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CONTENTS:

Guidelines on the use of antiviral drugs in an influenza pandemic **p. 1**

No one died from meningococcal infection in 2007 **p. 2**

Chlamydia and gonorrhoea cases in 2007 **p. 2**

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GUIDELINES ON THE USE OF ANTIVIRAL DRUGS IN AN INFLUENZA PANDEMIC

Infected individuals

Antiviral treatment should be started if possible on the first day of influenza symptoms but it is unlikely to be effective if initiated more than 48 hours after the onset of symptoms. The treatment time in most cases will be at least five days. Treatment with oseltamivir (Tamiflu®) is recommended in patients with suspected infections in other organs than the respiratory tract. Zanimivir (Relenza®) is effective locally in the respiratory tract mucosa, with only limited distribution to other organs.

Prophylactic medication

The incubation period of the influenza infection is assumed to be two to three days. An infected individual can be infectious from 24 hours before the onset of symptoms until 7–10 days after the onset. Since treatment with oseltamivir and zanimivir greatly reduces the likelihood of transmission (oseltamivir in particular), prophylactic treatment may not always be necessary for individuals who come into close contact (less than one metre) with patients receiving full antiviral treatment. Antiviral treatment of healthy people who will come in or have been in close contact with infected individuals must be based on the assessment of the doctor prescribing the treatment.

Physicians can therefore recommend the following antiviral prophylaxis:

a) No prophylaxis is administered while full antiviral treatment is started immediately (within 48 hours, preferably within 24 hours) after the onset of symptoms. This ensures the most effective use of the antiviral drugs.

b) Prophylaxis is started as soon as possible after an individual has come

into close contact with a patient (less than one metre) and is administered for 10 days.

If a healthy person receiving antiviral prophylaxis falls ill he or she should be given full treatment. If a person, who has been on prophylactic treatment, comes once again into close contact with a patient with influenza, a full antiviral treatment should be initiated if influenza symptoms appear. This kind of use ensures the second most effective use of the antiviral drugs.

c) Prophylaxis will be administered to a healthy individual before he or she comes into close contact with those who are infected.

Antiviral prophylaxis is administered for at least 10 days after the last contact with a patient and for a maximum of six weeks. A widespread use of antiviral drugs in this manner, however, is uneconomical and will be of use to only a limited number of people.

Those in need of prophylactic treatment can be classified into three groups:

1. Household of influenza cases

Influenza patients will be treated at home for as long as their condition permits. The whole household will be isolated for 10 days and the influenza patient will receive antiviral treatment as quickly as possible, while prophylaxis of family members without symptoms will be determined according to items a) and b) above.

2. Health-care workers

The risk of transmission in health-care institutions will be reduced by obliging health-care workers attending influenza patients to use personal protective equipment and follow various other infection

Cont. p. 2

In 2007, four individuals were diagnosed in Iceland with confirmed meningococcal infection.

The number of gonorrhoea cases has increased sharply in recent years, but this increase seems to have been somewhat reduced during last year

control instructions. Additionally, patients with influenza will be given antiviral treatment, which greatly reduces the risk of transmission. The risk of infection in health-care workers will thus be considerably reduced. Treatment will be available for them according to items a), b) and c) above.

3. Police and rescue teams

Every effort will be made to employ as few as possible in the transport and care of the ill. There will be great emphasis on the use

of personal protective equipment as well as adherence to instructions on infection control, and the provision of antiviral drugs in accordance with items a) and b).

Others

There is no reason to administer prophylactic treatment to those who have not been in close proximity to infected individuals. The public will be encouraged to follow instructions intended to reduce the risk of transmission.

See also: [Læknablaðið. 2008/94](#)

NO ONE DIED FROM MENINGOCOCCAL INFECTION IN 2007

In 2007, four individuals were diagnosed in Iceland with confirmed meningococcal infection, the same number of cases as in 2006.

These four individuals included:

- A three-year old child with meningococcal C disease who had not been vaccinated.
- Three individuals with meningococcal B disease, two of whom were between three and four years of age and one who was 17 years old.

No individual died in Iceland from meningococcal infection in 2007.

Since Men C vaccination was started in 2002, no vaccinated individual has been diagnosed with Men C disease and no change has been seen in the epidemiology of meningococcal infections caused by other serogroups.

Men C vaccination has proved very successful in Iceland as well as in other countries.

CHLAMYDIA AND GONORRHOEA CASES IN

In 2007, a total of 1863 individuals were diagnosed with chlamydia, which is an increase compared with the previous year. Most of the cases are diagnosed at the Department of Clinical Microbiology at the Landspítali University Hospital (LUH), while

diagnosis of chlamydia is also done at the Akureyri Regional Hospital. Chlamydia cases were diagnosed in 1108 women and 692 men but gender was unknown in 63 cases. The mean age for women at the time of diagnosis was 22 years, whereas the men were older, or around 25 years.

According to data from the Department of Clinical Microbiology at LUH, 21 cases of gonorrhoea were diagnosed in 2007, 15 men and 5 women, and one case in which gender information was unavailable. The mean age of the men diagnosed was just over 28 years and that of the women 27 years. The number of gonorrhoea cases has been increasing sharply in recent years, but it this increase seems to have been somewhat reduced during last year.

