



December 28, 2006

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Epidemiology: The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control health problems.

Stedman's Medical Dictionary, Ed. 27

At the Bureau of Epidemiology Statewide Seminar in October, one of the recipients of the Golden Partnership Award was the Brevard County Health Department, for its exceptional teamwork in the outbreak investigation regarding rash illnesses on a cruise ship, secondary to measles and rubella during February and March, 2006. The award winner was misidentified as Broward County in last month's issue, and we apologize for the error

Hepatitis B Elimination in the United States

by Phil Reichert, MPH

In a MMWR article published in December 2006, the Advisory Committee on Immunization Practices (ACIP) and the CDC recommended a comprehensive strategy to eliminate hepatitis B transmission in the United States. From 1990 through 2004, the incidence of acute hepatitis B declined from 8.5 per 100,000 population to 2.1 per 100,000 population; a 75% reduction in reported cases. According to the National Health Interview Survey (NHIS, 2004), vaccine coverage among adults at high risk increased from 30% in 2000 to 45% in 2004. Some of these numbers are reflected in the aging of persons who were vaccinated as adolescents.

In spite of great efforts made over the last fourteen years to vaccinate infants and children, hepatitis B vaccine coverage among adults at risk is still relatively low. National programs that support hepatitis B vaccine for children are not readily available to adults. Florida is fortunate to have legislative funding to support its Hepatitis '09 Program, which provides hepatitis A and B vaccine for adults through all 67 county health departments. Most states do not have funding for adult vaccine programs.

In 2007, the Hepatitis Prevention Program will have additional hepatitis B vaccine (more than the normal CHD allotment) available for the CHDs through the Hepatitis '09 Program. This vaccine has been made available from the Bureau of Immunization through its 317 Initiative fund. The hepatitis B, 317 Initiative involves targeting at-risk individuals from 25 to 39 years old who access STD services in county health departments. According to the CDC, if we vaccinate every at-risk individual in the U.S. who accesses STD or HIV services in health departments, at-risk individuals incarcerated in jails and prisons, and those who access substance abuse services, we could eliminate hepatitis B in this country in less than ten

years. Hepatitis B vaccine may be ordered via the form sent to the CHDs via e-mail on December 27, 2006. This is a modified version of the current vaccine order form used in the Hepatitis '09 Program.

Hepatitis B vaccine has been proven safe and effective. According to ACIP recommendations we should increase hepatitis B vaccine coverage in public health and primary care programs by, 1) Informing adults who receive preventive clinical services of the benefit of the hepatitis B vaccine, 2) vaccinating all adults who seek protection from hepatitis B (including individuals who report as men who have sex with men and former and current injecting drug users) and, 3) adopting strategies to ensure all adults at risk are offered hepatitis B vaccine.

Dr. Russell Eggert, director of the Division of Disease Control, sent an email that included details of this initiative to CHDs on December 7, 2006. Attached was the MMWR publication outlining guidance for the elimination of hepatitis B in the U.S. You may access this document by logging onto www.cdc.gov.

Phil Reichert is the hepatitis prevention program administrator at the Bureau of HIV/AIDS in Tallahassee and can be reached at 850.245.4426.

Investigation of Chicken Pox at Manatee County Jail - November 2006

by Alelis, K., MPH; Emmanuel, S., MPH; Sanderson, R., MA, BSN



Introduction

Varicella, also known as chickenpox, is an infectious disease caused by the varicella-zoster virus. This highly communicable disease is spread from person to person by airborne droplets from an infected person's respiratory secretions, or by direct contact with an infected person's lesion. Chickenpox is characterized by mild fever, tiredness, and an itchy, vesicular (blister-like) rash. The rash appears first on the trunk and face, and can spread over the entire body leading to over 100 vesicles. Incubation period for chickenpox is 10-21 days (average 14-16 days). A person is contagious 1-2 days before the rash appears and continues to be infectious until all blisters have formed scabs. Before the introduction of the varicella vaccine in 1995, chickenpox was considered a common childhood disease with most children acquiring it before age 15.

