week no. 6 ending February 9, 1985

Texas Preventable Disease NEWS

contents:

BUREAU OF EPIDEMIOLOGY 1100 West 49th Street, Austin, Texas 78756 (512-458-7207)

RATIONAL POST-EXPOSURE PREVENTION OF RABIES

Management decisions on whether to begin post-exposure rabies prophylaxis should take into consideration the following information:

1. The species of biting animal. Skunks, raccoons, foxes, bobcats, and bats are the animals most commonly infected with rabies. Most of the indigenous cases of human rabies in the US since 1960 have been caused by these animals. An unprovoked attack is more likely to indicate that the animal is rabid. Signs of rabies in a wild animal cannot be interpreted reliably. Therefore, any wild animal that bites or scratches a person should be killed at once (without unnecessary damage to the head) and the brain submitted for rabies testing.

2. Unless a wild animal is tested and shown to be non-rabid, post-exposure prophylaxis should be initiated when there is documented bite or non-bite exposure (scratch or lick) to humans by the animal. Treatment can be discontinued if subsequent testing in a competent laboratory verifies that the animal is not rabid.

3. Bites by dogs and cats continue to be the principal reasons given for antirabies treatment. All dogs and cats should be vaccinated against rabies. The occurrence of rabies in domestic dogs and cats varies from region to region. If in doubt, consult your local or state health department before making a decision to initiate post-exposure antirabies prophylaxis.

4. A healthy-appearing dog or cat responsible for biting a human may be observed for 10 days following the bite. During that time, if the animal develops symptoms compatible with rabies, it should be sacrificed immediately and its brain tested for rabies. If positive, post-exposure treatment should begin at once. A domestic dog or cat that develops rabies more than 10 days after having bitten a person did not have rabies virus present in its saliva at the time of the bite. Exposure to rabies virus has therefore not occurred and post-exposure prophylaxis is not necessary. On the other hand, a domestic dog or cat which does not develop rabies within the 10-day observation period cannot be considered to be free from rabies, especially in a case where the pet has had documented bite exposure from a rabid animal, since the incubation period for rabies may be as along 18 months. Therefore, the 10-day observation period is useful in ensuring that a dog or cat was not rabid at the time of biting the human, but it is not useful in excluding the possibility of rabies in the animal under observation. An observation period of six months to one year is necessary to exclude the possibility of subsequent rabies.

5. IMPORTANT POINT! LOCAL TREATMENT OF WOUNDS. Immediate and thorough washing of all bite wounds and scratches with soap and water is perhaps the most effective measure for preventing rabies. In experimental animals, simple local wound cleansing has been shown to reduce markedly the likelihood of rabies. Tetanus prophylaxis and measures to control bacterial infection should be given as indicated.

Human Rabies Immune Globulin (HRIG) is given only once at the beginning of post-exposure prophylaxis in persons who have not received prior rabies immunization. Because HRIG may suppress immune antibody response, no more than the recommended dose should be given. HRIG may be given as late as eight days following the initial dose of vaccine.

REFERENCE:

1. CDC. Recommendations of the Immunization Practices Advisory Committee. Rabies Prevention -- United States, 1984. MMWR 1984;33:393-402, 407-8.

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ADVERSE REACTIONS TO FANSIDAR® AND UPDATED RECOMMENDATIONS FOR ITS USE IN THE PREVENTION OF MALARIA

This article first appeared in the Centers for Disease Control (CDC) publication Morbidity and Mortality Weekly Report, January 4, 1985, Vol. 33/Nos. 51 & 52.

Since pyrimethamine-sulfadoxine (Fansidar) became available in the United States in 1982, it has been an integral part of the malaria prophylaxis regimen that CDC recommends for travelers at risk of exposure to chloroquine-resistant Plasmodium falciparum (CRPF). As the areas of the world with transmission of CRPF have expanded, the number of US travelers using Fansidar has increased. Fansidar is usually well tolerated; however, as with other sulfonamides, severe adverse reactions associated with its use have been reported. During the past three months, additional cases to those reported in the literature of severe cutaneous reactions (erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis) associated with the use of Fansidar over the past two years have been reported to CDC. These ten cases (four fatal) that have occurred among US travelers are currently being investigated by CDC in coordination with the US Food and Drug Administration and the drug manufacturer. In addition, there is a collaborative effort under way to assess the risks associated with the use of this drug for malaria prophylaxis.

Until the risk of adverse reactions to Fansidar is more thoroughly defined, CDC recommends the following:

1. Chloroquine remains the primary drug of choice for travelers to all malarious areas.

2. When considering the use of Fansidar for chemoprophylaxis of CRPF, physicians should carefully question travelers regarding any previous history of sulfonamide intolerance. Fansidar should not be prescribed if there is any history of previous untoward reaction to sulfonamides.

3. Travelers to CRPF regions in Asia or South America should take Fansidar in addition to chloroquine only if they stay overnight in rural areas. Travelers visiting urban areas of Asia and South America are at low risk of acquiring malaria, as are travelers to rural areas during daytime hours, because Anopheles mosquitoes bite during the evening and nighttime hours.

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CONFERENCE ON NEONATAL AND MATERNAL SEXUALLY TRANSMITTED DISEASES

The Texas Department of Health, Venereal Disease Control Division, together with the Centers for Disease Control, Sexually Transmitted Disease Division, will sponsor a symposium on neonatal and maternal Sexually Transmitted Diseases October 21–22, 1985, in Austin, Texas at the Hyatt Regency Hotel. The meeting will provide a forum for the discussion of the impact of sexually transmitted diseases on the outcome of pregnancy. Information on screening, diagnostic tests, clinical manifestations, treatment, and the epidemiology of these diseases will exchanged. Seating will be available for 500 participants. An announcement of keynote speakers and details about the agenda and registration will be published later. To obtain further information and future announcements, please complete the form below and mail to: Texas Department of Health, Venereal Disease Control Division, Neonatal Conference, 1100 West 49th Street, Austin, Texas, 78756.

