CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
Keeping Connecticut Healthy

Connecticut Epidemiologist

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Reportable Diseases and Laboratory Findings, 2002

The lists of Reportable Diseases and Laboratory Reportable Significant Findings are revised annually by the Department of Public Health (DPH). An advisory committee of public health officials, clinicians, and laboratorians contribute to the process. There is one modification to the lists effective January 1, 2002.

CHANGES TO THE HIV REPORTING SYSTEM

Newly recognized human immunodeficiency virus (HIV) infection in adolescents and adults has been added to the DPH Lists of Reportable Diseases and Significant Laboratory Findings and is reportable by both health care providers and laboratories. Since 1982, the DPH has relied heavily on acquired immunodeficiency syndrome (AIDS) surveillance data to monitor trends in the epidemic but due to improvements in the management and care of persons with HIV infection, trends in AIDS incidence do not necessarily reflect underlying trends in HIV transmission.

Except in certain cases, such as HIV infection in children or HIV/tuberculosis (TB) co-infection, HIV infection (non-AIDS) has not been monitored in Connecticut. In 1999, the DPH implemented laboratory reporting of positive HIV laboratory findings without patient identifiers. Although these data highlighted some important differences between AIDS trends and HIV trends, the system did not provide the level of detail needed to accurately monitor the epidemic.

The specific objectives of HIV reporting are to a) determine the number and epidemiologic characteristics of persons newly diagnosed with HIV infection; b) identify trends in the number of persons newly found with HIV infection over time; c) determine predictors of progression of HIV infection to AIDS; d) contribute to the national HIV reporting system; and e) position Connecticut to take advantage of federal funding opportunities for HIV/AIDS-related services that are based on the number of persons with HIV infection in addition to the number with AIDS.

REPORTING HIV BY NAME WITH A CODE OPTION

Although HIV infection will now be reportable by name, there is an option for physicians (but not laboratories) to report using a state-specified code instead of a name. The code option will allow the DPH to collect needed information and at the same time allow individuals to have a code reported instead of their name. The code option should be used at the patient's request. Patients should be apprised of this option during their pretest counseling session. It is recommended that consent forms be revised to include information about the option. The DPH will be developing and distributing a revised model consent form in the near future.

INSTRUCTIONS FOR LABORATORIES

Instructions for laboratory reporting of HIV infection have been sent in a separate mailing to laboratory directors. In summary, laboratories are now required to report positive tests for HIV infection in the same way as any other reportable laboratory significant finding—using name as the patient identifier. Thus, physician-laboratory communication including billing can continue to be done in the conventional manner, and HIV-related tests can continue to be ordered by providers using the patient name. Although laboratories will be reporting HIV to the DPH by name, only the patient identifier submitted by the health care provider on the completed HIV/AIDS report form will be entered into the DPH HIV/AIDS registry.

INSTRUCTIONS FOR PHYSICIANS

Beginning in January 2002, patients testing positive for HIV for the first time or being newly diagnosed with HIV infection should be reported to the DPH. Patients with an initial HIV diagnosis date or initial HIV test date prior to January 2002 are <u>not</u> required to be reported.

- Physicians should report HIV cases to the DPH using the patient's name or a DPH-specified code. Code reporting should be done at the patient's request.
- Physicians are encouraged to modify their consent forms to include information about the code option.
- There is <u>NO</u> code-reporting option for persons who meet the AIDS case definition, HIV-positive children (< 13 years), or persons with HIV/TB co-infection.

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In this issue...

R E P O R T A B L E   D I S E A S E S - 2 0 0 2

The Commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 2002 are noted in **bold** and with an asterisk (*).

Each report (by mail or telephone) should include the: full name and address of the person reporting, attending physician, disease being reported, and full name, address, race/ethnicity, sex and occupation of the person affected. The reports should be sent in envelopes marked "CONFIDENTIAL".

Category 1: Reportable immediately by telephone on the day of recognition or strong suspicion of disease. On weekdays, reports are made to the DPH and local health departments; in the evening and on weekends, to the DPH. A Confidential Disease Report (PD-23) or more disease-specific report form should be mailed to both the DPH and local health departments within 12 hours.

- Cholera
- Diphtheria
- Measles
- Meningococcal disease
- Outbreaks:
  - Foodborne outbreaks (involving ≥ 2 persons)
  - Institutional outbreaks
  - Unusual disease or illness (1)
- Pertussis
- Poliomyelitis
- Rabies (human and animal)
- Rubella (including congenital)
- *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin (2)

(list continued in next column)

- Tuberculosis
- Yellow Fever

Diseases that are possible indicators of bioterrorism.

