CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
Keeping Connecticut Healthy

Connecticut Epidemiologist

Volume 23, No. 1 **January 2003**

Reportable Diseases and Laboratory Findings, 2003

As required by Connecticut General Statute 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 of public health officials, clinicians, and laboratorians contribute to the process. There are five modifications to the lists effective January 1, 2003.

Rash Illness

Chickenpox in children (aged <18 years) requiring hospital admission, and all cases among adults (aged ≥ 18 years), even if not hospitalized, have been added to the list of Reportable Diseases as a Category 1 disease. Category 1 diseases are reportable immediately by telephone upon strong suspicion 7 days per week.

Chickenpox is the disease most likely to be confused with smallpox. From January-December 13, 2002, nearly 1700 cases were reported; 50 were adults ≥ 18 years of age including six who were hospitalized. Eleven children < 18 year of age were hospitalized.

Investigation of severe or unusual suspect cases of chickenpox, including rapid laboratory confirmation, may be one way to assure early detection of smallpox. Smallpox is of concern because there is increased potential for it to fall into the hands of terrorists. In the event of the intentional release of smallpox, early detection of the first cases is necessary for prompt institution of investigative and control measures to minimize the public health impact.

The objective of this surveillance change is to: a) establish a system for the early detection of smallpox among persons thought to have chickenpox, and b) assess implementation of standard “infectious rash illness” protocols to contain chickenpox and smallpox.

Gram-positive Rod Surveillance

Gram-positive rod septicemia or meningitis accompanied by growth within 72 hours of inoculation in the laboratory has been added to the lists of Reportable Diseases and Laboratory Reportable Significant Findings as a Category 1 finding.

Anthrax is one of the Category 1 bioterrorism agents. To limit overall morbidity from a mass exposure to anthrax spores, cases need to be recognized as early as possible so that antibiotic prophylaxis can begin.

In this issue...

While the Connecticut case of inhalational anthrax in 1991 was properly reported, there was a delay of 2 days because of the time required to determine if a gram-positive blood isolate is anthrax. Thus, reporting of persons ill with gram-positive rods in their blood or CSF could result in significant "advance notice" of a possible anthrax case.

Other causes of gram-positive rod sepsis also may have public health implications. In particular in the past 4 years, there have been two outbreaks of clostridial sepsis with death: one in injection drug users in England (1) and one in healthy persons undergoing elective surgery in Minnesota (2) who received contaminated ligament grafts.

The objectives of surveillance are to: a) detect persons with possible, confirmable anthrax septicemia or meningititis sooner, and b) determine the magnitude and epidemiology of important causes of gram-positive rod septicemia or meningititis in the absence of an intentional release of anthrax spores.

Babesiosis Confirmation Testing

Confirmation by the State Laboratory of positive blood smears for *Babesia* has been added to the list of Laboratory Significant Findings. *Babesia* are tick-borne parasites that can cause life threatening illness in some people, produce prolonged asymptomatic parasitemia in others, and be transmitted through blood transfusion.

Initial diagnosis relies on recognition via microscopic examination of blood smears, similar to malaria. Smears with low numbers of parasites may pose a diagnostic challenge for laboratories, especially those with little *Babesia* identification experience.

In Connecticut, babesiosis has been a reportable disease and laboratory finding for more than 10 years and has been reported in residents of each county except Tolland. From 1997-2001, an average of 45 cases have been reported annually (range: 31-56).

(cont. on page 4)

REPORTABLE DISEASES - 2003

The Commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 2003 are noted in **bold** and 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.

Chickenpox*
- **admission to hospital, any age**
- **adults > 18 years, any clinical setting**

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) *(list continued in next column)*
Tuberculosis
Yellow Fever

Diseases that are possible indicators of bioterrorism.

Anthrax
Botulism
Brucellosis
Gram positive rod septicemia or meningitis, growth within 72 hours of inoculation in laboratory*
Outbreaks of unusual disease or illness (1)
Plague
Q fever
Ricin poisoning
Smallpox
Staphylococcal enterotoxin B pulmonary poisoning
Tularemia
Venezuelan equine encephalitis

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 infant born 1/1/2001 or later (2,6)
HIV-1 infection in: (2)
- person with active tuberculosis disease
- person with latent tuberculosis infection (history or tuberculin skin test ≥ 5mm induration by Mantoux technique)
- child < 13 years of age
- person ≥ 13 years of age not included above (7)

