Connecticut Epidemiologist

CONNECTICUT PUBLIC HEALTH

Changes to the Lists of Reportable Diseases, Emergency Illnesses and Health Conditions, and Laboratory Findings - July 2024 Update

Effective July 1, 2024, pursuant to Section 19a-2a of the Connecticut General Statutes and Sections 19a-215 and 19a-36-A7 of the Regulations of Connecticut State Agencies, Manisha Juthani, MD, Commissioner of the Connecticut Department of Public Health (DPH) amends the List of Reportable Diseases, Emergency Illnesses and Health Conditions, and the List of Reportable Laboratory Findings as follows:

Blastomycosis

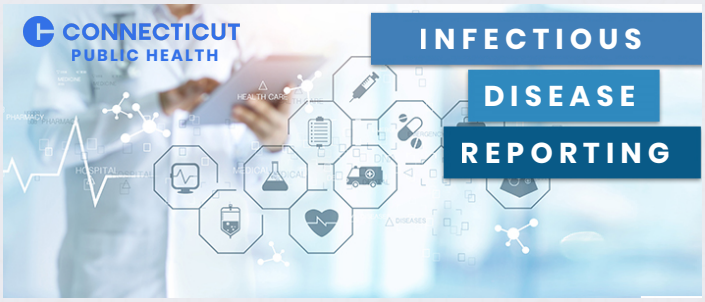
Blastomycosis, caused primarily by the fungi *Blastomyces dermatitidis* and *Blastomyces gilchristii*, is found in midwestern, south-central, and southeastern regions of the United States, and in the Great Lakes and St Lawrence River Basin in the northern United States and Canada.[1]

The identification of cases of blastomycosis in New York and New England suggest an expansion of the environmental range of the fungus, and a potential expansion of the population at risk.[2] Blastomycosis is not nationally notifiable, and is reportable in just 6 states. In 2019, 240 confirmed and probable blastomycosis cases were reported to CDC; 65% of blastomycosis patients were hospitalized, and 9% of blastomycosis patients died.[1]

To better understand the epidemiology of blastomycosis, including endemic range and populations at risk, statewide provider (Category 2) and laboratory surveillance for blastomycosis will begin July 1, 2024. Separate instructions on laboratory reporting criteria will be provided.

1 Smith DJ, Williams SL, Endemic Mycoses State Partners Group, Benedict KM, Jackson BR, Toda M. Surveillance for Coccidioidomycosis, Histoplasmosis, and Blastomycosis — United States, 2019. MMWR Surveill Summ 2022;71(No. SS-7):1–14. Doi: 10.15585/mmwr.ss7107a1

2 Ross JJ, Koo S, Woolley AE, Zuckerman RA. Blastomycosis in New England: 5 Cases and a Review. Open Forum Infectious Diseases 2023; 10(1): ofad029. doi.org/10.1093/ofid/ofad029



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Changes at a Glance

Disease	Healthcare Provider Reporting	Laboratory Reporting
Blastomycosis	Added	N/A
Blastomyces spp.	N/A	Added
Histoplasmosis	Added	N/A
H. capsulatum	N/A	Added
E. coli invasive disease (<1 year of age)	Added 1/2024	Added 1/2024
E. coli invasive disease (≥ 1 year of age)	N/A	Added
Negative HIV 1/2 Ab/Ag	N/A	Added

Contact Connecticut Epidemiologist

Connecticut Department of Public Health

(860) 509-7994

dph.epi@ct.gov

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Changes to the Lists of Reportable Diseases, Emergency Illnesses and Health Conditions, and Laboratory Findings - July 2024 Update *(continued)*

Histoplasmosis

Histoplasmosis occurs following the inhalation of spores of the fungus *Histoplasma capsulatum*, which is found in soil, with significant exposures possible in soil that is contaminated with bird or bat guano. In North America, histoplasmosis has been considered endemic to the Mississippi and Ohio River valleys. In 2019, 1,124 cases of histoplasmosis were reported to the Centers for Disease Control and Prevention (CDC).[1] More than half of histoplasmosis cases (54%) were hospitalized, and 5% of histoplasmosis cases died. [1]

Current understanding of the range and distribution of the *Histoplasma capsulatum* fungus and clinical cases of histoplasmosis is limited by multiple factors. Histoplasmosis is not a nationally notifiable condition and is currently reportable in just 14 states. Among states where histoplasmosis is reportable, surveillance is limited to clinical cases that have received a diagnosis, which is highly dependent on clinician suspicion and diagnostic testing capacity. Studies to detect broad population-level measures of exposure, such as histoplasmin skin test reactivity surveys have not been conducted in recent years.

