SUMMARY OF RECOMMENDED PERIODS OF ABSENCE FOR COMMUNICABLE DISEASES

ADULTS

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

Introduction

In accordance with national guidance, this document provides a summary of the recommended periods of absence for adults who are, or are thought to be, suffering from an infection which may spread to others.

The key to prevention and control of spread of infection is maintaining high standards of hygiene at all times. In particular:

Hands should be washed **after**:	Hands should be washed **before**:
• Using or cleaning the toilet • Immediately after handling raw meat/poultry • Preparing food in general • Blowing your nose or covering a sneeze or cough • Smoking, as fingers will come in contact with the mouth and nose • Touching pets or other animals	• Preparing food or drink • Eating food

High standards of hygiene should also be applied to:
- Food hygiene
- Environmental cleaning
- Disposal of waste.

For further information and advice on infectious diseases and the control of infection, contact the Health Protection Team, Lothian NHS Board.
Tel: 0131 465 5420/5422

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

Key for recommended period of absence:

Groups that pose a higher than normal risk of spreading infection.

Group A	Any person of doubtful hygiene or with unsatisfactory toilet, hand washing or hand drying facilities at home, work or school.
Group B	Children who attend pre-school groups or nursery
Group C	People whose work involves preparing or serving unwrapped foods not subjected to further heating/cooking.
Group D	Health or Social Care staff who have direct contact with highly susceptible patients or persons in whom an infection would have particularly serious consequences.

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

Disease/ Causative Organism	Typical Incubation Period	Route of Infection	Risk of person to person spread	Recommended Period of Absence		Action
				Cases	Contacts	
Campylobacter	3-4 Days (Can be 1-10 days).	Food borne. Contaminated food and water. Contact with infected animals.	Low risk of transmission from person to person can occur, especially where there is poor hygiene practice.	Until clinically recovered and diarrhoea has ceased for 48hrs.	None	Practice good hygiene, specifically hand hygiene.
Chickenpox (Varicella Zoster)	15-18 days (Can be 10-21 days).	Direct person to person contact – airborne and droplet spread.	High risk of transmission from 2 days before rash onset until all the lesions have crusted.	Until vesicles become dry (approx 7 days) but a minimum of 5 days after rash onset.	Healthcare workers without a history of chickenpox may be excluded by HPT.	Pregnant women and the immuno-compromised who are contacts of cases should seek medical advice as soon as possible.
Clostridium Difficile	Variable. Often triggered by antibiotic use and can start a few days or months after antibiotic course.	Contact with an infected person or contaminated environment or objects.	Those most at risk of transmission are elderly, people currently or recently taken antibiotics, been in hospital or are immunosuppressed.	Until clinically recovered and diarrhoea has ceased for 48hrs.	None	Practice good hygiene, specifically environmental and hand hygiene.
Colds	12hours to 5 days (Commonly 48 hours).	Respiratory droplet. Contact with secretions.	High risk of transmission during active infection.	None.	None.	Practice good hygiene. Practice good cough etiquette
Cold sores (Herpes Simplex)	2-12 days.	Direct contact with oral secretions or direct contact with lesion.	High risk of transmission until lesion crusted.	None.	None.	Practice good hygiene. Health education. Avoid kissing and contact with sores.

