EpiNotes

Florida Department of Health - Hillsborough County
Disease Surveillance Newsletter
May 2014

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Important Attachments and Links

The following announcements are attached:

- Chikungunya Fever – Information for Clinicians
- CDC Health Advisory - Notice to Public Health Officials and Clinicians: Recognizing, Managing, and Reporting Chikungunya Virus Infections in Travelers Returning from the Caribbean
- Key Points – Middle East Respiratory Syndrome Coronavirus
- Clinician Screening Tool for Identifying Patients Under Investigation for Middle East Respiratory Syndrome
- Reportable Disease List
- Disease Report Form

Additional Internet Resources:

- FDOH website with information on Middle East Respiratory Syndrome: http://www.floridahealth.gov/diseases-and-conditions/mers/
- FDOH website with information on Chikungunya: http://www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/chikungunya.html
- CDC guide for Preparedness and Response for Chikungunya Virus: Introduction in the Americas: http://www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/_documents/chickv-english.pdf

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-to-date	
	2011	2012	2013		Jan 13	Jan 14
Vaccine Preventable Diseases						
Diphtheria	0	0	0	0.00	0	0
Measles	0	0	0	0.00	0	0
Mumps	1	0	0	0.33	0	0
Pertussis	31	119	96	82.00	11	14
Poliomyelitis	0	0	0	0.00	0	0
Rubella	0	0	0	0.00	0	0
Smallpox	0	0	0	0.00	0	0
Tetanus	0	0	0	0.00	0	0
Varicella	46	45	65	52.00	9	13
CNS Diseases & Bacteremias						
Creutzfeldt-Jakob Disease	0	3	1	1.33	0	1
Haemophilus influenzae (Invasive Disease)	16	8	14	12.67	4	3
In Children 5 Years or Younger	2	2	2	2.00	0	0
Listeriosis	3	1	5	3.00	0	0
Meningitis (Bacterial, Cryptococcal, Mycotic)	21	5	11	12.33	3	2
Meningococcal Disease	1	3	6	3.33	2	2
Staphylococcus aureus (VISA, VRSA)	1	1	1	1.00	0	0
Streptococcal Disease, Group A (Invasive Disease)	17	18	17	17.33	3	9
Streptococcus pneumoniae (Invasive Disease)	100	55	59	71.33	23	28
Drug Resistant	54	29	29	37.33	9	15
Drug Susceptible	46	26	30	34.00	14	13
Enteric Infections						
Campylobacteriosis*	120	105	133	119.33	21	33
Cholera	0	1	0	0.33	0	0
Cryptosporidiosis	38	77	59	58.00	4	7
Cyclospora	1	2	9	4.00	0	0
Escherichia coli, Shiga toxin-producing (STEC)**	24	22	30	25.33	3	5
Giardiasis†	81	54	56	63.67	17	15
Hemolytic Uremic Syndrome	0	1	2	1.00	0	0
Salmonellosis	349	331	304	328.00	40	47
Shigellosis	378	36	63	159.00	0	16
Typhoid Fever	0	0	0	0.00	0	0
Viral Hepatitis						
Hepatitis A	4	5	10	6.33	0	1
Hepatitis B (Acute)	26	39	56	40.33	10	15
Hepatitis C (Acute)	7	26	38	23.67	9	7
Hepatitis +HBsAg in Pregnant Women	50	38	31	39.67	3	9
Hepatitis D, E, G	0	1	0	0.33	0	0