- Anthrax
- Botulism
- Brucellosis
- Outbreaks of unusual disease or illness (1)
- Plague
- Q fever
- Ricin poisoning
- Smallpox
- Staphylococcal enterotoxin B pulmonary poisoning
- Tularemia
- Venezuelan equine encephalitis
- Viral hemorrhagic fever

Category 2: Reportable by mail within 12 hours of recognition or strong suspicion to both the DPH and local health departments.

- Acquired immunodeficiency syndrome (2,3)
- Babesiosis
- Campylobacteriosis
- Carbon monoxide poisoning (4)
- Chancroid
- Chlamydia (*C. trachomatis*) (all sites)
- Chickenpox
- Chickenpox-related death
- Creutzfeldt-Jacob disease < 55 years of age
- Cryptosporidiosis
- Cyclosporiasis
- Ehrlichiosis
- Encephalitis
- *Escherichia coli* O157:H7 gastroenteritis
- Gonorrhea
- Group A streptococcal disease, invasive (5)
- Group B streptococcal disease, invasive (5)
- *Haemophilus influenzae* disease, invasive, all serotypes (5)
- Hansen's disease (Leprosy)
- Hemolytic-uremic syndrome
- Hepatitis A, C, Delta, Non-A/non-B
- Hepatitis B
  - acute infection
  - HBsAg positive pregnant woman
- HIV exposure in infant born 1/1/2001 or later (2,6)
- **HIV infection in: (2)***
  - person with active tuberculosis disease
  - person with latent tuberculosis infection (history or tuberculin skin test > 5mm induration by Mantoux technique)
  - child < 13 years of age
  - person ≥ 13 years of age not included above **(7)***
- Lead Toxicity (blood lead ≥ 20 ug/dL)
- Legionellosis
- Listeriosis
- Lyme disease
- Malaria
- Mercury poisoning
- Mumps
- Neonatal herpes (<1 month of age)
- Occupational asthma
- Pneumococcal disease, invasive (5)
- Reye syndrome
- Rheumatic fever
- Rocky Mountain spotted fever
- Salmonellosis
- Shiga toxin-related disease (gastroenteritis)
- Shigellosis
- Silicosis
- *Staphylococcus aureus* methicillin-resistant disease, invasive, community acquired (5,8)
- *Staphylococcus epidermidis* disease, reduced or resistant susceptibility to vancomycin (2)
- Syphilis
- Tetanus
- Toxoplasmosis
- Trichinosis
- Typhoid fever
- Typhus
- *Vibrio parahaemolyticus* infection
- *Vibrio vulnificus* infection

1 Individual cases of "significant unusual illness" are also reportable. 2 Report only to the State. 3 CDC case definition.
4 Includes person being treated in hyperbaric chambers for suspect CO poisoning.
5 Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, other normally sterile sites, and intraoperative swab from a normally sterile site or normally sterile tissue obtained during surgery.
6 "Exposure" includes infant born to known HIV-infected mother.
7 Reports for this category of people only can be made either by using name and full street address as the patient identifier or by using a state-specified unique identifier (UI) and town of residence. To make the UI, the first 3 letters of the patient's last name, date of birth, race and sex need to be reported.
8 Community-acquired: infection present on admission to hospital and person has no previous hospitalizations or regular contact with the health-care setting.

How to report: The PD-23 is the general disease reporting form and should be used if other specialized forms are not available. Specialized reporting forms from the following programs are available: HIV/AIDS Surveillance (860-509-7900), Sexually Transmitted Disease Program (860-509-7920), the Pulmonary Diseases Program (860-509-7722), or the Occupational Health Surveillance Program (860-509-7744). Forms may be obtained by writing the Department of Public Health, Epidemiology Program, 410 Capitol Ave., MS#11EPI, P.O. Box 340308, Hartford, CT 06134-0308 (860-509-7994); or by calling the individual program.

