

LORD FAIRFAX HEALTH DISTRICT

*Serving the Counties of Clarke, Frederick, Page, Shenandoah, Warren
and the City of Winchester*

2011 Communicable Disease Report



Dear Colleague:

Welcome to the Lord Fairfax Health District’s (LFHD) first annual Communicable Disease Report. Each year the district investigates hundreds of reports of suspected communicable diseases and this report presents the results of those investigations and highlights the reportable diseases that most impacted the LFHD in 2011. The report also describes the communicable disease services provided by the Health Department and offers practical guidance for clinicians that we believe will help mitigate the future impact of these diseases.

The effectiveness of public health investigations often depends on the timeliness of notification. Prompt reporting by clinicians can dramatically impact the course of these investigations and help to limit the spread of illness because Health Department staff are able to ensure the early implementation of appropriate infection control measures and facilitate laboratory testing. Staff are also able to conduct timely epidemiologic studies to determine the source of illness or perform contact tracing to identify exposed individuals when time-sensitive interventions such as antibiotic and vaccine prophylaxis are still indicated.

We would like to thank all community partners including healthcare providers, infection control practitioners, laboratorians, and public safety personnel who report cases to the Lord Fairfax Health District. Also we wish to acknowledge the hard work and dedication of the LFHD employees who investigate and control communicable diseases, STI, and TB.

Sincerely,
Charles J. Devine, III, MD



Director, Lord Fairfax Health District

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2011 LFHD Population

Clarke County	14,258
Frederick County	79,666
Page County	23,958
Shenandoah County	42,289
Warren County	37,749
Winchester City	26,587
TOTAL	224,507

Communicable Disease Summary

In 2011, the LFHD investigated 985 reports of communicable disease. Table 1 provides a summary of the diseases investigated.

Disease	2007	2008	2009	2010	2011 ^α	5-Year Average
Amebiasis	0	0	1	0	0	0.2
Anaplasma phagocytophilum infection	0	0	0	8	4	2.4
Botulism, infant	0	0	1	1	0	0.4
Campylobacteriosis	19	49	39	47	45	39.8
<i>Chlamydia trachomatis</i> infection	424	500	452	403	574	470.6
Cryptosporidiosis	9	5	7	4	6	6.2
Cyclosporiasis	1	0	1	0	0	0.4
Dengue fever	0	0	0	1	0	0.2
<i>Escherichia coli</i> infection, Shiga toxin-producing	11	11	3	11	8	8.8
Ehrlichia chaffeensis infection	0	1	0	2	4	1.4
Giardiasis	11	9	6	17	7	10
Gonorrhea	72	68	49	46	43	55.6
<i>Haemophilus influenzae</i> , invasive	2	4	4	5	6	4.2
Hepatitis A, acute	1	1		1	2	1.25
Hepatitis B, acute	2	4	6	9	3	4.8
Hepatitis C, acute	0	0	0	2	2	0.8
Hepatitis E, acute	0	0	0	1	0	0.2
HIV	4	10	10	4	11	7.8
Lead, elevated levels	7	4	11	8	6	7.2
Legionellosis	1	2	0	4	5	2.4
Listeriosis	1	0	0	0	0	0.2
Lyme disease	78	132	46	185	121	112.4
Malaria	0	3	0	0	3	1.2
Meningococcal disease (<i>Neisseria meningitidis</i>)	1	2	0	1	1	1
Mumps	0	2	0	0	0	0.4
Pertussis	2	2	3	1	9	3.4
Q fever, acute	0	0	1	0	0	0.2
Salmonellosis	37	47	42	40	25	38.2
Shigellosis	1	9	6	7	5	5.6
Spotted Fever Rickettsiosis (including RMSF)	1	6	4	12	10	6.6
<i>Staphylococcus aureus</i> infection, invasive (MRSA)	4	29	22	21	25	20.2
<i>Streptococcus pneumoniae</i> , invasive (age < 5)	1	1	1	4	1	1.6
Streptococcus, Group A, invasive	10	9	6	3	8	7.2
Syphilis - early stage	1	2	0	0	2	1
Toxic-shock syndrome, streptococcal	0	0	0	1	1	0.4
Tuberculosis	5	1	0	0	1	1.4
Varicella (Chickenpox)	49	31	89	44	45	51.6
Vibriosis, non-cholera	0	0	1	1	2	0.8
Total	755	944	811	894	985	877.8

*All communicable disease data are primary surveillance data from the Lord Fairfax Health District and the Virginia Department of Health
^α2011 data are provisional

