

# WEEKLY EPIDEMIOLOGY BULLETIN

## NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

### Weekly Spotlight

## Guillain-Barre Syndrome

Guillain-Barré syndrome (GBS) is a rare disorder in which a person's own immune system damages their nerve cells, causing muscle weakness and sometimes paralysis. It often follows infection with a virus or bacteria. Most people recover fully from GBS, but some people have permanent nerve damage.

**Risk Factors:**

- Possibly Autoimmune
- Association with Immunizations
- Frequently preceded by mild respiratory or intestinal infection

**GUILLAIN-BARRE SYNDROME**

**Symmetrical Paralysis**

**Causes Problems With:**

- Respiration
- Talking
- Swallowing
- Bowel & Bladder Function

**Progresses over hours to days**

**Minimal Muscle Atrophy**

Begins in lower extremities and ascends bilaterally =

- 1) Weakness
- 2) Ataxia
- 3) Bilateral Paresthesia

Progressing to Paralysis.

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**GBS is rare.**

Anyone can develop GBS; however, it is more common among older adults. The rate of GBS increases with age, and people older than 50 years are at greatest risk for developing GBS.

**GBS may have several causes.**

While it is not known what causes all cases of GBS, it is known that about two-thirds of people who get GBS do so several days or weeks after they have been sick with diarrhea or a lung or sinus illness. Infection with the bacteria *Campylobacter jejuni* is one of the most common risk factors for GBS. People also can develop GBS after having the flu or other infections such as cytomegalovirus and Epstein Barr virus. On very rare occasions, people develop GBS in the days or weeks after getting a vaccination.

Source: <http://www.cdc.gov/vaccinesafety/concerns/guillain-barre-syndrome.html>

## EPI WEEK 2

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**GASTROENTERITIS**

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 **NOTIFICATIONS-**  
All clinical sites

 **INVESTIGATION REPORTS-** Detailed Follow up for all Class One Events

 **HOSPITAL ACTIVE SURVEILLANCE-**30 sites\*. Actively pursued

 **SENTINEL REPORT-** 79 sites\*. Automatic reporting

\*Incidence/Prevalence cannot be calculated

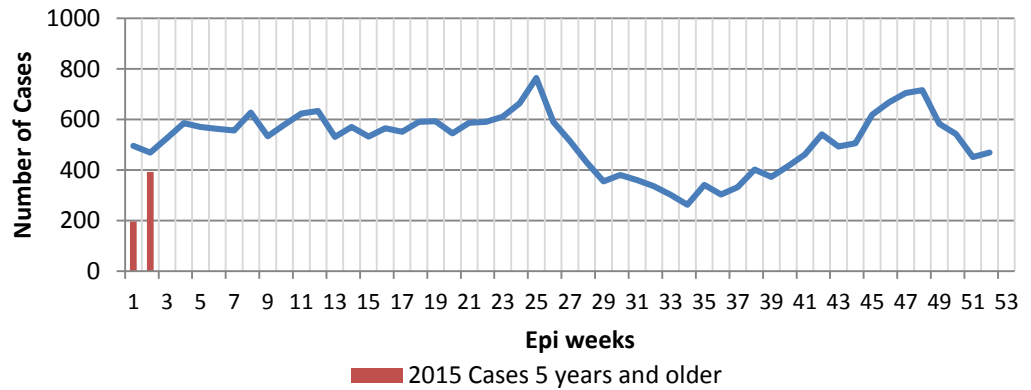
# REPORTS FOR SYNDROMIC SURVEILLANCE

## GASTROENTERITIS

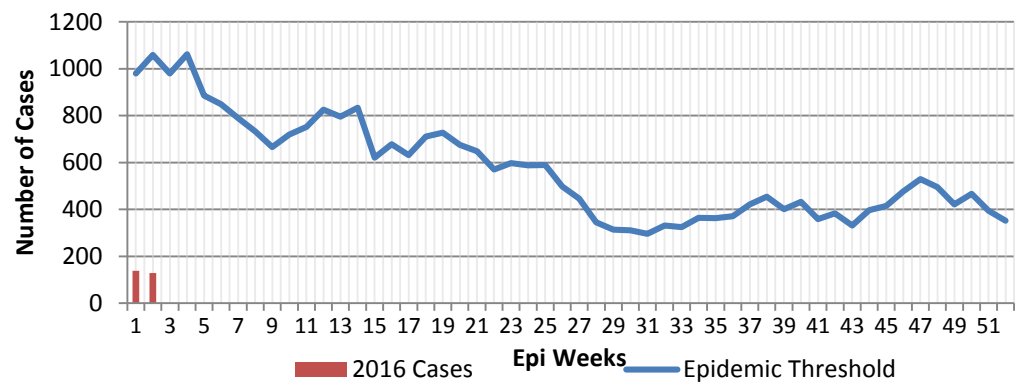
Three or more loose stools within 24 hours.



