

# Communicable Disease Summary 2016



ALBEMARLE | CHARLOTTESVILLE | FLUVANNA  
GREENE | LOUISA | NELSON

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# Table of Contents

<b>Topic</b>	<b>Page</b>
Selected Reportable Diseases, 2010-2016	1
Elevated Lead in Children	2
Lyme Disease 2015-2016	3
Pertussis (Whooping Cough)	4
Zika	5
Outbreaks in 2016	6
Reportable Disease List	7
District Contact Information	8

# Table of Selected Reported Diseases in Thomas Jefferson Health District, 2010-2016

Condition	2010	2011	2012	2013	2014	2015	2016 <sup>a</sup>	2016 5 Yr Average Rates <sup>§</sup>	
								TJHD	VA
Amebiasis	1	0	0	0	1	0	1	0.16	0.34
Arboviral Infection - West Nile Virus	0	0	2	0	0	0	0	0.16	0.18
Botulism, infant	0	0	1	0	0	0	0	0.08	0.03
Campylobacteriosis	28	35	10	6	13	70	47	12.01	12.64
Chlamydia	636	726	742	723	594	683	566	272.18	422.07 <sup>β</sup>
Cryptosporidiosis	5	5	1	3	6	9	17	2.96	2.17
Cyclosporiasis	1	1	0	0	0	2	2	0.33	0.00
E. coli infection, shiga toxin producing	11	5	5	5	4	6	5	2.06	1.31
Ehrlichiosis/anaplasmosis	6	5	10	5	5	9	13	3.46	1.55
Giardiasis	25	13	8	18	10	13	7	4.61	3.28
Gonorrhea	147	158	145	86	153	94	77	45.66	92.32 <sup>β</sup>
Haemophilus influenzae, invasive	0	1	1	5	2	2	3	1.07	1.27
Hemolytic uremic syndrome	0	0	0	1	0	0	0	0.08	0.06
Hepatitis A, acute	1	0	1	1	0	2	5	0.74	0.84
Hepatitis B, acute	0	1	1	1	0	1	0	0.25	0.82
Hepatitis C, acute	0	0	0	0	0	0	3	0.25	0.68
HIV disease	16	20	15	26	20	21	9	7.49	11.34 <sup>β</sup>
Influenza-associated mortality (less than age 18)	0	0	0	0	0	0	0	0.00	0.14
Lead - elevated blood levels in children (ages 0-15)	10	8	5	5	12	6	29	26.26	20.60
Legionellosis	5	2	1	3	3	2	6	1.23	1.43
Listeriosis	0	1	1	2	2	0	0	0.41	0.28
Lyme disease	80	76	57	59	68	83	62	27.07	15.57
Malaria	2	0	4	3	1	3	2	1.07	0.84
Measles (Rubeola)	0	4	0	0	0	0	0	0.00	0.00
Meningococcal disease (Neisseria meningitidis)	4	2	0	2	3	0	1	0.49	0.10
Mumps	1	0	1	3	9	22	1	2.96	0.44
Pertussis	65	30	12	27	28	71	31	13.66	5.06
Q fever	0	0	0	0	0	0	0	0.00	0.00
Rabies in animals	20	9	19	13	16	30	20	NA	NA
Salmonellosis	34	55	33	28	34	47	46	15.47	13.62
Shigellosis	0	0	3	1	13	3	5	2.06	2.59
Spotted Fever Rickettsiosis (including RMSF)	18	26	31	23	22	23	14	9.30	4.26
Staph aureus, methicillin resistant (MRSA)	15	41	18	11	14	23	25	7.49	13.89
Streptococcal infection, Group A, invasive	8	12	14	10	10	12	4	4.11	2.43
Streptococcus pneumoniae, invasive (age < 5)	2	0	1	0	0	1	2	5.95	6.00
Syphilis, early	7	12	7	11	7	11	9	3.70	8.18 <sup>β</sup>
Toxic Substance Exposure	7	7	4	0	5	0	1	0.82	4.71
Tuberculosis	10	6	3	6	7	6	3	2.06	2.42
Tularemia	0	0	0	1	0	1	0	0.16	0.02
Typhoid fever (Salmonella typhi)	0	0	1	0	0	0	0	0.08	0.13
Varicella (Chickenpox)	20	19	10	26	23	23	14	7.90	4.37
Vibrio infection - non-cholera	1	1	2	0	0	0	1	0.25	0.53

