



# VIRGINIA EPIDEMIOLOGY BULLETIN

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## **Summary of Notifiable Diseases, Virginia, 2006 – Part I Enteric, Respiratory, and Sexually Transmitted Infections**

### **Introduction**

Public health surveillance is the ongoing, systematic collection, analysis, and interpretation of data regarding health-related events. The goals of surveillance are to reduce morbidity and mortality and to improve health. For example, regular review of surveillance data allows healthcare professionals to improve their understanding of the health of the community and to identify new and emerging issues. To assist them, the Virginia Department of Health (VDH) Office of Epidemiology disseminates notifiable disease data through the *Virginia Epidemiology Bulletin* (VEB) and on the VDH website ([www.vdh.virginia.gov](http://www.vdh.virginia.gov)) monthly. In addition, VDH publishes an annual summary entitled *Reportable Disease Surveillance in Virginia* (available at [www.vdh.virginia.gov/epi/survdata.asp](http://www.vdh.virginia.gov/epi/survdata.asp)). This issue (Is-

sue 6) of the VEB summarizes some of the key findings from preliminary analysis of disease surveillance data related to enteric, respiratory, and sexually transmitted infections (including HIV/AIDS) in Virginia for 2006. Issue 7 will address surveillance data for select vaccine-preventable infections, toxic substance-related illnesses, and zoonotic diseases.

### **Data Sources**

Reports of confirmed or suspected notifiable conditions, including outbreaks, are primarily made by physicians, laboratories, infection control practitioners, administrators of long-term care facilities, childcare centers, camps, and schools. Reports are received by local health departments for appropriate action (e.g., further investigation, interventions, etc.), and forwarded to the

Office of Epidemiology for centralized data analysis. Available laboratory test results and/or clinical diagnostic criteria are assessed to determine if they meet case classifications developed by the Centers for Disease Control and Prevention (CDC). In some situations, due to the lack of available information, reported cases may not be included in case counts. Complete reporting ensures the best possible description of the burden of morbidity from conditions of public health importance in Virginia.

Data presented as incidences are based on the number of cases per 100,000 population. Population data for calculating incidence rates used 2005 U.S. Census estimates ([www.census.gov/popest/counties/asrh/CC-EST2005-alldata.html](http://www.census.gov/popest/counties/asrh/CC-EST2005-alldata.html)).

<b>Disease</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
AIDS	1,177	963	912	908	970	866	793	774	626	588
Amebiasis	30	31	34	24	37	16	20	25	42	45
Anthrax	0	0	0	0	2	0	0	0	0	0
Arboviral infection (SLE, WNV, EEE, LAC)	7	4	0	0	2	32	31	7	5	5
Botulism, foodborne	0	1	0	0	0	1	0	0	0	0
Botulism, infant	0	0	3	2	4	3	1	3	1	0
Brucellosis	1	1	0	1	1	0	2	1	1	0
Campylobacteriosis	644	700	637	574	583	686	882	668	618	669
Chickenpox (Varicella)	1,760	1,115	1,490	592	563	605	682	1,240	1,834	1,959
<i>Chlamydia trachomatis</i> infection	11,604	13,370	13,427	15,366	18,322	18,518	19,439	21,635	22,668	24,081
Creutzfeldt-Jakob disease (<55 yrs)	0	1	1	1	1	1	0	0	0	1
Cryptosporidiosis	22	23	30	21	27	35	56	66	77	71
Cyclosporiasis	47	5	1	0	1	1	3	1	3	0
Ehrlichiosis (HGE, HME, Unspecified)	3	4	7	1	2	6	12	8	13	8
<i>Escherichia coli</i> infection, Shiga toxin-producing	-	-	82	83	61	81	63	62	111	168
Giardiasis	465	503	471	437	417	386	426	563	602	514
Gonorrhea	8,731	9,215	9,315	10,166	11,082	10,462	9,062	8,565	8,346	6,473
<i>Haemophilus influenzae</i> infection, invasive	15	19	24	41	34	41	68	56	61	69
Hemolytic uremic syndrome	0	0	3	3	1	8	1	1	1	2
Hepatitis A	250	226	185	164	167	163	141	140	93	64
Hepatitis B, acute	137	109	106	174	213	224	227	303	146	78
Hepatitis C, acute	27	13	11	3	3	15	15	15	13	9
HIV infection	998	825	922	804	977	992	797	875	833	922
Kawasaki syndrome	27	36	33	29	28	11	11	16	19	6
Lead, elevated blood levels in children (<16 yrs)	750	689	531	727	679	791	644	703	529	515
Legionellosis	34	27	41	37	39	35	110	56	55	68
Listeriosis	7	8	17	9	15	10	18	27	17	20
Lyme disease	67	73	122	149	156	259	202	216	274	357
Malaria	73	61	76	55	54	36	60	59	44	55
Measles	1	2	18	2	1	0	0	0	0	0
Meningococcal disease	60	49	60	42	46	46	28	24	35	22
Mumps	21	13	11	11	8	5	1	11	2	116
Pertussis	59	56	65	134	272	168	219	400	363	221
Psittacosis	0	1	0	0	0	0	1	0	0	0
Q fever	1	0	1	0	0	0	0	0	2	4
Rabies in animals	690	549	581	574	502	592	542	474	495	637
Rabies in humans	0	1	0	0	0	0	1	0	0	0
Rocky Mountain spotted fever	23	14	20	7	40	43	34	45	121	114
Rubella, including congenital	1	1	0	0	1	0	0	0	0	0
Salmonellosis	1,120	1,135	1,286	1,020	1,368	1,277	1,175	1,196	1,172	1,089
Shigellosis	416	200	136	460	784	1,061	451	167	134	120
Streptococcal disease, Group A, invasive	-	-	30	57	85	82	111	74	110	132
<i>Streptococcus pneumoniae</i> , invasive (<5 yrs)	-	-	-	-	0	20	27	35	37	50
Syphilis, early	615	379	364	266	235	165	156	224	291	353
Tuberculosis	349	339	334	292	306	315	332	329	355	332
Typhoid fever	5	7	11	22	15	8	16	11	20	20
<i>Vibrio</i> infection	12	13	12	12	22	20	26	20	25	32
- Not a reportable disease at this time										

## Trend Data

Table 1 shows the annual number of reported cases for selected conditions in Virginia from 1997-2006.

