Florida Morbidity Statistics Report

2011

Florida Department of Health
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Florida Department of Health:
http://www.doh.state.fl.us/

Florida Morbidity Statistics Reports:
http://www.doh.state.fl.us/disease_ctrl/epi/Morbidity_Report/amr.html

Published August 2013

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Introduction

Background

The Florida Morbidity Statistics Report is the official record of the occurrence of reportable disease in Florida and this edition marks the fifty-sixth publication since 1945. The data contained here are final, unless otherwise noted. Florida Statutes Chapter 381 states, "The department shall conduct a communicable disease prevention and control program as part of fulfilling its public health mission." The mission of the Florida Department of Health is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts. This report directly supports the mission of the Department by identifying patterns and trends in the incidence of disease that are used as the scientific basis for development of disease control and prevention strategies and policies.

Disease control and prevention are core functions of any public health agency. Protection of the public's health from existing, emerging, and re-emerging diseases requires diligence in all aspects of public health. Public health partners in identifying and characterizing emerging trends in disease are the physicians, nurses, laboratorians, hospital infection preventionists, and other health care professionals who participate in reportable disease surveillance. Without their participation, the ability to recognize and intervene in emerging public health issues would be much more limited.

The Bureau of Epidemiology thanks all program areas within the Florida Department of Health that contributed to this report including Immunization, HIV/AIDS, Sexually Transmitted Disease, Tuberculosis, Environmental Health, and Public Health Laboratories. Finally, many thanks are extended to the county health department staff and other public health professionals who are involved in reportable disease surveillance, either through disease control activities, case investigations, data collection, or other essential functions.

Purpose

The Florida Morbidity Statistics Report is compiled in a single reference document to:

1. Summarize annual morbidity from reportable acute communicable and environmental diseases and cancer in Florida.
2. Describe patterns of disease that can be assessed over time, compared with trends from other states, and act as an aid in directing future disease prevention and control efforts.
3. Provide a resource to medical and public health authorities at county, state, and national levels.

Report Format

This report is divided into eight sections:

Section 1: Summary of Reportable Diseases/Conditions
Section 2: Selected Reportable Diseases/Conditions
Section 3: Summary of Cancer Data, 2009
Section 4: Summary of Antimicrobial Resistance Surveillance
Section 5: Summary of Foodborne Disease Outbreaks
Section 6: Notable Outbreaks and Case Investigations
Section 7: 2011 Publications with Florida Department of Health Authors
Section 8: Public Health Laboratory Status Report

Data Sources

Data presented in this report are based on reportable disease information received by county and state health department staff from physicians, hospitals, and laboratories throughout the state. Data on the occurrence of reportable diseases in Florida were obtained through passive and active surveillance. Reporting of suspected

and confirmed reportable diseases and conditions in the state of Florida is mandated under Florida Statute 381.0031 and Chapter 64D-3, Florida Administrative Code (F.A.C.). People in charge of laboratories, hospitals, medical facilities, or other facilities providing health services (which can include schools, nursing homes, and state institutions) are required to report certain diseases and conditions and the associated laboratory test results as listed in the Table of Notifiable Diseases or Conditions to be Reported, Chapter 64D -3, F.A.C. Reporting of test results by a laboratory does not nullify a practitioner's obligation to report the disease or condition. These data are the basis for providing useful information on reportable diseases and conditions in Florida to healthcare workers and policymakers, and would not be possible without the cooperation of the extensive network involving both private and public sector participants.

1. Passive surveillance relies on physicians, laboratories, and other healthcare providers to report diseases to the Florida Department of Health (FDOH) confidentially in one of three forms: electronically, by telephone, or by facsimile.
2. Active surveillance entails FDOH staff regularly contacting hospitals, laboratories, and physicians in an effort to identify all cases of a given disease or condition.
3. Increasingly, information about cases of reportable diseases and conditions is passed from providers, especially laboratories, to the FDOH as electronic records. This occurs automatically without the involvement of a person after the electronic transmission process has been established between FDOH and the reporting partner.

