



Yakima Health District BULLETIN

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Notifiable Conditions

This month's Bulletin includes an insert comprising the list of notifiable (reportable) conditions for health care providers and health care facilities set forth in Washington State law (WAC 246-101; <http://apps.leg.wa.gov/WAC>).

These conditions must be reported because their occurrence either warrants prompt investigation and disease control intervention or they are of general importance in monitoring the health status of Yakima County. Examples of YHD's disease control interventions include isolation of infectious cases, chemoprophylaxis of exposed contacts, and elimination of sources or vectors of transmission. YHD often gives feedback to reporting providers on a case-by-case basis regarding the outcomes of individual case reports and also provides general information on trends, epidemiology, outbreaks, and cases of special interest through this Bulletin and other forums. YHD appreciates and is proud of the strong disease surveillance and control partnership we enjoy with local health care providers, facilities, and laboratories.

The following scenarios provide examples to guide clinicians in reporting and to elaborate upon the rationale for and nature of interventions that follow a case report.

Example 1

A fifteen year-old female high-school student presents with a two-week history of coughing spasms unaccompanied by post-tussive vomiting, apnea, or whoop. The cough was preceded by a several day, non-febrile, prodrome of coryza. Two weeks prior, a 23-month old child who was being cared for by the high school student was diagnosed with whooping cough. The clinician suspects acute bronchitis or pertussis, collects a nasopharyngeal swab for pertussis PCR and culture, prescribes a five-day standard course of azithromycin for coverage of both conditions, tells the patient to stay home until the antibiotic course is completed, and awaits laboratory results prior to reporting the case to YHD.

Discussion

This patient presented with the typical picture of pertussis in adolescence (persistent paroxysmal cough without classical post-tussive phenomena) and has a history of close contact with a known case of

pertussis. The provider's clinical management was appropriate; however, reporting of a suspected pertussis case should be made at the time of diagnosis and should not await laboratory confirmation. Waiting for laboratory confirmation has several pitfalls. First, the sensitivity of PCR (70-90%) and culture (15-60%) are limited and may fail to provide laboratory confirmation of cases that still require intervention. Second, precious time may pass waiting for confirmatory results while vulnerable close contacts could be benefiting from chemoprophylaxis.

For each case of pertussis reported, YHD ensures that the patient obtains prescribed medication and observes isolation restrictions. YHD will also conduct an investigation to identify candidates for chemoprophylaxis and will educate concerned parties about the disease, its prevention, and the appropriate action for their degree of exposure. Isolation and chemoprophylaxis curb further transmission. Information prophylaxis limits the deluge of telephone calls and inappropriate requests for testing and prophylaxis that can befall primary care providers when news of a case of whooping cough makes it way through the community.

Please note that not all presumably communicable syndromes presenting for care obligate *immediate* reporting. The decision to report depends on the strength of the clinical suspicion (high in the case cited here), length of time required for laboratory confirmation, and the potential adverse consequences of delaying the report. In general, reporting upon initial clinical suspicion is most appropriate for tuberculosis, vaccine preventable diseases, bacterial meningitis, conditions with a possible food, water or environmental vector, and suspected clusters (≥ 2 linked cases) of any condition.

Example 2

A 22 year-old healthy, asymptomatic woman undergoes screening for genital chlamydia and gonorrhea infection using urine nucleic acid amplification testing and the results for chlamydia come back positive. The provider invites the patient back to the clinic, conducts a complete sexually transmitted diseases history and exam, offers HIV and syphilis serologic testing, and recommends that all partners from the preceding 60 days be

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referred for evaluation and treatment. The provider then gives the patient three 1gm doses of azithromycin; one for the patient herself and two for the patient to deliver to partners who are unwilling to seek follow-up. Because the laboratory should be reporting the positive chlamydia result to YHD and the provider has already managed the disease control aspects of the case, she does not report it to YHD.