Background

On October 31st, 2006 Roger Sanderson, an epidemiologist with the Bureau of Epidemiology, was notified by the Manatee County Health Department (CHD) of several deputies and inmates within the Manatee County Jail with chickenpox diagnoses. A phone briefing with the jail physician on October 31st revealed that the initial inmate case was a 24 year-old Hispanic male who had arrived at the jail on October 21st. The inmate did not have a rash on intake but did appear to be ill. On October 27th, he presented to the medical clinic with signs of chickenpox, including a rash primarily on the head and trunk. In addition, a total of 13 deputies were reportedly out from work due to chickenpox, with an additional three deputies listed as suspect cases because of a suspicious rash.

On November 1st, another briefing with the jail physician was held. The jail physician stated that to estimate the number of susceptible persons in the facility, he had drawn IgG titers on October 27th and October 30th for the 73 inmates in the pod (group dormitory) with the initial inmate case, and also on 76 deputies who were thought to have been in contact with the initial inmate case. In addition to those deemed susceptible, there was concern about other vulnerable populations such as those HIV positive and pregnant women. The jail physician estimated there were 16 HIV positive inmates and several pregnant inmates, one of whom was at 38 weeks gestation and another in the first trimester.

A Bureau of Epidemiology team consisting of a bureau epidemiologist, two Florida Epidemic Intelligence Service fellows (FL-EIS), and a Manatee CHD epidemiologist was assembled and deployed to Manatee County to assist in the investigation of chickenpox associated with the county jail. On November 2nd, the epidemiology team met with jail staff to develop an action plan consisting of vaccination of susceptible inmates in the pod with the index case as well as susceptible deputies. Concurrently, an investigation of the reported outbreak would be conducted. Due to the urgency to prevent further spread of disease, the dual plans of vaccination and investigation were initiated.

Methods

Vaccination

On November 2nd, the epidemiology team conducted a quick survey of inmates to determine the amount of vaccine doses needed for those deemed susceptible to chickenpox. The team interviewed 204 inmates from four pods (2 female and 2 male) to establish the number of inmates without a history of chickenpox or chickenpox vaccination. In addition, a team from the Manatee County Jail surveyed 155 deputies to obtain a similar history of disease.

Medical Rounds in the Jail

Medical rounds of the isolation unit were conducted on November 2nd with the jail physician. Five inmates (in addition to the index case) who were suspected as having chickenpox were placed in isolation for observation. It was noted that only the index case had a rash and symptoms compatible with chickenpox, with full body rash, concentrated primarily on his head and trunk with over 100 vesicles in various stages. The other individuals were later released back into the inmate population since they did not show progressive illness characteristic of chickenpox.

Outbreak Investigation

A list of the 16 deputies reportedly out from work due to chickenpox was obtained from the jail. The list contained phone numbers as well as notes indicating who called in and reported a “confirmed chickenpox” diagnosis. A survey instrument was developed and used to interview the 16 deputies. On November 6th, interviews were conducted with the deputies to determine symptoms, exposure source, and potential transmission opportunities. Additional information obtained from the survey included clinical data, specifically on the presence of rash, and a history of chickenpox. An interview with the employee health physician, who assessed and treated 14 of the 16 deputies, was conducted via telephone by a member of the investigation team.

On November 7th, the FL-EIS fellows conducted a home visit to one of the deputies reported to have chickenpox; a swab of two visible lesions was obtained. Also on this day, copies of the laboratory results from the IgG titers drawn by the jail physician were acquired. In addition, visits were made to the medical offices of the physicians who assessed and treated the deputies. Medical records for all 16 deputies were collected and reviewed to obtain information on the medical assessment and diagnosis.