Graphs of the number of cases over time show the five-year average (mean) for 2001-2005 as a dashed line and provides a 'baseline' for comparison with the number of cases seen in 2006.

It should be noted that for graphs showing age or age groups it is possible that differences may be related to both variation in disease severity with age as well as to potential biases (e.g., for some conditions, caregivers may be more likely to bring ill children to medical attention than adults might be to seek care for themselves).

## 2006 HIGHLIGHTS FOR SELECTED DISEASES

### Enteric Infections

#### Amebiasis

Infections with *Amoeba spp.* are a relatively rare, but serious, cause of gastroenteritis in Virginia. The 45 cases of amebiasis reported in 2006 were a 7% increase from the 42 cases reported in 2005. Overall, the number of cases represented a 61% increase over the five-year average of 28 cases per year (Figure 1). The rate of amebiasis in Virginia in the Central and Eastern Health Planning Regions was relatively low (combined incidence of 0.2/100,000) compared to the rest of the state (combined incidence of 0.9/100,000). In addition, although based on relatively small numbers, the incidence of amebiasis in 2006 was substantially higher in blacks (1.3/100,000) than in the general population (0.2/100,000). Although further investigation is necessary, this geographic and racial distribution may be at least partly explained by infections in foreign immigrants to Virginia.

#### Campylobacteriosis

*Campylobacter spp.* remain an important cause of bacterial gastroenteritis in Virginia. The 669 cases of campylobacteriosis reported in 2006 were an 8% increase from the 618 cases reported in 2005. Overall, the number of cases reported was 3% lower than the

five-year average of 687 cases per year (Figure 2). Campylobacteriosis cases occurred most frequently in the summer and fall months (May-October). The campylobacteriosis rate was fairly uniform

across Virginia, with an incidence of 7-10/100,000 in the five Health Planning Regions. Among reported cases, the highest incidence

(13/100,000) was in children 0-4 years of age (Figure 3). Illness can be quite severe: among the 472 cases for whom hospitalization data were available, 19% (383) required hospitalization. It is suspected that campylobacteriosis is significantly under-diagnosed as a bacterial cause of enteric disease in Virginia.

#### Giardiasis

In 2006, the number of reported cases of giardiasis decreased, ending three consecutive years of increasing numbers of cases. The 514 cases reported in 2006 were 15% lower than the 602 cases reported in 2005 and 7% higher than the five-year average of 479 cases (Figure 4). While the general increase in reported cases has occurred

