# 2018 Communicable Disease Report

**LORD FAIRFAX HEALTH DISTRICT**

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

# Lord Fairfax Health District
# 2018 Communicable Disease Report

Dear Colleague:

Welcome to the annual Communicable Disease Report from the Lord Fairfax Health District (LFHD). LFHD employees investigate hundreds of reports of suspected communicable diseases each year. This report presents the results of those investigations and highlights some reportable diseases that affected our district in 2018.

In addition to communicable disease data, the report also describes LFHD communicable disease services and offers practical guidance for clinicians to help mitigate the future impact of these diseases.

I would like to thank all community partners including healthcare providers, infection control practitioners, laboratorians, and public safety personnel who report cases to LFHD. In addition, I want to acknowledge the hard work and dedication of the LFHD employees who investigate and control communicable disease, sexually transmitted infection, and tuberculosis.

Our District Epidemiologist, Meredith Davis, is available to assist you with any communicable disease issue and can be reached by phone 540-771-3725 or by email at Meredith.davis@vdh.virginia.gov.

Sincerely,

Colin M. Greene, MD, MPH
Director, Lord Fairfax Health District

## Table of Contents



## 2018 LFHD Population Estimates*

| | |
|---|---|
| Clarke County | 14,508 |
| Frederick County | 86,484 |
| Page County | 23,731 |
| Shenandoah County | 43,225 |
| Warren County | 39,563 |
| Winchester City | 27,932 |
| TOTAL | 235,443 |

*Weldon Cooper Center for Public Service: http://www.coopercenter.org/demographics/virginia-

## District News and Updates

- In November 2018, the Virginia Reportable Disease list was updated (http://www.vdh.virginia.gov/content/uploads/sites/13/2018/11/Reportable_Disease_List.pdf). Changes include:
  - Carbapenemase-producing organisms were added to the list of reportable conditions. Carbapenem-resistant Enterobacteriaceae (CRE) and carbapenem-resistant *Pseudomonas aeruginosa* isolates should be submitted for further public health testing.
  - *Candida auris* was added to the list of reportable conditions.
  - Tuberculosis (TB) disease or latent TB infection is reportable among persons of any age.
  - Congenital syphilis is now a rapidly reportable condition.
  - Acquired immunodeficiency syndrome and Creutzfeldt-Jakob disease have been removed from the reportable disease list.

- In April 2019, Virginia was added to the growing list of states with outbreaks of hepatitis A. Those most affected by the ongoing hepatitis A outbreak include people who use drugs and people experiencing homelessness. Between January – June 2019, there were 104 hepatitis A cases reported among Virginia residents.
  - Healthcare providers can assist in prevention efforts by providing hepatitis A vaccination.

- HELP US UNDERSTAND FLU: We are in need of sentinel influenza sites to participate in public health surveillance activities during the 2019-2020 flu season. More information is available at http://www.vdh.virginia.gov/epidemiology/influenza-flu-in-virginia/influenza-surveillance/sentinel-influenza-reporting-for-virginia/. Please contact Meredith Davis at 540-771-3725 if your hospital or clinic would be willing to participate.

## COMMUNICABLE DISEASE SUMMARY

In 2018, the Lord Fairfax Health District (LFHD) conducted hundreds of communicable disease investigations in response to reports from healthcare providers and laboratories. To be included in annual case counts, the case must meet condition-specific surveillance case definitions, which include clinical and/or laboratory criteria. All communicable disease data are primary surveillance data from the Lord Fairfax Health District and the Virginia Department of Health.

Understanding the most commonly occurring reportable conditions is helpful to determine public health priorities and develop effective health promotion interventions. Figure 1 shows the incidence of the most common reportable conditions in LFHD in 2018, based on an estimated population of 235,443.

Figure 1. Rates of most frequently reported communicable disease, Lord Fairfax Health District, 2018.

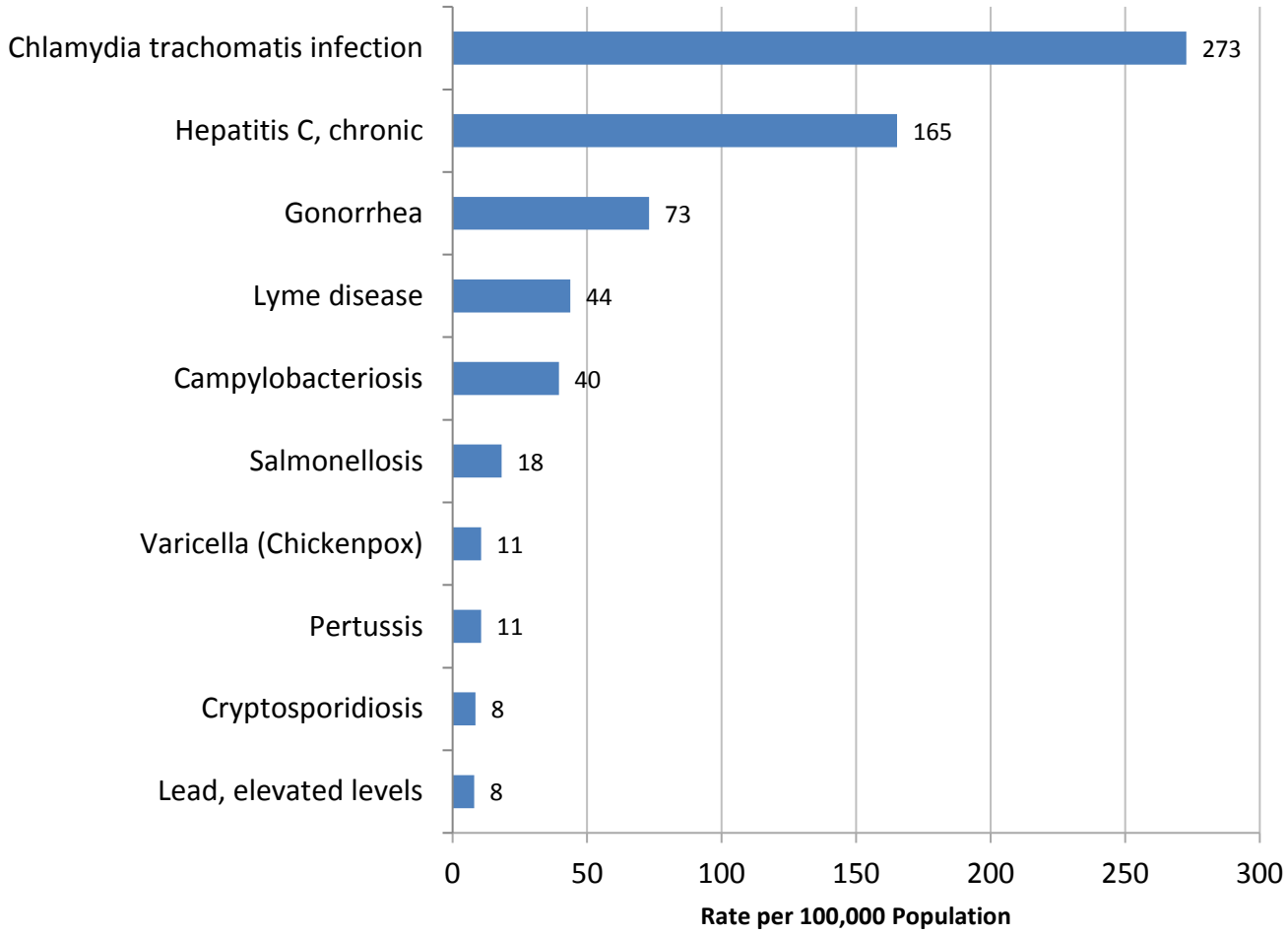


Table 1 shows counts of cases meeting surveillance case definitions for selected conditions in 2018 and the previous four years.

