Connecticut Department of Public Health

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Reportable Diseases and Laboratory Reportable Significant Findings - Changes for 2010

As required by Connecticut General Statutes Section 19a-2a and Section 19a-36-A2 of the Public Health Code, the lists of Reportable Diseases and Laboratory Reportable Significant Findings are revised annually by the Department of Public Health (DPH). An advisory committee, consisting of public health officials, clinicians, and laboratorians, contributes to the process. There are 2 additions, 4 deletions and 3 modifications to the lists effective January 1, 2010.

Changes to both the Lists of Reportable Diseases and Laboratory Reportable Significant Findings

Lymphocytic Choriomeningitis Virus (LCMV)

LCMV is removed from both lists. The main intervention for LCMV is to prevent/minimize exposure to rodents. The DPH laboratory will discontinue LCMV testing; however, samples submitted to the DPH laboratory will be sent to the Centers for Disease Control and Prevention for testing. Over the last 4 years, only 34 specimens have been tested; 2 (6%) were positive.

Arbovirus—other

"Other" arbovirus is removed from both lists. Currently, other arboviruses such as dengue or Japanese encephalitis occur in travelers to other parts of the country and the world, and are not contracted in Connecticut. If necessary, specific arboviral diseases can be added to the list of reportable findings.

Changes to the List of Reportable Diseases

Hospitalizations and Deaths due to Influenza

Hospitalization due to influenza has been added to the list of reportable diseases as a Category 1 finding. Faxing a case report form to the DPH satisfies the reporting requirement – hospitalizations in New Haven County should be reported to the Yale Emerging Infections Program. After hours or on holidays reporting should be done on the next normal business day. Death due to influenza has been added to the list of reportable diseases as a Category 1 finding. Hospital staff and physicians should report any death in a person with a positive influenza test of any kind by calling the DPH and faxing the hospitalization case report form. Details and reporting form can be found at www.ct.gov/ctfluwatch/cwp/view.asp?a=2533&q=314806#laboratory.

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Guillain-Barré Syndrome (GBS)

GBS has been added to the list of reportable diseases as a category 1 disease. In 1976, during the last circulating influenza virus of swine origin, an increased risk of GBS was associated with the vaccine. So far, there is no indication that the 2009 pandemic H1N1 vaccine has been associated with an increased risk of GBS. However, there is a need to be vigilant given the magnitude of the vaccination campaign.

Encephalitis

Encephalitis is removed from the list of reportable diseases. The DPH surveillance focus will remain on specific diseases of public health importance that have encephalitis clinical syndromes. Clusters of unusual illness, including encephalitis, are reportable and would capture future emergent illness in Connecticut.

Changes to the List of Laboratory Reportable Significant Findings

Gram-Positive Rods

Only non-motile, non-hemolytic *Bacillus* species are reportable to the DPH. This change will decrease the burden on laboratories while maintaining a timely surveillance system for the identification of anthrax bioterrorism. A footnote has been added to the laboratory significant findings list and the Laboratory Report of Significant Findings Form OL-15C.

Lead Toxicity

All lead laboratory results shall be reported to the DPH, including levels < 10µg/dL. Lead levels of ≥ 10µg/dL should also be reported to the local health director. To clarify this, a footnote has been added to the laboratory list of significant findings and the OL-15C. The DPH Lead Program will work with laboratories so that reporting of all results can be done in a pre-determined format on a monthly basis.

(cont. on page 4)

REPORTABLE DISEASES - 2010

The commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Each report (by mail, fax, or telephone) should include the full name and address of the person reporting, attending physician, disease being reported, and full name, address, date of birth, race/ethnicity, sex and occupation of the person affected. The PD-23 can be found at on the DPH website. Please see page 4 for a list of persons required to report reportable diseases. The reports should be sent in envelopes marked "CONFIDENTIAL." Changes for 2010 are noted in **bold** and with an asterisk (*****).

Category 1 Diseases: Report immediately by telephone on the day of recognition or strong suspicion of disease for those diseases marked with a telephone (☎). Also mail a report within 12 hours.

Category 2 Diseases: All other diseases not marked with a telephone are Category 2 diseases. Report by mail within 12 hours of recognition or strong suspicion of disease.