Interpreting the Data

Information in this report should be interpreted in light of the limitations below.

1. Underreporting

   The data presented in this report are primarily based on passive reporting by healthcare providers and laboratories across the state of Florida. Case reporting is most often dependent upon a person becoming ill, seeking medical attention, the healthcare provider ordering laboratory testing, and then the healthcare provider or laboratory reporting the case. Frequently, not all steps in this process occur, so the number of reported cases represents a fraction of the true number of cases of reportable illnesses occurring in Florida each year. Evaluations of infectious disease reporting systems have indicated that the completeness of reporting varies by disease. The less common, more severe reportable diseases such as bacterial meningitis, diphtheria, polio, botulism, anthrax, tuberculosis, and congenital syphilis are more completely reported than the more common but (individually) less severe diseases such as acute hepatitis C, lead poisoning, or campylobacteriosis. Variation in identified disease incidence at the local level probably reflects, to varying degrees, both differences in the true incidence of disease and differences in the vigor with which surveillance is performed.

2. Reliability of Rates

   All incidence rates in this report are expressed as the number of reported cases of a disease or condition per 100,000 population unless otherwise specified. Animal rabies is only expressed as the number of cases because no reliable denominators exist for animal populations. Rates for diseases with only a few cases reported per year can be unstable and should be interpreted with caution. The observation of zero events is especially difficult to interpret. All rates in the report based on fewer than 20 events should be considered unreliable. This translates into a relative standard error of the rate of 23% or more, which is the cut-off for rate reliability used by the National Center for Health Statistics. Based on this, rates were not generally calculated in this report when there were less than 20 events.

3. Reporting Period

   To ensure consistent case counting, the data in this report are aggregated by the date the case was reported to the Bureau of Epidemiology unless otherwise noted. The date of illness onset or the date of

diagnosis may not be available for all cases. Cases reported early in 2011 may have actually had onset or been diagnosed in 2010; rarely, cases reported in 2011 may have onset or diagnosis dates prior to 2010. Additionally, cases with illness onset or diagnosis late in 2011 may not have been reported to the Bureau of Epidemiology by the end of the 2011 reporting year, and thus would not be included in this report. The reporting year is defined by the standard reporting weeks as outlined by the Centers for Disease Control and Prevention (CDC), where every year has at least 52 reporting weeks and some years have 53. The data in this report are consistent with national surveillance data published weekly by CDC. Additionally, disease-specific reports describing data by other dates, such as disease onset and diagnosis dates, may also be published and available on the Florida Department of Health website. Diseases that use different dates to aggregate data in this report have an explanation of what date is used in the disease-specific chapter.

4. Case Definition

Cases of most diseases are classified as confirmed, probable, or suspect at the state level using a published set of surveillance case definitions in line with national case definitions where appropriate (Surveillance Case Definitions for Select Reportable Diseases in Florida, available at http:// www.doh.state.fl.us/disease_ctrl/epi/surv/CaseDefinitions.html). Case classifications are reviewed at the state level for many diseases. Following Morbidity and Mortality Weekly Report (MMWR) print criteria, only confirmed and probable cases have been included for all diseases (i.e., suspect cases are excluded) in this report unless otherwise specified.

Each year case definitions are evaluated for necessary revisions. A number of changes were made to reportable disease case definitions in 2011 as a result of position statements approved by the Council of State and Territorial Epidemiologists (CSTE) in 2010.

a. Summary of case definition changes effective January 2011:

i. Acute arboviral diseases: multiple revisions to case classification criteria.

ii. Botulism: adds a probable case classification category to the wound botulism case definition and expands the confirmed case definition to include a history of injection drug use within the two weeks before onset of symptoms.

iii. Campylobacteriosis: expands the probable case definition to include a positive stool enzyme immunoassay (EIA) (see also the summary of case definition changes July 27, 2011, below).