Table 1: Reported cases of selected diseases, Lord Fairfax Health District, 2014-2018[α].

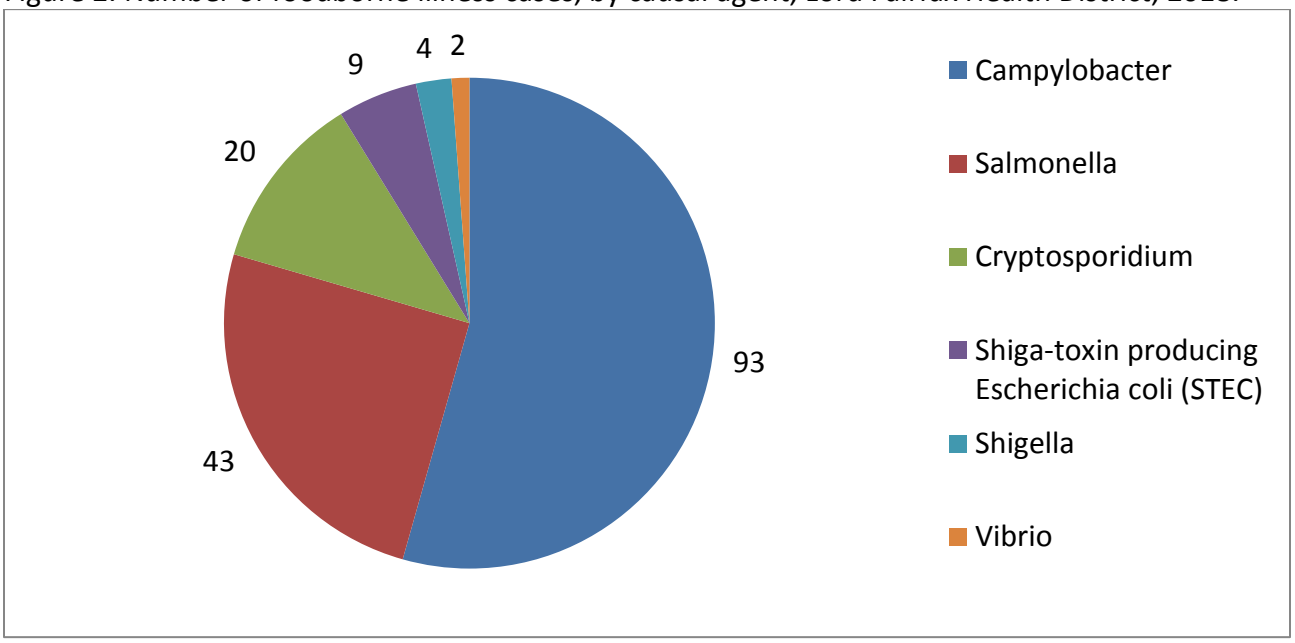
| Disease | 2014 | 2015 | 2016 | 2017 | 2018[α] | 5 year average |
|---|---|---|---|---|---|---|
| **Arboviral disease*** | 0 | 0 | 3 | 2 | 4 | 1.8 |
| **Arsenic, elevated levels** | 0 | 2 | 3 | 3 | 0 | 1.6 |
| **Botulism, infant** | 0 | 1 | 0 | 1 | 1 | 0.6 |
| **Campylobacteriosis** | 59 | 80 | 82 | 71 | 93 | 77 |
| ***Chlamydia trachomatis* infection** | 631 | 630 | 573 | 612 | 643 | 617.8 |
| **Cryptosporidiosis** | 1 | 4 | 8 | 11 | 20 | 8.8 |
| **E. coli infection, shiga toxin-producing** | 12 | 6 | 12 | 9 | 9 | 9.6 |
| **Ehrlichiosis/Anaplasmosis** | 6 | 4 | 1 | 11 | 10 | 6.4 |
| **Giardiasis** | 9 | 6 | 5 | 4 | 8 | 6.4 |
| **Gonorrhea** | 69 | 79 | 79 | 138 | 172 | 107.4 |
| ***Haemophilus influenzae*, invasive** | 5 | 6 | 6 | 8 | 3 | 5.6 |
| **Hemolytic uremic syndrome** | 0 | 2 | 0 | 0 | 1 | 0.6 |
| **Hepatitis A, acute** | 2 | 2 | 7 | 3 | 5 | 3.8 |
| **Hepatitis B, acute** | 2 | 1 | 2 | 3 | 0 | 1.6 |
| **Hepatitis B, chronic** | 20 | 13 | 18 | 29 | 16 | 19.2 |
| **Hepatitis C, acute** | 4 | 2 | 7 | 17 | 11 | 8.2 |
| **Hepatitis C, chronic** | 190 | 207 | 489 | 574 | 486 | 389.2 |
| **HIV** | 8 | 14 | 9 | 7 | 13 | 10.2 |
| **Lead, elevated levels**** | 3 | 3 | 14 | 17 | 19 | 11.2 |
| **Legionellosis** | 2 | 6 | 0 | 7 | 14 | 5.8 |
| **Leptospirosis** | 0 | 0 | 0 | 0 | 1 | 0.2 |
| **Lyme disease** | 108 | 122 | 109 | 137 | 103 | 115.8 |
| **Malaria** | 0 | 0 | 0 | 0 | 1 | 0.2 |
| **Meningococcal disease (*Neisseria meningitidis*)** | 0 | 0 | 0 | 1 | 0 | 0.2 |
| **Mumps** | 0 | 0 | 0 | 1 | 2 | 0.6 |
| **Pertussis** | 43 | 9 | 2 | 52 | 25 | 26.2 |
| **Salmonellosis** | 49 | 31 | 37 | 34 | 43 | 38.8 |
| **Shigellosis** | 1 | 5 | 2 | 1 | 4 | 2.6 |
| **Spotted Fever Rickettsiosis (including RMSF^)** | 15 | 7 | 6 | 21 | 13 | 12.4 |
| ***Streptococcus pneumoniae*, invasive (age < 5)** | 0 | 0 | 1 | 2 | 1 | 0.8 |
| **Streptococcus, Group A, invasive** | 18 | 9 | 8 | 14 | 15 | 12.8 |
| **Syphilis - early stage** | 4 | 5 | 6 | 8 | 8 | 6.2 |
| **Toxic-shock syndrome, streptococcal** | 0 | 1 | 1 | 4 | 2 | 1.6 |
| **Tuberculosis** | 2 | 1 | 1 | 1 | 3 | 1.6 |
| **Varicella (Chickenpox)** | 14 | 20 | 2 | 12 | 25 | 14.6 |
| **Vibriosis** | 0 | 1 | 0 | 0 | 2 | 0.6 |
| **Yersiniosis** | 2 | 0 | 1 | 0 | 0 | 0.6 |

[α]2018 data are provisional; *Arboviral infection = West Nile Virus and Zika virus; ** Lead = blood lead levels ≥5 ug/dL; ^RMSF = Rocky Mountain Spotted Fever

## FOODBORNE ILLNESS

The Foodborne Diseases Active Surveillance Network (FoodNet) conducts surveillance for bacterial infections caused by *Campylobacter, Cryptosporidium, Cyclospora, Listeria, Salmonella,* Shiga toxin-producing *Escherichia coli* (STEC), *Shigella, Vibrio*, and *Yersinia*. Figure 2 shows the number of confirmed cases of illness caused by FoodNet agents in LFHD in 2018. The 171 cases observed in 2018 represent a 36% increase over the 126 cases reported in 2017.