**GE ≥5 Weekly Threshold vs Cases 2016, EW 2**



**GE <5 Weekly Threshold vs Cases 2016, EW 2**

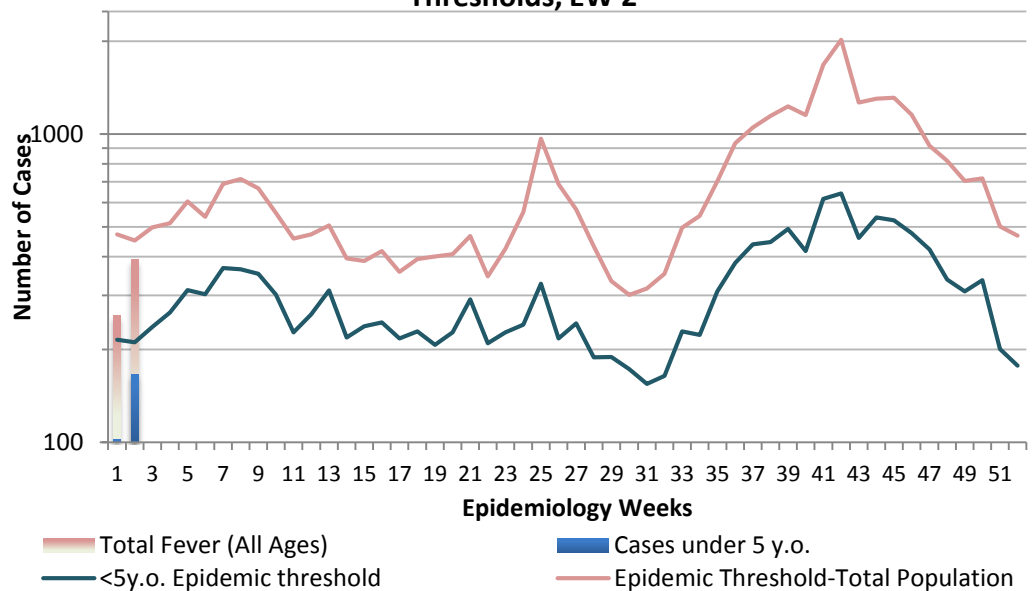


## FEVER

Temperature of  $>38^{\circ}C$  /  $100.4^{\circ}F$  (or recent history of fever) with or without an obvious diagnosis or focus of infection.



**Fever in under 5y.o. and Total Population 2016 vs Epidemic Thresholds, EW 2**



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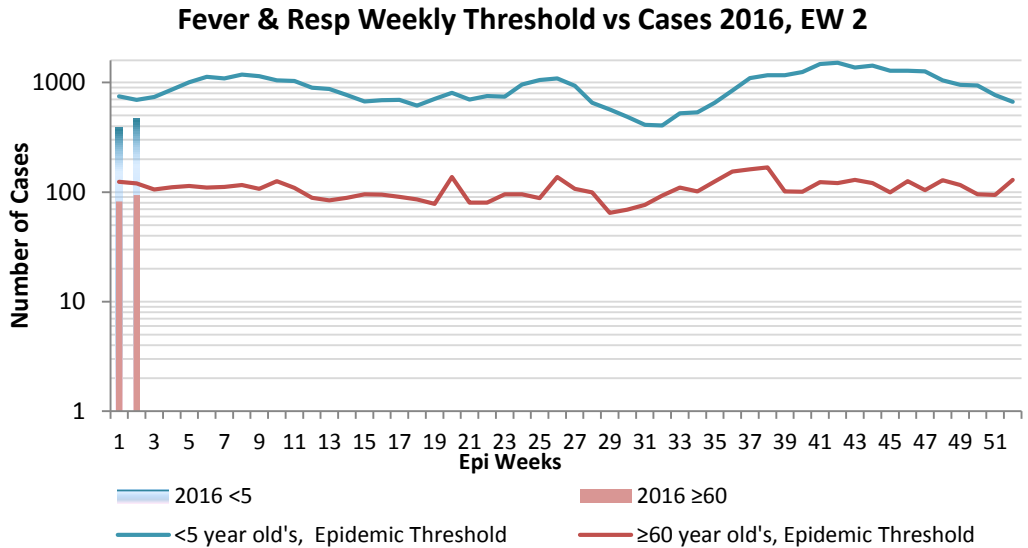
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# REPORTS FOR SYNDROMIC SURVEILLANCE

