CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
Keeping Connecticut Healthy

Connecticut Epidemiologist

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Reportable Diseases and Laboratory Reportable Significant Findings– Changes for 2007

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 were two modifications, one addition, and one deletion to the lists effective January 1, 2007.

Changes were made to the footnotes on the revised Laboratory Report of Significant Findings form OL-15C. Persons completing either the OL-15C, or the Reportable Disease Confidential Case Report form PD-23, should review footnotes associated with diseases being reported.

Change to the List of Reportable Diseases and the List of Laboratory Reportable Significant Findings

Hepatitis, Delta—deleted
Delta hepatitis was removed from the list of Reportable Diseases and the list of Laboratory Reportable Significant Findings. Delta hepatitis is a hepatitis B dependent virus that can cause outbreaks of severe hepatitis among acute and chronic HBsAg carriers. Delta hepatitis has been under surveillance in Connecticut since 1989. Since then, hepatitis B vaccine has been widely used and hepatitis B incidence has been decreasing, particularly among persons < 25 years old. Delta hepatitis has been rare in Connecticut with 14 cases reported since surveillance began. In the absence of outbreaks, no follow-up is done.

Change to the List of Reportable Diseases

Hepatitis C, acute infection modification
To help identify acute cases of hepatitis C, the criterion of having an ALT value > 400 IU/L was specified under hepatitis C, acute infection in the list of reportable diseases.

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Change to the List of Laboratory Reportable Significant Findings

Lyme disease—added
Laboratories with automated electronic reporting to the DPH are now required to report positive findings of *Borrelia burgdorferi*. Laboratories without automated electronic reporting will not be required to report until they have automated electronic laboratory reporting. Most clinical laboratories in Connecticut should be able to report electronically by the end of 2008 or 2009. Lyme disease was added to the laboratory list of reportable findings to more completely measure the magnitude of the Lyme disease problem in Connecticut.

Hepatitis B—modification

Footnote (1) on the OL-15C was modified to include: "For positive IgM anti-HBc, send $\geq$ 0.5 mL residual serum within 6 months." The DPH laboratory will subtype the sample. The purpose of this surveillance change is to enable more rapid and complete investigation of outbreaks by having serum from persons affected readily available and to enable identification of outbreaks of hepatitis B that might otherwise be missed. Additionally, subtyping will contribute to the genotype library being established at the Centers for Disease Control and Prevention. This library will help identify prevalent circulating genotypes in the United States. Some genotypes may not be effectively covered by the current hepatitis B vaccine.

(cont. on page 4)

REPORTABLE DISEASES - 2007

The commissioner of the Department of Public Health (DPH) is required to declare an annual list of reportable diseases. Changes for 2007 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
- Influenza-associated deaths in children <18 years of age (1)
- Measles
- Meningococcal disease
- Outbreaks:
  - Foodborne (involving ≥ 2 persons)
  - Institutional
  - Unusual disease or illness (2)
- Pertussis
- Poliomyelitis
- Rabies (human and animal)
- Rubella (including congenital)
- SARS-CoV
- *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin (3)
- Tuberculosis
- Yellow fever

Category 1 diseases that are possible indicators of bioterrorism

- Anthrax
- Botulism
- Brucellosis
- Plague
- Q fever
- Ricin Poisoning
- Septicemia or meningitis with growth of gram positive rods within 32 hours of inoculation
- 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 department.

- Acquired Immunodeficiency Syndrome (3,4)
- Babesiosis
- Campylobacteriosis
- Carbon monoxide poisoning (5)
- Chancroid
- Chlamydia (*C. trachomatis*) (all sites)
- Chickenpox
- Chickenpox-related death
- *Clostridium difficile*, community-onset (6)
- Creutzfeldt-Jacob disease (age < 55 years)
- Cryptosporidiosis
- Cyclosporiasis
- Ehrlichiosis
- Encephalitis
- *Escherichia coli* O157:H7 gastroenteritis
- Gonorrhea
- Group A streptococcal disease, invasive (7)
- Group B streptococcal disease, invasive (7)
- *Haemophilus influenzae* disease, invasive, all serotypes (7)
- Hansen's disease (Leprosy)
- Hemolytic-uremic syndrome
- Hepatitis A
- Hepatitis B
  - acute infection
  - HBsAg positive pregnant woman
- Hepatitis C, acute infection **(ALT > 400 IU/L)***
- HIV-1 exposure in infants born 1/1/2001 or later (8)
- HIV-1 infection in: (3)
  - persons with active tuberculosis disease
  - persons with latent tuberculosis infection (history or tuberculin skin test ≥ 5mm induration by Mantoux technique)
  - persons of any age
- Lead Toxicity (blood lead ≥ 20 μg/dL)
- Legionellosis
- Listeriosis
- Lyme disease
- Lymphocytic choriomeningitis virus infection
- Malaria
- Mercury poisoning
- Mumps
- Neonatal herpes (< 1 month of age)
- Neonatal bacterial sepsis (9)
- Occupational asthma
- Pneumococcal disease, invasive (7)
- Reye syndrome
- Rheumatic fever
- Rocky Mountain spotted fever
- Salmonellosis
- Shiga toxin-related disease (gastroenteritis)
- Shigellosis
- Silicosis
- *Staphylococcus aureus* methicillin-resistant disease, invasive, community acquired (7,10)
- *Staphylococcus epidermidis* disease, reduced or resistant susceptibility to vancomycin (3)
- 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* infection (*parahaemolyticus*, *vulnificus,* other*)*