Figure 1. Amebiasis: Ten-Year Trend, Virginia, 1997-2006

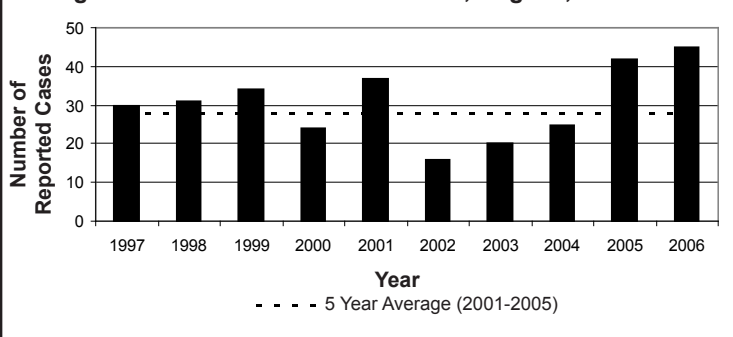


Figure 2. Campylobacteriosis: Ten-Year Trend, Virginia, 1997-2006

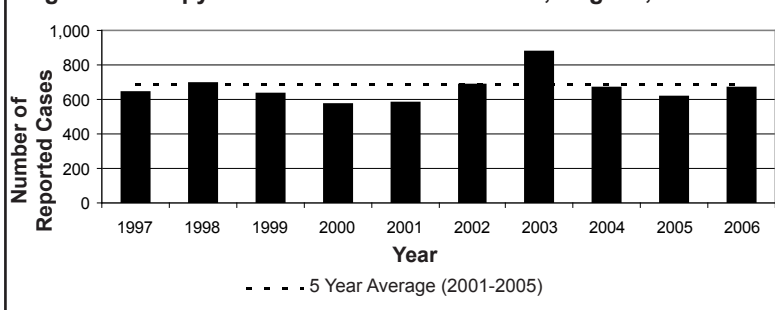
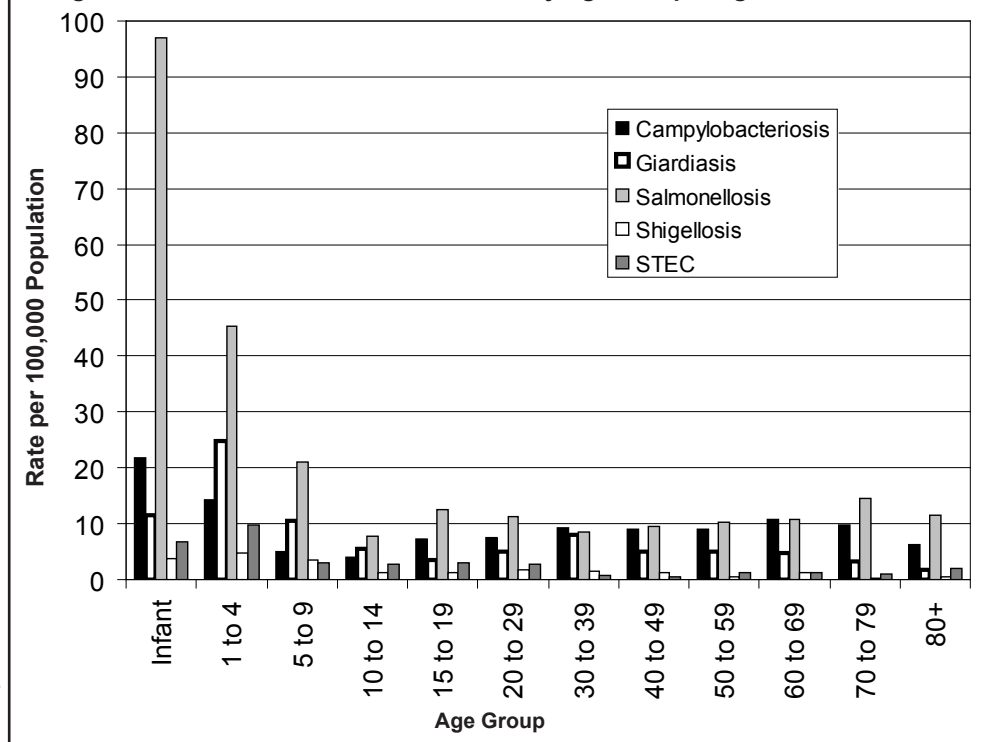


Figure 3. Common Enteric Illnesses: Rate by Age Group, Virginia, 2006

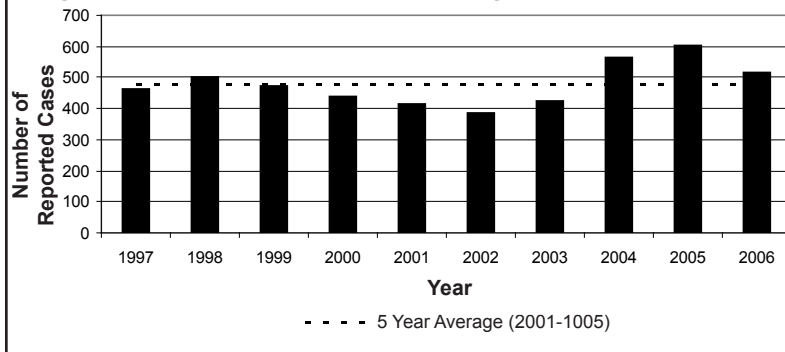


statewide, unlike in 2005 when the largest burden of giardiasis was in the Southwest and Central Health Planning Regions of Virginia, in 2006 the Northern and Northwestern Health Planning Regions had the highest proportion of cases (59%); the combined incidence of 10/100,000 for these regions was substantially greater than the incidence of 5/100,000 for the rest of the state (Figure 5). Cases peaked in the late summer (August-September). Reported cases tended to be in children: the incidence was highest in individuals 1-4 years of age (25/100,000) (Figure 3). For the 56% of cases for which race was reported, the ratio of black:white cases in 2005 was 1.5:1. This was a decrease from the ratio of over 3:1 observed in 2004 and 2005. This geographic and racial distribution may be at least partly explained by patterns of settlement of foreign immigrants to Virginia.

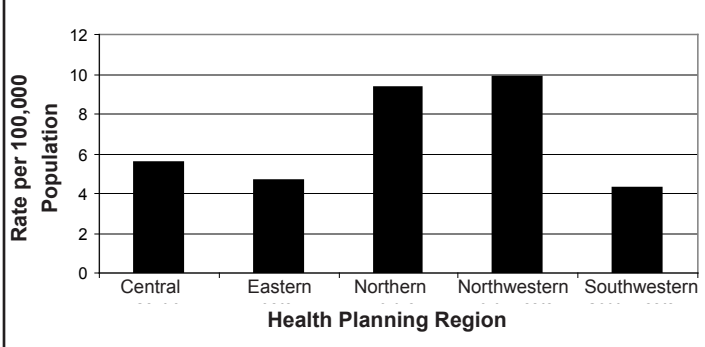
### Salmonellosis

*Salmonella spp.* infections are the most frequently reported enteric disease in Virginia. Reported cases have remained relatively stable in recent years: the 1,089 cases of salmonellosis reported in 2006 were 7% less than the 1,172 cases reported in 2005 and 12% less than the five-year average of 1,238 cases per year (Figure 6). Most cases in 2006 were 'sporadic' and few were linked to wider outbreaks. Among the 746 cases for which hospitalization data were available, 29% (217 cases) required hospitalization. As seen in previous years, cases of salmonellosis were more likely to occur in the summer and fall months (June-November). No substantial variation by race or sex in reported infections was apparent in

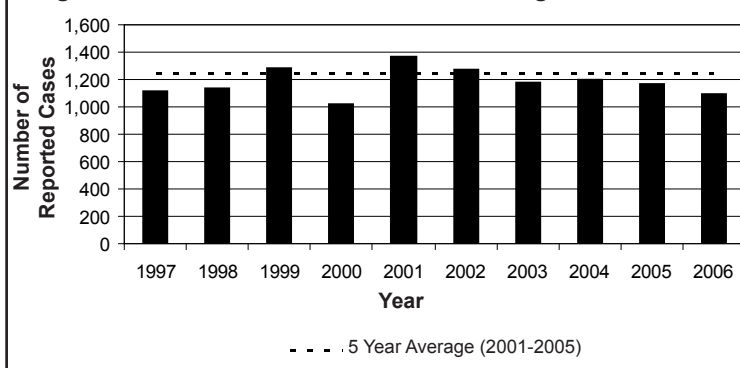
**Figure 4. Giardiasis: Ten-Year Trend, Virginia, 1997-2006**



