, mercury can cause damage to the brain and the kidneys. The organic form, methylmercury, is the main known cause of neurological damage. The sources of methylmercury are in the environment, with fish as a food source of greatest concern. Maximum tolerable levels for daily intake of methylmercury, relative to body weight, have been established.

Thimerosal contains ethylmercury, not methylmercury. The original concern regarding thimerosal in vaccine was a purely theoretical one, brought to the attention in the 1990's based on the total amount that would be received in the infant schedule as recommended in the United States at that time. The recommended maximum levels for methylmercury exposure were used because no such guidelines existed for ethylmercury.

Ethylmercury is eliminated much more quickly and is less likely to reach toxic levels in the blood than methylmercury. The levels of ethylmercury in vaccines are minute and have not been shown to cause harm. Millions of doses of thimerosal-containing vaccines have been given to patients since 1930's with no common or serious adverse events.

Some speculation has tried to link thimerosal in the MMR vaccine to autism, but the MMR routinely used in Canada has never contained thimerosal. DTap, polio and Hib vaccines have not contained this preservative since 1997-98. The influenza and most hepatitis B vaccines are in multidose vials and contain thimerosal as a preservative.

The best available science to date has shown that there is no link between vaccines containing thimerosal and autism or other behaviour disorders. The National Advisory Committee on Immunization (NACI) has reviewed the safety of thimerosal and concluded that the alleged adverse health effects from thimerosal in vaccines has never been substantiated. International bodies, such as the World Health Organization (WHO), the US Food and Drug Administration (U.S. FDA) and the Institute of Medicine in the U.S., share this opinion.

There is no safety reason to avoid thimerosal-containing vaccines. The National Advisory Committee on Immunization (NACI) has thoroughly reviewed the evidence and indicated that "There is no legitimate safety reason to avoid the use of thimerosal-containing products for children or older individuals, including pregnant women."

References:

Public Health Agency of Canada. Thimerosal in Vaccines and Autism

Canadian Coalition for Immunization Awareness and Protection immunize.ca

National Advisory Committee on Immunization. Canadian Immunization Guide 2006.

Submitted by Clinical Services Team, HNHU.

Revisions to the Publicly Funded Immunization Schedules for Ontario

The new revised schedule, January 2009, has replaced the February 2005 version. According to contacts at the Ministry of Health and Long-Term Care, "Schedules" packages have been sent to all family physicians, paediatricians, nurse practitioners, midwives, community health centres (CHC), long term care homes (LTCH) and hospitals. The following are key changes to the Schedules:

Human papilloma virus (HPV) vaccine

- The addition of the human papilloma virus (HPV) vaccine for Grade 8 females to the Schedules.
- The vaccine that is currently being provided through Ontario's publicly-funded immunization program is the Gardasil® vaccine produced by Merck Frosst.

Tetanus-diphtheria-acellular pertussis (Tdap) vaccine

- Tetanus-diphtheria-acellular pertussis (Tdap) plus inactivated poliovirus (IPV) vaccines for children 7 years and older who missed the 4 to 6 year old booster dose of DTaP-IPV (Quadracel®).
- Unimmunized children/adolescents 7 years to 17 may receive 3 doses of Tdap plus IPV as a series.
- Adolescents 14 to 16 years of age and 10 years after the 4 to 6 year old booster should receive a dose of Tdap.
- The vaccine that is currently being provided is the Adacel® vaccine, produced by Sanofi Pasteur.

Pneumococcal conjugate (Pneu-C-7) vaccine

- A change to the interval between the last dose in the primary series of pneu-C-7 and the booster dose from six (6) to eight (8) weeks to at least two (2) months.
- Additions to the high risk eligibility criteria for pneu-C-7 vaccine to include children less than five (5) years of age who attend a child care centre and/or who are of First Nations origin who were not previously vaccinated. They require one dose.
- The vaccine that is currently being provided is the Prevnar® vaccine, produced by Wyeth.

Pneumococcal polysaccharide (Pneu-P-23) vaccine

- A change in the criteria for reimmunization and the timing of reimmunization for the pneumococcal polysaccharide vaccine.
- The vaccines currently being provided are the Pneumo®23 vaccine, produced by Sanofi Pasteur and Pneumovax® produced by Merck Frosst.