Recent literature suggests that the endemic range of histoplasmosis in the United States might be expanding.[2] Because diagnostic delays can lead to poor clinical outcomes, statewide healthcare provider (Category 2) and laboratory surveillance for histoplasmosis will help to define risk and provide data to inform diagnostic and clinical decision-making. Separate instructions on laboratory reporting criteria will be provided.

1 Smith DJ, Williams SL, Endemic Mycoses State Partners Group, Benedict KM, Jackson BR, Toda M. Surveillance for Coccidioidomycosis, Histoplasmosis, and Blastomycosis — United States, 2019. MMWR Surveill Summ 2022;71 (No. SS-7):1–14. DOI: 10.15585/mmwr.ss7107a1

2 Ashraf, Nida et al. "Re-drawing the Maps for Endemic Mycoses" Mycopathologia 2020; 185(No. 5):843–865. DOI: 10.1007/s11046-020-00431-2 (0123456789().,-volV)

Escherichia coli invasive disease

Invasive *E. coli* (iEC) disease is responsible for significant morbidity and mortality in the United States, accounting for 27% of documented episodes of bacteremia.[1] Mortality related to iEC disease ranges from 12–22%.[1] [2] Invasive *E. coli* infections are also a significant cause of morbidity and mortality among neonates, in particular premature infants.

Given the burden of iEC disease, CDC-funded Emerging Infections Program (EIP) sites are implementing enhanced surveillance for iEC. As part of this work, identification of *E. coli* in a normally sterile body site from an infant <1 year of age was added as a Category 2 disease and as a reportable laboratory finding in January 2024. To date, laboratory and case surveillance of iEC among individuals ≥1 year of age has been limited to isolates exhibiting carbapenem resistance. Expansion of iEC laboratory surveillance to include reports of all isolates, regardless of phenotypic resistance observed and patient age, will provide more complete information on the mechanisms of antimicrobial resistance in invasive *E. coli* across the age continuum through comprehensive population-based surveillance.

Beginning July 1, 2024, two changes will take place related to iEC reporting. First, statewide laboratory reporting of *E. Coli* isolated from normally sterile body sites will expand to all ages. Second, iEC isolate submission for individuals >1 year of age will be required at a subset of laboratories as determined by DPH.

Laboratories statewide should continue to submit iEC isolates from infants (<1 year of age) to the State Public Health Laboratory. Laboratories not participating in iEC isolate submission for individuals ≥1 year of age should continue to submit carbapenem resistant *E. coli* (CRE) isolates. iEC will remain healthcare provider reportable only for infants <1 year of age. Healthcare provider case reporting (via PD-23 or electronic reporting through CTEDSS) is not required for cases of iEC in individuals ≥1 year of age.

iEC Reporting Actions

	Provider Report?	Lab Report?	Send isolate?
iEC in patients <1 year of age	Yes	Yes	Yes
iEC in patients ≥ 1 year of age	No	Yes	Yes - selected labs only
CRE	No	Yes	Yes

1 Bonten M, et al, Hermans P, Poolman JT. Epidemiology of *Escherichia coli* Bacteremia: A Systematic Literature Review. Clinical Infectious Diseases 2020; 72(7):1211–1219. doi.org/10.1093/cid/ciaa210.

2 Doua J, et al. Epidemiology, Clinical Features, and Antimicrobial Resistance of Invasive *Escherichia Coli* Disease in Patients Admitted in Tertiary Care Hospitals. Open Forum Infectious Diseases 2023; 10(2): doi.org/10.1093/ofid/ofad026.

Changes to the Lists of Reportable Diseases, Emergency Illnesses and Health Conditions, and Laboratory Findings - July 2024 Update *(continued)*

HIV

Human immunodeficiency virus (HIV) is the pathogen that causes acquired immune deficiency syndrome (AIDS). HIV disease is the term that encompasses all of the condition's stages—from infection to the deterioration of the immune system and the onset of opportunistic diseases.

In 2014, CDC and the Association of Public Health Laboratories (APHL) introduced a new diagnostic testing method for detecting HIV-1, HIV-2, and acute HIV infection called the Laboratory HIV Testing Algorithm for Serum or Plasma Specimens. In 2019, the APHL published additional resources to assist laboratories with interpretation and reporting language for 12 potential algorithm outcomes.[1] The 3-step diagnostic test method employs an HIV-1/2 antigen/antibody (Ab/Ab) combination immunoassay (Step 1), a supplemental HIV-1/HIV-2 antibody type-differentiating immunoassay (Step 2), and, if the results of Steps 1 and 2 are discordant, a nucleic acid amplification test (NAAT, Step 3).