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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						Mild self limiting.
Conjunctivitis	1-3 days.	Contact with discharges.	High risk of transmission whilst symptomatic.	If unwell and a serious infection stay off until eye no longer inflamed and infected.	None.	Practice good hygiene. If outbreak or cluster inform HPT.
Cryptosporidiosis	7-10 days (Can be 1-21 days average 7 days).	Faecal-oral. Waterborne. Contact with animal faeces.	High risk of transmission from person to person.	Until clinically recovered and diarrhoea has ceased for 48hrs. Avoid swimming until 2 weeks after symptoms cease.	None.	Practice good hygiene. Follow up by HPT/Environmental health.
Cytomegalovirus (CMV)	Variable. 3-8 weeks but can be up to 12.	Intimate exposure. Contact with infected tissue or fluids (e.g. body fluids/blood).	High risk of transmission through intimate contact with fluids, whilst organism present. Carriage may persist for many months.	None.	None.	Practice good hygiene.
Diarrhoea	Dependent on causative organism.	Often food or waterborne or due to poor hygiene. Can be faecal-oral. Some viruses may be airborne.	High risk of transmission whilst symptomatic, though dependent on cause.	Until clinically recovered and diarrhoea has ceased for 48hrs. (If cause known refer to disease).	None (If cause known refer to disease).	Practice good hygiene (If cause known refer to disease).
Diphtheria (very rare in UK)	2-5 days but may be longer.	Contact with discharge from lesions. Airborne droplet	Not highly infectious. Prolonged close contact is normally required for	Until clinically recovered and bacteriological	Household contacts should be	Notifiable. Investigation by HPT

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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				Cases	Contacts	
		spread. Direct contact with respiratory discharges. Infected animals or unpasteurised dairy products.	transmission. Cases remain infectious for up to 4 weeks after symptom onset or after 3 days of appropriate antibiotics.	specimens are clear. Always consult with local health protection team as exclusion will apply.	excluded until specimens are clear.	Preventable by vaccination. Contact tracing will be required.
Dysentery (Bacillary) =*Shigella flexneri* *Shigella boydii* *Shigella dysenteriae* **Shigella sonnei*	1-3 days (Can be 8hrs to 7 days).	Faecal-oral. Food borne. Occasionally waterborne	High risk of transmission from person to person especially whilst cases are symptomatic.	=2 negative stool specimens for groups A, B, C and D taken at least 48 hours apart. * 48 hours symptom free.	None. Unless contacts are symptomatic	Notifiable Practice good hygiene. Follow up by EHO/HPT.
E.coli O157 (VTEC)	2-7 days (Can be 1-14).	Faecal-oral. Food borne. Contact with animal faeces.	Very high risk of transmission from person to person. Cases can still pass on infection once asymptomatic and contacts can carry E-coli O157 with no symptoms and pass it on.	2 negative stool specimens for groups A, B, C and D taken 24 hours apart. Otherwise until clinically recovered and diarrhoea has ceased for 48 hrs.	2 negative stool specimens for groups A, B, C and D taken 24 hours apart. Otherwise 48 hrs symptom free.	Notifiable. Follow up by HPT/EHO. Practice good hygiene
E.coli in urine	Unknown.	Spread of the bacteria from the gut to the urinary system.	Low risk of transmission from person to person.	Until clinically recovered, usually 2-4 days. May require short course of antibiotics.	None	Practice good hygiene.
Fifth Disease (Parvovirus B19 or	13-18 days (4-20 days).	Through contact with respiratory secretions.	High risk of transmission 7 days before rash	Until clinically recovered.	None.	Pregnant women, immunocompromised and

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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'slapped-cheek' disease)			appears until one day after onset of rash. Most adults are immune to parvovirus.			people with haemolytic anaemia should avoid contact with known cases.
Food Poisoning	Dependent on causative organism.	Food borne.	Variable. Usually low risk of transmission if asymptomatic.	Until clinically recovered and diarrhoea has ceased for 48hrs. (If cause known refer to disease).	None. (If cause known refer to disease).	Practice good hygiene.
German Measles (Rubella)	14-17 days (Can be 14-21 days).	Droplet spread or direct contact with secretions.	High risk of transmission from 1 week before onset of rash to 4 days after.	Until clinically recovered but at least 4 days after onset of rash.	If contacts work with vulnerable groups or in large institutions they may be excluded by HPT.	Notifiable. Follow up of cases by HPT. Pregnant women should consult their GP or midwife if exposed. Children should be immunised with MMR.
Giardiasis	7-10 days (Can be 5-28 days).	Waterborne. Faecal-oral.	High risk of transmission whilst organism present in stool.	Until clinically recovered and diarrhoea has ceased for 48hrs	None.	Notifiable. Follow up by HPT/EHO. Practice good hygiene.
Glandular Fever (Infectious Mononucleosis)	4-6 weeks.	Close contact with pharyngeal secretions (e.g. kissing). Indirectly on hands.	Carriage may be prolonged with high risk of transmission.	Until clinically recovered.	None.	
Group A streptococcal infection	1-4 days for acute infection, 2-3 weeks for untreated sore	Person to person	Low risk of transmission	Until clinically recovered and 24 hours after appropriate	None unless symptomatic. Information will	HPT will investigate cases of invasive group A strep

