



Epi Update



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Malaria Among Recently Arrived Burundian Refugees: A Public Health Response

Taj Azarian, M.P.H.; Robyn S. Kay, M.P.H.; Laura Smith

Introduction

With an estimated 350-500 million cases of malaria occurring annually worldwide, this disease remains one of the most common causes of morbidity and death among refugees and displaced people¹⁻⁴. In addition, these individuals continue to relocate to areas of the world that were previously disease-free and have low disease activity⁵⁻⁶. The movement of infected populations into areas of low prevalence can spark large-scale malaria epidemics⁷⁻⁸. People contracting malaria while traveling to areas where the disease is endemic constitute the majority of malaria cases diagnosed in the United States⁹.

Prior to relocating to the United States, most refugees have been treated with sulfadoxine-pyrimethamine (SP) as presumptive malarial treatment. This combination has been used for many years, although there is documented resistance to this therapy. As a result of the increasing SP resistance in East Africa, the International Organization for Migration (IOM) recommended the use of Artemisinin combination therapy (ACT) for improved pre-departure treatment. However, this therapy regimen was implemented only for refugees arriving in the United States on or after July 10, 2007.

Background

On Friday, July 6, 2007, the Duval County Health Department (DCHD) was alerted to an EPI-X report from the Centers for Disease Control and Prevention (CDC) regarding undocumented and/or insufficient pre-departure therapy for malaria among East African refugees resettling in the United States. In addition, these refugees came from a region in Africa where chloroquine resistance is common. This posting was intended to inform local health authorities of the potential public health risk and suggest recommendations for presumptive treatment of refugees who had recently emigrated from East Africa.

Methods

A joint investigation was initiated between the Florida Department of Health (FDOH) Bureau of Tuberculosis (TB) and Refugee Health, Bureau of Community Environmental Health, Bureau of Epidemiology, and the Bureau of Laboratories (BOL) in conjunction with DCHD Epidemiology and Refugee Health Programs.

The CDC provided the Bureau of TB and Refugee Health with a list of all Burundian refugees who had relocated to the Jacksonville area prior to July 10, 2007. The DCHD Epidemiology Program used this list to begin locating the Burundian refugees who had arrived during the specified period and presumptively treating them using the joint CDC/IOM guidelines that were provided.

A meeting was convened between members of the DCHD Epidemiology Program and the Department of Communicable Disease. During this meeting, key issues were identified and addressed including: 1) specimen collection; 2) initial refugee follow-up health visits; 3) contacts for agencies sponsoring refugees in Jacksonville; 4) the availability of a Kirundi (the language spoken in Burundi) interpreter; 5) documentation of pre-departure anti-malarial therapy; and 6) the availability of Malarone, which is the preferred treatment for people who may have acquired malarial infections due to *Plasmodium falciparum* in areas where chloroquine resistance has been documented.

It was also determined that in addition to providing presumptive therapy, the DCHD Epidemiology Program, in conjunction with the DCHD Refugee Health Program (RHP), would screen incoming refugees for active parasitemia. Thick and thin blood smears were subsequently submitted to the BOL during initial health screenings.

Results

Thirty two refugees arrived during the target time frame. In addition to a chart review conducted to determine the medical history and pre-departure therapy of the refugees screened by DCHD-RHP, the respective sponsor agencies were contacted to verify the arrival and screening status of the additional individuals.

Of the 32 refugees identified as having arrived during the target time period, several lacked documentation of pre-departure therapy and some had no medical records. Consequently, these individuals were scheduled for screening and presumptive therapy. Testing of thick and thin blood smears was performed by the BOL-Jacksonville. While some of the refugees had complicated medical histories, none presented with clinical signs or symptoms of active malarial infections. All blood tests were smear-negative for active parasitemia. As part of this investigation, DCHD Epidemiology conducted on-site visits at two local refugee sponsor agencies and with the aid of an interpreter, explained the situation, answered questions, and provided appropriate therapy.

