Information for Health NZ Clinical Staff

September 2024

New requirements for management of notifiable invasive group A streptococcal infection (iGAS) from 1 October 2024

Background

From 1 October 2024, **invasive group A streptococcal Infection** (iGAS) has been added to Aotearoa New Zealand's schedule of notifiable diseases.

This places new legal requirements on health practitioners and laboratories for the management and reporting of both suspected and confirmed iGAS cases.

For Health NZ Clinical Staff, the following guidance provides important information about these new requirements.

iGAS case definition

iGAS is defined as detection of group A *Streptococcus* bacteria (GAS, *Streptococcus pyogenes,* Strep A) via culture or nucleic acid testing (e.g. polymerase chain reaction, PCR) in a specimen from normally sterile site of the body—an anatomical location where bacteria are not normally present in a healthy person.

Notification and reporting of iGAS

The case definition for an iGAS infection includes:

- a **confirmed case** – defined by meeting laboratory definitive criteria.
- a **probable** case – defined by meeting both clinical criteria and laboratory suggestive criteria.

Clinicians are responsible for notifying their local Medical Officer of Health, within the National Public Health Service of ***both confirmed and probable cases*** of iGAS that meet the case definition.

Confirmed case notification

Most iGAS cases are expected to be notified via a direct laboratory notification based on a set of specimen sterility guidelines as outlined by the case definition below.

- group A *Streptococcus* detected in specimens from sterile sites (e.g. blood cultures) will be notified via direct laboratory notification (DLN) as confirmed cases of iGAS.
- group A *Streptococcus* in specimens from non-sterile sites (e.g. skin, throat and genital swabs) will **NOT** be notified.

Probable case notification

The probable case definition is intended to identify people with iGAS whose laboratory evidence does not meet the confirmed case definition, but who are likely to have close contacts who could benefit from chemoprophylaxis.

Hospital clinicians are required to notify probable cases when they meet the following clinical criteria, when there is suggestive laboratory evidence that group A *Streptococcus* is the likely causative organism:

- peripartum infections up to 28 days post birth, or
- neonatal sepsis.

Peripartum infections are defined here as clinically suspected bacterial infections of the genital tract or its surrounding tissues, occurring at any time between the onset of rupture of membranes or labour, and the 28th day postpartum (e.g. chorioamnionitis, endometritis, maternal/puerperal sepsis). Peripartum infections include intrapartum and postpartum infections. This definition of peripartum infection has been adapted for use in this context from the WHO definition of 'maternal peripartum infection'.

Laboratory suggestive evidence for these people constitutes detection of group A *Streptococcus* from a non-sterile site (e.g. a person presenting with postpartum endometritis with group A *Streptococcus* detected on a vaginal swab would constitute a probable case of iGAS).

Contacts and close contacts

Health information should be provided by the local public health service to close contacts of all iGAS cases. An information sheet has been developed for close contacts, which is being made available in the new Communicable Disease Manual chapter on iGAS (see below).

New chemoprophylaxis guidance for close contacts of iGAS cases

For cases of iGAS in a birthing person-neonate pair, it is recommended that the close contact within the pair (e.g. the birthing person if the neonate is infected, or vice versa) receives antibiotic chemoprophylaxis to reduce their risk of developing iGAS. The public health service will facilitate the provision of chemoprophylaxis to these close contacts.

Chemoprophylaxis is **NOT** routinely recommended for other close contacts of iGAS cases.

The public health service may occasionally request clinician support to help quickly provide chemoprophylaxis to close contacts when needed.

Obstetrics and Gynaecology/Midwives/Lead Maternity Carers

Obstetrics and Gynaecology departments should be prepared to notify **probable** cases of iGAS in adults (i.e. cases of peripartum infection where group A *Streptococcus* is detected on a non-sterile site specimen).

For example, someone diagnosed with chorioamnionitis, endometritis, or maternal/puerperal sepsis within 28 days of giving birth and has group A *Streptococcus* detected on a vaginal swab will fall under this category. Group A *Streptococcus* detected on a vaginal swab is not notifiable via direct laboratory notification (as it was taken from a non-sterile site) and so the case must be clinically notified.

Paediatrics

Paediatric departments (particularly neonatologists) should be aware that they are likely to be responsible for notifying **probable** cases of iGAS in neonates.

In both departments, clinicians should ensure that cases meeting the **probable** case definition are promptly notified to the local Medical Officer of Health.

Infection Prevention and Control/Occupational Health

Infection prevention and control (IPC) and/or occupational health are responsible for following up airway-exposed healthcare workers, where a healthcare worker without appropriate personal protective equipment is exposed to an iGAS case with an airway or respiratory tract manifestation of iGAS.

These iGAS cases should be proactively identified to IPC/occupational health by public health services to enable follow-up (other manifestations of iGAS cases are not recommended for follow-up by IPC/occupational health).

Airway-exposed healthcare workers should receive close contact health information. These contacts are not recommended to routinely receive chemoprophylaxis but guidance on individual risk assessment will be provided in the CD manual chapter when it is made live.

New Communicable Disease Manual Chapter

The Communicable Disease Manual has also been updated to include a new chapter on iGAS which will be available from 1 October.

The chapter was developed at pace by a Clinical Technical Advisory Group, which contained representation from each of the four Regions, along with relevant clinical, microbiology and IPC expertise. We thank everyone who has been part of this mahi.

Summary

These changes aim to support best practice care of people with iGAS and their whānau, and improve the quality of information we collect for surveillance of this disease in Aotearoa. Thank you for your continued mahi to make this happen. Your support is greatly appreciated. Questions or queries regarding this content can be directed to protection.clinical@tewhatuora.govt.nz