CMO's Update 21

April 2002

IMPORTANT INFORMATION FROM THE CHIEF MEDICAL OFFICER

MMR Immunisation

MMR immunisation has again received considerable attention in the national and local media, resulting in more anxiety among parents, and presumably a fall in uptake rates, although this is not yet known. In England uptake rates in some areas are already as low as 75%, with the inevitable occurrence of outbreaks. At the time of writing, measles outbreaks are confirmed in London, and suspected in several other areas. Uptake rates in N Ireland have recovered well after previous scares, to about 90% overall. This is only because of the hard work of health professionals, who continue to be trusted by the public here to give sound advice.

This media coverage related to two studies published during the week beginning 5 February 2002. The first paper, published in the Journal of Molecular Pathology by V Uhlmann et al, proposed a viral pathogenic mechanism, implicating measles virus, for 'new variant' inflammatory bowel disease and development disorder. The study did not consider the immunisation history of cases or controls. The technique used to detect measles virus in the bowel has yet to be reviewed by independent experts and replicated elsewhere. An accompanying editorial on this study concludes, "it would be entirely wrong to jump to the conclusion that the measles component of MMR causes colitis or the developmental disorder in these particular or any other children."

The second paper, published on the British Medical Journal's website on 8th February 2002, firmly rejects any association between MMR and autism associated with developmental regression and bowel problems. Almost 300 children with autism were included in this population study, with case note review linked to independently recorded vaccine data.

The Joint Committee on Vaccination and Immunisation, and the Committee on Safety of Medicine, regularly review the extensive evidence and reports, from all around the world, and have agreed that there is no link between MMR and autism. The World Health Organisation, all major UK health organisations including professional bodies, the American Academy of Paediatrics, and the Institute of Medicine in the United States all support MMR immunisation. The Medical Research Council in the UK has recently carried out a review of autism research epidemiology and causes, which concluded that there is no link between MMR and autism.

continued overleaf

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Single Vaccines

There is some demand among the general public to give separate mumps, measles and rubella vaccines, spaced by at least 1 year. Dr Wakefield suggested this at a press conference following the publication of his paper in 1998. The suggestion is not supported by his 12 co-authors and there is no scientific evidence to support his view.

- No country in the world recommends giving these vaccines separately.
- Separating vaccines puts children at risk while they wait unnecessarily between each vaccine.
- Giving vaccine separately means that children are subject to unnecessary repeat injections and more risk of adverse reactions – even if mild – at the injection site.
- In addition, using separate vaccines would decrease the uptake of vaccination and thus increase the risk that these diseases will return. Experience of separating out the pertussis component of DTP vaccine in the 1970s showed that uptake of pertussis immunisation decreased to around 30%. As a result there were large increases in the rates of pertussis infection, including many deaths.

Currently none of the single component vaccines for mumps or measles which are licensed in the UK are manufactured for, or marketed in, the UK. The Medicines Control Agency (MCA) has restricted the importation of unlicensed single component vaccines on the ground that under law, unlicensed medicines should not be imported when a safe and effective licensed alternative, ie MMR vaccine, is available and meets the patients clinical needs. There are concerns that these unlicensed vaccines may be ineffective or less safe than MMR as they have not been subjected to the same rigorous trials and controls.

The Department remains convinced that MMR vaccine is both safe and the most effective way to protect children against measles, mumps and rubella. DHSSPS is currently developing further support materials, and considering any further measures which can be taken to support the uptake of MMR.

Prevention of outbreaks in N Ireland depends on the continuation of the hard work of health professionals in the community.

Useful sources of further information are:
www.dhsspsni.gov.uk
www.phls.org.uk
www.immunisation.org

Leaflets for patients have been produced by Sense, the National Deafblind and Rubella Association about rubella and the effects of congenital rubella syndrome. Copies of the leaflet "Remember Rubella" are available free to surgeries from Sense Communications Department at 11-13 Clifton Terrace, Finsbury Park, London N4 3SR (Tel: [redacted]).

Further information available from [redacted] *Senior Medical Officer (Communicable Diseases), Department of Health, Social Services and Public Safety, Room 3.16, Castle Buildings, Stormont, Belfast, BT4 3PP*
Tel: [redacted] *E-mail:* [redacted]

Informed choice project for PSA Testing

- A consultation exercise is now underway to assess the usefulness of leaflets on PSA testing for asymptomatic men
- These materials have been developed as part of the Informed Choice Programme announced last September in the NHS Prostate Cancer Programme
- They have been developed in recognition of the fact that more men are becoming aware of prostate cancer and are increasingly requesting PSA tests

Evidence has shown that if men who have no symptoms of prostatic disease are given full information about the implications of the PSA test they are less likely to want to go ahead with it. Any man over 50 approaching his GP requesting a PSA test should be offered the leaflets. He can then use the information to decide on whether to go ahead and have the PSA test, which the GP will be able to offer.