Figure 2. Number of foodborne illness cases, by causal agent, Lord Fairfax Health District, 2018.




*For Healthcare Providers*

- If a foodborne illness is suspected, conduct confirmatory testing whenever possible. All positive isolates from stool specimens (except those positive for *Campylobacter* or *Cryptosporidium*) are forwarded by local laboratories to the state laboratory (Division of Consolidated Laboratory Services, DCLS) for confirmatory testing. LFHD uses this information to identify outbreaks of foodborne illness.
- If you suspect a possible foodborne outbreak, please notify the local health department.

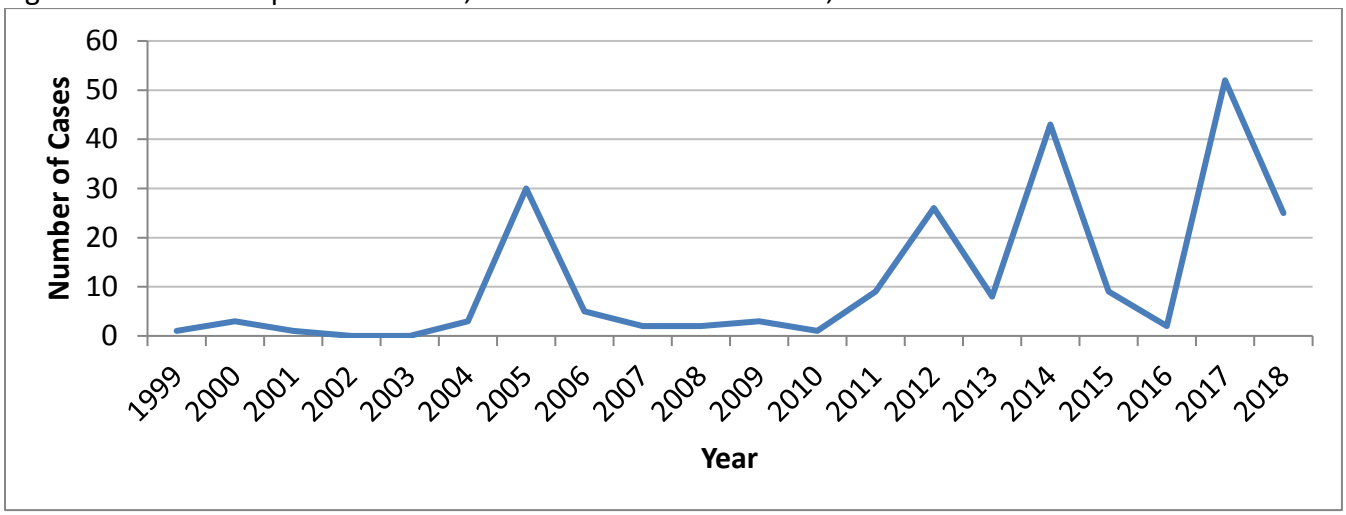
*Public Health Actions*

- Investigate 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.
- Inspect facilities, including restaurants, when indicated during an investigation.

## PERTUSSIS

Pertussis, or whooping cough, is a respiratory disease caused by the bacterium *Bordetella pertussis*. Pertussis is highly contagious, and has been shown to cause outbreaks, even among vaccinated populations, as immunity wanes over time. Most recently, LFHD experienced pertussis outbreaks in 2017 and 2018, in Warren County and Frederick County/Winchester City (Figure 3).

Figure 3. Number of pertussis cases, Lord Fairfax Health District, 1999-2018.




*Prevention*

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. Preteens (11-12 years) should receive a dose of Tdap, as should teens and adults who did not receive a dose as a preteen. Pregnant women should receive a dose of Tdap during each pregnancy, preferably during the third trimester, to confer protection on their baby. Breastfeeding further conveys protective maternal antibodies through breast milk.

*For Healthcare Providers*

- Promote vaccination by ensuring patients are fully vaccinated according to ACIP Guidelines.
- Ensure that ALL staff are immunized with Tdap.
- Report suspected cases to LFHD as soon as the case is suspected. Laboratory confirmed is not required if clinical presentation strongly indicates pertussis.
- Encourage maternal immunization and breastfeeding, unless there is a contraindication.

*Lord Fairfax Health District Services*

- LFHD follows up with contacts of individuals with pertussis and provides recommendations for post-exposure prophylaxis as indicated (www.cdc.gov/pertussis/outbreaks/pep.html).
- LFHD offers Tdap vaccine.

## HEPATITIS B AND C

Hepatitis, or liver inflammation, can be caused by a variety of factors, including infection with hepatitis viruses. The most common types of viral hepatitis are A, B, and C; hepatitis B and C can range from a mild, acute illness to serious chronic conditions.[1] Sharing items that may be contaminated with blood is a risk factor for both hepatitis B and C, and the ongoing opioid epidemic in the U.S. is likely related to an increase in acute hepatitis C infections.

Surveillance for chronic hepatitis B and C is challenging, since many people are asymptomatic and may not seek health care. Chronic hepatitis case counts for a given year represent cases newly reported to public health that year; they do not reflect year of diagnosis or year of infection.

The numbers of acute and chronic hepatitis B cases in Lord Fairfax Health District are shown in Figure 4, and acute and chronic hepatitis C cases in LFHD in Figure 5. In 2018, there was a decline in both hepatitis B and hepatitis C (acute and chronic) compared to 2017.

Figure 4. Acute and chronic hepatitis B cases, Lord Fairfax Health District, 2013-2018.