Acquired Immunodeficiency Syndrome (1,2)
☎ Anthrax
Arboviral disease (California group, EEE, SLE, WNV)
Babesiosis
☎ Botulism
☎ Brucellosis
Campylobacteriosis
Carbon monoxide poisoning (3)
Central-line associated blood stream infections (Do not use this form to report) (4)
Chancroid
Chickenpox
☎ Chickenpox
- admission to hospital, any age
- adults ≥ 18 years, any clinical setting

Chickenpox-related death
Chlamydia (*C. trachomatis*) (all sites)
☎ Cholera
Clostridium difficile, community-onset (5)
Creutzfeldt-Jakob disease (age < 55 years)
Cryptosporidiosis
Cyclosporiasis
☎ Diphtheria
Ehrlichiosis/Anaplasmosis
Escherichia coli O157:H7 gastroenteritis
Gonorrhea
Group A Streptococcal disease, invasive (6)
Group B Streptococcal disease, invasive (6)
☎***Guillain-Barré Syndrome**
Haemophilus influenzae disease, invasive all serotypes (6)
Hansen's disease (Leprosy)
Hemolytic-uremic syndrome
Hepatitis A
Hepatitis B
- acute infection
- HBsAg positive pregnant women

Hepatitis C - acute infection (ALT > 400 IU/L)
HIV-1 exposure in infants born 1/1/2001 or later (1,7)
HIV-1 infection in (1)
- persons with active tuberculosis disease
- persons with a latent tuberculous infection (history or tuberculin skin test ≥5mm induration by Mantoux technique)
- persons of any age

HPV: biopsy proven CIN 2, CIN 3 or AIS or their equivalent (1)
☎***Influenza-associated death**
☎***Influenza-associated hospitalization (8)**
Lead toxicity (blood level ≥ 15 µg/dL)
Legionellosis
Listeriosis
Lyme disease
Malaria
☎ Measles
☎ Meningococcal disease
Mercury poisoning
Mumps
Neonatal herpes (≤ 60 days of age)
Neonatal bacterial sepsis (9)
Occupational asthma
☎ Outbreaks:
- Foodborne (involving ≥ 2 persons)
- Institutional
- Unusual disease or illness (10)

☎ Pertussis
☎ Plague
Pneumococcal disease, invasive (6)
☎ Poliomyelitis
☎ Q fever
☎ Rabies (human and animal)
Reye syndrome
Rheumatic fever
☎ Ricin poisoning
Rocky Mountain spotted fever
☎ Rubella (including congenital)
Salmonellosis
☎ SARS-CoV
☎ Septicemia or meningitis with growth of gram positive rods within 32 hours of inoculation
Shiga toxin-related disease (gastroenteritis)
Shigellosis
Silicosis
☎ Smallpox
☎ Staphylococcal enterotoxin B pulmonary poisoning
☎ *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin (1)
Staphylococcus aureus methicillin-resistant disease, invasive, community acquired (6,11)
Staphylococcus epidermidis disease, reduced or resistant susceptibility to vancomycin (1)
Syphilis
Tetanus
Trichinosis
☎ Tuberculosis
☎ Tularemia
Typhoid fever
Vaccinia disease
☎ Venezuelan equine encephalitis
Vibrio infection (*parahaemolyticus, vulnificus*, other)
☎ Viral hemorrhagic fever
☎ Yellow fever

FOOTNOTES:

1. Report only to State.
2. CDC case definition.
3. Includes persons being treated in hyperbaric chambers for suspect CO poisoning.
4. Applies only to licensed hospitals (as defined by CGS. Ch368V). Hospitals report central-line associated blood stream infections associated with designated intensive care unites (ICUs): any pediatric ICU in the hospital (not including neonatal ICU) and the medical ICU, or, if no medical ICU, the medical-surgical ICU. Make reports to the DPH via the National Healthcare Safety Network (NHSN) using NHSN definitions, criteria, and protocols.
5. Community-onset: illness in a person living in the community at the time of illness onset and no known hospitalizations in preceding 3 months; if hospitalized, a positive test taken within 48 hours of admission.
6. Invasive disease: confirmed by isolation from sterile fluid (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous) bone, internal body sites, or other normally sterile sites. Includes muscle for group A *streptococcus*.
7. "Exposure" includes infant born to known HIV-infected mother.
8. ***Reporting requirements are satisfied by faxing the Hospitalized and Fatal Cases of Influenza—Case Report Form to the DPH (or in New Haven County- to Yale Emerging Infections Program at 203-764-4357); after hours or on holidays fax on the next normal business day.**
9. Clinical sepsis and blood or CSF isolate obtained from an infant < 7 days old.
10. Individual cases of "significant unusual illness" are also reportable.
11. Community-acquired: infection present on admission to hospital, and person has no previous hospitalizations or regular contact with the health-care setting.