§ – Rates are crude and use preliminary 2016 numbers. Units are number of cases per 100,000 population Source of population estimates: U.S. Census Bureau, <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

<sup>a</sup> – All 2016 numbers are preliminary and subject to change

<sup>β</sup> – 2016 STI numbers are not available on the state level, rates are 4 yr '12-'15 averages

# Elevated Lead in Children

## FAST FACTS

### Cases in 2016: 29

Rate: 66.4 per 100,000 persons aged 0-15

**Etiologic agent:** Lead

**Disease characteristics:** Wide range, including learning difficulties, behavior problems, irritability, loss of appetite, abdominal pain, or hearing loss. In cases of very high exposure, it can cause seizures, coma, or death

**Primary mode of transmission:** Ingestion, inhalation

**Incubation period:** N/A

**Period of communicability:** N/A

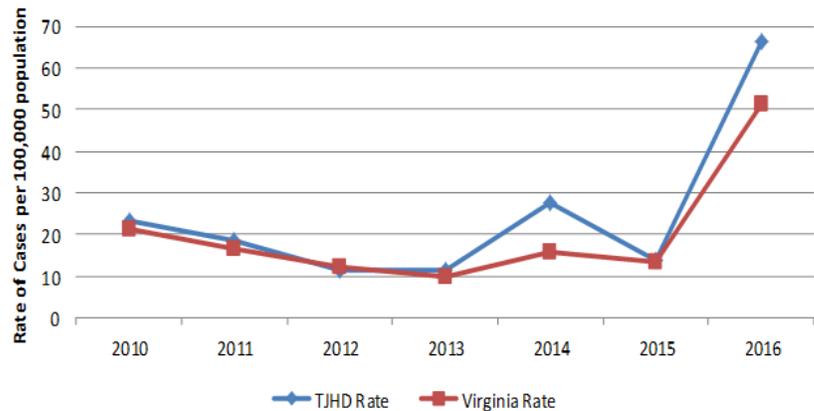
**Detection method:** Blood test (venous or capillary)

**High risk groups:** Young children

## PUBLIC HEALTH PRIORITIES

- Prevention is key. Healthcare providers should talk to parents about the dangers of lead poisoning, potential sources of lead, and ways to prevent exposure.
- Public health responses begin at blood lead levels  $\geq 10 \mu\text{g/dL}$  and, depending on levels, can include: education, testing, referral, home-visits, case management, and an environmental investigation.<sup>2</sup>
- Healthcare providers should perform confirmatory testing on screening blood lead levels  $\geq 5 \mu\text{g/dL}$  and follow-up testing for children with confirmed blood lead levels  $\geq 5 \mu\text{g/dL}$ .<sup>2</sup>

Elevated Blood Lead Levels in Children Incidence Rate by Year, Thomas Jefferson Health District (TJHD) and Virginia



## EPIDEMIOLOGIC DATA

TJHD has witnessed nearly a five-fold increase in reported cases of elevated lead in children - aged 15 and under - since 2015 (from 13.8 per 100,000 to 66.4 per 100,000).



In 2016 the CDC case definition was updated to be any diagnosed level  $\geq 5 \mu\text{g/dL}$ . This was down from the previous level of  $\geq 10 \mu\text{g/dL}$  and could help explain why both TJHD and the state saw a spike in the number of cases.<sup>1</sup>

In TJHD, slightly over half of the cases (17) occurred in children aged 1-3 while just under half of cases (14) occurred in the City of Charlottesville.

