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HALDIMAND-NORFOLK HEALTH UNIT

PHYSICIANS' NEWSLETTER

SOY FORMULA

Exclusive breastfeeding is recommended for six months and up to two years and beyond.



Iron-fortified cow's milk formulas are the recommended choice for healthy term infants who are not exclusively breastfed.

There are **very few** indications for the use of soy formula as further research is needed to determine acceptability. The indications are:

Infants with galactosemia (a very rare genetic disorder in which the infant is unable to metabolize the sugar galactose)

Infants who cannot consume dairy products based on cultural/religious/ personal reasons (i.e. vegan)

Soy formula has NOT been proven to prevent allergies or colic and should NOT be given to preterm infants.

For more information contact Michelle Saraiva, Public Health Dietitian at (519) 426-6170 Ext. 3237

Influenza and 'The Shot'

A recent Provincial Infectious Disease Advisory Committee (PIDAC) Knowledge Document "Best practices for infection prevention and control programs in Ontario" (2012), has been updated. This document has introduced a new section specifically discussing influenza and the importance of health care providers obtaining their influenza vaccine. The document states "influenza vaccination of health care workers is an individual benefit to each health care worker, and vaccination programs are safe and cost-effective because they reduce absenteeism" (p.30). While the client care you deliver may not involve similar close contacts as those in an acute or long term care setting, it is still essential for all of you, and your colleagues to receive an influenza vaccine annually, to **protect yourself, your families and your clients.**

Reference:

Provincial Infectious Diseases Advisory Committee (PIDAC). (2012). *Best practices for infection prevention and control programs in Ontario.* (Ed. 3rd). Retrieved from http://www.oahpp.ca/resources/documents/pidac/BP%20Infection%20Prevention%20Control_English_Final_2012-08-01%20Final.pdf

Testing for West Nile Virus (WNV) and Lab Interpretation

Screening:

Serum is the preferred specimen, CSF is not recommended for Abrovirus serology (including WNV or other flaviviruses)

The West Nile Virus (WNV) IgM and IgG Enzyme-linked Immunosorbent Assays (ELISA) are used to screen: (Ontario Agency for Health Protection and Promotion – Lababstract, 2008)

- A reactive IgM antibody response using ELISA is specific to WNV and is rarely due to cross reaction with other flaviviruses
- A reactive IgG antibody response using ELISA may be due to infection with WNV or other flaviviruses that may be causing a cross reaction

All IgM and/or IgG reactive samples will be further tested using the Plaque Reduction Neutralization test (PRNT) which is highly specific for WNV.

For more information regarding West Nile Virus testing and interpretation check out the Lababstract at <http://www.oahpp.ca/resources/lababstracts.html>

Chlamydia: Myths and Facts

MYTH: Chlamydia can remain dormant for a number of years.

FACT: Unlike some other STIs (eg. HPV), Chlamydia cannot lay dormant. Chlamydia is often under diagnosed because the majority of infected individuals are asymptomatic. Therefore, until they are screened or develop symptoms, the individual will not know they are infectious and will continue to spread the disease. In the absence of treatment, infection persists for many months.

Reference: Canadian Guidelines on Sexually Transmitted Infections, 2006.

MYTH: It is common for Chlamydia results to be “false-positive”.

FACT: Chlamydia urine NAAT and endocervical/urethral swabs for NAAT are highly sensitive and specific thus it is very rare to get a false-positive result. In both males and females, the swabs for NAAT are more than 97% sensitive and 96% specific. For the urine NAAT, in females the sensitivity is over 94% and the specificity is 98%. For males, the urine NAAT has a sensitivity of 96% and a specificity over 97%.

Reference: Public Health Ontario, Labstract: Chlamydia trachomatis and Neisseria gonorrhoeae - Sensitivity and Specificity of the GEN-PROBE APTIMA Assay – May 2011.

MYTH: Only young adults and teens need to be screened for Chlamydia.

FACT: In older Canadians (45-54 years of age) Chlamydia cases increased from 997 in 1997 to 3387 in 2007. The Public Health Agency of Canada identifies a lack of awareness as being the cause for the increases as well as more single older adults and new avenues available for finding a partner (eg. Online dating). Of adults 57-64 years of age, 73% report being sexually active but only 38% men, 22% women had discussed sex with their health care provider since age 50.

References: Public Health Agency of Canada. (2011). Sexually Transmitted Infections: Middle-aged Adults. Retrieved from: <http://www.phac-aspc.gc.ca/std-mts/sti-its-pro-eng.php>.
Tessler Lindau, S., Schumm, L., Laumann, E., Levinson, W., O'Muircheartaigh, C. (2007). A study of sexuality and health among older adults in the United States. The New England Journal of Medicine, 358(8): 762 – 74.

MYTH: When treating client's with Chlamydia, it is best to provide them with a prescription to take to the pharmacy.

FACT: To ensure the treatment is taken in a timely matter it is best to have the client treated while they are in the office. This not only ensures they are treated with little delay but that there will be no charge for their treatment. You can even treat their partners if you are concerned about re-infection! Azithromycin is available from the Haldimand-Norfolk Health Unit for no charge to provide to your clients. To place your order, please complete the relevant section on your vaccine order form. When your stock is getting low, don't forget to request more.

Treatment of Pregnant Women with Chlamydia

The Canadian Guidelines on Sexually Transmitted Infections (2008), states “*Doxycycline and quinolones are contraindicated in pregnancy and in lactating women*” (p.7)

Clinical trials compared amoxicillin, erythromycin and azithromycin showed similar microbiological and clinical cure, but maternal gastrointestinal side effects were found more often with erythromycin.

Treatment Suggestions for pregnant women and nursing mothers: urethral, endocervical, rectal infection are:

- Azithromycin 1 g PO in a single dose *

OR

- Amoxicillin 500mg PO tid for 7 days +

OR

- Erythromycin 2g/day PO in divided doses for 7 days □ ◊

OR

- Erythromycin 1 g/day PO in divided doses for 14 days □ ◊

*If vomiting occurs more than 1 hour post administration, a repeat dose is NOT required

+If erythromycin or amoxicillin has been used for treatment in nursing mothers, test of cure should be performed 3-4 weeks after the completion of treatment

□ ◊ Erythromycin dosage refers to the use of erythromycin base. Equivalent dosages of other formulations may be substituted (*with the exception of the estolate formulation being contraindicated in pregnancy*). Gastrointestinal side effects are more severe with erythromycin than amoxicillin.

Reference:
Public Health Agency of Canada. (2008). Canadian guidelines on sexually transmitted infections.



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