Adding negative HIV-1/2 Ag/Ab combination immunoassay results (Step 1) as a reportable laboratory finding is essential to identifying early HIV infection (Stage 0), inferred from a negative HIV test result within 6 months of a confirmed positive result.[2] It will allow DPH to identify and prioritize follow-up for the most infectious HIV cases to reduce onward transmission. Identification and prioritization of Stage 0 HIV infection cases will also help DPH understand how well initiatives to prevent HIV spread, such as PrEP, are working.

1 Suggested Reporting Language for the HIV Laboratory Diagnostic Testing Algorithm

2 Revised surveillance case definition for HIV infection--United States, 2014

Health Care Provider Reportable Diseases, Emergency Illnesses and Health Conditions: Category 1

Physicians and other health care providers are required to report using the Reportable Disease Case Report form (PD-23) or other disease specific form.

Diseases with specialized reporting forms are asterisked (*) in the disease list below. Links to reporting forms are available in the lower left column. All forms can be found on the DPH "Forms" webpage.

Reporting Category 1 Diseases

1. Report to DPH by phone on the day of diagnosis or suspicion.
   Business hours: (860) 509-7994
   Evenings, weekends, holidays: (860) 509-8000
2. Complete and submit a PD-23 within 12 hours.
3. Report to the local Director of Health for the town where the patient resides.

- Acute HIV Infection* [1, 2]
- Anthrax
- Botulism
- Brucellosis
- Cholera
- Diphtheria
- Measles
- Melioidosis
- Meningococcal disease
- Outbreaks
  - foodborne (involving ≥ 2 persons)
  - institutional
  - unusual disease or illness [3]
- Plague
- Poliomyelitis
- Q fever
- Rabies
- Ricin poisoning
- Severe Acute Respiratory Syndrome (SARS)
- Smallpox
- Staphylococcal enterotoxin B pulmonary poisoning
- *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin [1]
- Syphilis, congenital*
- Tuberculosis*
- Tularemia
- Venezuelan equine encephalitis virus infection
- Viral hemorrhagic fever
- Yellow fever

Footnotes

Category 1 Diseases

1. Report only to DPH.
2. As described in the CDC case definition.
3. Individual cases of "significant unusual illness" are also reportable.

Specialized Reporting Forms

Report Type	Fax to:
HIV Case Report Form	(860) 509-8237
Sexually Transmitted Diseases	(860) 730-8380
Tuberculosis Report Form	(860) 730-8271

Health Care Provider Reportable Diseases, Emergency Illnesses and Health Conditions: Category 2

Reporting Category 2 Diseases

1. Complete and submit a PD-23 within 12 hours.
2. A Hospital IP entering a case in CTEDSS (when applicable) satisfies the reporting requirement.
3. Diseases with specialized reporting forms are asterisked (*) in the list below.

Note: Reporting changes for July 2024 are in **bold font**.