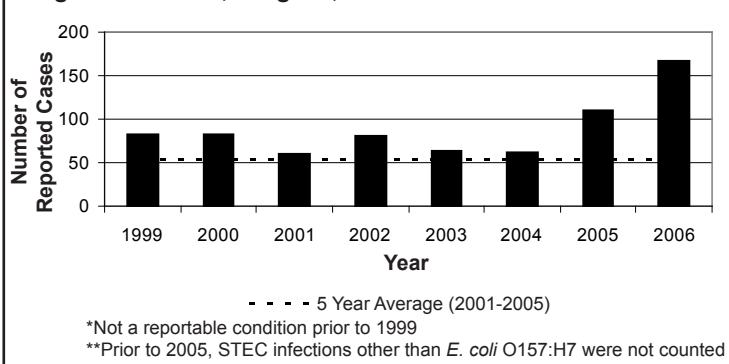
**Figure 5. Giardiasis: Rate by Region, Virginia, 2006**



**Figure 6. Salmonellosis: Ten-Year Trend, Virginia, 1997-2006**



**Figure 7. Shiga Toxin-Producing *Escherichia coli* Infections: Eight-Year Trend,\* Virginia, 1999-2006**



2006. Incidence was strongly associated with age, with infants having the highest incidence (97/100,000), followed by children 1-4 years of age (45/100,000); individuals five years of age and older

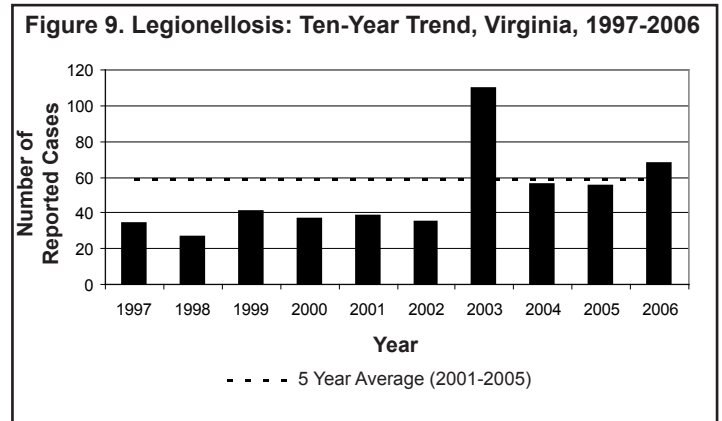
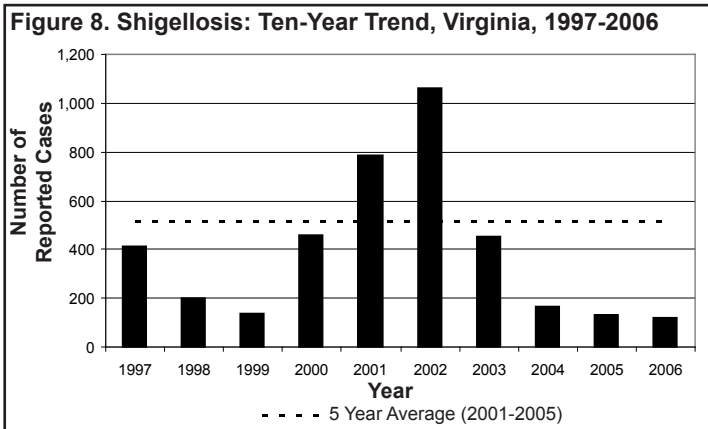
had a combined incidence of 11/100,000 (Figure 3).

### Shiga Toxin-Producing *E. coli* (including O157:H7)

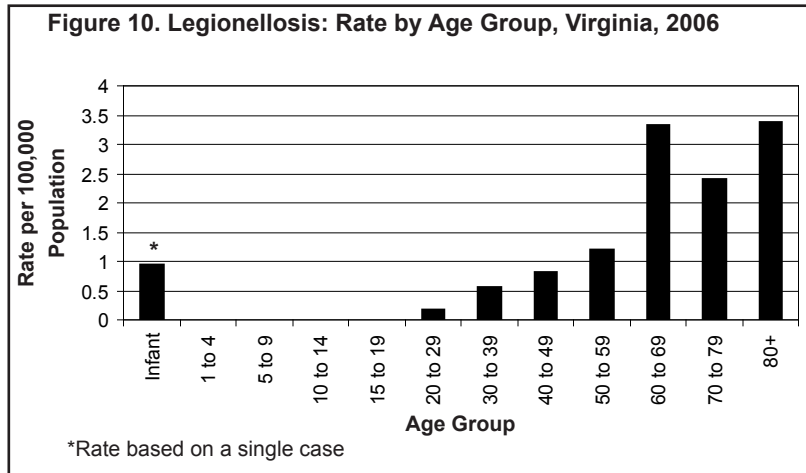
In 2006, 168 cases of Shiga toxin-producing *Escherichia coli* (STEC) infection, including *E. coli* O157:H7 infections, were reported. This was an increase of approximately 51% from the 111 cases in 2005, and 217% more than the five-year average of 76 cases/year (Figure 7). However, this increase is partly due to the inclusion of all reported STEC (not only *E. coli* O157:H7) in case counts beginning in 2005.