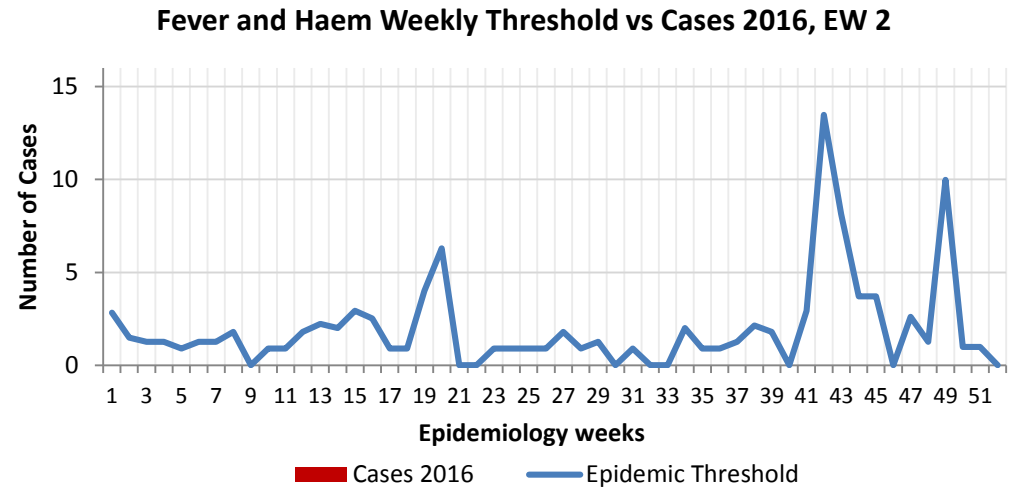
## FEVER AND RESPIRATORY

Temperature of  $>38^{\circ}\text{C}$  /  $100.4^{\circ}\text{F}$  (or recent history of fever) in a previously healthy person with or without respiratory distress presenting with either cough or sore throat.



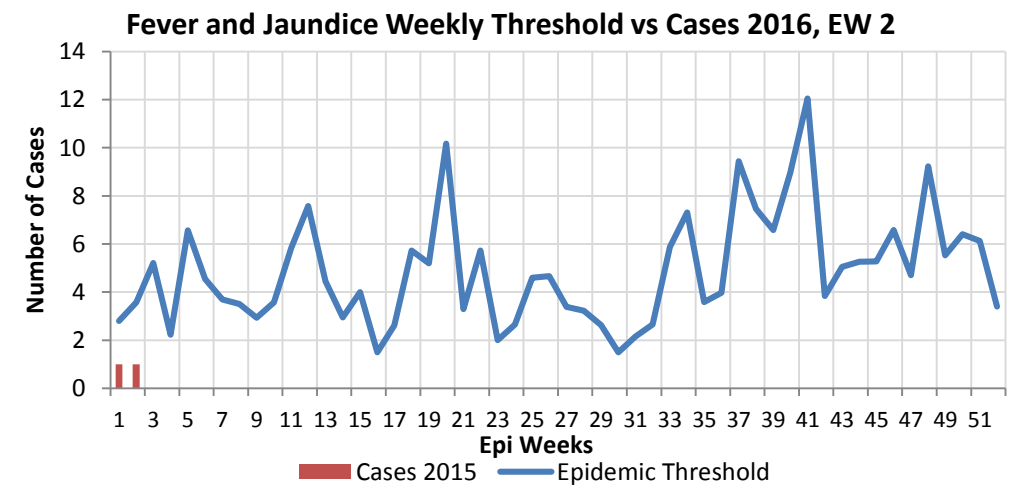
## FEVER AND HAEMORRHAGIC

Temperature of  $>38^{\circ}\text{C}$  /  $100.4^{\circ}\text{F}$  (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



## FEVER AND JAUNDICE

Temperature of  $>38^{\circ}\text{C}$  /  $100.4^{\circ}\text{F}$  (or recent history of fever) in a previously healthy person presenting with jaundice.



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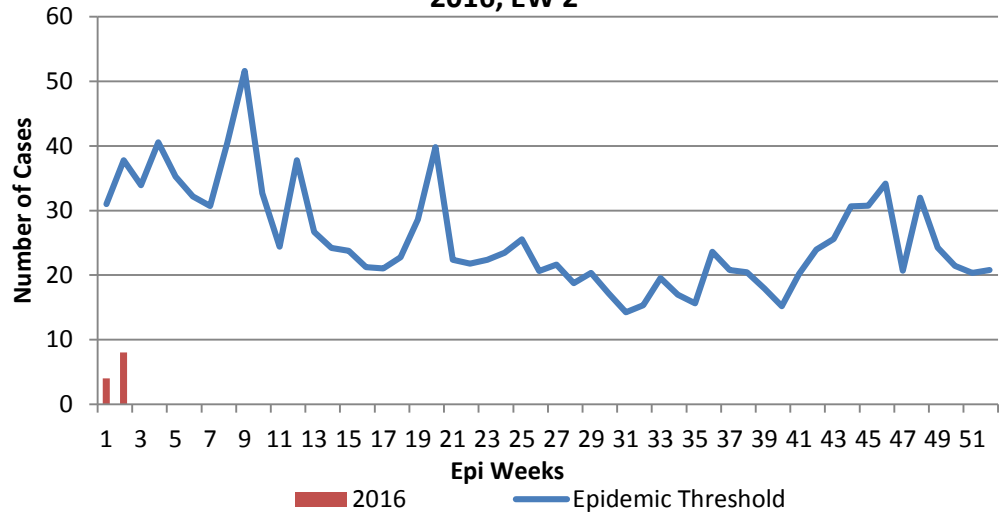
**FEVER AND NEUROLOGICAL**