- Acquired Immunodeficiency Syndrome (AIDS)* [1, 2]
- Acute flaccid myelitis
- Anaplasmosis
- Babesiosis
- **Blastomycosis**
- *Borrelia miyamotoi* disease
- California group arbovirus infection
- Campylobacteriosis
- *Candida auris*
- Chancroid
- Chickenpox (Varicella)*
- Chickenpox-related death*
- Chikungunya
- Chlamydia (*C. trachomatis*) (all sites)*
- COVID-19 (SARS-CoV-2 infection) [4]
- COVID-19 death
- COVID-19 hospitalization
- *Cronobacter*
- Cryptosporidiosis
- Cyclosporiasis
- Dengue
- E-cigarette or vaping product use associated lung injury (EVALI)*
- Eastern equine encephalitis virus infection
- *Ehrlichia chaffeensis* infection
- *Escherichia coli* O157:H7 infection
- *Escherichia coli*, invasive in infants <1 year of age [5]
- Gonorrhea*
- Group A Streptococcal disease, invasive [5]
- Group B Streptococcal disease, invasive [5]
- *Haemophilus influenzae* disease, invasive [5]
- Hansen's disease (Leprosy)
- Healthcare-associated infections [6]
- Hemolytic-uremic syndrome [7]
- Hepatitis A
- Hepatitis B
  - acute infection [2]
  - HBsAg positive pregnant women
- Hepatitis C
  - acute infection [2]
  - perinatal infection
  - positive rapid antibody test result
- **Histoplasmosis**
- HIV-1/HIV-2 infection* [1, 2]
- HPV: biopsy proven CIN 2, CIN 3, or AIS or their equivalent [1]
- Influenza-associated death
- Influenza-associated hospitalization
- Legionellosis
- Listeriosis
- Malaria
- Mercury poisoning
- Mpox
- Multisystem inflammatory syndrome in children (MIS-C)
- Mumps
- Neonatal bacterial sepsis [8]
- Occupational asthma*
- Pertussis
- Pneumococcal disease, invasive [5]
- Powassan virus infection
- Respiratory Syncytial Virus (RSV) associated death
- RSV-associated hospitalization
- Rocky Mountain spotted fever
- Rubella (including congenital)
- Salmonellosis
- Shiga toxin-related diseases (gasteroenteritis)
- Shigellosis
- Silicosis
- St. Louis encephalitis virus infection
- *Staphylococcus aureus* methicillin-resistant disease, invasive, community acquired [5, 9]
- *Staphylococcus epidermidis* disease, reduced or resistant susceptibility to vancomycin [1]
- Syphilis*
- Tetanus
- Trichinosis
- Typhoid fever
- *Vaccinia* disease
- *Vibrio* infection (*V. parahaemolyticus*, *V. vulnificus*, others)
- West Nile virus infection
- Zika virus infection

Footnotes

Category 2 Diseases

1. Report only to DPH.
2. As described in the CDC case definition.
3. Individual cases of "significant unusual illness" are also reportable.
4. Report COVID-19 cases only when a diagnostic test was performed on-site in a healthcare facility (provider's office, urgent care clinic, long-term care facility, etc.).
5. Invasive disease: from sterile fluid (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous), bone, internal body sites, or other normally sterile site, including muscle.
6. Report HAIs according to current CMS pay-for-reporting or pay-for-performance requirements. Detailed instructions on the types of HAIs, facility types and locations and methods of reporting are available on the DPH website.
7. On request from the DPH and if adequate serum is available, send serum from patients with HUS to the State Public Health Laboratory for antibody testing.
8. Clinical sepsis and blood or CSF isolate obtained from an infant < 3 days of age.
9. Community-acquired: infection present on admission to hospital, and person has no previous hospitalizations or regular contact with the health-care setting.

Specialized Reporting Forms

Report Type	Fax to:
Chickenpox (Varicella) Report	(860) 707-1905
HIV Case Report Form	(860) 509-8237
Occupational Diseases Report	(860) 730-8424
Sexually Transmitted Diseases	(860) 730-8380
Vaping Lung Injury Case Report	(860) 706-1262

Contact DPH Infectious Disease Programs

Program	Phone:
Epidemiology & Emerging Infections	(860) 509-7994
Healthcare Associated Infections	(860) 509-7995
HIV/HCV Surveillance Program	(860) 509-7900
Immunization Program	(860) 509-7929
STD Control Program	(860) 509-7920
Tuberculosis Control Program	(860) 509-7722

Reportable Laboratory Findings

The director of a clinical laboratory must report laboratory evidence suggestive of reportable diseases. The Reportable Laboratory Findings Form (OL-15C) can be found on the DPH "Forms" webpage.