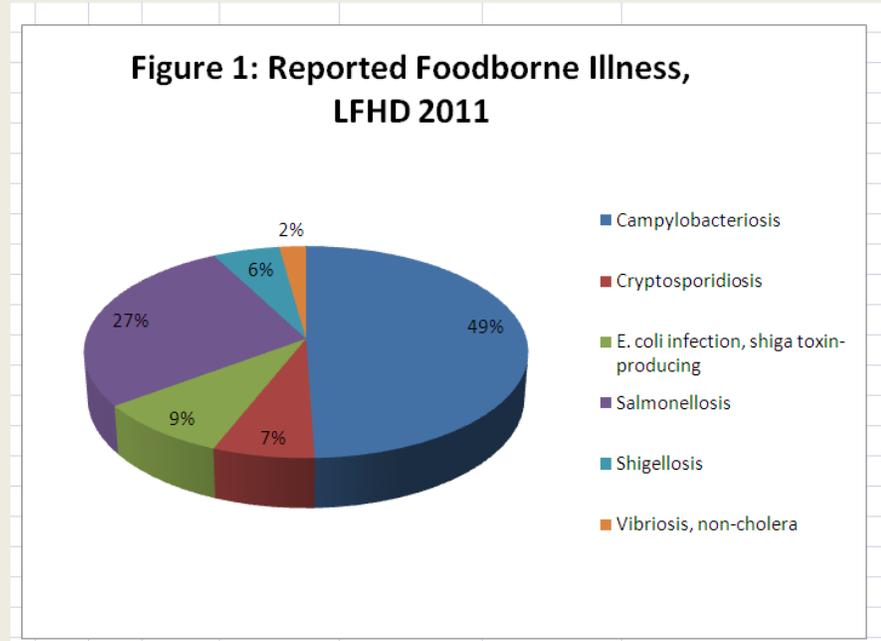
Foodborne Illness

The Centers for Disease Control and Prevention (CDC) estimates that 1 in 6 Americans (or 48 million people) gets sick, 128,000 are hospitalized, and 3,000 die of foodborne diseases each year.¹ The Foodborne Diseases Active Surveillance Network (FoodNet) is a collaborative program established in July 1995 between the CDC, 10 state health departments, the [U.S. Department of Agriculture's Food Safety and Inspection Service \(USDA-FSIS\)](#), and the [Food and Drug Administration \(FDA\)](#). FoodNet conducts surveillance for *Campylobacter*, *Cryptosporidium*, *Cyclospora*, *Listeria*, *Salmonella*, Shiga toxin-producing *Escherichia coli* (STEC) O157 and non-O157, *Shigella*, *Vibrio*, and *Yersinia* infections diagnosed by laboratory testing of samples from patients.

Figure 1 shows the percentages of reported FoodNet agents by etiology in the LFHD in 2011. As noted, *Campylobacter* was the most commonly identified agent, followed by *Salmonella*, *Escherichia coli* (STEC) O157 and non-O157, and *Cryptosporidium*.

The CDC states that everyone can do the following to prevent foodborne illness:

- Wash hands, cutting boards, utensils, and countertops.
- Keep raw meat, poultry, and seafood separate from ready-to-eat foods.
- Use a food thermometer to ensure that foods are cooked to a safe internal temperature: 145°F for whole meats, 160°F for ground meats, and 165°F for all poultry.
- Keep your refrigerator below 40°F and refrigerate food that will spoil.
- Don't prepare food for others if you have diarrhea or vomiting.
- Report suspected illness from food to your local health department.



For Healthcare Providers

- If a foodborne illness is suspected, conduct confirmatory testing whenever possible. In VA, all positive isolates from stool specimens are forwarded by local laboratories to the state laboratory (DCLS) for confirmatory testing. The LFHD and the state of VA use this information to identify outbreaks of foodborne illness.

Lord Fairfax Health District Services

- LFHD will conduct an investigation for each reported case of a foodborne illness. During the investigation, LFHD will provide prevention information, identify potential sources of infection, and recommend control measure to prevent further disease transmission.
- The LFHD will also inspect facilities, including restaurants, when indicated during an investigation.

¹CDC. Vital Signs: Incidence and Trends of Infection with Pathogens Transmitted Commonly Through Food --- Foodborne Diseases Active Surveillance Network, 10 U.S. Sites, 1996-2010. MMWR June 10, 2011 / 60(22):749-755

Pertussis

Pertussis, or whooping cough, is an acute infectious disease caused by the bacterium *Bordetella pertussis* and despite the availability of vaccine, the incidence has been gradually increasing since the early 1980s². While the reasons for this increase are not fully understood, multiple factors have likely contributed to the increase including waning immunity from childhood pertussis vaccines, increased recognition of the disease, and better diagnostic testing and increased reporting³.

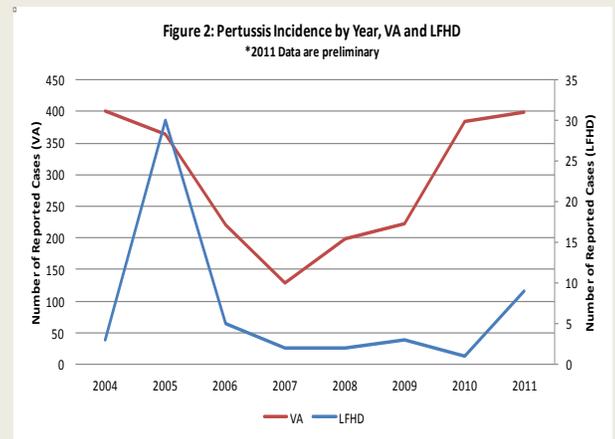
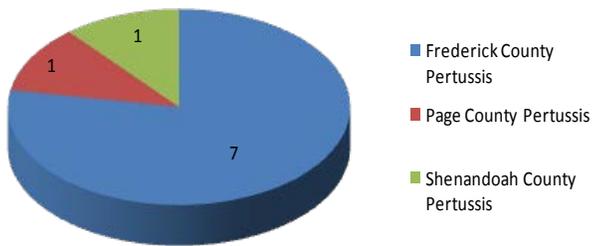


Figure 3: Pertussis Cases by County, 2011



From 2001-2004 the LFHD saw an average of 1-3 cases of pertussis reported each year. In 2005 the number of reported cases peaked at 30, and then returned to 1-3 cases per year until 2011 (Figure 2). In 2011, there were a total of 9 cases, 7 cases in Frederick County, and one case each in Page and Shenandoah counties (Figure 3).