How to report: The PD-23 is the general disease reporting form and should be used if other specialized forms are not available. Specialized reporting forms from the following programs are available: HIV/AIDS Surveillance (860-509-7900), Sexually Transmitted Disease Program (860-509-7920), Tuberculosis Control Program (860-509-7722), Occupational Health Surveillance Program (860-509-7740), or Epidemiology and Emerging Infections Program for the PD-23 or Hospitalized and Fatal Cases of Influenza—Case Report Form (860-509-7994). The PD-23 can be found on the DPH website or by writing the Department of Public Health, 410 Capitol Ave., MS#11EPI, P.O. Box 340308, Hartford, CT 06134-0308 (860-509-7994); or by calling the individual program.

Telephone reports of Category 1 disease should be made to the local director of health for the town in which the patient resides and to the Epidemiology and Emerging Infections Program (860-509-7994). Tuberculosis cases should be directly reported to the Tuberculosis Control Program (860-509-7722). For the name, address, or telephone number of the local Director of Health for a specific town contact the Office of Local Health Administration (860-509-7660). **For public health emergencies, an epidemiologist can be reached evenings, weekends, and holidays through the DPH emergency number (860-509-8000).**

LABORATORY REPORTABLE SIGNIFICANT FINDINGS - 2010

The director of a clinical laboratory must report laboratory evidence suggestive of reportable diseases. The Laboratory Report of Significant Findings (OL-15C) can be obtained from the Connecticut Department of Public Health (DPH), 410 Capitol Ave., MS#11EPI, P.O. Box 340308, Hartford, CT 06134-0308; telephone: (860-509-7994) or on the DPH website. The OL-15Cs are not substitutes for physician reports; they are supplements to physician reports which allow verification of diagnosis. A listing of possible bioterrorism diseases is highlighted at the end of this list. Changes for 2010 are noted in **bold** and with an asterisk (*).

AIDS (report only to the State)
- CD4+ T-lymphocyte counts <200 cells/µL: _____cells/µL
- CD4+ count < 14% of total lymphocytes: _____%

Arboviral infection (replaces "encephalitis"):
California group virus (species) _____
Eastern equine encephalitis virus
St. Louis encephalitis virus
West Nile virus infection

Babesiosis: ❑ IFA IgM (titer) _____ IgG (titer):_____
❑ Blood smear (1) ❑ PCR ❑ Other: _____

Campylobacteriosis (species) _____

Carboxyhemoglobin ≥ 9%: _____% COHb

Chancroid

Chickenpox, acute: ❑ IgM ❑ Culture ❑ PCR
❑ DFA ❑ Other: _____

Chlamydia (*C. trachomatis)* (test type: _____)

Creutzfeldt-Jakob disease, age < 55 years (biopsy)

Cryptosporidiosis (method of ID) _____

Cyclosporiasis (method of ID) _____

Diphtheria (1)

Ehrlichiosis/Anaplasmosis (2) ❑ *A. phagocytophilum* ❑ *E. chaffeensis*
❑ Unspecified ❑ IFA (titers): IgM _____ IgG _____
❑ Blood smear ❑ PCR ❑ Other: _____

Enterococcal infection, vancomycin-resistant (2,3)_____

Escherichia coli O157 infection (1)

Giardiasis

Gonorrhea (test type: _____)

Group A streptococcal disease, invasive (3)

Group B streptococcal disease, invasive (3)

Haemophilus influenzae disease, invasive, all serotypes (1,3)

Hansen's disease (Leprosy)

Hepatitis A ❑ IgM anti-HAV (1)

Hepatitis B ❑ HBsAg ❑ IgM anti-HBc (1)

Hepatitis C (anti-HCV) Ratio: _____ ❑ RIBA ❑ PCR (4)