Temperature of  $>38^{\circ}\text{C}$  /  $100.4^{\circ}\text{F}$  (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).



**Fever and Neurological Symptoms Weekly Threshold vs Cases**

2016, EW 2

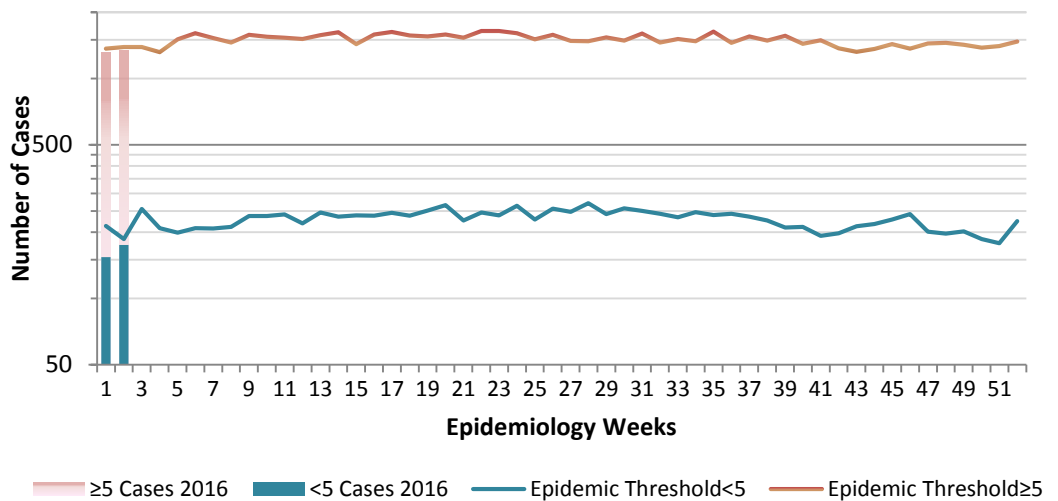


**ACCIDENTS**

Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



**Accidents Weekly Threshold vs Cases 2016**

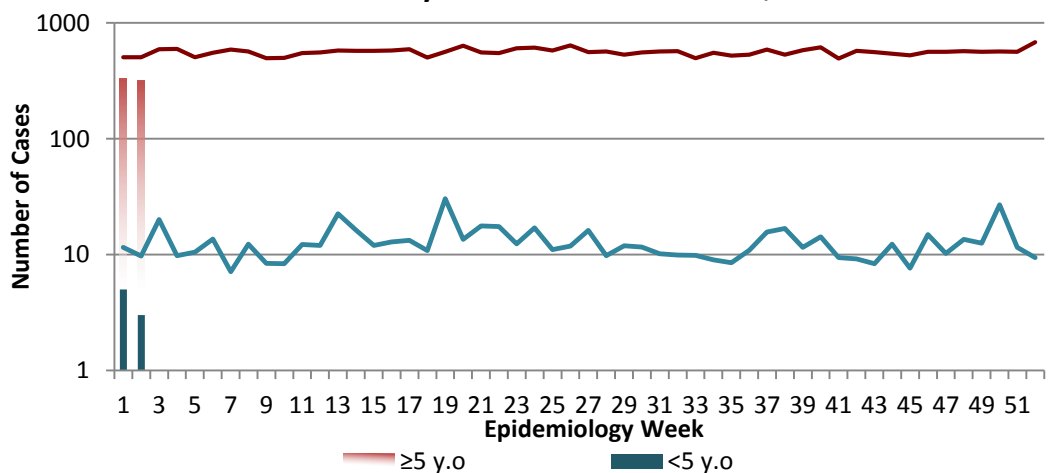


**VIOLENCE**

Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.