iv. Creutzfeldt-Jakob disease: includes reformatting of the laboratory evidence section of the case definition; detection of tau protein is now included in criteria to meet the probable case definition.

v. Cryptosporidiosis: includes reformatting of the laboratory evidence section of the case definition; detection of *Cryptosporidium* antigen has been removed from the criteria to meet the confirmed case definition; antigen detection is used as criteria to meet the probable case definition.

vi. Giardiasis: includes a reformatting and expansion of the laboratory evidence section of the case definition and revisions to the confirmed case definition. The laboratory evidence section now includes DNA. The confirmed case definition requires a case to be clinically compatible in addition to meeting the laboratory criteria; the 2010 confirmed case definition required laboratory evidence only.

vii. Lyme disease: includes a reformatting and expansion of the laboratory evidence section of the case definition. The laboratory evidence section now includes cerebrospinal fluid (CSF) antibody positive for *B. burgdorferi* by EIA or immunofluorescence assay (IFA) when the titer is higher than it was in serum.

viii. Viral hemorrhagic fever (VHF): adds viruses included in the VHF surveillance case definition. VHF case definition includes Crimean-Congo, Ebola, Guanarito, Junin, Lassa, Lujo, Machupo, Marburg, and Sabia viruses. In addition, the clinical presentation criteria and the criteria for epidemiologic linkage in the case definition have been revised.

A number of additional changes to the reportable disease case definitions were implemented mid-2011 as a result of the increase in use of non-culture based laboratory methods and position statements approved by CSTE in 2011.

b. Summary of case definition changes effective July 27, 2011:

i. Campylobacteriosis: revised the confirmed case definition, eliminating the need for clinically compatible illness for confirmed cases. Revised the probable case definition: only those cases that are epidemiologically linked to a confirmed case will continue to meet the probable case definition. Added a suspect case definition that includes all positive non-culture based laboratory results (including antigen detection) regardless of symptoms.

ii. Salmonellosis: added a suspect case definition that includes cases with positive non-culture based laboratory results regardless of symptoms.

iii. Shigellosis: added a suspect case definition that includes cases with positive non-culture based laboratory results regardless of symptoms.

iv. *Escherichia coli*, Shiga toxin-producing (STEC): updated the note section to add clarification to current procedures; all Shiga toxin positive specimens should be sent to the Bureau of Public Health Laboratories for confirmation and additional testing.

Changes to case definitions can affect the number of cases reported, which can impact calculated incidence rates, but ultimately case definition changes do not change the true incidence of a disease.

5. Assigning Cases to Counties
Cases are assigned to Florida counties based on the county of residence at the time of the disease. Cases are assigned to their county of residence regardless of where they became ill or were hospitalized, diagnosed, or exposed. Cases who reside outside of Florida are not counted as Florida cases regardless of whether they became ill or were hospitalized, diagnosed, or exposed in Florida. Cases in out-of-state residents exposed or infected in Florida are not counted as Florida cases and are not included in this report. These cases are referred through an interstate reciprocal notification system to the state where the person resides.

6. Population Estimates
All population estimates are from the Community Health Assessment Resource Tool Set (CHARTS). CHARTS receives estimates from the Florida Department of Health Office of Health Statistics and Assessment in consultation with the Florida Legislature's Office of Economic and Demographic Research (EDR). Estimates are updated once per year. Note that previous editions of this report may show somewhat different populations for a given year than the ones shown here, as these estimates are revised periodically. This is especially true given the recent 2010 census.

7. Florida Disease Codes in Merlin

Reported cases are stored in Merlin, Florida's web-based reportable disease surveillance system. When entering a case into Merlin, users assign a Florida Disease Code based on the disease. Due to changes in case definitions over time, new codes have been added and outdated codes have expired. In addition, some diseases have multiple disease codes that represent different clinical manifestations. Diseases that include cases from multiple or expired Florida Disease Codes in this report are listed below.