Meningococcal conjugate C (Men-C) vaccine

- A new recommendation that one year old children immunized against Men-C in infancy (ie, < one year of age) require another dose at least one (1) year after the last dose in the infant series for enhanced protection against meningococcal disease, serogroup C.
- The vaccine currently being provided is the Menjugate® vaccine produced by Merck Frosst.

Meningococcal conjugate ACYW-135 (Men-C-ACWY) vaccine

- The addition of high risk eligibility criteria for the meningococcal ACYW-135 conjugate vaccine.

- The vaccine currently being provided is the Menactra® vaccine produced by Sanofi Pasteur.

Influenza vaccine

- New recommendations for children receiving influenza vaccine as recommended by the National Advisory Committee (NACI) are: Previously unvaccinated children under nine (9) years of age require two doses of influenza vaccine given 4 weeks apart. Eligible children less than nine (9) years of age who have properly received one or more doses of influenza vaccine in the past are recommended to receive one dose per season thereafter.

Varicella vaccine

- The high risk criteria has changed, please refer to the Canadian Immunization Guide (CIG) available at: http://www.phac-aspc.gc.ca/naci-ccni/index.html.

Guide errata and clarifications, March 2008. Available at: http://www.phac-aspc.gc.ca/publicat/cig-gci/errarta-eng.php

- The vaccines currently being provided are Varivax III® produced by Merck Frosst and Varilrix® produced by GlaxoSmithKline.

Measles immunity

- Change to the cut-off year for the assumption of immunity to measles from 1957 to 1970. This change is being made based on the epidemiology of measles in Ontario, the introduction of publicly funded measles-containing vaccine in 1970, the recommendation of Provincial Infectious Diseases Advisory Committee (PIDAC) and to be consistent with National Advisory Committee on Immunization (NACI) recommendations.

An additional table (Schedule 4) has been added to the Schedules, for adults 18 years and older, not immunized in childhood.

Revisions to the Schedules are based on the recommendations from NACI, feedback from health unit staff, the PIDAC immunization subcommittee and a representative group of community physicians. The Publicly Funded Immunization Schedules for Ontario - January 2009 are posted on the Ministry of Health and Long-Term Care web site at: http://www.health.gov.on.ca/immunization.

NOTE: Also included in the ministry package is "Recommended and minimum ages and intervals between vaccine doses of publicly funded routine childhood vaccines". This is a handy tool many practitioners will find useful, as it saves looking through the Canadian Immunization Guide and product monographs for intervals between vaccines.

Look in up-coming editions of the Physicians' Newsletter for more details on each of the above changes.

Patient Delivered Partner Therapy (PDPT)

Patient Delivered Partner Therapy (PDPT) refers to the treatment of sexual partners of cases diagnosed with chlamydia and/or gonorrhea by providing the case with medication/prescription for them selves as well as their partner. This is performed without the health care provider examining the partner before providing treatment. This therapy is meant to ensure the "hard to reach" partners receive appropriate treatment and aids in the avoidance of re-infection when partners are treated at the same time as cases.

According to the Centres for Disease Control, they state using PDP therapy was a "useful option" for the treatment of partners, especially when dealing with male partners of women with chalmydia and/or gonorrhea.

The College of Physicians and Surgeons of Ontario (CPSO) created a policy which grants physicians to offer PDPT to those outside the "established doctor-patient relationship". The policy states, "Treatment for a sexual partner of a patient with a sexually transmitted infection (STI) who, in the physician's determination, would not otherwise receive treatment and where there is a risk of further transmission of the STI" (Policy #2-05; www.cpso.on.ca/policies /drug prac.htm).

Remember FREE STI medication is now available at the Health Unit….fax your order TODAY!