## THINGS TO REMEMBER

- There is no safe level of lead in children.
- $5 \mu\text{g/dL}$  is the national blood lead reference level for children. This value is based on the 97.5th percentile of the National Health and Nutrition Examination Survey (NHANES)'s blood lead distribution in children and will be updated once data from the most recent surveys is complete.<sup>3</sup>
- The primary source of lead for children is exposure to lead-based paint. Other potential sources of exposure can include renovations; imported toys, beads, or jewelry; imported pottery or glazed cooking/serving utensils; ethnic medicines or make-up (e.g., kohl); and carry-home exposure by family members with occupations or hobbies that involve lead.<sup>2,3</sup>
- Guidelines for testing children in Virginia are available at <http://www.vdh.virginia.gov/leadsafe/documents/Childhood>

<sup>1</sup>Centers for Disease Control and Prevention. National Notifiable Disease Surveillance System: Lead, Elevated Blood Levels. Accessed from: <https://wwwn.cdc.gov/nndss/conditions/lead-elevated-blood-levels/>

<sup>2</sup>Virginia Department of Health. Childhood Lead Poisoning Prevention: 2015 Annual Lead-Safe Virginia Summary Surveillance Report. Accessed from: <http://www.vdh.virginia.gov/leadsafe/data.htm>

<sup>3</sup>Virginia Department of Health. Childhood Lead Poisoning Prevention: Parent Fact Sheet Accessed from: <http://www.vdh.virginia.gov/leadsafe/documents/pdf/ParentFactSheet.pdf>

# Lyme Disease in 2015-2016

## FAST FACTS

### Cases in 2016: 62

Rate: 25.1 per 100,000 persons

**Etiologic agent:** *Borrelia burgdorferi* (bacteria)

**Disease characteristics:** Erythema migrans (“bull’s-eye”) rash, fatigue, fever, headache, muscle and joint pains, and swollen lymph nodes

**Primary mode of transmission:** Tickborne (*Ixodes scapularis*, the blacklegged or deer tick)

**Incubation period:** 3-30 days

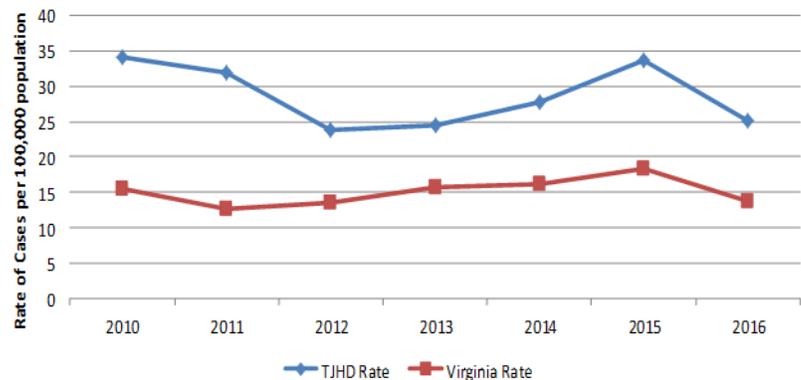
**Period of communicability:** N/A

**Detection method(s):** Signs and symptoms, serology (2 step testing process via EIA/IFA and Western Blot)<sup>2</sup>

**High risk groups:** Persons spending time in a tick environment, such as forested areas (leaf litter), grass surrounding forests, and shaded vegetation

**Prevention:** Avoid tick bites, check for ticks after coming indoors, and remove ticks early

Lyme Incidence by Year, Thomas Jefferson Health District (TJHD) and Virginia



## EPIDEMIOLOGIC DATA

TJHD experienced a 22% increase in Lyme cases between 2014 and 2015. In 2016, the rate of Lyme in TJHD looks to be lower than 2015, currently a 25% decrease. However, these numbers are preliminary and expected to increase but remain below 2015 levels. Nationally, 95% of cases are reported from 14 states in the northeast and upper Midwest.<sup>1</sup>



Of those cases of Lyme in TJHD, the median age was 45, although every age group was affected. Most cases (60%) were reported among males. Albemarle County reported 41% of all Lyme cases from TJHD. Of confirmed cases, 9 were hospitalized over the 2015-2016 timespan.