California serogroup virus
- CALIFORNIA SEROGROUP, NEUROINVASIVE - 06250
- CALIFORNIA SEROGROUP, NON-NEUROINVASIVE - 06251

Dengue fever
- DENGUE FEVER - 06100
- DENGUE HEMORRHAGIC FEVER - 06101

Eastern equine encephalitis
- EASTERN EQUINE ENCEPHALITIS, NEUROINVASIVE - 06220
- EASTERN EQUINE ENCEPHALITIS, NON-NEUROINVASIVE - 06221

E. coli, Shiga toxin-producing
- ENTEROHEMORRHAGIC E. COLI (EHEC) O157:H7 - 41601 (EXPIRED)
- E. COLI SHIGA TOXIN + (SEROGROUP NON-O157) - 41602 (EXPIRED)
- E. COLI SHIGA TOXIN + (NOT SEROGROUPED) - 41603 (EXPIRED)
- ESCHERICHIA COLI, SHIGA TOXIN PRODUCING - 00800

Ehrlichiosis/anaplasmosis
- EHRLICHIOSIS, HUMAN - 08380 (EXPIRED)
- EHRLICHIOSIS/ANAPLASMOSIS, E. EWINGII - 08383,
- EHRLICHIOSIS/ANAPLASMOSIS, HGE, A. PHAGOCYTOPHILUM - 08381,
- EHRLICHIOSIS/ANAPLASMOSIS, HME, E. CHAFFEENSIS - 08382,
- EHRLICHIOSIS/ANAPLASMOSIS, UNDETERMINED - 08384

Encephalitis, other
- ENCEPHALITIS, CHICKENPOX - 05200 (EXPIRED)
- ENCEPHALITIS, HERPES - 05430 (EXPIRED)
- ENCEPHALITIS, INFLUENZA - 48780 (EXPIRED)
- ENCEPHALITIS, MEASLES - 05500 (EXPIRED)
- ENCEPHALITIS, MUMPS - 07220 (EXPIRED)
- ENCEPHALITIS, OTHER - 32390 (EXPIRED)
- ENCEPHALITIS, OTHER (NON-ARBOVIRAL) - 03236

Haemophilus influenzae, invasive disease
- H. INFLUENZAE CELLULITIS - 69290 (EXPIRED)
- H. INFLUENZAE EPIGLOTTITIS - 46430 (EXPIRED)
- H. INFLUENZAE MENINGITIS - 32000 (EXPIRED)
- H. INFLUENZAE SEPTIC ARTHRITIS - 71100 (EXPIRED)
- HAEMOPHILUS INFLUENZAE (INVASIVE DISEASE) - 03841

Listeriosis
- LISTERIOSIS - 02700
- MENINGITIS, LISTERIA MONOCYTOGENES – 32070 (EXPIRED)

Meningococcal disease
- MENINGITIS, MENINGOCOCCAL - 03600 (EXPIRED)
- MENINGOCOCCAL DISEASE - 03630
- MENINGOCOCCEMIA, DISSEMINATED - 03620 (EXPIRED)
- PNEUMONIA N.MENING - 03689 (EXPIRED)

Plague
- PLAGUE, BUBONIC - 02000
- PLAGUE, PNEUMONIC - 02050

Poliomyelitis
- POLIOMYELITIS - 04590
- POLIOMYELITIS, NONPARALYTIC - 04520

Q fever
- Q FEVER - 08300 (EXPIRED)
- Q FEVER ACUTE - 08301
- Q FEVER CHRONIC - 08302

St. Louis encephalitis
- ST. LOUIS ENCEPHALITIS VIRUS, NEUROINVASIVE - 06230
- ST. LOUIS ENCEPHALITIS VIRUS, NON-NEUROINVASIVE - 06231