Compared to *Salmonella spp.* and *Campylobacter spp.* infections, infection by STEC does not account for a large proportion of the reported cases of gastroenteritis in Virginia. However, STEC infection can cause significant morbidity and mortality, including complications such as hemolytic uremic syndrome (HUS). Among the 100 cases for whom data were available, 59% required hospitalization.

Cases occurred most frequently in the summer months (June-August). Incidence of reported STEC infection was highest in young children (incidence in infants: 7/100,000; incidence in children 1-4 years of age: 11/100,000); combined incidence among individuals five years of age and older was 2/100,000 (Figure 3). There was essentially no sex difference in reported cases in 2006. In 2006, the Northern and Northwestern Health Planning Regions accounted for 61% of cases and showed an incidence of 3/100,000, compared to 2/100,000 for the rest of Virginia.



Investigating STEC infections has become more complicated, as increasing numbers of clinicians use Shiga toxin testing without performing stool cultures. Unfortunately, this practice does not enable isolation of specimens for genetic fingerprinting and linkage of cases to outbreaks. For patients who test positive for Shiga toxin, clinicians are strongly encouraged (and laboratories are required) to submit stool specimens for culture.

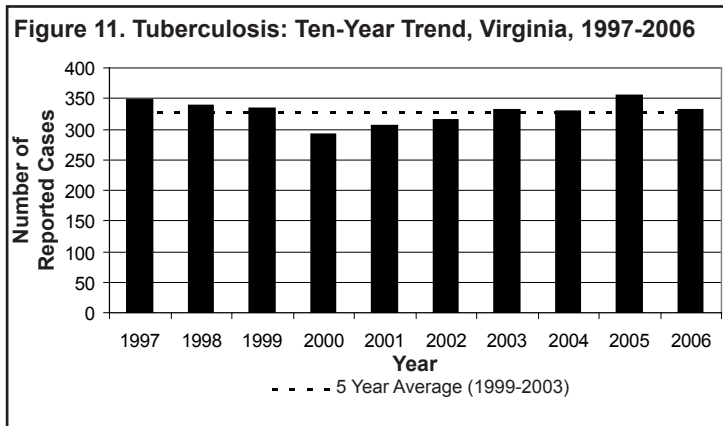


96% (55 cases) required hospitalization. Unlike previous years, in 2006 cases of legionellosis did not show a strong seasonal pattern (i.e., cases were not clustered in summer months when environmental conditions are typically more favorable for this ubiquitous organism). In 2006, persons 60 years of age and older had the highest incidence (3/100,000) (Figure 10); 82% of reported cases occurred in males.

### Shigellosis

The 120 cases of shigellosis reported in 2006 represented a moderate decrease (10%) from the 134 cases reported in 2005, but a considerable decrease (77%) when compared to the five-year average of 519 cases per year (Figure 8). The reason for this recent decline in shigellosis cases is not known, but it may reflect a recurring cyclic trend in *Shigella spp.* infections.

Cases are most likely to be reported in late summer and early fall (August-November). Of the 94 cases for which data were available, 21 cases (22%) required hospitalization. Incidence was strongly associated with age, with children age 0-9 years having the highest rate (4/100,000 compared with a rate of 1/100,000 for all other age groups combined) (Figure 3). No substantial variation by sex in incidence was apparent in 2006. The rate in the Northern Health Planning Region (3/100,000)



was substantially higher compared to the rest of the state (1/100,000).

### Respiratory Infections

#### Legionellosis

In 2006, 68 cases of infection caused by *Legionella pneumophila* were reported. This was an increase of 24% from the 55 cases reported in 2005, and was 15% higher than the five-year average (Figure 9). Legionellosis is a relatively uncommon but serious form of community-acquired pneumonia: of the cases for which data were provided,

#### Tuberculosis

Tuberculosis (TB) persists among Virginia residents and should be considered in any individual with symptoms compatible with active disease, especially those with recurrent or persistent community-acquired pneumonia. Although the 332 cases of tuberculosis reported in 2006 represented a 7% decrease compared to the 355 cases reported in 2005, TB levels have remained relatively stable. The number of cases in 2006 was only 1% over the five-year average (Figure 11). Five cases of multi-drug resistant TB (MDR-TB) were reported in 2006 compared to three in 2005. In 2006, 22 TB cases (7%) were co-infected with HIV compared to 20 cases (6%) reported in 2005. Seventy percent of cases reported in 2006 were born outside the U.S. The highest incidence in 2006 was in adults 25 years of age and older (Figure 12). Among the pediatric cases under the age of five

years, 75% were children born in the U.S. to foreign-born parents.

## Sexually-Transmitted Infections

### Chlamydia

In 2006, *Chlamydia trachomatis* infection (chlamydia) was the most frequently reported sexually transmitted infection in Virginia. The 24,081 reported cases represented the ninth consecutive annual increase, with a relatively large increase from 2005 to 2006 (6%) (Figure 13). This trend is likely a result of the increased awareness of the importance of this organism combined with the increased use of sensitive laboratory amplification techniques that enhance case finding. Incidence in persons 20-24 years of age continues to be very high, at 1,755/100,000 (Figure 14). In 2006, the chlamydia rate was highest in the Eastern Health Planning Region (542/100,000) and lowest in the Northern Health Planning Region (159/100,000).

### Gonorrhea

*Neisseria gonorrhoea* infection levels continue to decline, with 2006 being the fifth consecutive year that reported cases have decreased. The 6,473 cases of gonorrhea reported in 2006 were 22% less than the number of cases reported in 2005, and 32% less than the five-year average (Figure 15). This decline, also observed nationally, may be partially attributable to increased efforts in sexually transmitted infection education, detection, and treatment by local health departments.

