



EPI-UPDATE

VOLUME 1, ISSUE 2

NOTIFIABLE CONDITIONS RULE HAS BEEN REVISED

Chapter 246-101 of the Washington Administrative Code (WAC), or the **Notifiable Conditions Rule**, which defines what diseases are reportable, who is responsible to report them, and when they are to be reported has been revised. For health care providers and facilities, added conditions include Prion Disease, lab-confirmed Influenza-associated death, and Varicella-associated death. Two conditions have been removed (Typhus and HUS to be addressed by reporting of Shigatoxin producing *E. coli*). Also, rare diseases that must be reported immediately are listed individually (e.g. Anthrax, Burkholderia, Smallpox, etc).

For clinical laboratories, the list of notifiable conditions is now consistent with the list of notifiable conditions for health care providers and facilities. Some specimen submission requirements have been added (most notably, any available cultures of Pertussis, Listeria, and Cryptococcus other than known *v. neoformans*). While not part of the rule revisions, the public health laboratories would like to remind clinical laboratories that specimen labels and forms must include two identifiers: patient name AND a second identifier, e.g. date of birth.

Reporting timeframes have been modified. Three categories: Immediately, reportable within 24 hours, and 3 business days.

The system for locating reported cases has been improved. The revisions to the rule specify that health care providers and facilities must provide patient identifying information, including at least zip code of residence, to clinical laboratories when ordering lab tests for a notifiable condition. By January 1, 2013, laboratories must have databases capable of storing and retrieving this information.

The final revised rule is available at <http://www.doh.wa.gov/Rules/adoptedrules.htm> including changes. The final rule will be posted at <http://apps.leg.wa.gov/wac/default.aspx?cite=246-101>. Other resources include notifiable conditions posters at: <http://www.doh.wa.gov/notify/forms/> and a newsletter: http://www.doh.wa.gov/hsqa/FSL/Documents/LQA_Docs/Jan-Feb11.pdf

ANIMAL BITES



TO REPORT A NOTIFIABLE CONDITION:
PHONE:
 (509) 766-7960
FAX:
 (509) 764-2813
24-HOUR HOTLINE
 (509) 398-2083

Amber McCoy, RS
 The reporting requirements in WAC 246-101 for Animal Bites changed on February 4, 2011. In past versions of the rule, ALL animal bites to humans were reportable to the Health District. **With the new rule, only animal bites which the provider assesses to be an actual "suspected human Rabies exposure" are to be reported.** For example, a provoked or casual bite by vaccinated and healthy domestic dogs (non-stray) would not be considered a suspected human Rabies exposure. An unprovoked bite by a stray dog who shows signs of illness could represent such an exposure. Other suspected Rabies exposures not directly resulting from a bite are also immediately reportable; these include scratches, open wounds or mucous membranes that are contaminated with saliva or neural tissue of a mammal suspected of being infected with Rabies, and most bat exposures (bites and non-bites).

A guide is available to assist determination of suspected Rabies exposure and when post-exposure prophylaxis (PEP) is recommended. It lists factors such as geographic location; animal health and behavior; animal vaccination status; circumstances of exposure (provoked vs. unprovoked); likelihood the animal could have been exposed to another rabid animal; and likelihood the wound was contaminated with saliva or neural tissue. The require

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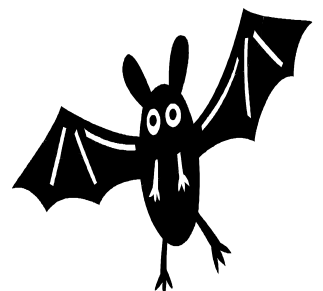
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ment for a 10-day confinement (quarantine) and observation has not changed and is still required for all healthy dogs, cats and ferrets involved in a bite incident to watch for signs of Rabies.

Health District staff are also available for consultation in assessing potential Rabies exposures and PEP recommendations. The "Suspect Rabies Exposure" report form and guide are available online at www.doh.wa.gov/notify/forms, or contact the Health District at (509) 754-6060.



MENINGOCOCCAL DISEASE (NEW): SECOND BOOSTER RECOMMENDED

Alexander Brzezny, MD MPH

In October 2010, ACIP (Advisory Committee on Immunization Practices) recommended **adding a booster dose of the quadrivalent (serogroups A, C, Y, and W-135) meningococcal conjugate vaccines (Menveo, Novartis; and Menactra, Sanofi Pasteur) at age 16** to address waning immunity among older teens against meningococcal meningitis. The waning immunity phenomenon is now a well-established challenge in public health affecting other vaccine-preventable diseases like Pertussis, Measles, Mumps or Varicella-Zoster.

This new recommendation means, that all children are to routinely receive **TWO SHOTS** of meningococcal vaccine: **first** during the preadolescent doctor's visit, in those 11- to 12-year-old, and **second** at age 16 (or 4-5 years after the first).

