



Epi Update



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Ciguatera Outbreak in Southwest Florida

Terri Harder, B.S.N., R.N.; Pedro C. Castellon, M.P.H.

Background

On September 18, 2007, the Collier County Health Department (CHD) received a call from a local hospital concerning a man who presented to the emergency department with nausea, vomiting, diarrhea, perioral and hand paresthesias, bradycardia, and hypotension. His wife and son had similar symptoms and were being evaluated at another local hospital. All three people were admitted to the hospital and subsequently diagnosed with Ciguatera poisoning. Collier CHD Epidemiology and Environmental Health staff initiated an investigation by contacting the three ill people and following up with both hospitals.

Case Investigation

On September 18, the Collier CHD obtained information on the location of the three ill people from the respective hospitals, and all three were interviewed after their conditions improved.

The initial case was in a 41-year-old man who was transported to the hospital via emergency medical services (EMS). He developed symptoms 4.5 hours after consuming a meal with other family members that included fresh fish. In addition to his initial symptoms, as noted above, he developed temporary loss of vision, temperature reversal, numbness/tingling, dizziness, difficulty breathing, and muscle weakness. He was treated with Mannitol and was discharged after two days when his condition improved. He had ongoing symptoms of muscle weakness and temperature reversal for 64 days.

The second case was in a 48-year-old woman, the wife of the initial case, who developed symptoms of hypotension, bradycardia, vomiting, diarrhea, numbness/tingling, abdominal pain, joint and muscle pain, fatigue, sweating, temporary loss of vision, muscle weakness, and difficulty breathing three hours after consuming the fresh fish meal. Upon admission to the hospital, she was treated with Mannitol and was discharged four days later, when the majority of her symptoms had resolved. She continued to have abdominal pain for 14 days, but was tolerating an oral diet without difficulty.

The third case was in the 21-year-old son of the first two ill people, who developed symptoms of vomiting, diarrhea, dizziness, difficulty breathing difficulty urinating, muscle weakness, bradycardia, and hypotension 7.5 hours after consuming the fresh fish meal. He was treated with Mannitol, Phenergan, and Protonix and was discharged after two days. He continued to have symptoms of muscle weakness for 14 days. All three ill people were instructed to avoid consuming alcohol, caffeine, fish, and nuts for six months to avoid the possibility of triggering a recurrence of any of the symptoms caused by Ciguatera.

The suspect fish was initially identified as a Kingfish caught on September 16 in the Gulf of Mexico, approximately 32 miles west of Marco Island. Two fishermen caught a total of 10 fish, and each fisherman kept five. The three family members who became ill had received the fish as a gift and consumed it on September 17 at 7:30 p.m. A fourth family member ate one bite of the fish and did not become ill. The family gave a portion of the fish to their neighbor. This portion had not been cooked, nor had the neighbor eaten any of the fish. The Collier CHD collected this fish specimen and sent it to the Food and Drug Administration (FDA) Gulf Coast Seafood Laboratory for analysis. The remaining four fish from the first fisherman were eaten with no reports of illness. The Collier CHD attempted to contact the second fisherman to determine the disposition of the other five fish, but was unsuccessful. No other cases suggestive of Ciguatera fish poisoning were found.

Results

Among the three ill people, two were men and one was a woman. The age of the ill people ranged from 21 to 48 years. The incubation period ranged from three to 7.5 hours, and the duration of symptoms ranged from 14 to 64 days days.

On September 28, the FDA Gulf Coast Seafood Laboratory examined the raw fish sample for the presence of Ciguatera-related toxins using a sodium channel-specific neuroblastoma (“cytotoxicity”) assay. Caribbean ciguatoxin-1 (C-CTX-1) was used as a standard. The “cytotoxicity” test result was positive, 1.2 ng C-CTX-1 eq/g of fish flesh was found. On October 12, confirmation testing (LC-MS) was done, and the sample was positive for Caribbean ciguatoxin-1.

The FDA Gulf Coast Seafood Laboratory identified the fish as being barracuda. On November 28, this was confirmed by DNA bar-coding analysis at the University of Guelph in Ontario, Canada.

