EPIDEMIOLOGY SECTION

Connecticut Epidemiologist

STATE OF CONNECTICUT DEPARTMENT OF HEALTH SERVICES
FREDERICK G. ADAMS, D.D.S., M.P.H., Commissioner

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INFLUENZA UPDATE

The most recent U.S. Public Health Service Immunization Practices Advisory Committee (ACIP) recommendations for use of 1987-88 influenze vaccine* (MMWR 1987; 36:373-387) are summarized below:

Age Group	Product†	Dosage(ml)	Number of Doses	Route¶
6-35 mos	Split virus only	0.25	2**	IM
3-12 yrs.	Split virus only	0.5	2**	IM
>12 yrs.	Whole or split virus	0.5	1	IM

*Contains 15 ug each of A/Taiwan/1/86(H1N1), A/Leningrad/360/86(H3N2), and B/Ann Arbor/1/86 hemagglutinin antigens in each 0.5 ml.
†Because of their lower potential for causing febrile reactions, only split (subvirion) vaccines should be used in children.
¶The recommended site of vaccination for adults and older children is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh.
**Two doses are recommended for maximum protection, with at least four weeks between doses. However, if the individual received at least one dose of influenza vaccine between the 1978-79 and 1986-87 influenza seasons, one dose is sufficient.

The ACIP has subclassified the high-risk groups for whom influenza vaccine is recommended:

Greatest Risk: a) Adults and children with chronic cardiovascular or pulmonary system conditions severe enough to have required regular medical follow-up or hospitalization during the preceding year. b) Residents of nursing homes and other chronic care facilities housing patients of any age with chronic medical conditions.

Groups at Moderate Risk: a) Otherwise healthy persons 65 years and older. b) Adults and children with chronic metabolic diseases (including diabetes mellitus), renal dysfunction, anemia, and immunosuppression that required regular medical follow-up or hospitalization during the preceding year. c) Children and teenagers (6 months through 18 years of age) on long-term aspirin therapy.

Groups Capable of Infecting High-Risk Persons: Physicians, nurses, and other personnel (e.g., primary care and certain specialty clinicians and staff of chronic care facilities and intensive-care units, particularly neonatal intensive-care units), visiting nurses, volunteer workers, and family/household members who have extensive contact with the patients at greatest risk, as described above.

The ACIP strongly recommends annual influenza immunization for the above persons, unless a contraindication exists. the Committee recommends that the vaccine be given in clinics, nursing homes, other chronic care facilities, physicians' offices, and hospitals each November. Vaccine can be given earlier (September-October) if influenza activitiy begins earlier than normal regionally, or if high-risk patients who are discharged from the hospital or outpatient clinics earlier in the fall may not be seen again until after November. Influenza vaccine can be administered simultaneously (but at separate anatomic sites) with pneumococcal vaccine, tetanus-diptheria toxoids, or any of the routinely given pediatric vaccines.

While not making a strong recommendation for these groups, the ACIP states that persons providing essential community services (e.g., police and fire department staff) may be considered for immunization during severe influenza epidemics and that any persons wishing to reduce his/her chances of influenza may be given the vaccine by his/her physician, unless a contraindication exists. Copies of the ACIP recommendations are available on request (566-5058).

INFLUENZA TESTING

Fee Exemption for Throat Swabs Submitted for Influenza Testing

Isolation and identification of influenza virus is an important part of the State's influenza surveillance system. Identification of the dominant circulating influenza virus(es) each season is useful for predicting the number of cases and severity of illness. In addition, distinguishing outbreaks caused by influenza A from those caused by influenza B and other respiratory viruses is essential to help physicians decide whether to recommend amantadine prophylaxis and treatment for their high-risk patients. The most effective way to identify the dominant virus(es) is by virus isolation from throat swabs collected from acutely ill patients early in the flu season.

Therefore, the State of Connecticut Department of Health Services encourages physicians to submit throat swabs for virus isolation to the virology laboratory from patients with a typical influenza syndrome (abrupt onset of fever, myalgia, and cough). Specimens should be collected no later than three days after onset of symptoms and sent immediately to the virology laboratory, on wet ice if possible.

Throat swab kits (VRCs) may be obtained from the Health Laboratory (566-2824).

To facilitate influenza surveillance in Connecticut, throat swabs submitted by a health care provider for influenza will be exempt from fees effective December 1, 1987 and until January 31, 1988. In order to be eligible for the fee exemption, the physician must specify "FLU STUDY" in section #1 of the Virology request form. All requested information on the form should be provided as well.

In addition, health care providers are encouraged to report, as early as possible, clusters of influenza-like illness occurring in nursing homes and other health-care institutions. Assistance in the investigation of influenza outbreaks can be arranged through the State Epidemiology Program at 566-5058.

SHIGELLA UPDATE

Surveillance for Multiply Resistant Shigella sonnei, Nationwide Dissemination Following a Common-Source Outbreak

In July, 1987, a large outbreak of multiply resistant Shigella sonnei gastroenteritis occurred among persons who attended the Rainbow Family Gathering in North Carolina. Approximately 12,000 persons from throughout the country attended, and the attack rate may have been greater than 50 percent. Subsequent surveillance has identified culture-confirmed infection in 75 attendees from 26 States* and in 14 contacts of these persons. The latter group presumably acquired their infections by person-to-person transmission. The Shigella sonnei isolates obtained from these cases are resistant to most antibiotics usually used to treat shigellosis, including ampicillin, tetracycline, and trimethoprim-sulfamethoxazole. Resistance to trimethoprim-sulfa has previously been very uncommon in isolates from Shigella sonnei infections acquired in the United States.