Figure 12. Tuberculosis: Rate by Age Group, Virginia, 2006

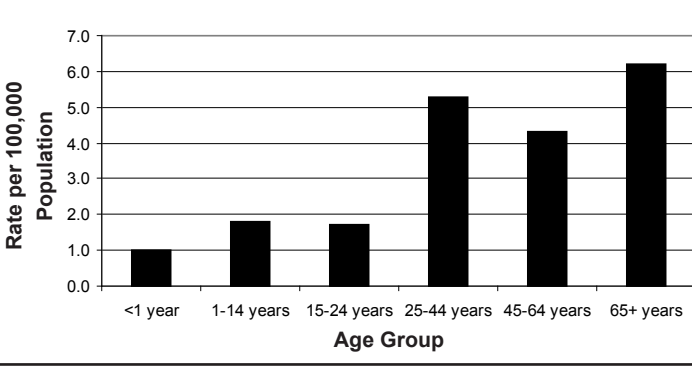


Figure 13. Chlamydia trachomatis Infections: Ten-Year Trend, Virginia, 1997-2006

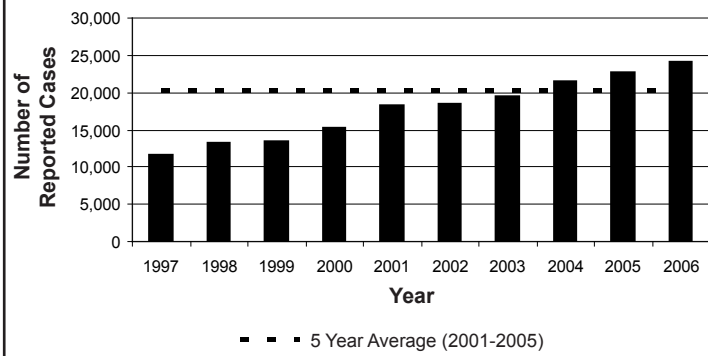


Figure 14. Chlamydia and Gonorrhea Infections: Rate by Age Group, Virginia, 2006

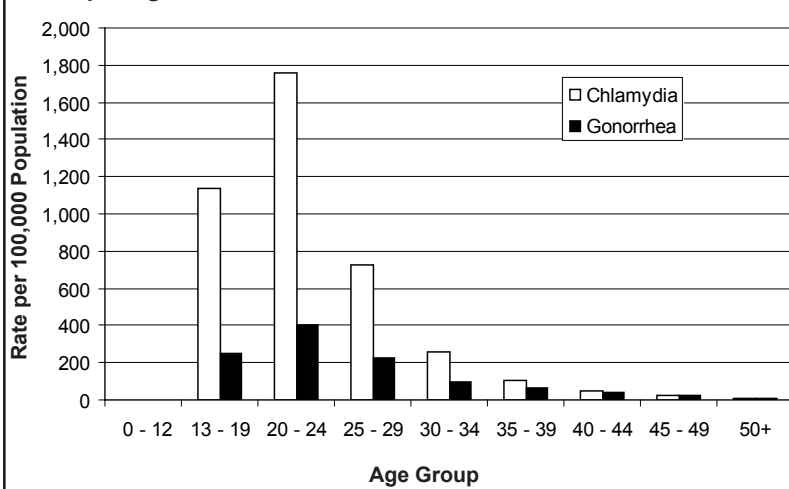
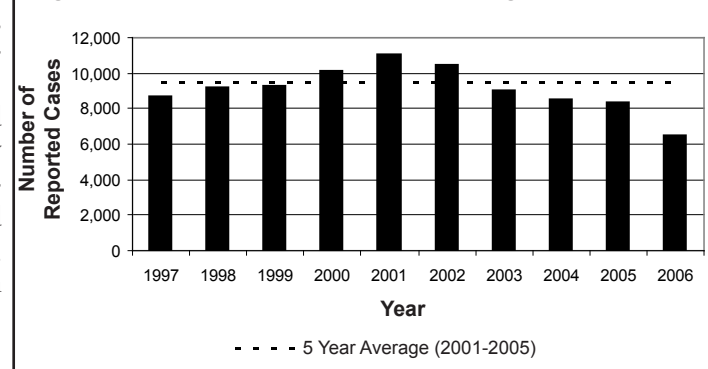


Figure 15. Gonorrhea: Ten-Year Trend, Virginia, 1997-2006



The emergence of antimicrobial resistance has threatened this progress. As a result, the CDC has released new treatment guidelines for gonorrhea (available at: [www.cdc.gov/std/treatment/2006/updated-regimens.htm](http://www.cdc.gov/std/treatment/2006/updated-regimens.htm)). Healthcare providers are also urged to report drug resistance in any cases of *N. gonorrhoea* infection to the local health department.

Of note, routine dual therapy of patients with gonorrhea, without testing for chlamydia, may be cost effective in some populations due to the probability of co-infection. Although specific testing to determine the etiology of cervicitis/urethritis is encouraged, clinicians may consider empiric treatment of symptoms without testing for patients who are at high risk for infection and who are unlikely to return for a follow-up evaluation. Such patients should be treated for both gonorrhea and chlamydia. Partners of patients who are treated empirically should also be evaluated and treated.

### HIV/AIDS

The 922 newly-reported cases of HIV infection in 2006 represented a 10% increase from 2005 (Figure 16). While HIV-infection prevention efforts have shown an impact on stabilizing disease transmission and remain extremely important, additional progress is needed, especially in racial/ethnic subpopulations. In 2006, the incidence for blacks and Hispanics were nine and three times higher, respectively, when compared to whites.

