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

Reportable Diseases and Laboratory Findings, 1999

The lists of Reportable Diseases and Laboratory Reportable Significant Findings are revised annually by the Department of Public Health. An advisory committee of public health officials, clinicians, and laboratorians contribute to the process. There are seven additions or modifications to the lists effective January 1, 1999.

***Campylobacter jejuni* Isolates**

In 1998, a requirement was added to send all *Campylobacter jejuni* isolates to the State Laboratory for antibiotic sensitivity testing and banking for one year as part of a case-control study. This study was completed and the data are being analyzed; thus, the requirement to send *C. jejuni* isolates to the State Laboratory is discontinued.

Diseases That May Indicate Bioterrorism

In recent years, the public health community has become increasingly concerned about the national and local preparedness to detect and respond to possible bioterrorism events. In August 1998, the Centers for Disease Control and Prevention held a workshop on the public health response to bioterrorism. One workshop recommendation was that all states should require reporting of 11 "high priority" diseases that could be indicators of a bioterrorism event.

These 11 diseases are added to: a) the list of Category 1 reportable diseases, in a special listing of diseases that are suspect for bioterrorism; and b) the list of laboratory reportable findings in a special highlighted sublisting. The new diseases to be added to the reportable disease list are Q fever, ricin poisoning, smallpox, Staphylococcal enterotoxin B poisoning, tularemia, Venezuelan equine encephalitis, and viral hemorrhagic fever. The diseases that are already on the list of reportable diseases that will be moved to this special sublisting are anthrax, botulism, brucellosis and plague. The laboratory list of significant findings will add all the above plus botulism.

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The objectives of surveillance are to: a) assure the opportunity to immediately investigate highly suspect or confirmed cases of these diseases, b) detect clusters of these diseases in time, c) determine their background occurrence and epidemiology, regionally and nationally, and d) highlight these diseases for increased clinician awareness for their diagnosis.

Hepatitis C Infection

Acute hepatitis C infection has been clinician reportable for several years. To extend surveillance to include chronic infection, hepatitis C infection is added to the list of reportable laboratory findings, with a specification that laboratories are not required to report hepatitis C viral load tests. The objectives of surveillance are to: a) assess the epidemiology of hepatitis C infection over time, and b) provide a context in which to interpret the findings from the chronic liver disease surveillance project in New Haven County.

HIV Infection in Persons ≥ 13 Years Of Age

The HIV Reporting Task Force recommended that laboratories report confirmatory findings indicative of HIV infection in persons ≥ 13 years of age without using names or actual street address. Western blot, ELISA, and antigen positive confirmatory test results are to be reported, but not the results of viral load testing. Since the recommended no-name reporting system will not be able to eliminate duplicate reports, inclusion of viral load testing would potentially make the system less rather than more useful. Viral load testing is used to determine and monitor treatment, and any given individual may have many such tests.

(continued on page 4)

R E P O R T A B L E D I S E A S E S - 1 9 9 9

The Commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 1999 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 DPH and local health departments; in the evening and on weekends, to the DPH. A confidential Disease Report (PD-23) or more disease-specific report form should be mailed to both the DPH and local health departments within 12 hours.

Cholera
Diphtheria
Foodborne outbreaks (involving ≥ 2 persons)
Institutional outbreaks
Measles
Meningococcal disease
Pertussis
Poliomyelitis
Rabies (human and animal)
Rubella (including congenital)
***Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin**
***Staphylococcus epidermidis* disease, reduced or resistant susceptibility to vancomycin**
Tuberculosis
Yellow Fever

Diseases which are possible indicators of bioterrorism*,
Anthrax
Botulism
Brucellosis
Plague
Q fever*
Ricin poisoning*
Smallpox*
Staphylococcal enterotoxin B pulmonary poisoning*
Tularemia*
Venezuelan equine encephalitis*
Viral hemorrhagic fever*

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

Acquired immunodeficiency syndrome[1,2]
Babesiosis
Campylobacteriosis
Carbon monoxide poisoning[3]
Chancroid
Chlamydia (*C. trachomatis*) (all sites)
Chickenpox-related death
Cryptosporidiosis
Cyclosporiasis
Escherichia coli O157:H7 gastroenteritis
Ehrlichiosis
Gonorrhea
Group A streptococcal disease, invasive[4]
Group B streptococcal disease, invasive[4]
Haemophilus influenzae disease, invasive, all serotypes[4]
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 active tuberculosis disease
- persons with latent tuberculosis infection (history or current tuberculin skin test ≥ 5mm by Mantoux technique)

