CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
Keeping Connecticut Healthy

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Reportable Diseases and Laboratory Reportable Significant Findings - Changes for 2008

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, consisting of public health officials, clinicians, and laboratorians, contributes to the process. There are two additions, two modifications, and one deletion to the lists effective January 1, 2008.

Changes to the lists of Reportable Diseases and Laboratory Reportable Significant Findings

Human Papillomavirus (HPV) related cervical neoplasia- added

HPV infection with a high-risk HPV type underlies all cases of cervical cancer, ~90% of anal cancer, ~40% of vulvar, vaginal and penile cancers, and ~12% of oropharyngeal cancers. An HPV vaccine was licensed in June 2006. This vaccine is highly efficacious in preventing cervical intraepithelial neoplasia grades 2 and 3 (CIN 2/3) and adenocarcinoma-in-situ (AIS) in females vaccinated before having type-specific HPV infection (~100% efficacious against HPV types 16 and 18; 70-80% efficacious against all HPV types).

Surgical pathology laboratories are required to report all newly diagnosed cases of CIN2/3, and AIS or their equivalent. At the DPH's request and if adequate tissue is available, laboratories are required to send fixed tissue from the specimen used to diagnose CIN2/3 or cervical AIS for HPV typing per instructions from the DPH. Footnote (10) was added to the OL-15C. The purpose of this HPV surveillance is to monitor the statewide impact of the vaccine on the incidence and epidemiology of biopsy-proven early outcomes of HPV infection that lead to cervical cancer. It will also monitor the impact of the vaccine on the types of HPV causing biopsy-proven disease.

Typhus - deleted

Typhus is removed from both lists because it is a rare disease that is not present in Connecticut and does not constitute a potential public health emergency. There have been no confirmed cases in Connecticut in more than 27 years. Typhus can still be legally reported under the heading "Outbreaks-Other unusual diseases and illness".

In this issue...

Changes to the List of Reportable Diseases

Encephalitis and Arboviral Infection – modified

The List of Laboratory Significant Findings was modified to remove the heading "Encephalitis" and replace it with "Arboviral infection." Initially, surveillance for arboviral infection was limited to those with encephalitis. Surveillance is now being conducted for the full clinical spectrum of arboviral infection, particularly for all clinical forms of West Nile virus infection. A similar change was made to the List of Reportable Diseases, which now lists "Arboviral disease" with a list of relevant arboviruses. However, "encephalitis" remains reportable by providers.

Vaccinia disease - modified

The listing for reporting of vaccinia disease had details that are no longer relevant given the lack of active efforts to vaccinate against smallpox; therefore, these details were removed from the list. Vaccinia disease remains a reportable disease.

Changes to the List of Laboratory Reportable Significant Findings

Glanders and Melioidosis - added

Glanders and melioidosis, infections caused by *Burkholderia mallei* and *pseudomallei*, respectively, are added to the list of Laboratory Reportable Significant Findings. It is rare to isolate either of these organisms from ill persons in Connecticut. The DPH Bioterrorism laboratory has polymerase chain reaction tests to confirm the identity of these bacteria. Isolates will need to be sent to the State laboratory for confirmation. This will enable state level identification, validation, and reporting to the Centers for Disease Control and Prevention of these possible bioterrorism agents.

(cont. on page 4)

REPORTABLE DISEASES - 2008

The commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. 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, date of birth, race/ethnicity, sex and occupation of the person affected. Please see page 4 for a list of persons required to report reportable diseases. The reports should be sent in envelopes marked "CONFIDENTIAL." Changes for 2008 are noted in **bold** and with an asterisk (*****).

Category 1 Diseases: Report immediately by telephone on the day of recognition or strong suspicion of disease for those diseases marked with a telephone (☎). Also mail a report within 12 hours.

Category 2 Diseases: All other diseases not marked with a telephone are Category 2 diseases. Report by mail within 12 hours of recognition or strong suspicion of disease.