Discussion

Ciguatera poisoning results from consuming tropical reef fish that have acquired the ciguatoxins from marine microalgae, *Gambierdiscus toxicus*, which are found in their diet. Large reef fish have high concentrations of the toxins due to eating smaller fish that are also contaminated with the toxins.¹

Ingestion of ciguatoxin results in gastrointestinal, neurological, and cardiovascular symptoms including nausea, vomiting, diarrhea, and muscle aches. Temperature reversal sensations (hot food tasting cold and vice versa) are frequently noted.³ Onset of symptoms occurs from minutes up to six hours after consuming the fish.¹

Diagnosis of Ciguatera poisoning is based on symptoms and a recent history of eating reef fish. Leftover fish can be tested for the presence of Ciguatera-related toxins.¹ Treatment is supportive. Symptoms usually subside within days, but neurological symptoms may persist for months.²

Ciguatera in Florida

Between January 1, 2003 and December 12, 2007, a total of 76 confirmed cases of Ciguatera fish poisoning were reported in Florida through the Merlin electronic reporting system. In 2003, a total of seven cases were reported, followed by four cases in 2004, 10 cases in 2005, 32 cases in 2006, and 23 cases to date in 2007 (Figure 1). During this time period, the greatest number of cases were reported from Palm Beach County (23), Broward County (13), Collier County (10), Orange County (7), and Dade County (7) (Table 1).

Of these 76 cases, 44 (58%) were male, 32 (42%) were female; 54 (71%) were White, four (5%) were Asian/Pacific Islander, one (1%) was another race, and 17 (22%) were of unknown race; 69 (91%) were acquired in Florida, and seven (9%) were acquired outside the United States.

Conclusion

Ciguatera is a notable cause of morbidity throughout Florida and in many other areas where consumption of reef fish is common. Worldwide, an estimated 50,000 cases of Ciguatera fish poisoning occur each year. Currently there is no mechanism to determine if a fish is toxic unless “cytotoxicity” assays are conducted in a laboratory. The consumption of large, predatory reef fish, especially barracuda, should be avoided unless prior screening is done.³

Figure 1. Ciguatera Fish Poisoning Cases in Florida

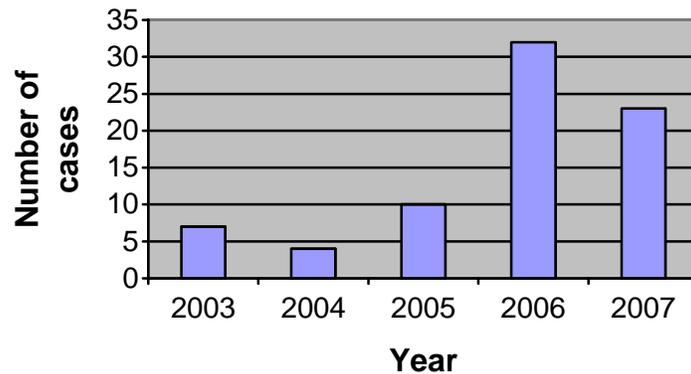


Table 1. Ciguatera Fish Poisoning Cases in Florida, 2003-2007

<i>County</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007*</i>	<i>Total</i>
Broward	2	0	0	8	3	13
Collier	0	0	0	7	3	10
Dade	0	0	0	3	4	7
Escambia	0	0	0	1	0	1
Lee	0	0	0	3	1	4
Martin	0	1	0	1	1	3
Monroe	2	2	0	0	0	4
Orange	0	0	7	0	0	7
Palm Beach	3	0	3	6	11	23
Santa Rosa	0	0	0	1	0	1
Sarasota	0	0	0	1	0	1
St. Lucie	0	0	0	1	0	1
Volusia	0	1	0	0	0	1
Total	7	4	10	32	23	76

Data reported in Florida through the Merlin electronic disease reporting system

*1/1/2007-12/12/2007

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Cluster of Pertussis Cases, Charlotte County

Sharleen Traynor, M.P.H.

Background

On Friday, September 21, 2007, the Charlotte County Health Department (CCHD) Epidemiology Program received a phone call from an individual concerned about his 11-week-old grandchild who had been hospitalized for whooping cough. Until this phone call, CCHD had not received any reports of possible pertussis cases. This call prompted immediate action to verify if this was a true case of pertussis and to begin an epidemiological investigation. The hospital infection control practitioner, hospital microbiology laboratory, and the patient's on-call pediatrician were contacted for more information.

Case Investigation

The infant had a history of runny nose, cough, and congestion with onset on September 6. The symptoms progressed to paroxysmal cough, posttussive vomiting, cyanotic episodes, and pneumonia. The child was hospitalized in isolation on September 13 and treated with azithromycin. The presumptive clinical diagnosis was pertussis, and lab work was ordered through the hospital laboratory. *Bordetella* direct fluorescent antibody (DFA) test and titers were negative. *Bordetella* culture and polymerase chain reaction (PCR) tests were ordered, but not completed because specimens were not sent on appropriate media. Rapid tests for influenza and respiratory syncytial virus (RSV) were negative. The infant improved with antibiotic treatment and was discharged on September 18. Despite the clinical presentation consistent with pertussis, the treating pediatrician did not report the case due to the lack of laboratory confirmation.