Telephone reports of Category 1 disease should be made to the local director of health for the town in which the patient resides and to the Epidemiology Program (860-509-7994). Tuberculosis cases should be directly reported to the Pulmonary Diseases Program (860-509-7722). For the name, address, or telephone number of the local Director of Health for a specific town contact the Office of Local Health Administration (860-509-7660). **For public health emergencies, an epidemiologist can be reached nights and weekends through the DPH emergency number (860-509-8000).**

LABORATORY REPORTABLE SIGNIFICANT FINDINGS - 2002

The director of any clinical laboratory must report any laboratory evidence suggestive of reportable diseases. A standard form, known as the Laboratory Report of Significant Findings (OL-15C) is available for reporting these laboratory findings. These forms are available from the Connecticut Department of Public Health, Epidemiology Program, 410 Capitol Ave., MS#11EPI, P.O. Box 340308, Hartford, CT 06134-0308; telephone: (860 509-7994). The laboratory reports are not substitutes for physician reports; they are supplements to physician reports which allow verification of diagnosis. A special listing of diseases indicative of possible bioterrorism is highlighted at the end of this list. Changes for 2002 are noted in **bold** and with an asterisk (*).

AIDS (report only to the State)
- CD4+ T-lymphocyte counts <200 cells/uL: _____cells/uL
- CD4+ count < 14% of total lymphocytes: ______%

Babesiosis: ❑IFA IgM (titer) _____ IgG (titer):_____ ❑Blood smear ❑PCR ❑Other: ______
Campylobacteriosis (species) ____________________
Carboxyhemoglobin ≥ 9%: ___________% COHb
Chancroid
Chickenpox, acute: ❑IgM ❑Culture ❑PCR ❑DFA ❑Other: ___________
Chlamydia (*C. trachomatis)* (test type: ____________)
Creutzfeldt-Jakob disease, age < 55 years (biopsy)
Cryptosporidiosis (method of ID) _________________
Cyclosporiasis (method of ID) ___________________
Diphtheria (1)
Ehrlichiosis (2) ❑HGE ❑HME ❑Unspecified ❑IFA ❑Blood smear ❑PCR ❑Other: _________
Encephalitis:
- California group virus (species) ___________________
- Eastern equine encephalitis virus
- St. Louis encephalitis virus
- West Nile virus infection – human or animal
- Other arbovirus (specify) _______________________

Enterococcal infection, vancomycin-resistant (2, 3)_________
Escherichia coli O157 infection (1)
Food poisoning (2) :_________________
Giardiasis
Gonorrhea (test type: ____________________________)
Group A streptococcal disease, invasive (1,3)
Group B streptococcal disease, invasive (3)
Haemophilus influenzae disease, invasive, all serotypes (1,3)
Hansen's disease (Leprosy)
Hepatitis A ❑ IgM anti-HAV
Hepatitis B ❑ HBsAg ❑ IgM anti-HBc
Hepatitis C (anti-HCV)
Hepatitis delta ❑HDAg, ❑ IgM anti-HD
HIV Infection (report only to the State)
- HIV-1 infection in child < 13 years of age (4)
- HIV-1 infection in person ≥ 13 years of age (5)

Influenza: ❑ A ❑ B
Lead Poisoning (blood lead ≥ 10 ug/dL)
❑ Finger Stick: ______ ug/dL ❑ Venous: ______ ug/dL
Legionellosis
❑ Culture ❑ DFA ❑ Ag positive
❑ Four-fold serologic change (titers): ______________
Listeriosis (1)
Lyme disease (check all that apply)
EIA IgM ______ IgG ______ Polyvalent _______
W. blot IgM ______ IgG ______ Polyvalent _______
Malaria/blood parasites (1,2) : _______________________
Measles (Rubeola) (titer): ________________________
Meningococcal disease, invasive (1,3)
Mercury poisoning (urine ≥ 35 ug/g creatinine or blood ≥ 1.5 ug/dL)
Mumps (titer): _________________
Pertussis (titer): ________________
DFA Smear: ❑ Positive ❑ Negative
Culture: ❑ Positive ❑ Negative
Pneumococcal disease, invasive (1,3)
Oxacillin disk zone size: _________ mm
MIC to penicillin: _______________ ug/mL
Poliomyelitis
Rabies
Rocky Mountain spotted fever
Rubella (titer): _________________
Salmonellosis (1,2) (serogroup/serotype) _______________
Shiga toxin-related disease (1)
Shigellosis (1,2) (serogroup/species) ___________________
Staphylococcus aureus infection with MIC to vancomycin ≥ 4 ug/mL (1)
MIC to vancomycin: __________ ug/mL
Staphylococcus aureus disease, invasive (3)
methicillin-resistant Date pt. Admitted _____/_____/______
Staphylococcus epidermidis infection with MIC to vancomycin ≥ 4 ug/mL (1)
MIC to vancomycin: __________ ug/mL
Syphilis ❑ RPR (titer): ______ ❑ FTA (titer): ________ ❑ VDRL (titer): ______ ❑ MHA (titer): _______
Toxoplasmosis (7) ❑ IgM (titer) ___ ❑ IgG (titer) ____ ❑ PCR
Trichinosis
Tuberculosis (1)
Specimen type: ______________________________
AFB Smear: ❑ Positive ❑ Negative
If positive: ❑ Rare ❑ Few ❑ Numerous
Culture:
❑ *Mycobacterium tuberculosis* only
❑ Other mycobacterium (specify: M. ____________)
Typhus
Vibrio infection (6) (species) _______________________
Yersiniosis (species) ____________________________

Diseases that are possible indicators of bioterrorism.