Lead Toxicity (blood lead ≥ 20 µg/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 (5,8)
Staphylococcus epidermidis disease, reduced or resistant susceptibility to vancomycin (2)
Syphilis
Tetanus
Toxoplasmosis
Trichinosis
Typhoid fever
Typhus
Vaccinia disease*
- **persons not vaccinated**
- **persons vaccinated with the following manifestations: autoinoculation, generalized vaccinia, eczema vaccinatum, progressive vaccinia, or post-vaccination encephalitis**

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 person 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 infant born to known HIV-infected mother.
7 Persons with HIV infection and active tuberculosis or latent tuberculosis infection (history of tuberculin skin test = 5 mm induration by Mantoux technique), or children (<13 years of age) should be reported using full name and street address. Persons =13 years of age. should be reported by full name and street address or by state-specified unique identifier (UI). To make the UI, the first 3 letters of the patient's last name, date of birth, gender and race need to be reported.
8 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-2003

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 2003 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: _____%

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 (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 child < 13 years of age (4)
- HIV-1 infection in person ≥ 13 years of age (5)

Influenza: ❑ A ❑ B
Lead Poisoning (blood lead ≥ 10 µg/dL)
❑ Finger Stick: _____ µg/dL ❑ Venous: _____ µg/dL
Legionellosis
❑ Culture ❑ DFA ❑ Ag positive
❑ Four-fold serologic change (titers): _____
Listeriosis (1)
Malaria/blood parasites (1,2) : _____
Measles (Rubeola) (titer): _____
Meningococcal disease, invasive (1,3)
Mercury poisoning
❑ Urine ≥ 35 µg/g creatinine _____ µg/g
~~❑ Blood ≥ 15 µg/L _____ µg/L~~
Mumps (titer): _____
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) _____
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 ≥ 4 µg/mL (1)
MIC to vancomycin: _____ µg/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) _____

Diseases that are possible indicators of bioterrorism.
Anthrax (1)
Botulism
Brucellosis (1)
Gram positive rod septicemia or meningitis, growth within 72 hours of inoculation*
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 **with name*** and street address. 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.

Connecticut Department of Public Health
410 Capitol Ave., MS11EPI
P.O. Box 340308
Hartford, CT 06134-0308

PRSRT STD
U.S. Postage
PAID
Hartford, CT
Permit No. 4313

In This Issue... **Reportable Diseases and Laboratory Findings for 2003.**

The objective of this surveillance change is to more accurately define the epidemiology of babesiosis in Connecticut.

Vaccinia Vaccination Complications Surveillance

Vaccinia disease in persons without vaccination and vaccinated persons with manifestations of autoinoculation, generalized vaccinia, eczema vaccinatum, progressive vaccinia, or post-vaccination encephalitis have been added to the list of Reportable Diseases as a Category 2 disease.

In January 2003, smallpox vaccination of core hospital medical care teams and public health response teams is anticipated to begin. During this stage, there will be systematic active monitoring of complications in vaccinees, and any requests for vaccinia immune globulin will be known to both state and federal officials. However, monitoring for vaccinia in contacts will be more problematic as vaccination is offered to other populations. Most likely, systematic recognition of such events will depend on voluntary reporting to the national Vaccine Adverse Event Reporting System (VAERS). Often, reports to VAERS are not known to state officials.

It is assumed that most "contact" vaccinia disease results from transmission to household contacts; however, the true magnitude, epidemiology, and spectrum of illness for contact vaccinia has not been systematically determined.

The objectives of surveillance are to: a) accurately determine the magnitude of the problem of contact vaccinia as a complication of smallpox vaccination efforts; and b) provide a mechanism for reporting of contact vaccinia and other potentially severe medical complications of vaccinia vaccination.

Lyme Disease Laboratory Reporting Deletion

Lyme disease (LD) is deleted from the list of Laboratory Reportable Significant Findings.

When laboratory reporting began 5 years ago to supplement long-standing reporting by physicians, it was in anticipation of evaluating vaccine efficacy against laboratory diagnosed LD. With the withdrawal of LD vaccine, it is no longer necessary to sustain this reporting burden for laboratories. The majority of confirmed LD cases are reported by physicians, and physician reports have contributed greatly to our understanding of LD in Connecticut.

Physicians are reminded that LD is still a reportable disease. If reporting forms are needed please contact the Epidemiology Program at (860) 509-7994.

References
1. CDC. Update: *Clostridium novyi* and unexplained illness among injecting-drug users—Scotland, Ireland, and England, April-June 2000. MMWR 2000: 49;543-5.
2. CDC. Public Health Dispatch: Update: Unexplained deaths following knee surgery-Minnisotat 2001. MMWR 2001: 50-1080.