Discussion

Even though the laboratory should report the case, health care providers are required to report, as well. Laboratory reporting accounts for the vast majority of *initial* notifications to YHD, but it lacks important clinical and epidemiologic information and does not address to what degree treatment and disease intervention has occurred. Like other processes that affect health and safety, the surveillance of notifiable conditions merits redundant mechanisms.

Example 3

Five weeks after conducting an uneventful excisional cervical lymph node biopsy, an otolaryngologist receives a laboratory report indicating isolation of *M. tuberculosis* complex from the surgical specimen. He assigns his supporting clinical staff to ensure that the patient follows-up with her primary care provider about the result, and notes the result and plan of action in the patient record. Assuming that the primary care provider already has or will report the case, he then closes the file.

Discussion

Specialists, subspecialists, and consultants (along with primary care providers) are required to report notifiable conditions unless they know (*for certain*) that the case has already been reported. If this patient had been harboring as-yet-unrecognized pulmonary tuberculosis and her follow-up with the primary care provider were delayed, her children and other close contacts could continue to be exposed without intervention while this follow-up is pending. Preventable cases of pediatric tuberculosis have occurred under this very type of scenario.

Example 4

Four days after returning from a vacation abroad, the daughter of an attorney presents with fever, malaise, bloody diarrhea, and abdominal pain. She improves after a 3-day course of fluoroquinolones and returns to work as a child care provider. Results of a stool culture collected at the time of initial evaluation indicate growth of *Shigella dysenteriae*. When YHD receives the laboratory's report, it calls the requesting provider to obtain more information about the case. *Shigella* cases may not return to food handling, child care or health care until they have two consecutive negative stool cultures. Fearing complaints of unauthorized disclosure of personal information by the patient, the provider cites HIPAA restrictions on release of protected health information as cause for withholding the information requested by YHD.

Discussion

The Privacy Rule of the federal Health Insurance Portability and Accountability Act of 1996 recognizes the legitimate need for public health authorities and others responsible for ensuring the public's health and safety to have access to protected information vital to their missions. Consequently, public health disease control activities are explicitly exempted from the HIPAA Privacy Rule and

patient authorization is not required for these activities. Such public health activities include birth and death certificate completion, notifiable condition surveillance and reporting, case investigation and intervention, and even release of information about potentially exposed persons. Reporting of child abuse is also exempted. For more information, visit <http://www.cdc.gov/privacyrule/>

Example 5

A previously healthy 27 year-old male agricultural worker is brought by family to the emergency department. They report a 2-3 week progressive illness with headache, body aches, abdominal pain, nausea, diarrhea, and rash. Upon evaluation he is found to be febrile, obtunded, and hypotensive. He is noted to have a centripetal petechial rash and has signs of disseminated intravascular coagulopathy. He dies within 24 hours of admission. Bacterial, viral, and fungal cultures of blood, CSF, urine, and tracheal aspirate are negative. Two weeks later, results from reference laboratory testing reveal a serum IFA titer of 1:512 against *Rickettsia rickettsii* (Rocky Mountain Spotted Fever). Should this case be reported?

Discussion

Yes, even though RMSF is not set forth as notifiable condition *per se* in the reporting rule, this case would be reportable under both of the following provisions in the rule:

- *unexplained critical illness or death* (prior to receipt of laboratory results)
- *other rare diseases of public health significance* (once results received)

Note that diseases of suspected bioterrorism origin are also reportable, as are clusters of suspected food- or water-borne disease. When in doubt, please report.

Other Helpful Hints

When making a case report, do not worry about what specific information needs to be provided in your first effort to notify. To get started, all we need for most acute communicable diseases is the patient's name, date of birth, telephone, your name, the diagnosis, and a contact person and telephone number for you or your designee. It is also helpful to know whether or not you have informed the patient about the diagnosis. This information can be submitted via telephone to the communicable disease reporting line at (509) 249-6541 or via fax at (509) 249-6628.