**Violence Weekly Threshold vs Cases 2016, EW 2**



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— CLASS ONE NOTIFIABLE EVENTS and LEPTOSPIROSIS

Comments

	CLASS 1 EVENTS	CONFIRMED YTD			
		CURRENT YEAR	PREVIOUS YEAR		
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	12	21	AFP Field Guides from WHO indicate that for an effective surveillance system, detection rates for AFP should be 1/100,000 population under 15 years old (6 to 7) cases annually.  Pertussis-like syndrome and Tetanus are clinically confirmed classifications.	
	Cholera	0	0		
	Dengue Hemorrhagic Fever <sup>1</sup>	0	0		
	Hansen's Disease (Leprosy)	0	0		
	Hepatitis B	0	1		
	Hepatitis C	0	0		
	HIV/AIDS - See HIV/AIDS National Programme Report				
	Malaria (Imported)	1	0		
	Meningitis	11	18		
EXOTIC/ UNUSUAL	Plague	0	0	The TB case detection rate established by PAHO for Jamaica is at least 70% of their calculated estimate of cases in the island, this is 180 (of 200) cases per year.  *Data not available  **Leptospirosis is awaiting classification as class 1, 2 or 3  <sup>1</sup> Dengue Hemorrhagic Fever data include Dengue related deaths;  <sup>2</sup> Maternal Deaths include early and late deaths.	
HIGH MORBIDITY/ MORTALITY	Meningococcal Meningitis	0	0		
	Neonatal Tetanus	0	0		
	Typhoid Fever	0	0		
	Meningitis H/Flu	0	0		
	AFP/Polio	0	0		
SPECIAL PROGRAMMES	Congenital Rubella Syndrome	0	0		
	Congenital Syphilis	0	0		
	Fever and Rash	Measles	0		0
		Rubella	0		0
	Maternal Deaths <sup>2</sup>	0	0		
	Ophthalmia Neonatorum	9	23		
	Pertussis-like syndrome	0	0		
	Rheumatic Fever	0	0		
	Tetanus	0	0		
Tuberculosis	0	0			
Yellow Fever	0	0			
UNCLASSED**	Leptospirosis	1	0		



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# NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT


**EW 2**

January 10– January 16, 2016

Epidemiology Week 2

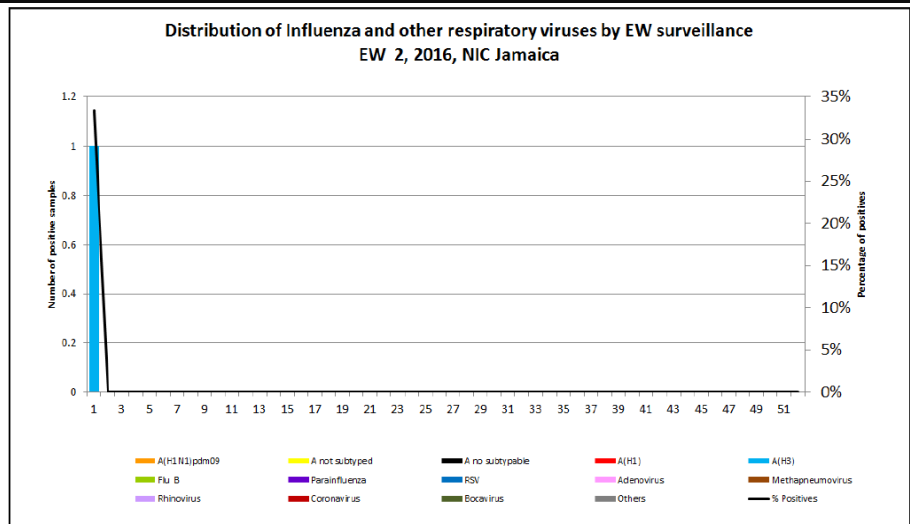
January, 2016		
	EW 2	YTD
SARI cases	21	49
<b>Total Influenza positive</b>	<b>0</b>	<b>1</b>
<b>Samples</b>		
<b>Influenza A</b>	<b>0</b>	<b>1</b>
H3N2	0	1
H1N1pdm09	0	0
<b>Influenza B</b>	<b>0</b>	<b>0</b>

## Admitted Lower Respiratory Tract Infection and LRTI-related Deaths

	Current year		Previous year	
	Week 2 2016	YTD 2016	Week 2 2015	YTD 2015
 Admitted Lower Respiratory Tract Infections	63	129	87	165
Pneumonia-related Deaths	4	5	2	3

### Comments:

The percent positivity of influenza viruses circulating among respiratory samples tested in EW 2, 2016 was 0%. Influenza A/H3N2 is the predominant circulating virus (84%), while Influenza B Yamagata continues to circulate at low levels of 16%. Both viruses are components of the 2014 -2015 Influenza Vaccines for the Northern Hemisphere. There has been no detection of the influenza variant A/H3 virus (A/H3N2v), influenza Avian H5 or H7 viruses among samples tested.



### INDICATORS

#### Burden

Year to date, respiratory syndromes account for 4.1% of visits to health facilities.