One reported outbreak was investigated at the end of 2001. This outbreak was associated with a middle school.

Vaccination

The Advisory Committee on Immunization Practices (ACIP) recommends a four-dose primary series of DTaP, administered at 2, 4, 6 and 15–18 months of age, followed by a fifth booster dose given at 4–6 years. In 2005 and 2006, the ACIP recommended the replacement of a single Td booster with a dose of Tdap for adolescents (ages 11–18) and adults (ages 19–64) who have not previously received Tdap. In 2010, ACIP expanded Tdap recommendations to include adults aged 65 years and older who anticipate close contact with an infant and who have not previously received the vaccine. In 2011, ACIP recommended that all healthcare personnel who have not yet received a dose of Tdap, regardless of age, should be vaccinated³.

For Healthcare Providers

- Promote vaccination by ensuring that patients are fully vaccinated against pertussis according to the Advisory Committee Immunization Practices (ACIP) Guidelines.
- Ensure that you and ALL staff are immunized with Tdap
- Report suspected cases of pertussis to the Lord Fairfax Health District Health Department as soon as the case is suspected. This allows the LFHD to follow up on cases, to identify high-risk contact, and to recommend prophylaxis to those that need it to protect them from the disease.

Lord Fairfax Health District Services

- LFHD offers free Tdap vaccine to those 19 years of age and older, and per school requirements.

²CDC. Epidemiology and Prevention of Vaccine-Preventable Diseases. The Pink Book: Course Textbook - 12th Edition Second Printing (May 2012)

³CDC. Chapter 10: Pertussis. Manual for the Surveillance of Vaccine-Preventable Diseases (5th Edition, 2011)

Rabies

Wild animals continue to account for more than 90% of reported cases of rabies in the U.S., with raccoons being the most frequently reported rabid animal species, followed by skunks, bats, fox, and other wild animals⁴. The number of reported rabid domestic animals has decreased among all domestic species except cats. The number of reported human rabies cases averages two to three per year in the United States⁴. Virginia has had two human rabies cases in the last decade: 2009 involved an imported case after contact with a dog in India; 2003 exposure is unknown, but it was confirmed to be a raccoon variant of the disease.

- LFHD received reports of 632 animal bites in 2011. Of those, about 14% received PEP. Most of these cases did not result in Post Exposure Prophylaxis being used as the biting animal was domestic and could be observed for 10 days to rule out the possibility of rabies transmission, or were wild or feral and were captured, euthanized, and tested.

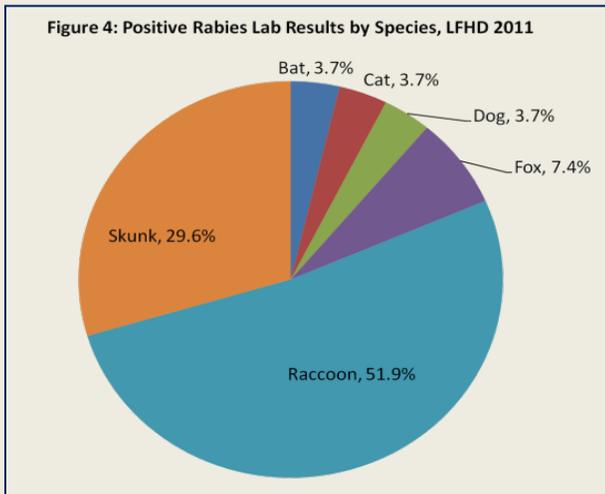


Table 2: Pre and Post Exposure Prophylaxis, LFHD 2011

	Post-Exposure	Pre-Exposure	Bites Reported
Clarke	17	5	46
Frederick/Winchester	37	4	286
Page	14	0	60
Shenandoah	11	2	105
Warren	13	0	135
LFHD Totals	92	11	632

Post-Exposure - Number of people reported to the local health department who received rabies post-exposure treatment (either the full series or the 2 injections given to exposed individuals who had previous rabies vaccinations)

Pre-Exposure - Number of people reported to the local health department who received rabies pre-exposure vaccinations (either the initial 3 injection series or the 1 injection booster).

Bites Reported - Number of humans reported to the local health department with animal bites.

- In 2011, LFHD tested 147 animals for rabies.
- As noted in Figure 4, raccoons and skunks were the primary carriers of rabies in the district (51.9% and 29.6% respectively).
- In 2011 one domestic dog (family pet) tested positive for rabies. Ten people received PEP from this exposure.

