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School-based hepatitis B vaccination programme
University of British Columbia and Vaccine Evaluation Centre

Unexplained Illness and Death Among Injecting-Drug Users - Glasgow, Scotland; Dublin, Ireland; and England, April - June 2000
article is from Morbidity and Mortality Weekly Report (MMWR)

Communiqué From Theory to Practice: Supporting Our Communities' Parents
Middlesex London Teaching Health Units

BULLETINS and NOTICES

The following is a research letter reprinted from The Lancet, Vol. 355, February 12, 2000

We investigated multiple sclerosis in adolescents in British Columbia before and after a hepatitis B vaccination programme was begun. There was no evidence of a link between hepatitis B vaccination and multiple sclerosis or other demyelinating disease.

In October, 1998, despite a absence of any objective scientific evidence, [1,2] French health authorities suspended hepatitis B (HB) vaccination of adolescent schoolchildren because of public concerns that HB vaccination might be linked to new cases or exacerbations of demyelinating diseases, in particular multiple sclerosis. Since then, the overall use of HB vaccine has fallen in France, where vaccine labels now list multiple sclerosis as a contraindication. [3]The World Health Organization, along with other groups such as Canada's Laboratory Centre for Disease Control (LCDC) and the US Centers for Disease Control and Prevention, decried this decision, emphasising that external experts, as part of a special consultative session in September, 1998, carefully reviewed the data and did not find evidence to support any such relation. [4]WHO further emphasised that no definitive evidence supports a causal association between multiple sclerosis and any vaccine. [5]

The most useful data to investigate a causal association between HB vaccination and multiple sclerosis would come from a comparison of vaccinated and non-vaccinated individuals. There are scant data for adolescent populations, among whom multiple sclerosis is much less common than in adults. In British Columbia (BC), Canada, HB vaccination has been offered annually to 11-12-year-old students (grade six) since October, 1992. The number and proportion of students who completed the three-dose vaccination series has been determined by the BC Centre for Disease Control. From October, 1992 to September, 1998, when programme participation averaged 92.3%, 267,412 grade six students completed the vaccination series (A King, unpublished data), providing a follow-up of about 966000 person-years. During the 6.75 years (January, 1986 to September, 1992) preceding the HB vaccination programme, about 41237 children attended grade six annually, providing about 1.14 million person-years

of observation.

We looked at the onset of multiple sclerosis among adolescents aged 11-17 years of age. Data were obtained from the medical records of the British Columbia's Children's Hospital (BCCH), the only paediatric hospital in the province, and the database of the provincial multiple sclerosis clinic. All paediatric neurologists in the province were also contacted to confirm that all cases known to them were assessed in the specified settings.

There were nine cases of adolescent onset multiple sclerosis among 288657 who had attended grade six during the prevaccination period (January, 1986 to September, 1992) (table). This number was not significantly different from the five cases out of a total of 289651 grade six students from October, 1992 to September, 1998, of whom 267412 (92.3%) completed the three-dose vaccination series ..X2 test. These data provide no evidence for a relation between HB vaccination, at age 11-12 years and the subsequent onset of School-based hepatitis B vaccination programme and adolescent multiple sclerosis despite improved diagnostic methods in recent years (e.g. easier access to magnetic resonance image scans at the Children's Hospital).

Estimated number of grade six students

	Prevaccination	**Postvaccination**
Total eligible for vaccination		289,651
Total vaccinated		267,412*
Total cases of adolescent multiple sclerosis	9	5
Total adolescents without multiple sclerosis	288,648	289,646
Total denominator	288,657†	289,651*

* 267,412 students completed the three-dose HB vaccination series, which represents 92.3% of the 289,651 grade six students offered HB vaccination.

†The number of grade six students for the period 1986 to 1992 is an estimate, based on available numbers for 1992 to 1998; this may, in fact, be an overestimatate given the migratory pattern into BC

Frequency of adolescent onset multiple sclerosis in BC

We also obtained data from the medical records of the Children's Hospital to allow an assessment of the number of cases of postinfectious encephalomyelitis, since French concerns included demyelinating diseases other than multiple sclerosis. Before the initiation of the HB vaccination programme, there were 29 cases of postinfectious encephalomyelitis (25 among children up to 10 years and 4 among 11-17 years olds). After the HB vaccination programme began, there were 31 cases of postinfectious encephalomyelitis (28 among children up to 10 years; three among 11-17 year olds, of which none occurred during the year in which the child was

actually in grade six). These data provide no evidence for a link between vaccination and postinfectious encephalomyelitis.

