



REPORTED CASES OF SELECTED COMMUNICABLE DISEASES WASHOE COUNTY Oct – Dec 2004

**To report
 communicable disease
 phone:
 775-328-2447 or
 fax reports to:
 775-328-3764**

DISEASE	Oct '03	Nov '03	Dec '03	Q4 '03	Total '03	Q4 '02	Total '02	Q4 '01	Total '01
AIDS	3	0	1	4	29	8	30	5	30
Campylobacteriosis	4	4	1	9	29	10	37	13	38
Chlamydia	85	72	94	251	991	260	984	275	1057
Cryptosporidiosis	0	1	0	1	2	0	2	2	3
E. coli 0157:H7	2	0	0	2	5	1	6	0	3
Giardiasis	4	1	2	7	22	7	21	17	42
Gonorrhea	22	16	20	58	202	58	182	42	204
Haemophilus influenzae type b (Hib)	0	0	0	0	0	0	1	0	1
Hepatitis A (acute)	1	1	0	2	29	6	18	4	12
Hepatitis B (acute)	1	1	1	3	9	3	10	3	11
Hepatitis B (chronic)	6	3	2	11	54	19	64	19	64
Hepatitis C (acute)	0	1	0	1	3	2	6	0	4
Hepatitis C (chronic)	115	76	78	269	1225	390	DNC	DNC	DNC
HIV	1	2	3	6	43	14	47	11	64
Influenza (A & B)	1	26	2	29	38	0	13	1	13
Measles	0	0	0	0	0	0	0	0	0
Meningitis, Viral or Aseptic	10	4	2	16	67	17	41	5	21
Meningococcal Disease	0	0	0	0	1	2	5	0	1
Pertussis (confirmed only)	0	0	0	0	5	0	3	6	14
Pneumococcal Disease	0	0	0	0	3	2	7	2	2
Rabies (bat)	1	0	0	1	5	7	10	0	1
Rotavirus	16	15	13	44	110	58	141	75	202
RSV	4	21	45	70	450	44	382	26	279
Salmonellosis	6	1	2	9	36	4	17	12	24
Shigellosis	1	0	0	1	11	1	15	2	12
Syphilis (all stages)	0	0	7	7	20	7	26	12	25
Tuberculosis	0	2	7	9	30	5	13	5	25

DNC – Data Not Collected

Please share this document with all physicians & staff in your facility/office.

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

Recent SARS Cases in China

On January 13, 2004, the Chinese Ministry of Health (MOH) and the World Health Organization (WHO) reported a new suspect case SARS in a 35-year-old man living in Guangdong Province, China. This case is the third recent report of suspected or confirmed SARS in patients in southern China. No link has been established at present between the confirmed case and the two recent suspect SARS cases, and the source of exposure for all three cases is unclear.

On January 5, 2004, Chinese and WHO authorities announced that laboratory results confirmed evidence of SARS-associated coronavirus infection (SARS-CoV) in a 32-year-old man in Guangdong Province who had become ill on December 16, 2003. On January 8, 2004, a suspect case of SARS was reported in a 20-year-old woman who works in a restaurant in Guangdong Province and had onset of illness on December 25, 2003. On January 12, 2004, a suspect case of SARS was reported in a 35-year-old man from Guangdong Province who had onset of illness on December 31, 2003, and was admitted to Guangdong People's Hospital and placed in isolation on January 6. All three patients are reported to be doing well, and no signs or symptoms of SARS-like illness have been reported among their identified contacts to date. Details on the clinical features and laboratory results of the 2 suspect SARS cases are not yet available.

Recommended U.S. SARS Control Measures

In light of these reports, the Centers for Disease Control and Prevention (CDC) is recommending that U.S. physicians maintain a greater index of suspicion of SARS in patients who require hospitalization for radiographically confirmed pneumonia or acute respiratory distress syndrome (ARDS) AND who have a history of travel to Guangdong Province (or close contact with an ill person with a history of recent travel to Guangdong Province) in the 10 days before onset of symptoms. When such patients are identified, the following actions should be taken:

- ◆ Patients should immediately be placed in appropriate isolation precautions for SARS (i.e., contact and airborne precautions).
- ◆ Patients should promptly be reported to the state or local health department.
- ◆ Patients should promptly be tested for evidence of SARS-CoV infection as part of the diagnostic evaluation (see Appendix 2 "Updated Guidelines for Collecting Specimens from Potential SARS Patients," in the CDC document, "In the Absence of SARS-CoV Transmission Worldwide: Guidance for Surveillance, Clinical and Laboratory Evaluation, and Reporting" at <http://www.cdc.gov/ncidod/sars/absenceofsars.htm>).

- ◆ Washoe District Health Department will identify, evaluate, and monitor relevant contacts of the patient, as indicated. In particular, the health status of household contacts or persons who provided care to symptomatic patients will be assessed.

In addition, CDC continues to recommend that health care providers and public health officials identify and report patients who require hospitalization for radiographically confirmed pneumonia or ARDS without identifiable etiology AND who have one of the following risk factors in the 10 days before the onset of illness:

- ◆ Travel to mainland China, Hong Kong, or Taiwan, or close contact with an ill person with a history of recent travel to one of these areas, OR
- ◆ Employment in an occupation associated with a risk for SARS-CoV exposure (e.g., health care worker with direct patient contact; worker in a laboratory that contains live SARS-CoV), OR
- ◆ Part of a cluster of cases of atypical pneumonia without an alternative diagnosis.