For Healthcare Providers

- All exposures should be reported immediately to your local health department. After-hours call number: 540-665-8611
- Not all individuals exposed to a potentially rabid animal will need PEP. If the animal is located, PEP should be delayed pending the outcome of testing or confinement.
- When anatomically feasible, the full dose of RIG should be infiltrated into and around the wound.
- PEP administration should be reported to LFHD using the VDH Morbidity Report.
- Call us and we will provide advice and assistance in testing or confining the offending animal.

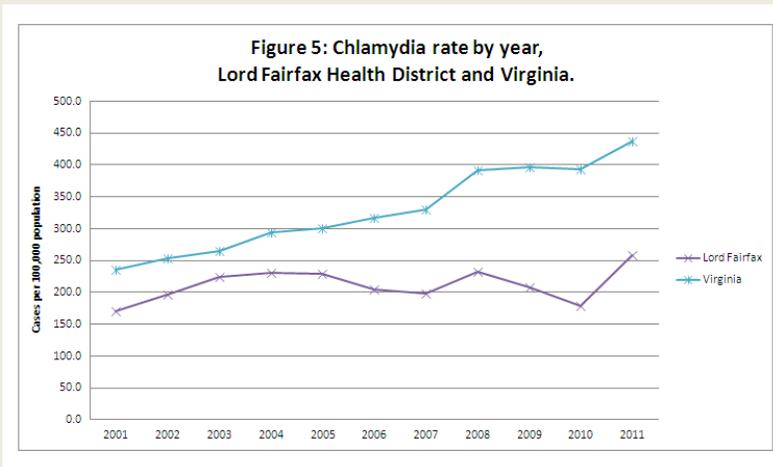
Rabies Exposure Definition

Any bite, scratch, or other situation where saliva or central nervous system tissue or CSF from a potentially rabid animal enters a fresh, open wound or contacts a mucous membrane by entering the eye, mouth, or nose.

⁴CDC. Rabies Surveillance Data in the United States. <http://www.cdc.gov/rabies/location/usa/surveillance/index.html>

Chlamydia

C. trachomatis infection is the most commonly reported notifiable disease in the United States. It is among the most prevalent of all STDs, and since 1994, has comprised the largest proportion of all STDs reported to CDC⁵. The increase in reported chlamydial infections during the last 20 years reflects the expansion of chlamydia screening activities, the use of increasingly sensitive diagnostic tests, an increased emphasis on case reporting from providers and laboratories, and improvements in the information systems used for reporting. However, many women who are at risk are still not being tested—reflecting, in part, the lack of awareness among some health care providers and the limited resources available to support these screenings.



- Although the chlamydia incidence rate in LFHD has slightly increased over the last decade, it still remains well below the rate for the rest of Virginia⁶ (Figure 5).

For Healthcare Providers

- The CDC recommends that all sexually active women aged ≤ 25 years and older women with risk factors should receive annual screening for chlamydia.
- Screening of sexually active men should be considered in areas with a high prevalence of chlamydia.
- Sexual partners of those diagnosed with chlamydia should be seen for evaluation, testing and treatment. If the partner is not enrolled in your practice, please refer them to their private physician or to their local health department.

Lord Fairfax Health District Services

- Testing and treatment services for chlamydia are free at one of the five local health departments in the LFHD.
- Please call the local health department for hours and appointments. A list of contact numbers is included at the end of this report.

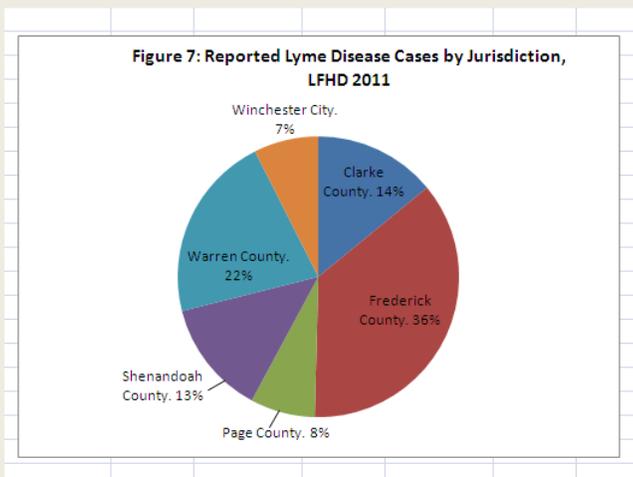
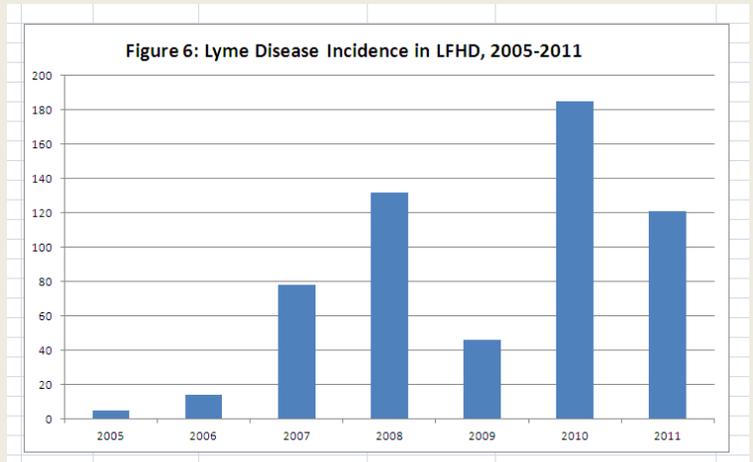
⁵CDC. 2010 Sexually Transmitted Diseases Surveillance. <http://www.cdc.gov/std/stats10/chlamydia.htm>