New arrivals to the refugee clinic through July 10 were screened for parasitemia and presumptively treated with Malarone. In addition to the initial group of 32 refugees, eight additional Burundian refugees arriving after July 10 were screened and found to be negative for malaria. An additional four refugees were confirmed to have the correct pre-departure therapy indicating implementation of the new CDC/IOM recommendations.

Discussion

In total, 32 individuals were prophylaxed with Malarone. No active cases of malaria were identified in the group of refugees resettling in Jacksonville, Florida.

Increased global travel, immigration, and the presence of anopheline vectors throughout Florida and the United States contribute to the ongoing threat of malaria transmission¹⁰. Several historical incidents have demonstrated the possibility of local transmission and the potential for reintroduction of malaria into the United States. Most recently, in July and August of 2003, seven cases of locally-acquired *Plasmodium vivax* malaria occurred in Palm Beach County⁸. Outbreaks such as this emphasize the need for maintaining vigilant surveillance and vector control programs.

The importation of malaria also demonstrates critical implications for clinical care, blood safety, and the possibility of autochthonous transmission¹¹. *P. falciparum* recrudescence is common if the parasite is drug resistant or if inadequate treatment is received¹². In *P. falciparum* infections, the parasites can remain in the blood for months or even years and can cause recurrent symptoms. Without proper treatment, *P. falciparum* infections can rapidly progress to coma, renal failure, pulmonary edema, and death. Untreated infections can persist for up to 18 months¹². Additionally, *P. falciparum* may not be apparent on an initial blood smear¹⁴. Coupled with the existence of vector-competent mosquito species, this provides a rationale to prophylax asymptomatic individuals under conditions such as these¹⁵.

Challenges to this public health response included: 1) a lack of medical records or documentation of pre-departure therapy; 2) limited Medicaid reimbursement for therapy and follow-up care due to the lack of documentation; 3) difficulty in securing the appropriate treatment since Malarone is not on the FDOH formulary; and 4) initial difficulty in locating a Kirundi interpreter for the interviews.

The primary strength of this public health response was a well-coordinated interagency collaboration between the CDC, FDOH Bureaus of Epidemiology, Bureau of TB and Refugee Health, Bureau of Community and Environmental Health, the DCHD Epidemiology and Refugee Health Programs, and the Department of Communicable Disease, DCHD Pharmacy, and the BOL-Jacksonville.

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Brucellosis Associated with Feral Swine Hunting and Report of a Laboratory-Acquired Infection in Brevard County

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Synopsis

On October 19, 2007, the Epidemiology Department of the Brevard County Health Department (BCHD) initiated investigation of a presumptive positive case of brucellosis in a hunter's wife that was reported by a local hospital. The patient was interviewed, a clinical history was obtained, and arrangements were made for the blood samples to be sent to the Bureau of Laboratories (BOL) in Jacksonville for polymerase chain reaction (PCR) testing and culturing/speciation. Six weeks later on November 30, three more suspect *Brucella* infections were reported: the laboratory worker who handled the index case's culture and two men who hunted in the same area as the index case's husband. Epidemiologists interviewed the three individuals, conducted a site visit at the hunting camp, and provided educational materials and advice on infection control to the Hunter Association. Blood samples from the two hunters were also sent to BOL in Jacksonville for PCR testing and culturing.

Epidemiological Investigation

The index case was a 56-year-old woman with symptoms of intermittent fever, night sweats, chills, progressive fatigue, malaise, and weight loss that began on July 1, 2007. She was admitted to the hospital on October 10, discharged on October 12, and then re-admitted on October 15. BCHD was notified on October 19 when blood cultures submitted to a private laboratory returned positive for *Brucella* species; the patient was treated with rifampin and doxycycline. Subsequently, laboratory culturing at BOL confirmed *Brucella suis*. The investigation revealed that the woman's husband was an avid hunter of feral swine, deer, and raccoons at a local hunting ground. She denied contact with farm or wild animals, but reported that in late June she laundered her husband's soiled clothing after he had skinned and cleaned a feral swine from his hunt. She remembered having dry, cracking skin and cuts on her finger while she was handling the clothing and did not use any gloves or other personal protective equipment (PPE). Her husband was also interviewed, but reported no symptoms. The couple was advised about proper infection control practices, including the use of PPE.