Typhus fever
- TYPHUS FEVER - 08190 (EXPIRED)
- TYPHUS FEVER, ENDEMIC (MURIN) - 08100
- TYPHUS FEVER, EPIDEMIC (LOUSE) - 08000

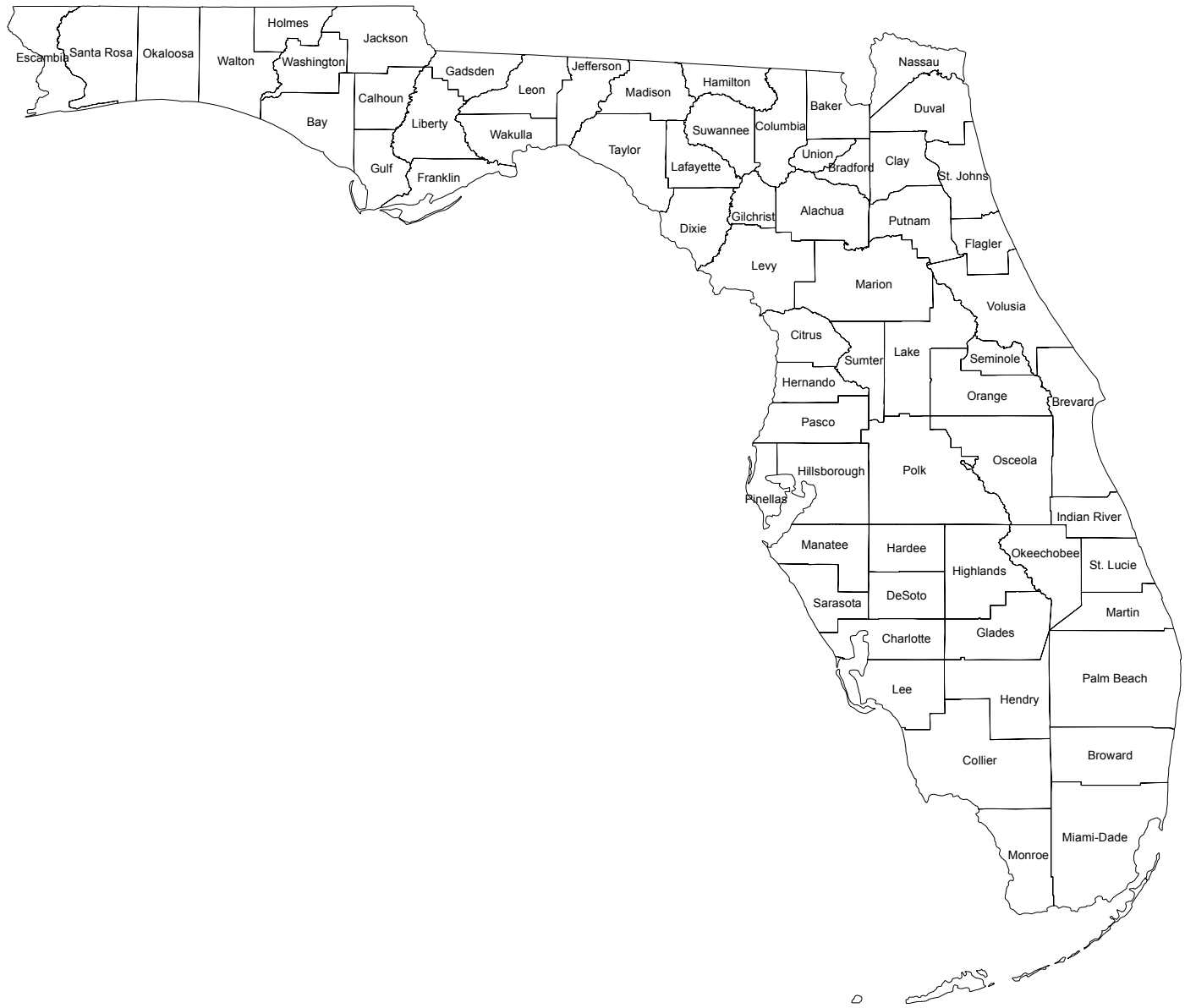
Venezuelan equine encephalitis
- VENEZUELAN EQUINE ENCEPHALITIS VIRUS, NEUROINVASIVE - 06620
- VENEZUELAN EQUINE ENCEPHALITIS VIRUS, NON-NEUROINVASIVE - 06621