GPs and patient focus groups have been involved in developing the leaflets which fully explain the details of the test – setting out its benefits and drawbacks.

- Over the next six months, GPs and the general public will be able to access these leaflets.
- Feedback on their usefulness and the impact they have on the general level of requests for PSA tests from men are welcomed.
- There will be a message box for comments from users and any suggestions for improvements necessary for a final version to be published next year.
- A full education pack for GPs is being developed and will be published and circulated to all GPs, with the launch and the full publication of the leaflets next year.

For further information contact Gillian Batt on [redacted] *Cancer Policy Team, 339 Wellington House, 135-155 Waterloo Road, London SE1 8UG*

Copies of the leaflets and other materials are available on the National electronic Library for Health website: www.nelh.nhs.uk/psatesting/

Update on Hepatitis C

Hepatitis C is a blood-borne virus identified in 1988. Acute symptomatic disease only occurs in a minority of people infected. Even in those who have acute symptoms, illness is usually mild, with anorexia, malaise, pyrexia and abdominal pain reported. Jaundice and other obvious indicators of hepatitis may not occur.

Only about 20% of people infected will clear the virus. The other 80% will become chronic carriers who remain infectious; 10-20% of these carriers will develop cirrhosis 20-30 years later. Hepatocellular carcinoma will also occur in a small but significant percentage.

Up to 400,000 are affected in the UK, with over 300 in N Ireland. Hepatitis C is therefore an important cause of long-term disability and severe liver disease.

Hepatitis C is spread by:

- injecting drug use (the most common route of infection – about 80% in Britain);
- blood transfusions or blood products given before 1991 when testing was introduced;
- unhygienic tattooing and body piercing;
- sexual contact (unusual, but can occur);
- mother to baby at delivery (again this is unusual).

Primary care teams should be aware that Hepatitis C is increasing in Northern Ireland, and is more common than Hepatitis B or HIV.

Primary care teams should:

1. consider testing people at risk, with appropriate advice and information (remember the potential for infection with other blood-borne viruses);
2. think about Hepatitis C as a cause of acute illness, especially in people at risk;
3. if patients test positive for Hepatitis C:
   a) refer to a hepatologist for assessment and possibly treatment;
   b) give initial advice on preventing spread (see box);
   c) give advice on reducing risk of liver damage from other causes such as alcohol; and prescribed and over-the-counter medicines;
   d) vaccinate against Hepatitis B if not already infected and have on-going risk factors.

Reducing risk of spread of Hepatitis C

Harm reduction advice if they continue to inject drugs (never share <u>any</u> equipment)

Do not share personal items eg toothbrushes and razors

Clean up blood carefully

Cover wounds

Practise safer sex, including using condoms.

Without good information on the numbers infected with Hepatitis C and how they have acquired their infection it is difficult to provide appropriate prevention and treatment services. Therefore please help us help patients by:

- recording risk factors which may have lead to infection in Hepatitis C positive patients;
- telling your Consultant in Communicable Disease Control about these risk factors.

This is important to enable further public health action such as investigation of linked cases, planning services, and targeting health promotion activities at at-risk groups identified in N Ireland.

The Department of Health, Social Services and Public Safety is currently developing a Hepatitis C Strategy which will be available by June 2002.

Further information available from [redacted] *Senior Medical Officer (Communicable Diseases), Department of Health, Social Services and Public Safety, Room 3.16, Castle Buildings, Stormont, Belfast, BT4 3PP Tel:* [redacted] *E-mail:* [redacted]

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Extending Meningitis C Vaccine to 20-24 year olds

Since the new Group C Conjugate Meningococcal Vaccine (Men C) was introduced for under-18s in November 1999, uptake rates in Northern Ireland have been high and the campaign has been a great success. The Communicable Disease Surveillance Centre (CDSC NI) reports a very large reduction in confirmed cases of Meningitis C here.

However there remains substantial disease in 20-24 year olds.

The Joint Committee on Vaccination and Immunisation (JCVI) have therefore recommended that Conjugate Meningococcal C Vaccine should be made available to people up to and including 24 years of age who have not received Conjugate Vaccine previously. If an individual has received the Meningococcal A+C Polysaccharide Vaccine previously they should now receive Men C Vaccine, provided 3 years have elapsed since they received Polysaccharide Vaccine.