⁶Virginia Department of Health. HIV/AIDS, Sexually Transmitted Disease (STD), and Tuberculosis Data and Statistics. <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/DAta/>

Lyme Disease

Lyme disease is the most commonly reported vectorborne illness in the United States--in 2011, it was the 6th most common Nationally Notifiable disease. However this disease does **not** occur nationwide and is concentrated heavily in the northeast and upper Midwest⁷. In 2011, 96% of Lyme disease cases were reported from 13 states, including VA.

- As noted in Figure 6, cases of Lyme Disease steadily increased from 2005, peaking at 185 cases in 2010. In 2011, the number of cases dropped to 121.
- Lyme Disease cases are reported throughout the year in all jurisdictions within LFHD. In 2011, 36% of the cases were reported in Frederick County, followed by Warren County at 22% (Figure 7). All residents should be considered at risk for the disease.



- Although Lyme disease continues to be the most commonly reported tickborne disease in Virginia, other tickborne diseases are also increasing in incidence.
- In 2011, there were **231 cases of RMSF**, and **131 cases of ehrlichiosis/anaplasmosis** (76% were determined to be ehrlichiosis).

For Healthcare Providers

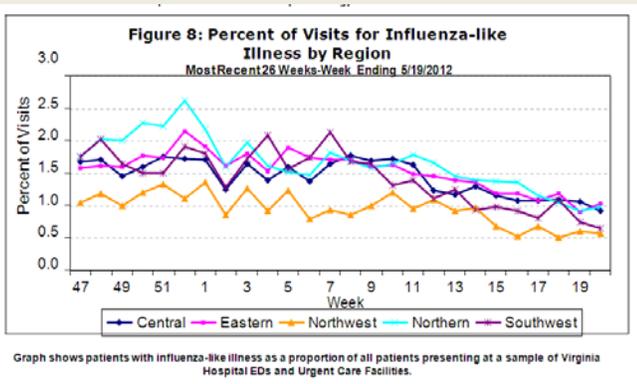
- Consider Lyme disease and other tickborne infections in any patient who presents with a febrile illness during the warm weather months. Most patients, when treated with antibiotics in the early stages, quickly recover.
- All cases of suspected Lyme Disease are to be reported to your local health department. Contact information is found at the end of this report.
- For surveillance purposes, the CDC Lyme Disease case definition requires clinical and laboratory evidence of infection (i.e., 2-tier testing with EIA and Westernblot).
- For serological testing, if blood is drawn within 30 days of infection:
 - Positive or equivocal **ELISA (Enzyme Linked Immunoabsorbant Assay)** (or IFA), **AND**;
 - Positive **Western Blot IgM** serology are sufficient to meet the case definition.
- If blood is drawn more than 30 days after infection:
 - Positive **Western Blot IgG** serology is necessary to meet the case definition.

⁷CDC. Lyme Disease Data. Found at: <http://www.cdc.gov/lyme/stats/index.html>

Influenza

According to the Centers for Disease Control (CDC), the 2011-2012 influenza season 'began late and was mild compared to most previous seasons'.⁸ In fact, the season set a new record for the lowest and shortest peak for influenza-like-illness since this type of surveillance began. Reasons for the mild season aren't clear but are probably due to the following contributing factors: a mild winter; most circulating influenza viruses were similar to those that circulated for the past two seasons; most circulating viruses matched the 2011-2012 vaccine; the low levels of influenza virus "drift" (change) for two consecutive years; and increased influenza vaccination coverage.⁸

- The Virginia Department of Health monitors influenza-like illness (ILI) activity each week from October through May. Those are the months when influenza ("flu") is most likely to occur in VA.
- Flu surveillance is not designed to count every person who has the disease, but assesses ILI activity at the community level. VDH monitors changes in ILI activity the five health planning regions (LFHD is in the Northwest region). ILI is based on patient complaints at medical appointments. ILI is defined as a fever along with a cough and/or a sore throat.
- During the 2011-2012 season, influenza activity was categorized as widespread in VA for only three weeks, beginning in the week of February 25, 2012. By comparison, VA reported widespread activity for 14 weeks during the 2010-2011 influenza season.



- Figure 8 is a graph of percent of visits for ILI, by region. Although LFHD does not have district level data for ILI, they are included in the Northwest region, which had lower levels of ILI compared to the rest of the state.
- There were no reported influenza-associated pediatrics deaths in the LFHD during the 2011-2012 influenza season.