Vibrio infections
- VIBRIO ALGINOLYTICUS - 00195
- VIBRIO CHOLERAE NON-O1 - 00198
- VIBRIO FLUVIALIS - 00194
- VIBRIO HOLLISAE - 00196
- VIBRIO MIMICUS - 00197
- VIBRIO PARAHAEMOLYTICUS - 00540
- VIBRIO VULNIFICUS - 00199
- VIBRIO, OTHER - 00193

West Nile virus
- WEST NILE VIRUS, NEUROINVASIVE - 06630
- WEST NILE VIRUS, NON-NEUROINVASIVE - 06631

Western equine encephalitis
- WESTERN EQUINE ENCEPHALITIS, NEUROINVASIVE - 06210
- WESTERN EQUINE ENCEPHALITIS, NON-NEUROINVASIVE - 06211

Florida County Boundaries



Florida Population Estimates

Table 1. Florida Population by Year, 2002-2011

Year	Population
2002	16,772,201
2003	17,164,199
2004	17,613,368
2005	18,018,497
2006	18,440,700
2007	18,731,287
2008	18,812,155
2009	18,819,000
2010	18,788,795
2011	18,934,287

Table 2. Florida Population by Age Group, 2011

Age Group	2011 Population
<1	209,739
1-4	861,809
5-9	1,089,617
10-14	1,131,815
15-19	1,213,606
20-24	1,245,246
25-34	2,327,217
35-44	2,399,046
45-54	2,716,012
55-64	2,397,657
65-74	1,786,874
75-84	1,107,266
85+	448,383
Total	18,934,287

Table 3. Florida Population by Gender, 2011

Gender	2011 Population
Female	9,675,000
Male	9,259,287
Total	18,934,287

Table 4. Florida Population by Race, 2011

Race	2011 Population
White	14,164,982
Black	3,040,498
Other	1,728,807
Total	18,934,287

List of Reportable Diseases/Conditions in Florida, 2011

Section 381.0031 (2), Florida Statutes, provides that "Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; any hospital licensed under part I of chapter 395; or any laboratory licensed under chapter 483 that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health." County health departments serve as the Department's representative in this reporting requirement. Furthermore, Section 381.0031 (4) provides that "The department shall periodically issue a list of infectious or noninfectious diseases determined by it to be a threat to public health and therefore of significance to public health and shall furnish a copy of the list to the practitioners listed in subsection (2)…". This list reflects diseases and conditions that were reportable in 2011. Updates may be made in future years; Morbidity Statistics Reports for subsequent years will reflect changes in the list.