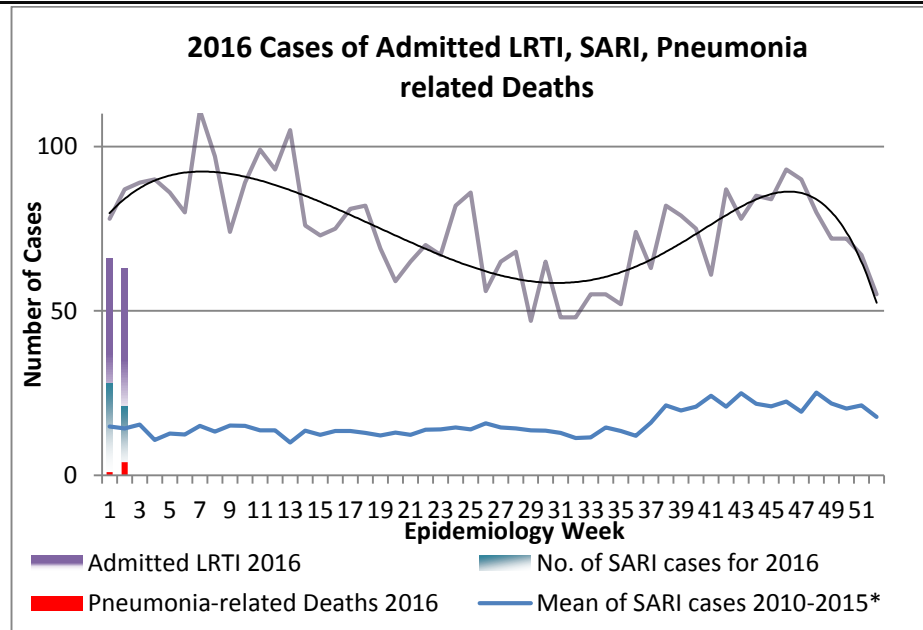
#### Incidence

Cannot be calculated, as data sources do not collect all cases of Respiratory illness.



#### Prevalence

Not applicable to acute respiratory conditions.



**\*Additional data needed to calculate Epidemic Threshold**



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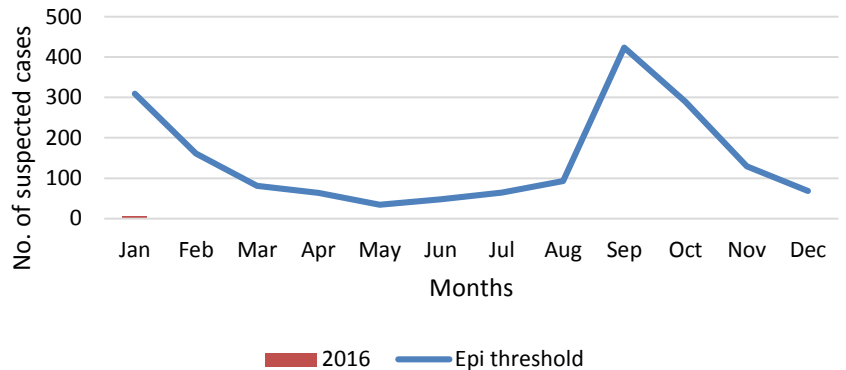
# Dengue Bulletin

January 10–January 16, 2016

Epidemiology Week 2



2016 Cases vs. Epidemic Threshold

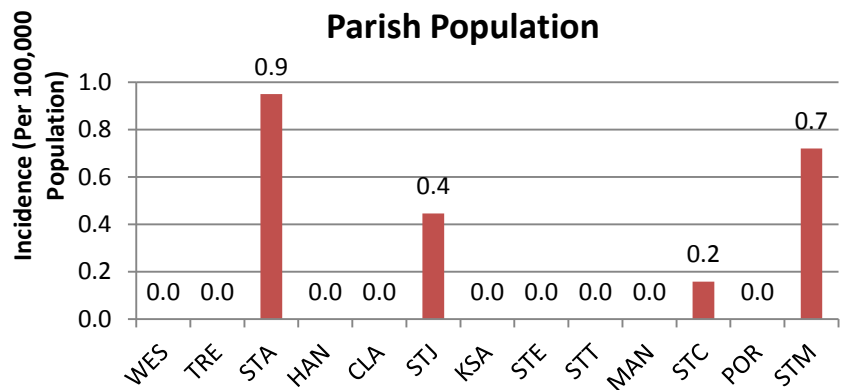


## DISTRIBUTION

### Year-to-Date Suspected Dengue Fever

	M	F	Total	%
<1	0	1	1	20
1-4	0	0	0	0
5-14	1	0	1	20
15-24	1	1	2	40
25-44	0	0	0	0
45-64	0	0	0	0
≥65	0	0	0	0
Unknown	1	0	1	20
<b>TOTAL</b>	<b>3</b>	<b>2</b>	<b>5</b>	<b>100</b>