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-to-date	
	2011	2012	2013		Apr 13	Apr 14
Vectorborne, Zoonoses						
Dengue	4	5	4	4.33	2	2
Eastern Equine Encephalitis††	0	0	1	0.33	1	0
Ehrlichiosis/Anaplasmosis	0	0	1	0.33	1	0
Leptospirosis	0	0	0	0.00	0	0
Lyme Disease	7	9	12	9.33	0	3
Malaria	7	7	8	7.33	3	3
Plague	0	0	0	0.00	0	0
Psittacosis	0	0	0	0.00	0	0
Q Fever (Acute and Chronic)	0	0	0	0.00	0	0
Rabies (Animal)	2	5	6	4.33	2	1
Rabies (Human)	0	0	0	0.00	0	0
Rocky Mountain Spotted Fever	0	1	1	0.67	0	0
St. Louis Encephalitis††	0	0	0	0.00	0	0
Toxoplasmosis	1	1	1	1.00	1	3
Trichinellosis	0	0	0	0.00	0	0
Tularemia	0	0	0	0.00	0	0
Typhus Fever (Epidemic and Endemic)	2	0	0	0.67	0	0
Venezuelan Equine Encephalitis††	0	0	0	0.00	0	0
West Nile Virus††	0	1	0	0.33	0	0
Western Equine Encephalitis††	0	0	0	0.00	0	0
Yellow Fever	0	0	0	0.00	0	0
Others						
Anthrax	0	0	0	0.00	0	0
Botulism, Foodborne	0	0	0	0.00	0	0
Botulism, Infant	0	0	0	0.00	0	0
Brucellosis	1	0	0	0.33	0	0
Glanders	0	0	0	0.00	0	0
Hansen's Disease (Leprosy)	0	2	2	1.33	0	0
Hantavirus Infection	0	0	0	0.00	0	0
Legionellosis	12	8	18	12.67	3	3
Melioidosis	0	0	0	0.00	0	0
Vibriosis	8	14	13	11.67	1	1

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-to-date	
	2011	2012	2013		Apr 13	Apr 14
Chemicals/Poisoning						
Arsenic	0	0	0	0.00	0	0
Carbon Monoxide	13	4	4	7.00	0	0
Lead	193	330	329	284.00	34	127
Mercury	0	0	0	0.00	0	0
Pesticide	15	4	4	7.67	1	1
Influenza						
Influenza, Pediatric Associated Mortality	0	0	1	0.33	1	0
Influenza, Novel or Pandemic Strain	7	0	0	2.33	0	0
HIV/AIDS						
AIDS	192	172	231	198.33	68	57
HIV Infection	318	327	403	349.33	130	129
STDs						
Chlamydia	7288	7124	7220	7210.67	2522	2690
Gonorrhea	2343	2160	2023	2175.33	697	639
Syphilis, Congenital	3	6	3	4.00	1	0
Syphilis, Latent	134	129	189	150.67	42	46
Syphilis, Early	91	117	124	110.67	41	48
Syphilis, Infectious	124	155	156	145.00	51	76
Tuberculosis						
TB	46	51	54	50.33	14	NA
Food and Waterborne Illness Outbreaks						
Food and Waterborne Cases	13	74	73	53.33	6	0
Food and Waterborne Outbreaks	3	4	4	3.67	1	0

December 13, 2013
Contact: Florida Department of Health Hillsborough County Epidemiology Program Office (813) 307-8010

Chikungunya Fever– Information for Clinicians

Please contact Hillsborough County Health Department (CHD) by the next business day if you suspect a patient has a chikungunya infection to ensure prompt mosquito control efforts.

Chikungunya, a dengue-like illness, has just been identified in 10 patients from the Caribbean island of St. Martin. Outbreaks have been documented in Africa, Southern Europe, Southeast Asia, the Indian subcontinent, and islands in the Indian and Pacific Oceans, prior to this introduction into the Caribbean. Spread to other areas in the Caribbean is a concern. **An infected person should avoid mosquito bites while ill to prevent infection of local mosquitoes.**

Transmission occurs through the bite of an infected mosquito. Chikungunya infection can also occur in neonates (aged <1 month) via transmission from infected mothers during the intrapartum period.

Incubation period is 2-12 days.

Clinical Presentation: A majority of people infected with chikungunya virus become symptomatic. Infection is characterized by acute fever and polyarthralgia, and can result in chronic join pain and fatigue of several weeks to years duration. Children may have more mild illness than adults. Persons at risk for more severe disease include: neonates exposed intrapartum, adults > 65 years of age, and persons with underlying medical conditions (e.g., hypertension, diabetes, or cardiovascular disease). Common symptoms include:

- Acute onset of fever with polyarthralgia (joint pain is often severe and debilitating)
- Other symptoms may include: headache, myalgia, arthritis, or rash

Patients with suspected chikungunya fever also should be evaluated, tested and managed for possible dengue virus infection if travel was to areas where both are present as co-infection is possible.

Please contact Hillsborough County Health Department (CHD) if you have a patient that has:

- Acute onset of high fever and polyarthralgia with or without recent (2 weeks prior to onset) travel to an endemic area including the Caribbean.