## PUBLIC HEALTH PRIORITIES

- Collection of data enables us to determine the incidence and distribution of Lyme disease in our community, monitor trends over time, and focus educational and prevention efforts.
- Public health follow-up involves confirming laboratory results as well as clinical signs and symptoms.

## THINGS TO REMEMBER

- To take preventative measures against tick bites, avoid direct contact by avoiding woody and brushy areas with high grass and leaf litter and by walking in the center of trails.
- Repellents containing 20%-30% DEET and treating clothes with permethrin are also effective at preventing tick bites.
- There are also many effective landscaping strategies to tick proof the yards around homes; the Connecticut Agricultural Experiment Station has developed a comprehensive guide.<sup>3</sup>
- Most infections are transmitted through the bite of immature (nymph) ticks, which can be very small, approximately the size of a poppy seed.
- Peak transmission is during the late spring and early summer months, when nymph ticks are most active, although infection

<sup>1</sup>Centers for Disease Control and Prevention. Lyme Disease: Data and Statistics. Accessed from <http://www.cdc.gov/lyme/stats/index.html>.

<sup>2</sup>Centers for Disease Control and Prevention. Lyme Disease: Two-step Laboratory Testing Process. Accessed from <https://www.cdc.gov/lyme/diagnosis/testing/labtest/twostep/index.html>

<sup>3</sup>[http://www.ct.gov/caes/lib/caes/documents/special\\_features/tickhandbook.pdf](http://www.ct.gov/caes/lib/caes/documents/special_features/tickhandbook.pdf)

# Pertussis (Whooping Cough)

## FAST FACTS

Cases in 2016: **31**

(Rate: 12.5 per 100,000 persons)

**Etiologic agent:** *Bordetella pertussis* (bacteria)

**Disease characteristics:** Cold like symptoms (runny nose, sneezing, mild fever, cough) with a cough followed by a whooping noise lasting 4-6 weeks

**Primary mode of transmission:** Droplet, fomite

**Incubation period:** 9-10 days

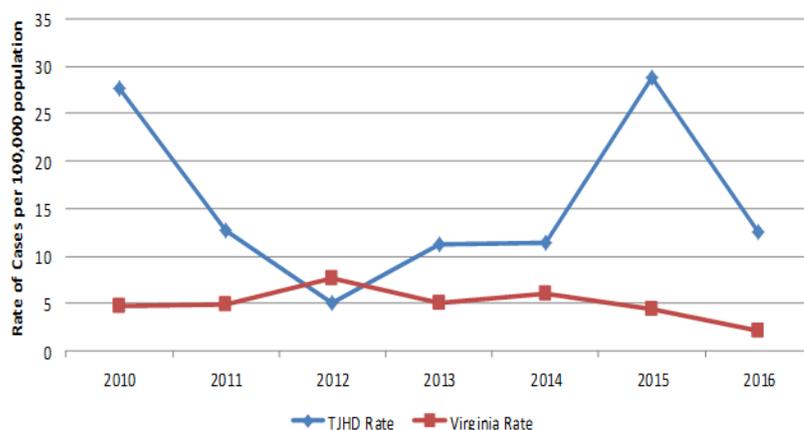
**Period of communicability:** Highly communicable in first 2 weeks with decreasing communicability by 3 weeks; patients not contagious after 5 days of treatment

**Detection method(s):** Signs and symptoms (characteristic cough), laboratory test

**High risk groups:** Young children (less than 1 yr.) who have not been vaccinated

**Prevention:** DTaP and Tdap vaccine

Pertussis Incidence by Year, Thomas Jefferson Health District (TJHD) and Virginia



## EPIDEMIOLOGIC DATA

After experiencing 71 cases in 2015, the number of confirmed cases dropped to 31 in 2016. This was similar to the 2014 level. In 2015, 45 of the cases (63%) were counted as part of an outbreak. If those cases are subtracted from the 2015 total, then this year's numbers reflect a flat trend line since 2013.