The decrease in the number of newly-reported cases of AIDS in 2006 continued the downward trend observed over the past decade. The 588 new cases of AIDS reported in Virginia in 2006 were 6% below the level from 2005 and

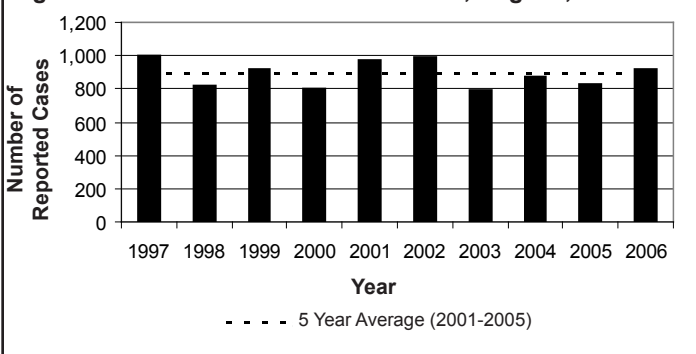
represented a 27% decrease from the five-year average (Figure 17). This marked the lowest number of reported cases since the case classification was changed in 1993. The main cause for the decline in the number of cases of AIDS has been improved treatment of HIV infection.

Without a cure for HIV the continued new infections combined with the improved survival of individuals infected with HIV means that the prevalence of HIV infection in Virginia continues to increase. Since 1996, the number of people living with HIV has increased by about 1,200 persons per year. As a result, over 18,000 people were estimated to be living with HIV in Virginia in 2006 (Figure 18). This has significant implications for healthcare and public health efforts in the Commonwealth. The CDC recommends HIV testing of adults, adolescents, and pregnant women in healthcare settings.

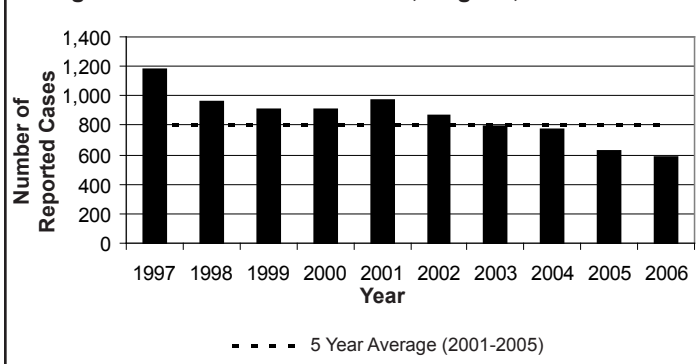
### Syphilis

Early syphilis (i.e., primary, secondary, and early latent stages of syphilis) increased in 2006 (by 21% from 2005). The 353 cases reported in 2006 were 66% higher than the five-year average, and represented the third consecutive year of increase since the historic low of 153 cases in 2003 (Figure 19). The increase in the number of reported cases was partly related to improved case finding by the VDH Virginia Epidemiology Response Team (VERT) in the Eastern Health Planning Region of the Commonwealth. Contact tracing and social networking activities continue

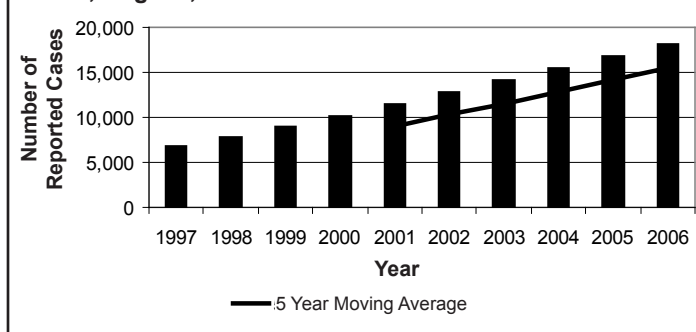
**Figure 16. HIV Infection: Ten-Year Trend, Virginia, 1997-2006**



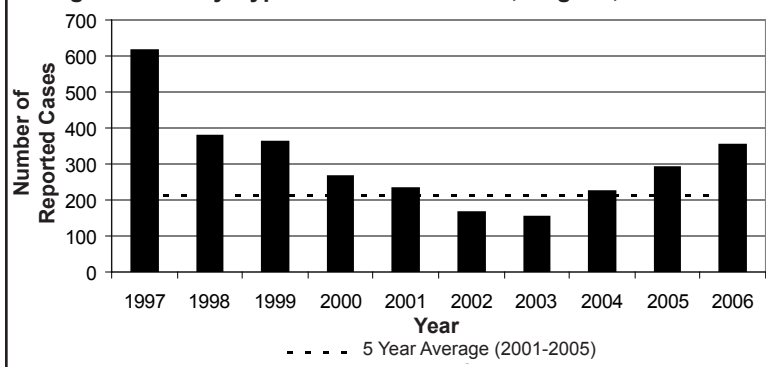
**Figure 17. AIDS: Ten-Year Trend, Virginia, 1997-2006**



**Figure 18. HIV (including AIDS) Prevalence: Ten-Year Trend, Virginia, 1997-2006**



**Figure 19. Early Syphilis: Ten-Year Trend, Virginia, 1997-2006**



to identify pockets of high-risk activity and infection.

Similar to the national pattern, 82% of cases since 2005 have been in males (M:F ratio: 6.8:1), with most of the cases falling into two risk behavior groups: men who have sex with men (MSM) or bisexual risk behavior. Approximately 30% of the reported cases in 2006 were co-infected with HIV. In addition, in 2006, for the first time since the 1980s, a newborn meeting the case definition for syphilis stillbirth was reported in Virginia.