For Healthcare Providers

- ACIP recommends routine influenza vaccination for all persons aged 6 months and older.
- ACIP recommends routine influenza vaccination for all healthcare workers
- Vaccination efforts should continue throughout the season, because the duration of the season varies and may not peak until February or March

LFHD Services

- LFHD provides influenza vaccine. Please call your local health department for more information (numbers can be found at the end of this report)

Virginia Influenza Activity Levels

During influenza season, the Virginia Department of Health categorizes **State-wide** influenza activity using the following CDC definitions:

No Activity: No laboratory-confirmed cases of influenza and no reported increase in the number of cases of ILI.

Sporadic: Small numbers of laboratory-confirmed influenza cases or a single laboratory-confirmed influenza outbreak reported, but no increase in cases of ILI.

Local: Outbreak of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of the state.

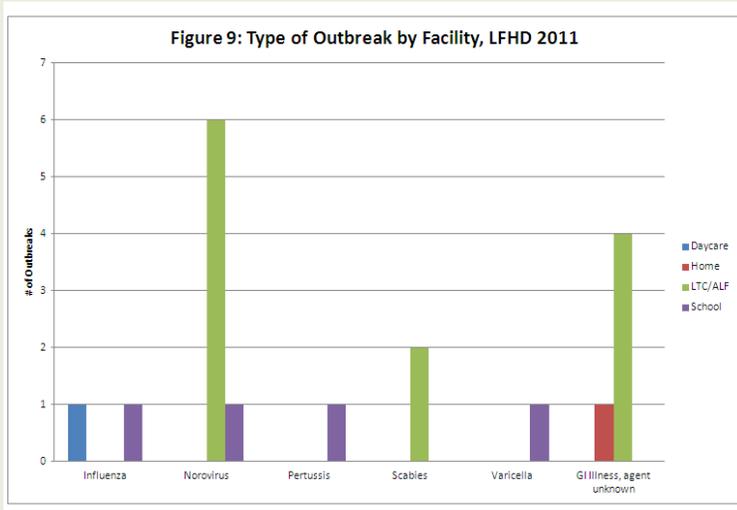
Regional: Outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least 2 but less than half the regions of the state.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state.

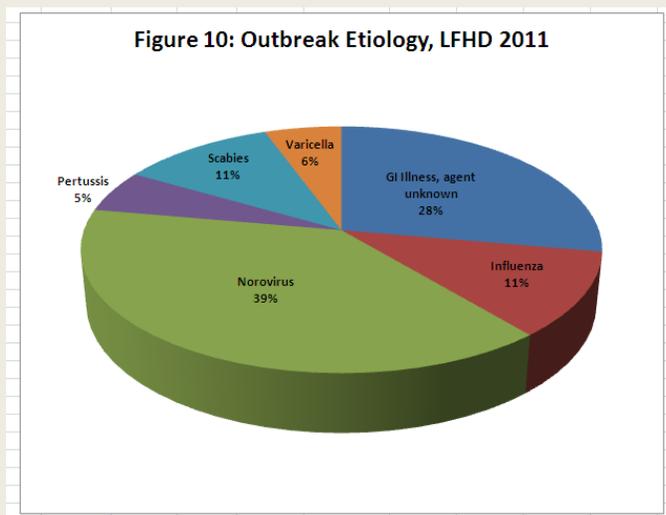
⁸CDC. 2011-2012 Flu Season Draws to a Close. Found at: <http://www.cdc.gov/flu/spotlights/2011-2012-flu-season-wrapup.htm>

Outbreak Summary, 2011

According to the World Health Organization (WHO) and for public health purposes, an outbreak is defined as the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season.⁹ A single case of a communicable disease long absent from a population, or caused by an agent not previously recognized or the emergence of a previously unknown disease, may also constitute an outbreak and should be reported and investigated.



- In 2011, LFHD investigated 18 outbreaks of illness
- As in previous years, non-foodborne gastroenteritis outbreaks in long term care or assisted living facilities were the most commonly reported outbreak in LFHD (Figure 9)
- Of the 18 outbreaks in 2011, 39% were due to norovirus, followed by GI illness, agent unknown, at 28% (Figure 10).
- The most common outbreak investigation settings were long-term care and assisted living facilities



For Healthcare Providers

- Report all suspected outbreaks for any disease to your local health department as soon as possible
- For each reported outbreak, LFHD will conduct an investigation to determine the causative agent and assist the facility with implementing prevention and control measures
- Frequent and proper hand washing with soap and water is the key measure for preventing most norovirus and other GI outbreaks.

⁹World Health Organization. Disease Outbreaks. Found at: http://www.who.int/topics/disease_outbreaks/en/

Tuberculosis

Tuberculosis (TB) is one of the world's deadliest diseases, with approximately one third of the world's population being infected with TB. In 2011, nearly 9 million people around the world became sick with TB disease and around 1.4 million TB-related deaths occurred worldwide. TB is also a leading cause of death of people who are HIV infected¹⁰. Many different factors can contribute to the spread of tuberculosis. TB/HIV co-infection, poor and unhealthy living conditions, poor medical care, and incomplete antibiotic regimens are just a few factors that can intensify the condition of an individual infected with tuberculosis

In 2011, the United States reported a TB rate of 3.4 cases per 100,000, which represents a 6.4% decrease compared to 2010 and, for the second year in a row, reached the lowest number and lowest rate since reporting began in 1954¹¹. Foreign-born persons accounted for 62% of the cases in 2011, which is approximately 11 times higher than US born persons¹¹.