Acquired Immunodeficiency Syndrome (1,2)
☎ Anthrax
* **Arboviral disease (e.g., California group, EEE, SLE, WNV, other)**
Babesiosis
☎ Botulism
☎ Brucellosis
Campylobacteriosis
Carbon monoxide poisoning (3)
Chancroid
Chickenpox
☎ Chickenpox
- admission to hospital, any age
- adults ≥ 18 years, any clinical settin

Chickenpox-related death
Chlamydia (*C. trachomatis*) (all sites)
☎ Cholera
Clostridium difficile, community-onset (4)
Creutzfeldt-Jakob disease (age < 55 years)
Cryptosporidiosis
Cyclosporiasis
☎ Diphtheria
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
Hepatitis B
- acute infection
- HBsAg positive pregnant women

Hepatitis C - acute infection (ALT > 400 IU/L)
HIV-1 exposure in infants born 1/1/2001 or later (1,6)
HIV-1 infection in (1)
- persons with active tuberculosis disease
- persons with a latent tuberculous infection (history or tuberculin skin test ≥5mm induration by Mantoux technique)
- persons of any age

* **HPV: biopsy proven CIN 2, CIN 3 or AIS or their equivalent (1)**
☎ Influenza-associated deaths in children <18 years of age (7)
Lead toxicity (blood level ≥ 20 µg/dL)
Legionellosis
Listeriosis
Lyme disease
Lymphocytic choriomeningitis virus infection
Malaria
☎ Measles
☎ Meningococcal disease
Mercury poisoning
Mumps
Neonatal herpes (< 1 month of age)
Neonatal bacterial sepsis (8)
Occupational asthma
☎ Outbreaks:
- Foodborne (involving ≥ 2 persons)
- Institutional
- Unusual disease or illness (9)

☎ Pertussis
☎ Plague
Pneumococcal disease, invasive (5)
☎ Poliomyelitis
☎ Q fever
☎ Rabies (human and animal)
Reye syndrome
Rheumatic fever
☎ Ricin poisoning
Rocky Mountain spotted fever
☎ Rubella (including congenital)
Salmonellosis
☎ SARS-CoV
☎ Septicemia or meningitis with growth of gram positive rods within 32 hours of inoculation
Shiga toxin-related disease (gastroenteritis)
Shigellosis
Silicosis
☎ Smallpox
☎ Staphylococcal enterotoxin B pulmonary poisoning
☎ *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin (1)
Staphylococcus aureus methicillin-resistant disease, invasive, community acquired (5,10)
Staphylococcus epidermidis disease, reduced or resistant susceptibility to vancomycin (1)
Syphilis
Tetanus
Trichinosis
☎ Tuberculosis
☎ Tularemia
Typhoid fever
Typhus
* **Vaccinia disease**
☎ Venezuelan equine encephalitis
Vibrio infection (*parahaemolyticus, vulnificus*, other)
☎ Viral hemorrhagic fever
☎ Yellow fever

FOOTNOTES:
1. Report only to State.
2. CDC case definition.
3. Includes persons being treated in hyperbaric chambers for suspect CO poisoning.
4. 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.
5. Invasive disease: confirmed by isolation from sterile fluid (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous) bone, internal body sites, or other normally sterile sites. Includes muscle for group A *streptococcus*.
6. "Exposure" includes infant born to known HIV-infected mother.
7. Death in child or adolescent who never fully recovers from influenza and dies from a possible complication (e.g., encephalophathy, bacterial pneumonia).
8. Clinical sepsis and blood or CSF isolate obtained from an infant < 7 days old.
9. Individual cases of "significant unusual illness" are also reportable.
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, weekends, and holidays through the DPH emergency number (860-509-8000).**

LABORATORY REPORTABLE SIGNIFICANT FINDINGS - 2008

The director of a clinical laboratory must report laboratory evidence suggestive of reportable diseases. A standard reporting form, the Laboratory Report of Significant Findings (OL-15C) 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 OL-15Cs are not substitutes for physician reports; they are supplements to physician reports which allow verification of diagnosis. A listing of possible bioterrorism diseases is highlighted at the end of this list. Changes for 2008 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: _____%