An interview with family members revealed that three household contacts were symptomatic with cough, including the child's mother and grandmother, who each work in separate long-term care (LTC) facilities in Sarasota County, and a 3-year-old sibling. In addition, the index baby and the symptomatic sibling are attendees of a day care. An interview with the daycare director revealed that several other children in the daycare center had coughs, but no staff were symptomatic. A list of the symptomatic children was provided to the CCHD, and these families were contacted for interviews and screening for pertussis.

Contact Management

On Sunday, September 23, CCHD held a screening for symptomatic contacts. Specimens (nasopharyngeal and nasal swabs) were collected from 12 contacts and tested for *Bordetella*, influenza, and RSV at the Jacksonville State Laboratory. This included the index baby, five household contacts, and six daycare contacts. The symptomatic contacts in sensitive situations were excluded from work and/or attendance at daycare and LTC facilities.

On Monday, September 24, a letter was sent home to the parents of children who attended the daycare center encouraging them to monitor their children for symptoms of respiratory illness. Additionally, a site visit to the center was made with Bureau of Immunization field staff to review immunization records. Of note, the index baby did receive one dose of pertussis vaccine and was considered up-to-date for his age. Of 72 attendees, 69 (96%) of the children in the day care were up-to-date for pertussis vaccine. Parents of the remaining three children had already been sent letters reminding them to immunize. None of the 14 employees at the day care had received the pertussis booster vaccine (Tdap).

Preliminary laboratory results became available on September 25. Of 12 specimens tested, four were presumptively PCR-positive for *Bordetella pertussis*, including the index baby. Based on these presumptive results, antibiotic prophylaxis was initiated. Prophylaxis was recommended for all household contacts. Within the day care, prophylaxis was recommended for those considered to be high-risk contacts. This included all infants less than 12 months of age, children sharing a classroom with the index baby or the 3-year-old sibling, children in early morning care with the index baby, and any staff who handled the index baby. Although prophylaxis was recommended for these particular groups, CCHD also provided prescriptions for antibiotics to all contacts who were concerned about exposure. A total of 51 contacts (six household, 45 day care) contacts received prescriptions for antibiotic prophylaxis with azithromycin or erythromycin. In addition, 12 daycare staff members were given the Tdap vaccine.

Results

Final bacteriology results were received from the Jacksonville State Laboratory on October 1. Three specimens were PCR-positive for *Bordatella pertussis*. This included the index baby, and the baby's mother and grandmother. One specimen that was presumptively positive was downgraded to equivocal. Of the three PCR-positive specimens, the specimen obtained from the infant's mother was also culture positive. All specimens tested negative for influenza and RSV.

The three laboratory-confirmed cases were reported in Merlin. Active surveillance was initiated in the day care to identify additional cases. Surveillance was also conducted in the two Sarasota County LTC facilities where the infant's mother and grandmother were employed. No additional cases have been identified.

Discussion

Pertussis, commonly called whooping cough, is a respiratory illness caused by the bacterium *Bordatella pertussis*. Illness usually lasts 6-10 weeks and occurs in three stages. The initial catarrhal stage resembles a common cold with non-specific symptoms, such as a runny nose and cough. The second stage, the classic paroxysmal stage, is characterized by paroxysms of cough, whooping, and posttussive vomiting. This stage is followed by the final convalescent stage during which cough gradually improves.¹

Pertussis is transmitted from person to person via aerosolized respiratory droplets. It is highly contagious and was once one of the most common childhood diseases. With the introduction of the whole-cell pertussis vaccine in the 1940s, the incidence of disease has drastically declined. However, since the 1980s, reported cases of pertussis have been on the rise. According to the Centers for Disease Control and Prevention's (CDC), National Notifiable Disease Surveillance System, over 25,000 cases were reported in the United States in 2004.² In Florida, 228 cases were reported in 2006. Most cases occur among children less than one year of age, but an increasing proportion of cases are now occurring in adolescents and adults. This investigation is a good example of this, with two adult cases that would likely have gone undiagnosed if the infant had not become ill. In fact, the source of illness may have been the child's grandmother who reported cold-like symptoms weeks before the index baby fell ill.

In 2005, the Food and Drug Administration (FDA) approved two pertussis booster vaccines for use in adolescents and adults. These vaccines (Tdap) also contain tetanus and diphtheria toxoid. The Advisory Committee on Immunization Practices recommends routine Tdap vaccination for adolescents. For adults, Tdap should replace Td. Vaccination is especially important for adults who have contact with infants such as childcare workers.² Since the booster vaccine is relatively new, it has not yet become a routine part of adult health care. In this investigation, a recommendation to vaccinate all staff was made to the day care.