Although the HB vaccination programme continues to be monitored in BC and other Canadian provinces by LCDC as part of a comprehensive surveillance programme of vaccine-associated adverse effects, there are no plans in Canada to reduce or stop school-based HB vaccination programmes. This decision is in accordance with recent WHO recommendations.[4]

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Disease Control Service

For further information on the non-association between hepatitis B vaccine and multiple sclerosis see the following references:

- Statement on hepatitis B vaccine from the Centers for Disease Control (CDC), Atlanta, Georgia http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqbvax.htm#7
- Statement from World Health Organization (WHO) http://www.who.int/wer/pdf/1997/wer7221.pdf
- Statement from MS International Organization http://www.ifmss.org.uk/newpwms/frame-HepatitisB2.htm

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Unexplained Illness and Death Among Injecting-Drug Users - Glasgow, Scotland; Dublin, Ireland; and England, April - June 2000

The following article is from Morbidity and Mortality Weekly Report (MMWR), June 09, 2000 / 49(22);489-492

ISince April 19, 2000, 30 injecting-drug users (IDUs) died or were hospitalized with unexplained severe illness in Glasgow, Scotland. Illness was characterized by extensive local inflammation at a subcutaneous or intramuscular injection site often followed by hypotension and circulatory collapse. Since April 24, 2000, 15 IDUs in Dublin, Ireland, and 14 IDUs in England with similar illnesses have been identified. Despite debridement and broad spectrum antibiotics, 30 (51%) of the 59 patients in all three countries have died. This report further describes the clinical syndrome and key epidemiologic features of the illness as characterized by a preliminary investigation by health authorities in Scotland, Ireland, England, and the United States (1).

A case of unexplained illness was defined as soft tissue inflammation (i.e., abscess, cellulitis, fasciitis, or myositis) at an injection site, and either 1) severe systemic toxicity (i.e., sustained systolic blood pressure <90 mm Hg despite fluid resuscitation and total peripheral white blood cell count [WBC] >30,000 cells/mm^3), or 2) postmortem evidence of a diffuse toxic or infectious process including pleural effusions and soft tissue edema or necrosis, in an IDU admitted to a hospital or found dead since April 1, 2000. As of June 5, in Glasgow, 16 (53%) of 30 IDUs evaluated had illnesses that met the case definition (Figure 1). In Dublin, eight (53%) of 15 IDUs, and in England, six (42%) of 14 IDUs had illnesses that met the case definition (Figure 1). Demographic information, peripheral WBC, and case-fatality among IDUs were similar in all three countries (Table 1). Most cases had progressive symptoms with a median of 3 days (range: 0--14 days) between illness onset and hospitalization. Among persons who died while hospitalized, the median time from admission to death was 2 days (range: 0--13 days). Pleural effusion and extensive edema at an injection site were prominent features at postmortem examination.

TABLE 1. Demographic characteristics, peripheral white blood cell count (WBC), and percentage case-fatality among injecting-drug users who had illnesses that met the case definition for unexplained severe illness and death — Glasgow, Scotland; Dublin, Ireland; and England, April–June 2000

Characteristic	Glasgow (n=16)	Dublin (n=8)	England (n=6)
Median age, yrs	29	34	34
(Range)	(20–48)	(22–51)	(30–48)
Women	56%	25%	33%
Median WBC, cells/mm^3	76,600	60,000	51,900
(Range)	(39,200–153,000)	(8,200*–96,500)	(39,700–82,000)
Case-fatality	94%	100%	83%

* One patient from Dublin with a WBC of 8,200 on admission to a hospital died 6 days later and had an illness that met the case definition based on findings at postmortem examination.

Cultures of blood and tissue yielded multiple organisms from several

patients including group A streptococcus, *Staphylococcus aureus, Clostridium species, and Bacillus* species. However, the variable and polymicrobial results and potential postmortem contamination complicate the interpretation of these findings and fail to reveal a definitive etiologic agent. Clinical and drug specimens are being evaluated at CDC, the Public Health Laboratory Service in England, and local laboratories in Glasgow and Dublin. Culture, serologic, molecular, immunopathologic, and histopathologic evaluation of blood and tissue from case-patients have revealed no evidence of *Bacillus anthracis. B. anthracis* was isolated from the cerebrospinal fluid of an IDU residing in Oslo, Norway, hospitalized in early April 2000 with a localized abscess, elevated WBC (45,000 cells/mm^3), and hemorrhagic meningitis resulting in death (2).