Laboratory testing
Polymerase Chain Reaction (PCR) can be used to detect viral RNA in serum samples collected during the first week post-symptom onset. Virus-specific IgM and neutralizing antibody testing should be requested for serum specimens taken > 1 week post-onset. Both acute (< 1 week post onset) and convalescent (> 1 week post onset) should be collected. Hillsborough CHD can provide guidance on how and when to submit samples to the Department of Health (DOH) Bureau of Public Health Laboratories.

Centers for Disease Control and Prevention
CDC 24/7: Saving lives, protecting people, reducing health costs
Emergency Preparedness and Response

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CDC HEALTH ADVISORY

HEALTH ALERT NETWORK
Distributed via the CDC Health Alert Network
December 13, 2013, 1400:00 (2:00 PM ET)
CDCHAN-00358

Notice to Public Health Officials and Clinicians: Recognizing, Managing, and Reporting Chikungunya Virus Infections in Travelers Returning from the Caribbean

Summary

On December 7, 2013, the World Health Organization (WHO) reported the first local (autochthonous) transmission of chikungunya virus in the Americas. As of December 12th, 10 cases of chikungunya have been confirmed in patients who reside on the French side of St. Martin in the Caribbean. Laboratory testing is pending on additional suspected cases. Onset of illness for confirmed cases was between October 15 and December 4. At this time, there are no reports of other suspected chikungunya cases outside St. Martin. However, further spread to other countries in the region is possible.

Chikungunya virus infection should be considered in patients with acute onset of fever and polyarthralgia, especially those who have recently traveled to the Caribbean. Healthcare providers are encouraged to report suspected chikungunya cases to their state or local health department to facilitate diagnosis and to mitigate the risk of local transmission.

Background

Chikungunya virus is a mosquito-borne alphavirus transmitted primarily by *Aedes aegypti* and *Aedes albopictus* mosquitoes. Humans are the primary reservoir during epidemics. Outbreaks have been documented in Africa, Southern Europe, Southeast Asia, the Indian subcontinent, and islands in the Indian and Pacific Oceans. Prior to the cases on St. Martin, the only chikungunya cases identified in the Americas were in travelers returning from endemic areas.

Clinical Disease

A majority of people infected with chikungunya virus become symptomatic. The incubation period is typically 3–7 days (range, 2–12 days). The most common clinical findings are acute onset of fever and polyarthralgia. Joint pains are often severe and debilitating. Other symptoms may include headache, myalgia, arthritis, or rash. Persons at risk for more severe disease include neonates (aged <1 month) exposed intrapartum, older adults (e.g., ≥ 65 years), and persons with underlying medical conditions (e.g., hypertension, diabetes, or cardiovascular disease).

Diagnosis

Chikungunya virus infection should be considered in patients with acute onset of fever and polyarthralgia who recently returned from the Caribbean. Laboratory diagnosis is generally accomplished by testing serum to detect virus, viral nucleic acid, or virus-specific immunoglobulin M (IgM) and neutralizing antibodies. During the first week of illness, chikungunya virus infection can often be diagnosed by using viral culture or nucleic acid amplification on serum. Virus-specific IgM and neutralizing antibodies normally develop toward the end of the first week of illness. To definitively rule out the diagnosis, convalescent-phase samples should be obtained from patients whose acute-phase samples test negative.

Chikungunya virus diagnostic testing is performed at CDC, two state health departments (California and New York), and one commercial laboratory (Focus Diagnostics). Healthcare providers should contact their state or local health department to facilitate testing.

Treatment

No specific antiviral treatment is available for chikungunya fever. Treatment is generally palliative and can include rest, fluids, and use of analgesics and antipyretics. Because of similar geographic distribution and symptoms, patients with suspected chikungunya virus infections also should be evaluated and managed for possible dengue virus infection. People infected with chikungunya or dengue virus should be protected from further mosquito exposure during the first few days of illness to prevent other mosquitoes from becoming infected and reduce the risk of local transmission.

Prevention

No vaccine or preventive drug is available. The best way to prevent chikungunya virus infection is to avoid mosquito bites. Use air conditioning or screens when indoors. Use insect repellents and wear long sleeves and pants when outdoors. People at increased risk for severe disease should consider not traveling to areas with ongoing chikungunya outbreaks.