- *Anaplasma phagocytophilum* PCR IgG ≥1:128 only
- *Babesia* IFA IgM (titer) IgG (titer)
  - Blood smear PCR Other:
  - *microti* *divergens* *duncani* Unspeciated
- ***Blastomyces*** (3) spp
- *Bordetella pertussis* (titer)
  - Culture (1) DFA PCR
  - Non-pertussis Bordetella (1) spp
- *Borrelia burgdorferi* (2)
- *Borrelia mayonii*
- *Borrelia miyamotoi*
- California group virus (3) spp
- *Campylobacter* (3) spp Culture PCR EIA
- *Candida* auris [report samples from all sites] (1)
- *Candida* spp, [blood isolates only] (1,3)
- Carbapenem-resistant *Acinetobacter baumannii* (CRAB) (1,4)
- Carbapenem-resistant Enterobacterales (CRE) (1,3,4)
  - Genus spp
- Carbapenem-resistant *Pseudomonas aeruginosa* (CRPA) (1, 4)
- Carboxyhemoglobin > 5% (2) % COHb
- Chikungunya virus
- *Chlamydia trachomatis* (test type) PCR TMA
- *Clostridium difficile* (6)
- *Corynebacterium diphtheria* (1)
- *Cronobacter* (3) spp
- *Cryptosporidium* (3) spp PCR DFA
  - EIA Microscopy Other:
- *Cyclospora* (3) spp PCR Microscopy Other:
- Dengue virus
- Eastern equine encephalitis virus
- *Ehrlichia chaffeensis* PCR IgG ≥1:128 only Culture
- Enterotoxigenic *Escherichia coli* (ETEC) PCR Culture
- *Escherichia coli* O157 (1) PCR Culture
- ***Escherichia coli*, invasive** (4, 5)
- *Giardia* (3) spp
- Group A *Streptococcus*, invasive (1,4) Culture Other:
- Group B *Streptococcus*, invasive (1,4) Culture Other:
- *Haemophilus ducreyi*
- *Haemophilus influenzae*, invasive (1,4) Culture Other:
- Hepatitis A: IgM anti-HAV (7) NAAT Positive (7)
  ALT Total Bilirubin Not Done
- Hepatitis B:
  - HBsAg (8) Pos Neg IgM anti-HBc Pos Neg
  - HBeAg (2) Pos Neg HBV DNA (2)
  - anti-HBs (8) Pos (titer) Neg
- Hepatitis C (9):
  - Anti-HCV Pos Neg
  - PCR TMA Other Genotype
- Herpes simplex virus (infants < 60 days of age)
  - Culture PCR IFA Ag detection
- ***Histoplasma capsulatum*** EIA Culture Other:
- HIV Related Testing (Report only to the State) (10)
  - **HIV screen (IA)** Pos **Neg**

  Antibody Confirmation (WB/IFA/Type-diff)

  HIV-1: Pos Neg/Ind HIV-2: Pos Neg/Ind
  - HIV NAAT (or qualitative RNA) Det Not Det
  - HIV Viral Load (all results) copies/mL
  - HIV Genotype CD4 count: cells/uL; %
- HPV (Report only to the State) (11)

  Biopsy proven CIN 2 CIN 3 AIS

  or their equivalent, (specify)
- Influenza virus (report only to the State)
  - Rapid antigen (2) RT-PCR Type A Type B
  - Type Unknown Subtype:
- Lead poisoning (blood lead ≥3.5 µg/dL within 48 hrs; <3.5 µg/dL monthly)(12)
  - Fingerstick µg/dL Venous µg/dL
- *Legionella* spp
  - Culture (1) DFA Ag positive
  - Four-fold serologic change (titers)
- *Listeria monocytogenes* (1) Culture PCR
- Mercury poisoning
  - Urine ≥ 35 µg/g creatinine µg/g Blood ≥ 15 µg/L µg/L
- Monkeypox virus PCR IgM anti-MPXV Sequencing
  - Orthopoxvirus PCR IHC Sequencing
  - Non-variola orthopoxvirus PCR
- Mumps virus (13) (titer) PCR
- *Mycobacterium leprae*
- *Mycobacterium tuberculosis* Related Testing (1)
  - AFB Smear Positive Negative
    If positive Rare Few Numerous
  - NAAT Positive Negative Indeterminate
  - Culture *Mycobacterium tuberculosis*
    Non-TB *Mycobacterium* (spp)
- *Neisseria gonorrhoeae* (test type)
- *Neisseria meningitidis*, invasive (1,4) Culture Other:
- Neonatal bacterial sepsis (3,14) Genus spp
- *Plasmodium* (1,3) spp
- Poliovirus
- Powassan virus
- Rabies virus
- *Rickettsia rickettsii* PCR IgG ≥1:128 only Culture
- Respiratory syncytial virus
- Rubella virus (13) (titer)
- Rubeola virus (Measles) (13) (titer) PCR
- St. Louis encephalitis virus
- *Salmonella* (1,3) (serogroup & type)
  - Culture PCR
- SARS-CoV (1) IgM/IgG PCR Other:
- SARS-CoV-2 NAAT Antigen
- Shiga toxin (1) Stx1 Stx2 Type Unkn PCR EIA
- *Shigella* (1,3) (serogroup/spp) Culture PCR
- *Staphylococcus aureus*, invasive (4) Culture Other:
  methicillin-resistant methicillin-sensitive
- *Staphylococcus aureus*, vancomycin MIC ≥ 4 µg/mL (1)
  - MIC to vancomycin µg/mL
- *Staphylococcus epidermidis*, vancomycin MIC ≥ 32 µg/mL (1)
  - MIC to vancomycin µg/mL
- *Streptococcus pneumoniae*
  - Culture (1,4) Urine antigen Other (4)
- *Treponema pallidum*
  - RPR (titer) FTA EIA
  - VDRL (titer) TPPA
- *Trichinella*
- Varicella-zoster virus
  - Culture PCR DFA Other:
- *Vibrio* (1,3) spp Culture PCR
- West Nile virus
- Yellow fever virus
- *Yersinia*, not pestis (1,3) spp Culture PCR
- Zika virus
- BIOTERRORISM AGENTS (15)
  - *Bacillus anthracis* (1)
  - *Brucella* spp (1)
  - *Burkholderia mallei* (1)
  - *Burkholderia pseudomallei* (1)
  - *Clostridium botulinum*
  - *Coxiella burnetii*
  - *Francisella tularensis*
  - Ricin
  - *Staphylococcus aureus*-enterotoxin B
  - Variola virus (1)
  - Viral agents of hemorrhagic fevers
  - Venezuelan equine encephalitis virus
  - *Yersinia* pestis (1)

