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State of Connecticut Department of Public Health
Stephen A. Harriman, Commissioner

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REPORTABLE DISEASES AND LABORATORY FINDINGS, 1997

The lists of Reportable Diseases and Laboratory Reports of Significant Findings are revised annually by the Department of Public Health (DPH). An advisory committee of public health officials, clinicians, and laboratorians contribute to the process. There are five additions and one deletion to the list for 1997. Physicians are urged to save these lists for future reference.

Additions include: campylobacteriosis, *Cyclospora* infection, legionellosis, carbon monoxide poisoning, and mercury poisoning. Hepatitis C has been removed from the list of Laboratory Reports of Significant Findings, but acute hepatitis C infection remains a reportable disease. Hepatitis B reporting has been expanded to include HBsAg positivity (both acute and chronic) during pregnancy. Laboratories are required to send isolates of *E. coli* O157:H7 to the State Laboratory for confirmatory sensitivity testing and subtyping.

Campylobacteriosis

Intestinal illness due to *Campylobacter* is one of the diseases targeted for intensive surveillance in our Emerging Infections Program (EIP) foodborne disease surveillance project. It is one of the most common foodborne (and sometimes waterborne) diseases. The objectives of surveillance are to describe the distribution, incidence, and public health impact of campylobacteriosis. A case-control study will be done to determine risk factors for its occurrence in the absence of a recognized outbreak.

Cyclospora Infection

Cyclospora, a recently recognized pathogen, is probably transmitted by contaminated food or water. *Cyclospora* was the cause of a nationwide outbreak of gastroenteritis associated with imported raspberries in the summer of 1996. How common this infection is in the United States and what percentage of cases may be generated locally versus associated with imported foods are unknown. The objectives of surveillance for *Cyclospora* infection are to determine its distribution, incidence, and public health impact; detect outbreaks; and determine risk factors for acquisition of infection.

Carbon Monoxide Poisoning

Carbon monoxide (CO) poisoning is potentially fatal and its unintentional occurrence is often preventable. It can be associated with faulty or poorly designed equipment, or improper use of carbon-monoxide generating equipment. The objectives for surveillance are to describe the epidemiology of CO poisoning in Connecticut and determine risk factors for its occurrence. To meet these objectives, it is important to have both laboratory and clinician reporting. Laboratories are required to report carboxyhemoglobin levels >12%. Clinicians are required to report any suspect case of carbon monoxide poisoning, including use of hyperbaric chambers to treat suspect cases.

E. coli O157:H7 Isolates

Escherichia coli O157:H7 infections are already clinician and laboratory reportable.

Laboratories are now required to send suspect *E. coli* O157:H7 isolates to the DPH laboratory for confirmation. These isolates will be tested by Pulsed Field Gel Electrophoresis (PFGE). This will aid in the detection of outbreaks .

Hepatitis B

The listing for hepatitis B on the reportable disease list is being changed to specify reporting of acute infection and HBsAg positivity (both acute and chronic) during pregnancy. It is important to detect acute and chronic carriage of hepatitis B virus among pregnant women to assure that their infants get the recommended post-exposure treatment to prevent perinatal transmission.

Legionellosis

Legionellosis continues to cause occasional outbreaks of illness both in the community and in hospitals and other institutions (see surveillance case definition this page). The objectives of surveillance are to monitor the epidemiology of community-acquired legionellosis and detect possible community or institutional outbreaks. A single confirmed case of hospital-acquired legionellosis will result in public health follow-up.

Mercury Poisoning

Mercury poisoning is potentially fatal and potentially preventable. Based on anecdotal reports to DPH, mercury exposure occurs in both community and occupational settings. The objectives for surveillance are to describe the epidemiology of mercury poisoning in Connecticut and determine risk factors for its occurrence. To meet these objectives, it is important to have both laboratory and clinician reporting. Laboratories are required to report urine mercury levels of ≥35ug/g creatinine and blood levels ≥1.5ug/dL.

For Public Health Emergencies
after 4:30 p.m. and
on weekends
call the
Department of Public Health
(860) 509-8000

SURVEILLANCE CASE DEFINITION LEGIONELLOSIS

Clinical Description

Legionellosis is associated with two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is characterized by fever, myalgia, cough, and pneumonia; and Pontiac fever, a milder illness without pneumonia.

