Communicable Disease Summary 2018

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THOMAS JEFFERSON HEALTH DISTRICT
ALBEMARLE | CHARLOTTESVILLE | FLUVANNA
GREENE | LOUISA | NELSON

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### Table of Selected Reported Diseases in Thomas Jefferson Health District, 2012-2018

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<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<td>13</td>
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<td>7.43</td>
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<td>Vibrio infection - non-cholera</td>
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\(^8\) - Rates are crude and use preliminary 2018 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, 5-Year ACS estimates.

*CREs and CPOs were not reportable until November, 2018. Incidence is therefore a three month incidence. Additionally, investigations occur in jurisdictions where positive patients visit, but are attributed to the district in which they live.
**Tickborne Diseases**

**TJHD FAST FACTS**

**Lyme Disease cases in 2018: 62**  
Rate: 25.14 per 100,000 persons

**Spotted Fever Rickettsiosis (including RMSF) Cases in 2018: 23**  
Rate: 9.32 per 100,000 persons

**Primary mode of transmission:** Tickborne

**Period of communicability:** N/A

**Detection method(s):** Signs and symptoms, serology (2 step testing process via EIA/IFA and Western Blot for Lyme, IFA for Spotted Fever rickettsiosis)

**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

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**FACTS and EPIDEMIOLOGIC DATA**

Nationally, 95% of Lyme disease cases are reported from 14 states in the northeast and upper Midwest.¹

For all counties in TJHD Lyme disease is the most common tick-borne condition:

- Albemarle (22.3 per 100K)
- Nelson (53.5 per 100K)
- Fluvanna (3.8 per 100K)
- Greene (43.5 per 100K)
- Charlottesville (29.2 per 100K)
- Louisa (19.5 per 100K)

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**PUBLICATION 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.

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**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 many effective landscaping strategies to tick proof the yards around homes,³ however it is also important to remember that ticks will often transfer between animals and humans.

- 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, but often discovered much later when more noticeable symptoms begin.

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⁴Map made from CDC Data by Sean Morris
THINGS TO REMEMBER

- Frequent hand washing is key to preventing illness: after using the bathroom, changing diapers, handling live animals or animal byproducts, and prior to and after cooking
- Handle all raw meat as if contaminated
- Wash cutting boards or surfaces after raw meat or eggs have touched them, especially if using the same space for foods that will not be cooked
- Those working in high risk occupations (healthcare, child care or food service industry) or attend daycare are at increased risk of spreading disease and are required to stay out of work if ill with diarrhea until 24 hours without diarrhea

3 Graph made from VDH Surveillance Data
Epidemiologic Data

The 2017-18 flu season saw an increase in morbidity and mortality over recent years. Of the 4,338 specimens tested, at the state public health laboratory 4,150 were positive for influenza.\(^1\)

Influenza A viruses were the most prevalent during the 2017-2018 flu season, with 68.4% of tested specimens positive. Further subtyping showed 72.4% of the specimens testing positive for Influenza A were A (H3) and 27.6% were A (H1).\(^1\)

*The 2018-2019 Flu Season is ongoing, and all data for it is preliminary, so is not discussed in detail.*\(^1\)

THINGS TO REMEMBER

- An influenza vaccine is recommended for everyone 6 months of age and older
- FluMist was available this flu season
- If ill, stay home for at least 24 hours after fever subsides\(^2\)
- Cover nose and mouth with elbow or tissue when coughing or sneezing
- Perform frequent hand washing\(^2\)
- Avoid contacting eyes, nose and mouth\(^2\)
- To help decrease spread, remember to clean and disinfect surfaces that may be contaminated\(^2\)


\(^3\)Graphs taken from Virginia Department of Health, Weekly Influenza Report, accessed 4/2/2019
FAST FACTS

**Etiologic agents:** Include E. Coli, Shigella, Salmonella, etc.

**Primary mode of transmission:** Carbapenem resistance is typically shared person to person. Resistance can be shared among bacteria, meaning a carbapenemase (one mechanism of resistance) producing E. Coli could share that protein with a Shigella, and show up in a second patient as resistant Shigella.