Publicly Funded Schedules 2005 VS 2009

Pneumococcal conjugate (Pneu-C-7) vaccine

- A change to the interval between the last dose in the primary series of pneu-C-7 and the booster dose from six (6) to eight (8) weeks to at least two (2) months.
- Additions to the high risk eligibility criteria for pneu-C-7 vaccine to include children less than five (5) years of age who attend a child care centre and/or who are of First Nations origin.
- The vaccine that is currently being provided is the Prevnar® vaccine, produced by Wyeth

2005

Detailed Schedule for Pneumococcal Conjugate vaccine depending on age at first dose

Age at first dose	*Primary series*	*Age at Booster dose[x]*
2-6 months	*3 doses, 2 months apart*	*12-15 months*
7-11 months	*2 doses, 2 months apart*	*12-15 months*
12-23 months[xx]	*2 doses, 2 months apart*	
24-59 months – with high risk conditions	*2 doses, 2 months apart*	

x The pneumococcal conjugate booster dose should be given at least 6 – 8 weeks after the previous dose.

xx Publicly funded vaccine is available only for children born on or after January 1, 2004 AND those at high risk under 5 years of age.

2009

Table 2: Detailed schedule for Pneumococcal Conjugate vaccine depending on age at first dose

Age at first dose	*Primary series*	*Age at Booster dose †*
2-6 months	*3 doses, 2 months apart*	*12-15 months*
7-11 months	*2 doses, 2 months apart*	*12-15 months*
12-23 months ‡	*2 doses, 2 months apart*	
24-59 months – with high risk conditions	*2 doses, 2 months apart*	

† The pneumococcal conjugate booster dose should be given at least 2 months after the final dose of the primary series.

‡ Publicly funded vaccine is available for all children less than 2 years of age AND those at high-risk under 5 years of age

Pneumococcal polysaccharide (Pneu-P-23) vaccine

- A change in the criteria for reimmunization and the timing of reimmunization for the pneumococcal polysaccharide vaccine.
- The vaccines currently being provided are the Pneumo®23 vaccine, produced by Sanofi Pasteur and Pneumovax® produced by Merck Frosst.

2005

Schedules: Reimmunization with Pneumococcal Polysaccharide Vaccine

Criteria for Reimmunization	*Timing*
A single revaccination with Pneumococcal Polysaccharide vaccine is appropriate for those 2 years of age and older with: • *Functional or anatomic asplenia or sickle cell disease* • *Debilitating cardiorespiratory disease* • *Hepatic cirrhosis* • *Chronic renal failure or nephrotic syndrome* • *HIV infection and immunosuppression related to disease or therapy*	*1 dose after 5 years for those 11 years of age or older at the time of revaccination* *OR* *1 dose after 3 years for those 10 years of age or less at the time of revaccination*

2009

Table 4: Reimmunization with Pneumococcal Polysaccharide Vaccine

Criteria for Reimmunization	*Timing*
A single revaccination with Pneumococcal Polysaccharide vaccine is appropriate for those 2 years of age and older with: • *Functional or anatomic asplenia or sickle-cell disease* • *Hepatic cirrhosis* • *Chronic renal failure or nephrotic syndrome* • *HIV infection* • *Immunosuppression related to disease or therapy*	*1 dose after 5 years for those 11 years of age or older at the time of initial immunization* *OR* *1 dose after 3 years for those 10 years of age or less at the time of initial immunization*

Sources: Communication from Ontario Ministry of Health and Long-Term Care, Chief Medical Officer of Health, December 19, 2008
Publicly Funded Immunization Schedules for Ontario-February 2005. Publicly Funded Immunization Schedules for Ontario-January 2009

Submitted by: Vaccine Preventable Diseases Team

Obesity and the Built Environment

The Prognosis for Patients is Dire

In 2005, The Ontario College of Family Physicians published a review of recent research on urban sprawl and human health. One report, OBESITY, outlined how urban sprawl contributes to obesity and related illnesses, how obesity threatens our health, and how to build healthier communities. (www.ocfp.on.ca/local/files/Urban%20Sprawl/UrbanSprawl-Obesity.pdf)

The Heart and Stroke Foundation has taken a closer look at urban sprawl and the rising rates of obesity. The research found that each additional kilometer walked per day reduces the likelihood of becoming obese by nearly 5%. Each hour per day spent in a car increases the likelihood of becoming obese by 6%. (www.heartandstroke.nf.ca/site/c.inKLKTOwHoE/b.3654911/k.8498/2005_Report_Card__Has_the_subarban_dream_gone_sour.htm)

> *"Don't let people drive you crazy when you know it's in walking distance"*
>
> *Author Unknown*

The built environment can either make it easier or harder for people to be physically active. Unfortunately, a growing majority of people in Haldimand and Norfolk are exhibiting the negative health impacts of living in communities that make walking or biking to destinations difficult. In 2007, a higher percentage of Haldimand and Norfolk residents, age 12 years and older, were inactive compared to 2005 (52.1% and 45.9% respectively).