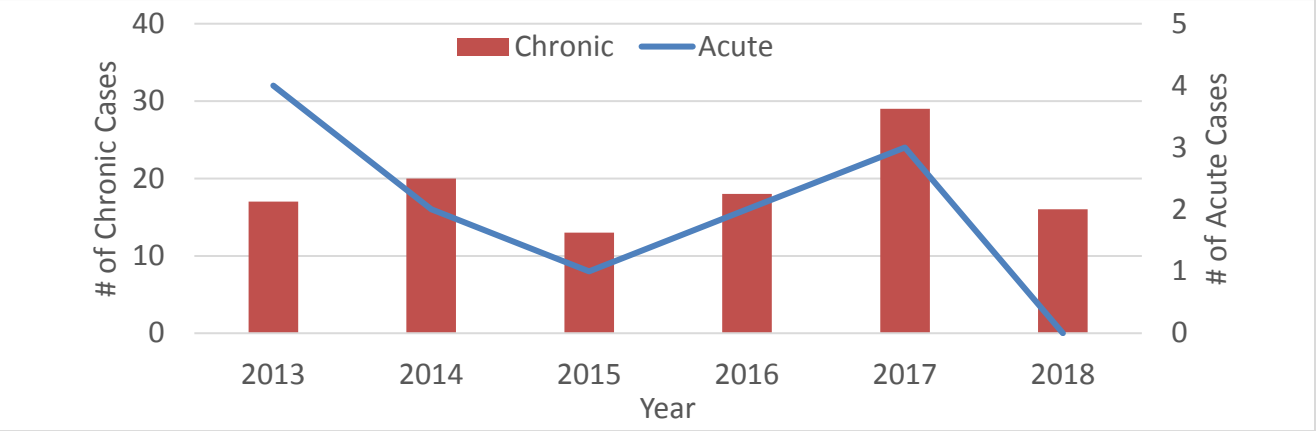
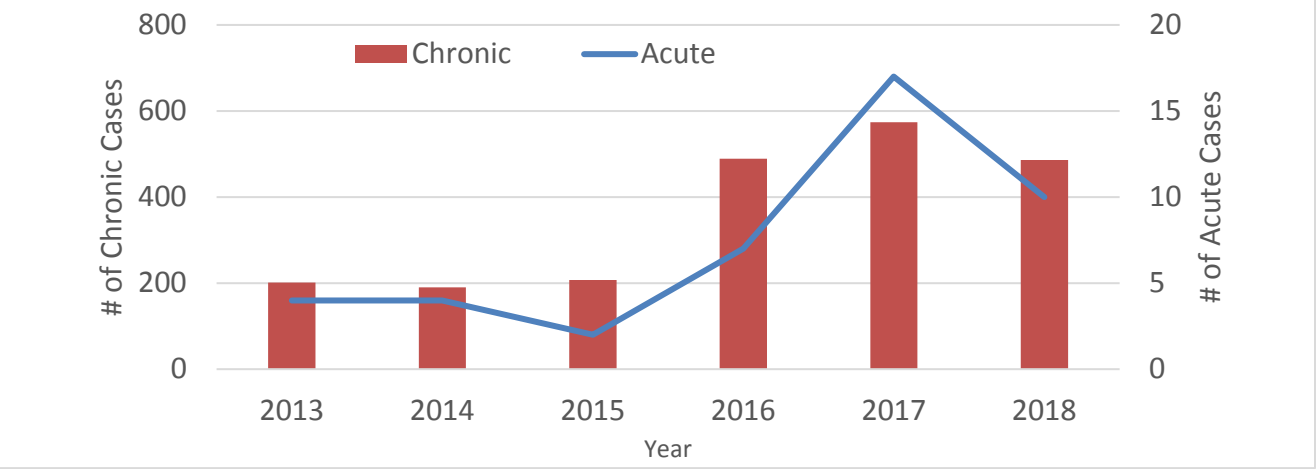



Figure 5. Acute and chronic hepatitis C cases, Lord Fairfax Health District, 2013-2018.




[1] CDC, 2018. Viral hepatitis. https://www.cdc.gov/hepatitis/abc/index.htm, Accessed July 6, 2018.

## RABIES

Rabies is a preventable viral disease affecting the central nervous system, causing brain disease and death. Most reported cases in the U.S. occur in wild animals like raccoons, skunks, foxes, and bats. The virus is transmitted to humans through the saliva of an infected animal. Controlling rabies depends on vaccination of domestic pets, especially dogs and cats, and use of rabies vaccine for post-exposure prophylaxis (PEP) after a possible rabies exposure to humans.

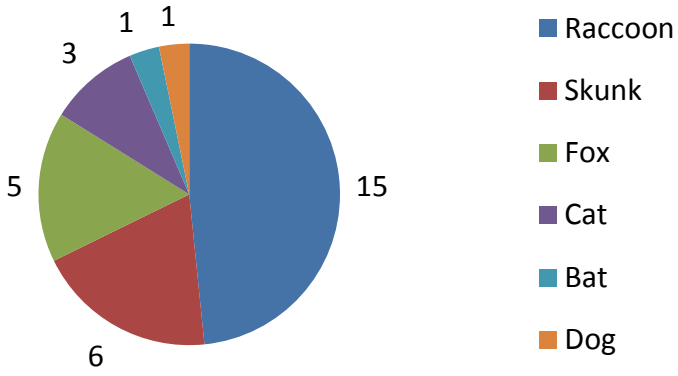
Table 2. Number of potential human rabies exposures, LFHD, 2018.

| Jurisdiction | Number of Encounters |
|---|---|
| Clarke | 58 |
| Frederick | 320 |
| Page | 104 |
| Shenandoah | 178 |
| Warren | 210 |
| Winchester | 108 |
| **Total** | **978** |

LFHD received reports of 996 human exposures to potentially rabid animals in 2018; 18 were non-LFHD residents (Table 2). Of the 978 encounters in LFHD, 58 people (about 6%) received PEP. Most people did not receive PEP because: 1) the attacking animal was a dog, cat, or ferret, and could be observed for 10 days to rule out the possibility transmission, 2) the animal was wild or feral and was captured, euthanized, and tested negative for rabies, 3) the animal was a species not likely to carry rabies, or 4) the type of contact carried a negligible risk of transmission.

In 2018, LFHD tested 189 animals for rabies; 31 were positive. Among these were 15 raccoons, 6 skunks, and 5 foxes (Figure 6).

Figure 6. Animals testing positive for rabies, LFHD, 2018.




**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.

*For Healthcare Providers*

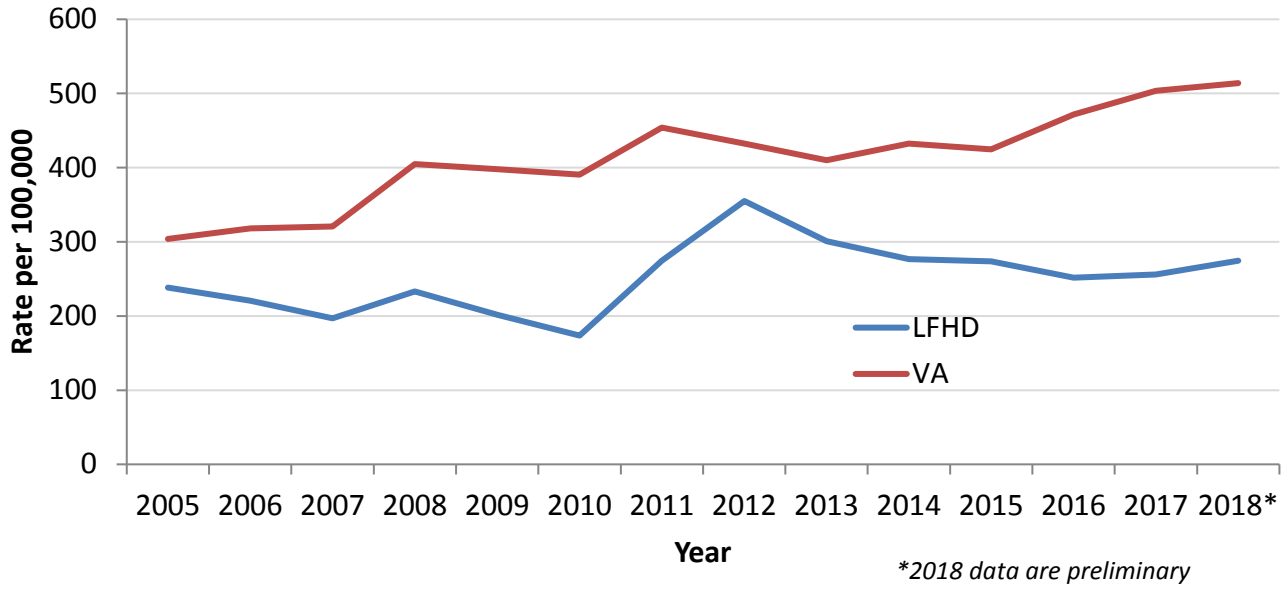
- Report all exposures immediately to your local health department.
- Not all individuals exposed to a potentially rabid animal will need post-exposure prophylaxis (PEP). If the animal is located, PEP should be delayed pending results of animal testing or confinement.
- When feasible during PEP, the full dose of RIG should be infiltrated into and around the wound.
- PEP administration should be reported to LFHD using the VDH Morbidity Report (page 18).