Anthrax (1)
Botulism
Brucellosis (1)
Plague
Q fever
Ricin poisoning
Smallpox
Staphylococcal enterotoxin B pulmonary poisoning
Tularemia
Venezuelan equine encephalitis
Viral hemorrhagic fever

1 Send isolate, culture or slide to the State Laboratory for confirmation. For Shiga-toxin, send broth culture from which positive Shiga-toxin test was made.
2 Specify etiologic agent.
3 Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, other normally sterile sites, and intraoperative swab from a normally sterile site or normally sterile tissue obtained during surgery.
4 Report any tests indicative of HIV infection including antibody, antigen, PCR-based and viral load tests with name and street address.
5 Report only confirmed HIV antibody tests or positive HIV antigen tests **with name*** and street address. Viral load and PCR-based test results not reportable for this age group.
6 Send *V. cholerae, V. parahaemolyticus*, and *V. vulnificus* isolates to the State Laboratory for confirmation.
7 Report only IgG titers that are considered significant by the laboratory performing the test.

Connecticut Department of Public Health
410 Capitol Ave., MS11EPI
P.O. Box 340308
Hartford, CT 06134-0308

In This Issue...

- CONSENT: Patient consent is required for testing - consent is not required for reporting.
- HIV reports, whether by name or code, should be submitted using the *Adult HIV/AIDS Confidential Case Report Form*. Forms can be obtained by calling the HIV/AIDS Surveillance Program at (860) 509-7900. AIDS and HIV cases are reported using the same form.
- CODE REPORTING: If a code is being used, the first three letters of the client's last name should be put in the "*Patient's Name*" space on the *Adult HIV/AIDS Confidential Case Report Form*. The DPH will complete the code from other information on the form (sex, race, date of birth). If a code is being used, do not report street address, just town of residence.
- Anonymous testing at DPH-funded HIV counseling and testing sites will continue to be available.
- **SEND CASE REPORTS TO:**
  Connecticut Department of Public Health
  410 Capitol Ave MS #11ASV
  PO Box 340308
  Hartford CT 06134-0308.
  (Mark envelopes "CONFIDENTIAL")

For additional information please contact the HIV/AIDS Surveillance Program at (860) 509-7900. HIV/AIDS surveillance data can be found at www.dph.state.ct.us.

US and Connecticut AIDS Cases

	US (1)		CT (2)	
	No.	%	No.	%
Sex				
Male	36,074	76.6%	384	65.1%
Female	11,007	23.4%	206	34.9%
Race				
White	15,443	32.9%	268	45.4%
Black	21,728	46.3%	149	25.3%
Hispanic	9,255	19.7%	171	29.0%
Other/Unk	517	1.1%	2	0.3%
Age				
<20	578	1.3%	0	0.0%
20-29	6,146	13.4%	53	9.0%
30-39	19,475	42.2%	245	41.5%
40-49	13,777	30.0%	201	34.1%
50+	6,009	13.1%	91	15.4%
Risk				
MSM	15,999	34.0%	92	15.6%
IDU	10,536	22.4%	248	42.0%
MSM/IDU	1,940	4.1%	10	1.7%
Adult Hemophiliac	171	0.4%	1	0.2%
Heterosexual	7,051	15.0%	79	13.4%
Transfusion	266	0.6%	0	0.0%
Undetermine	10,798	22.9%	160	27.1%
Pediatric	322	0.7%	0	0.0%
Total	47,083	100%	590	100%

(1) CDC, HIV/AIDS Surveillance Report, June 2000, reported cases July 1999-June 2000.
(2) Reported cases in 2001.

John G. Rowland, Governor
Joxel Garcia, MD, MBA, Commissioner of Health

James L. Hadler, MD, MPH
State Epidemiologist
Division of Infectious Diseases

AIDS Epidemiology	(860) 509-7900
Epidemiology	(860) 509-7994
Immunizations	(860) 509-7929
Pulmonary Diseases	(860) 509-7722
Sexually Transmitted Diseases (STD)	(860) 509-7920

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