Investigations continue to characterize further the 29 reported unexplained illnesses among IDUs whose illnesses failed to meet the case definition but may be linked to this outbreak. Surveillance activities have been initiated in all hospitals in Scotland, Ireland, England, and Wales to identify additional cases. Information regarding these illnesses is being disseminated to medical practitioners and IDUs, and a case-control study is under way to identify risk factors for disease and to develop prevention strategies. As of June 5, no similar illnesses have been reported in the United States to CDC through the Council of State and Territorial Epidemiologists.

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Editorial Note

The localized inflammatory process affecting skin or muscle combined with systemic toxicity characterized by a leukemoid reaction suggests the role of a toxin-mediated cause of illness among IDUs in Scotland, Ireland, and England. Despite extensive microbiologic evaluation for several of these cases, no specific causative pathogen has been identified. Although the initial symptoms of anthrax can be nondescript before the onset of circulatory collapse and death (3), the absence of B. anthracis bacteremia or histologic or molecular evidence for B. anthracis suggests that anthrax-associated toxemia is not a cause of illness among these IDUs. Streptococcal toxic shock syndrome and staphylococcal toxic shock syndrome are both characterized by the sudden onset of shock and organ failure, often associated with skin and soft tissue damage (4,5). However, most cases in Scotland, Ireland, and England have not had group A streptococcus isolated (a required feature of streptococcal toxic shock syndrome), and none developed a rash or desquamation of the palms and soles (diagnostic criteria of staphylococcal toxic shock syndrome). Fastidious, anaerobic bacteria, such as Clostridium species, have caused a distinctive, toxin-mediated, often fatal infection characterized by sudden onset of shock with unrelenting hypotension, myonecrosis, generalized tissue edema, and a profound leukemoid reaction in the absence of high fever and rash (6)---a clinical course resembling that seen among cases in Scotland, Ireland, and England. Laboratory procedures have been enhanced for the identification of anaerobic bacteria and noninfectious toxins.

The emergence of a new illness among IDUs is possible because the injection of nonsterilized drugs into skin and soft tissue can provide a suitable environment for contaminating pathogens and their toxins or noninfectious toxins alone. Up to 32% of IDUs, particularly those who inject drugs subcutaneously or intramuscularly, have soft tissue abscesses or cellulitis at any given time (7,8). Unusual infections have been linked to subcutaneous or intramuscular drug use, including tetanus and wound botulism among heroin and black tar heroin users, respectively, in California (9,10), and group A streptococcal infections among cocaine users in Switzerland (11). Microbial or chemical contamination can occur at one of many steps, including production, mixing, dilution, or preparation of the drugs or at the time of injection through contaminated paraphernalia or skin. Because the source of contamination remains unknown and may be common in these countries, this investigation highlights the importance of enhanced surveillance for syndrome-based illness across national boundaries. Health-care providers and public health personnel are encouraged to report persons with illnesses meeting the case definition to their designated public health authorities.

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Comment

As stated in the Editorial Note, this outbreak highlights the need for enhanced surveillance and prompt sharing of information by public health authorities. The following case definition has been developed for use in the United Kingdom and Ireland:

*An IDU admitted to hospital or found dead since 1 April 2000 with soft tissue inflammation (abscess, cellulitis, fasciitis, or myositis) at an injection site AND **either** severe systemic toxicity (total peripheral white blood cell count > 30 x 10^9/L and sustained systolic pressure < 90 mmHg despite fluid resuscitation) **or** evidence at necropsy of a diffuse toxic or infectious process including pleural effusion and soft tissue oedema or necrosis at an injection site.*

To date, we are unaware of similar current illnesses occurring in IDUs in the United States or Canada.

Discussions with regional representatives of Ontario's 19 needle/syringe exchange programs on June 13, 2000 revealed no reports of unusual deaths, hospital admissions or increased infections in IDUs in the province.

In this instance, it now appears that the source of the illness was the heroin, contaminated either at source or along the distribution network and intense investigations are being undertaken to identify the agent involved. However, drug users need to be constantly reminded of the dangers of both intramuscular and intravenous injections and encouraged to seek medical help anytime abscesses occur. New information on this unique outbreak will be shared as soon as it becomes available.