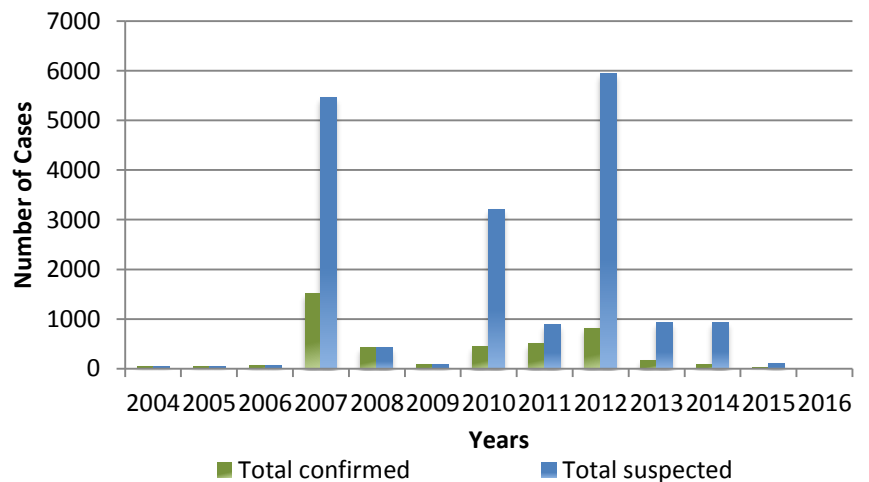
Suspected Dengue Fever Cases per 100,000 Parish Population



### Weekly Breakdown of suspected and confirmed cases of DF,DHF,DSS,DRD

		2016		2015 YTD
		EW 2	YTD	
Total Suspected Dengue Cases		2	5	7
Lab Confirmed Dengue cases		0	0	0
CONFIRMED	DHF/DSS	0	0	0
	Dengue Related Deaths	0	0	0

Dengue Cases by Year: 2004-2016, Jamaica



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# Gastroenteritis Bulletin

**EW**  
**2**

January 10 –January 16, 2016

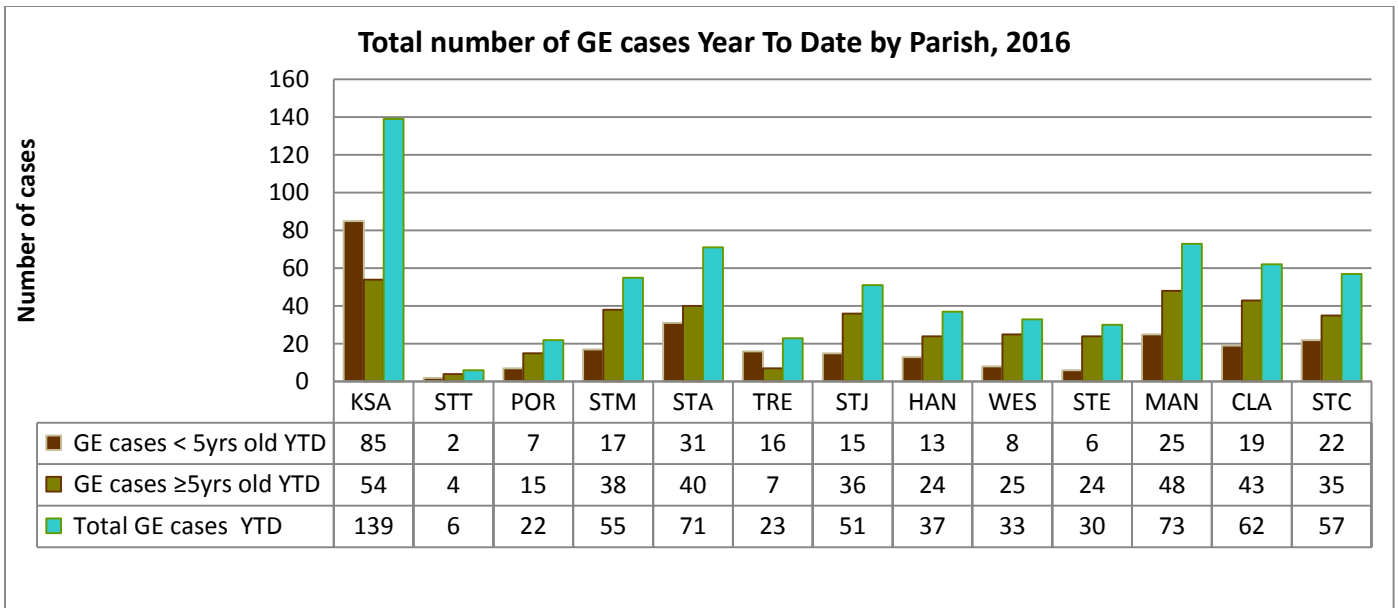
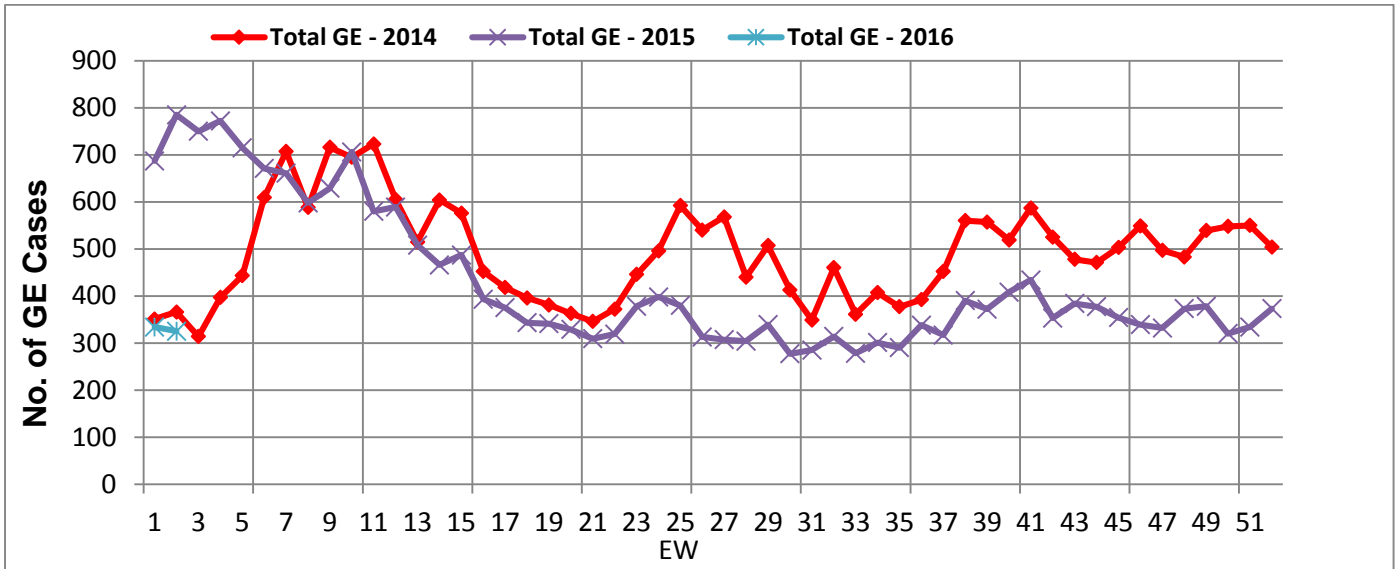
Epidemiology Week 2