(1) Death in child or adolescent who never fully recovers from influenza and dies from a possible complication (e.g., encephalopathy, bacterial pneumonia)
(2) Individual cases of "significant unusual illness" are also reportable.
(3) Report only to the State.
(4) CDC case definition.
(5) Includes persons being treated in hyperbaric chambers for suspect CO poisoning.
(6) Community-onset: illness in a person living in the community at the time of illness onset and no known hospitalizations in preceding 3 months; if hospitalized, a positive test taken within 48 hours of admission.
(7) Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, or internal body sites, vitreous fluid or other normally sterile sites. Includes muscle for group A *streptococcus*.
(8) "Exposure" includes infant born to known HIV-infected mother.
(9) Clinical sepsis and blood or CSF isolate obtained from an infant < 7 days old.
(10) 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 - 2007

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 and can be obtained 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 listing of diseases indicative of possible bioterrorism is highlighted at the end of this list. Changes for 2007 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)
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 (1)
Hepatitis B ❑ HBsAg ❑ **IgM anti-HBc (1)***
Hepatitis C (anti-HCV) Ratio: _____ ❑RIBA ❑PCR (4)
HIV Infection (report only to the State) (1)
- HIV-1 infection in persons of all ages **(5)***

Influenza: ❑ A ❑ B ❑ Unk.
❑ RT-PCR ❑ 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)
Lyme disease (6)*
Lymphocytic choriomeningitis virus infection
Malaria/blood parasites (1,2) : _____
Measles (Rubeola) (titer) **(7)***: _____
Meningococcal disease, invasive (1,3)
Mercury poisoning
❑ Urine ≥ 35 μg/g creatinine _____ μg/g
❑ Blood ≥ 15 μg/L _____ μg/L
Mumps (titer): _____
Neonatal bacterial sepsis **(8)*** spp _____
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 (10) ❑ 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 **(1)*** (species) _____
Yellow fever
Yersiniosis (species) _____

Diseases that are possible indicators of bioterrorism* (9)
Anthrax (1)
Botulism
Brucellosis (1)
Gram positive rods in blood or CSF, growth within 32 hours of inoculation (specify:_____)
Plague (1)
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. For **positive** HIV and **IgM anti-HAV**, send ≥ 0.5 mL residual serum to the State Laboratory. **For positive IgM anti-HBc, send ≥ 0.5 mL residual serum within 6 months.**
2. Specify species/serogroup.
3. Sterile site isolates. Sterile site defined as blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, bone, internal body site (lymph node, brain, heart, liver, spleen, kidney, pancreas, or ovary), vitreous fluid, or other normally sterile site; includes muscle for invasive group A streptococcal disease.
4. Report all positive anti-HCV with signal to cutoff ratio, all positive RIBA, but only confirmatory PCR tests.
5. Report any tests indicative of HIV infection including antibody, antigen, PCR-based and **all** viral load tests, **including those with *no virus detectable***, with name and street address.
6. **Only laboratories with automated electronic reporting to the Connecticut Electronic Disease Surveillance System database are required to report positive *Borrelia burgdorferi* results.**
7. Report all IgM titers, but only IgG titers that are considered significant by the laboratory performing the test.
8. Report all bacterial isolates from blood or CSF obtained from an infant <7 days old.
9. Report by telephone to the Department of Public Health, weekdays 860-509-7994; weekends and evenings 860-509-8000.

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In This Issue... **Reportable Diseases and Laboratory Findings for 2007, Persons Required to Report.**

Persons Required to Report Reportable Diseases

1. Every health care provider who treats or examines any person who has or is suspected to have a reportable disease shall report the case to the local director of health or other health authority within whose jurisdiction the patient resides and to the Department of Public Health.
2. If the case or suspected case of reportable disease is in a health care facility, the person in charge of such facility shall ensure that reports are made to the local director of health and Department of Public Health. The person in charge shall designate appropriate infection control or record keeping personnel for this purpose.
3. If the case or suspected case of reportable disease is not in a health care facility, and if a health care provider is not in attendance or is not known to have made a report within the appropriate time, such report of reportable diseases shall be made to the local director of health or other health authority within whose jurisdiction the patient lives and the Department of Public Health by:
   A. the administrator serving a public or private school or day care center attended by any person affected or apparently affected with such disease;
   B. The person in charge of any camp;
   C. The master or any other person in charge of any vessel lying within the jurisdiction of the state;
   D. The master or any other person in charge of any aircraft landing within the jurisdiction of the state;
   E. The owner or person in charge of any establishment producing, handling, or processing dairy products, other food or non-alcoholic beverages for sale or distribution;
   F. Morticians and funeral directors.

Persons Required to Report Laboratory Significant Findings

The director of a laboratory that receives a primary specimen or sample, which yields a reportable laboratory finding, shall be responsible for reporting such findings within forty-eight (48) hours to the local director of health of the town in which the affected person normally resides. In the absence of such information, the reports should go to the town from which the specimen originated, and to the Department of Public Health.

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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