## CHLAMYDIA

Chlamydia, the disease caused by *C. trachomatis* infection, is the most commonly reported notifiable disease in the U.S. In 2017, there were 1.7 million cases of chlamydia in the U.S., a rate of 529 cases per 100,000 people.[2] Virginia reported over 42,000 cases of chlamydia in 2017, a rate of 504 per 100,000. Chlamydia is associated with pelvic inflammatory disease, or PID, which causes infertility, ectopic pregnancy, and pelvic pain. Since reporting began in 1994, chlamydia rates have increased steadily in the U.S.

The chlamydia incidence rate in LFHD remains well below the rate for the rest of Virginia (Figure 7).

Figure 7. Chlamydia rates by year, Lord Fairfax Health District and Virginia, 2005-2018.




*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 for chlamydia is available at local health departments in LFHD.
- Please call the local health department (see page 16) for hours and appointments.

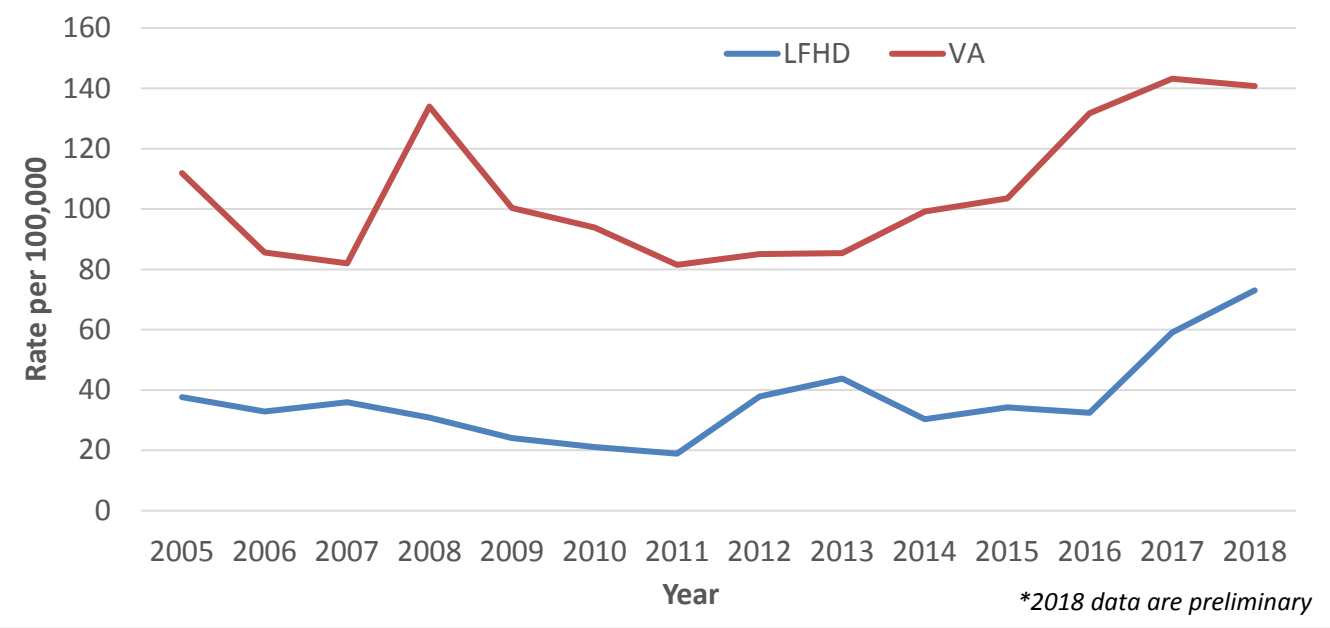
[2] CDC. Sexually Transmitted Disease Surveillance 2017. https://www.cdc.gov/std/stats17/default.htm. Accessed June 11, 2019.

## GONORRHEA

Gonorrhea is a bacterial infection caused by *Neisseria gonorrhoeae.* It is the second most commonly reported notifiable disease in the U.S. Gonorrhea is transmitted through sexual contact and perinatally from mother to child during birth. Untreated gonorrhea can cause pelvic inflammatory disease in women, infertility in men, and disseminated gonococcal infection in anyone. In 2017, there were 555608 cases of gonorrhea in the U.S., or 171.9 cases per 100,000 people. This represents an 18.6% increase over the rate in 2016.[3]

In LFHD, the gonorrhea rate has more than doubled between 2016 and 2018 (Figure 8). Still, the 2018 rate of 73.1 cases per 100,000 people remains well below the state rate of 140.8 cases per 100,000.

Figure 8. Gonorrhea rates by year, Lord Fairfax Health District and Virginia, 2008-2018.




*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 gonorrhea.
- Sexually active men who have sex with men should be tested annually for gonorrhea.
- Sexual partners of those diagnosed with gonorrhea 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 for gonorrhea is available at local health departments in LFHD.
- Please call the local health department (see page 16) for hours and appointments.

