CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
Keeping Connecticut Healthy

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Reportable Diseases and Laboratory Findings, 2004

As required by Connecticut General Statutes Section 19a-2a and Section 19a-36-A2 of the Public Health Code, 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 are four modifications to the lists effective January 1, 2004.

SARS-Associated Coronavirus (SARS-CoV) Disease

SARS was made reportable by a declaration by the Commissioner in April 2003. For 2004, SARS-CoV infection will continue on the list of Reportable Diseases as a Category 1 disease reportable by telephone immediately on day of recognition or strong suspicion. SARS-CoV infection has also been added to the list of Laboratory Reportable Significant Findings, and laboratories performing testing are required to send residual specimens to the DPH laboratory for confirmatory testing.

The Centers for Disease Control and Prevention (CDC) and the Council of State and Territorial Epidemiologists (CSTE) have developed guidelines to monitor for the possible re-emergence of SARS-CoV. These include considering SARS in the differential diagnosis of anyone with pneumonia or acute respiratory distress syndrome who has occupational or travel risk factors that might lead them to early exposure to SARS-CoV. These guidelines are available on the CDC Website at: www.cdc.gov/ncidod/sars/updatedguidance.htm.

The DPH will provide free SARS laboratory testing for persons meeting the clinical and epidemiologic criteria established by the CSTE and the CDC.

The purpose of surveillance is to: 1) accurately determine whether SARS-CoV has re-emerged; 2) detect all cases of SARS-CoV infection as early as possible so that adequate isolation and public health control measures can be implemented; 3) detect outbreaks of SARS-CoV and limit their duration and health impact; and 4) determine the magnitude of morbidity caused by SARS-CoV and to monitor its epidemiology over time.

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Gram Positive Rod Surveillance in Blood/CSF

The List of Laboratory Reportable Significant Findings has been modified so that laboratories are required to report by telephone any (not just "clinically significant") blood or CSF specimen with growth of gram positive rods within 32 hours (instead of 72 hours) of inoculation. Also, gram positive rod septicemia/meningitis has been removed from the List of Reportable Diseases. Of note, there is no mandatory reporting either by telephone or by mail of gram positive rod isolates from blood first obtained after 32 hours. These modifications were made to simplify reporting based on experience in the past year.

The purpose of surveillance for gram positive rods remains to: 1) detect persons with possible, confirmable anthrax septicemia sooner than waiting for the laboratory identification of genus and species; and 2) determine the magnitude and epidemiology of important causes of gram positive rod septicemia/meningitis in the absence of an intentional release of anthrax spores.

Toxoplasmosis

Toxoplasmosis has been removed from both the List of Reportable Diseases and the List of Laboratory Reportable Significant Findings.

Toxoplasmosis was made reportable by laboratories and clinicians in 2001, as part of a

(cont. on page 4)

REPORTABLE DISEASES - 2004

The Commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 2004 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.

Chickenpox
- admission to hospital, any age
- adults > 18 years, any clinical setting

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) *(list continued in next column)*

SARS-CoV disease *
Staphylococcus aureus disease, reduced or resistant susceptibility to vancomycin (2)
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-1 exposure in infant born 1/1/2001 or later (2,6)
HIV-1 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 µg/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
Trichinosis
Typhoid fever
Typhus
Vaccinia disease
- persons not vaccinated
- persons vaccinated with the following manifestations: autoinoculation, generalized vaccinia, eczema vaccinatum, progressive vaccinia, or post-vaccination encephalitis

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 Persons with HIV infection and active tuberculosis or latent tuberculosis infection (history of tuberculin skin test = 5 mm induration by Mantoux technique), or children (<13 years of age) should be reported using full name and street address. Persons =13 years of age. should be reported by full name and street address or by state-specified unique identifier (UI). To make the UI, the first 3 letters of the patient's last name, date of birth, gender and race 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-2004

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 2004 are noted in **bold** and with an asterisk (*).