Extra stocks of Men C Vaccine will become available for use in January 2002, from the usual suppliers. The Department has made funding available for vaccine costs and item of service payments – these are also available for those missed in the earlier school-based programme.

There will be media publicity and advertising about the extension of the age-range. Leaflets and posters will be sent to all GP practices towards the end of January 2002.

People should remain alert to the signs and symptoms of meningitis. The Men C Vaccine does not protect against meningococcal B disease, which is now responsible for almost all childhood cases of meningitis. In addition, not all individuals have been immunised with the new vaccine.

Pneumococcal Vaccine for At-Risk Children under 2

The JCVI has recommended that the small number of children under 2 years of age in the "at-risk" groups for Pneumococcal infection, who would be recommended to receive Poly-Saccharide Vaccine if they were over 2 years, should now have the new Conjugate Pneumococcal Vaccine (Prevenar).

The current guidelines for the use of 23-Valent Pneumococcal Polysaccharide Vaccine are contained in "Immunisation Against Infectious Disease" (the Green Book). This vaccine is not suitable for use in children under aged 2 years in the "at-risk" groups as it is not efficacious in this age group. However, there is now a licensed and available Conjugate Pneumococcal Vaccine (Prevenar) that overcomes the shortcomings of the Polysaccharide Vaccine. It is licensed for use from 2 months of age to 2 years of age.

Children under 2 in the "at-risk" groups for Pneumococcal infection should receive 3 single doses of Conjugate Pneumococcal Vaccine, at 2, 3 and 4 months of age, or 2 doses at least 1 month apart if aged 5-24 months. After their 2nd birthday they should receive a single dose of 23-Valent Pneumococcal Polysaccharide Vaccine and this will provide protection against the sero types of Strep. pneumoniae not covered in the Conjugate Vaccine.

Prevenar is manufactured by Wyeth and supplies may be ordered through community pharmacies. Community pharmacies should order supplies of Prevenar direct from Wyeth Laboratories [redacted]

Further information available from [redacted] Senior Medical Officer (Communicable Diseases), Department of Health, Social Services and Public Safety, Room 3.16, Castle Buildings, Stormont, Belfast, BT4 3PP Tel: [redacted] E-mail: [redacted]

New Information Leaflets for Cervical Screening

Three new cervical screening leaflets and a poster have been produced for the Northern Ireland Cervical Screening Programme.

- A Positive Approach to your Smear Test
- What your Abnormal Smear Test Result Means
- Colposcopy – Information for Women

These leaflets have been produced as the result of extensive focus group work with local women's groups and health professionals.

The leaflet "A Positive Approach to your Smear Test" replaces the previous one entitled "Women – the Positive Approach to the Cervical Smear". A copy of it should be enclosed with the letter inviting women to attend for cervical screening.

Copies of the new leaflets and the new poster can be obtained from the Health Promotion Units at each Health Board. The information contained in the leaflets is also available in other languages and formats on request by contacting [redacted]

Further information can be obtained from [redacted] Senior Medical Officer, DHSSPS, C3.17 Castle Buildings, Stormont, Belfast BT4 3PP. Telephone [redacted] or by email: [redacted]

RACC Report 2002

The Regional Advisory Committee on Cancer (RACC) has now published its second report. This provides a very full account of the development of services across Northern Ireland over the last 3 years on a Board by Board basis. It outlines the progress in establishing the Cancer Units and Cancer Centre along with the development of a wide range of community services, many of which involve both statutory and voluntary sectors. A brief review of the major areas of cancer research in the Province has been included along with details of the Cancer Recognised Research Group under the R&D strategy of the DHSS&PS. The report also highlights the international Cancer Consortium collaboration between the National Institute of Health of the USA, the DHSS&PS and the Department of Health and Children, Ireland.

A full copy of the report is available on the departmental website: www.dhsspsni.gov.uk.

Further information from [redacted] Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety, Room C5.16, Castle Buildings, Belfast, BT4 3PP. Tel: [redacted] E-mail: [redacted]

Sexually Transmitted Infections in Northern Ireland

A recent report from the Communicable Disease Surveillance Centre for Northern Ireland (CDSC NI) reveals worrying trends in sexually transmitted infections (STIs) in Northern Ireland. The report, based on a decade of statistical returns to the DHSS&PS from Genito-Urinary Medicine (GUM) Clinics in Northern Ireland, shows that the number of new attendances has doubled since 1990, reaching almost 18,000 in 2000/01. The number of new STIs diagnosed has risen from an annual total of 6,000 in 1991/92 to over 11,000 in 2000/01.

This mirrors the pattern in the UK generally, where there were almost 1.2 million episodes in 1999 alone, reversing the downward trend which occurred following the emergence of HIV/AIDS.