Previously unimmunized adolescents at high school entry (14-15-year-olds) and unimmunized college freshmen living in dormitories should receive their first dose of vaccine as soon as possible. The goal of the ACIP meningococcal immunization recommendations is to protect persons aged 16 through 21 years, when meningococcal disease rates experience a second peak (**Figure 1**). The quadrivalent vaccine provides protection against four of the five serogroups of *Neisseria meningitidis*.

The ACIP also made a recommendation for a **2-dose primary series administered 2 months apart** for persons aged 2 through 54 years **at high risk for infection**: those with persistent complement component deficiency (e.g., C5--C9, properdin, factor H, or factor D) and functional or anatomic asplenia, and for adolescents with human immunodeficiency virus (HIV) infection.

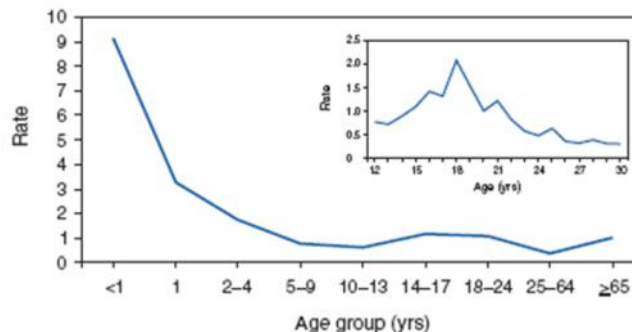
When implementing these recommendations consider following:

1. Persons aged 21 years or younger should have documentation of receipt of a dose of meningococcal conjugate vaccine not more than 5 years before enrollment.
2. If the primary dose was administered before the 16th birthday, a booster dose should be administered before enrollment in college.
3. The booster dose can be administered anytime after the 16th birthday to ensure that the booster is provided.
4. The minimum interval between doses of meningococcal conjugate vaccine is 8 weeks.
5. Whenever feasible, the same brand of vaccine should be used for all doses of the vaccination series. If vaccination providers do not know or have available the type of vaccine product previously administered, any product should be used to continue or complete the series.
6. Persons with complement component deficiency, asplenia, or HIV infection who have previously received a single dose of meningococcal conjugate vaccine should receive their booster dose at the earliest opportunity.

About Meningococcal Disease

Neisseria meningitidis has become a leading cause of bacterial meningitis in the United States after dramatic reductions in the incidence of *Streptococcus pneumoniae* and *Haemophilus influenzae* type b. **Meningococcal disease strikes up to 3,000 Americans each year; nearly 30 percent of these cases are among teenagers and college students.** Distribution of cases remains

FIGURE 1. Rate* of meningococcal disease, by age — United States, 1991–2002



Source: Active Bacterial Core surveillance data.
* Per 100,000 population.

approximately similar to what was observed a decade ago (**Figure 1**).

In Washington State, each year 30 to 60 cases are reported, including 1 to 8 deaths. In **2009**, 26 cases (0.4 cases/100,000 population) were reported with 3 deaths. 22 cases had known serogroup: 12 serogroup B, 8 serogroup Y, and 2 serogroup C. Serogroup B, which is not included in the vaccine, caused the 3 deaths.

Crowded living conditions, low socioeconomic status, and tobacco smoke exposure may increase risk, as do certain immune deficiencies including asplenia. Other causes of meningitis include Group B Strep, Gram-negative organisms, Mycobacteria, many viruses, and certain parasites and fungi. Of all the causative agents, most *Neisseria* types, many *Streptococci* and Hib are considered vaccine-preventable. Grant County Health District becomes involved in all cases of meningitis reported in Grant County or occurring in Grant County residents. Our communicable diseases section works with the health-care professionals, local, re-

gional or the state lab, as well as with the patient or their family to determine a need for contact investigation or any post-exposure prophylaxis.

Post-exposure prophylaxis

In general, only *Haemophilus* and *Neisseria meningitidis* or septicemia require a post-exposure chemoprophylaxis.

For meningococcal meningitis, chemoprophylaxis consists of one of the following:

- **Rifampin**; **PREFERRED** 600 mg (for children > 1 mo, 10 mg/kg; for children < 1 mo, 5 mg/kg) po q 12 h **for 4 doses**
- **Ceftriaxone**; the most suitable choice for PREG-NANT contact 250 mg (for children < 15 yr, 125 mg) IM **for 1 dose**
- **Fluoroquinolone**; **ADULTS ONLY** (resistance to fluoroquinolones has been reported in some states) ciprofloxacin or levofloxacin, 500 mg or ofloxacin 400 mg po **for 1 dose**

Chemoprophylaxis against *H. influenzae* type b is **rifampin** 20 mg/kg po once/day (maximum: 600 mg/day) **for 4 days**. (Specific conditions and situations apply; for more details

For references see page 3.