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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				Cases	Contacts	
	throat			antibiotics	be given to close contacts	
Haemophilus Influenzae B (HIB)	Unknown but probably 2-4 days.	Respiratory droplet or contact with secretions.	High risk of transmission whilst symptomatic and/or whilst organism is present in nasopharynx. Non infectious after 48 hours of appropriate antibiotic treatment.	Until clinically recovered but at least 48 hours after commencing treatment.	None.	Investigation by HPT. Children should have been immunised pre-school.
Hand, Foot & Mouth Disease	3-5 days.	Direct contact with faeces, blisters and respiratory droplets (aerosol droplet spread).	High risk of transmission during acute stage of illness (occasionally longer as virus can persist in faeces for several weeks).	When clinically recovered.	None.	Report outbreaks to HPT. Practice good hygiene.
Head Lice	Head lice mature in 6-12 days and live for about 20 days.	Direct head to head contact.	High risk of transmission until adequately treated.	Until treated. (After first treatment and no visible live lice). Treatment only recommended when live lice are seen.	None if asymptomatic.	Health education. Practice good hygiene.
Hepatitis A	28-30 days (Can be 15-50).	Faecal-oral. Waterborne.	High risk of transmission from two weeks before onset of jaundice until one week after jaundice starts.	Until 7 days after onset of jaundice (if present) or other symptoms.	None. (unless they have symptoms suggestive of hepatitis A or are food handlers)	Notifiable. Follow up by HPT/EHO. Practice good hygiene.
Hepatitis B	2-6 months (Commonly 2-3).	Blood borne. Mother to baby vertical transmission.	Infectious during incubation period and up to 6 months after acute illness. 10% of	Until clinically recovered.	None.	Notifiable. Investigation by HPT. Practice good hygiene,

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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				Cases	Contacts	
		Sexual transmission. Sharing injecting equipment.	cases develop chronic infection and continue to be infectious Low risk of transmission if social contact only.			with care when dealing with blood and body fluids. Practice safe sex Do not share needles.
Hepatitis C	2 weeks to 6 months (commonly 6-10 weeks)	Blood borne. Sexual transmission. Sharing injecting equipment.	Probably infectious for life. Low risk of transmission if social contact only.	Until clinically recovered.	None.	Notifiable. Practice good hygiene with care when dealing with blood/body fluids.
Hepatitis E	15-64 days Mean value 26-42 days	Faecal-Oral Contaminated food/water	Virus present in faeces during late incubation and have been detected 14 days after onset of jaundice. No evidence of person-person transmission.	Until clinically recovered but all should be reminded of the importance of hand hygiene.	None	Notifiable Investigation by HPT/EHO Hand Hygiene.
HIV	1-3 months for detectable antibodies	Blood borne. Sexual transmission. Sharing injecting equipment. Mother to child vertical transmission.	Infectious for life. Low risk of transmission if social contact only.	None.	None.	Notifiable. Practice good hygiene. take care when dealing with blood/body fluids.
Impetigo	1-10 days.	Direct contact with lesions. Indirect contact with infected items (e.g. towels, clothes).	Highly infectious whilst lesions are present and until they are healed and crusted over.	Until lesions are crusted or healed or 48 hours after commencing appropriate antibiotics.	None.	Report outbreaks to HPT. Practice good hygiene.
Influenza	1-5 days.	Airborne/droplet. Contact with respiratory secretions.	Highly infectious in the first 3-5 days (up to 10 days in young children).	Until clinically recovered.	None.	Immunisation for at risk groups. Practice good hygiene.
Measles	7-18 days (can be up to 21 days).	Airborne. Direct contact with	Highly infectious from 5 days before onset of	4 days from the onset of rash.	Contacts who work with	Notifiable Investigation by HPT