Apart from new diagnoses, the figures show a three-fold increase in the workload associated with the provision of other sexual health services, such as HIV testing, counselling and the provision of advice.

The most important issue in STI surveillance in Northern Ireland currently is the recent detection of an outbreak of syphilis. Throughout the 1990s, about 3 new cases of syphilis (primary, secondary, early latent) were diagnosed annually. In the 18 months from July 2000 – December 2001, there have been 18 new diagnoses. Early cases had sexual contacts in Dublin, where a syphilis outbreak is ongoing (over 170 cases) and with which this outbreak has many features in common.

The NI outbreak mainly affects men who have sex with men (MSM), the mean age is 37.5 years and, to date, the most common route of spread is anal intercourse. Whilst there has been a general increase in diagnosis of STIs amongst MSM, the most marked increase is in the diagnosis of syphilis. This suggests that the behaviour change (safer sex practices) which occurred, as a result of the HIV/AIDS epidemic and particularly amongst homosexual and bisexual males, may no longer predominate.

Trends in gonorrhoeal infections are also considered to reflect trends in sexual behaviour. Diagnoses of gonorrhoeal infection have increased by 182% since 1995, which is proportionally the most marked increase of any STI. In 2000/2001, 144 cases of gonorrhoea were diagnosed in N Ireland. In England and Wales, 30% of those diagnosed are female suggesting that heterosexual spread is important and rising. In N. Ireland, 17% of gonorrhoeal infections diagnosed are in females but the numbers remain small (24 diagnoses in 2000/01).

Genital warts are the commonest STI diagnosed at GUM clinics in the UK generally and in N. Ireland specifically. This represented about 1 in 5 of all acute STIs diagnosed at GUM clinics in 2000 in N. Ireland.

The most common bacterial STI diagnosed in N. Ireland is uncomplicated genital chlamydial infection. The number of cases annually has doubled since 1995/96 (965 diagnoses in 2000)

There are a number of factors underlying the increase in diagnosis of sexually transmitted infections. Greater awareness of sexually transmitted infections, both public and professional, greater acceptability and accessibility of GUM services and improved diagnostic methods have all contributed to the rise.

However, the significant increases in gonorrhoea and syphilis are considered most likely to reflect increased transmission, not withstanding the influence of other factors. The figures indicate that the risk of acquiring sexually transmitted infections is highest amongst young people, specifically amongst 16-24 year olds. The reasons for this are complex and reflect the interaction of biology and behaviour, complicated by disadvantage and difficulty accessing services and information.

As these data include only those diagnoses made at GUM clinics, they represent a considerable underestimate of the actual burden of sexually transmitted infection in the wider community.

CDSC (NI) is indebted to staff at the GUM clinics throughout Northern Ireland, in the laboratories and at the Department of Health, Social Services and Personal Safety for the data on which this report is based.

Further information and a copy of the complete report can be obtained from [redacted] *at CDSC (NI), McBrien Building, Belfast City Hospital, BT9 7AB. Telephone* [redacted]
E-mail: cdscni[redacted]

Food Allergy - still goes unrecognised

The number of people who suffer severe systemic allergic reactions is increasing. Peanut allergy affects at least 1 in 100 children. A growing number of people also experience severe reactions to other nuts, sesame seeds, milk, fish, shellfish, eggs, fruit, latex and insect stings.

Symptoms may include some or all of the following:

- Urticarial rash/itch/feeling hot
- Burning sensation of lips or mouth/metallic taste
- Angio-oedema, especially of the face or larynx
- Eyes red/watering/itching
- Bronchospasm
- Abdominal cramps/nausea/vomiting/diarrhoea
- Collapse/unconsciousness

Severity is unpredictable. A mild reaction may be followed by a more severe one at a later date. For a full assessment of risk, referral is important for anyone whose symptoms suggest anaphylaxis. No patient should ever be advised to test their reaction by eating the suspected food.

Epinephrine (adrenaline) is the frontline treatment for a severe reaction. Patients can carry easy-to-use auto-injectors (Epipens/Anapens) available for all age groups. "Trainer pens" are also available for teaching purposes, from both drug companies. Beta-blockers and ACE inhibitors may counteract the benefits of IM adrenaline.

One of the most important factors, leading to a poor outcome in a severe reaction, is pre-existing poorly controlled asthma.

The Anaphylaxis Campaign is a support group with an active local committee. We are happy to be contacted by families affected by severe allergy, to offer practical advice and support.

