Medical Health Officers
UPDATE for Physicians
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In this Issue:

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IH STOP-HIV/AIDS Program (Seek and Treat for Optimal Prevention of HIV/AIDS)

IH has received ongoing operational provincial funding beginning April 1, 2013 to implement the STOP HIV/AIDS program. STOP HIV/AIDS strategies include identifying HIV positive individuals who are unaware of their status, and engaging all HIV positive individuals in appropriate care and treatment, to ensure supports are in place to allow them to adhere to maximally-beneficial anti-retroviral treatment (ART) and reduce individual and community viral load to minimize and prevent further transmission. Information on STOP HIV/AIDS strategies and deliverables can be found at the Ministry of Health website under "Hope to Health: Towards and AIDS Free Generation". The IH STOP HIV/AIDS implementation is being coordinated by IH Medical Health Officers and Communicable Disease Unit, as directed by a multi-disciplinary IH steering committee with significant physician involvement. The full implementation across all IH communities is expected to take two years, with the three initial implementation site-communities (Merritt; Vernon; Trail) commencing over the next few months, and then additional IH communities in the fall and winter. Work in the initial implementation sites and subsequent communities will be closely evaluated to help identify any changes that may be needed as the program expands.

What this means for physicians in community practice is:

a. **A change from risk based testing** which requires the physician to be aware that the patient is involved with a risk behavior through patient disclosure, **to the offer of a routine HIV test opportunistically to all adult patients** with other blood work already being drawn or medical appointments. This strategy has been endorsed by the BC College of Physicians and will be reflected in the revised testing guidelines expected by early summer. A webinar and print physician training session is available to support introduction into primary care practice at: http://hiv.ubccpd.ca/category/testing-implementation

b. **A change from specialist delivered HIV care** available only in large urban centers, **to a chronic disease care model provided by the primary care physicians at the local community level**, but supported by specialists in larger centers. BC Centre for Excellence in HIV/AIDS offers training for family physicians and nurse practitioners in HIV diagnosis and management. The training consists of completion of an on-line module (http://cfenet.ubc.ca/clinical-activities/education-training/online-courses) and an intensive one week clinical practicum at BCCfE. IH will be offering funding to support family physician in accessing the BCCfE intensive one week clinical practicum – interested physicians can contact Denise.Mckay@interiorhealth.ca

c. **A change, with dedicated IH health outreach nurses acting as HIV client case managers, providing care and coordination support to both HIV positive patients and family physicians** providing the clinical care.

The BC STOP HIV program is the greatest change in HIV care since the initial risk-based testing program was developed, and antiretroviral treatment initiated in 1996. This new 'treatment as prevention' approach will significantly mitigate the further transmission of HIV, and change the course of the epidemic in BC.

2012-2013 Assessment of Physician Interest in Delivering Child Immunizations - The September 2012 survey of IH physicians found that 45 physicians were potentially interested in taking on in-office childhood immunization; the remaining majority of 150 physicians responding were not interested, being quite satisfied with childhood vaccine delivery done by public health nurses. We subsequently reviewed with public health staff the processes necessary to support any physician desiring to do childhood immunizations in their office practice. In checking back with those 45 physicians during February 2013, most decided on sober second thought not to take on office-based childhood immunization. A few physician offices decided they would still like to commence in-office childhood immunization. From our perspective, this was still a very worthwhile project to undertake because: a.) we had never assessed the scope of physician interest previously; we now know that not many physicians have the time, interest and capacity in taking on In-office childhood immunization; and b.) over the years we had unduly and unfairly turned down occasional physician requests for access to childhood vaccines. We now have processes and protocols in place to support any additional physician offices wanting to take on childhood immunization in the future.

Ticks and Lyme Disease - While most ticks in the IH region are Rocky Mountain Wood Ticks (*D. andersoni)* not known to carry the lyme disease bacteria (*B. burgdorferi*), occasional *Ixodes* species ticks are found here, and these ticks are capable of carrying and transmitting Lyme disease. The majority of IH and BC residents do travel all across the province, including the more Lyme-endemic coastal areas of BC. As most people do not notice the tick bite or attachment when it occurs, any patients presenting to physicians with initial signs and symptoms compatible with acute Lyme disease should be fully evaluated and treated, even in the absence of a recognized tick bite. About 60-70% of all, newly infected patients will develop an expanding circular red (EM - erythma migrans) rash from 3-10 days after the bite. All patients presenting in IH with these signs should receive prompt early antibiotic treatment for suspected Lyme disease. Acute and convalescent serology are worthwhile for lab-confirmation but are often negative even with true Lyme infection, since early treatment may blunt seroconversion. NOTE: If a physician wishes a tick tested for a zoonotic disease, contact the BC Centre for Disease Control (BCCDC) Parasitology at (604) 707-2629. For questions regarding testing of humans, call BCCDC Zoonotic Diseases and Emerging Pathogens at (604) 707-2628. **NB -Ticks are <u>not</u> received at nor forwarded from IH Public Health Offices, and patients should not be directed to PH offices with ticks.**

Bats & Rabies - Bats are the only BC animal species endemically infected with rabies. A bat that comes into physical contact or bites a person suggests a sick bat. Of such bats, when captured and submitted, 5-10% test positive for rabies. Any human physical contact with a bat should be referred to the IH Communicable Disease (CD) Unit (toll-free 1-866-778-7736), or after hours to the MHO on-call, for assessment of the need for rabies vaccine prophylaxis. Any animal bites of IH residents occurring outside BC or overseas, should also be referred for assessment. Animal bites incurred by people intentionally hand-feeding squirrels, rabbits or rodents are considered 'provoked' , and do not warrant rabies vaccine. Bites by domestic pets or stray cats and dogs within BC do not usually necessitate rabies vaccine prophylaxis, but if you feel the circumstances of the bite or the animal behavior was suspicious of rabies, feel free to consult us.

Mosquitoes & West Nile Virus (WNv) - WNv was first detected in IH in the southern Okanagan region in the summer of 2009. There have been a limited number of positive lab detections in mosquitoes, birds and people since that time, but neither the prevalence (risk) nor geography seems to have expanded beyond low levels in the south and central Okanagan. Physicians wanting to test patients for suspected WNv infection should order WNv serology and PCR testing (local lab should draw blood in both a SST-gold top and EDTA -purple top tube) for submission to provincial PHSA Lab. PCR can also be done on CSF if requested. Acute and convalescent serology, collected 10-14 days later, are required to confirm an infection of WNv. Positive PCR can confirm a case, however a negative PCR in CSF alone does not rule out infection, and serology will be needed for confirmation. The CD Unit and/or MHO can be called to help interpret lab results. A four-fold increase in WNv neutralizing antibody titres in paired serology, or seroconversion along with the clinical criteria confirms a case of WN Non-NS ("West Nile fever") or WNNS (West Nile Neurological Syndrome).