Update: MMWR, June 23,2000 / 49(24);543-5

Among the 35 patients with illnesses meeting the case definition, nine (26%) have laboratory evidence of clostridial infections based on culture isolation or 16S ribosomal DNA polymerase chain reaction and sequencing performed on blood or tissue, including three *C. novyi*, three *C. perfringens*, one with both *C. novyi* and *C. perfringens*, and two clostridial species awaiting further typing. Of the remaining 41 patients with illnesses who failed to meet the case definition but who may be linked to this outbreak, and for whom data are available, nine (22%) have evidence of clostridial infections, including five *C. novyi* and four with species pending. Although the role of other pathogens requires further delineation, only four (11%) patients with illnesses meeting the case definition have evidence of other etiologic agents (*Staphylococcus aureus*, group A *Streptococcus*, and group C *Streptococcus*), compared with 12 (29%) of 41 patients with unexplained soft tissue infections but lacking severe systemic toxicity.

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Communiqué
Public Health Research, Education and Development Program

From Theory to Practice: Supporting Our Communities' Parent

Introduction

This article offers an example of how research informs program planning and influences practice. Using the results from a survey of parents with preschoolers, practitioners adapted the work of others and formed a coalition to develop and implement a population-based approach to support parents and to promote the health of children in the counties of Elgin, Middlesex and Oxford.

The Literature

The early years are the foundation for healthy growth and development, future learning and health[1,2]. A key requisite for healthy child development is secure attachment to a nurturing adult who can provide consistent care, support and affection early in life. Parents provide the primary social network for children, therefore enhancing parental capacity is an effective strategy for healthy child development.

The Federal/Provincial/Territorial Advisory Committee on Population Health[3] provides further support for the importance of parenting. This document cites normal birthweight, **effective parenting**, good nutrition, the absence of trauma, plentiful opportunities for stimulation in early childhood and the development of mastery or self-confidence as factors which contribute to lifelong health.

It follows that communities/programs that support parents in their parenting role promote healthy child development. A healthy child is one who reaches physical, emotional and social developmental milestones and is ready for school at the time of school entry. Such a child has the ability to learn, think critically, form positive relationships and develop problem solving and coping skills, is confident and demonstrates positive health related behaviour.

The Carnegie Task Force on Meeting the Needs of Young Children[4] suggested that although no job is as important or challenging as that of a parent, society acts as though parenting skills come naturally. The task force concluded that many parents can benefit from parent education and support since. Parenting can be demanding and at times overwhelming even in the best of circumstances. Parental roles change with children's rapid physical, emotional and intellectual development.

The Survey: Parents with Children 4 years of age and under[5]

A review of the literature reinforced the decision by Middlesex-London Health Unit to survey parents of children four years of age and under in the Middlesex-London area. The survey was designed to identify what topics parents would like more information on, their preferred method of obtaining information, where and when they want to access needed information and support, and barriers to getting the information they need. The goal was to

use the results to plan a comprehensive population health approach that would target parents of young children.

In November 1998, a convenience sample of parents and guardians in the City of London and Middlesex County who had children four years of age and under were asked to complete a self-administered questionnaire. Various community organizations assisted with the distribution of the survey to the families that attended their programs or services. Four hundred and ninety-two (492) surveys were returned, with the majority, 445 (92.1%) completed by mothers.

Survey Results

The results of the survey clearly indicated that parents in Middlesex-London want to obtain more information to assist them in their role as parents. Respondents were willing to utilize a variety of strategies to obtain this information, including written materials, parenting classes, speakers or a parenting fair. Most, (89.6%), stated they preferred material in a written format such as pamphlets, newsletters and magazines. Over 50% of respondents in the City of London and over 70% of the respondents in Middlesex County felt that they did not know what resources were available.

Barriers to obtaining information were diverse, with "don't know what is offered" as the most frequent response. Significantly more respondents with an income of less than $20,000 identified cost, transportation, location and language as barriers to obtaining information. Survey results reinforced plans to reduce barriers such as cost, transportation, and language by providing information and support to parents in their own homes

Call to Action

The results were shared with an interagency committee on parent education and the advisory committee to the local Healthy Babies Healthy Children Initiative. A decision was made to pursue a collaborative population health strategy that focused on the parents of young children. In addition, the findings were shared with agencies and community members who had participated in the distribution of the survey and those who work with parents and children in the preschool population. Having multi-sector involvement and potentially using a variety of approaches was seen as important in addressing determinants of health from the perspective of parents.