For further information, contact:

[redacted] *Tel:* [redacted] *or* [redacted]

The Anaphylaxis Campaign, PO Box 275, Farnborough, Hampshire, GU14 6SX,
Tel: [redacted] *www.anaphylaxis.org.uk*

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Carbon Monoxide: The Forgotten Killer

Carbon monoxide poisoning may result in death or disability and is almost certainly underdiagnosed. There is a need for greater awareness amongst the public and greater vigilance amongst health professionals of the signs and symptoms of exposure in their patients.

Carbon monoxide is produced by the incomplete combustion of carbon-containing fuel: gas (domestic or bottled), coal, coke, oil and wood. Gas stoves, fires and boilers, gas powered water heaters, paraffin heaters, solid fuel powered stoves, boilers and room heaters are all potential sources. Inadequate maintenance leading to poor combustion of fuel and inadequate removal of waste products as a result of blocked and partially blocked flues and chimneys are the main causes of poisoning.

The diagnosis of carbon monoxide poisoning is not easy as it may simulate many other conditions; unless poisoning is suspected the diagnosis will be missed. The onset of symptoms is often insidious and may not be recognised by either the patient or the doctor. The commonest symptoms and signs are headache, nausea and vomiting, vertigo, alteration of consciousness and subjective weakness. Whilst exposure to high concentrations of carbon monoxide leads to collapse, chronic exposure to lower concentrations may lead to the symptoms and signs of influenza or food poisoning. Apparently classic cases of food poisoning of a whole family may be produced by carbon monoxide poisoning.

Prolonged exposure to concentrations that produce only minor symptoms include difficulties in concentrating and emotional liability may, in some cases, be associated with lasting neurological effects.

Clues to alert one to the possibility of carbon monoxide poisoning are if more than one person in the house are affected, symptoms are better when away from the house, related to cooking when the stove is in use and worse in the winter when the heating is in use. There may be black sooty marks on the radiants of gas fires and on the wall around stoves, boilers and fires; smoke accumulating in rooms due to faulty flues – though you cannot smell carbon monoxide you can smell other combustion products; and yellow instead of blue flames from gas.

Clinically neurological signs must be looked for:

> a neurological examination including tests of free movement and balance (finger-nose movement, Rhomberg's test, normal gait and heel-toe walking) a mini-mental state examination and testing of short term memory and the ability to subtract 7 serially from 100, are vital.

The cherry red skin colour produced when COHb concentrations exceed about 20% is rarely seen in life.

Sources of Assistance

The local Environmental Health Department can provide assistance in relation to CO from all sources.

If there are concerns regarding gas installations consult the

- Gas supplier
- The Council for Registered Gas Installers (CORGI) Tel: [redacted]
- The Health and Safety Executive for Northern Ireland Tel: [redacted]

Advice on management of poisoning:

Refer to the local National Poisons Information Services Centre, which in Northern Ireland is: The Regional Drugs & Poisons Information Service, Royal Group of Hospitals, Belfast BT12 6BA.
Tel: [redacted]
Fax:

Carbon monoxide detectors are available (British Standard 7860) and could be recommended. These detectors alarm at high concentrations of CO and so protect against acute poisoning: they do not protect against chronic exposure to lower levels of CO.

An in-depth review of the health effects of domestic CO exposure is contained in **Indoor Air Quality in the Home (2): Carbon Monoxide, Assessment A5.** Institute for Environment and Health, Leicester, 1998, 203pp.

Leaflet:

1. Gas Appliances – Get Them Checked, Keep Them Safe. From the Health and Safety Executive. Tel: [redacted]

Further information is available on the DoH website: www.doh.gov.uk/cmo/letters.htm.

National Guidance on the Safe Administration of Intrathecal Chemotherapy

National guidance on the safe administration of intrathecal chemotherapy was issued on 6 November 2001 following the publication in April of two reports on intrathecal errors. By 31 December 2001 all Trusts where intrathecal chemotherapy is administered were required to be fully compliant with "*National Guidance on the Safe Administration of Intrathecal Chemotherapy*". Implementation of the national guidance will be monitored by the Chief Medical Officer.

Since 1985 there have been 13 recorded cases of patient death or paralysis as a result of the intrathecal rather than intravenous administration of Vincristine. In future no patients should die or be paralysed by maladministered spinal injections.

The guidance is available on:
www.doh.gov.uk/publications/coinh.html or
www.doh.gov.uk/intrathecalchemotherapy/index.htm

Further information from [redacted] *Senior Medical Officer, DHSSPS. Tel:* [redacted] *or e-mail:* [redacted]

Hyponatraemia

Guidance on the prevention of hyponatraemia in children will be issued soon. It has been prepared by a multidisciplinary group in response to an identified need for clear advice for staff who care for children in hospital.