Lead Toxicity (blood lead ≥ 20 ug/dL)
Legionellosis
Listeriosis
Lyme disease
Malaria
Mercury poisoning
Mumps
Neonatal herpes (<1 month of age)
Occupational asthma
Pneumococcal disease, invasive[4]
Reye syndrome
Rheumatic fever
Rocky Mountain spotted fever
Salmonellosis
Shigellosis
Silicosis
Syphilis
Tetanus
Trichinosis
Typhoid fever
Typhus
Vibrio parahaemolyticus* infection
Vibrio vulnificus* infection

1 Report only to the State. 2 CDC case definition.
3 Includes persons being treated in hyperbaric chambers for suspect CO poisoning.
4 Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, and intraoperative swab from a normally sterile site or normally sterile tissue obtained during surgery.

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, Epidemiology Program, 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 HIV/AIDS Surveillance Program (860-509-7900), the Sexually Transmitted Disease Program (860-509-7920), the Pulmonary Diseases Program (860-509-7722), or the Occupational Health Surveillance 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 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 (860-509-7660). **For public health emergencies, an epidemiologist can be reached nights and weekends through the DPH emergency number (860-509-8000).**

L A B O R A T O R Y R E P O R T A B L E S I G N I F I C A N T F I N D I N G S - 1 9 9 9

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 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 1999 are noted in **bold** and with an asterisk (*).

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

Babesiosis
California encephalitis
Campylobacteriosis (species) _____
Carboxyhemoglobin ≥ 9%: _____% COHb
Chancroid
Chlamydia (*C. trachomatis)* (test type: _____)
Cryptosporidiosis (method of ID) _____
Cyclosporiasis (method of ID) _____
Diphtheria[1]
Eastern equine encephalitis
Ehrlichiosis[2] :_____
Enterococcal infection, vancomycin-resistant [2,3] *:* _____
Escherichia coli O157[1] infection
Food poisoning[2] :_____
Giardiasis
Gonorrhea (test type: _____)
Group A streptococcal disease, invasive [1,3]
Group B streptococcal disease, invasive [3]
Haemophilus influenzae disease, invasive, all serotypes[1,3]
Hansen's disease (Leprosy)
Hepatitis A (IgM anti-HAV)
Hepatitis B ❑ HBsAg ❑ IgM anti-HBc)
Hepatitis C (anti-HCV)
Hepatitis delta (HDAg, IgM anti-HD)
HIV Infection (report only to the State)
- HIV-1 infection in children < 13 years of age[4]
- **HIV-1 infection in persons ≥ 13 years of age[5]***

Influenza: ❑ A ❑ B
Lead Poisoning (blood lead ≥ 10ug/dL)
❑ Finger Stick: _____ ug/dL ❑ Venous: _____ ug/dL
Legionellosis
❑ Culture ❑ DFA ❑ Ag positive
❑ Four-fold serologic changes (titer): _____
Listeriosis [1]
Lyme disease (check all that apply)
EIA IgM _____ IgG _____ Polyvalent _____
W. blot IgM _____ IgG _____ Polyvalent _____
Malaria/blood parasites[1,2] : _____
Measles (Rubeola) (titer): _____
Meningococcal disease, invasive[1,3]
Mercury poisoning (urine ≥ 35 ug/g creatinine or blood ≥ 1.5 ug/dL)
Mumps (titer): _____
Pertussis (titer): _____
DFA Smear: ❑ Positive ❑ Negative
Culture: ❑ Positive ❑ Negative
Pneumococcal disease, invasive[1,3]
Oxacillin disk zone size: _____ mm
MIC to penicillin: _____ ug/mL
Poliomyelitis
Rabies
Rocky Mountain spotted fever
Rotavirus gastroenteritis
Rubella (titer): _____
Salmonellosis[1,2] (serogroup/serotype) _____
Shigellosis[1,2] (serogroup/species) _____
Staphylococcus aureus infection with MIC to vancomycin ≥ 4 ug/mL [1]
MIC to vancomycin: _____ ug/mL
Staphylococcus epidermidis infection with MIC to vancomycin ≥ 4 ug/mL [1]
MIC to vancomycin: _____ ug/mL
Syphilis ❑ RPR (titer): _____ ❑ FTA (titer): _____
❑ VDRL (titer): _____ ❑ MHA (titer): _____
Trichinosis
Tuberculosis[1]
Specimen type: _____
AFB Smear: ❑ Positive ❑ Negative
If positive: ❑ Rare ❑ Few ❑ Numerous
Culture:
❑ *Mycobacterium tuberculosis*
❑ Other mycobacterium (specify: M. _____)
Typhus
Vibrio* infection[6] (species) _____
Yersiniosis (species) _____