- In 2011, Virginia reported 221 tuberculosis (TB) cases, a substantial decrease from the 268 cases reported in 2010¹². Virginia ranks 12th in the nation for reported TB cases with a case rate of 2.7 per hundred thousand compared to 3.4 for the United States (see Figure 11)¹².
- LFHD reported one case of TB in 2011. Five cases were reported in 2007, one case in 2008, and zero cases in 2009 and 2010. For reporting purposes, LFHD is part of the Northwest region. As noted in Figure 12, northwest region hovers around 20 cases per year since 2007, which is well below the other regions in the state¹².

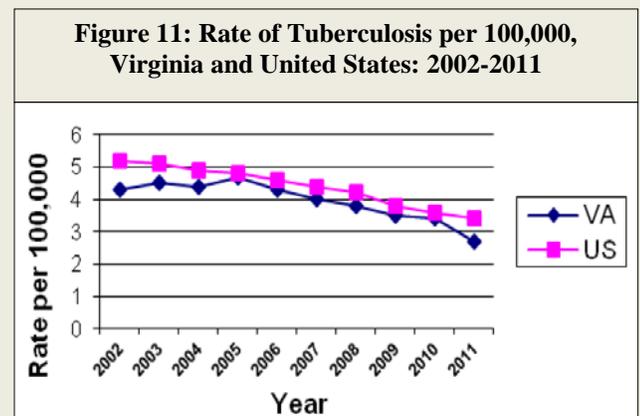
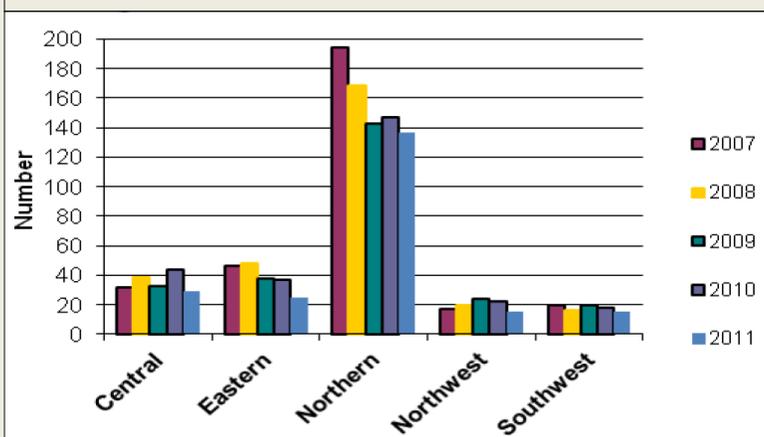


Figure 12: TB Cases by Health Region, VA: 2007-2011



For Healthcare Providers

- Report all suspected tuberculosis cases to your local health department, regardless of location of infection or treatment status. LFHD will conduct contact investigations to identify exposed individuals and provide appropriate follow-up.
- The new Core Curriculum on Tuberculosis: What the Clinician Should Know is available online from the CDC at: <http://www.cdc.gov/tb/education/corecurr/index.htm>.

¹⁰Centers for Disease Control and Prevention. Found at: <http://www.cdc.gov/tb/statistics/default.htm>

¹¹CDC. *Reported Tuberculosis in the United States, 2011*. Atlanta, GA: U.S. Department of Health and Human Services, CDC, October 2012

¹²Virginia Department of Health, Office of Epidemiology, Division of Disease Prevention, 2011 Annual Tuberculosis Surveillance Report, August, 2012

Data Source

Unless otherwise noted, data are LFHD primary surveillance data available in the Virginia Electronic Disease Surveillance System (VEDSS) as of May 31, 2012. All 2011 data are considered provisional.

Acknowledgements

Alexandria Health Department

Fairfax County Health Department

This report was prepared by LFHD Epidemiologist Patricia Bair, MPH and Nathan Rinard, Public Health Student Intern from Shenandoah University and approved by LFHD Health Director Charles A. Devine, MD; any errors are solely their responsibility. Feedback is welcome: patricia.bair@vdh.virginia.gov or charles.devine@vdh.virginia.gov.

Contact Information for Reportable Diseases

Conditions listed in **black** can be submitted within three days of suspected or confirmed diagnosis on an [Epi-1 form](#), by mail or fax.

Conditions listed in **RED** must be reported immediately by the most rapid means available (preferably phone call).