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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				Cases	Contacts	
	Rash usually appears 14 days after exposure.	respiratory secretions.	rash until 4 days after the rash develops.		vulnerable people or in large institutions may be excluded by HPT	Children should be routinely immunised with MMR. Pregnant women should seek advice from their GP/midwife.
Meningococcal Disease/Septicemia	2-10 days. Commonly 3-4.	Direct contact. Contact with respiratory droplets from nose and throat.	Low risk of transmission person to person until 48 hrs of appropriate antibiotic therapy.	Until clinically recovered.	None.	Notifiable. Investigation by HPT. Meningitis ACWY vaccination recommended for 14-18 year olds and University fresher's. Men B vaccine now also part of childhood immunisation schedule.
Mumps	16-18 days (Can be 12-25 days).	Airborne/droplet spread. Direct contact with saliva.	Medium risk of transmission 7 days before onset of symptoms until 9 days after.	Until clinically recovered but no less than 5 days from the onset of symptoms/ swollen glands.	None.	Notifiable. Preventable by vaccination with 2 X MMRs. Inform HPT if outbreak suspected.
Norovirus (Winter vomiting bug)	15-50 hours (can be 4-77 hours)	Faecal-Oral Aerosol transmission	High risk of transmission from person to person and environmental transmission.	Until recovered. 48 hours since symptoms have ceased.	None	Inform HPT if outbreak suspected. Practice good hygiene
Poliomyelitis (very rare in UK)	7-14 days (Can be 3-35 days).	Faecal-oral.	High risk of transmission when virus present in stools and/or nasopharynx.	At the discretion of the duty Consultant in Public Health Medicine (CPHM)	None.	Notifiable. Investigation by HPT. Children should be routinely immunised.
Ringworm	2-6 weeks.	Direct skin to skin contact with infected person or animal. Indirect contact with	Medium risk of transmission whilst infected lesions are present.	None, but lesions should be covered.	Families should be checked for ringworm.	Avoid direct contact with lesions. Good hygiene practice.

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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				Cases	Contacts	
		fomites or environmental surfaces.				
Rubella (see German Measles)						
Salmonella (excluding typhoid and paratyphoid)	12-36 hrs (can be 6hrs to 7 days)	Faecal-oral Contaminated food	High risk of transmission when symptomatic.	None but until clinically recovered and 48hrs after diarrhoea has ceased.	None	Notifiable. Follow up by HPT/EHO. Practice good hygiene
Scabies	2-6 weeks if not previously infected. 1-4 days if re-infected.	Prolonged skin to skin contact. E.g. hand holding.	High risk of transmission until adequately treated.	Until treated. Can return after first treatment.	All household and close contacts may require treatment	Practice good hygiene. Health education. Contact HPT if two or more cases.
Scarlet Fever	1-3 days.	Airborne/droplet. Contact with respiratory secretions. Direct contact with patients or carriers.	Medium risk of transmission whilst organism present in nasopharynx, although minimal risk after 24 hours of appropriate antibiotic treatment.	Until clinically recovered and 24 hours after start of treatment.	None.	None.
Shigella (see Dysentery)						
Shingles (Varicella-Zoster virus)	Reactivation of Varicella infection (chickenpox).	Direct contact with lesions.	Moderate risk of transmitting chickenpox in the 7 days after the appearance of lesions.	None if lesions can be covered and are not weeping. Otherwise for 7 days after onset of lesions.	None. Can cause Chicken Pox in those who have not had it	Practice good hygiene. Seek advice from GP or midwife if pregnant/immunocompromised.