Results

Case Interviews

Of the 16 deputies reported to be out of work due to chickenpox, 13 were interviewed. The interviewed deputies were primarily white and non-Hispanic (83.3%). Of all 16 deputies, 10 (62.5%) were male and the mean age was 35 years old (range: 21-60).

Clinical information on the presence of rash was obtained from the 13 deputies interviewed. Ten (76.9%) reported a rash illness with onsets ranging from October 27th to October 31st. Among these 10, four deputies (40%) reported less than 10 lesions, three (30%) reported 10-20 lesions, and one (10%) reported 21-50 lesions on the date of the interview. Two (20%) reported that they no longer had a rash.

The deputies were also surveyed to obtain information on possible work exposures. Deputies at the Manatee County Jail are placed into one of four squads; their squad number corresponds to their work schedule. Of the deputies that provided information on their squad, six (50%) worked on squad one (morning shift 1), five (41.7%) worked on squad two (evening shift 1), and one (8.3%) worked on squad three (morning shift 2). Only three (23.1%) of the interviewed deputies reported a common exposure outside of work. This exposure was a Halloween party on October 28th attended by all three. While there were no other common events outside of work linking the deputies reporting a rash, 12 (92.3%) of the 13 deputies interviewed did congregate with co-workers in muster (jail debriefing) before their shifts.

Laboratory Result

Seventy-three inmates who shared a pod with the index case had IgG titers drawn. Of these, 57 (78.1%) had a positive IgG titer, and 14 (19.2%) had a negative or equivocal IgG titer. Among the 76 deputies whose blood was drawn, 66 (86.8%) had a positive IgG titer, and 10 (13.2%) had a negative or equivocal IgG titer. Negative or equivocal titer results indicated a susceptibility to chickenpox. Blood was also drawn on the clinically diagnosed inmate case several days after the appearance of his rash. His results showed an equivocal IgG titer.

Twelve (75%) of the 16 deputies reportedly out due to chickenpox were among the group of deputies that had IgG titers drawn. Of these 12, 11 (91.7%) had a positive IgG titer and one had an equivocal IgG titer. Also of the 12 who had titers drawn, only four (33.3%) reported a prior history of chickenpox during the case interviews. Six (50%) reported that they did not have a history of chickenpox, and two (16.7%) could not recall whether or not they had a prior history of the disease.

The specimen collected from one of the deputies was transported to the state laboratory in Tampa where a Polymerase Chain Reaction test was performed and reported as being negative. This deputy had only a few (<10) scattered lesions, mostly located on the back, and overall did not appear to have an illness compatible with chickenpox.

Vaccinations

On November 3rd, a nursing team from the Manatee CHD administered one dose of chickenpox vaccine to the 14 susceptible inmates housed in the same pod as the confirmed index case.

Medical Chart Review

Of the 16 deputies reportedly out from work, 14 (87.5%) deputies were seen by the same employee health physician, and two (12.5%) were seen by the same primary care physician. Additional symptoms were obtained after reviewing the medical charts for all 16 deputies. Fifteen of the 16 deputies had a temperature documented in their medical records; of these, six (40%) had a low grade fever ranging from 98.8°F - 99.6°F. Several deputies reported various upper respiratory symptoms including sore throat (11), nasal congestion (5), cough (3), and runny nose (1). Other symptoms observed included diarrhea (1), vomiting (1), nausea (1), malaise (2), and myalgia (2). Of the 16 deputies, 10 (62.5%) were scheduled to return to the clinic within two days for follow-up appointments. According to the physician's medical assessment after following-up, only one deputy had progressive disease. Three had a resolution of illness and six had no change in disease status. Three deputies (18.8%) were medically diagnosed as having chickenpox (2 of whom had positive IgG titers), while 13 (81.3%) only had a diagnosis of chickenpox exposure. The medical chart review did not contain documentation of the deputies' past history of chickenpox, how they were exposed to chickenpox, or if information on preventing transmission to others was provided. Fifteen of the 16 deputies were prescribed antiviral medication.