Bioterrorism: possible disease indicators
Anthrax[1]
Botulism*
Brucellosis[1]
Plague
Q fever*
Ricin poisoning*
Smallpox*
Staphylococcal enterotoxin B pulmonary poisoning*
Tularemia*
Venezuelan equine encephalitis*
Viral hemorrhagic fever*

1 Send isolate, culture or slide to the State Laboratory for confirmation.
2 Specify etiologic agent.
3 Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, and intraoperative swab from a normally sterile site or normally sterile tissue obtained during surgery.
4 Report any tests indicative of HIV infection including antibody, antigen, PCR-based and viral load tests with name and street address.
5 Report only confirmed HIV antibody tests or positive HIV antigen tests without names or street addresses. Viral load and PCR-based test results not reportable for this age group.
6 Send *V. cholerae* and *V. parahaemolyticus* isolates to the State Laboratory for confirmation.

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HIV infection is included in the list of laboratory reportable findings with the following contingencies:

- For persons ≥ 13 years of age, reporting should occur without names and street addresses, and only positive confirmatory tests for HIV antibody and positive HIV antigen tests should be reported.
- For children < 13 years of age, all tests indicative of HIV infection are reportable by name and street address, including all the above tests plus tests positive by PCR and for viral load.
- HIV infection is reportable to the State only, not to the local health department.

Rotavirus Gastroenteritis

Rotavirus is the leading cause of diarrhea and hospital admission for dehydration in children under the age of 5 years in the US. It also causes between 100-600 hospitalizations per year in children aged ≤ 4 years in Connecticut. Recently, a vaccine has been licensed by the FDA, making this a vaccine-preventable disease. The vaccine is likely to begin to be distributed in Connecticut through the Vaccines for Children Program during 1999. To monitor the burden, epidemiology, and potential preventability of confirmed rotavirus infection in the vaccine era, rotavirus gastroenteritis is added to the list of reportable laboratory findings.

***Staphylococcus aureus* and *S. epidermidis* Infections With Reduced Susceptibility to Vancomycin**

To better monitor the emergence of vancomycin-resistant *Staphylococcal* infections, the minimum inhibitory concentration (MIC) threshold for laboratories to send isolates of *S. aureus* to the State Laboratory for confirmation is lowered from 8 ug/mL to 4 ug/mL. Laboratories are also required to report and send isolates from cases of *S. epidermidis* infection with vancomycin reduced susceptibility or resistance (MIC also ≥ 4 ug/mL).

This reporting requirement does not mean that laboratories are required to perform MIC testing on all *S. aureus* and *S. epidermidis* isolates. Such testing should be done on isolates as necessary in accordance with laboratory protocol. The objectives of surveillance are to: a) monitor the emergence of vancomycin reduced susceptible, non-susceptible and resistant strains, b) confirm suspect isolates, and c) determine mechanisms for relative antibiotic resistance.

***Vibrio parahaemolyticus* and *Vibrio vulnificus* Infections**

Several bacteria that are related to cholera are occasional causes of foodborne disease and have been associated with ingestion of contaminated shellfish. *Vibrio parahaemolyticus* and *Vibrio vulnificus* infections were added to both the list of reportable diseases and the list of laboratory reportable findings. Isolates of *V. parahaemolyticus* are required to be sent to the State Laboratory for confirmatory testing and subtyping. The objectives of surveillance are to: a) describe the magnitude and epidemiology of the problem caused by these organisms; b) monitor trends over time; c) determine risk factors for acquiring infections with these organisms and changes in risk factors over time; and d) assist in the detection of interstate outbreaks.