Algorithm 2. Management of iGAS case linked to a crèche, school or other childcare setting Version 2.2 23/01/2024

Identification of iGAS infection in child or staff with attendance at crèche, school or other childcare setting within 7 days of onset of symptoms [1,2]

Conduct Public Health Risk Assessment (PHRA)

Factors for consideration include:

Any other children/staff with:

- GAS[3] infection within last 7 days

OR

- iGAS[4] in last 30 days

OR

- Evidence of co-circulating chickenpox or influenza

OR

- Other public health concern, (e.g. possible household-type contact a concern e.g. a childminders home)

Yes

If outbreak is suspected public health to convene an Outbreak Control Team (OCT) (include local micro/IMSRL)

- identify possible routes of transmission (identify commonality with location/staffing, social/sports groups)
- consider chemoprophylaxis based upon PHRA
- consider targeted swabbing[5] (throat /skin lesions) to identify extent of transmission (refer GAS +ve isolates) or if suspect specific clone involved.
- consider communication to local healthcare providers
- Consider additional control measures if there is co-circulating chickenpox[6] or influenza[7]

No

Provide letter and **HPSC Strep A factsheet** to parents and staff based upon PHRA

Implement control measures

- review infection prevention and control measures, with emphasis on hand hygiene, respiratory etiquette and environmental cleaning
- inform parents and staff of outbreak
- ensure treatment and exclusion of symptomatic staff/children (until 24h treatment received)
- After control measures are implemented and the outbreak declared over[8] on OCT direction, maintain surveillance for an additional 6 months and ensure any laboratory isolates are saved.

1. iGAS is defined through isolation of GAS from a normally sterile body site. GAS isolated from non-sterile site in combination with severe clinical presentation should be managed as per iGAS.

2. It may be necessary to inform the facility even if the case hasn't attended the setting in the last 7 days, if severe illness or death.

3. Symptoms suggestive of GAS infection include sore throat, fever, minor skin infections, scarlatiniform rash.

4. Symptoms suggestive of invasive disease include high fever, severe muscle aches or localised muscle tenderness, increasing pain, swelling and redness at the site of a wound, unexplained diarrhoea or vomiting

5. Although mass swabbing of children is not routinely recommended, it can be considered in exceptional circumstances by the OCT.

6. If **chickenpox** is co-circulating in a creche, school or other childcare setting where an iGAS case has been notified **the OCT will need to consider**

- the chickenpox outbreak management aspect
- post-exposure prophylaxis with varicella vaccine.

7. If **influenza** is suspected or confirmed to be co-circulating in a creche, school or other childcare setting where an iGAS case has been confirmed, this provides an opportunity to remind eligible children, including those in high risk groups who are at increased risk of severe disease, to take up their offer of flu vaccination. Flu vaccination is not routinely recommended as post-exposure prophylaxis in this context.

8. For outbreak closure, a conservative approach of 60 days since last iGAS case (2 x 30 day period).