Albemarle County accounted for most of the cases, 68%, with 21 cases in 2016. Charlottesville City had 7 cases, Nelson County had 2 cases, and Greene County had 1 case. Louisa and Fluvanna did not have any reported cases. Children, ages 0-17 years, accounted for 22 cases or 71% of the total number.

## PUBLIC HEALTH PRIORITIES

- Public health investigations involve confirming signs and symptoms, facilitating testing, recommending isolation as appropriate, and contact tracing.
- Education efforts to help prevent exposure from infected individuals, especially to prevent infection of infants.

## THINGS TO REMEMBER

- Pertussis is a vaccine preventable disease.
- Infants who have not been vaccinated usually present the most severe symptoms. While older persons who received vaccination may contract pertussis, their symptoms are often more mild.
- Pregnant women should get a dose of Tdap during every pregnancy to protect the newborn from pertussis.
- One dose of Tdap is routinely given at age 11 or 12. People who did not get Tdap at that age should get it as soon as possible.

<sup>1</sup>Virginia Department of Health. Reportable Disease Surveillance in Virginia, 2014. Accessed from: <http://www.vdh.virginia.gov/content/uploads/sites/3/2016/03/FullText2014.pdf>

<sup>2</sup>Centers for Disease Control and Prevention. Mumps Cases and Outbreaks. Accessed from: <http://www.cdc.gov/mumps/outbreaks.html>.

<sup>3</sup>Centers for Disease Control and Prevention. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2011; 60 (No. 7): 1-45.

# Zika

## FAST FACTS

**Etiologic agent:** Zika virus

**Disease characteristics:** Many people infected will not have symptoms, but those who do may have fever, rash, joint pain, conjunctivitis, muscle pain, and headache. The symptoms last several days up to a week. It is risky for pregnant women because infection can cause birth defects.

**Primary mode of transmission:** Mosquito bite from an infected mosquito, from a pregnant woman to her fetus, sexual, blood transfusion

**Detection method:** Urine or blood test

**Incubation period:** Symptoms, if present, occur within 3 to 14 days

**Period of communicability:** Men who have traveled to a place with Zika should wait at least 6 months after travel (or 6 months after symptoms started if they get sick) before trying to conceive with their partner. Women should wait at least 8 weeks after travel (or 8 weeks after symptoms started if they get sick) before trying to get pregnant. The waiting period is longer for men because Zika stays in semen longer than in other body fluids.

**High risk groups:** Pregnant women

**Prevention:** Use EPA-registered insect repellents, wear long-sleeved shirts and long pants, sleep under a mosquito bed net if air conditioned or screened rooms are not available or sleeping outdoors. Condoms can reduce the chance of getting Zika from sex.

## EPIDEMIOLOGIC DATA

Between December 1st, 2015 and December 31st, 2016, the Virginia Department of Health has reported 112 cases of Zika virus disease in Virginia residents. This includes 17 cases in the Northwest Region of which TJHD is a part. All Virginia cases are associated with travel to a Zika-affected area and none are attributable to local transmission.<sup>1</sup>

Nationally, 2,382 cases were reported during January 1st, 2016 to July 31st, 2016 to ArboNET, the national arboviral surveillance system managed by CDC and state health departments. 99% of the cases were travel associated, with 26 cases being locally acquired mosquito-borne disease and one laboratory-acquired infection.<sup>2</sup>

## PUBLIC HEALTH PRIORITIES

The CDC has taken a number of steps to assess, understand, and prevent Zika from spreading within the United States. Zika has been of special concern to the CDC and general public because of the establishment of a causal link between Zika virus infection during pregnancy and serious brain abnormalities, including microcephaly. Among the prevention measures taken have been issuing travel guidance. As of December 15, 2016, a total of 60 international Zika travel notices have been issued, including 49 in the Americas. These notices advise pregnant women to avoid travel to areas of active Zika virus transmission, provide recommendations for travelers to avoid exposure to Zika virus, and inform returning travelers about transmission prevention and testing. To monitor the effect of Zika virus infection during pregnancy, pregnancy and infant surveillance was put in place in U.S. states and territories.