Do not worry if you do not get a live voice and have to leave a message. The reporting line is monitored continuously during working hours, your message will be reviewed, and we will respond in a timely fashion. If, however, you have a critical condition or public health emergency warranting immediate attention (e.g., suspected botulism), during business hours call (509)952-7976. After hours call (509) 575-4040 and follow the prompt to obtain immediate attention via our answering service. If for some reason that fails, you can call 911, identify yourself as a health care provider, and ask the dispatcher to notify YHD of an urgent public health matter. The YHD person on-call will be paged and will respond promptly.

Suspected tuberculosis cases should be reported by telephone to (509) 249-6532. Please remember that reporting of hospitalized

Notifiable Conditions & the Health Care Provider



The following conditions are notifiable to local public health authorities in Washington in accordance with WAC 246-101. Timeframes for notification are indicated in footnotes. **Immediately notifiable conditions are indicated in bold** and should be reported when suspected or confirmed. (April 2005)

Acquired immunodeficiency syndrome (AIDS)³ (including AIDS in persons previously reported with HIV infection)

Animal bites¹

Arboviral disease³ (West Nile virus disease, dengue, Eastern & Western equine encephalitis, etc.)

Botulism¹ (foodborne, wound and infant)

Brucellosis¹

Campylobacteriosis³

Chancroid³

*Chlamydia trachomatis*³

Cholera¹

Cryptosporidiosis³

Cyclosporiasis³

Diphtheria¹

Disease of suspected bioterrorism origin¹ (including Anthrax and Smallpox)

Disease of suspected foodborne origin¹ (clusters only)

Disease of suspected waterborne origin¹ (clusters only)

Enterohemorrhagic *E. coli*, including *E. coli* O157:H7 infection¹

Giardiasis³

Gonorrhea³

Granuloma inguinale³

***Haemophilus influenzae* invasive disease¹ (under age five years, excluding otitis media)**

Hantavirus pulmonary syndrome³

Hemolytic uremic syndrome (HUS)¹

Hepatitis A, acute¹

Hepatitis B, acute³; chronic^M (initial diagnosis only)

Hepatitis B, surface antigen positive pregnant women³

Hepatitis C, acute and chronic^M (initial diagnosis only)

Hepatitis, unspecified (infectious)³

Herpes simplex, genital (initial infection only) and neonatal³

HIV infection³

Immunization reactions³ (severe, adverse)

Legionellosis³

Leptospirosis³

Listeriosis¹

Lyme disease³

Lymphogranuloma venereum³

Malaria³

Measles (rubeola)¹

Meningococcal disease¹

Mumps³

Paralytic shellfish poisoning¹

Pertussis¹

Plague¹

Poliomyelitis¹

Psittacosis³

Q fever³

Rabies¹

Rabies post-exposure prophylaxis³

Relapsing fever (borreliosis)¹

Rubella¹ (including congenital)

Salmonellosis¹

Shigellosis¹

Syphilis³ (including congenital)

Tetanus³

Trichinosis³

Tuberculosis¹

Tularemia³

Typhus¹

Vibriosis³

Yellow fever¹

Yersiniosis³

Unexplained critical illness or death¹

Rare diseases of public health significance¹

The following diagnoses are notifiable to the Washington State Department of Health in accordance with WAC 246-101. Timeframes for notification are indicated in footnotes. **Immediately notifiable conditions are indicated in bold** and should be reported when suspected or confirmed.