(PLEASE PRINT OR TYPE)

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Last First Middle Initial

ORGANIZATION _____

TITLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE (Office) _____

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4. Travelers to areas of east and central Africa where transmission of CRPF has been documented should continue to use the combination of chloroquine and Fansidar. The risk of acquiring CRPF in these areas is substantial because of the intense transmission of malaria, especially in those rural areas usually frequented by tourists.

5. Travelers should be advised to discontinue Fansidar use immediately in the event of a possible ill effect, especially if any mucocutaneous signs or symptoms develop, such as pruritus, erythema, rash, orogenital lesions, or pharyngitis.

6. Travelers should be informed that, regardless of the prophylactic regimen employed, it is still possible to contract malaria. Medical attention should be sought promptly in the event of a febrile illness, and the physician should be advised of the recent travel history and possibility of exposure to malaria.

The above recommendations differ from earlier statements and should be applied as the most current information available. CDC will update these interim malaria chemoprophylaxis recommendations in the near future. Additional cases of adverse reactions to Fansidar should be reported to the Malaria Branch, Division of Parasitic Diseases, Center for Infectious Diseases, CDC; telephone (404) 452-4046.

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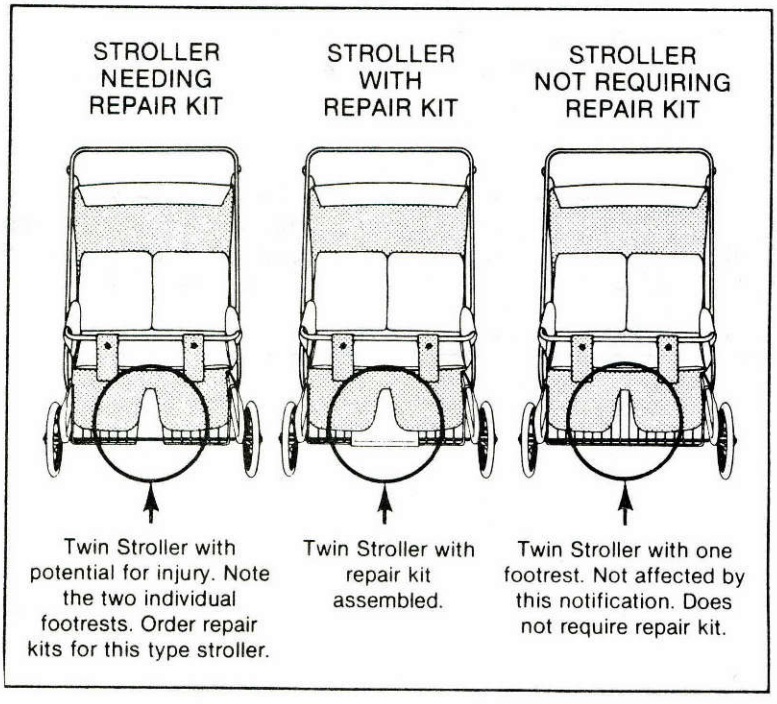
CONSUMER PRODUCT SAFETY ALERT

HEDSTROM TO VOLUNTARILY REPAIR TWIN TOTLINER STROLLERS



In cooperation with the US CPSC, Hedstrom Company of Bedford, Pennsylvania, has announced a voluntary repair program affecting approximately 34,200 Twin Totliner strollers manufactured between October 1975 and April 1982. The firm has received reports that six children have suffered broken legs after getting a foot caught between the stroller's two footrests.

To eliminate the potential for injury, Hedstrom has developed a plastic footrest guard that prevents access between the wire footrests. To obtain a free guard, consumers who own a Twin Totliner stroller may contact the retail store where the stroller was purchased or call Hedstrom's toll-free number: 1-800-233-3271. Consumers may also write to: Department 100, Hedstrom Company, PO Box 432, Bedford, PA 15522.

These strollers were distributed nationally and in Canada. Hedstrom model numbers affected are: 15-063, 15-163, 15-562, 15-5623, 15-662, 15-763, 15-862, and 15-963. Also affected are Sears, Roebuck and Co. units with model number 36494 and Sears Canada, Inc., formerly Simpson Sears, model number 66068. Look for the model number on an identification label attached to the frame of the stroller. Twin Totliner strollers manufactured after April 1982 have a single footrest and are not affected by this repair program.

The Commission and Hedstrom advise parents not to use the stroller until the guard is in place. After repair has been completed, be sure children are properly seated and seat belts are securely fastened whenever using the stroller.

Consumers may also call the CPSC toll-free hotline for information at 1-800-638-CPSC. A teletypewriter number for the hearing-impaired is 1-800-638-8270.

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1984 COMMUNICABLE DISEASE REPORTS

The official statistical cut-off date for communicable disease reports from 1984 will be **February 22, 1985.** Please forward all reports of cases with dates of onset in 1984 to the Bureau of Epidemiology before that date.

TEXAS PREVENTABLE DISEASE NEWS ( ) is a free, weekly publication of the Texas Department of Health, 1100 West 49th Street, Austin, TX, 78756-3180. Second-class postage paid at Austin, TX. POSTMASTER: Send address changes to TEXAS PREVENTABLE DISEASE NEWS, 1100 West 49th Street, Austin, TX 78756-3180.

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