Recommendations for Health Care Providers and Public Health Practitioners

- Chikungunya virus infection should be considered in patients with acute onset of fever and polyarthralgia, especially those who have recently traveled to the Caribbean.
- Healthcare providers are encouraged to report suspected chikungunya cases to their state or local health department to facilitate diagnosis and to mitigate the risk of local transmission.
- Health departments should perform surveillance for chikungunya cases in returning travelers and be aware of the risk of possible local transmission in areas where *Aedes* species mosquitoes are currently active.
- State health departments are encouraged to report laboratory-confirmed chikungunya virus infections to ArboNET, the national surveillance system for arthropod-borne viruses.

For more information

- General information about chikungunya virus and disease: http://www.cdc.gov/chikungunya/ (http://www.cdc.gov/chikungunya/)
- Chikungunya information for clinicians: http://www.cdc.gov/chikungunya/pdfs/CHIKV_Clinicians.pdf (http://www.cdc.gov/chikungunya/pdfs/CHIKV_Clinicians.pdf)
- Protection against mosquitoes: http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-2-the-pre-travel-consultation/protection-against-mosquitoes-ticks-and-other-insects-and-arthropods (http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-2-the-pre-travel-consultation/protection-against-mosquitoes-ticks-and-other-insects-and-arthropods)
- Travel notices related to chikungunya virus: http://wwwnc.cdc.gov/travel/notices (http://wwwnc.cdc.gov/travel/notices)
- Information about chikungunya for travelers and travel health providers: http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-3-infectious-diseases-related-to-travel/chikungunya (http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-3-infectious-diseases-related-to-travel/chikungunya)
- Chikungunya preparedness and response guidelines: http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=16984&Itemid (http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=16984&Itemid)
- Dengue clinical management guidelines: http://whqlibdoc.who.int/publications/2009/9789241547871_eng.pdf (http://whqlibdoc.who.int/publications/2009/9789241547871_eng.pdf)

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HAN Message Types

- **Health Alert:** Conveys the highest level of importance; warrants immediate action or attention. Example: HAN00001 (/HAN/han00001.asp)
- **Health Advisory:** Provides important information for a specific incident or situation; may not require immediate action. Example: HAN00346 (/HAN/han00346.asp)
- **Health Update:** Provides updated information regarding an incident or situation; unlikely to require immediate action. Example: HAN00342 (/HAN/han00342.asp)
- **Info Service:** Provides general information that is not necessarily considered to be of an emergent nature. Example: HAN00345 (/HAN/han00345.asp)

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This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations.

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Additional Resources

- HAN Archive By Year (/HAN/dir.asp)
- HAN Types (/HAN/hantable.asp)
- Sign Up for HAN E-mail Updates (/HAN/updates.asp)
- HAN Jurisdictions (/HAN/hanjuris.asp)

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800-CDC-INFO (800-232-4636) TTY: (888) 232-6348 - Contact CDC-INFO

Key Points – Middle East Respiratory Syndrome Coronavirus (MERS-CoV)
May 13, 2014
Information in this document is subject to change, and newer versions supersede this document

On Monday May 12, the Florida Department of Health (DOH) confirmed the first Florida case of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) infection in a patient at an Orlando hospital. The patient is a healthcare worker who resides and works in Saudi Arabia and is visiting the United States. The patient first flew to London and then through Boston and Atlanta, arriving in Orlando on May 1. The patient was hospitalized on May 9 and was placed in isolation once MERS-CoV was suspected. Efforts are underway to make contact with any individuals who had close contact with the patient during travel or in the Orlando area. There is no evidence the case is linked to the first case of MERS identified in Indiana and confirmed on May 2, 2014.

Situation Update

- The first two U.S. cases of MERS represent a very low risk to the general public in this country.
- At this time, in the United States no additional MERS cases have been identified, in association with these two cases or otherwise.
- Our guidance and recommendations may change as the situation evolves and we learn more.
- CDC advises that people protect themselves from respiratory illnesses by washing their hands often, using a tissue when coughing or sneezing, avoiding touching their face with unwashed hands, staying away from ill people, and disinfecting frequently touched surfaces.