Hyponatraemia is potentially extremely serious, a rapid fall in sodium leading to cerebral oedema, seizures and death. Any child on IV fluids or oral rehydration is potentially at risk.

Hyponatraemia most often reflects failure to excrete fluids. Stress, pain and nausea all stimulate antidiuretic hormone (ADH), which inhibits water excretion. Consequently post-operative patients and sick children are at particular risk.

The guidance provides clear and concise advice for medical and nursing staff on the baseline assessment required before prescribed fluids are started, and the essential measures that require monitoring. Rigorous monitoring of fluid balance and serum sodium in all children receiving prescribed fluids will help ensure that hyponatraemia and its consequences are prevented. The guidance does not consider the choice of fluid in detail, rather it is designed to complement fluid protocols in individual paediatric units.

The guidance will be issued to acute Trusts and will also be available on the Departmental website at www.dhsspsni.gov.

Further information can be obtained from [redacted] *Senior Medical Officer, DHSSPS. Tel:* [redacted] *e-mail* [redacted]

Better Use of Blood in Northern Ireland

Blood and blood products save lives and provide clinical benefit to many patients. However, there is an increasing awareness of the need to use blood only when it is essential to do so.

CREST published Guidelines for Blood Transfusion Practice in Northern Ireland in February 2001. These included guidelines for red cell transfusion, the management of massive haemorrhage and use of blood components in obstetrics and neonatal transfusion. These were issued widely at the time of publication.

Clinical Guidelines on Perioperative Blood Transfusion for Elective Surgery have also been published by the Scottish Intercollegiate Guidelines Network (SIGN) in October 2001. These include recommendations on deciding whether or not to transfuse, reducing the risks of allogeneic blood transfusion, blood sparing strategies and blood use in cardiac and orthopaedic surgery. Guidance on implementation and audit of the guidelines is also included. Recommendations are graded A, B, C and D to indicate the strength of the supporting evidence.

Both these sets of guidelines are of relevance to Northern Ireland practitioners who use blood.

Crest Guidelines are available from Ms. Angela Lowry, CREST Secretariat, Room 517, Dundonald House, Upper Newtownards Road, Belfast and on the CREST website: . www.n-i.nhs.uk/crest

SIGN guidelinesare available on the SIGN website: www.sign.ac.uk./

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Northern Ireland Health and Social Wellbeing Survey 2001

The Northern Ireland Statistics and Research Agency (NISRA) today published results from the second Northern Ireland Health and Social Wellbeing Survey. The survey was commissioned by the Department of Health, social Services and Public Safety to monitor the health and wellbeing of the Northern Ireland population.

The results of the survey, which was conducted between February and July 2001, reflect the findings from interviews of a representative sample of adults aged 16 and over, living in Northern Ireland.

Among the key findings of the survey:-

General Health
Just over half (52%) of respondents said their health had been 'good' in the previous 12 months, 31% said it had been 'fairly good' and 17% said it was 'not good'.

Over a quarter of men (26%) and women (29%) indicated they had a health problem or disability that substantially limited their ability to carry out day-to-day activities.

People were asked about circulatory illness, diabetes and asthma. 11% had been told by a doctor that they were suffering from asthma, 7% with angina and 2% with diabetes. 76% stated that they had not experienced any of these conditions.

Cigarette Smoking
Less than a third (29%) of people aged 16 and over said that they currently smoke cigarettes, 31% had given up smoking cigarettes and 39% had never smoked cigarettes.

Men were the heaviest smokers and were almost twice as likely (19%) as women (10%) to smoke more than 25 cigarettes a day.

Drinking
Overall, 76% of people were current drinkers, 7% used to drink and 17% were lifetime abstainers.

Men were almost twice as likely as women to drink above the sensible weekly limit. 25% of male drinkers exceeded the sensible weekly limit of 21 units while 14% of female drinkers drank over the 14 unit sensible limit.

Mental Health
Respondents were asked about the level of stress they had experienced over the previous 12 months. Overall, 12% of persons aged 16 and over had experienced a great deal of worry or stress and 61% had experienced little or no worry or stress.

17% of men and 24% of women showed signs of a possible mental health problem. Women in most age groups, with the exception of those aged 55-64, were more likely than men to show signs of mental health problems.

Sexual Health
This section was only asked of respondents aged 16-44, using a self-completion form.

Half of the respondents reported having had sexual intercourse for the first time by the age of 17 for men and age 18 for women.

7% of men and 5% of women who have had sexual intercourse have attended a Genito Urinary Medicine (GUM) clinic.

9% of people said that they, or their partner, had sought medical or professional help about infertility.

