Yakima Health District
BULLETIN

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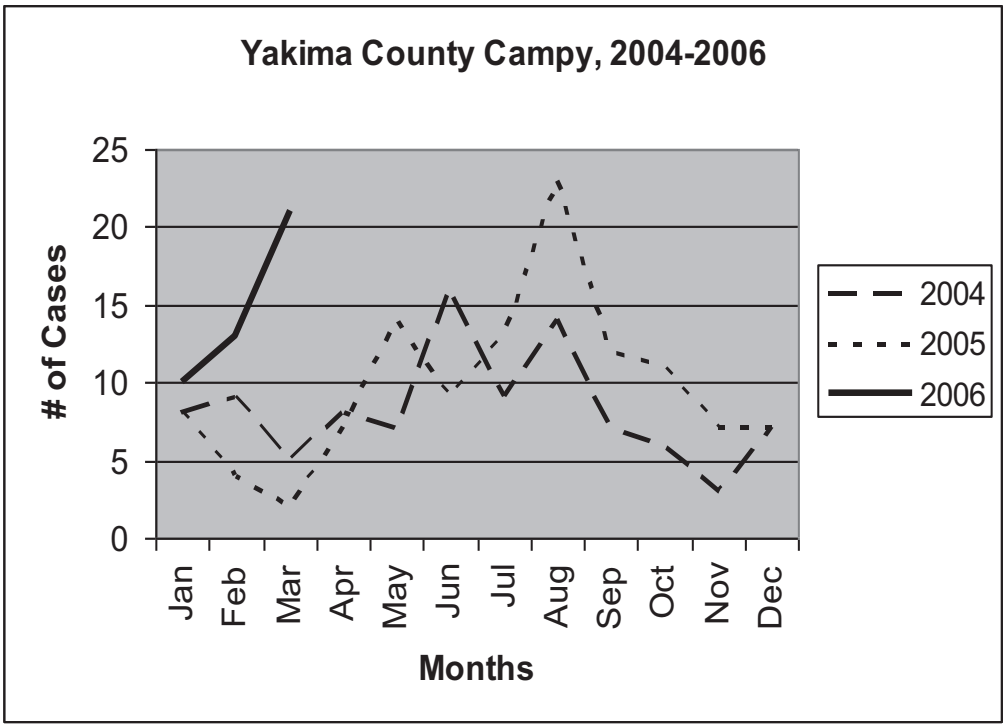
CAMPYLOBACTERIOSIS ALERT

Inside this issue:

From January 1 through March 31, 47 cases of campylobacteriosis have been reported in Yakima County. This trend is well outside historical limits for this time of year. A preliminary analysis on the early cases showed that both genders and all age groups have been affected, with 11 cases (27%) among children <5 years of age and 5 cases (12%) among individuals >65 years of age. Twenty-four (59%) have been reported in residents of the lower Yakima Valley. Eight (29%) of 28 investigated thus far have reported ingestion of unpasteurized dairy products; a majority of these cases reside in the lower valley. No other suspicious risk factors have emerged. Recent poultry ingestion has been almost universal in Yakima County cases. However, poultry consumption in the general population is also nearly universal, whereas raw milk product consumption is probably less common. Possible causes of this increase in reported cases include (1) ongoing presence of one or more contaminated food sources or products in the community (e.g., unpasteurized milk or cheese), (2) increased testing and or reporting by providers, or (3) statistical abberation.

Campylobacteriosis is caused by *Campylobacter jejuni*. Transmission is via ingestion of organisms from undercooked or raw meat (e.g., poultry), unpasteurized dairy products, or direct contact with pets, livestock (including petting zoos), or ill infants. Cross contamination of other food with uncooked poultry via kitchen surfaces or utensils is probably a common route of exposure. The usual peak in cases during summer months is attributed to cook outs, picnics, and other seasonal events associated with mishandling or undercooking



animal products. Person-to-person transmission is rare.

