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Reportable Diseases and Laboratory Reportable Significant Findings - Changes for 2009

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 three additions and one modification to the lists effective January 1, 2009.

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

Neonatal herpes
Nationally, herpes infection among infants has high morbidity and mortality rates. Mortality rates for untreated central nervous system or disseminated disease range from 50–85%. In Connecticut, neonatal herpes has been physician reportable for many years. For 2009, the age of infants that physicians report has been changed from <30 days to ≤ 60 days. Also, laboratories are now required to report all herpes simplex virus positive clinical specimens by culture, antigen detection, polymerase chain reaction/nucleic acid amplification, or immunoflorescence assay in infants ≤ 60 days of age. The purpose of this surveillance is to establish a baseline measurement of the disease burden in Connecticut and to determine potential risk factors for neonatal herpes infection.

Changes to the List of Reportable Diseases

Lead toxicity
The reporting level for lead toxicity has been reduced from ≥20 µg/dL to ≥15 µg/dL, making reporting consistent with a legislative change that took effect on January 1, 2009. This change also reduces the blood lead level at which public health intervention will be required by local health departments.

Central-line associated blood stream infections
This new reportable condition category with special reporting instructions applies only to hospitals that must report certain healthcare associated infections to DPH in accordance with state law (Connecticut General Statutes § 19a-490 (n) to 19a-490 (0). It permits efficient sharing of the required data while ensuring compliance with the provisions of the federal Health Insurance Portability and Accountability Act. The reporting is made through the National Healthcare Safety Network (NHSN) data collection system using NHSN criteria, definitions, and protocols and does not use the PD-23 form.

In this issue...

Changes to the List of Laboratory Reportable Significant Findings

HIV genotype sequence (electronic file)
HIV genotype DNA sequence has been made reportable as part of a Centers for Disease Control and Prevention-funded multistate surveillance system to monitor trends in HIV drug resistance. Laboratories performing the HIV resistance test (HIV genetic sequence analysis) are required to report the DNA sequence information in the *pol* region of the HIV genome. This information is stored as an electronic file in the DNA sequencing computer. The DNA sequence file must be encrypted and sent to the DPH electronically. Staff of the DPH will contact individual laboratories to set up reporting procedures, provide encryption software, and provide training on downloading the electronic file. Laboratories should not initiate reporting until contacted by DPH staff.

Other Changes

Tuberculosis*:* There are two changes to the Laboratory Report of Significant Findings for reporting clinical specimens positive for tuberculosis. First, results from nucleic acid amplification testing (NAAT) have been added. Second, under "Culture" "Other mycobacteria" has been changed to "Non-tuberculosis mycobacteria." The species should still be specified, if known.

(cont. on page 4)

REPORTABLE DISEASES - 2009

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 2009 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)
***Central-line associated blood stream infections (Do not use this form to report) (4)**
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 (5)
Creutzfeldt-Jakob disease (age < 55 years)
Cryptosporidiosis
Cyclosporiasis
☎ Diphtheria
Ehrlichiosis/***Anaplasmosis**
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 women

Hepatitis C - acute infection (ALT > 400 IU/L)
HIV-1 exposure in infants born 1/1/2001 or later (1,7)
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 (8)
* Lead toxicity (**blood level ≥ 15 µg/dL)**
Legionellosis
Listeriosis
Lyme disease
Lymphocytic choriomeningitis virus infection
Malaria
☎ Measles
☎ Meningococcal disease
Mercury poisoning
Mumps
* Neonatal herpes **(≤ 60 days of age)**
Neonatal bacterial sepsis (9)
Occupational asthma
☎ Outbreaks:
- Foodborne (involving ≥ 2 persons)
- Institutional
- Unusual disease or illness (10)

☎ Pertussis
☎ Plague
Pneumococcal disease, invasive (6)
☎ 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 (6,11)
Staphylococcus epidermidis disease, reduced or resistant susceptibility to vancomycin (1)
Syphilis
Tetanus
Trichinosis
☎ Tuberculosis
☎ Tularemia
Typhoid fever
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. ***Applies only to licensed hospitals (as defined by CGS. Ch368V). Hospitals report central-line associated blood stream infections associated with designated intensive care unites (ICUs): any pediatric ICU in the hospital (not including neonatal ICU) and the medical ICU, or, if no medical ICU, the medical-surgical ICU. Make reports to the DPH via the National Healthcare Safety Network (NHSN) using NHSN definitions, criteria, and protocols.**
5. 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.
6. 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.*
7. "Exposure" includes infant born to known HIV-infected mother.
8. Death in child or adolescent who never fully recovers from influenza and dies from a possible complication (e.g., encephalophathy, bacterial pneumonia).
9. Clinical sepsis and blood or CSF isolate obtained from an infant < 7 days old.
10. Individual cases of "significant unusual illness" are also reportable.
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, weekends, and holidays through the DPH emergency number (860-509-8000).**

LABORATORY REPORTABLE SIGNIFICANT FINDINGS - 2009

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 2009 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/**Anaplasmosis** (2) ❑HGE/**HGA** ❑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)

***Herpes simplex virus, infant ≤ 60 days of age (specify type)**
❑ Culture ❑ PCR ❑ IFA ❑ Ag detection

***HIV genotype (electronic file) (report only to State) (5)**

HIV Infection (report only to the State) (1)
- HIV-1 infection in persons of all ages (5)

HPV (report only to state): (6)
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 (7)

Lymphocytic choriomeningitis virus infection

Malaria/blood parasites (1,2) : _____

Measles (Rubeola) (titer) (8): _____

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)
AFB Smear: ❑ Positive ❑ Negative
If positive: ❑ Rare ❑ Few ❑ Numerous
* **NAAT: ❑ Positive ❑ Negative ❑ Indeterminate**
Culture: ❑ *Mycobacterium tuberculosis*
❑ **Non-tuberculosis mycobact.** (specify: M. _____)

Vibrio infection (1) (species) _____

Yellow fever

Yersiniosis (species) _____

Diseases that are possible indicators of bioterrorism (10)

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: 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 group A *streptococcus*.
4. Report all positive anti-HCV with signal to cutoff ratio, all positive RIBA, but only confirmatory PCR tests.
*** 5. Laboratories conducting HIV genotype tests should report the HIV DNA sequence file electronically. Report all positive HIV antibody and antigen tests, and all viral load tests (including those with no virus detectable).**
6. 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.
7. Only laboratories with automated electronic reporting to the DPH are required to report positive results.
8. Report all IgM titers, but only IgG titers that are considered significant by the laboratory performing the test.
9. Report all bacterial isolates from blood or CSF obtained from an infant <7 days old.
10. Report by telephone to the DPH, weekdays 860-509-7994; nights, weekends, and holidays 860-509-8000.

Connecticut Department of Public Health
410 Capitol Ave., MS11EPI
P.O. Box 340308
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In This Issue... **Reportable Diseases and Laboratory Findings for 2009, 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.

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