The gold standard of laboratory testing for pertussis is culture. However, the organism is difficult to grow, and isolation of the organism is dependent on the quality of the specimen and the use of appropriate media. The preferred specimen is a nasopharyngeal swab collected using a Dacron swab. The specimen must then be kept in Regan-Lowe or other appropriate enriching media. In addition to culture, the use of PCR as a supplemental laboratory tool is increasing due to faster reporting of results. DFA and serological tests are also available for pertussis testing, but are unreliable and therefore not recommended for diagnostic purposes.³ It is important to emphasize the specific requirements for pertussis testing to ensure that healthcare providers and laboratory staff conduct appropriate testing. As illustrated in this investigation, healthcare providers who see pertussis cases infrequently may not be familiar with preferred diagnostic testing. Similarly, laboratories may not stock required supplies for *Bordatella* tests. This can be a barrier to proper diagnosis and management of pertussis. More information about these tests can be supplied by the Florida Department of Health Bureau of Laboratories.

Nasopharyngeal swab is the preferred specimen for pertussis testing.



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Trypanosoma cruzi Infections in Florida

Rebecca Shultz, M.P.H.; Danielle Stanek, D.V.M.; Carina Blackmore, D.V.M., Ph.D.

In January 2007, American Red Cross blood banks in the United States began screening blood donations for *Trypanosoma cruzi*, the parasite that causes American trypanosomiasis or Chagas disease. Primarily transmitted by insects from the subfamily Triatominae, *T. cruzi* infection is prevalent in Mexico and many Central and South American countries. Vector-borne transmission occurs when infected Triatome bugs defecate after feeding, and the infected fecal droplets enter the bite wound or contact mucosal membranes and cause an infection. Though less common, transmission can also occur via blood transfusion or organ transplant, via vertical transmission from mother to child, and (rarely) through ingestion of contaminated food or drink.

The initiation of blood screening for *T. cruzi* has resulted in the detection of numerous infections in Florida. As of November 14, 52 infections have been confirmed statewide. The majority of these infections have occurred in Latin American immigrants residing in South Florida. There is currently no evidence of autochthonous transmission in Florida, although studies have demonstrated the presence of both infected Triatome bugs and infected reservoirs (raccoons, opossums) in the state. Like the rest of the country, better housing conditions and less efficient vectors result in minimal risk for locally-acquired human infections in Florida.

Individuals in the acute phase of the disease, up to eight weeks after infection, are often asymptomatic, but when symptoms are present they can include fever, fatigue, body aches, headache, rash, loss of appetite, diarrhea, and vomiting. During the chronic phase, many people remain asymptomatic and are referred to as having the indeterminate form of Chagas disease. Roughly 30% of chronically-infected individuals will develop severe cardiac and/or gastrointestinal complications. For this reason, it is important to identify and evaluate infected individuals for treatment. Current treatment for Chagas disease in the United States consists of either nifurtimox or benznidazole, both available only from the Centers for Disease Control and Prevention (CDC) under investigational new drug protocols. Baseline evaluation for treatment includes physical exam and 12-lead electrocardiogram (ECG) with a 30-second lead II rhythm strip. If any abnormalities are detected, a more comprehensive evaluation is necessary¹. Treatment is recommended for all disease cases in people 18 years of age or younger and for those between age 19 and 50 years without advanced heart disease. Therapy is considered optional for those over 50 years of age. Because of potential side effects, individuals receiving treatment must be monitored by a physician. Questions on case evaluation and management, as well as requests for drugs and information on dosage regimen can be directed to the CDC Division of Parasitic Diseases Public Inquiries line at 770.488.7775.

The detection of *T. cruzi* infections in Floridians raises several public health issues. Currently, Chagas disease is not reportable in Florida, nor is it nationally notifiable. For this reason, many blood banks do not report positive donors to the county health departments (CHD). When a positive donor is reported, the public health response is three-fold: 1) an investigation must be conducted to determine where the exposure likely occurred to rule out locally-acquired infections; 2) the positive individual must be evaluated by a physician to determine if s/he is eligible for treatment; and 3) testing must be facilitated for any at-risk family members, especially children of infected mothers. These investigations are labor-intensive. As this is a "new" disease to most

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people, much of the focus is on education. In addition, many individuals in the affected population do not have easy access to the U.S. healthcare system. The Florida Department of Health is currently working with the CHDs and the CDC to develop protocols to streamline the investigation and data collection processes, as well as ways to facilitate access to health care.

Resources

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CDC Update Regarding Exposure to Hepatitis A

Phil E. Reichert, M.P.H.

The Centers for Disease Control and Prevention (CDC) recently released guidance stating that people recently exposed to hepatitis A virus and who have *not* previously been vaccinated may be administered a single dose of hepatitis A vaccine, instead of immune globulin (IG), *if they are 12 months to 40 years old*. If they are over 40, they should receive IG. Both vaccines should be administered within two weeks following exposure to hepatitis A. This post-exposure prophylaxis is covered in detail in the CDC document titled, "Update: Prevention of Hepatitis A After Exposure to Hepatitis A Virus" and in "International Travelers-Updated Recommendations of the Advisory Committee on Immunization Practices (AICP)" at www.cdc.gov. The MMWR article is dated October 19, 2007.