Asthma, occupational (suspected or confirmed)^M **1-888-66-SHARP**
 Birth Defects^M: Autism spectrum disorders,
 Cerebral palsy, Alcohol related birth defects **360-236-3492**
Pesticide Poisoning (hospitalized, fatal, or cluster)¹ **1-800-222-1222**
 Pesticide Poisoning (all other)³ **1-800-222-1222**

Notification time frame: ¹ Immediately,

³ Within 3 work days, ^M Within one month

Report to Yakima Health District	
By MAIL	Yakima Health District Communicable Disease Program 1210 Ahtanum Ridge Drive Union Gap, WA 98903-1813
By FAX	(509) 249-6628
By PHONE	(509) 249-6541 (800) 535+5016 ext 541
Public Health Emergencies:	
	After business hours (509) 575-4040 @ prompt #1
	During business hours (509) 952-7976

For more information, please see WAC 246-101 or <http://www.doh.wa.gov/notify>

tuberculosis suspects should occur prior to discharge.

HIV infection and AIDS should be reported to the Communicable Disease Reporting Line at (509)249-6541.

Other sexually transmitted diseases should be reported using the pre-printed form whenever feasible and faxed to (509) 249-6628. Alternatively, you may call (509) 249-6541 to report the case.

In the follow-up communication from YHD we will ask for a complete set of demographic and locating information, relevant clinical and laboratory data, and other epidemiologic information. In some cases, we also may ask for a copy of relevant laboratory or clinical records.

For more information on surveillance and reporting of notifiable conditions, please visit <http://www.co.yakima.wa.us/health/commhealth/cd_repdisease.htm> or call the communicable disease reporting line at (509) 249-6541.

Increased Risk of Measles Importation

Outbreaks of measles in California, Arizona, and Wisconsin have been linked to the occurrence of significant numbers (i.e., thousands) of cases occurring in several European nations, Israel and Japan. Many secondary cases transmitted domestically in the United States have been among unvaccinated health care personnel exposed when index cases sought care.

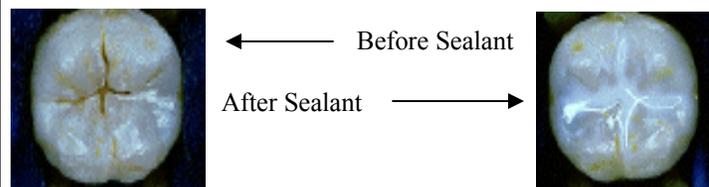
Fortunately, no measles cases have been identified in Washington related to the report of a confirmed case in an unvaccinated traveler flying from Amsterdam to Seattle and then from Seattle to Portland on March 26th. One Yakima County child with a recent rash illness and a preliminarily positive anti-measles IgM is under investigation, but the preponderance of evidence to-date suggests that the child had another illness and that the measles serology result was either falsely positive or reflected recent immunization.

Improving measles vaccination coverage, especially among health care workers, is essential to containing and preventing further outbreaks and for reaching the goal of elimination. Meanwhile, increased vigilance is warranted due to the frequency of international travel and the rise in the level of measles activity in many countries and the United States described above.

The typical measles case presentation is one of cough, coryza, and conjunctivitis (“the three Cs”) accompanied by high fever and a maculopapular rash that starts on the head and trunk and spreads centrifugally. Koplik’s spots (hypopigmented papules on the buccal mucosa) can also be seen occasionally. Place such patients in airborne isolation, draw blood for anti-measles IgM serology, and submit urine and pharyngeal swabs for viral culture. Also collect and refrigerate one red or red gray top tube or serum separator tube to be saved for contingency testing. Please notify YHD immediately.

Free Dental Sealants

The Sixteenth Annual Free Sealant Day was held at the Yakima



Valley Community College Dental Hygiene Clinic on February 23, 2008. Sixty-five dental volunteers including dentists, hygienists, assistants, and hygiene students screened ninety-nine patients ages 6-21. Three hundred seventy-five dental sealants were placed. A dental sealant is a plastic material applied to the chewing surfaces of the premolars and molars. The sealant acts as a barrier, protecting the tooth from plaque and acid that cause decay. Sealants are important because the chewing surface of the tooth is one of the most common places to get dental decay due to the deep pits and grooves that cannot be reached with a toothbrush.

