CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
Keeping Connecticut Healthy

Connecticut Epidemiologist

Volume 25, No. 1 **January 2005**

Reportable Diseases and Laboratory Findings, 2005

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 of public health officials, clinicians, and laboratorians contribute to the process. There are three additions, two modifications, and one deletion to the lists effective January 1, 2005.

Please note, changes were made to the footnotes on both the revised Laboratory Report of Significant Findings form OL-15C and Reportable Disease Confidential Case Report form PD-23. Persons completing these forms should review footnotes associated with diseases being reported.

Laboratory Reportable Significant Findings

Hepatitis C

Laboratories are required to continue reporting all positive anti-hepatitis C virus (HCV) screening test results with signal to control ratios (if known) and all positive recombinant immunoblot assay (RIBA) and polymerase chain reaction (PCR) confirmatory tests. The resources to manage the RIBA and PCR confirmatory test results that are now formally required are available.

This change will: 1) clarify that the healthcare provider reporting requirement is for acute hepatitis C infection only; 2) officially make all laboratory tests indicative of HCV infection reportable; 3) more accurately determine the magnitude, descriptive epidemiology, and trends for detection of chronic hepatitis C infection; and 4) determine the percentage of persons who have positive anti-HCV screening tests, have confirmatory testing, and can be counted as true cases of HCV infection.

Neonatal Bacterial Sepsis

Neonatal sepsis was added to the list of Laboratory Reportable Significant Findings. Reports should only be submitted for infants with blood or cerebrospinal fluid (CSF) bacterial isolates obtained <7 days after birth.

The purpose for this change is to determine the epidemiology of clinically significant bacteremia in neonates, trends over time, and risk factors, including intrapartum antibiotic exposure.

HIV

Laboratories doing HIV-antibody testing are required to send residual serum specimens to the DPH for confirmation and further testing by a detuned assay. This will determine whether HIV infection occurred recently (within past 12 months) or in the more distant past.

The purpose of this change is to: 1) establish a system to measure the epidemiology of new HIV infection and monitor trends in epidemiology and relative incidence over time; and 2) contribute to the national CDC-funded effort to measure HIV incidence in the United States.

Reportable Diseases

Influenza-associated Deaths

Influenza-associated deaths in children <18 years old has been added to the list of Reportable Diseases and should be reported by telephone.

The purpose for this surveillance change is to:
1) formalize the system begun on declaration by the Commissioner in the 2003-2004 influenza season; 2) determine the magnitude, descriptive epidemiology, and trends and risk factors for deaths thought to be due to influenza in children <18 years old; and 3) enable efforts (autopsy) to confirm infection with influenza in children dying from presumed influenza complications.

In this issue...

(cont. on page 4)

REPORTABLE DISEASES - 2005

The Commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 2005 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
Influenza-associated deaths in children <18 years of age (1)*
Measles
Meningococcal disease
Outbreaks:
- Foodborne (involving ≥ 2 persons)
- Institutional
- Unusual disease or illness (2)

Pertussis
Poliomyelitis
Rabies (human and animal)
Rubella (including congenital)
SARS-CoV
Staphylococcus aureus disease, reduced or resistant susceptibility to vancomycin (3)
Tuberculosis
Yellow fever

Diseases that are possible indicators of bioterrorism.

Anthrax
Botulism
Brucellosis
Plague
Q fever
Ricin Poisoning
Septicemia or meningitis with growth of gram positive rods within 32 hours of inoculation.
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 (3,4)
Babesiosis
Campylobacteriosis
Carbon monoxide poisoning (5)
Chancroid
Chlamydia (*C. trachomatis*) (all sites)
Chickenpox
Chickenpox-related death
Creutzfeldt-Jacob disease (age < 55 years)
Cryptosporidiosis
Cyclosporiasis
Ehrlichiosis
Encephalitis
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
- HBsAg positive pregnant woman

Hepatitis C, acute infection*
Hepatitis Delta
HIV-1 exposure in infants born 1/1/2001 or later (7)
HIV-1 infection in: (3)
- person with active tuberculosis disease
- person with latent tuberculosis infection (history or tuberculin skin test ≥ 5mm induration by Mantoux technique)
- **persons of any age (8)***