The **Hepatitis 09 Program** guidance states that county health departments (CHD) may provide hepatitis A and B vaccine and hepatitis test panels (for hepatitis A, B, and C antibodies) to individuals at risk, free of charge, at all CHDs in Florida. The Hepatitis Prevention Program pays for testing through the state laboratory and for the vaccine.

County health departments may use **Hepatitis 09 Program** vaccine in cases where individuals *18 to 40 years old* have been exposed to hepatitis A and have not previously been vaccinated. Large hepatitis A outbreaks are rare and the Hepatitis Prevention Program can fill this need during the foreseeable future.

Chuck Alexander, Chief of the Bureau of Immunization, stated that individuals *12 months through 17 years old* who have been exposed to hepatitis A may be vaccinated with hepatitis A vaccine through the Vaccines for Children (VFC) Program, if there is no previous history of being vaccinated.

In each case, those who receive post-exposure prophylaxis using hepatitis A vaccine, instead of IG, should receive their second dose of hepatitis A vaccine 6-12 months after the first.

The Hepatitis 09 Program Manual is being updated and will be available on the Intranet under the "Division of Disease Control/Bureau of HIV-AIDS/Hepatitis Resources" in early 2008. If you have any questions, please call Nosipho Beaufort, Field Services Coordinator, who is responsible for vaccine accountability at 850.245.4444 Ext. 2430.

Phil Reichert is the Program Administrator in the Hepatitis Prevention Program, Florida Department of Health. He can be reached at 850.245.4426, or by email at Phil_Reichert@doh.state.fl.us.

State Syndromic Surveillance System Update

Aaron Kite-Powell, M.S.

The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) was recently chosen to be used for the state-level component of Florida's statewide syndromic surveillance system. In October, the Bureau of Epidemiology installed the system on its servers and since then, surveillance staff has been busy getting the system up and running. There are two ways the state ESSENCE system can receive hospital data: 1) If the hospital is already participating with an existing local or regional syndromic surveillance system their data can be forwarded from that system to the state system; and 2) the hospital can send their data directly to the state system. Both of these approaches work equally well.

The Bureau of Epidemiology's initial focus has been to establish daily automated data feeds from the existing regional syndromic surveillance systems. To date, the bureau is receiving 38 of the 40 available hospital data feeds from the south Florida ESSENCE system, and has just started to receive data from one of the former STARS hospitals. In January 2008, a letter and memorandum of understanding (MOU) will be sent to those county health departments with hospitals in their county to begin recruiting hospitals that are not currently sending data to any other syndromic surveillance system. Additional background information on the system will be provided at that time as well. Please contact Aaron Kite-Powell (850.245.4444 Ext. 2638) at the Bureau of Epidemiology if you have any questions or if you need assistance coordinating this process with your local hospitals.

Aaron Kite-Powell is the Syndromic Surveillance and Special Projects Epidemiologist in the Bureau of Epidemiology, Florida Department of Health. He can be reached at 850.245-4444 Ext. 2638, or by email at Aaron_Kite-Powell@doh.state.fl.us.

Florida Year-to-Date Mosquito-Borne Disease Through December 29, 2007

Rebecca Shultz, M.P.H.; Caroline Collins; Danielle Stanek, D.V.M.; Carina Blackmore, D.V.M., Ph.D.

During the period January 1-December 29, 2007, the following arboviral activity was recorded in Florida: Eastern equine encephalitis virus (EEEV), West Nile virus (WNV), St. Louis encephalitis virus (SLEV), Highlands J virus (HJV), and California encephalitis group viruses (CEV).

EEEV Activity

Positive samples from 113 live wild birds, 104 sentinel chickens, 18 horses, and one antelope were received from 24 counties.

WNV Activity

Two human cases of locally acquired WNV encephalitis were confirmed in Bay County residents in August. One case of WNV encephalitis was confirmed in a resident of Pinellas County with travel history. This case was reported as a Florida case acquired out-of-state. Positive samples from 57 sentinel chickens were received from nine counties. In addition, samples from 13 live wild birds in four counties were found to be flavivirus-reactive (indeterminate for either SLEV or WNV antibodies).

SLEV Activity

Positive samples from five sentinel chickens were received from two counties.

HJV Activity

Positive samples from 15 sentinel chickens were received from six counties. In addition, virus was cultured from a mosquito pool (*Culiseta melanura*) collected in May in Flagler County.

