EPI INVESTIGATOR

Florida Department of Health- Alachua

Spring 2017

"Improving Public Health in Our Community Through Cooperation"

Alachua County Health Department
(352) 334-7900

To report a disease, phone or fax the appropriate office below:

Administrator
Paul Myers, MS
(352) 334-8892

Environmental Health
Director Anthony Dennis
(352) 334-7931

HIV/AIDS
Richard Willis, Surveillance
(352) 334-7968
Fax (352) 334-8867

Martha Buffington, Ryan White
(352) 334-7967

Epidemiology/Hepatitis
Nadia Kovacevich, MPH, CPH
(352) 225-4181
Fax (352) 955-6464
Devin Myers, MPH
(352)334-7900 x 3470
If you would like to receive the Epi InvestiGator by email or fax, please contact us at the following email address:
DOHAlachuaUpdates@flhealth.gov

Immunizations
Michael Smith, RN
(352) 334-8827
Fax: (352) 334-7943

Sexually Transmitted Disease
Larissa Cantlin-Plemmons
(352) 334-7900 ext 3434
Fax: (352) 334-8818

Tuberculosis
Geneva Saulsberry, RN, BSN
(352) 225-4188
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Johnny Lloyd, HSPC II
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After Hours:
(352) 334-7900

Editor
Sheila Griffis

STD Awareness

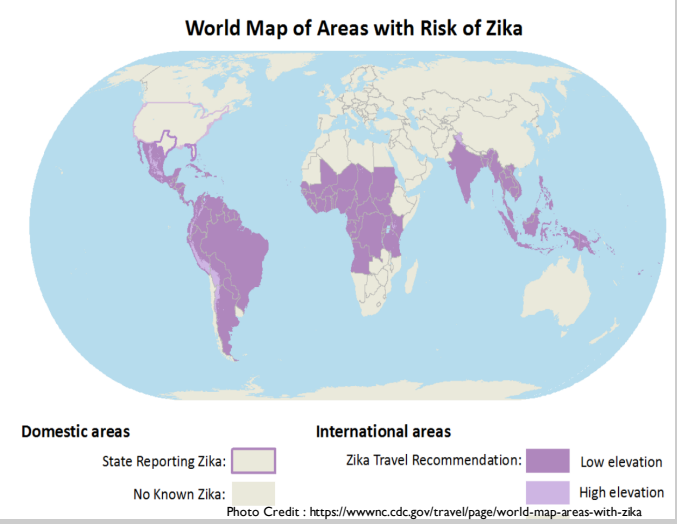
Submitted By: Gay Koehler-Sides, Human Services Program Manager

April is STD Awareness Month, a month dedicated to raising awareness about the importance of STD prevention, testing and treatment. As providers, we encourage you to remind your clients to reduce their risk of STDs by using condoms correctly, limiting sexual partners and engaging in routine testing. PrEP (Pre-exposure prophylaxis) is an additional tool that we can use to prevent HIV infection in high-risk HIV negative individuals. Clients may benefit from PrEP if they are with an HIV positive partner, treated for an STD, engage in high-risk sexual behaviors or are an injection drug user. This month marks the one year anniversary of the opening of the PrEP Clinic at the Florida Department of Health in Alachua County! Our PrEP program has 43 active clients and is accepting more.

Updated Zika Guidance

Submitted By: Devin Myers, MPH Epidemiologist

Zika virus (ZIKV) research is ongoing and recommendations are constantly changing as we learn more about the virus, highlighting the need to remain informed about new developments. ZIKV has spread throughout the Americas, Caribbean, Africa, and Asia. The potential adverse pregnancy outcomes are concerning, and research is ongoing.



The Florida Department of Health (DOH) and the Centers for Disease Control and Prevention (CDC) recommend that pregnant women should avoid non-essential travel to areas of active ZIKV transmission. Please find the latest travel updates: http://wwwnc.cdc.gov/travel/page/zika-travel-information

Pregnant women who traveled to identified areas of active ZIKV transmission or had sex with a partner who lives in or traveled to these areas without using condoms or other barrier methods to prevent infection, but do not have ongoing exposure, should consult with their healthcare provider and should be tested in accordance with CDC guidance. For additional information, see: https://www.cdc.gov/zika/pregnancy/index.html

Clinician Guidance

Clinicians that suspect a patient has a Zika virus infection should:
1) Test for dengue, chikungunya, and other viruses due to similar geographic spread of diseases and clinical presentation;
2) Contact DOH-Alachua at 352-225-4181 to report the disease upon suspicion. We will be able to provide consultation for current laboratory testing recommendations.