Laboratory Criteria for Diagnosis

- Isolation of *Legionella* from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluids; or

- Demonstration of a fourfold or greater rise in the reciprocal immunofluorescence antibody (IFA) titer to ≥128 against *Legionella pneumophila* serogroup 1 between paired acute- and convalescent-phase serum specimens; or

- Detection of *L. pneumophila* serogroup 1 in respiratory secretions, lung tissue, or pleural fluid by direct fluorescence antibody testing; or

- Demonstration of *L. pneumophila* serogroup 1 antigens in urine by radioimmunoassay or enzyme-linked immunosorbent assay.

Case Classification

Confirmed: a clinically compatible illness that is laboratory confirmed.

Comment

The previous version of the surveillance case definition included a category of "probable case," which was based on a single IFA titer. This category lacked specificity for surveillance, and is no longer included in the national surveillance case definition.

Surveillance case definitions are intended to establish uniform criteria for disease reporting. They should not be used as sole criteria for establishing clinical diagnoses, determining the standard of care necessary for a particular patient, setting guidelines for quality assurance, providing standards for reimbursement, or initiating public health actions. Use of additional clinical, epidemiologic, and laboratory data may enable a physician to diagnose a disease even though the surveillance case definition may not be met.

REPORTABLE DISEASES - 1997

The Commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 1997 are marked in **bold** with an asterisk (*).

Each report (by mail or telephone) should minimally include: the full name and address of the person reporting and the attending physician, the disease being reported, and the full name, address, race/ethnicity, sex and occupation of the person affected. The reports should be sent in envelopes marked "**CONFIDENTIAL**."

Category 1: **Reportable immediately** by telephone on the day of recognition or strong suspicion of disease. On weekdays, reports are made to the local and State health departments; in the evening and on weekends, to DPH. A Confidential Disease Report (PD-23) or more disease-specific report form should be mailed to both the local and State health departments with 12 hours.

Anthrax
Botulism
Cholera
Diphtheria
Foodborne Outbreaks (involving ≥2 persons)
Institutional Outbreaks
Measles
Meningococcal disease[2]
Pertussis
Plague
Poliomyelitis
Rabies (human and animal)
Rubella (including congenital)
Tuberculosis
Yellow Fever

Category 2: Reportable by mail **within 12 hours** of recognition or strong suspicion to both local and State health departments.

Acquired Immunodeficiency Syndrome[1]
Babesiosis
Brucellosis
Campylobacteriosis*
Carbon monoxide poisoning[3]*
Cryptosporidiosis
Cyclospora* infection
E.coli O157:H7 gastroenteritis
Ehrlichiosis
Group A Streptococcal disease, invasive[2]
Group B Streptococcal disease, invasive[2]
H. influenza disease, invasive, all serotypes[2]
Hansen's disease (Leprosy)
Hemolytic-uremic syndrome
Hepatitis A,C,Delta, non-A/non-B
Hepatitis B
. acute infection*
. HBsAg positive pregnant woman*
HIV-1 infection in:
. children <13 years of age
. persons with tuberculosis
. persons with a positive tuberculin skin test ≥5mm induration by Mantoux technique
Lead Toxicity (blood lead ≥20 ug/dL)
Legionellosis*
Listeriosis
Lyme disease
Malaria
Mercury poisoning*
Mumps
Occupational Asthma
Pneumococcal disease, invasive[2]
Reyes Syndrome
Rheumatic Fever
Rocky Mountain Spotted Fever
Salmonellosis
Sexually Transmitted Diseases
. Chancroid
. Chlamydia (*C. trachomatis*) (all sites)
. Gonorrhea
. Neonatal herpes (<1 month of age)
. Syphilis
Shigellosis
Silicosis
Tetanus
Trichinosis
Typhoid Fever
Typhus

1 Reporting required only to State.
2 Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, or normally sterile tissue obtained during surgery.
3 Includes persons being treated in hyperbaric chambers as suspect CO poisoning.