(Source: Haldimand and Norfolk Chronic Disease Prevention Health Status Report 2009)

One way to get people walking, cycling and being physically active everyday is to build communities where residents can choose to walk, cycle or use other forms of wheeled-transportation instead of driving for short distance trips. The iCANwalk campaign raises awareness about the elements that support or prevent walking in an individual's neighbourhood and encourages residents to gather that data using a simple checklist.

What you can do:

- Ask your patients if they are able to walk regularly to do daily chores where they live and encourage them to adopt this simple health behaviour
- Refer patients and staff to www.icanwalk.ca where they can find out how they can support the development of more walkable communities in Haldimand and Norfolk.
- Display posters and checklists from the iCANwalk campaign in your reception areas.

Health Action will use the returned checklists to compile data on existing supports for walkable communities in Haldimand and Norfolk, as well as those areas in need of improvement. This information will be shared with decision makers such as mayors and municipal staff.

Checklists and posters can be obtained FREE by calling 519-426-6170 ext. 3208 or emailing info@healthaction.ca

Let's work together to create communities that make healthy choices like walking easier choices for everyone.

Submitted by:
Josh Daley, Heart Health Coordinator
Health Action

Working Together in Rabies Investigations

Although not as prevalent as in the past, rabies continues to be a risk to the health of our local residents. Bat rabies in particular continues to be a constant threat in our region while sporadic wildlife cases have appeared in neighbouring counties and raccoon rabies looms at the nearby boarders of our country. For the latest information and statistics on rabies in Ontario, please visit the Ministry of Natural Resources' Rabies Reporter site at: http://www.mnr.gov.on.ca/en/Business/Rabies/2ColumnSubPage/196811.html

Most rabies investigations begin with the health care provider. As a reportable disease, health care providers are legally responsible to forward all relevant information regarding possible rabies exposure incidents to public health authorities. This is explained in section 2 (1) of Ontario Regulation 557 where it states; "a physician, registered nurse… or any other person who has information concerning any animal bite or other animal contact that may result in rabies in persons shall as soon as possible notify the medical officer of health and provide the medical officer of health with the information."

This information is crucial to the success of the Health Unit's investigation and, in doing so, preventing human rabies cases.

To provide this information, the Health Unit has attached the Report of Animal Bite/Contact with Animal Suspected of Rabies form below. As first responders to these incidents, the information you gather from the victim is essential to the success of the Health Unit's investigation. Inadequate and inaccurate information can result in undue risk and harm to the victim.

Please note that it is the responsibility of the attending physician to determine if treatment with rabies post-exposure prophylaxis (PEP) is required. The MOHLTC's Guidelines for Management of Suspected Rabies Exposures available on our website at www.hnhu.org can be used as an aid in making this decision. The Haldimand-Norfolk Health Unit is also available for consultation and will provide PEP upon the physician's request.

The Haldimand-Norfolk Health Unit would like to thank all health care providers for their continued participation in rabies investigations. This disease could not be controlled without your help.

HALDIMAND-NORFOLK HEALTH UNIT

REPORT OF ANIMAL BITE/CONTACT WITH ANIMAL SUSPECTED OF RABIES

"Personal information contained on this form is collected pursuant to the Municipal Freedom of Information and Protection of Privacy Act 1990" for the purpose of fulfilling the regulations of the Health Promotion and Protection Act, 1990. Questions and/or concerns should be directed to the, Records Management/FOI Coordinator, Norfolk County (519)426-5870.

Reported by _____ *Date* _____ *Faxed* ❍

Simcoe Office Fax Number: 519-426-9974 • Caledonia Office Fax Number: 905-765-8905

PERSON(S) IN CONTACT WITH ANIMAL					
NAME	SEX	AGE	WEIGHT	ADDRESS	PHONE

Type of Animal _____ Owner _____

Address _____ Phone _____

Lot _____ Concession _____ City/Township _____

Type of wound(s): Bite(s) ❍ Scratch(es) ❍ Other ❍ _____

Location of wound(s): _____

Additional Information: _____

_____

_____

_____

_____

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