Physical Activity
Within the definitions used in the survey, 25% of people aged 16 and over can be classed as sedentary. This is, they have not performed some activity of at least a moderate level, lasting 20 minutes, on at least one occasion in the last 7 days.

Approximately a quarter of both men (24%) and women (25%) were sedentary. Young women aged 16-24, however, were almost twice as likely to be sedentary (16%) as young men (8%), whereas men aged 35-44 were more likely to be sedentary (17%) than women (10%). There was no difference between men and women in other age groups.

28% of all people take above the recommended level of physical activity of at least 30 minutes per day, 5 days a week.

Overall, 24% of people said that they were not regularly active in the previous six months and did not intend to be so in the next six months. Women were more likely to be of this opinion than men, 25% and 22% respectively.

Copies of the bulletin and tables are available from the NISRA internet site at:- www.nisra.gov.uk

Additionally, the bulletin may be accessed through the Department of Health, Social Services and Public Safety internet site at: www.dhsspsni.gov.uk

Alternatively, copies of the bulletin and tables can be obtained from:-

Central Survey Unit, NISRA, McAuley House
2-14 Castle Street, BELFAST BT1 1SY

Tel: [redacted]
Fax:

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Defibrillators - Important Information

Defibrillators need to be regularly serviced and maintained in order to ensure that they are in good working order when required.

CREST Evaluation of Equipment sub group are currently evaluating this type of Equipment and have discovered that many defibrilators, especially in Community and Primary Care settings, are not on a service and maintenance contract. **Some staff have been checking that the red light is illuminated thinking that this indicates that the defibrillator is operational. This actually means that the battery needs replacing rather than it is fit for use** .

There are an increasing number of medical devices now used in the primary care setting. Two publications are, therefore, particularly important:-

- Device Bulletin DB9904(NI), "Medical Device Equipment Management for Hospital and Community Based Organisations", issued in October 1999, provides guidance to all those persons who have responsibility for equipment management, purchasing, maintaining and repairing medical devices. It is primarily intended for use by HSS Trusts and Private Facilities

- Guidance booklet "Devices in Practice", issued in October 2001, provides a practical guide to medical device management. and can be obtained by contacting the Northern Ireland Adverse Incident Centre (NIAIC) at:

Northern Ireland Adverse Incident Centre (NIAIC)
Estate Policy Administration
Estate Policy Directorate
Health Estates
Stoney Road
Dundonald
Belfast BT16 1US
Tel: [redacted]
Fax:
E-mail: NIAIC [redacted]

NIAIC Device Bulletins and Guidance Booklets are also available on the NIAIC website at: www.dhsspsni.gov.uk/niaic

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Warning Notices, Device Bulletins and Guidance Booklets issued by the Northern Ireland Adverse Incident Centre (NIAIC)

The key aim of the Northern Ireland Adverse Incident Centre (NIAIC) is to record and investigate reported adverse incidents involving medical devices, non-medical equipment, plant and building items used in the delivery of healthcare in Northern Ireland. We are interested in any event that may have implications for patients, staff and clients - not just when something has failed!

One of our most important tasks is to identify actions to minimise any risks associated with medical devices and alert users by issuing Warning Notices. Those relevant to General Practice are listed below. If you have not seen any of these publications, please contact NIAIC.

We also publish Device Bulletins and other guidance booklets from time to time. These review good practice in the management and use of Medical Devices.

NIAIC WARNING NOTICES AND OTHER PUBLICATIONS
26 October 2001 – 16 January 2002

ADVICE NOTICE	DATE ISSUED	TITLE
AN(NI)2001/09	19/12/2001	ABBOT LABORATORIES LTD LCx CHLAMYDIA TRACHOMATIS ASSAY HIGH NEGATIVE CONTROL RATES
SAFETY NOTICE		
SN(NI)2002/02	03/01/2002	MATECHANA/PROSPECT MEDICAL MINICLAVE MODEL 21LE CONTROL SYSTEM & USER INSTRUCTIONS INADEQUATE
SN(NI)2002/01	02/01/2002	REPORTING ADVERSE INCIDENTS AND DISSEMINATING WARNING NOTICES RELATING TO MEDICAL DEVICES, NON-MEDICAL EQUIPMENT, BUILDINGS, AND PLANT
SN(NI)2001/53	13/12/2001	INVACARE POWERED WHEELCHAIRS RISK OF DRIVE WHEELS BECOMING DETACHED FROM WHEELCHAIR DURING USE
SN(NI)2001/52	07/12/2001	MANUAL RESUSITATORS/SELF INFLATING RESUSITATION BAG RISK OF MISASSEMBLY FOLLOWING CLEANING
SN(NI)2001/49	07/12/2001	MAERSK MEDICAL/NIKP SURGICAL DEFIBRILLATION PADS MANUFACTURERS RECALL POSSIBLE DEFECT IN FOIL
SN(NI)2001/48	28/11/2001	COMPATABILITY OF MEDICAL DEVICES AND REPORCESSING EQUIPMENT
SN(NI)2001/46	05/11/2001	PROGRAMMABLE HYDROCEPHALUS SHUNTS REPROGRAMMING DURING MAGNETIC RESONANCE IMAGING (MRI) PROCEDURES
DEVICE BULLETIN		
DB(NI)2001/02	13/11/2001	NIAIC WARNING NOTICES ISSUED IN 1995 A CONVENIENT SOURCE FOR ALL WARNING NOTICES RELATING TO MEDIAL DEVICES ISSUED DURING 1995 WHICH ARE STILL IN FORCE