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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Staphlococcus aureus infection (MRSA/MSSA/PVL)	Variable and indefinite	Contact with patients with purulent lesions, or with an asymptomatic carrier. Airbourne spread is rare	High for certain groups of patients, and if patients have active infection and there is skin to skin contact, poor hygiene or sharing of personal items.	Special considerations for Health care workers: contact occupational health.	None	HPT will only follow up cases of PVL staph aureus. Hand hygiene is very important. Health education should be provided. Any active lesions should be covered.
Threadworm	Variable- days to weeks.	Faecal oral.	Medium risk of transmission whilst eggs in stool.	None but should be treated properly.	Household contacts should be treated at the same time as the case.	Practice good hygiene. Health education.
Thrush (candidiasis)	Variable. 2-5 days in infants.	Contact with secretions from mouth, skin, vagina and faeces. Vertical mother to child transmission at birth.	High risk of transmission.	None.	None.	Practice good hygiene. Health education.
Toxocariasis	Weeks or months depending on the severity of infection.	Ingestion of eggs from contaminated soil, hands or contact with dogs (especially puppies).	Not spread from person to person.	None.	None.	Practice good hygiene. Health education.
Toxoplasmosis	5-23 days.	Ingestion of eggs from sand boxes/play areas contaminated with cat faeces. Also from rare, undercooked meats.	Not spread from person to person.	None.	None.	Practice good hygiene. Health education.
Tuberculosis –	2-12 weeks	Airborne/droplet.	Medium to low risk until	After consultation with	At the	Notifiable.

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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pulmonary	(Disease can be "sleeping" for decades).		2 weeks after treatment. Requires close prolonged contact.	specialist physician the TB nurse/CPHM will inform the patient about their return to work.	discretion of the CPHM.	Investigation by HPT. At risk children should be vaccinated as babies.
Tuberculosis – non-pulmonary	Indefinite.	Not usually infectious.	Not usually transmitted from person to person.	Until clinically recovered.	None.	Notifiable Investigation by HPT.
Typhoid and Paratyphoid Fever	10-14 days (Can be 1-3 weeks).	Food borne. Waterborne. Faecal/Urine-oral.	High risk of transmission whilst symptomatic.	3 negative stool specimens 48hrs apart if in a risk group (starting at least one week after antibiotic course completed).Otherwise 48 hrs symptom free.	None unless symptomatic in which case should be excluded until symptoms have ceased for at least 48hrs.	Notifiable. Follow up by HPT/EHO. Practice good hygiene.
Viral Gastro-enteritis	Dependant on causative organism.	Faecal-oral. Airborne secondary to environmental contamination. Food borne.	High risk of transmission during acute vomiting and diarrhoea and up to 48 hrs after symptom free.	48hrs after symptoms cease.	None.	Outbreaks followed up by HPT/EHO's. Practice good hygiene.
Viral Meningitis	Dependant on virus.	Dependant on the virus. Person to person spread usually droplet spread or may be airborne.	Considered to be very unlikely.	Until clinically recovered (usually within a week).	None.	If more than one case then may wish to speak to HPT for advice. Practice good hygiene.
Vomiting	Dependant on causative organism.	Often food or waterborne or due to poor hygiene. Can be faecal-oral. Some viruses may be airborne.	High risk of transmission whilst symptomatic, though dependent on cause.	Until clinically recovered and symptoms have ceased for 48 hrs.	None.	Outbreaks followed up by HPT/EHO's. Practice good hygiene.

LOTHIAN NHS BOARD
HEALTH PROTECTION TEAM
Recommended Periods of Absence for Communicable Disease - Adults

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Warts/Verrucae	2-3 months (But can be 1-20 months).	Direct contact with warts. Verrucas may spread in pools or showers.	Can probably be transmitted at least as long as visible lesions present.	None. Verrucae should be covered in swimming polls, gyms and changing rooms.	None.	Practice good hygiene.
Whooping Cough (pertussis)	7-10 days (Can be 5-21).	Airborne/droplet. Contact with respiratory secretions.	Highly infectious in early stages of illness and up to 3 weeks after onset of cough (rarely 6 weeks).	Until clinically recovered and 3 weeks from onset of cough or 5 days of appropriate antibiotic therapy.	If symptomatic see case absence.	Notifiable. Investigation by HPT. Children should be routinely immunised pre-school.