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

Babesiosis: ❑IFA IgM (titer) _____ IgG (titer):_____
❑Blood smear (1) ❑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 (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) Ratio: _____ ❑RIBA ❑PCR
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 ❑ Unk. ❑ Culture ❑ Rapid test
Lead Poisoning (blood lead ≥ 10 µg/dL)
❑ Finger Stick: _____ µg/dL ❑ Venous: _____ µg/dL
Legionellosis
❑ Culture ❑ DFA ❑ Ag positive
❑ Four-fold serologic change (titers): _____
Listeriosis (1)
Malaria/blood parasites (1,2) : _____
Measles (Rubeola) (titer): _____
Meningococcal disease, invasive (1,3)
Mercury poisoning
❑ Urine ≥ 35 µg/g creatinine _____ µg/g
❑ Blood ≥ 15 µg/L _____ µg/L
Mumps (titer): _____
Pertussis (titer): _____
DFA Smear: ❑ Positive ❑ Negative
Culture: ❑ Positive ❑ Negative
Pneumococcal disease, invasive (1,3)
Oxacillin disk zone size: _____ mm
MIC to penicillin: _____ µg/mL
Poliomyelitis
Rabies
Rocky Mountain spotted fever
Rubella (titer): _____
Salmonellosis (1,2) (serogroup/serotype) _____
SARS-CoV infection (7) * ❑ IgM/IgG
❑ PCR _____ (specimen) ❑ Other _____
Shiga toxin-related disease (1)
Shigellosis (1,2) (serogroup/species) _____
Staphylococcus aureus infection with MIC to vancomycin ≥ 4 µg/mL (1)
MIC to vancomycin: _____ µg/mL
Staphylococcus aureus disease, invasive (3)
methicillin-resistant Date pt. Admitted _____/_____/_____
Staphylococcus epidermidis infection with MIC to vancomycin ≥ 4 µg/mL (1)
MIC to vancomycin: _____ µg/mL
Syphilis ❑ RPR (titer): _____ ❑ FTA (titer): _____
❑ VDRL (titer): _____ ❑ MHA (titer): _____
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) _____
Yellow fever
Yersiniosis (species) _____

Diseases that are possible indicators of bioterrorism.
Anthrax (1)
Botulism
Brucellosis (1)
Gram positive rod from blood or cerebrospinal fluid, growth within 32 hours of inoculation* (specify:_____)
Plague
Q fever
Ricin poisoning
Smallpox **(1)***
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. **Send residual serum, sputum, stool or other specimen testing positive for SARS-CoV to the State Laboratory for confirmation.***

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pilot Emerging Infections Program/FoodNet project in several states to determine incidence and possible methods for ongoing surveillance. Follow-up was time and resource intensive, and no distinct trends have been observed.

In addition, not enough acute cases of infection have been detected to make it possible to conduct meaningful studies to determine risk factors for acquisition of toxoplasmosis on an ongoing basis.

Invasive Group A Streptococcal Disease

Invasive group A strepotococcal (GAS) disease is a physician and laboratory reportable disease; however, laboratories are no longer required to send GAS isolates to the DPH laboratory from patients with invasive GAS disease.

In 1995, as one of a family of Emerging Infections Program surveillance projects, invasive GAS disease was made laboratory reportable, with a requirement for laboratories to send isolates to the DPH for subtyping.

Over the past 8 years, the occurrence of invasive GAS has ranged from 100-150 cases per year. There has been no remarkable shift in the clinical spectrum of GAS seen in Connecticut during this time period, although there has been a slight shift toward more virulent M types. We will continue to monitor GAS incidence and trends in virulence by looking at clinical syndromes (e.g., streptococcal toxic shock syndrome, necrotizing fasciitis) without collecting isolates.

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For Public Health Emergencies after 4:30 P.M. and on weekends call the Department of Public Health emergency number (860) 509-8000

AIDS Epidemiology (860) 509-7900
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Sexually Transmitted Diseases (STD) (860) 509-7920

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