As of early September, the Centers for Disease Control received reports of two small clusters of infections caused by this resistant organism among persons who had no apparent contact with those who attended the Gathering. Further spread into communities may present

significant problems for both clinical treatment of severe cases and adequate control of outbreaks. In the past, use of trimethoprim-sulfa has proved effective in both of those circumstances, but widespread dissemination of this organism would make sensitivity testing of Shigella isolates necessary to ensure appropriate antibiotic use. In addition, antibiotic sensitivity testing of Shigella isolates can facilitate surveillance, early identification, and prompt reporting to help prevent further spread in communities where the organism is identified. The antibiotic sensitivity pattern of the outbreak strain shows resistance to ampicillin, carbenicillin, cephalothin, chloramphenicol, erythromycin, sulfa, tetracycline, and trimethoprim-sulfamethoxazole.

Infections that are caused by this multiply resistant Shigella and that require antimicrobial therapy can be treated with nalidixic acid or norfloxacin. Although studies in other countries suggest that both nalidixic acid and norfloxacin are effective for the treatment of shigellosis, it is important to note that neither nalidixic acid nor norfloxacin has been approved by the Food and Drug Administration (FDA) for treatment of bacterial gastroenteritis. Both nalidixic acid and norfloxacin are quinolones, and care should be exercised in prescribing either one for children because of experimental evidence that quinolones can cause arthropathy in young animals. No such lesions have been reported to the FDA in association with nalidixic acid therapy in humans. Life threatening infections are rare with S. sonnei, but could be treated with gentamicin or chloramphenicol, to which the outbreak strain is sensitive.

Clinicians should be aware of the problem of multiply resistant Shigella sonnei and the need for appropriate diagnostic laboratory testing and prompt reporting to the public health officials. The Shigella surveillance system will help us to identify early spread of the multiply resistant strain in to the community, to apply control measures, and to provide advice on prevention and treatment for practicing physicians and local public health personnel. Please direct any general questions to the Epidemiology Program (566-5058).

AIDS Update: State Supported Counseling & Testing Sites

Bridgeport Health Department
752 East Main Street
Bridgeport, CT 06608
Tel. 576-7469

Danbury Health Department at
Public Health/Danbury Hospital
24 Locust Avenue
Danbury, CT 06810
Tel. 797-7900

Greenwich Health Department
Town Hall
101 Field Point
Greenwich, CT
Tel. 622-6488

Hartford Gay Health Collective
Community Health Services
520 Albany Ave
Hartford, CT 06103
Tel. 724-5194

Hartford Health Department
Burgdorff Health Center
80 Coventry Street
Hartford, CT 06112
Tel. 722-6742

New Haven Health Department
1 State Street
New Haven, CT 06511
Tel. 787-6453

New London Health Department
120 Broad Street
New London, CT 06320
Tel. 447-AIDS, 447-2437

Norwalk Health Department
137-139 East Avenue
Norwalk, CT 06851
Tel. 854-7976

Norwich Health Department at
William Backus Hospital
STD Clinic
326 Washington Street
Norwich, CT 06360
Tel. 823-6343

Stamford Health Department
299 North Street
Stamford, CT 06902
Tel. 977-4399, 967-AIDS

Waterbury Health Department at
Public Health Nursing
232 North Elm Street
Waterbury, CT 06702
Tel. 574-6883

STAFF ASSIGNMENTS

As of July 1, 1987, Dr. Lyle Petersen has taken a position with the Surveillance Branch in the AIDS Program at the Centers for Disease Control in Atlanta, Georgia, where he is a resident in preventive medicine. Dr. Petersen made important contributions to the Epidemiology Section during his 2-year assignment here with CDC's Epidemic Intelligence Service. We wish him well in his new assignment.

In July, 1987, Dr. Tom Farley took up his post as the new Epidemic Intelligence Service Officer for Connecticut. Dr. Farley is a pediatrician who received his medical education at Tulane University and completed his residency training at Northwestern University in Chicago, Illinois. Before joining us here in Connecticut, Dr. Farley spent a year in Haiti, working on a village-based health care project.

COMMUNICABLE DISEASES REPORTED

CONNECTICUT
Week 1-36

(Thru September 11, 1987)

Name	1987 To Date	1986 To Date	% Change From 1986
AIDS	122	121	+ .83
GONORRHEA	6942	7070	- 1.8
SYPHILIS P&S	203	102	+ 99.0
MEASLES	22	3	+633.3
RUBELLA	0	1	-100.0
TUBERCULOSIS	113	127	- 11.0
HEPATITIS A	119	107	+ 11.2
HEPATITIS B	200	277	- 27.8
SALMONELLOSIS	1091	680	+ 60.4
SHIGELLOSIS	160	71	+125.4

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EPIDEMIOLOGY SECTION
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