A community coalition of interested agencies, parents and services was called together in the fall of 1999 to articulate a strategic plan for this initiative. A number of strategies to address the identified concerns of parents were discussed[6]. Consensus was reached to offer parents a newsletter, mailed at regular intervals during their child's first five years. This newsletter would provide information on healthy growth and development, parenting, safety, stimulation and play and local community resources. In order to meet the needs of a larger section of the southwest region,

representatives from Elgin-St. Thomas Health Unit and the Oxford County Board of Health were invited to participate.

Customizing the Experiences of Others

"Let's Grow... with your child" is an age paced newsletter that was initiated by the Bruce-Grey Owen Sound Interagency Committee in 1998. Following on the strategic direction to offer a newsletter, a Tri-County Lets Grow Committee was formed to customize this initiative for Elgin, Middlesex and Oxford counties. The "Let's Grow…with your child" newsletter was revised and adapted in collaboration with the Bruce-Grey Owen Sound Interagency Committee to reflect the diverse cultures and current practices in our communities.

A multi-sector approach has proven highly successful. Committee members contribute their unique perspectives to help guide the planning and coordination of information given to parents. This collaborative effort is also assisting local agencies in avoiding unnecessary duplication of resources. In addition, linking families with current information about infant, toddler and preschool growth and development and the supports and services that are available, fills a gap. This gap exists in the years between supports available to a family around the time of their child's birth until school entry. Providing parents with information on developmental milestones in a timely manner also helps to ensure the recognition and support of those children not achieving their developmental milestones. Early intervention, with these children, prior to reaching school age has proven very effective.[2]

In addition, the Tri-County Let's Grow Committee is actively working on the addition of relevant material about local community resources and supports for parents in our community. Parents who deliver a child in the counties of Elgin, Middlesex and Oxford will now be given the opportunity to subscribe, free of charge, to "Let's Grow…with your child". Barriers to accessing information are reduced as the material is written at a grade three to five level, has numerous pictures to illustrate strategies for promoting healthy child development, is available at no cost, and provides parents with an ongoing venue to receive information about community resources and supports available to them at each stage of their child's development.

"Let's Grow... with your child" has been evaluated and received positive results in the Bruce-Grey Owen Sound area. A comprehensive evaluation strategy for the Elgin, Middlesex and Oxford initiative is planned.

Conclusions

Children in our communities are a priority. Research has shown that experiences in early childhood can shape a child's future. Parents have a vital role in providing the opportunities for children to achieve their optimal physical, emotional and cognitive development. Communities need to

support parents in this role. "Let's Grow ...with your child", is one component of an ongoing network of supports to assist parents in developing their parental role.

This initiative demonstrates the importance of a comprehensive planning approach: What are the needs? What is the evidence? What are the best practices of others? Reviewing the literature, assessing the population, building on the work of others, collaborating across sectors and evaluating outcomes has provided a solid framework to deliver an innovative program based on community needs. Our experiences demonstrate the pivotal role of research, the importance of evidence-based decision making and how such an approach influences program planning and informs public health practice.

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Population Health Service Comment

The results of this survey are noteworthy. This survey utilized a convenience sample of women already accessing community services, yet 50% of respondents in the City of London and 70% of the respondents in Middlesex County "felt that they did not know what resources were available". What would be the response if all parents, or parents not using community services were surveyed? Part of the worth of a community resource or support is its ability to reach the people who would benefit from it. While we are making worthwhile efforts to ensure that parents are aware of their local resources, this survey highlights that we have some way to go yet. The "Let's Grow…with your child" newsletter is one positive step towards linking parents with the information, resources and supports they need to develop and grow as parents.

Since the survey sample was limited to parents and guardians already accessing community services, it also raises the question of whether the preference for material in a written format is shared across all families in the community. As barriers to obtaining information might vary for families not included in the sample, the need for alternate approaches might be an area for future evaluation or assessment.

The article also got us thinking about the timing of effective public health interventions to enhance capacity for parenting. The Reproductive Health Technical Review Committee is currently exploring the inclusion of population-based strategies that support readiness to parent prior to birth within the Reproductive Health Program. Similarly, one-to-one supports and service coordination-type strategies to support readiness to parent prior to birth will be included in the Healthy Babies, Healthy Children prenatal component. The aim is to provide a continuum of support to parents that is continued in the Child Health/Healthy Babies, Healthy Children programs. Future evaluation and assessment of the "Let's Grow…with your child" might consider the need for/value of information and resources supporting

readiness to parent for families in the prenatal period, as well as for families planning pregnancies.

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