Lead Toxicity (blood lead ≥ 20 μg/dL)
Legionellosis
Listeriosis
Lyme disease
Malaria
Mercury poisoning
Mumps
Neonatal herpes (<1 month of age)
Neonatal bacterial sepsis (9)*
Occupational asthma
Pneumococcal disease, invasive (6)
Reye syndrome
Rheumatic fever
Rocky Mountain spotted fever
Salmonellosis
Shiga toxin-related disease (gastroenteritis)
Shigellosis
Silicosis
Staphylococcus aureus methicillin-resistant disease, invasive, community acquired (6,10)
Staphylococcus epidermidis disease, reduced or resistant susceptibility to vancomycin (3)
Syphilis
Tetanus
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) Death in child or adolescent who never fully recovers from influenza and dies from a possible complication (e.g., encephalopathy, bacterial pneumonia)*
(2) Individual cases of "significant unusual illness" are also reportable.
(3) Report only to the State. (4) CDC case definition.
(5) Includes persons being treated in hyperbaric chambers for suspect CO poisoning. (6) Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, or internal body sites, vitreous fluid or other normally sterile sites. Includes muscle for group A *streptococcus*. (7) "Exposure" includes infant born to known HIV-infected mother. (8) Reports for this category of people only can be made by using name and full street addresses as the patient identifier. There is no longer an option for reporting using a state-specified unique identifier. (9) Clinical sepsis and blood or CSF isolate obtained from an infant <7days old.* (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), 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 - 2005

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 and can be obtained 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 listing of diseases indicative of possible bioterrorism is highlighted at the end of this list. Changes for 2005 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)
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
Hepatitis B ❑ HBsAg ❑ IgM anti-HBc
Hepatitis C (anti-HCV) Ratio: _____ ❑RIBA ❑PCR **(4)***
Hepatitis Delta ❑HDAg, ❑ IgM anti-HD
HIV Infection (report only to the State) **(1)***
- HIV-1 infection in child < 13 years of age (5)
- HIV-1 infection in person ≥ 13 years of age (6)

Influenza: ❑ A ❑ B ❑ Unk. ❑ Culture ❑ Rapid test
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) (7): _____
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 (9)* spp _____
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) _____
SARS-CoV infection **(10)*** ❑ 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 ≥ 4 μg/mL (1)
MIC to vancomycin: _____ μg/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* only
❑ Other mycobacterium (specify: M. _____)
Typhus
Vibrio infection (11) (species) _____
Yellow fever
Yersiniosis (species) _____

Diseases that are possible indicators of bioterrorism. (8)
Anthrax (1)
Botulism
Brucellosis (1)
Gram positive rods in blood or CSF, growth within 32 hours of inoculation (specify:_____)
Plague (1)
Q fever
Ricin poisoning
Smallpox (1)
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. **For HIV, send ≥ 0.2 cc residual specimen from confirmatory testing.*** (2) Specify species/serogroup.
(3) Sterile site isolates. Sterile site defined as blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, internal body site (lymph node, brain, heart, liver, spleen, kidney, pancreas, or ovary), vitreous fluid or other normally sterile site; includes muscle for invasive GAS disease. **(4) Report all positive anti-HCV with ratio of signal to control ratio, all positive RIBA, but only confirmatory PCR tests.***. (5) Report any tests indicative of HIV infection including antibody, antigen, PCR-based and viral load tests with name and street address. (6) 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 on this age group. (7) Report all IgM titers, but only IgG titers that are considered significant by the laboratory performing the test. (8) Report by telephone to the Departmnet of Public Health, weekdays 860-509-7994; weekends and evenings 860-509-8000.
(9) Report all bacterial isolates from blood or CSF obtained from an infant <7 days old.* (10) Send residual serum, sputum, stool or other specimen testing positive for SARS-CoV to the State Laboratory for confirmation. (11) Send *V. cholerae, V. parahaemolyticus*, and *V. vulnificus* isolates to the State Laboratory for confirmation.

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In This Issue... | **Reportable Diseases and Laboratory Findings for 2005.**

Hepatitis

Non/A, non/B hepatitis is removed from the list of Reportable Diseases. Only acute hepatitis C infections are reportable.

If surveillance for a newly emerging non/A, non/B, non/C hepatitis needed to be conducted, consideration to change back to reporting this syndromic category could be made at that time.

HIV Reporting

There is no longer an option to use a coded identifier when reporting. Reports should be completed using name and full street address.

The purpose of this change is to: 1) enable Connecticut to contribute to national HIV surveillance; and 2) enable more flexibility to pursue HIV-incidence surveillance and monitoring of initial access, and continuity of care among persons reported with HIV infection in Connecticut.

Neonatal Bacterial Sepsis

Neonatal sepsis is added to the list of Reportable Diseases. For the purposes of surveillance, a case is defined as an infant <7 days old with clinical evidence of sepsis and a bacterial blood or CSF isolate.

The purpose of surveillance is to determine the epidemiology of clinically significant bacteremia in neonates, trends over time, and risk factors including intrapartum antibiotic exposure.

For Public Health Emergencies after 4:30 P.M. and on weekends call the Department of Public Health emergency number
(860) 509-8000

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