Discussion

While most adults have immunity to chickenpox, there are a few that have not been exposed to the disease and are susceptible to infection. Adults who acquire chickenpox can experience a more severe illness than what would be expected in a child. In a jail setting where there are several high-risk groups (i.e., HIV patients and pregnant women) housed in close quarters, timely investigation of a potential outbreak such as chickenpox is essential.

Since the incubation period for chickenpox is 10 – 21 days (average 14 – 16 days), the clinically-diagnosed inmate could not have been the source of chickenpox for the 16 deputies out from work due to a rash. Given that the onset of rash for the inmate was documented as October 27th, cases from this exposure would be expected to develop between November 3rd and November 14th.

The data from the laboratory tests, interviews and medical chart reviews, suggest that the deputies did not have chickenpox, but possibly another viral illness. This conclusion is based on the fact that most of the deputies reported upper respiratory symptoms including sore throat, nasal congestion and cough, but no rash. In addition, among the 12 deputies that had IgG titers drawn, 11 had positive IgG results indicating past infection or immunity.

Vaccination of susceptible individuals has been shown to decrease the length of an outbreak in an institution. Yet, timing is critical in determining who may benefit from vaccination. Using a case history of chickenpox can be a viable alternative to obtaining IgG titers. Literature indicates that among adults, approximately 80% recall a history of chickenpox. While the remaining 20% say they are unsure of prior history, 80% of these will have serologic evidence of previous infection.

Recommendations

This "outbreak" emphasizes the importance of determining prior infection or immunity to chickenpox either through a history of chickenpox or a draw of IgG titers. During this investigation, failing to obtain a history of chickenpox placed an undue burden of antiviral cost and possible side effects on the deputies. We recommend that physicians evaluate their diagnosis and consider the cost and side effects of a drug before writing a prescription to treat an infectious disease.

With the recent addition of varicella to the reportable disease list, it has become more important that those in the medical community be educated on the signs and symptoms associated with this disease. This investigation has shown how important it is for physicians to recognize a case of chickenpox and become familiar with the proper intake history that should be a standard part of a patient medical review when being worked up for chickenpox.

Health care workers at the jail are in contact with many inmates, especially those at high risk for varicella-related complications, which includes pregnant women and immunocompromised persons. As a result, we recommend that all health care workers receive the chickenpox vaccination if they are susceptible to this disease, and that they follow published recommendations for immunization of health care workers. If they cannot recall a history of chickenpox, an IgG titer should be obtained to eliminate unnecessary vaccinations.

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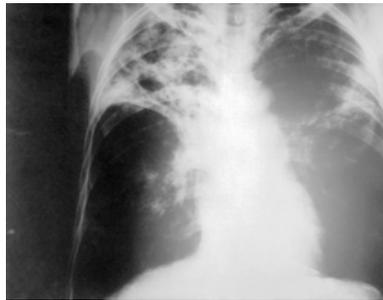
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Manual for the Surveillance of Vaccine-Preventable Diseases: <http://www.cdc.gov/nip/publications>

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Drug-resistant Tuberculosis a Growing Problem

by Jaime Forth



The fight against tuberculosis has been growing more difficult to manage during the last several years due to the development of resistant strains of bacterium that no longer respond to the usual drugs, experts say.

Twenty-two countries account for 80% of the TB cases in the world, according to the World Health Organization. The US is not listed among those countries, but after a century of decline in the west, the disease made a comeback in the late 80s and early 90s.

Once acquired, the disease, manifest by persistent cough, blood in phlegm, fever, night sweats and loss of weight, has been treated using the same regimen for the past 40 years. The treatment consists of isoniazid, rifampicin, pyrazinamide and ethambutol or streptomycin for two months, followed by isoniazid and rifampicin for another four months. The regimen is accompanied by direct observed care by a health provider. The combined-drug method is more effective at preventing drug resistance than using single medications, and observation by a health professional through hospitalization or doctor's office visits to receive medications, helps to ensure patient adherence to the routine.