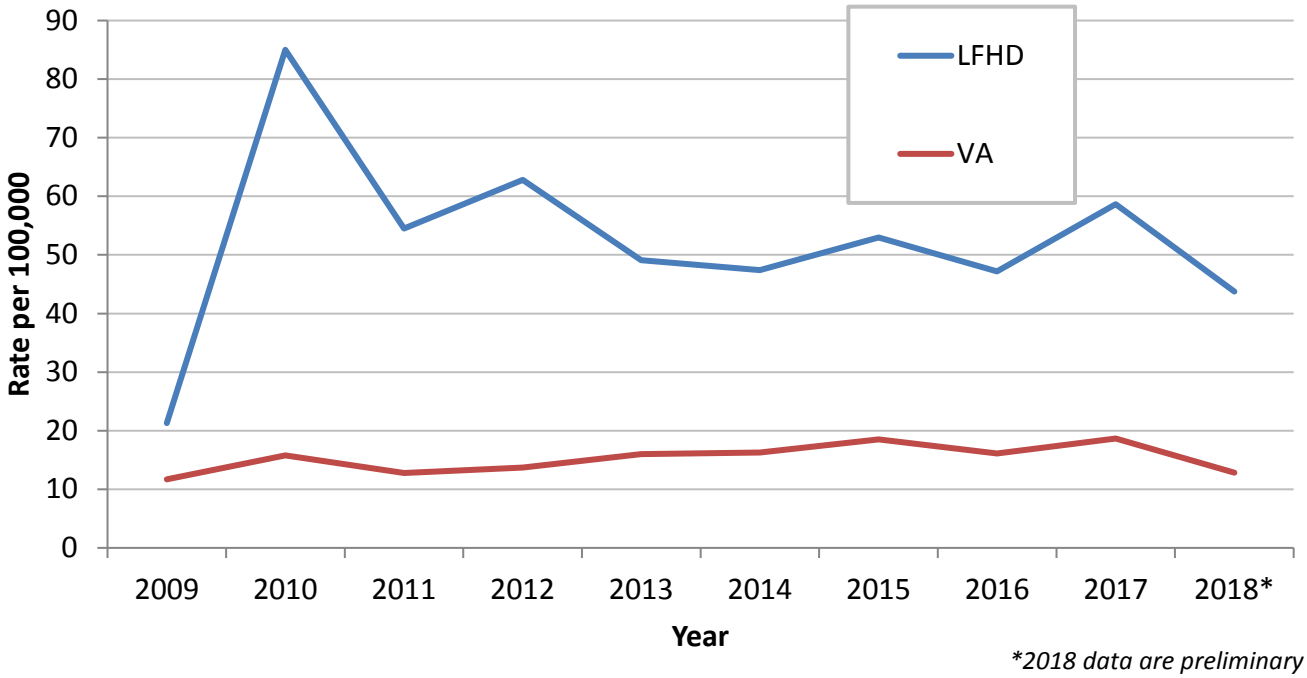
[3] CDC. Sexually Transmitted Disease Surveillance, 2017. https://www.cdc.gov/std/stats17/Gonorrhea.htm. Accessed July 18, 2019.

## Lyme and Other Tickborne Diseases

Tickborne diseases in Virginia include Lyme disease, Rocky Mountain Spotted Fever (RMSF), ehrlichiosis and anaplasmosis. Lyme disease is the most commonly reported tickborne illness in the United States.

In 2018, there was a decrease in Lyme disease in the Lord Fairfax Health District and Virginia overall compared to 2017 (Figure 7). In 2018, LFHD had a rate of 43.7 cases per 100,000 population (103 cases), which was the lowest rate observed since 2009. However, LFHD continues to observe a much higher rate of Lyme disease than Virginia overall. In addition, there were 13 cases of RMSF, 9 cases of ehrlichiosis, and 1 case of anaplasmosis.

Figure 7. Rates of Lyme Disease, Lord Fairfax Health District and Virginia, 2009-2018.

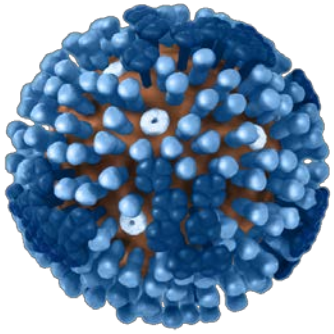



**2018 data are preliminary*

*For Healthcare Providers*

- Consider tickborne infections in patients with febrile illness during warm weather months. Most patients treated early with antibiotics quickly recover.
- Report all suspected cases of Lyme, Rocky Mountain Spotted Fever, ehrlichiosis and anaplasmosis to your local health department (see page 16).
- Testing for Lyme disease is a two-step process:
  1) **EIA** (enzyme immunoassay) or IFA (indirect immunofluorescence assay), **AND**;
  2) If EIA is positive or equivocal, **Western Blot IgM and IgG** serology should be performed.
- CDC recommends empiric treatment with doxycycline for patients with suspected RMSF.

## INFLUENZA (FLU)



According to the Centers for Disease Control and Prevention (CDC), the 2018-2019 U.S. influenza season was of moderate severity with two waves of influenza A activity.[4] The 21-week season was the longest in 10 years. Influenza A (H1N1)pdm09 predominated until February 2019, and influenza A (H3N2) predominated for the latter half of the season. The season was notable for a relative absence of influenza B.

Pediatric deaths are the only nationally notifiable outcome for seasonal influenza. There were 5 laboratory-confirmed, influenza-associated pediatric deaths in Virginia during the 2018-19 season, none of which were in LFHD residents.

The Virginia Department of Health monitors ILI activity each week from October through May, the months when influenza is most likely to occur in VA. **ILI is defined as fever with cough and/or sore throat.** 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 by five health planning regions.

*For Healthcare Providers*

- The Advisory Committee on Immunization Practices (ACIP) recommends routine influenza vaccination for **all persons** aged 6 months and older.
- Healthcare workers may be required to receive vaccination or sign a waiver.
- The live attenuated influenza vaccine is available and recommended as an option by ACIP.[5]
- Vaccination efforts should continue throughout the season, because the duration of the season varies and may not peak until February or March.

*Lord Fairfax Health District Services*

- LFHD provides influenza vaccine, on a walk-in basis whenever the "Flu Vaccines Available" sign is posted. Please call your local health department (see page 16) for more information.

[4] CDC, 2019. Update: Influenza activity in the United States during the 2018-19 season and composition of the 2019-20 influenza vaccine. https://www.cdc.gov/mmwr/volumes/68/wr/mm6824a3.htm?s_cid=mm6824a3_x. Accessed July 18, 2019.

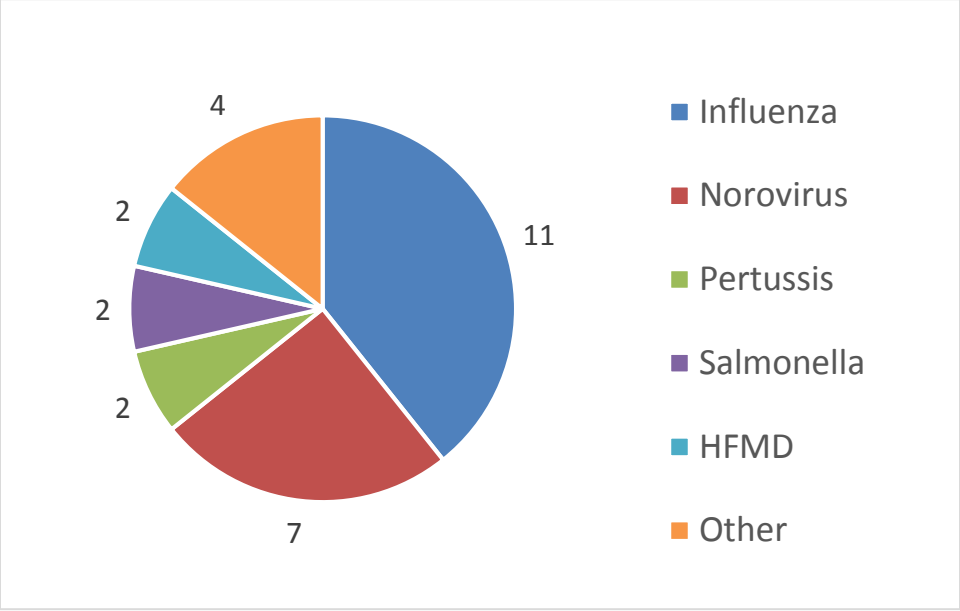
[5] CDC, 2018. Update: ACIP recommendations for the use of quadrivalent live attenuated influenza vaccine (LAIV4) – United States, 2018-19 influenza season. https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a5.htm?s_cid=mm6722a5_x. Accessed July 18, 2019.