Herpes simplex virus, infant ≤ 60 days of age (specify type)
❑ Culture ❑ PCR ❑ IFA ❑ Ag detection

HIV genotype (electronic file) (report only to State) (5)

HIV Infection (report only to the State) (1)
- HIV-1 infection in persons of all ages (5)

HPV (report only to state): (6)
Biopsy proven ❑ CIN 2 ❑ CIN 3 ❑ AIS
or their equivalent (specify): _____

Influenza: ❑ A ❑ B ❑ Unk.
❑ RT-PCR ❑ Culture ❑ Rapid test

Lead Poisoning (blood lead ≥10 µg/dL) (7) *
❑ Finger Stick: _____ µg/dL ❑ Venous: _____ µg/dL

Legionellosis
❑ Culture ❑ DFA ❑ Ag positive
❑ Four-fold serologic change (titers): _____

Listeriosis (1)

Lyme disease (8)

Malaria/blood parasites (1,2) : _____

Measles (Rubeola) (titer) (9): _____

Meningococcal disease, invasive (1,3)

Mercury poisoning
❑ Urine ≥ 35 µg/g creatinine _____ µg/g
❑ Blood ≥ 15 µg/L _____ µg/L

Mumps (titer): _____

Neonatal bacterial sepsis (10) spp _____

Pertussis (titer): _____
DFA Smear: ❑ Positive ❑ Negative
Culture: ❑ Positive ❑ Negative

Pneumococcal disease, invasive (1,3)
Oxacillin disk zone size: _____ mm
MIC to penicillin: _____ µg/mL

Poliomyelitis

Rabies

Rocky Mountain spotted fever

Rubella (titer): _____

Salmonellosis (1,2) (serogroup/serotype) _____

SARS-CoV infection (11) ❑ IgM/IgG
❑ PCR _____ (specimen) ❑ Other _____

Shiga toxin-related disease (1)

Shigellosis (1,2) (serogroup/species) _____

Staphylococcus aureus infection with MIC to vancomycin ≥ 4 µg/mL (1)
MIC to vancomycin: _____ µg/mL

Staphylococcus aureus disease, invasive (3)
methicillin-resistant Date pt. Admitted _____/_____/_____

***Staphylococcus epidermidis* infection with MIC to vancomycin ≥ 32 µg/mL** (1)
MIC to vancomycin: _____ µg/mL

Syphilis ❑ RPR (titer): _____ ❑ FTA (titer): _____
❑ VDRL (titer): _____ ❑ MHA (titer): _____

Trichinosis

Tuberculosis (1)
AFB Smear: ❑ Positive ❑ Negative
If positive: ❑ Rare ❑ Few ❑ Numerous
NAAT: ❑ Positive ❑ Negative ❑ Indeterminate
Culture: ❑ *Mycobacterium tuberculosis*
❑ Non-tuberculosis mycobact. (specify: M. _____)

Vibrio infection (1) (species) _____

Yellow fever

Yersiniosis (species) _____

Diseases that are possible indicators of bioterrorism

Anthrax (1, 11)

Botulism (11)

Brucellosis (1, 11)

Glanders (1, 11)

***Bacillus* species, non-hemolytic, non-motile, from blood or CSF, growth within 32 hours of inoculation (1, 11) ***

Melioidosis (1, 11)

Plague (1, 11)

Q fever (11)

Ricin poisoning (11)

Smallpox (1, 11)

Staphylococcal enterotoxin B pulmonary poisoning (11)

Tularemia (11)

Venezuelan equine encephalitis (11)

Viral hemorrhagic fever (11)

1. Send isolate, culture, or slide to the State Laboratory for confirmation. For Shiga-toxin, send positive broth. For positive HIV and IgM anti-HAV, send ≥ 0.5mL residual serum. For positive IgM anti-HBc, send ≥ 0.5mL residual serum within 6 months.
2. Specify species/serogroup.
3. Sterile site isolates: defined as sterile fluids (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous), bone, internal body site (lymph node, brain, heart, liver, spleen, kidney, pancreas, or ovary), or other normally sterile site; includes muscle for group A *streptococcus*.
4. Report all positive anti-HCV with signal to cutoff ratio, all positive RIBA, but only confirmatory PCR tests.
5. Laboratories conducting HIV genotype tests should report the HIV DNA sequence file electronically. Report all positive HIV antibody and antigen tests, and all viral load tests (including those with no virus detectable).
6. On request from the DPH and if adequate tissue is available, send fixed tissue from the specimen used to diagnose CIN2, 3 or cervical AIS or their equivalent for HPV typing according to instructions from the DPH.