Due to the potential for aerosol transmission of *Brucella* species, hospital staff who came in contact with specimens from the index case were tested for the organism as a precautionary measure. One 30-year-old laboratory worker, was immunoglobulin-M (IgM) positive for *Brucella* species on November 30, but was asymptomatic. She was placed on a combination of rifampin and doxycycline therapy for prophylaxis. During the interview, she denied hunting or eating unpasteurized dairy products, and reported only limited outdoor activities, with no animal contact. However, she did come in contact with the index case's laboratory specimen when she opened the incubator door to check on the sample, and may have inhaled the organism at that time. Due to the absence of clinical symptoms and little chance of illness because of early intervention with antibiotic prophylaxis, this individual did not meet the surveillance case definition for brucellosis.

On November 28, two men, ages 74 and 78, were admitted to the same hospital as the index case with flu-like symptoms, including intermittent fever, chills, body ache, and malaise. Both patients informed the healthcare staff that they were hunting partners with the index case's husband. BCHD was informed of the suspect cases on November 30 and preliminary lab tests identified gram-variable coccobacilli. Both men were treated with doxycycline, rifampin, and gentamicin. Arrangements were made for blood samples to be sent to BOL for culturing, and subsequently, *Brucella suis* species was confirmed. During the investigation, both patients reported that on September 28, another hunting partner brought a feral swine carcass to the hunting camp to get help with the skinning and cleaning/butchering. All three men handled the swine carcass, and one of the patients reported that he was responsible for discarding the viscera. No PPE was used. The third man, who brought the swine to the hunting camp, did not become ill.

Epidemiologists arranged a meeting with members of the Hunter Association and conducted a site visit at the hunting camp. The outdoor butchering area, knives, and other equipment were inspected (see image below). A metal "gut bucket" was observed. Although there was a sink with running water in the immediate area, no hot water or antibacterial soap was available. Additionally, no gloves, smocks, or aprons were present and the

hunters denied using any PPE during butchering. There was a formal kitchen and dining area with restrooms nearby. Infection control measures such as hand hygiene, disinfection, and PPE were discussed. Educational material about brucellosis was provided.



Discussion

Pathogenicity of Brucellosis

Brucellosis, caused by the *Brucella* species of bacteria, is a zoonotic disease of wild and domestic animals. The most common reservoirs are cattle (*B. abortus*), swine (*B. suis*), goats and sheep (*B. melitensis*), and dogs and coyotes (*B. canis*). However, infection may occur in bison, elk, caribou, and some species of deer (primarily *B. abortus*).¹ *B. abortus*, *B. melitensis*, *B. suis*, and rarely, *B. canis* can also infect humans.² These organisms are small, gram-negative coccobacilli that are transmitted to humans via abrasions in the skin, inhalation, ingestion, or contact with conjunctival mucosa.² Most often, humans contract the disease by direct contact with infected animals, their carcasses or bodily fluids, or by ingesting unpasteurized milk or milk products. Human-to-human and congenital transmission are rare.² Incubation is typically between five and 60 days, but can be several months. Symptoms of brucellosis are flu-like and may include fever, sweats, headaches, back pains, weakness, malaise, anorexia, weight loss, arthralgia, and myalgia. Chronic symptoms include recurrent fevers, joint pain, and fatigue, and are common in untreated patients. Severe infections of the central nervous system or lining of the heart may occur in a small percentage of cases.³ Occupational exposure is most common, with abattoir workers, farm workers, hunters, meat inspectors, veterinarians, and laboratory personnel at highest risk for infection.^{1,2} Travelers and immigrants from endemic countries are also at increased risk. *Brucella* species are classified as category B bioterrorism threat agents because of the high potential for aerosol transmission, therefore use as a bio-weapon should also be considered a potential source of exposure.^{4,5}

Brucellosis in the United States

Brucellosis remains the world's most common bacterial zoonosis with half a million new infections annually.⁴ It is endemic in domestic animals in many developing countries where animal disease control programs are inadequate. Over the past 50 years, effective control of brucellosis in animals and animal products in the United States has dramatically reduced infection in domestic livestock and humans.⁶ *B. melitensis* is not present in U.S. animals. In Florida, *B. abortus* has been eradicated and *B. canis* is rare, but *B. suis* is still endemic in the state's feral swine population.