- Acquired Immunodeficiency Syndrome (AIDS)
- Amebic encephalitis
- Anthrax
- Arsenic poisoning
- Botulism
- Brucellosis
- California serogroup virus disease (neuroinvasive and non-neuroinvasive)
- Campylobacteriosis
- Cancer (except non-melanoma skin cancer, and including benign and borderline intracranial and CNS tumors)
- Carbon monoxide poisoning
- Chancroid
- Chlamydia
- Cholera
- Ciguatera fish poisoning
- Congenital anomalies
- Conjunctivitis (in neonates ≤14 days old)
- Creutzfeldt-Jakob disease
- Cryptosporidiosis
- Cyclosporiasis
- Dengue
- Diphtheria
- Eastern equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
- Ehrlichiosis/anaplasmosis
- Encephalitis, other (non-arboviral)
- Enteric diseases due to:
  - *Escherichia coli*, O157:H7
  - *Escherichia coli*, other pathogenic E. coli including entero-toxigenic, invasive, pathogenic, hemorrhagic, aggregative strains and Shiga toxin-producing strains
- Giardiasis
- Glanders
- Gonorrhea
- Granuloma inguinale
- *Haemophilus influenzae*, invasive disease
- Hansen's Disease (Leprosy)
- Hantavirus infection
- Hemolytic uremic syndrome
- Hepatitis A
- Hepatitis B, C, D, E, and G
- Hepatitis B surface antigen in pregnant women or children ≤24 months old
- Herpes simplex virus in infants ≤6 months old, anogenital in children ≤12 years old
- Human immunodeficiency virus (HIV) infection
- Human papillomavirus in children ≤6 years old, anogenital in children ≤12 years old, cancer associated strains
- Influenza due to novel or pandemic strains
- Influenza-associated pediatric mortality (in children <18 years old)
- Lead poisoning
- Legionellosis
- Leptospirosis
- Listeriosis
- Lyme disease
- Lymphogranuloma venereum
- Malaria
- Measles
- Melioidosis
- Meningitis (bacterial, cryptococcal, mycotic)
- Meningococcal disease
- Mercury poisoning
- Mumps
- Neurotoxic shellfish poisoning
- Pertussis
- Pesticide-related illness and injury
- Plague
- Poliomyelitis
- Psittacosis
- Q Fever
- Rabies (human, animal, possible exposure)
- Ricin toxicity
- Rocky Mountain spotted fever
- Rubella (including congenital)
- St. Louis encephalitis virus disease (neuroinvasive and non-neuroinvasive)
- Salmonellosis
- Saxitoxin poisoning (including paralytic shellfish poisoning)
- Severe acute respiratory syndrome-associated *Coronavirus* (SARS-CoV) disease
- Shigellosis
- Smallpox
- *Staphylococcus aureus* (with intermediate or full resistance to vancomycin)
- *Staphylococcus aureus*, methicilin resistant (MRSA), community associated mortality
- *Staphylococcus* enterotoxin B poisoning
- Streptococcal invasive disease (Group A)
- *Streptococcus pneumoniae*, invasive disease
- Syphilis
- Tetanus
- Toxoplasmosis (acute)
- Trichinosis
- Tuberculosis
- Tularemia
- Typhoid fever
- Typhus fever (epidemic and endemic)
- Vaccinia disease
- Varicella mortality
- Venezuelan equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
- Vibriosis
- Viral hemorrhagic fevers (Ebola, Marburg, Lassa, Machupo)
- West Nile virus disease (neuroinvasive and non-neuroinvasive)
- Western equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
- Yellow fever
- Any disease outbreak
- Any grouping or clustering of disease

Selected Division of Disease Control and Health Protection Contacts

Bureau of Epidemiology
(850) 245-4401 (accessible 24/7/365)
http://www.doh.state.fl.us/disease_ctrl/epi/

Bureau of Communicable Disease
http://www.doh.state.fl.us/disease_ctrl/communicable/index.html

HIV/AIDS and Hepatitis Prevention Program
(850) 245-4334
http://www.doh.state.fl.us/disease_ctrl/aids/

Immunization Program
(850) 245-4342
http://www.doh.state.fl.us/disease_ctrl/immune/index.htm

Sexually Transmitted Disease Program
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http://www.doh.state.fl.us/disease_ctrl/std/index.html

Tuberculosis Program
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2011 Summary of Key Disease Trends

Sexually transmitted diseases (STDs), HIV, and AIDS are the most common reportable diseases in Florida, particularly among 15 to 54-year-olds. Chlamydia incidence has been increasing over the past 10 years, with over 76,000 cases reported in Florida in 2011. As chlamydia has increased, the number of gonorrhea cases has consistently decreased in past years. A shift in treatment guidelines and recommendations for screening of women under the age of 25 contributed to the decrease in gonorrhea cases. The incidence of HIV and AIDS has also decreased over the last 10 years, though both diseases increased slightly in 2011 compared to 2010. Syphilis incidence has remained relatively stable for the past 10 years, with only a 5.8% increase in 2011 compared to the previous 5-year average.