## Outbreak Summary, 2018

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.[10] 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 2018, LFHD investigated 28 outbreaks of illness, 11 (39%) caused by influenza, 7 (25%) by norovirus, and 2 each by pertussis, salmonella, and hand, foot, and mouth disease (Figure 8). The majority of reported outbreaks occurred in nursing homes or assisted living facilities (15; 54%) and schools (7; 25%).

Figure 8. Outbreaks in Lord Fairfax Health District, by etiology, 2018.




*For Healthcare Providers, Long-Term Care Facilities, and Schools*

- Report all suspected outbreaks for any disease to your local health department as soon as possible (page 16).
- Frequent and proper hand washing with soap and water is the key measure for preventing most norovirus and other gastrointestinal outbreaks.

*LFHD Services*

- For each reported outbreak, LFHD will conduct an investigation to determine the causative agent and assist individuals and facilities with implementing prevention and control measures.

## COUNTY-SPECIFIC CASE COUNTS, 2018

| Disease | Clarke | Frederick | Page | Shenandoah | Warren | Winchester | Total |
|---|---|---|---|---|---|---|---|
| **Botulism, infant** | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Campylobacteriosis** | 3 | 28 | 12 | 37 | 7 | 6 | 93 |
| ***Chlamydia trachomatis* infection** | 21 | 242 | 52 | 83 | 108 | 140 | 643 |
| **Cryptosporidiosis** | 1 | 6 | 2 | 1 | 7 | 3 | 20 |
| **E. coli infection, shiga toxin-producing** | 1 | 4 | 0 | 1 | 1 | 2 | 9 |
| **Ehrlichiosis/Anaplasmosis** | 0 | 4 | 3 | 1 | 1 | 1 | 10 |
| **Giardiasis** | 0 | 1 | 2 | 1 | 2 | 2 | 8 |
| **Gonorrhea** | 3 | 40 | 18 | 31 | 34 | 48 | 172 |
| ***Haemophilus influenzae*, invasive** | 0 | 2 | 0 | 0 | 0 | 1 | 3 |
| **Hepatitis A, acute** | 0 | 1 | 1 | 1 | 2 | 0 | 5 |
| **Hepatitis C, acute** | 0 | 4 | 0 | 1 | 5 | 1 | 11 |
| **HIV** | 1 | 4 | 2 | 1 | 2 | 2 | 12 |
| **Lead, elevated levels*** | 1 | 2 | 3 | 4 | 2 | 7 | 19 |
| **Legionellosis** | 0 | 5 | 1 | 4 | 3 | 1 | 14 |
| **Lyme disease** | 11 | 38 | 10 | 13 | 23 | 8 | 103 |
| **Mumps** | 1 | 0 | 0 | 0 | 0 | 1 | 2 |
| **Pertussis** | 1 | 18 | 0 | 1 | 0 | 5 | 25 |
| **Salmonellosis** | 3 | 20 | 4 | 6 | 2 | 8 | 43 |
| **Shigellosis** | 0 | 1 | 1 | 0 | 2 | 0 | 4 |
| **Spotted Fever Rickettsiosis**** | 0 | 3 | 0 | 2 | 7 | 1 | 13 |
| ***Streptococcus pneumoniae*, invasive (age < 5)** | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| **Streptococcus, Group A, invasive, or TSS^** | 0 | 10 | 2 | 4 | 0 | 1 | 17 |
| **Syphilis - early stage** | 0 | 2 | 0 | 1 | 4 | 1 | 8 |
| **Tuberculosis** | 0 | 1 | 0 | 1 | 0 | 1 | 3 |
| **Varicella (Chickenpox)** | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| **West Nile Virus** | 0 | 1 | 0 | 1 | 0 | 2 | 4 |

[α]2018 data are provisional; * Lead = blood lead levels ≥5 ug/dL; ** includes Rocky Mountain Spotted Fever; ^TSS = Streptococcal toxic shock syndrome

## LORD FAIRFAX COMMUNICABLE DISEASE EPIDEMIOLOGY PROGRAM CONTACT INFORMATION

| Health Department | Address | Phone | Fax |
|---|---|---|---|
| **Clarke County** | 100 North Buckmarsh Street, Berryville VA 22611 | 540-955-1033 | 540-955-4094 |
| **Frederick/Winchester** | 10 Baker Street, Winchester VA 22601 | 540-722-3470 | 540-722-3475 |
| **Page County** | 75 Court Lane, Luray VA 22835 | 540-743-6528 | 540-743-3811 |
| **Shenandoah County** | 494 North Main Street, #100, Woodstock VA 22664 | 540-459-3733 | 540-459-8267 |
| **Warren County** | 465 West 15th Street, Suite 200, Front Royal VA 22630 | 540-635-3159 | 540-635-9698 |
| **After Hours Phone** | | 540-665-8611 | |
| **District Epidemiologist** | | 540-771-3725 | |

### Data Source

Unless otherwise noted, data are LFHD primary surveillance data available in the Virginia Electronic Disease Surveillance System (VEDSS) as of May 24, 2019. All 2018 data are considered provisional.

### Acknowledgements and Feedback

This report was prepared by Meredith Davis, MPH, District Epidemiologist with the Virginia Department of Health, and approved by LFHD Health Director, Colin M. Greene, MD, MPH; any errors are solely their responsibility. We welcome your feedback and suggestions at meredith.davis@vdh.virginia.gov or colin.greene@vdh.virginia.gov.

## REPORTABLE DISEASES

Suspected or confirmed diagnosis should be submitted on an Epi-1 form (see next page) via web, mail or fax. Conditions listed in the **RED box** must be reported immediately by the most rapid means available (preferably phone call).

VDH VIRGINIA DEPARTMENT OF HEALTH
*To protect the health and promote the well-being of all people in Virginia.*

# 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 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 (LDH). Reports may be submitted by computer-generated printout, Epi-1 form, CDC or VDH surveillance form, or upon agreement with VDH, by means of secure electronic submission.

**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 the timeframe specified below.

## REPORT IMMEDIATELY

**Anthrax (*Bacillus anthracis*)** [a]
**Botulism (*Clostridium botulinum*)** [a]
**Brucellosis (*Brucella* spp.)** [a]
**Cholera (*Vibrio cholerae* O1/O139)** [a]
**Coronavirus infection, severe (e.g., SARS-CoV, MERS-CoV)** [a]
**Diphtheria (*Corynebacterium diphtheriae*)** [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 if younger than 18 years of age
**Influenza A, novel virus** [a]
Measles (Rubeola) [a]
**Meningococcal disease (*Neisseria meningitidis*)** [a]
Outbreaks, all (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, waterborne, and any other outbreak)
Pertussis (*Bordetella pertussis*) [a]
**Plague (*Yersinia pestis*)** [a]
**Poliovirus infection, including poliomyelitis** [a]
Psittacosis (*Chlamydophila psittaci*) [a]
**Q fever (*Coxiella burnetti*)** [a]
Rabies, human and animal [a]
Rubella [a], including congenital rubella syndrome [a]
Smallpox (Variola virus) [a]
Syphilis (*Treponema pallidum*), congenital, primary, and secondary [a]
**Tuberculosis, active disease (*Mycobacterium tuberculosis* complex)** [a,b]
**Tularemia (*Francisella tularensis*)** [a]
**Typhoid/Paratyphoid infection (*Salmonella* Typhi, *Salmonella* Paratyphi)** [a]
Unusual occurrence of disease of public health concern
Vaccinia, disease or adverse event [a]
**Vibriosis (*Vibrio* spp.)** [a,e]
Viral hemorrhagic fever [a]
Yellow fever [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, *M. tuberculosis* complex or any other mycobacteria, and antimicrobial susceptibility for *M. tuberculosis* complex.
[c] Includes submission of *Candida haemulonii* specimens to DCLS.
[d] Laboratories that use EIA without a positive culture should forward positive stool specimens or enrichment broth to DCLS.
[e] Includes reporting of *Photobacterium damselae* and *Grimontia hollisae*.