Footnotes

1. Send isolate/specimen to the State Public Health Laboratory. Send laboratory report (electronic or paper) on first identification of an organism. For CRE, CRAB, and CRPA, include antimicrobial test results with report. For GBS, send isolate for cases <1 year of age. For *Salmonella*, *Shigella*, *Vibrio*, and *Yersinia* (not pestis) tested by non-culture methods, send isolate if available; send stool specimen if no isolate available. For Shiga toxin-related disease, send positive broth or stool specimen.
2. Only laboratories with electronic file reporting are required to report positive results.
3. Specify species/serogroup/serotype.
4. Sterile site: 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 including muscle. For CRE, CRAB and CRPA also include urine or sputum; for CRAB and CRPA, also include wounds.
5. Send isolate/specimen to DPH Laboratory for infants <1 year of age or upon request from DPH.
6. Report all *C. difficile* positive stool samples by electronic reporting or upon request from DPH.
7. Report peak ALT and Total Bilirubin results if conducted within one week of HAV positive test, if available. Otherwise, check "Not Done."
8. Negative HBsAg and all anti-HBs results only reportable in children ≤ 2 years old.
9. Report positive Antibody, and all RNA and Genotype results.
10. Report all HIV antibody, antigen, viral load, and qualitative NAAT results. Negative HIV 1/2 Ab/Ag, HIV genotype (DNA sequence) and all CD4 results are only reportable by electronic file reporting.
11. Upon request from the DPH, send fixed tissue from the diagnostic specimen for HPV typing.
12. Report results >3.5 µg/dL within 48 hours to the Local Health Department and DPH; submit ALL lead results at least monthly to DPH only.
13. Report all IgM positive titers; only report IgG titers considered significant by the lab that performed the test.
14. Report all bacterial isolates from blood or CSF from infants <3 days of age.
15. Call DPH: Weekdays (860) 509-7994
    Evenings, weekends, holidays (860) 509-8000

Supplemental Information for Isolate or Specimen Submission to the Connecticut State Public Health Laboratory