Diagnostic testing for SARS should be considered in such patients, as described in the guidelines at <http://www.cdc.gov/ncidod/sars/absenceofsars.htm>. Infection control practitioners and other health care personnel should also be alert for clusters of pneumonia among two or more health care workers who work in the same facility.

Advice for Travelers (SARS)

At this time, WHO and CDC have not issued any alerts or advisories for travel to China (<http://www.cdc.gov/ncidod/sars/travel.htm#outside>). Previous SARS research has shown that SARS can be controlled and contained through early detection, isolation of suspect cases, and tracing of their contacts. On the basis of limited available data, it would be prudent for travelers to China to avoid visiting live food markets and avoid direct contact with civets and other wildlife from these markets. Although there is no evidence that direct contact with civets or other wild animals from live food markets has led to cases of SARS, viruses very similar to SARS-CoV—the virus that causes SARS—have been found in these animals. In addition, some persons working with these animals have evidence of infection with SARS-CoV or a very similar virus.

US Bans Importation of Civet Cats

On January 13, 2004, the Department of Health and Human Services (HHS) announced an immediate embargo on the importation of civets to the United States (http://www.cdc.gov/ncidod/sars/civet_ban_exec_order.htm). These small animals have been identified as a possible link to SARS transmission in China. The

embargo, which applies to dead and live civets as well as civet products, will remain in place until further notice. Civet products that have been processed to render them noninfectious, such as fully taxidermied animals and finished trophies, are not included in the embargo. The ban does not apply to civet cats approved by CDC for importation for educational or scientific purposes.

More Information About SARS

For more information about current U.S. SARS control guidelines, see the CDC document, "In the Absence of SARS-CoV Transmission Worldwide: Guidance for

Surveillance, Clinical and Laboratory Evaluation, and Reporting" at <http://www.cdc.gov/ncidod/sars/absenceofsars.htm>. The document is part of CDC's draft *Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS)* <http://www.cdc.gov/ncidod/sars/sarsprepplan.htm>.

For additional information about the reported SARS cases in China, see the Web sites of CDC (<http://www.cdc.gov/>) and WHO (<http://www.who.int/en/>).

INFLUENZA A (H5N1) VIRUS INFECTIONS

Recent Influenza A (H5N1) Cases

Since the end of October 2003, 14 persons (13 children and one adult) in Vietnam have been admitted from surrounding provinces to hospitals in Hanoi for severe respiratory illness. Among the 14 patients, three (two children and one adult) have had avian influenza A (H5N1) virus infections confirmed by testing conducted at the National Institute of Hygiene and Epidemiology in Hanoi and in Hong Kong. Twelve of the patients, including 11 children and the mother of one of the deceased children, have died.

Influenza A (H5N1) viruses normally circulate among wild birds but can infect poultry and rarely have infected people in the past. In 1997, 18 persons in Hong Kong were hospitalized because of influenza A (H5N1) infections and six of them died. In 2003, two residents of Hong Kong who traveled to China developed influenza A (H5N1) virus infections and one of them died. In Vietnam, large outbreaks of influenza A (H5N1) have been reported among poultry in the southern and northern regions of the country. WHO has reported that the H5N1 strain implicated in the outbreak has now been partially sequenced. All genes are of avian origin, indicating that the virus that caused death in the three confirmed cases had not yet acquired human genes. The acquisition of human genes increases the likelihood that a virus of avian origin can be readily transmitted from one human to another.

Staff from CDC will travel to Vietnam to work with WHO and Vietnam's human and animal health authorities to evaluate the situation, including patterns of transmission of the influenza A (H5N1) viruses.

During December 2003, an outbreak of avian influenza A (H5N1) was reported among poultry in South Korea. Earlier this week, Japan reported the deaths of 6,000 chickens on a single farm in the western part of Honshu due to influenza A (H5N1) virus infection. No human cases of infection with the avian influenza virus have been reported in either of these outbreaks.

Enhanced U.S. Influenza Surveillance

At this time, CDC recommends enhanced surveillance efforts by state and local health departments, hospitals, and clinicians to identify patients who have been hospitalized with unexplained pneumonia, ARDS, or severe respiratory illness AND who have traveled to Vietnam, South Korea, and Japan within 10 days from onset of symptoms.

All such patients should be tested for influenza virus infection; these tests should include viral culture of nasopharyngeal and throat swabs. All influenza A viruses should be subtyped, and those that cannot be identified as H3 or H1 viruses should be sent immediately to CDC for testing for influenza A (H5N1).

CDC will make additional recommendations on enhanced surveillance if influenza A (H5N1) activity continues to evolve.

SARS and Influenza A (H5N1)

There is considerable potential for the clinical presentation and travel history of persons with either SARS or influenza A (H5N1) infection to overlap. Therefore, the following actions should be taken:

- ◆ Influenza A infection should be considered in the differential diagnosis when evaluating a SARS patient.
- ◆ Laboratories should make subtyping of influenza A viruses isolated from potential SARS cases a priority.
- ◆ The laboratory should immediately notify the CDC's Influenza Branch if any influenza A virus cannot be subtyped.

More Information About Influenza

For further details about the reported cases of influenza A(H5N1) in Vietnam, see the WHO Web site <http://www.who.int/en/>. Additional information about influenza is available on the CDC Web site at <http://www.cdc.gov/>.

Adapted from CDC Advisory 00183.