Please contact DOH-Alachua to request Zika virus testing for patients without insurance. **Clinicians are still required to report suspected Zika fever cases to DOH at the time testing is ordered, regardless of which lab performs the testing, to ensure appropriate mosquito control actions are taken. Additional Healthcare Resources:**

http://www.cdc.gov/zika/hc-providers/index.html

http://www.floridahealth.gov/diseases-and-conditions/zika-virus/index.html

Latest DOH News Updates: http://www.floridahealth.gov/newsroom/index.html

BCG Vaccine

Submitted By: :Geneva Saulsberry, RN, BSN
Senior CHN Supervisor, ACHD
TB Department

BCG, or bacille Calmette-Guerin, is a vaccine for tuberculosis (TB) disease. Many foreign-born persons have been BCG-vaccinated. BCG is used in many countries with a high prevalence of TB to prevent childhood tuberculous meningitis and miliary disease. However, BCG is not generally recommended for use in the United States because of the low risk of infection with Mycobacterium tuberculosis, the variable effectiveness of the vaccine against adult pulmonary TB, and the vaccine's potential interference with tuberculin skin test reactivity. The BCG vaccine should be considered only for very select persons who meet specific criteria and in consultation with a TB expert.

Recommendations

Children. BCG vaccination should only be considered for children who have a negative tuberculin skin test and who are continually exposed, and cannot be separated from, adults who:

•Are untreated or ineffectively treated for TB disease (if the child cannot be given long-term treatment for infection); or
•Have TB caused by strains resistant to isoniazid and rifampin.

Health Care Workers. BCG vaccination of health care workers should be considered on an individual basis in settings in which:

•A high percentage of TB patients are infected with M. tuberculosis strains resistant to both isoniazid and rifampin;
•There is ongoing transmission of such drug-resistant M. tuberculosis strains to health care workers and subsequent infection is likely; or
•Comprehensive TB infection-control precautions have been implemented, but have not been successful.

Health care workers considered for BCG vaccination should be counseled regarding the risks and benefits associated with both BCG vaccination and treatment of Latent TB Infection (LTBI).

Contraindications

Immunosuppression. BCG vaccination should not be given to persons who are immunosuppressed (e.g., persons who are HIV infected) or who are likely to become immunocompromised (e.g., persons who are candidates for organ transplant).

Pregnancy. BCG vaccination should not be given during pregnancy. Even though no harmful effects of BCG vaccination on the fetus have been observed, further studies are needed to prove its safety.

Testing for TB in BCG-Vaccinated Persons

The Tuberculin Skin Test (TST) and blood tests to detect TB infection are not contraindicated for persons who have been vaccinated with BCG. BCG vaccination may cause a false-positive reaction to the TST, which may complicate decisions about prescribing treatment. The presence or size of a TST reaction in persons who have been vaccinated with BCG does not predict whether BCG will provide any protection against TB disease. Furthermore, the size of a TST reaction in a BCG-vaccinated person is not a factor in determining whether the reaction is caused by LTBI or the prior BCG vaccination. (See below for specific guidance on skin test results.)

TB Blood Tests to detect TB infection, unlike the TST, are not affected by prior BCG vaccination and are less likely to give a false-positive result.

Treatment for LTBI in BCG-Vaccinated Persons

Treatment of LTBI substantially reduces the risk that TB infection will progress to disease. Careful assessment to rule out the possibility of TB disease is necessary before treatment for LTBI is started. Evaluation of TST reactions in persons vaccinated with BCG should be interpreted using the same criteria for those not BCG-vaccinated. Persons in the following high-risk groups should be given treatment for LTBI if their reaction to the TST is at least 5 mm of induration or they have a positive result using a TB blood test:

•HIV-infected persons
•Recent contacts to a TB case
•Persons with fibrotic changes on chest radiograph consistent with old TB
•Patients with organ transplants
•Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of >15 mg/day of prednisone for 1 month or longer, taking TNF-a antagonists)