In the mid-1980s tuberculosis (TB) re-emerged as a public health threat in the U.S. The number of cases of TB in Florida has decreased every year since 1994. Over the past 20 years, the number of TB cases counted in foreign-born people has remained relatively constant while decreasing dramatically in U.S.-born people. The incidence in 2011 decreased 18.4% from the previous 5-year average.

Florida consistently has one of the highest rates of enteric disease in the nation, with 10,000 to 12,000 cases reported annually. Incidence continued to be high in 2011. Shigellosis activity increased statewide starting in June 2010 and remained high throughout 2011. An increase in non-culture diagnostic laboratory testing and a change in case definition for campylobacteriosis in 2011 contributed to a 68.4% increase in cases compared to 2010. Incidence of other enteric diseases remained relatively stable in 2011.

Despite high vaccine coverage in Florida, vaccine-preventable diseases (VPDs) continued to occur. VPD incidence decreased slightly overall in Florida in 2011 compared to 2010. Acute hepatitis A and hepatitis B incidence has declined drastically over the past decade, likely due to increased vaccination coverage. In contrast, pertussis has been increasing over the past decade, though fewer cases were reported in 2011 than in 2010. More measles cases were reported in 2011 than in any other year since 1997. Eight measles cases were reported; five (62.5%) of these infections were acquired outside the U.S. and seven (87.5%) were in unvaccinated children (vaccination status was unknown for one case in an adult).

Overall, reported tick-borne disease incidence increased by more than 60% in 2011 compared to the previous 5-year average. Lyme disease and ehrlichiosis/anaplasmosis accounted for the increase (largely due to changes in the surveillance case definition), while Rocky Mountain spotted fever incidence actually declined by 27.7%. While most people with ehrlichiosis/anaplasmosis and Rocky Mountain spotted fever continue to acquire their infections in Florida, most people with Lyme disease continue to acquire infections in other states (primarily Northeast and upper Midwest U.S.).

Mosquito-borne disease continued to be a threat in Florida. The number of reported malaria and dengue fever cases decreased in 2011, after both diseases had large increases in activity in 2010. The large number of dengue fever cases in 2010 was partially due to infections acquired in Florida (primarily Monroe County), as well as epidemics in areas with high volumes of travelers to the U.S., such as Puerto Rico. Isolated cases of locally-acquired dengue fever were also identified in south Florida counties in 2011. The increase in malaria cases reported in 2010 was primarily due to cases imported from Haiti following a large earthquake at the beginning of the year. After several years of drought, West Nile virus illness cases began increasing in 2010 and continued to increase in 2011. While most exposures in 2010 occurred in counties located in the central and southern part of the state, cases occurring in 2011 were focused in Duval County.

Chronic hepatitis continues to account for a large bulk of infectious disease burden in Florida with over 25,000 cases reported annually. In 2011, the rate of newly diagnosed chronic hepatitis C cases was the highest it has been since 2008. Overall, the highest rates occurred among people 45 to 64 years old, with stable rates since 2008. In contrast, the rate of chronic hepatitis C new diagnoses has continued to increase since 2005

among people aged 20 to 34 years. This trend is seen in acute hepatitis C cases as well. While the overall rate of acute hepatitis C remained level in 2011, for the first time the number of cases diagnosed in young adults (aged 20 to 34 years) outpaced those in older adults. The 2011 rate of newly diagnosed chronic hepatitis B cases was the lowest it has been since 2007, with the majority of cases occurring in people 30 to 54 years old.

For additional information on disease-specific trends, refer to the full 2011 Florida Morbidity Statistics Report, available online at http://www.doh.state.fl.us/disease_ctrl/epi/Morbidity_Report/amr.html.