Important future priorities include continuing to protect pregnant women and fetuses and infants from Zika virus infection; developing improved diagnostics, including the ability to distinguish among flaviviruses serologically; collaborating among government and private partners to accelerate vaccine development; developing and implementing improved vector surveillance and control strategies and capacities; improving contraceptive access to reduce unintended pregnancies; and improving understanding of the long-term outcomes for infants exposed to Zika virus in utero.<sup>3</sup>

## THINGS TO REMEMBER

- Zika primarily spreads through infected mosquitoes. You can also get Zika through sex.
- The best way to prevent Zika is to prevent mosquito bites.
- Zika is linked to birth defects.
- Pregnant women should not travel to areas with Zika.
- Returning travelers infected with Zika can spread the virus through mosquito bites.
- There have been no locally acquired cases within the state of Virginia. The number of cases of Zika virus disease will be updated monthly on the Virginia Department of Health website.

<sup>1</sup>Virginia Department of Health. Zika Virus Update, accessed 1/12/2017 Accessed from: <http://www.vdh.virginia.gov/zika/zika-virus-update/>

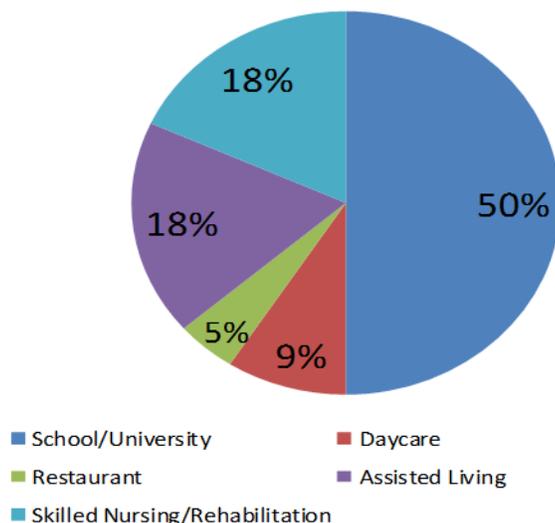
<sup>2</sup>Centers for Disease Control and Prevention. Zika Virus Disease Cases — 50 States and the District of Columbia, January 1–July 31, 2016. Accessed from: [https://www.cdc.gov/mmwr/volumes/65/wr/mm6536e5.htm?\\_cid=mm6536e5\\_w](https://www.cdc.gov/mmwr/volumes/65/wr/mm6536e5.htm?_cid=mm6536e5_w)

<sup>3</sup>Centers for Disease Control and Prevention. Zika Virus —10 Public Health Achievements in 2016 and Future Priorities Accessed from: [https://www.cdc.gov/mmwr/volumes/65/wr/mm6552e1.htm?\\_cid=mm6552e1\\_e](https://www.cdc.gov/mmwr/volumes/65/wr/mm6552e1.htm?_cid=mm6552e1_e)

# 2016 OUTBREAKS

Organism	C. perfringens	1
	Group A Streptococcal, non-invasive	3
	Hand, foot, and mouth disease (HFMD)	1
	Influenza	8
	Norovirus	6
	Pertussis	2
	Pinworm	1
	Salmonella	1
	TOTAL	20

2016 Outbreak Settings by Type of Facility



## Outbreak Release

In February of this year, 2016, there was an outbreak of gastrointestinal illness caused by *Clostridium perfringens*. This outbreak occurred during a public event at a restaurant within Charlottesville. The day after the event, the environmental health food protection supervisor was notified by environmental health staff that they had received multiple complaints from patrons who ate at the restaurant on the previous evening. The same day they were notified, the supervisor did an inspection of the restaurant inquiring what types of food were served the previous evening and their preparation method. Identified ill contacts were interviewed by the TJHD epidemiologist or public health nurses. A survey was developed that was distributed by the restaurant owner through the Facebook event page.