In addition, persons in the following high-risk groups should be considered for treatment of LTBI if their reaction to the TST is at least 10 mm of induration or they have a positive result using a TB blood test:

•Recent arrivals (less than 5 years) from high-prevalence countries
•Injection drug users
•Residents and employees of high-risk congregate settings (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)
•Mycobacteriology laboratory personnel
•Persons with clinical conditions that place them at high-risk for developing TB disease (e.g., diabetes)
•Children less than 4 years of age, or children and adolescents exposed to adults in high-risk categories

Persons with no known risk factors for TB may be considered for treatment of LTBI if their reaction to the tuberculin test is at least 15 mm of induration or they have a positive result using a TB blood test. Targeted skin testing programs should only be conducted among high-risk groups. All testing activities should be accompanied by a plan for follow-up care for persons with TB infection or disease.

Information for this article obtained directly from https://www.cdc.gov/tb/publications/factsheets/prevention/bcg.htm

FLORIDA REPORTABLE DISEASES *Alachua County 2 year activity*

Disease Activity	2017 Jan-Mar	2016 Jan-	2016 Jan-Dec
AIDS	**	**	**
Anaplasmosis, HGA(Anaplasma Phag)	0	0	1
Anthrax	0	0	0
Arsenic Poisoning	0	0	0
Botulism	0	0	0
Brucellosis	0	0	0
Campylobacteriosis	3	8	39
Carbon Monoxide Poisoning	1	0	0
Chikungunya fever	0	0	0
Chlamydia	500	544	2238
Ciguatera	0	0	0
Creutzfeldt-Jakob Disease (CJD)	0	0	0
Cryptosporidiosis	1	1	11
Cyclosporiasis	0	0	0
Dengue	0	2	2
Diphtheria	0	0	0
Ehrlichiosis/anaplasmosis	0	0	6
Escherichia coli infection, Shiga toxin-producing	1	2	4
Giardiasis (acute)	0	3	13
Gonorrhea	114	119	596
Haemophilus influenzae, invasive disease in children <5 years old	1	0	1*
Hansen's Disease (Leprosy)	0	0	1
Hantavirus infection	0	0	0
Hemolytic uremic syndrome (HUS)	0	0	0
Hepatitis A	0	0	0
Hepatitis B Acute	0	0	2
Hepatitis B Chronic	14	9	43
Hepatitis B surface antigen in pregnant women or children <2 years old	2	1	7
Hepatitis C Acute	0	0	1
Hepatitis C Chronic	105	96	390
Herpes B Virus, Possible Exposure	0	0	0
Herpes simplex virus (HSV) in infants	0	0	0
HIV	**	**	**
Influenza A, novel or pandemic strains	0	0	0
Lead Poisoning	0	1	3
Legionellosis	0	0	2
Listeriosis	0	0	1
Lyme Disease	0	0	3
Lymphogranuloma Venereum (LGV)	0	0	0
Malaria	0	0	1

Disease Activity Cont'd.	2017 Jan-Mar	2016 Jan-Mar	2016 Jan-Dec
Measles	0	0	0
Meningitis, bacterial or mycotic	0	2	4
Meningococcal disease	0	0	0
Mercury poisoning	0	0	0
Mumps	0	0	0
Neurotoxic shellfish poisoning	0	0	0
Pertussis	0	1	1
Pesticide-related Illness and injury, acute	0	0	0
Plague	0	0	0
Psittacosis (ornithosis)	0	0	0
Q Fever	0	0	0
Rabies, animal or human	2	0	5
Rabies, possible exposure	13	7	66
Ricin toxin poisoning	0	0	0
Rocky Mountain spotted fever and other spotted fever rickettsioses	0	0	0
Rubella	0	0	0
Salmonellosis	7	13	79
Saxitoxin poisoning (paralytic shellfish poisoning)	0	0	0
Severe acute respiratory disease syndrome associated with coronavirus infection	0	0	0
Shigellosis	0	0	16
Smallpox	0	0	0
Staphylococcal enterotoxin B poisoning	0	0	0
Staphylococcus aureus infection (VISA, VRSA)	0	0	0
Streptococcus pneumoniae invasive disease in children (drug-resistant) <6 years old	0	0	0*
Streptococcus pneumoniae invasive disease in children (susceptible) <6 years old	1	0	0*
Syphilis	20	28	114
Syphilis in pregnant women & neonates	0	0	0
Tetanus	0	0	0
Trichinellosis (trichinosis)	0	0	0
Tuberculosis (TB)	2	2	4
Typhoid fever (Salmonella serotype Typhi)	0	0	1
Typhus fever, epidemic	0	0	0
Vaccinia disease	0	0	0
Varicella (chickenpox)	2	4	9
Vibrio cholerae type 01	0	0	1
Vibrio vulnificus	1	0	1
West Nile virus disease	0	0	0
Zika Virus Disease and Infection Non Congenital	0	4	10