***7. Report lead results ≥10µg/dL within 48 hours to the Local Health Director and the DPH; submit ALL lead results at least monthly to the DPH.**

8. Only laboratories with automated electronic reporting to the DPH are required to report positive results.
9. Report all IgM titers, but only IgG titers that are considered significant by the laboratory performing the test.
10. Report all bacterial isolates from blood or CSF obtained from an infant <7 days old.
11. Report by telephone to the DPH, weekdays 860-509-7994; evenings, weekends, and holidays 860-509-8000.

Staphylococcus epidermidis with reduced/ resistant susceptibility to vancomycin

This has been modified to bring current surveillance in line with the CDC definitions. The MIC to vancomycin is being changed from ≥ 4 to ≥ 32. These surveillance definitions do not impact patient management.

West Nile Virus (WNV) infection in animals

WNV infection in animals is removed from the list of laboratory reportable significant findings. Mosquito testing is a better indicator of circulating virus and it replaced the bird sentinel surveillance. WNV infection in horses and other domestic animals is still reportable to the Department of Agriculture.

Persons Required to Report Reportable Diseases

1. Every health care provider who treats or examines any person who has or is suspected to have a reportable disease shall report the case to the local director of health or other health authority within whose jurisdiction the patient resides and to the Department of Public Health.
2. If the case or suspected case of reportable disease is in a health care facility, the person in charge of such facility shall ensure that reports are made to the local director of health and Department of Public Health. The person in charge shall designate appropriate infection control or record keeping personnel for this purpose.
3. If the case or suspected case of reportable disease is not in a health care facility, and if a health care provider is not in attendance or is not known to have made a report within the appropriate time, such report of reportable diseases shall be made to the local director of health or other health authority within whose jurisdiction the patient lives and the Department of Public Health by:
   A. the administrator serving a public or private school or day care center attended by any person affected or apparently affected with such disease;
   B. The person in charge of any camp;
   C. The master or any other person in charge of any vessel lying within the jurisdiction of the state;
   D. The master or any other person in charge of any aircraft landing within the jurisdiction of the state;
   E. The owner or person in charge of any establishment producing, handling, or processing dairy products, other food or non-alcoholic beverages for sale or distribution;
   F. Morticians and funeral directors.

Persons Required to Report Laboratory Significant Findings

The director of a laboratory that receives a primary specimen or sample, which yields a reportable laboratory finding, shall be responsible for reporting such findings within 48 hours to the local director of health of the town in which the affected person normally resides. In the absence of such information, the reports should go to the town from which the specimen originated and to the Department of Public Health.

IMPORTANT NOTICE

Reporting forms are available electronically on the DPH website. Persons required to report reportable diseases must use the Reportable Disease Confidential Case Report Form PD-23 to report any diseases found on the current Reportable Diseases List unless there is a specialized reporting form available. The director of a clinical laboratory must report laboratory evidence suggestive of reportable diseases using the Laboratory Report of Significant Findings Form OL-15C or other written or electronic format approved by the DPH. Reporting forms can be obtained by writing or calling the Connecticut Department of Public Health, 410 Capitol Ave., MS#11EPI, P.O. Box 340308, Hartford, CT 06134-0308; telephone: (860-509-7994), or from the DPH website. Please follow these guidelines when submitting reports:

- Complete all required information (at minimum: full name and address of the person reporting, attending physician, disease/test result being reported, onset of illness date, and full name, address, date of birth, race/ ethnicity, sex and occupation of the person affected if known).
- Make 2 copies of the report
  - ► Send one copy to the DPH via fax (860-509-7910), or mail to the State of Connecticut, Department of Public Health, 410 Capitol Ave., MS#11EPI, P.O. Box 340308, Hartford, CT 06134-0308. Any mailed documents should have “CONFIDENTIAL” marked on the envelope.
  - ► Send a copy of the report to the local health department of the town in which the patient resides.
  - ► Keep a copy for the patient’s medical record.

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