Connecticut Epidemiologist

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Reportable Diseases and Laboratory Findings, 2001

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 five additions or modifications to the lists effective January 1, 2001.

ADDITIONS AND MODIFICATIONS

Chickenpox

Chickenpox has been added to the lists of Reportable Diseases and Laboratory Reportable Significant Findings. In addition to health care providers, schools and daycare centers will also be requested to report cases. Laboratories are required to report findings consistent with acute chickenpox only.

Since 1995, chickenpox has been a vaccine-preventable disease and immunization rates have climbed over time. With vaccination, the epidemiology of chickenpox is rapidly changing, and we need to systematically monitor the impact of our vaccination efforts.

The objectives of surveillance are to: a) determine incidence and monitor trends over time; b) recognize and respond to outbreaks; and c) determine risk factors for infection in children and adults.

Toxoplasmosis

Toxoplasmosis has been added to the lists of Reportable Diseases and Laboratory Reportable Significant Findings. Laboratories should limit reporting of positive results to those that the laboratory considers "significant".

Toxoplasmosis is a potentially severe disease in infants, persons with immunosuppression, and non-immunocompromised individuals when it involves the retina. As many as 60% of cases may be acquired via consumption of undercooked/non-irradiated meats. The federal Food Safety initiative and the recent approval for irradiation of all meats could result in a changing incidence and epidemiology of toxoplasmosis.

The objectives of surveillance are to determine: a) incidence and trends over time; and b) risk factors and trends in risk factors over time.

Perinatal HIV exposure - infants

HIV perinatal exposure to infants has been added to the List of Reportable Diseases. Transmission of HIV from perinatal exposure can now be prevented. Screening either the mother for HIV infection or the newborn for HIV exposure is now mandatory and widely implemented in Connecticut. Thus, the HIV exposure status of all newborns in Connecticut is now known to the clinicians managing the infants, whether or not the infant ever has a positive HIV laboratory test.

The objectives of surveillance are to: a) determine more accurately the number of infants born each year who were exposed to HIV; b) assess the extent to which recommendations for prevention of perinatal HIV infection are being carried out; and c) compile a more complete registry of HIV-exposed children who were treated with antiretroviral agents. This registry will facilitate studies of the effects of antiretroviral therapy in the perinatal period whenever significant concern is generated about the safety of antiretroviral agents in current use.

Shiga toxin-producing Escherichia coli

Shiga toxin-producing *E. coli* (STEC) has been added to the List of Reportable Diseases. One of the most important foodborne pathogens for which surveillance is being conducted nationally is *E. coli* O157:H7. This pathogen is important because it often produces Shiga toxin, which can cause severe

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REPORTABLE DISEASES - 2001

The Commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 2001 are marked in **bold** with an asterisk (*).

Each report (by mail or telephone) should include the: full name and address of the person reporting, attending physician, disease being reported, and 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
- Measles
- Meningococcal disease
- Outbreaks:
  - Foodborne outbreaks (involving ≥ 2 persons)
  - Institutional outbreaks
  - Unusual disease or illness (1)
- Pertussis
- Poliomyelitis
- Rabies (human and animal)
- Rubella (including congenital)
- *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin (2)
- Tuberculosis
- Yellow Fever

Diseases which are possible indicators of bioterrorism.

- Anthrax
- Botulism
- Brucellosis
- Outbreaks of unusual disease or illness (1)
- 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 (2,3)
- Babesiosis
- Campylobacteriosis
- Carbon monoxide poisoning (4)
- Chancroid
- Chlamydia (*C. trachomatis*) (all sites)
- **Chickenpox***
- Chickenpox-related death
- Creutzfeldt-Jacob disease < 55 years of age
- Cryptosporidiosis
- Cyclosporiasis
- Ehrlichiosis
- Encephalitis
- *Escherichia coli* O157:H7 gastroenteritis
- Gonorrhea
- Group A streptococcal disease, invasive (5)
- Group B streptococcal disease, invasive (5)
- *Haemophilus influenzae* disease, invasive, all serotypes (5)
- 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 exposure in infants born 1/1/2001 or later* (6)**
- 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 (5)
- Reye syndrome
- Rheumatic fever
- Rocky Mountain spotted fever
- Salmonellosis
- **Shiga toxin-related disease (gastroenteritis)***
- Shigellosis
- Silicosis
- *Staphylococcus aureus* methicillin-resistant disease, invasive, community acquired (5,7)
- *Staphylococcus epidermidis* disease, reduced or resistant susceptibility to vancomycin (2)
- Syphilis
- Tetanus
- **Toxoplasmosis***
- Trichinosis
- Typhoid fever
- Typhus
- *Vibrio parahaemolyticus* infection
- *Vibrio vulnificus* infection