The counts include suspect, probable, and confirmed cases reported in Alachua county residents (regardless of where infection was acquired) by date reported to the Department of Health. Counts are provisional and subject to change until their respective database closes.

* Changes to case definitions can affect the number of cases reported.

**Data from the most recent calendar year (2016) are considered provisional and therefore should not be used to confirm or rule out an increase in newly reported cases in Florida. The final year-end numbers are generated in July of the following year, after duplicate cases are removed from the dataset, as is customary of HIV surveillance in the US.

Statistics can be found at http://www.flhealthcharts.com/charts/communicablediseases/default.aspx

PLEASE BE AWARE OF RECENT PHONE NUMBER CHANGES FOR OUR EPIDEMIOLOGY PROGRAM

- REGULAR BUSINESS HOURS (8AM-5PM, M-F): **352-225-4181**
- After-hours and Holidays (24/7): **352-334-7900** (please listen to prompts to receive a callback).

The Epidemiology Program conducts disease surveillance and investigates suspected occurrences of infectious diseases and conditions that are reported from physician's offices, hospitals, and laboratories. Surveillance is primarily conducted through passive reporting from the medical community as required by Chapter 381, Florida Statutes. Data is collected and examined to determine the existence of trends. Our staff ensures that action is taken to prevent infectious disease outbreaks from occurring in Alachua County.

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SPRING QUARTER 2017

Updated Guidelines for Hepatitis B Post-Vaccination Serologic Testing

Submitted By: Nadia Kovacevich, MPH
Epidemiologist

According to the Centers for Disease Control and Prevention (CDC, 2015), at least 40% of babies in the U.S. born to mothers infected with Hepatitis B, who do not receive appropriate post exposure immunoprophylaxis at birth, become infected with Hepatitis B. The CDC recommends a **shortened interval** for post-vaccination serologic testing (PVST) of infants born to hepatitis B virus (HBV) positive mothers to minimize the possibility for unnecessary revaccination.

Because new evidence suggests that hepatitis B antibody levels decline following vaccination, the CDC now recommends that PVST take place earlier – at age 9–12 months, or 1–2 months after the final dose of the hepatitis B vaccine series – in order to ensure antibodies are detected.. The PVST interval after the final dose in the primary Hep B series no longer needs to extend to 18 months (CDC, 2015).

Vaccine dose	Age of infant
First	Birth (within 4 hours)
HBIG	Birth (within 4 hours)
Second	1 month
Third	6 months
post-vaccination serologic testing (PVST)	***1–2 months after the final dose of the hepatitis B vaccine series**
Infants born to HBsAg+ women who weigh less than 1,000 g at birth get a fourth dose of vaccine. The third dose should be given 1-2 months after the second with the fourth dose at six months. Premature infants whose mothers HBsAg status is unknown should receive a fourth dose, as described in the schedule for babies of lower birth weight.	

Schillie, S., Murphy, T.V., Fenlon, N., Ko, S., & Ward, J.W. (2015). Update: Shortened interval for postvaccination serologic testing of infants born to hepatitis B-infected mothers. *Mortality and Morbidity Weekly Report (MMWR), 64(*39), 1118-20. Retrieved from www.cdc.gov/mmwr/preview/mmwrhtml/mm6439a6.htm?s_cid=mm6439a6_e

Centers for Disease Control and Prevention. (2015). Perinatal transmission. Retrieved from http://www.cdc.gov/hepatitis/HBV/PerinatalXmtn.htm

Florida HEALTH Alachua County

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