Reportable Finding	Which specimens should be submitted?
Bordetella pertussis and non-pertussis *Bordetella* spp.	Submit all isolates.
Candida auris	Submit first isolate/specimen from any source. Submit upon first identification of colonization and first identification of clinical infection. Submit additional isolates once every 30 days; additional susceptibility testing for clinical management may be requested. See *Candida* spp. for *C. auris* isolated from blood.
Candida spp.	Blood isolates only. Submit all *C. glabrata* and *C. auris* isolates. For other species, submit isolate upon identification of new species and every 30 calendar days for each species identified.
CRAB	See detailed guidance for multidrug resistant organisms.
CRE	See detailed guidance for multidrug resistant organisms.
CRPA	See detailed guidance for multidrug resistant organisms.
Corynebacterium diphtheria	Submit all isolates.
Escherichia coli O157	Submit first isolate per specimen source. If tested by non-culture methods, send isolate if available from reflex culture; send stool/broth specimen if no isolate available.
E. coli, invasive	Cases < 1 year of age or upon request from DPH; from sterile sites. [1] Submit one isolate per specimen source per collection date.
Group A *Streptococcus*, invasive	From sterile sites. [1] Submit one isolate per specimen source per collection date.
Group B *Streptococcus*, invasive	Cases < 1 year of age only; from sterile sites. [1] Submit one isolate per specimen source per collection date.
Human papilloma virus	Upon request from DPH, submit fixed issue from the diagnostic specimen for HPV typing.
Haemophilus influenzae, invasive	From sterile sites.[1] Submit one isolate per specimen source per collection date.
Legionella spp.	Submit all isolates.
Listeria monocytogenes	Submit all isolates.
Mycobacterium tuberculosis Related Testing	Submit first isolate, unless otherwise specified by DPH.
Neisseria meningitidis, invasive	From sterile sites.[1] Submit one isolate per specimen source per collection date.
Plasmodium spp.	Submit first specimen.
Salmonella spp.	Submit first isolate per specimen source. If tested by non-culture methods, send isolate if available from reflex culture; send stool specimen if no isolate available.
SARS-CoV	Submit all positive specimens.
Shiga toxin	Submit first positive broth or stool specimen.
Shigella spp.	Submit first isolate per specimen source. If tested by non-culture methods, send isolate if available from reflex culture; send stool specimen if no isolate available.
Staphylococcus aureus, vancomycin MIC ≥4 μg/mL	Submit one isolate per specimen source per collection date. *May require discussion with DPH if multiple positives identified depending upon stability of MIC values at clinical lab.*
Staphylococcus epidermidis, vancomycin MIC ≥32 μg/mL	Submit one isolate per specimen source per collection date. *May require discussion with DPH if multiple positives identified depending upon stability of MIC values at clinical lab.*
Streptococcus pneumoniae	From sterile sites.[1] Submit one isolate per specimen source per collection date.
Vibrio spp.	Submit first isolate per specimen source. If tested by non-culture methods, send isolate if available from reflex culture; send stool specimen if no isolate available.
Yersinia spp., not pestis	Submit first isolate per specimen source. If tested by non-culture methods, send isolate if available from reflex culture; send stool specimen if no isolate available.
Bioterrorism Agents	
Bacillus anthracis *Brucella* spp. *Burkholderia mallei* *Burkholderia pseudomallei* Variola virus *Yersinia pestis*	**Call DPH immediately.** Weekdays: (860) 509-7994. Evenings, weekends, holidays: (860) 509-8000. Submit all specimens.

1 Sterile site: 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, including muscle.

Infectious Diseases Section

Annual Statistics - Total Reported Cases, Statewide, by Disease, 2021 and 2022

REPORTED DISEASES	2021	2022
Acute flaccid myelitis	0	1
Anaplasmosis	140	80
Anthrax	0	0
Babesiosis	281	115
Borrelia miyamotoi disease	14	7
Botulism, infant	2	0
Brucellosis	0	0
California encephalitis virus disease	0	0
Campylobacteriosis	722	714
Candida auris - clinical	1	2
Candida auris - colonization	0	0
Candidemia	292	248
Carbapenem-resistant Enterobacterales (CRE) - clinical	353	316
Carbapenemase-producing CRE (CP-CRE) - clinical	93	79
Carbapenem-resistant *Acinetobacter baumanii* (CRAB) - clinical	5	15
Carbapenemase-producing CRAB (CP-CRAB) -clinical	2	8
Carbapenemase-producing Organism (CPO) -colonization	4	40
Chancroid	0	0
Chikungunya virus diseases	0	0
Chlamydia trachomatis infection	14,750	12,738*
Cholera (toxigenic *Vibrio cholerae* O1 or O139)	1	3
Coronavirus Disease (COVID-19)	379,698	289,266
Cryptosporidiosis	71	52
Cyclosporiasis	27	25
Dengue virus infections	0	4
Diphtheria	0	0
Eastern equine encephalitis virus disease	0	0
Ehrlichiosis	8	5
Enterotoxigenic *E. coli* (ETEC)	62	134
Giardiasis	151	182