The typical illness presents 2-5 days after exposure with diarrhea (with or without blood or mucous), abdominal pain, fever, malaise, and myalgia. Nausea and vomiting can also be present. The differential diagnosis includes salmonellosis, shigellosis, yersiniosis, *E. coli* O157:H7, *C. difficile*, and occasionally other organisms, as well as inflammatory bowel disease. Specific diagnosis is based on isolation of the organism from a stool sample. The disease can be asymptomatic and will resolve spontaneously without specific treatment in most cases. Treatment for mild-to-moderate cases includes fluids with or without antimotility agents. Avoid antimotility agents if bloody diarrhea is present or antibiotic-associated diarrhea is present. For moderate-to-severe cases, antimicrobial therapy can shorten the duration of illness and consists typically of a 3-5 day course of a fluoroquinolone or trimethoprim/sulfamethoxazole. Resistance of *Campylobacter* isolates to these agents is emerging in the United States, and is well established in the western Pacific. The organism can continue to be isolated from untreated cases for up to two months, but this is not felt to play a significant role in transmission. Occasionally, post-infectious sequelae including reactive arthritis and Guillan-Barre syndrome can be precipitated by campylobacteriosis.

Please obtain stool specimens for stool pathogen testing among cases of febrile and/or bloody diarrhea. When blood is present in stool or recent antimicrobial therapy has been ingested, communicate with your laboratory to make sure that testing for *E. coli* O157:H7 or *C. difficile*, respectively, is also done; these require special procedures. Ask suspected cases about travel and the exposure routes mentioned above, as patients sometimes may be more willing to share sensitive information with clinicians than with public health authorities. Please report all confirmed cases of bacterial gastroenteritis and suspected outbreaks of any illness to YHD at (509) 249-6541.

Although the cause of this rise in campylobacteriosis remains to be determined, the possible association with unpasteurized dairy products is a reminder that numerous outbreaks of enteric disease, particularly campylobacteriosis, have been linked to consumption of raw milk or products derived from raw milk. Soft cheeses (e.g., homemade queso fresco) made with raw milk have also caused outbreaks. In Washington it is indeed legal to distribute unpasteurized milk, provided the distributor has the appropriate license from WSDA. Furthermore, non-retail access to raw milk directly from dairy farms or through individuals who frequent or work on farms is probably common. Regardless of the means or mode of acquisition, YHD encourages you to advise your patients against the ingestion of raw milk or raw milk products. For more information contact the Yakima Health District Notifiable Condition Reporting Line at (509) 249-6541.

IMMUNIZATION NEWS

School Immunizations

School immunization requirements have been updated with the addition of varicella (vaccination or documentation of immunity). See the table entitled, *Vaccines Required For School Attendance 2006-2007*, at http://www.co.yakima.wa.us/health/providersonly/bulletin.htm.

The Washington State Board of Health has selected an implementation date for the varicella requirement: July 1, 2006 (i.e., the start of the next school year), pending funds made available by the 2006 legislature to purchase the vaccine. The new law (WAC 246-100-166) specifies "children under thirteen years of age." The implementation plan translates this into a kindergarten AND 6th grade school entry requirement for children under thirteen years of age using a *single dose* of vaccine. Alternative methods of documenting immunity are parental history or provider diagnosis of clinical illness. Children 19 months of age up to kindergarten entry attending licensed childcare or preschool will also be required to show proof of immunity to varicella beginning July, 1 2006.

While there is no school requirement for children 13 years of age or older (regardless of their grade in school) to document varicella immunity, it is nonetheless recommended that these children also be offered vaccination on a voluntary basis. The Advisory Committee on Immunization Practices (ACIP) recommendation for children 13 years of age and older (with no history of either prior disease or vaccination) is to receive *two doses* of varicella vaccine at least 28 days apart.