Only about 100-200 human cases occur in the United States each year, although rates may be higher as brucellosis remains under-diagnosed and under-reported due to its non-specific clinical presentation.^{3,4} In 2005, California, Texas, and Illinois accounted for over 46% of the reported human *Brucella* infections, with 26, 17, and 13 cases, respectively.⁵ In Florida the disease is rare, but the incidence rate has increased over the past ten years with an annual average of 3.8 cases reported from 1997 to 2001 compared to 6.4 in 2002-2006.⁷ Men accounted for over 76% of cases,⁷ with hunting or handling carcasses identified as the highest risk factors involved.⁷

Conclusion

Brevard County ranks among the Florida counties with the lowest rates of brucellosis, accounting for only three of the 51 cases reported from 1997 to 2006.⁷ However in 2007, Brevard saw three brucellosis cases within 60 days, all linked to feral swine hunting. This is a concern because Florida has one of the highest feral swine populations in the United States and Brevard is home to a large and active hunting community.

Since there is no human vaccine for brucellosis, public health efforts need to be focused on education and partnership among state and local entities. The local health department should maintain relationships with hunter associations in the county and develop targeted educational materials that stress hand hygiene and PPE when handling wild animals. Since family members of hunters are also at risk when exposed to soiled clothing, they should be educated about PPE use and proper laundering of contaminated garments. In addition, healthcare providers may not consider brucellosis in a differential diagnosis due to its non-specific manifestation and the rarity of the disease in Florida.⁶ Therefore, the health department should encourage clinicians to inquire about travel history, occupational history, and hunting practices for individuals presenting with flu-like symptoms or recurrent fever. This may reduce delays in diagnosis and laboratory testing.

Furthermore, the occurrence of laboratory transmission highlights the challenges that clinicians and laboratorians face when dealing with this organism. Communication between clinicians and laboratory personnel should facilitate prompt and accurate identification and appropriate handling of the organism.⁶ Public health officials should notify laboratory personnel who may have handled the cultures of confirmed cases to identify possible laboratory exposures and promote early diagnosis and intervention with antibiotic prophylaxis. Finally, the Florida Department of Agriculture and Consumer Services should be informed of human cases of brucellosis involving animals residing in Florida to ensure that there is no threat to domestic livestock.

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Florida Year-to-Date Mosquito-Borne Disease Through January 19, 2008

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

During the period January 1-19, 2008, 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 three live wild birds and two sentinel chickens were received from three counties.

WNV Activity

None

SLEV Activity

None

HJV Activity

None

CEV Activity

None

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, 28 reports representing a total of 72 dead birds (1 crow, no jays, 3 raptors and 68 other species) were received from 14 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/.

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.