CEV Activity

One case of La Crosse encephalitis was confirmed in a Hillsborough County resident with travel history. This case was reported as a Florida case acquired out-of-state. La Crosse virus is a member of the California encephalitis group of viruses. In addition, virus was detected in a mosquito pool (*Anopheles crucians*) collected in March in Sarasota County.

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. Since January 1, 1,048 reports representing a total of 4,569 dead birds (55 crows, 55 jays, 98 raptors, 4,361 other species) were received from 59 of Florida's 67 counties. 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/.

Year-to-Date Summary

Since January 1, 24 counties have reported EEEV activity, 12 have reported WNV activity (or undetermined flavivirus), two have reported SLEV activity, seven have reported HJV activity, and one has reported CEV activity. Due to colder temperatures and the return of arboviral activity to baseline levels, the mosquito-borne illness alert for Bay County was lifted, as was the advisory for Nassau County.

See the following web site for more information:

<http://www.doh.state.fl.us/environment/community/arboviral/index.html>.

The Department of Health Disease Outbreak Information Hotline offers recorded updates on the latest medical alerts issued and surveillance information at 888.880.5782.

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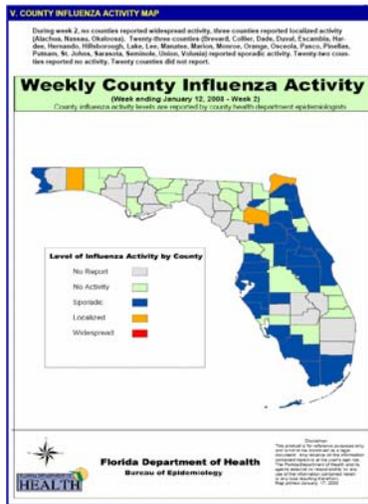
Florida Influenza Surveillance Report

Kate Goodin, M.P.H.; Kateesha McConnell, M.P.H.

Influenza surveillance in Florida consists of six surveillance components: 1) Florida Sentinel Physician Influenza Surveillance Network (FSPISN); 2) Florida Pneumonia and Influenza Mortality Surveillance System; 3) State laboratory viral surveillance; 4) County influenza activity levels; 5) Notifiable Disease Reports; and 6) Influenza or influenza-like illness (ILI) outbreaks. During reporting weeks 47, 48, 49, 50, 51, 52, 1, and 2 statewide influenza activity was sporadic. The proportion of patient visits for influenza-like illness (ILI) as reported by the Florida Sentinel Physician Influenza Surveillance Network averaged 1.07% for these eight weeks and this is below the state threshold for moderate activity of 1.75%. Since September 30, 2007, Florida Department of Health Laboratories have tested a total of 178 specimens for influenza viruses and 39 (22%) were positive. Among the 39 influenza viruses, 31 (79%) were influenza A viruses and eight (21%) were influenza B viruses. During week two only, three counties reported localized activity. Twenty-three counties reported sporadic activity. Twenty-two counties reported no activity. Twenty counties did not report.

The report is available on EpiCom and on the Bureau of Epidemiology website:

http://www.doh.state.fl.us/disease_ctrl/epi/htopics/flu/reports.htm.



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Just Published

Pseudo-outbreak of *Mycobacterium abscessus* Infection Caused by Laboratory Contamination

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D.B. Blossom, M.D., M.S.; K.A. Alelis, M.P.H.; D.C. Chang, M.D.; A.H. Flores, B.A.; J. Gill, Ph.D., M.P.H.; D. Beall, Ph.D.; A.M. Peterson, M.P.H.; B. Jensen, M.M.Sc.; J. Noble-Wang, Ph.D.; M. Williams, Ph.D.; M.A. Yakrus, M.S., M.P.H.; M.J. Arduino, Dr.P.H.; A. Srinivasan, M.D.

Outbreak of Cutaneous Larva Migrans at a Children's Camp --- Miami, Florida 2006

MMWR, December 14, 2007/56(49); 1285-1287

E. O'Connell, M.P.H.; J. Suarez, F. Leguen, M.D.; G. Zhang, M.D.; M. Etienne; A. Torrecilla; A. Jimenez, M.P.H.; F. Farahi, M.P.H.; M. Alzugaray; D. Rodriguez, M.P.H., Miami-Dade County Health Department; S. Pizano, D.V.M., Miami-Dade County Animal Services; C. Blackmore, D.V.M., Ph.D.; D. Goodman, Ph.D., R.S. Hopkins, M.D., M.S.P.H., Florida Department of Health; P. Ragan, Ph.D., Florida Department of Health; J. Schulte, D.O.; T. Doyle, M.P.H., CDC.

Available online: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5649a2.htm>.

Announcements

The County Behavioral Risk Factor Surveillance System (BRFSS) Survey received a *Best of the Best, Best Practices Award for Process Management*. Under this category, the award recipient exemplifies a comprehensive, systematic process to mobilize community partnerships to identify and improve the community's health. The BRFSS program will also receive a \$1,500 scholarship, which will be used to disseminate data and reports from the 2007 County BRFSS Survey.