Acellular Pertussis Booster (Tdap)

Tdap is now recommended by ACIP for the following groups:

- adolescents 11and 12 years of age (replacing the Td booster formerly given at this age), and
- adolescents 13 through 18 years who missed the Td booster at 11 to 12 years or age, and adolescents 11 through 18 years of age who have had > 5 years since their last Td vaccine.

ACIP also has made recommendations for use of Tdap among adults ages 19-64 years who have not yet received Tdap.

- Adults should receive a ***SINGLE*** dose of Tdap (replacing formerly administered Td) for booster immunization against tetanus, diphtheria, and pertussis if they received their most recent tetanus toxoid-containing vaccine (e.g., Td) ≥ 10 years earlier.
- Adults who have contact with infants under 12 months of age (e.g., parents, child care providers, health care providers) should receive a single dose of Tdap if it has been >2 years since receipt of their last tetanus toxoid-containing vaccine.

In addition, information regarding ACIP's recommendations on the prevention of Pertussis in adolescents can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr550.

Hepatitis A Vaccination

ACIP is now recommending universal hepatitis A vaccination for children: two doses ≥ 6 months apart, beginning at 12 months of age. Previously, childhood immunization against hepatitis A was targeted to high incidence states and (in Washington State) high-incidence counties. The success of that effort now leaves most hepatitis A cases coming from what were formerly considered "low incidence" (i.e., less than 20 cases/100K population) jurisdictions. The current recommendation aims to bring the success of these targeted HAV immunization efforts to all communities.

Funding of New Vaccine Recommendations

The Washington State Department of Health is not yet supplying these vaccines. DOH is working through its budgetary process to seek state funding to implement the school requirement for varicella, as well as recommendations for use of Tdap, meningococcal conjugate vaccine (MCV), and hepatitis A vaccine. The objective is to add them to the state's universal immunization access program. If all goes well, DOH hopes to begin supplying all but HAV vaccine sometime this summer. DOH is also working to secure funding to enable implementation of universal childhood hepatitis A vaccination, but on a timeline that probably will fall behind the former two vaccines.

The new combined measles/mumps/rubella/varicella vaccine is not being supplied by DOH at this time and there are no plans to do so in the immediate future. DOH is working with staff in the Medical Assistance Administration to put together information on Medicaid reimbursement, which YHD will forward to you when it becomes available. Meanwhile, the Washington State Vaccine Advisory Committee is working with DOH to provide criteria for considering funding of combination vaccines on a case-by-case basis.

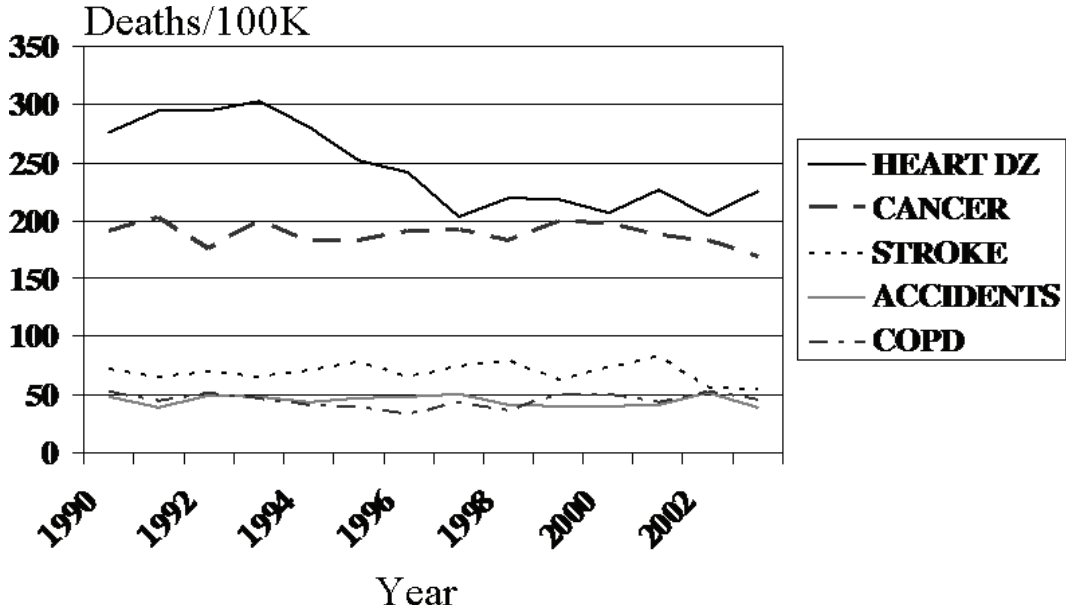
If you have questions about clinical immunization practices, vaccine supply issues, or other issues related to immunizations, please call YHD at (509) 249-6541.

