CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
Keeping Connecticut Healthy

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Reportable Diseases and Laboratory Findings, 2006

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 were five proposed additions and one modification to the lists effective January 1, 2006.

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.

Reportable Diseases

Clostridium difficile, community-onset

Clostridium difficile, community-onset is added to the List of Reportable Diseases with the following footnote: "Community-onset: illness in a person living in the community at the time of illness and no known hospitalizations in the preceding 3 months; if hospitalized, a positive test taken within 48 hours of admission".

The purpose of surveillance is to determine the magnitude, descriptive epidemiology and trends, and risk factors for community-onset infections due to *C.difficile*. This addition was prompted by the recognition of a new, more toxigenic strain of *C. difficile* that is not only capable of causing more symptomatic and severe disease in hospitalized persons, but also in persons in the community (1).

Lymphocytic Choriomeningitis Virus (LCMV) Infection

LCMV infection is added to the lists of Reportable Diseases and Laboratory Reportable Significant Findings. The purpose of surveillance is to: 1) determine the descriptive epidemiology and risk factors for infections due to LCMV; 2) identify infections associated with pet rodents; and 3) enable efforts to confirm the diagnosis. This addition was prompted by the fatal cases of transplant-associated LCMV infection from a donor likely infected through a pet rodent (2).

Free testing for LCMV is available for physicians through the DPH laboratory. Specimens sent will be tested using a complement fixation test at DPH followed by an ELISA test at CDC. Follow-up by Epidemiology Program staff will be conducted on all requests for testing. In suspect cases with pet rodent exposure, staff will work with the patient's primary care physician to attempt to obtain convalescent specimens.

Laboratory Reportable Significant Findings

Hepatitis A

Laboratories are required to send residual serum from positive hepatitis A IgM anti-HAV tests to the DPH Laboratory. Specimens will be saved and then sent to the CDC in batches for fingerprinting. Precedent for this requirement has already been established with HIV. A footnote has been added to the Laboratory Report of Significant Findings form OL-15C specifying that at least 0.5 mL of residual serum be sent to the DPH Laboratory for subtyping.

This change will: 1) enable more rapid investigation of outbreaks by having serum from affected individuals readily available; and 2) enable identification of outbreaks of hepatitis A that might otherwise be missed.

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REPORTABLE DISEASES - 2006

The commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 2006 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 department.

Acquired Immunodeficiency Syndrome (3,4)
Babesiosis
Campylobacteriosis
Carbon monoxide poisoning (5)
Chancroid
Chlamydia (*C. trachomatis*) (all sites)
Chickenpox
Chickenpox-related death
Clostridium difficile*, community-onset (6)
Creutzfeldt-Jacob disease (age < 55 years)
Cryptosporidiosis
Cyclosporiasis
Ehrlichiosis
Encephalitis
Escherichia coli O157:H7 gastroenteritis
Gonorrhea
Group A streptococcal disease, invasive (7)
Group B streptococcal disease, invasive (7)
Haemophilus influenzae disease, invasive, all serotypes (7)
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 (8)
HIV-1 infection in: (3)
- persons with active tuberculosis disease
- persons with latent tuberculosis infection (history or tuberculin skin test ≥ 5mm induration by Mantoux technique)
- persons of any age (9)

Lead Toxicity (blood lead ≥ 20 μg/dL)
Legionellosis
Listeriosis
Lyme disease
Lymphocytic choriomeningitis virus infection *
Malaria
Mercury poisoning
Mumps
Neonatal herpes (<1 month of age)
Neonatal bacterial sepsis (10)
Occupational asthma
Pneumococcal disease, invasive (7)
Reye syndrome
Rheumatic fever
Rocky Mountain spotted fever
Salmonellosis
Shiga toxin-related disease (gastroenteritis)
Shigellosis
Silicosis
Staphylococcus aureus methicillin-resistant disease, invasive, community acquired (7,11)
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 infection (*parahaemolyticus*, *vulnificus,* other*)*

(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) Community-onset: illness in a person living in the community at the time of illness onset and no known hospitalizations in preceding 3 months; if hospitalized, a positive test taken within 48 hours of admission.*
(7) 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*.
(8) "Exposure" includes infant born to known HIV-infected mother.
(9) 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.
(10) Clinical sepsis and blood or CSF isolate obtained from an infant <7days old.
(11) 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 - 2006

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 2006 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 **(1)***
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 persons of all ages (5)(6)***

Influenza: ❑ A ❑ B ❑ Unk.
❑ RT-PCR ❑ 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)
Lymphocytic choriomeningitis virus infection*
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 **and hepatitis A**, send ≥ 0.5 mL residual **serum to the State Laboratory**.
(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 group A streptococcal disease.
(4) Report all positive anti-HCV with signal to cutoff 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 *all* HIV viral load test results, including those with *no virus detectable*, with name and street address.
(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 Department 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 *all Vibrio* isolates to the State Laboratory for confirmation.

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HIV Viral Load Tests

Laboratories are required to report HIV viral load tests with the viral load measurement, including those that have no detectable viral load. Due to the anticipated large volume, this reporting should be done electronically in a format specified by the HIV/AIDS Surveillance Program. Laboratories are not required to begin reporting viral loads until they have been contacted by DPH staff, and the correct format for reporting has been determined.

The purpose for this change is to: 1) provide population-based information about the interval between initial testing and entry into care for all HIV-infected persons; 2) provide information about consistency and effectiveness of care; 3) determine whether there are subgroups of persons with longer delays and/or less consistent care; and 4) track changes over time.

Identification of *Vibrio* Isolates

The requirement to send *Vibrio* isolates to DPH for confirmation and subtyping is modified to include all *Vibrio* isolates, not just selected species.

The purpose of this change is to: a) enable species identification and subtyping of any clinically significant *Vibrio* isolates in order to determine the epidemiology of *Vibrio*-related disease by species; and b) enable subtyping of *Vibrio* species to enhance outbreak detection and investigation.

References

1. CDC. Severe C*lostridium difficile*-associated disease in populations previously at low risk – four states, 2005. *MMWR* 2005;54:1201-5.
2. CDC. Lymphocytic choriomeningitis virus infection in organ transplant recipients – Massachusetts, Rhode Island, 2005. *MMWR* 2005:54;537-9.

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