The Department of Health (DOH) Office of Performance Improvement (HPI) solicits best and promising practices submissions throughout the year. Submissions are judged by at least three representatives from county health departments and state program offices. A DOH Best Practice is defined as an initiative, program, resource, administrative practice, or tool that demonstrates exemplary and replicable qualities in response to a local public health need and meets the following criteria: local public health agency role, collaboration, innovation, responsiveness, sustainability, and evaluation. Funding for the Best Practice award is provided by the Robert Wood Johnson Foundation. For more information on this project or to access the Best Practices Compendium, visit the HPI website at: <http://www.doh.state.fl.us/HPI/index.html>.

The County BRFSS is a collaborative effort by the state health prevention and education programs and all county health departments to collect timely county-level data while minimizing cost for the state of Florida. This surveillance system is designed to monitor chronic diseases and conditions, behavioral risk factors, and emerging health issues in every county by expanding the national/state program. It is based on existing scientific methods to ensure data reliability and suggestions from county and state health representatives were incorporated into the design to ensure data utility. Approximately 33,500 Floridians were contacted for this survey in 2007, a minimum sample of 500 respondents per county. The county survey will be administered every three years. Data collected through this project will be used by local, state, and national disease prevention and education programs to:

- Assess risk for chronic diseases and conditions.
- Identify health disparities.
- Monitor trends in health-related behaviors.
- Design and evaluate health programs.
- Address emerging health issues.
- Develop policy and legislation for health initiatives.
- Measure progress toward achieving local, state, and national health objectives.

The Bureau of Epidemiology's Chronic Disease Section is responsible for the collection and dissemination of BRFSS data. For more information on the County BRFSS, contact Melissa Murray, Chronic Disease Surveillance Administrator, at 850.245.4444 Ext. 2445, or by email at Melissa.Murray@doh.state.fl.us. Please visit the BRFSS web site at http://www.doh.state.fl.us/disease_ctrl/epi/brfss/index.htm to access survey instruments, reports, and other resources. County-specific results are expected to be available in March 2008.

Upcoming Events

Bureau of Epidemiology Monthly Grand Rounds

Time: 10 a.m.-11 a.m.

Location: Building 2585, Room 310A

Dial-In Number: 877.646.8762 (password: Grand Rounds)

Upcoming Topics:

January 29 - Malaria in Burundi Refugees, presented by Taj Azarian, Duval County

February 26 - *Acanthamoeba* Keratitis investigation with the CDC, presented by Kateesha McConnell, Volusia County, along with Roberta Hammond as commentator.

March 25 - Meningococcal Disease, presented by Kate Goodin

Field Investigator Response and Surveillance Training (FIRST)

Target Audience: Public health professionals who may serve epidemiology surge roles, are on regional strike teams, or simply have an interest in improving their field investigation techniques. The programs are open to Florida Department of Health staff and their community partners in health care, mental health care, emergency response, and education.

Registration fees: None

Continuing education credits: Available at no charge

Sponsor: Florida Center for Public Health Preparedness, College of Public Health, University of South Florida

Course Pre-requisite: None

Lake County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=FIRST78LAK>

Date: January 9, 2008

Location: Best Western Lake County Inn & Suites, 1380 E. Burleigh Boulevard, Tavares, FL 32778

Hernando County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=FIRST78HER>

Date: January 17, 2008

Location: Career Central, 7361 Forest Oaks Blvd., Spring Hill, FL 34606

Hendry County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=FIRST78HEN>

Date: February 13, 2008

Location: Hendry County Health Department, 11 South Olympia Street, Clewiston, FL 33440

Intermediate Field Investigator Response and Surveillance Training (IFIRST)

IFIRST is a two-day program that focuses on G.I. Illness and Pandemic Influenza

Course Pre-requisite: Completion of the four hour online *Basic Epidemiology* program.

Pinellas County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=IFIRST78PIN>

Dates: February 7-8, 2008

Location: Room 109A (2nd floor), Pinellas County Health Department, 205 Dr. Martin Luther King Jr. Street North, St. Petersburg, FL 33701

Brevard County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=IFIRST78BRE>

Dates: March 11-12, 2008

Location: Wuesthoff Brevard Homecare, 8060 Spyglass Hill Road, Viera, FL 32940

Intermediate Field Investigator Response and Surveillance Training2 (IFIRST2)

IFIRST2 is the second in the IFIRST series. It is a one day program that focuses on Anthrax and Plague

Course Pre-requisite: Completion of the on-site IFIRST program, or the four hour online *Basic Epidemiology* program.