Clinical Laboratory Practice Guidelines

In concert with its Clinical Laboratory Advisory Committee, the Washington State Department of Health's Division of Laboratoy Quality Assurance has developed a set of clinical laboratory practice guidelines which can be accessed through the internet at http://www.doh.wa.gov/hsqa/FSL/lqa_practice_guidelines.htm Conditions covered range from communicable diseases to chronic diseases, hematologic conditions, and cancer screening.

An example of the beneficial impact of systematically applied screening practices is presented in the figure below, demonstrating the temporal association between implementation of coordinated Group B streptococcal (GBS) screening efforts among pregnant women and declining infant morbidity. In addition to the DOH screening algorithm for GBS, which can be found on the aforementioned website, CDC's most recent recommendations for GBS prevention can be found at http://www.cdc.gov/groupBstrep/gbs/hospitals_guidelines.htm.

Yakima County Leading Causes of Death, 1990-2003



For background data on local health behaviors associated with these conditions, see "Health Behavior Surveillance" in the December 2005 edition of the Bulletin (http://www.co.yakima.wa.us/health/documents/bulletin/bulletin4_6.pdf).

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Toll Free: (800) 535-5016 x 541

Confidential Fax: (509) 249-6628

http://www.yakimapublichealth.org

Condition *(includes confirmed, probable, and suspect cases)*	**Cases Jan-Mar**			**Total Cases by Year**	
	2006	**2005**	**2004**	**2005**	**2004**
Campylobacteriosis	**47**	**13**	**22**	**116**	**99**
Cryptosporidiosis	**2**	**0**	**0**	**7**	**2**
Enterohemorrhagic E. coli	**0**	**0**	**0**	**3**	**3**
Giardiasis	**4**	**2**	**6**	**28**	**30**
Salmonellosis	**6**	**7**	**9**	**49**	**36**
Shigellosis	**15**	**3**	**2**	**25**	**7**
Hepatitis A acute	**0**	**1**	**0**	**3**	**2**
Hepatitis B acute	**0**	**0**	**1**	**1**	**3**
Hepatitis B chronic	**5**	**5**	**3**	**14**	**22**
Hepatitis C acute	**2**	**0**	**1**	**1**	**2**
Hepatitis C chronic	**68**	**53**	**57**	**214**	**219**
Meningococcal	**0**	**0**	**1**	**2**	**3**
Pertussis	**5**	**29**	**13**	**197**	**62**
Tuberculosis	**2**	**2**	**5**	**14**	**12**
HIV New	**0**	**4**	**4**	**14**	**12**
HIV Deaths	**0**	**1**	**0**	**2**	**1**
HIV Cumulative Living	**141**	**132**	**124**	**141**	**129**
Chlamydia	**288**	**244**	**251**	**973**	**1002**
Genital Herpes—Initial	**19**	**26**	**37**	**99**	**125**
Gonorrhea	**42**	**34**	**31**	**138**	**198**
Primary and Secondary Syphilis	**3**	**0**	**0**	**2**	**0**

Notifiable Conditions Summary Jan-March, 2006