1 Individual cases of "significant unusual illness" are also reportable. 2 Report only to the State. 3 CDC case definition.
4 Includes persons being treated in hyperbaric chambers for suspect CO poisoning.
5 Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, other normally sterile sites, and intraoperative swab from a normally sterile site or normally sterile tissue obtained during surgery.
6 "Exposure" includes all infants born to known HIV-infected mothers.
7 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), the Pulmonary Diseases Program (860-509-7722), or the Occupational Health Surveillance Program (860-509-7744). Forms may be obtained by writing the Department of Public Health, Epidemiology Program, 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 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).**

LABORATORY REPORTABLE SIGNIFICANT FINDINGS - 2001

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. A special listing of diseases indicative of possible bioterrorism is highlighted at the end of this list. Changes for 2001 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: ❑IFA IgM (titer) _____ IgG (titer):_____
❑Blood smear ❑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 (2) ❑HGE ❑HME ❑Unspecified
❑IFA ❑Blood smear ❑PCR ❑Other: _____
Encephalitis:
California group virus (species) _____
Eastern equine encephalitis virus
St. Louis encephalitis virus
West Nile virus infection – human or animal
Other arbovirus (specify) _____
Enterococcal infection, vancomycin-resistant (2, 3)_____
Escherichia coli O157 infection (1)
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 ≥ 10 ug/dL)
❑ Finger Stick: _____ ug/dL ❑ Venous: _____ ug/dL
Legionellosis
❑ Culture ❑ DFA ❑ Ag positive
❑ Four-fold serologic change (titers): _____
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
Rubella (titer): _____
Salmonellosis (1,2) (serogroup/serotype) _____
Shiga toxin-related disease (1)
Shigellosis (1,2) (serogroup/species) _____
Staphylococcus aureus infection with MIC to vancomycin ≥ 4 ug/mL (1)
MIC to vancomycin: _____ ug/mL
***Staphylococcus aureus* disease, invasive * (3)**
methicillin-resistant Date pt. Admitted _____/_____/_____
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): _____
Toxoplasmosis* (7) ❑ IgM (titer) ___ ❑ IgG (titer) ____ ❑ PCR
Trichinosis
Tuberculosis (1)
Specimen type: _____
AFB Smear: ❑ Positive ❑ Negative
If positive: ❑ Rare ❑ Few ❑ Numerous
Culture:
❑ *Mycobacterium tuberculosis* only
❑ 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. For Shiga-toxin, send broth culture from which positive Shiga-toxin test was made.
2 Specify etiologic agent.
3 Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, other normally sterile sites, 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, V. parahaemolyticus*, and *V. vulnificus* isolates to the State Laboratory for confirmation.
7 Report only IgG titers that are considered significant by the laboratory performing the test.

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illness and death. However, O157:H7 is not the only *E. coli* strain to produce Shiga toxin and foodborne outbreaks of bloody diarrhea or HUS. Adding this to the list of reportable diseases will enable clinicians to report epidemiologic information on cases found through laboratory surveillance begun in 2000.

Community-acquired methicillin-resistant Staphylococcus aureus invasive infection

Community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) reporting requirements on the list of Laboratory Reportable Significant Findings have been expanded. The requirement is changed from "Methicillin-resistant *S. aureus* bloodstream infection" to findings consistent with "Methicillin-resistant *S. aureus* invasive disease". This expansion in laboratory reporting complements reporting of community-acquired invasive disease by health care providers begun in 2000.

Status Note: HIV Infection Reporting in Adults

The Reportable Disease Advisory Committee discussed the status of HIV infection reporting in adults in Connecticut. The data from the "no-name" laboratory reporting system has not been adequate to determine the epidemiology and trends in who is acquiring HIV infection each year in Connecticut. In addition, the quantitative and epidemiologic data from AIDS case reporting only is of increasingly limited use, as persons with AIDS are living longer and healthier lives and functionally differ little from persons with HIV infection alone. Furthermore, federal support of HIV/AIDS case management and housing in the future is likely to be based on the number of people with HIV infection, not just AIDS. Several Committee members were outspoken that the state does not know what is happening with the epidemiology of HIV infection, cannot do any service-based or evaluative follow-up of persons with HIV infection, and would benefit from having HIV infection reporting as exists in most other states.

In light of these concerns, the DPH supports reporting of HIV infection in adults in the same manner as HIV infection reporting is done for children, by name. However, the agency intends to collaborate with interested parties and agencies in the educational processes needed to gain consensus regarding this surveillance initiative.

AIDS Epidemiology (860) 509-7900
Epidemiology (860) 509-7994
Immunizations (860) 509-7929
Pulmonary Diseases (860) 509-7722
Sexually Transmitted Diseases (STD) (860) 509-7920

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