### Summary

This report summarizes the disease surveillance statistics for selected notifiable conditions in Virginia during the 2006 calendar year. Enteric, respiratory, and sexually-transmitted infections in 2006 with a significant increase in the number of cases, or that continued to be significantly elevated, included amebiasis, *C. trachomatis* infection, legionellosis, Shiga toxin-producing *E. coli*, and syphilis. While newly-reported cases of AIDS decreased, cases of HIV increased. Finally, while the number of new cases of tuberculosis remained relatively unchanged in 2006, the number of multi-drug resistant cases and the number of cases co-infected with HIV both increased in 2006. On the positive side, reported cases of giardiasis, pertussis, gonorrhea, and shigellosis declined in 2006.

Limitations in the data include under-detection of cases who do not seek healthcare (e.g., due to asymptomatic infections, mild illness, or barriers to access), misdiagnosis of cases, a low incentive for diagnostic testing for some conditions, and the accuracy and

Note: In Issue #3 of the 2007 Virginia Epidemiology Bulletin, in the article entitled *Syphilis in Virginia*, the change in 'infectious' syphilis (i.e., primary and secondary syphilis, but not early latent) in Virginia from 2005 to 2006 was correctly noted to be an increase of 31%.

## Cases of Selected Notifiable Diseases Reported in Virginia\*

Disease	Total Cases Reported, May 2007						Total Cases Reported Statewide, January - May		
	State	Regions					This Year	Last Year	5 Yr Avg
		NW	N	SW	C	E			
<b>AIDS</b>	100	7	10	3	7	73	257	205	281
<b>Campylobacteriosis</b>	31	7	10	7	4	3	151	161	165
<b>Chickenpox</b>	226	31	51	12	24	108	692	811	385
<b><i>E. coli</i>, Shiga toxin-producing</b>	10	2	3	3	2	0	45	39	16
<b>Giardiasis</b>	28	7	6	10	4	1	163	164	141
<b>Gonorrhea</b>	553	31	32	62	185	243	2,527	2,509	3,469
<b>Group A Strep, Invasive</b>	8	2	0	0	0	6	70	66	49
<b>Hepatitis, Viral</b>									
<b>A</b>	6	0	2	2	2	0	35	22	33
<b>B, acute</b>	16	2	2	2	9	1	65	15	63
<b>C, acute</b>	0	0	0	0	0	0	2	1	3
<b>HIV Infection</b>	85	4	22	4	17	38	294	361	342
<b>Lead in Children†</b>	65	7	2	12	29	15	192	192	213
<b>Legionellosis</b>	1	0	0	0	1	0	8	14	9
<b>Lyme Disease</b>	52	4	40	0	3	5	140	15	16
<b>Measles</b>	0	0	0	0	0	0	0	0	0
<b>Meningococcal Infection</b>	2	1	0	0	0	1	8	11	12
<b>Pertussis</b>	5	0	3	1	0	1	40	86	64
<b>Rabies in Animals</b>	60	17	18	13	5	7	284	259	229
<b>Rocky Mountain Spotted Fever</b>	7	1	0	3	2	1	16	14	5
<b>Rubella</b>	0	0	0	0	0	0	0	0	0
<b>Salmonellosis</b>	48	4	16	6	14	8	260	246	267
<b>Shigellosis</b>	4	0	3	0	0	1	28	22	116
<b>Syphilis, Early§</b>	30	1	13	2	5	9	150	125	85
<b>Tuberculosis</b>	25	3	15	1	5	1	83	86	92

*Localities Reporting Animal Rabies This Month:* Accomack 1 raccoon; Alleghany 1 raccoon; Bedford 1 raccoon; Caroline 1 fox; Charles City 1 raccoon; Culpeper 1 fox; Danville 1 fox; Fairfax 3 foxes, 3 raccoons, 1 skunk; Fauquier 3 raccoons; Frederick 1 bat; Giles 1 raccoon; Henry 1 raccoon; Isle of Wight 1 raccoon; King George 1 groundhog, 1 raccoon; King William 1 raccoon; Loudoun 1 dog, 5 raccoons, 1 skunk; Mecklenburg 2 skunks; Montgomery 1 raccoon; New Kent 1 raccoon; Newport News 1 raccoon; Nottoway 1 bat; Prince William 1 fox, 1 groundhog, 2 raccoons; Pulaski 1 raccoon; Richmond 1 raccoon; Roanoke 2 raccoons; Rockbridge 1 groundhog, 2 raccoons; Rockingham 1 cat, 2 raccoons; Shenandoah 1 cow, 1 raccoon; Smyth 1 raccoon; Tazewell 1 fox; Virginia Beach 1 raccoon; Warren 2 raccoons; Wythe 1 coyote, 1 raccoon.

*Toxic Substance-related Illnesses:* Adult Lead Exposure 14; Asbestosis 2; Pneumoconiosis 12.

\*Data for 2007 are provisional. †Elevated blood lead levels  $\geq 10\mu\text{g/dL}$ . §Includes primary, secondary, and early latent.

completeness of case reporting to local health departments. In reporting suspected or diagnosed conditions to public health, healthcare professionals are encouraged to provide as much detail as possible, and to complete all data fields on the reporting forms as accurately as possible. For more information on ways

to improve the reporting process for your practice or facility, please contact your local health department.

Finally, only some key reportable conditions are included in this report. Selected vaccine-preventable infections, toxic substance-related illnesses, and zoonotic diseases are reviewed

in Issue 7 of the VEB. For additional information about disease surveillance in Virginia, and updated information on reportable conditions, visit the VDH Office of Epidemiology web site ([www.vdh.virginia.gov/epidemiology/](http://www.vdh.virginia.gov/epidemiology/)).

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Office of Epidemiology

**Next issue: Summary of Notifiable Diseases (2006) Part II: Vaccine-Preventable Infections, Toxic Substance-Related Illnesses, and Zoonotic Diseases**