Laboratory test results on human specimens and food leftovers were able to isolate *C. perfringens* with the same DNA signature from both. The owner of the restaurant also described an insufficient cooling process for part of the food prepared that would have enabled the bacteria to grow. This outbreak was a single point-source event and did not result in any secondary illnesses. An immediate inspection by environmental health resulted in a voluntary cancellation of a second restaurant event night on the following evening by the restaurant owner, potentially preventing additional illnesses.

## EPIDEMIOLOGIC DATA

In 2016 a total of 20 outbreaks were reported. The outbreaks were caused by eight different organisms across five localities. The vast majority (90%) were person-to-person transmission. There were also two foodborne outbreaks (salmonellosis and *C. perfringens*). This was the first time TJHD experienced an outbreak related to a restaurant since 2013. This was also the second time in five years that we had zero outbreaks originate from either local hospital.

Norovirus accounted for 40% of all outbreaks in 2016 with 151 people confirmed affected. Schools and universities account are the most common places for outbreaks to occur in our health district with 11 of the 20 outbreaks occurring in these facilities.

### THINGS TO REMEMBER

- All outbreaks are reportable, including but not limited to foodborne, healthcare-associated, occupational, toxic-substance related, and waterborne.
- We try to test for etiologic agents during most outbreaks. Usually this can be done through the state public health laboratory free of charge. Determining the cause of an outbreak helps us make more targeted recommendations for disease prevention and control.

# VIRGINIA REPORTABLE DISEASE LIST

Reporting of the following diseases is required by state law (Sections 32.1-36 and 32.1-37 of the *Code of Virginia* and 12 VAC 5-90-80 and 12 VAC 5-90-90 of the Board of Health *Regulations for Disease Reporting and Control* - <http://www.vdh.virginia.gov/surveillance-and-investigation/division-of-surveillance-and-investigation/commonwealth-of-virginiastate-board-of-health/>). Report all conditions when suspected or confirmed to your local health department (LHD). Reports may be by computer-generated printout, Epi-1 form, CDC or VDH surveillance form, or upon agreement with VDH, by means of secure electronic transmission.

**BOLD** – Laboratories must submit initial isolate or other initial specimen to the Division of Consolidated Laboratory Services (DCLS) within 7 days of identification. All specimens must be identified with patient and physician information, and the LHD must be notified within the timeframe specified below.

## REPORT IMMEDIATELY

**Anthrax** [a]  
**Botulism** [a]  
**Brucellosis** [a]  
**Cholera** [a]  
 Coronavirus infection, severe (e.g., SARS-CoV, MERS-CoV) [a]  
**Diphtheria** [a]  
 Disease caused by an agent that may have been used as a weapon  
**Haemophilus influenzae** infection, invasive [a]  
 Hepatitis A [a]  
 Influenza-associated deaths <18 years of age  
**Influenza A, novel virus** [a]  
 Measles (Rubeola) [a]  
**Meningococcal disease** [a]  
 Outbreaks, all (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, and waterborne)  
**Pertussis** [a]  
**Plague** [a]  
**Poliovirus infection, including poliomyelitis** [a]  
**Psittacosis** [a]  
**Q fever** [a]  
 Rabies, human and animal [a]  
 Rubella [a], including congenital rubella syndrome [a]  
 Smallpox (Variola) [a]  
 Syphilis, primary and secondary [a]  
**Tuberculosis (TB), active disease** [a,b]  
**Tularemia** [a]  
**Typhoid/Paratyphoid fever** [a]  
 Unusual occurrence of disease of public health concern  
 Vaccinia, disease or adverse event [a]  
**Vibrio** infection [a]  
 Viral hemorrhagic fever [a]  
 Yellow fever [a]