*Data still under review

Infectious Diseases Section

Annual Statistics - Total Reported Cases, Statewide, by Disease, 2021 and 2022

REPORTED DISEASES	2021	2022
Gonorrhea	5,405	4,979*
Group A Streptococcal disease, invasive	77	143
Group B Streptococcal disease, invasive	369	382
Haemophilus influenzae, invasive	18	53
Hansen's disease (Leprosy)	0	0
Hemolytic uremic syndrome postdiarrheal	2	0
Hepatitis A, acute	11	5
Hepatitis B, acute	0	0
Hepatitis B, chronic	356	335
Hepatitis B, perinatal infection	0	0
Hepatitis C, acute	36	14
Hepatitis C, chronic	809	766
Hepatitis C, perinatal infection	3	0
HIV	233	222
Legionellosis	118	115
Listeriosis	19	15
Lyme disease	541	2,022
Malaria	7	19
Measles (rubeola)	2	0
Melioidosis	0	NR
Meningococcal disease (*Neisseria meningitidis*)	4	2
Mpox	NR	145
Mumps	1	1
Neonatal sepsis	7	15
Pertussis	7	7
Plague	0	0
Pneumococcal disease, invasive (*Streptococcus pneumoniae*)	120	199
Poliomyelitis	0	0
Powassan virus disease	3	6
Q fever	0	0

*Data still under review | NR: Not reportable

Infectious Diseases Section

Annual Statistics - Total Reported Cases, Statewide, by Disease, 2021 and 2022

REPORTED DISEASES	2021	2022
Rabies, human	0	0
Rocky Mountain spotted fever	4	1
Rubella	0	0
Salmonellosis (excluding S. Typhi infection and S. Paratyphi infection)	434	454
Severe Acute Respiratory Syndrome -associated Coronavirus disease (SARS-CoV)	0	0
Shiga toxin-producing *Escherichia coli* (STEC)	114	147
Shigellosis	93	119
Smallpox	0	0
St. Louis encephalitis virus disease	0	0
Staphylococcus aureus, methicillin-resistant (MRSA), invasive	671	709
Staphylococcus aureus, methicillin-sensitive (MSSA), invasive	1,577	1,499
Staphylococcus aureus, vancomycin-intermediate (VISA)	0	3
Staphylococcus aureus, vancomycin-resistant (VRSA)	0	0
Syphilis, congenital	6	7
Syphilis, early non-primary, non-secondary	284	275*
Syphilis, primary	130	101*
Syphilis, secondary	199	147*
Syphilis, unknown duration or late	269	230*
Tetanus	0	0
Trichinellosis	0	0
Tuberculosis	54	67
Tularemia	0	0
Typhoid (*S. typhi*)/paratyphoid (*S. paratyphi*) fever	11	13
Varicella (Chickenpox)	43	67
Venezuelan equine encephalitis virus	0	0
Vibriosis (any species of the family Vibrionaceae, other than toxigenic *Vibrio cholerae* O1 or O139)	51	52
Viral hemorrhagic fevers	0	0
West Nile virus disease	7	7
Yellow Fever	0	0
Yersiniosis	74	102
Zika virus	0	0

*Data still under review

Persons Required to Report Reportable Diseases, Emergency Illnesses and Health Conditions

1. Health care providers who treat or examine any person who has or is suspected to have a reportable disease, emergency illness or health condition 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, emergency illness or health condition 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 the 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, emergency illness or health condition 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 disease, emergency illness or health condition 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, emergency illness or health condition;
   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 Significant Laboratory 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. Reports must include name, address, contact phone number, date of birth, race, ethnicity, gender, and occupation of patient.

IMPORTANT...

1. The Reportable Disease Case Report Form (PD-23) can be used to report conditions on the current list, unless there is a specialized form or other authorized method.
2. The Laboratory Report of Significant Findings Form (OL-15C) can be used by staff of clinical laboratories to report evidence suggestive of reportable diseases.
3. Reporting forms can be found at: (https:// portal.ct.gov/DPH/Communications/Forms/Forms).
4. Please follow these guidelines when submitting paper reports:
   - Forms must include name, address, and phone number of person reporting and healthcare provider, infectious agent, test method, date of onset of illness, and name, address, date of birth, race, ethnicity, gender, and occupation of patient.
   - Fax completed PD-23 forms to DPH via fax number (860) 629-6962.
   - Fax completed OL-15C forms to DPH via fax number (860) 920-3131.

CONNECTICUT PUBLIC HEALTH

Manisha Juthani, MD — **Commissioner**

Lynn Sosa, MD — **State Epidemiologist**

Infectious Diseases Section Programs

Epidemiology & Emerging Infections	(860) 509-7994	HIV Healthcare and Support Services	(860) 509-7801
Healthcare Associated Infections	(860) 509-7995	Immunization Program	(860) 509-7929
HIV/HCV Prevention Program	(860) 509-7797	STD Control Program	(860) 509-7920
HIV/HCV Surveillance Program	(860) 509-7900	Tuberculosis Control Program	(860) 509-7722

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