**Risk Factors:** These are typically transmitted in hospital and long-term care facilities, and are typically opportunistic, meaning they occur among sick patients who may be receiving treatment for other conditions. The highest risk is in patients who are on long courses of certain antibiotics, or on devices like ventilators or catheters.

**Carbapenems:** CREs are resistant to common antibiotics given to patients with these illnesses, limiting treatment options. Unlike other drug resistant organisms like MRSA, CREs can become resistant to carbapenems through a variety of mechanisms.

**Public Health Concerns:** Because patients with CREs tend to have been to multiple healthcare facilities between health districts, investigations can become very complex and time consuming. Because these are typically hospital acquired infections, the vulnerable population is also especially susceptible. Due to commonness of enterobacteriaceae infections, resistance among these could have a “far-reaching impact” as quoted by the CDC.

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THE PROBLEM

Carbapenem based antibiotics are commonly given to treat a variety of illnesses. CREs are resistant to this class of antibiotics, limiting treatment options. Due to this resistance, and the common appearance in patients with other comorbidities, mortality is much higher in CREs and CROs than non-resistant enterobacteriaceae. As a response to this emerging public health issue, VDH made CREs reportable as of November, 2018.

What Can I Do?1

**Patients**
- Tell your doctor if you have been hospitalized elsewhere
- Expect all providers to wash their hands before and after touching you or tubes going into you
- Wash your own hands frequently

**Providers**
- Follow proper infection control protocol
- Carefully clean and disinfect equipment
- Isolate patients with CREs from those without
- Remove temporary medical devices as soon as possible

Find More Information & Guidance At:
https://www.cdc.gov/hai/organisms/cre

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THINGS TO REMEMBER

- It is important to take all antibiotics to completion and as prescribed. **Symptoms subsiding does not mean the bacteria is completely gone**, and not finishing a course of antibiotics can cause disease reoccurrence and antibiotic resistance.
- Discuss with your provider the need for antibiotics. **Remember that antibiotics only treat bacterial infections, not viral infections.**
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.

Outbreak Epidemiologic Data

This was the third straight year that we had zero outbreaks originate from either local hospital. Outbreaks are defined as an unusual increase in number of cases of a specific disease over baseline, in a defined population and time period.

Outbreak response includes determining factors such as the susceptible population, the proportion of exposed people infected, and risk factors. TJHD works with facilities to put into place appropriate control measures and track outbreak progression.

In 2018 TJHD conducted over 1,000 reportable disease investigations, which may or may not be connected to other cases. Investigation timeline and details are specific to each disease, but typically take into account risk factors for the disease and possible contacts at risk of exposure. The goal of disease a investigation is to identify the source of infection and potential contacts, as well as educate the public about prevention.

Epidemiology Outreach

The Epidemiology Department for the Thomas Jefferson Health District receives a number of phone calls and questions from the community in regards to a multitude of subjects. These calls can come from hospitals, urgent care facilities, clinics or community members with concerns.

The most common calls are about infection control measures, education, and coordination of lab specimens (whether what specimen types to collect or setting up specimen testing at DCLS, the state lab).

### 2018 OUTBREAKS & INVESTIGATIONS

<table>
<thead>
<tr>
<th>Organism</th>
<th>Cases</th>
</tr>
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<tbody>
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<td>Gastrointestinal Illness (GI)</td>
<td>6</td>
</tr>
<tr>
<td>Influenza-Like</td>
<td>6</td>
</tr>
<tr>
<td>Hand Foot and Mouth Disease</td>
<td>2</td>
</tr>
<tr>
<td>Pertussis</td>
<td>1</td>
</tr>
<tr>
<td>Scabies</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total:** 15 cases

**2018 Outbreak Settings by Facility Type:**

- School (K-12): 35.33%
- Assisted Living: 20.00%
- Daycare/Pre-K: 20.00%
- Nursing Home: 26.67%

**Outbreaks & Investigations by Organism:**

- Gastrointestinal Illness (GI): 6 cases
- Influenza: 6 cases
- Hand Foot and Mouth Disease: 2 cases
- Pertussis: 1 case
- Scabies: 1 case

**Total:** 15 cases
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-virginia-state-board-of-health/). Report all conditions when suspected or confirmed to your local health department (LHD). 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.

**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]

**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]

**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*.

Effective November 2018
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.