<u>Health Department</u>	<u>Address</u>	<u>City</u>	<u>Zip</u>	<u>Phone</u>	<u>Fax</u>
Clarke County	100 N. Buckmarsh St.	Berryville	22611	540-955-1033	540-955-4094
Frederick/Winchester	10 Baker St.	Winchester	22601	540-722-3470	540-722-3475
Page County	75 Court Ln.	Luray	22835	540-743-6528	540-743-3811
Shenandoah County	494 N. Main St. #100	Woodstock	22664	540-459-3733	540-459-8267
Warren County	134 Peyton St.	Front Royal	22630	540-635-3159	540-635-9698
After Hours Phone:	540-665-8611				
District Epidemiologist	540-722-3480, x228				

Virginia Reportable Disease List

Reporting of the following diseases is required by state law (§32.1-36 and §32.1-37 of the *Code of Virginia* and 12VAC5-90-80 and 12VAC5-90-90 of the Board of Health *Regulations for Disease Reporting and Control*, <http://www.vdh.virginia.gov/epidemiology/regulations.htm>). Report all conditions when suspected or confirmed to your local health department within three days on an [Epi-1 form](#), except those listed in **RED** must be reported immediately by the most rapid means available.

<ul style="list-style-type: none"> Acquired immunodeficiency syndrome (AIDS) Amebiasis ANTHRAX Arboviral infections (e.g., dengue, EEE, LAC, SLE, WNV) BOTULISM BRUCELLOSIS Campylobacteriosis Chancroid Chickenpox (Varicella) <i>Chlamydia trachomatis</i> infection CHOLERA Creutzfeldt-Jakob disease if <55 years of age Cryptosporidiosis Cyclosporiasis DIPHTHERIA DISEASE CAUSED BY AN AGENT THAT MAY HAVE BEEN USED AS A WEAPON Ehrlichiosis/Anaplasmosis [^] Escherichia coli infection, Shiga toxin-producing Giardiasis Gonorrhea Granuloma inguinale HAEMOPHILUS INFLUENZAE INFECTION, INVASIVE Hantavirus pulmonary syndrome Hemolytic uremic syndrome (HUS) HEPATITIS A Hepatitis B (acute and chronic) Hepatitis C (acute and chronic) Hepatitis, other acute viral Human immunodeficiency virus (HIV) infection # Influenza <ul style="list-style-type: none"> INFLUENZA A, NOVEL VIRUS immediately) INFLUENZA-ASSOCIATED DEATHS IN CHILDREN <18 YEARS OF AGE Lead, elevated blood levels Legionellosis Leprosy (Hansen disease) Listeriosis Lyme disease Lymphogranuloma venereum Malaria MEASLES (RUBEOLA) MENINGOCOCCAL DISEASE 	<ul style="list-style-type: none"> MONKEYPOX Mumps MYCOBACTERIAL DISEASES (INCLUDING AFB), (IDENTIFICATION OF ORGANISM) AND DRUG SUSCEPTIBILITY Ophthalmia neonatorum OUTBREAKS, ALL (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, and waterborne) PERTUSSIS PLAGUE POLIOVIRUS INFECTION, INCLUDING POLIOMYELITIS PSITTACOSIS Q FEVER RABIES, HUMAN AND ANIMAL Rabies treatment, post-exposure RUBELLA, INCLUDING CONGENITAL RUBELLA SYNDROME Salmonellosis SEVERE ACUTE RESPIRATORY SYNDROME (SARS) Shigellosis SMALLPOX (VARIOLA) Spotted fever rickettsiosis <i>Staphylococcus aureus</i> infection, (invasive methicillin-resistant) and (vancomycin-intermediate or vancomycin-resistant) Streptococcal disease, Group A, invasive or toxic shock <i>Streptococcus pneumoniae</i> infection, invasive, in children <5 years of age Syphilis (report PRIMARY and SECONDARY immediately) Tetanus Toxic substance-related illness Trichinosis (Trichinellosis) TUBERCULOSIS, ACTIVE DISEASE Tuberculosis infection in children <4 years of age TULAREMIA TYPHOID/PARATYPHOID FEVER UNUSUAL OCCURRENCE OF DISEASE OF PUBLIC HEALTH CONCERN VACCINIA, DISEASE OR ADVERSE EVENT VIBRIO INFECTION VIRAL HEMORRHAGIC FEVER YELLOW FEVER Yersinia
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^b These conditions are reportable by directors of laboratories. In addition, these and all other conditions except methicillin-resistant *Staphylococcus aureus* (MRSA), invasive and mycobacterial diseases are reportable by physicians and directors of medical care facilities. Laboratory reports may be by computer-generated printout, Epi-1 form, CDC surveillance form, or upon agreement with VDH, by means of secure electronic transmission.

I A laboratory identifying evidence of these conditions shall notify the local health department of the positive culture and submit the initial isolate to the Virginia Division of Consolidated Laboratory Services (DCLS) or, for tuberculosis, to another lab designated by the Board.

[^] Laboratories that use a Shiga toxin EIA methodology without a simultaneous culture should forward all positive stool specimens or positive broth cultures to DCLS for confirmation and further characterization.

Physicians and directors of medical care facilities should report influenza by number of cases only (report total number per week and by type of influenza, if known); however, individual cases of influenza A novel virus should be reported immediately by rapid means.

Note: 1. Central line-associated bloodstream infections in adult intensive care units are reportable. Contact the VDH Healthcare-Associated Infections Program at (804) 864-8141 or see 12VAC5-90-370 for more information.

2. Cancers are also reportable. Contact the VDH Virginia Cancer Registry at (804) 864-7866 or see 12VAC5-90-150-180 for more information.