continued overleaf

HOW TO REPORT ADVERSE INCIDENTS

Adverse Incidents relating to medical devices, non-medical equipment, plant and buildings should be reported to NIAIC as soon as possible. Advice on how to report is given in Safety Notice SN (NI) 2002/01. If you are in doubt about how to report incidents, please contact NIAIC using the telephone number provided.

Heath Estates is an Executive Agency of the Department of Health, Social Services and Public Safety

NIAIC warning notices, Device Bulletins and Guidance Booklets are now available on-line at www.dhsspsni.gov.uk/niaic. Adverse Incident reporting forms are available for downloading from the website and there is also a facility for on-line incident reporting.

Further copies of publications listed may also be obtained from:

Northern Ireland Adverse Incident Centre (NIAIC)
Health Estates
Estate Policy Directorate
Stoney Road
Dundonald
Belfast
BT16 1US

Tel: [redacted] e-mail: NIAIC[redacted]
Fax:

AIR TRAVEL RELATED DEEP VEIN THROMBOSIS (DVT)

Limited research suggests that immobilisation on journeys lasting more than five hours may increase the risk of DVT and pulmonary embolism (PE). The vast majority of air passengers do not need clinical intervention but all should do regular flexion/extension exercises of the lower limbs, deep breathing exercises, and walk around the cabin when safe to help reduce risk. Passengers should also drink plenty water, avoiding excess coffee and alcohol.

Those at increased risk include anyone with a history of DVT or PE, those who have experienced recent hospitalisation for major surgery especially hip or knee replacement, those with congestive heart failure, paralysis of the lower limbs or malignancy and those who have suffered stroke. Clinical advice may be sought about the advisability of travelling, suitable exercise, and the suitability of compression stockings or anticoagulants. Pregnant women or those who have recently been delivered, and those who are on the contraceptive pill or HRT may also be at increased risk.

The Department of Health, Social Services and Public Safety has developed advice for passengers about DVT. It is available on the Department's website: www.dhsspsni.gov.uk.

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MONTHLY CREUTZFELDT-JAKOB DISEASE STATISTICS

The Department of Health issued the latest information about the numbers of known cases of Creutzfeldt-Jacob disease on 7 January 2002. This included cases of variant Creutzfeldt-Jacob disease (vCJD) – the form of the disease through to be linked to BSE. The position is as follows:

Definite and probable CJD cases in the UK:

REFERRALS OF SUSPECT CJD		DEATHS OF DEFINITE AND PROBABLY CJD						
Year	Referrals	Year	Sporadic	Iatrogenic	Familial	GSS	*vCJD confirmed	Total
1997	161	1997	59	6	4	1	10	80
1998	154	1998	63	3	4	1	18	89
1999	169	1999	61	6	2	0	15	84
2000	178	2000	48	1	2	1	28	80
2001*	170	2001*	37	3	2	2	20	64
Total Referrals	**1471**	**Total Deaths**	**535**	**40**	**33**	**18**	**104**	**730**

*As at 7 January 2002

Summary of vCJD cases

Number of definite and probable cases of vCJD (deaths) as above	104
Number of definite and probable cases of vCJD (alive)	9
Number of definite and probable cases of vCJD (dead & alive)	113

Further information can be found on the website: www.doh.uk/cjd/stats

Further information from:

Dr Henrietta Campbell, Chief Medical Officer, Department of Health, Social Services and Public Safety, C5, Castle Buildings, Stormont, Belfast BT4 3PP.
Telephone: [redacted]

Dr Margaret Mark, Medical Officer, Department of Health, Social Services and Public Safety, C3.13, Castle Buildings, Stormont, Belfast BT4 3PP.
Telephone: [redacted]

The CMP Update is now available on the Department of Health, Social Services and Public Safety website: www.dhsspsni.gov.uk

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