## REPORT WITHIN 3 DAYS

Amebiasis (*Entamoeba histolytica*) [a]
Arboviral infections (e.g., CHIK, dengue, EEE, LAC, SLE, WNV, Zika) [a]
Babesiosis (*Babesia* spp.) [a]
Campylobacteriosis (*Campylobacter* spp.) [a]
***Candida auris*, infection or colonization** [a,c]
**Carbapenemase-producing organism, infection or colonization** [a]
Chancroid (*Haemophilus ducreyi*) [a]
Chickenpox (Varicella virus) [a]
*Chlamydia trachomatis* infection [a]
Cryptosporidiosis (*Cryptosporidium* spp.) [a]
Cyclosporiasis (*Cyclospora* spp.) [a]
Ehrlichiosis/Anaplasmosis (*Ehrlichia* spp., *Anaplasma phagocytophilum*) [a]
Giardiasis (*Giardia* spp.) [a]
Gonorrhea (*Neisseria gonorrhoeae*) [a]
Granuloma inguinale (*Calymmatobacterium granulomatis*)
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, confirmed seasonal strain [a]
Lead, blood levels [a]
Legionellosis (*Legionella* spp.) [a]
Leprosy/Hansen's disease (*Mycobacterium leprae*)
Leptospirosis (*Leptospira interrogans*) [a]
**Listeriosis (*Listeria monocytogenes*)** [a]
Lyme disease (*Borrelia* spp.) [a]
Lymphogranuloma venereum (*Chlamydia trachomatis*)
Malaria (*Plasmodium* spp.) [a]
Mumps [a]
Neonatal abstinence syndrome (NAS)
Ophthalmia neonatorum
Rabies treatment, post-exposure
**Salmonellosis (*Salmonella* spp.)** [a]
**Shiga toxin-producing *Escherichia coli* infection** [a,d]
**Shigellosis (*Shigella* spp.)** [a]
Spotted fever rickettsiosis (*Rickettsia* spp.) [a]
**Streptococcal disease, Group A, invasive or toxic shock** [a]
*Streptococcus pneumoniae* infection, invasive and <5 years of age [a]
Syphilis (*Treponema pallidum*), if not primary, secondary, or congenital
Tetanus (*Clostridium tetani*)
Toxic substance-related illness [a]
Trichinosis/Trichinellosis (*Trichinella spiralis*) [a]
Tuberculosis infection [a]
**Vancomycin-intermediate or vancomycin-resistant *Staphylococcus aureus* infection** [a]
**Yersiniosis (*Yersinia* spp.)** [a]

*Effective November 2018*

MAIL THE TOP TWO COPIES TO YOUR LOCAL HEALTH DEPARTMENT

## VIRGINIA DEPARTMENT OF HEALTH
## Confidential Morbidity Report

Patient's Name (Last, First, Middle Initial):

SSN: ___-___-___

Home #: ( ) ___-___

Work #: ( ) ___-___

Patient's Address (Street, City or Town, State, Zip Code):

City or County of Residence

Date of Birth: (mm/dd/yyyy) | Age: | Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Unknown | Hispanic: ☐ Yes ☐ No | Sex: ☐ F ☐ M

DISEASE OR CONDITION:

Pregnant: ☐ Yes ☐ No ☐ Unknown

Death: ☐ Yes ☐ No

Death Date:

Date of Onset:

Date of Diagnosis:

Influenza: (Report # and type only. No patient identification)

Number of Cases: Type, if Known:

Physician's Name: Phone #: ( ) ___-___

Address:

Hospital Admission: ☐ Yes ☐ No Hospital Name:

Date of Admission: Medical Record Number:

### Laboratory Information and Results

Source of Specimen:

Date Collected:

Laboratory Test(s) and Finding(s):

Name/Address of Lab:

CLIA Number:

### Other Information

Comments: (e.g., Risk situation [food handling, patient care, day care], Treatment [including dates], Immunization status [including dates], Signs/Symptoms, Exposure, Outbreak-associated, etc.)

Name, Address, and Phone Number of Person Completing this Form:

Date Reported:

Check here if you need more of these forms, or call your local health department. (Be sure your address is complete.) ☐

### For Health Department Use

Date Received:

VEDSS Patient ID:

Please complete as much of this form as possible

Form Epi-1, 10/2011

LORD FAIRFAX HEALTH DISTRICT

# Suspected Outbreak Form

VDH VIRGINIA DEPARTMENT OF HEALTH *Protecting You and Your Environment*

**All** known or suspected outbreaks are reportable to your local health department. Use this form to gather as much information as possible. Call 540-722-3470 or 540-771-3725; fax to 540-722-3475.

**Contact Information** Date: _____

Name_____ Phone number _____ Email _____

Facility: _____ County: _____

Address: _____ City: _____ Zip: _____

**Outbreak Information**

| | | | | |
|---|---|---|---|---|
| Disease Suspected: | | | **Residents/ Students/Other** | **Staff** |
| First Symptom Onset Date : | | Number Ill | | |
| | | Number Hospitalized | | |
| Affected Area: | ☐ One classroom, wing, or floor<br>☐ Multiple wings or floors<br>☐ Whole facility | Total Number in Facility | | |
| | | For vaccine-preventable diseases only (e.g. pertussis, mumps): | | |
| | | Number ill who are vaccinated | | |
| | | Total number vaccinated | | |

***Signs & Symptoms***

| | | | |
|---|---|---|---|
| **Respiratory** | ☐ Fever<br>☐ Cough<br>☐ Sore Throat<br>☐ Congestion<br>☐ Other _____ | **Rash** | ☐ Suspect Scabies<br>☐ Suspect MRSA<br>☐ Suspect Hand, Foot, and Mouth Disease<br>☐ Other _____<br>Please describe progression of the rash: |
| **GI** | ☐ Vomiting<br>☐ Diarrhea<br>☐ Abdominal Cramps<br>☐ Fever<br>☐ Other _____ | **Other** ☐ | Please describe symptoms: |

***Lab:*** Please describe any relevant lab results _____

**Infection Control Measures Currently Implemented**

| | |
|---|---|
| ☐ Emphasized hand hygiene | ☐ Served meals in rooms |
| ☐ Isolated or cohorted sick residents | ☐ Used paper plates, cups, etc |
| ☐ Excluded sick staff from work | ☐ Removed food and drinks from common areas |
| ☐ Cohorted staff to work only with sick OR with well | ☐ Posted signs to limit visitors |
| ☐ Conducted thorough environmental cleaning | ☐ Closed facility to new admissions |
| ☐ Discontinued group activities | ☐ Used personal protective equipment |

**Other Comments/Details:**