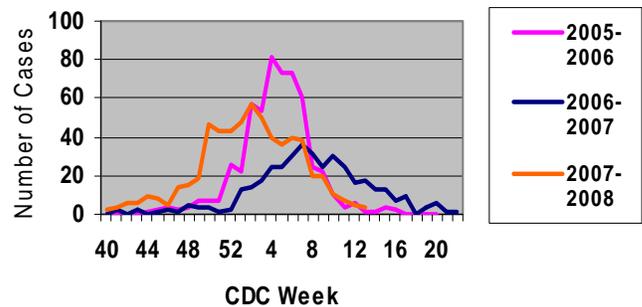
If you would like more information about this annual event or other oral health activities, please contact Heather Young, RDH, BS, Yakima Oral Health Coordinator at 249-6529.

Health of Washington State

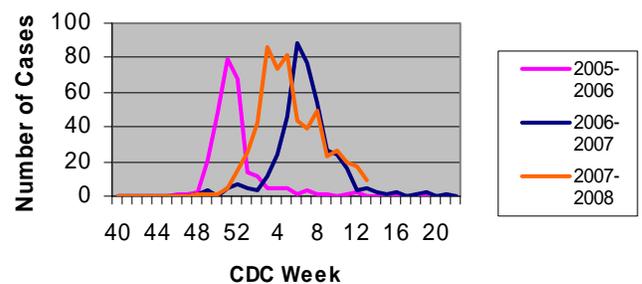
The Washington State Department of Health has released *The Health of Washington State 2007* (<http://www.doh.wa.gov/hws>). This report includes sections on general health status, major risk and protective factors, infectious diseases, chronic diseases, injury and violence, maternal and child health, occupational health, and health care services. It provides data by county and discusses health disparities associated with age, gender, and race/ethnicity. Information about effective interventions is also presented.

2007-2008 Flu/RSV Season Winds Down

Yakima County Positive RSV Tests 2005-2008



Yakima County Positive Influenza Tests 2005-2008



YAKIMA HEALTH DISTRICT

**1210 Ahtanum Ridge Drive
Union Gap, WA 98903**

← **ATTENTION! NEW ADDRESS!**



Reporting Line: (509) 249-6541
After hours Emergency: (509) 575-4040 #1
Toll Free: (800) 535-5016 x 541

Thomas Bell, DO
Sunnyside Community Hospital ER
P O Box 719
Sunnyside, WA. 98944



Confidential Fax: (509) 249-6628



<http://www.yakimapublichealth.org>

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Jessica Brown, BS, CHES, Assessment Specialist
Laura Kramer, BS, Environmental Health Specialist
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Notifiable Conditions Summary Jan– March, 2008

Condition (includes confirmed and probable cases)	Cases			Total Cases by Year	
	Jan-Mar	Jan-Mar	Jan-Mar	Total Cases by Year	Total Cases by Year
	2008	2007	2006	2007	2006
Campylobacteriosis	22	15	49	202	114
Cryptosporidiosis	1	3	1	7	7
Enterohemorrhagic E. coli	1	0	0	5	3
Giardiasis	0	10	6	31	28
Salmonellosis	1	5	3	34	52
Shigellosis	0	4	11	32	29
Hepatitis A acute	1	0	0	1	3
Hepatitis B acute	0	1	1	5	1
Hepatitis B chronic	2	2	4	11	14
Hepatitis C acute	0	1	1	1	2
Hepatitis C chronic	35	49	60	176	213
Meningococcal	1	1	0	1	2
Pertussis	3	8	6	21	188
Tuberculosis	5	3	2	16	14
HIV New	4	10	10	10	14
HIV Deaths	2	1	2	2	2
HIV Cumulative Living	154	152	142	142	132
Chlamydia	315	296	288	1120	973
Genital Herpes—Initial	25	16	19	70	99
Gonorrhea	36	36	42	166	138
Primary and Secondary Syphilis	1	1	3	3	2