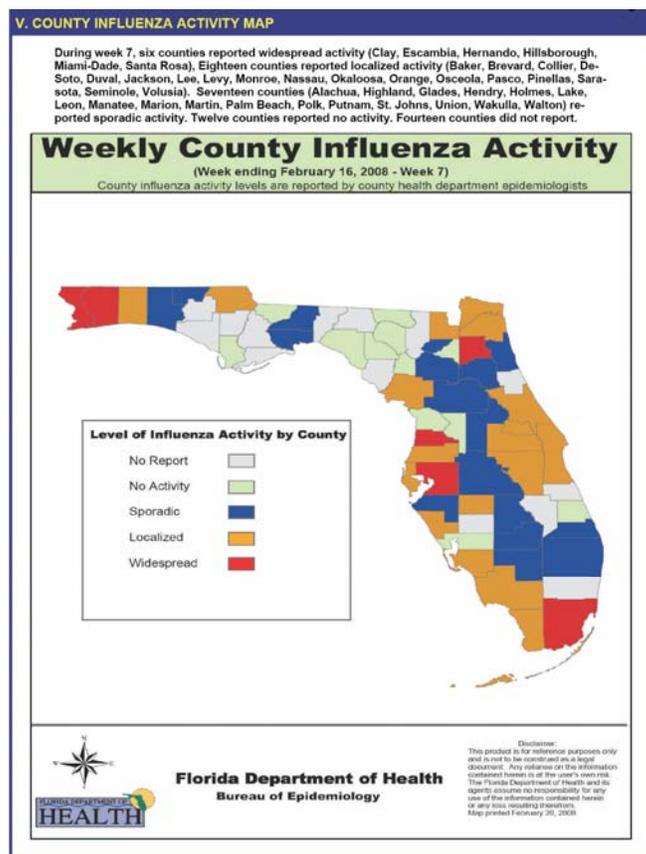
Influenza surveillance in Florida consists of six surveillance components: 1) Florida Sentinel Physician Influenza Surveillance Network (FSPISN); 2) Florida Pneumonia and Influenza Mortality Surveillance System; 3) State laboratory viral surveillance; 4) County influenza activity levels; 5) Notifiable Disease Reports; and 6) Influenza or influenza-like illness (ILI) outbreaks.

During reporting weeks three, four, five, six, and seven statewide influenza activity was localized, on average, according to the CDC influenza activity criteria. The proportion of patient visits for ILI as reported by the FSPISN averaged 1.4% for these five weeks and this is below the state threshold for moderate activity of 1.75%; however, the last two weeks have been above the threshold. The percentage ILI has changed significantly over the five weeks. In Florida, there have been isolated ILI outbreaks in several areas of the state including two school-associated outbreaks in Escambia and Miami-Dade counties, and two correctional institution outbreaks in the panhandle region. There have also been reports of community associated increases in Alachua and Hardee counties. There has been a corresponding increase in the influenza activity across the nation. Since September 30, 2007, the Florida Department of Health Laboratories have tested a total of 413 specimens for influenza viruses and 199 (48%) were positive. Among the 199 influenza viruses, 176 (88%) were influenza A viruses and 23 (12%) were influenza B viruses. During week seven only, six counties reported widespread activity. Eighteen counties reported localized activity. Seventeen counties reported sporadic activity. Twelve counties reported no activity. Twelve counties did not report.

Please encourage all sentinels to still submit samples for testing to the state lab.

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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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:

March 25 - Meningococcal Disease, presented by Kate Goodin

April 29 - Shigella: A Countywide Outbreak: Risk Factors Associated with Disease Transmission among Childcare Centers, presented by Kim Fraser, EIS

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:

- Confirmed outbreak of *Staphylococcus aureus* from smoked ham, Jackson County.
- Suspected foodborne outbreak in Palm Beach County.
- Rabid fox bites five, Boynton Beach.
- Probable meningococcal disease, Brevard County.
- Confirmed and suspected meningococcal disease in two university students, Orange County.
- Confirmed Legionella case in a Wisconsin visitor to Volusia County.
- Pertussis outbreak at St. Croix Country Day School (Virgin Islands), 10 students traveling to Florida.
- Shigella outbreak at a childcare facility, Escambia County.
- Pertussis cases, Alachua and Columbia counties.
- New Era Canning Company, Mich., voluntarily recalled green beans and garbanzo beans, potential botulism.
- Probable human case of psittacosis in a pet store employee in Minnesota, linked to a Florida vendor.
- *Vibrio vulnificus* death from undercooked oysters, Brevard County.
- Possible ciguatera cluster, Duval County.
- Influenza outbreak, Desoto Correctional Institution.
- Mumps in traveler from Philippines, Charlotte County.
- Rochester Meat Company, Minn., voluntarily recalled 188,000 pounds of ground beef products, possible *E. coli* O157:H7 contamination.
- Suspected foodborne outbreak, Pinellas County.
- Hepatitis A, Alachua County.
- Rabid horse, Glades County.
- 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/2008/January2008EpiUpdate.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.



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Tallahassee, Florida