## Weekly Breakdown of Gastroenteritis cases

Year	EW 2			YTD		
	<5	≥5	Total	<5	≥5	Total
2016	128	197	325	266	393	659
2015	441	344	785	827	645	1472

In Epidemiology Week 2, 2016, the total number of reported GE cases showed a 58% decrease compared to EW 2 of the previous year. The year to date figure showed a 55% decrease in cases for the period.

**Figure 1: Total Gastroenteritis Cases Reported 2014-2016**



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# RESEARCH PAPER

## A Description of Registered Nurses' Documentation Practices and their Experiences with Documentation in a Jamaican Hospital

*C Blake-Mowatt, JLM Lindo, S Stanley, J Bennett*

*The UWI School of Nursing, Mona, The University of the West Indies, Mona, Kingston 7, Jamaica*

**Objective:** To determine the level of documentation that exists among registered nurses employed at a Type A Hospital in Western Jamaica.

**Method:** Using an audit tool developed at the University Hospital of the West Indies, 79 patient docketts from three medical wards were audited to determine the level of registered nurses' documentation at the hospital. Data were analyzed using the SPSS® version 17 for Windows®. Qualitative data regarding the nurses' experience with documentation at the institution were gathered from focus group discussions including 12 nurses assigned to the audited wards.

**Results:** Almost all the docketts audited (98%) revealed that nurses followed documentation guidelines for admission, recording patients' past complaints, medical history and assessment data. Most of the docketts (96.7%) audited had authorized abbreviations only. Similarly, 98% of the nurses' notes reflected clear documentation for nursing actions taken after identification of a problem and a summary of the patients' condition at the end of the shift. Only 25.6% of the docketts had nursing diagnosis which corresponded to the current medical diagnosis and less than a half (48.3%) had documented evidence of discharge planning. Most of the nurses' notes (86.7%) had no evidence of patient teaching. The main reported factors affecting documentation practices were workload and staff/patient ratios. Participants believed that nursing documentation could be improved with better staffing, improved peer guidance and continuing education.

**Conclusion:** Generally, nurses followed the guidelines for documentation; however, elements were missing which included patient teaching and discharge planning. This was attributed to high patient load and nurse/patient ratio.



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REPORTS- Detailed Follow  
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