How to report: The PD-23 is the most generally used form and can be used if other specialized forms are not available. Several other forms are also in use. These include the Acquired Immunodeficiency Syndrome (AIDS) Case Report, the Sexually Transmitted Disease Confidential Case Report (STD-23), the Tuberculosis Case Report (TB-86), and the Physician's Report of Occupational Disease form.

Forms may be obtained from the Department of Public Health, 410 Capitol Ave., MS#11EPI, P.O. Box 340308, Hartford, CT 06134-0308. Telephone: (860-509-7994). The disease-specific report forms may be obtained by calling or writing the specific program at the same address: the Epidemiology Unit/AIDS Section (860-509-7900), the Sexually Transmitted Disease Program (860-509-7920), the Pulmonary Diseases Program (860-509-7722), or the Occupational Disease Program (860-509-7744).

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 State Epidemiology Program (860-509-7994). Tuberculosis cases should be directly reported to the Pulmonary Diseases 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 at (860-509-7660). **For public health emergencies, an epidemiologist can be reached nights and weekends through the DPH emergency number (860-509-8000).**

LABORATORY REPORTABLE SIGNIFICANT FINDINGS - 1997

The director of any clinical laboratory must report any laboratory evidence suggestive of reportable diseases. A standard form, known as the Laboratory Report of Significant Findings (OL-15C) is available for reporting these laboratory findings. These forms are available from the State of Connecticut Department of Public Health, Epidemiology Program, 410 Capitol Ave., MS#11EPI, P.O. Box 340308, Hartford, CT 06134-0308; telephone: (860)509-7994. The laboratory reports are not substitutes for physician reports; they are supplements to physician reports which allow verification of diagnosis. Changes for 1997 are noted in **bold** and with an asterisk (*).

AIDS (reporting only required to state)
. CD4+ T-lymphocyte counts <200 cells/uL
. CD4+ count <14% of total lymphocytes
. HIV-1 infection in children < 13 years of age
Anthrax[4]
Babesiosis
Brucellosis[4]
California Encephalitis
Campylobacteriosis*
Carboxyhemoglobin >12%*
Cholera[4]
Cryptosporidiosis
Cyclospora* infection
Diphtheria[4]
Eastern Equine Encephalitis
Enterococcal infection, vancomycin-resistant[1,3]
Ehrlichiosis[1]
E.coli* O157:H7[4]
Food Poisoning[1]
Giardiasis
Group A Streptococcal disease, invasive[3,4]
Group B Streptococcal disease, invasive[3]
H. influenza disease, invasive, all serotypes[3,4]
Serotype _____
Hansen's disease (Leprosy)
Hepatitis A (IgM anti-HAV)
Hepatitis B (HBsAg, IgM anti-HBc)
~~**Hepatitis C** (deleted)~~*
Hepatitis Delta (HDAg, IgM anti-HD)
Influenza A and B[1]
Lead Poisoning (blood lead ≥ 10ug/dL)
□ Finger Stick _____ ug/dL
□ Venous _____ ug/dL

Legionellosis (culture, DFA, Ag positive or four-fold serologic change[2])*
Listeriosis
Malaria/blood parasites[1,4]
Measles (Rubeola)
Meningococcal disease, invasive[3,4]
Mercury poisoning (urine ≥35ug/g creatinine or blood ≥1.5ug/dL)*
Mumps
Pertussis
Plague
Pneumococcal disease, invasive[3,4]
Zone size by oxacillin disk testing:_____mm
MIC to penicillin: _____ug/mL
Poliomyelitis
Rabies
Rocky Mountain Spotted Fever
Rubella[2]
Salmonellosis[1,4]
Sexually Transmitted Diseases
. Chancroid
. Chlamydia (*C. trachomatis*)
. Gonorrhea
. Syphilis
□ RPR[2]_____ □ FTA_____
□ VDRL[2]_____ □ MHA _____
Shigellosis[1,4]
Trichinosis
Tuberculosis[4] (*M.tuberculosis* only)
Typhus
Yersiniosis

1 Specify etiologic agent.
2 Indicate titer.
3 Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, or normally sterile tissue obtained during surgery.
4 Send isolate, culture or slide to the State Laboratory for confirmation.

State of Connecticut
Department of Public Health
Division of Infectious Diseases
410 Capitol Avenue, MS#11EPI
P.O. Box 340308
Hartford, CT 06134-0308

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