Alachua County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=I2FIRST78ALA>

Date: January 29, 2008

Location: Conference Center, Alachua County Health Department, 224 SE 24th Street, Gainesville, FL 32641

Lake County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=I2FIRST78LAK>

Date: February 27, 2008

Location: Best Western Lake County Inn and Suites, 1380 E. Burleigh Boulevard, Tavares, FL 32778

Collier County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=I2FIRST78COL>

Date: March 7, 2008

Location: Collier County Health Department, Building H, 3301 E. Tamiami Trail, Naples, FL 34112

Hernando County, FL: <http://www.fcphp.usf.edu/courses/course/course.asp?c=I2FIRST78HER>

Date: March 20, 2008

Location: Career Central, 7361 Forest Oaks Blvd., Spring Hill, FL 34606

For more information about the *Basic Epidemiology* online program:

<http://www.fcphp.usf.edu/courses/course/course.asp?c=BEPI>

Completing the IFIRST pre-requisite and registration steps:

<http://www.fcphp.usf.edu/courses/help/IFIRST1.htm>

Completing the IFIRST2 pre-requisite and registration steps:

<http://www.fcphp.usf.edu/courses/help/IFIRST2.htm>

For general program questions contact Pam Price at pprice@health.usf.edu.

For technical questions contact Balaji Ramadoss at bramados@health.usf.edu.

Reportable Diseases in Florida

Up-to-date information about the occurrence of reportable diseases in Florida, based on the Merlin surveillance information system, is available at the following site: <http://www.floridacharts.com/merlin/freqrpt.asp>. Counts can be displayed by disease, diagnosis status, county, age group, gender, or time period.

This Month on EpiCom



EpiCom is located within the Florida Department of Health's Emergency Notification System (FDENS). The Bureau of Epidemiology encourages *Epi Update* readers not only to register on the EpiCom system by emailing the Florida Department of Health Emergency Notification System Helpdesk at FDENS-help@doh.state.fl.us, but to sign up for features such as automatic notification of certain events. Users are invited to contribute appropriate public health observations related to any suspicious or unusual occurrences or circumstances through the system. EpiCom is the primary method of

communication between the Bureau of Epidemiology and other state medical agencies during emergency situations. Following are selected recent postings:

- Suspected norovirus outbreak in a LTC facility, Alachua County.
- Cluster of G.I. illness in high school band tour from Pennsylvania, Orange County.
- Suspected foodborne illness outbreak in staff at a LTC facility, Miami.
- Varicella cases, Hillsborough and Seminole counties.
- Custom Culinary Inc. recalls beef and chicken base products, may contain undeclared allergens.
- Rabies alert, Indian River County.
- Neisseria meningitidis-Meningococemia, Pinellas County.
- Probable *Shigella sonnei* foodborne outbreak, Escambia County.
- Suspected foodborne outbreak at a World AIDS Day benefit lunch, Palm Beach County.
- Suspected foodborne outbreak, Okeechobee County.
- The Canadian Food Inspection Agency found E. coli O157:H7 in the Dole Hearts Delight Salad product.
- The California Department of Food and Agriculture detected *Listeria monocytogenes* in the Organic Pastures brand Grade A Raw Cream 100% Pasture Glazed product.
- Campbell's Chunky Baked Potato with Cheddar and Bacon Bits product may contain plastic fragments.
- Top Ramen Oodles of Noodles, various flavors, product contains undeclared krill.
- G.I. Outbreak in an Assisted Living facility, Broward County.
- DOACS recalls Gourmet de Lyon food products purchased at two Green Markets, Palm Beach County.
- Two clusters of illness possibly linked to consumption of Alaskan king crab, Orange County.
- Legionellosis case with history of travel to Broward County, Sarasota County.
- The Florida DOH is working with the CDC in assessing an outbreak of *Serratia marcescens* infections associated with pre-filled heparin syringes.
- Harmful Gulf of Mexico and east coast algal blooms have been identified.
- Lead Paint Standard violations and recalls online:
http://www.doh.state.fl.us/environment/community/lead/The_Lead_Alert_Network.htm.

Epi Update is the peer-reviewed journal of the Florida Department of Health, Bureau of Epidemiology, and is published monthly on the Internet. Current and past issues of *Epi Update* are available online: http://www.doh.state.fl.us/disease_ctrl/epi/Epi_Updates/index.html. The current issue of *Epi Update* is available online: http://www.doh.state.fl.us/disease_ctrl/epi/Epi_Updates/2007/December2007EpiUpdate.pdf. For submission guidelines or questions regarding *Epi Update*, please contact Gail Morales, Communications Coordinator at 850.245.4444 Ext. 2401, or by email at Gail_Morales@doh.state.fl.us.



The Bureau of Epidemiology is a part of the Division of Disease Control
Tallahassee, Florida