***Arboviral infection (replaces "encephalitis"):**
California group virus (species) _____
Eastern equine encephalitis virus
St. Louis encephalitis virus
West Nile virus infection – human or animal
Other arbovirus (specify) _____

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 (titers):
IgM _____ IgG _____ ❑Blood smear ❑PCR ❑Other: _____
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 (1)
Hepatitis C (anti-HCV) Ratio: _____ ❑RIBA ❑PCR (4)
HIV Infection (report only to the State) (1)
- HIV-1 infection in persons of all ages (5)

***HPV (report only to state): (10)**
Biopsy proven ❑ CIN 2 ❑ CIN 3 ❑ AIS
or their equivalent (specify): _____
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)
Lyme disease (6)
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 (8) 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. _____)
Vibrio infection (1) (species) _____
Yellow fever
Yersiniosis (species) _____

Diseases that are possible indicators of bioterrorism (9)
Anthrax (1)
Botulism
Brucellosis (1)
*** Glanders (1)**
Gram positive rods in blood or CSF, growth within 32 hours
of inoculation (specify:_____)
*** Melioidosis (1)**
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 positive broth. For positive HIV and IgM anti-HAV, send ≥ 0.5 mL residual serum. For positive IgM anti-HBc, send ≥ 0.5 mL residual serum within 6 months.
2. Specify species/serogroup.
3. Sterile site isolates: defined as sterile fluids (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous), bone, internal body site (lymph node, brain, heart, liver, spleen, kidney, pancreas, or ovary), 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 all viral load tests, including those with no virus detectable, with name and street address.
6. Only laboratories with automated electronic reporting to the DPH surveillance database are required to report positive results.
7. Report all IgM titers, but only IgG titers that are considered significant by the laboratory performing the test.
8. Report all bacterial isolates from blood or CSF obtained from an infant <7 days old.
9. Report by telephone to the DPH, weekdays 860-509-7994; nights, weekends, and holidays 860-509-8000.
10. ***On request from DPH and if adequate tissue is available, send fixed tissue from the specimen used to diagnose CIN2, 3 or cervical AIS or their equivalent for HPV typing according to instructions from DPH (CIN = cervical intraepithelial neoplasia; AIS = adenocarcinoma-in-situ)**

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

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In This Issue... **Reportable Diseases and Laboratory Findings for 2008, Persons Required to Report.**

Persons Required to Report Reportable Diseases

1. Every health care provider who treats or examines any person who has or is suspected to have a reportable disease shall report the case to the local director of health or other health authority within whose jurisdiction the patient resides and to the Department of Public Health.
2. If the case or suspected case of reportable disease is in a health care facility, the person in charge of such facility shall ensure that reports are made to the local director of health and Department of Public Health. The person in charge shall designate appropriate infection control or record keeping personnel for this purpose.
3. If the case or suspected case of reportable disease is not in a health care facility, and if a health care provider is not in attendance or is not known to have made a report within the appropriate time, such report of reportable diseases shall be made to the local director of health or other health authority within whose jurisdiction the patient lives and the Department of Public Health by:
   A. the administrator serving a public or private school or day care center attended by any person affected or apparently affected with such disease;
   B. The person in charge of any camp;
   C. The master or any other person in charge of any vessel lying within the jurisdiction of the state;
   D. The master or any other person in charge of any aircraft landing within the jurisdiction of the state;
   E. The owner or person in charge of any establishment producing, handling, or processing dairy products, other food or non-alcoholic beverages for sale or distribution;
   F. Morticians and funeral directors.

Persons Required to Report Laboratory Significant Findings

The director of a laboratory that receives a primary specimen or sample, which yields a reportable laboratory finding, shall be responsible for reporting such findings within 48 hours to the local director of health of the town in which the affected person normally resides. In the absence of such information, the reports should go to the town from which the specimen originated and to the Department of Public Health.