The most common strain of TB is fully treatable, but multi-drug and extreme drug-resistant TB have been observed in eastern Europe, Africa and even the US.

Multi-drug resistance is identified as resistance to at least two first-line anti-TB drugs - isoniazid and rifampicin. Extreme drug-resistant TB is resistant not only to front-line drugs, but to three or more of the six classes of second-line drugs, rendering the disease untreatable. When the World Health Organization and the CDC surveyed 18,000 TB samples between November 2004 -2005, they found 20% of the samples were multi-drug resistant. Another 2% were extreme drug-resistant. (See *Drug-resistant TB: A Survival Guide for Clinicians*)

In 1953, 84,000 cases of tuberculosis were reported to the CDC in the US, and that number declined to 22, 255 by 1984. By 1993, however, the number of cases increased by 14%, attributable, the organization estimates, to the rise in HIV infections, the number of persons living in congregate settings such as nursing homes and correctional facilities, the rising

number of persons arriving in the US from countries where the disease is endemic, and the condition of the public health infrastructure in some areas.

One of the factors leading to drug resistance during the treatment for TB is previous treatment with antituberculosis medicines. A second risk factor is contact with someone who has infectious, drug-resistant TB.

Most patients in the US are compliant in treatment and recover without complications. However, for those who take their medications erratically, fail to finish their regimen, or who may be immunocompromized, there is increased risk of relapse or development of a drug-resistant strain of TB.

For further information on this topic, go to these links:

<http://www.doh.state.fl.us/AGHolley/index.html>

<http://www.iom.edu/CMS/3793/5522/4119.aspx>

<http://www.cdc.gov/nchstp/tb/>

<http://www.niaid.nih.gov/factsheets/tb.htm>

http://www.tbalert.org/news_press/news.php?id=XDR%20TB

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Catchment Area of a Children's Hospital Emergency Room - Implications for Syndromic Surveillance in Miami-Dade County

Rene Borroto-Ponce, BSc; Guoyan Zhang, MD MPH; Fermin Leguen, MD, MPH; Rodlescia Sneed, MPH; Claudio Micieli, MPH



Objective

This research aimed to determine the catchment area of a children's hospital emergency department (ED). The purpose was to identify pediatric populations and territories within Miami-Dade County that are insufficiently covered by this hospital's ED.

Background

Miami-Dade County Health Department is using the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) to conduct syndromic surveillance^[1]. Patients' chief complaint records from 11 Hospital EDs are fed into ESSENCE daily. This research focused on a children's hospital in Miami-Dade County

Methods

A total of 85,661 residents in Miami-Dade County below 18 years old visited a children's hospital ED in 2005. Direct standardization was used to calculate age standardized rates of visits by patient's zip code of residence. The 2000 US population aged 0-17 was used as standard. Standardized ratios were calculated by dividing each zip code rate by the countywide age-standardized rate. The zip codes' absolute number and standardized ratio of ED visits were mapped using the ArcView 9 Geographic Information System (GIS). Hot Spot cluster analysis was done with the ArcToolBox capability of the GIS. The Getis-Ord Gi statistics was used to determine the main catchment areas of the hospital. Using the zip codes as analytical units, ecological multiple regression analysis was performed in SPSS to identify socio-demographic and accessibility variables that are associated to the spatial pattern of the standardized ratio of visits.

Results

Two main clustered local catchment areas were detected. One is located north of the children's hospital and is made up of West Little Havana, Doral, Hialeah, and Brownsville. The other is in the south and is formed by Cutler, Perrine, and Palmetto Estates. Statistically significant variables that were positively associated to the standardized ratio of visits were the proportion of county households with annual income below \$25,000 ($p=.012$), and distance to neighboring Broward County ($p=.05$). Distance to this children's hospital showed negative association ($p=.006$). Overall, these variables accounted for 34% of the variance of the standardized ratio of ED visits.