INFLUENZA

Carol Schimke, RN PHN

Grant County is currently experiencing increasing numbers of influenza-like illness (ILI) especially in school aged children. Influenza season has not fully peaked and so far has been mild. Sporadic cases of Influenza A (H3N2) and more cases of Influenza B have been seen this year. It is still not too late for a flu shot: the Grant County Health District recommends continued promotion of this intervention.

2011 Centers for Disease Control and Prevention (CDC) Week 4 (1/23/11–1/29/11)

Summary:

1. Influenza activity remained stable last week. Influenza virus is circulating in most regions in Washington.
2. During weeks 3–4 (1/16/11–1/29/11), 47 (7.4%) specimens tested by the World Health Organization/ National Respiratory and Enteric Virus Surveillance System (WHO/NREVSS) collaborating laboratories in Washington were positive

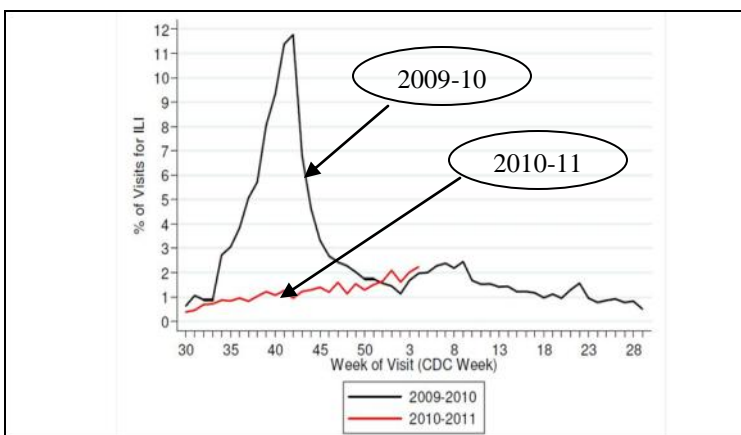
for influenza. Of these specimens, 96% were influenza A and 4% were influenza B. Of the sub-typed influenza A specimens, 61% were influenza A (H3) viruses and 39% were 2009 H1N1 viruses.

3. The proportion of outpatient visits for ILI remained below the Washington baseline. The proportion of emergency room visits for ILI increased slightly.
4. There were no laboratory-confirmed influenza deaths reported to the Washington State Department of Health during week 4.
5. The Centers for Disease Control and Prevention recommend that everyone age 6 months and older get a yearly flu shot. Vaccination is especially important for babies, young kids, pregnant women, anyone over 50, and people with certain medical conditions like diabetes, asthma, and heart disease.

For more information on seasonal Influenza: <http://www.cdc.gov/flu/>

Percentage of ER Visits for ILI by CDC Week, Eastern Washington, 2009–2011

Eastern Washington: Week 4, emergency departments in Eastern Washington reported 134 ILI visits (2.2%) out of 6015 total patient visits. Figure 2



Grant County Case Numbers Reported to Washington State Department of Health		
DISEASE/CONDITION	YEAR TOTAL 2010	YEAR TOTAL 2009
Blood Lead – Child	1	0
Campylobacter	18	17
Chlamydia	281	261
Cryptosporidium	0	0
E. coli	1	3
Giardia	5	5
Gonorrhea	16	9
Hepatitis A	1	1
Hepatitis B	9	2
Hepatitis C chronic	98	54
Hantavirus	0	0
Herpes Simplex	16	14
HIV	4	*
Influenza Deaths	0	0
Influenza H1N1	4	*
Listeriosis	0	0
Malaria	0	0
Measles	0	0
Meningococcal	0	1
Mumps	1	0
Pertussis	19 Confirmed 9 Probable	2
Rabies PEP	2	0
Relap. Fever/Lyme	0	0
Rubella	0	0
Salmonella	12	7
Shigella	2	3
Syphilis	4	2
Tuberculosis	1	3
Yersiniosis	1	0
West Nile Virus	1	1
Totals Reported to DOH	421	385

* Not reported in 2009

Meningococcal References

- www.cdc.gov/mmwr/preview/mmwrhtml/rr5407a1.htm
 - www.cdc.gov/mmwr/preview/mmwrhtml/mm5837a4.htm
 - www.cdc.gov/mmwr/preview/mmwrhtml/mm6003a3.htm?s_cid=mm6003a3_w
- Red Book, 28th Edition, American Academy of Pediatrics, page 317, Table 3.9



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Moses Lake Office 1038 W. Ivy, Suite #1 Moses Lake, WA 98837 (509) 766-7960

PERTUSSIS UPDATE

The pertussis outbreak in Grant County is ongoing. To date 28 (19 confirmed, 9 suspect) cases have been reported and at time of this printing there are 2 suspect cases, 12 pending cultures and 3 pending PCRs. All

Health District recommended policies and procedures are still in effect. All pertussis related alerts can be found at

<http://www.granthealth.org/HealthcarePro.html>

GRANT COUNTY HEALTH DISTRICT

‘Always working for a Safer and Healthier Grant County’

www.granthealth.org

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