## REPORT WITHIN 3 DAYS

Acquired immunodeficiency syndrome (AIDS)  
 Amebiasis [a]  
 Arboviral infections (e.g., CHIK, dengue, EEE, LAC, SLE, WNV, Zika) [a]  
 Babesiosis [a]  
 Campylobacteriosis [a]  
 Chancroid [a]  
 Chickenpox (Varicella) [a]  
*Chlamydia trachomatis* infection [a]  
 Creutzfeldt-Jakob disease <55 years of age [a]  
 Cryptosporidiosis [a]  
 Cyclosporiasis [a]  
 Ehrlichiosis/Anaplasmosis [a]  
**Escherichia coli** infection, Shiga toxin-producing [a,c]  
 Giardiasis [a]  
 Gonorrhea [a]  
 Granuloma inguinale  
 Hantavirus pulmonary syndrome [a]  
 Hemolytic uremic syndrome (HUS)  
 Hepatitis B (acute and chronic) [a]  
 Hepatitis C (acute and chronic) [a]  
 Hepatitis, other acute viral [a]  
 Human immunodeficiency virus (HIV) infection [a]  
 Influenza [a,d]  
 Lead, reportable levels [a]  
 Legionellosis [a]  
 Leprosy (Hansen's disease)  
 Leptospirosis [a]  
**Listeriosis** [a]  
 Lyme disease [a]  
 Lymphogranuloma venereum  
 Malaria [a]  
 Mumps [a]  
 Ophthalmia neonatorum  
 Rabies treatment, post-exposure  
**Salmonellosis** [a]  
**Shigellosis** [a]  
 Spotted fever rickettsiosis [a]  
**Staphylococcus aureus** infection, vancomycin-intermediate or vancomycin-resistant [a]  
**Streptococcal disease, Group A, invasive or toxic shock** [a]  
*Streptococcus pneumoniae* infection, invasive, <5 years of age [a]  
 Syphilis, other than primary and secondary  
 Tetanus  
 Toxic substance-related illness [a]  
 Trichinosis (Trichinellosis) [a]  
 Tuberculosis (TB) infection <4 years of age  
**Yersiniosis** [a]

## LEGEND

[a] Reportable by directors of laboratories. These and all other conditions listed must be reported by physicians and directors of medical care facilities.

[b] Laboratories report AFB, mycobacterial identification, and drug susceptibility for *M. tuberculosis*

[c] Laboratories that use EIA without a positive culture should forward positive stool specimens or enrichment broth to DCLS

[d] Physicians and directors of medical care facilities 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 or influenza-related deaths in persons <18 must be reported immediately

# Contact Information for Thomas Jefferson Health District

**Marcia Hornberger, RN, BSN, Epidemiologist**

[Marcia.Hornberger@vdh.virginia.gov](mailto:Marcia.Hornberger@vdh.virginia.gov)

**Office** – 434-972-4305

**Fax** – 434-972-6249

**Denise Bonds, MD, MPH, Health Director**

**Office** – 434-972-6226

**Fax** – 434-972-4310

Persons calling for assistance in having an animal tested for rabies because of a human exposure to a potentially rabid animal should call

TJHD Environmental Health

**434-972-6219**

Monday – Sunday, 8:00 AM and 4:30 PM.

## Thomas Jefferson Health District Charlottesville/Albemarle, Fluvanna, Greene, Louisa, and Nelson Local Health Departments

### Communicable Disease Reporting Hotline

Normal Business Hours: **434-972-6217**

After Hours: **866-531-3068**

**Fax : 434-972-6249**

<p><b>Charlottesville/ Albemarle Health Department</b> 1138 Rose Hill Dr. Charlottesville 22903</p>	<p><b>Fluvanna County Health Department</b> 132 Main St. Rt. 15 Palmyra 22963</p>	<p><b>Greene County Health Department</b> 50 Stanard St. Stanardsville 22973</p>	<p><b>Louisa County Health Department</b> 540 Industrial Dr. Louisa 23093</p>	<p><b>Nelson County Health Department</b> 4038 Thomas Nelson Hwy Arrington 22922</p>
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