Conclusions

The weakest links to a children's hospital ED are in zip codes located in the northeast, Miami Beach, the downtown area, overtown, and the southernmost areas of the county. An estimate of 7,900 of the county's most vulnerable pediatric populations reside in these territories. A question to answer is whether populations of these areas visit other EDs currently feeding data into ESSENCE. Was the answer negative, they should be prioritized by alternative surveillance systems targeting pediatric populations, such as school absenteeism or outpatient visits. This research should be replicated for all hospitals feeding data into ESSENCE to determine catchment areas for each of them.

Reference

1. Lombardo J, Burkom H, Pavlin J. ESSENCE II and the framework for evaluating syndromic surveillance systems. MMWR 2004; 53 (Suppl): 159-165.

Fermin Leguen is the senior physician at the Miami-Dade County Health Department and can be reached at 305.470.6827. Dr. Zhang is the senior epidemiologist at the Miami-Dade CHD and can be contacted at 305.470.5606. Rene Borroto-Ponce is a health service representative at the department and can be reached at 305.470.5646. Epidemiologists Rodlescía Sneed and Claudio Micieli can be reached at extensions 5655 and 5688. This abstract appeared as an entry at the October 2006 juried poster session held by the Bureau of Epidemiology at its annual statewide seminar.

Pesticide Poisoning Surveillance in Florida

by Rosanna Barrett, MPH

Background

Pesticides are toxic to most life forms though intended for pests such as insects, rodents, plants, etc. They have the potential to cause adverse health effects in humans and other non-target animals. Although laws are in place and the use, distribution and sale of pesticides are regulated, the widespread use of pesticides imposes risks of exposures both in occupational and residential settings. The Florida Department of Health/Pesticide Exposure Surveillance Program monitors acute illnesses associated with pesticide use. The surveillance program is designed to assess pesticide-related risks within the state by collecting and evaluating data on poisoning incidents, to identify risky activities, populations at high risk, and to implement strategies to reduce these risks.

Methodology

The data analyzed were comprised of 1,180 cases collected over a period of eight years, from 1998 to 2005. These data were collected from other surveillance partners, public, media, self reporting and other non-traditional sources. The data fields were first screened for completeness. Additional information was collected by interviewing cases, witnesses or proxies and reviewing medical records, laboratory reports, and regulatory field reports. Pesticide toxicity information was gathered from pesticide toxicity profiles and texts and epidemiological case studies. The cases were classified based on the exposure evidence, adverse health effects and pesticide toxicity per National Institute of Occupational Safety and Health /Sentinel Event Notification System for Occupational Risk (NIOSH/SENSOR) case definition guidelines. Routine descriptive analysis was performed to determine trends and distribution of the data. Categorical variables such as age, gender, disease classification, disease severity, chemical group, occupation type, and other characteristics typical of the disease were used to define the cases. The data were analyzed by an ecological study design. Each year's data were analyzed singly and then compared to the other data sets using common variables.

Results

The results were tabulated to show frequency of occurrences as they related to each variable (i.e., disease classification, occupation type, etc.). The results were presented using bar graphs, pie charts, and line graphs. Over the eight year period, 2010 exposure incidents were reported of which only 60% were classified as definite, probable, and possible. Seventy percent of all cases were from residential exposures and 30% were from work-related exposures. Forty-two

percent of all occupational cases were agricultural workers. Most workers in the farming industry were exposed from pesticide drift while working in fields or nurseries and not from mixing/loading or applying pesticides.

Conclusions

- A significant percentage of exposure reports did not result into cases. This discrepancy stemmed from lack of supporting evidence (e.g., exposure verification records, presence of health effects, pesticide type, etc.) to classify cases.
- Most reported pesticide-related cases are from residential exposures. Work-related cases are greatly under-reported due to a lack of available sources by which workers can report exposure incidents. Also, most work-related reports have weak supporting evidence for classification, as access to workers is limited.
- Migrant and seasonal farm workers are at highest risk for acute pesticide poisoning, especially those who do hand labor such as planting and reaping of plants and vegetables. In such instances, workers become poisoned working in fields where pesticides were recently applied or close to fields where pesticides were being applied.

