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Reportable Diseases and Laboratory Reportable Significant Findings Changes for 2011

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, 2 deletions and 3 modifications to the lists effective January 1, 2011.

Changes to the List of Reportable Diseases

Chickenpox-hospitalizations and adult cases

Chickenpox-related hospitalizations, and chickenpox in adults ≥18 years of age are deleted from the list of reportable diseases. This surveillance was originally initiated to detect smallpox. Currently, two syndromic surveillance systems monitor for syndromes consistent with smallpox. Chickenpox and chickenpox-related death remain on the List of Reportable Diseases as part of routine surveillance for vaccine-preventable diseases. Chickenpox also remains on the List of Laboratory Reportable Significant Findings. Smallpox remains a Category 1 reportable disease.

Influenza-related hospitalization and deaths

The reporting of influenza-related hospitalization and influenza-related death has been modified. These reportable findings have been moved from Category 1 diseases to Category 2 diseases to facilitate reporting. In 2009, these findings were added to the list of reportable diseases as Category 1 diseases to monitor the severity of pandemic and seasonal influenza. The 2010-2011 influenza season is expected to be characterized by currently circulating strains included in the vaccines.

HIV infection and pregnancy

"HIV-1 exposure in infants born 1/1/2001 or later" is modified to "HIV infection and pregnancy" on the list of reportable diseases and the Reportable Disease Confidential Case Report Form PD-23. Reliable data are necessary to determine needed resources for perinatal HIV prevention and to evaluate existing programs. Complete and timely reporting of HIV infection during pregnancy will facilitate case management, partner notification and referral, and monitoring adherence to prevention recommendations. DPH staff will conduct follow-up with cases to provide education, referrals, ensure appointments are kept, and conduct partner notification, testing, and referral services. Maternal and infant medical records will be abstracted to obtain standardized information for the perinatal HIV surveillance project funded by the Centers for Disease Control and Prevention (CDC).

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Changes to the List of Laboratory Reportable Significant Findings

Antibiotic susceptibility results for invasive pneumococcal disease (IPD)

Antibiotic susceptibility results for IPD are deleted from the laboratory significant findings list and the Laboratory Report of Significant Findings Form OL-15C. In 2010, IPD was nationally notifiable regardless of antibiotic susceptibility. This change was made after new breakpoints for defining susceptibility to penicillin were published in 2008. All *S. pneumoniae* isolates from patients with IPD are routinely submitted to the DPH Laboratory and forwarded to the CDC for antibiotic susceptibility testing. The DPH uses the CDC test results to monitor antibiotic resistance as part of the Connecticut Emerging Infections Program.

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

Dengue

Dengue is added to both lists under arboviral disease. In 2009, an outbreak in Key West, Florida was identified by the report from New York of a resident diagnosed with dengue infection who traveled to

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REPORTABLE DISEASES 2011

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 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 2011 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, **Dengue*,** 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-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)
Haemophilus influenzae disease, invasive all serotypes (6)
Hansen's disease (Leprosy)
Hemolytic-uremic syndrome
Hepatitis A
Hepatitis B
- acute infection (2)
- HBsAg positive pregnant women

Hepatitis C - acute infection (2)
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
- pregnant women

HPV: biopsy proven CIN 2, CIN 3 or AIS or their equivalent (1)
Influenza-associated death *
Influenza-associated hospitalization (7) *
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 (**8***)
Occupational asthma
☎ Outbreaks:
- Foodborne (involving ≥ 2 persons)
- Institutional
- Unusual disease or illness (9)

☎ Pertussis
☎ Plague
Pneumococcal disease, invasive (6)
☎ Poliomyelitis
☎ Q fever
☎ Rabies (human and animal)
Reye syndrome
Rheumatic fever
☎ Ricin poisoning
Rocky Mountain spotted fever
Rotavirus*
☎ 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 (6,10)
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. Reporting requirements are satisfied by submitting the Hospitalized and Fatal Cases of Influenza—Case Report Form to the DPH (or in Hartford, Middlesex, and New Haven counties to Yale Emerging Infections Program at 203-764-4357); in a manner specified by the DPH.
8. Clinical sepsis and blood or CSF isolate obtained from an infant **≤ 72 hours of age**.
9. Individual cases of "significant unusual illness" are also reportable.
10. 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 2011

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 2011 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): _____
Dengue*
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) (1,5)

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

Influenza: ❑ A ❑ B ❑ Unk. ❑ Subtype: _____
❑ 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) *

Poliomyelitis

Rabies

Rocky Mountain spotted fever

Rotavirus*

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 **≤72 hours of age**.
11. Report by telephone to the DPH, weekdays 860-509-7994; evenings, weekends, and holidays 860-509-8000.

Florida. Surveillance will contribute to national surveillance for dengue infections acquired in the continental U.S. The mosquito species responsible for transmission of dengue are not established in Connecticut.

Rotavirus

Rotavirus is added to both lists. Before the advent of rotavirus vaccine, rotavirus caused approximately 600 hospitalizations annually in Connecticut and 1 death. Most of the children were <3 years of age, and 80% were infected by age 5 years. Currently, two rotavirus vaccines are available, RotaTeq® and Rotarix®. Each protects against approximately 90% of strains. Connecticut has received funding from the CDC for a case-control study to monitor the effectiveness of Rotarix®. This surveillance is part of that initiative.

Age criterion for neonatal bacterial sepsis

The age criterion for neonatal bacterial sepsis is modified on both lists to match the national criterion. The revised age requirement for neonatal bacterial sepsis is ≤72 hours of age.

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 method specified 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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Immunizations	860-509-7929
Tuberculosis Control	860-509-7722
Sexually Transmitted Diseases (STD)	860-509-7920

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