This abstract was one of many submitted for inclusion in the juried poster session at the October 2006 Bureau of Epidemiology Statewide Seminar. Author Rosanna Barrett is the pesticide surveillance coordinator at the Bureau of Environmental Health in Tallahassee and can be reached by telephone at 850.245.4444, ext. 2819.

Training News

Epidemiology and Prevention of Vaccine-preventable Diseases January 25, February 8 and February 15, 2007

Information will be available soon at <http://www2.cdc.gov/phtn/> and <http://www2.cdc.gov/phtn/calendar.asp#Jan07>

For more information about these trainings, contact John Keegan at the Bureau of Immunization in Tallahassee by calling 850.245.4444, ext. 2391.

Mosquito-borne Disease Summary December 3-9, 2006 Rebecca Shultz, MPH, Caroline Collins, Daneshia Roberts, Carina Blackmore, PhD

During the period December 3-9, 2006, the following arboviral activities (St. Louis Encephalitis [SLE] virus, Eastern Equine Encephalitis [EEE] virus, Highlands J [HJ] virus, West Nile [WN] virus, California Group [CE] virus) were recorded in Florida:

EEE virus activity: Of 73 wild birds captured between 11/9 and 11/30 in three counties, one red-shouldered hawk from Volusia County tested positive for antibodies to EEE virus. A total of 22 counties reported EEE virus activity so far this year, compared to 50 at this time last year.

WN virus activity: One seroconversion to WN virus was reported in a sentinel chicken from Hillsborough County. A total of 20 counties have reported WN virus activity so far this year, compared to 35 at this time last year.

SLE virus activity: None this week. Seven counties reported SLE activity so far this year, compared to four at this time last year.

HJ virus activity: None this week. Six counties reported HJ virus so far this year, compared to 16 at this time last year. No locally-acquired human cases of arboviral infection were reported yet this year.

Dead Bird Reports: The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, 11 reports representing 31 dead birds were received from nine counties. Of the reported birds, none was identified as a type of corvid, 2 were identified as raptors, and the

remaining 29 were identified as other birds. Please note that FWC collects reports of birds that have died from a variety of causes, not only arboviruses. Dead birds should be reported to www.myfwc.com/bird/.

See the web page for more information at <http://www.doh.state.fl.us/environment/community/arboviral/index.html>. The Disease Outbreak Information Hotline offers recorded updates on medical alert status and surveillance at 888.880.5782.



This Week on EpiCom

by Christie Luce

The Bureau of Epidemiology encourages Epi Update readers to not only register on the EpiCom system at <https://www.epicomfl.net>, but to sign up for features such as automatic notification of certain events at EpiCom_Administrator@doh.state.fl.us and contribute appropriate public health observations related to any suspicious or unusual occurrences or circumstances. EpiCom is the primary method of communication between the Bureau of Epidemiology and other state medical agencies during emergency situations.

- A chemical incident in St. John's County
- A probable case of diphtheria in Duval County

Christie Luce is administrator of the Surveillance Systems Section in the Bureau of Epidemiology. She can be reached at 850.245.4444, ext. 2450.

Weekly Disease Table

by D'Juan Harris, MSP

Go to http://www.doh.state.fl.us/disease_ctrl/epi/Disease_Table/2006_Weeks/dt_Week5020061.HTML to review the most recent disease figures provided by the Florida Department of Health, Bureau of Epidemiology.

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Epi Update is the peer-reviewed journal of the Florida Department of Health Bureau of Epidemiology, and is published monthly on the Internet. To receive a special email reminder, simply send an email request to HSD_EpiUpdate@doh.state.fl.us.

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