MERS and MERS-CoV

- Middle East Respiratory Syndrome (MERS) is the illness caused by Middle East Respiratory Syndrome Coronavirus (MERS-CoV).
- MERS-CoV is different from other coronaviruses that have been found to infect people.
    - MERS-CoV is not the same coronavirus that caused SARS in 2003. However MERS-CoV has caused severe acute respiratory illness and pneumonia in many reported cases.
- We don't know where the virus came from or exactly how it spreads.
    - Scientists are investigating clusters of MERS in countries in and near the Arabian Peninsula[1] to learn how the initially infected people (index cases) were exposed to the virus.
    - MERS-CoV has been shown to spread among family members and to care takers in hospital settings, where there has been close contact, but there is no evidence of sustained spread in community settings.
    - In efforts to determine where the virus may have come from, studies have been done to test animals, including camels, for evidence of MERS-CoV infection.
        - A recent study detected evidence of MERS-CoV (gene sequences) in three out of 14 camels on a farm, linked to two confirmed human infections from Qatar.
        - MERS-CoV gene sequences have also been identified from dromedary camels in Saudi Arabia and Egypt, some associated with human cases.
        - Other studies have shown that camels from several countries, including Egypt, Oman, and Spain, had antibodies to MERS-CoV. One study identified a limited gene sequence for MERS-CoV in a bat in Saudi Arabia. This indicates that the animals had previous exposure to MERS-CoV or

another closely related virus. More information is needed to define the role that camels, bats, and other animals may play in possible transmission of MERS-CoV.

- In other countries affected by MERS:
  - Limited human-to-human spread has been reported, usually after close and prolonged contact, such as caring for or living with an infected person. The few instances where human to human spread has been identified have most frequently occurred among healthcare workers caring for MERS patients.
  - There is no definitive evidence of sustained spreading in community settings.

Florida Department of Health Response

- FDOH and hospital officials are investigating and responding to the situation by:
  - Reviewing appropriate infection control measures being taken by the hospital.
  - Interviewing the healthcare staff who had close contact[2] with the patient and family members to obtain detailed information on their exposures, collecting and testing specimens from them, and monitoring their health for relevant respiratory symptoms related to MERS-CoV infection.
  - Identifying other people who had close contact[2] with the patient, and
    - interviewing them
    - monitoring them to see if they become ill
    - collecting and testing specimens from them, if needed
    - requesting that they monitor their health and seek care if they develop symptoms

- CDC in conjunction with state health departments are conducting airline contact tracing to identify and notify U.S. travelers who may have been exposed to the U.S. imported case during that person's travel.
  - CDC will also provide information to international partners about any non-U.S. citizens who are identified through contact tracing.

- Contact investigations are conducted to:
  - Refer any contacts, such as fellow passengers or crew, who are identified with fever or signs of respiratory illness, for medical evaluation, laboratory testing, and medical care, as needed.
  - Provide information to exposed passengers and crew so they can recognize any symptoms of illness, then isolate themselves, if needed, and seek medical care.
  - Determine whether MERS-CoV may have spread on the flights and which passengers were at risk.

Symptoms

- Most people confirmed to have MERS-CoV infection have had severe acute respiratory illness.
  - Symptoms included fever, cough, and shortness of breath.
  - Many of them had pneumonia.
  - Some people also had gastrointestinal symptoms, including diarrhea.
  - Some have had kidney failure.
  - More than 30% of them died.

- Some people did not have any symptoms, or had only mild respiratory illness; they recovered.

Risks

- Based on the information we have so far, people with pre-existing health conditions (comorbidities) or weakened immune systems may be more likely to become infected with, or have a severe case of, MERS.
  - Comorbidities from reported cases for which we have information have included diabetes; cancer; and chronic lung, heart, and kidney disease.

Transmission

- In some cases, infected people have spread the virus to others through close contact, such as to people who were caring for or living with them. There is no definitive evidence of sustained spreading of MERS-CoV in the community.

- Infected people have been shown to spread MERS-CoV to others in healthcare settings. This has happened in hospitals in Saudi Arabia, France, Jordan, UAE, and Qatar.
  - A large MERS outbreak occurred April through May 2013 in eastern Saudi Arabia and involved 23 confirmed cases in four healthcare facilities.
  - Additional hospital outbreaks are currently ongoing in Saudi Arabia and the United Arab Emirates.

- Most people who had close contact[2] with people who had MERS-CoV infection did not get infected or ill.
    - This information is based on public health investigations of cases in Jordan, Saudi Arabia, the United Kingdom (UK), France, and Germany.
    - To better understand the risk for infection, additional information is needed about the extent of exposures to infected people, frequency of community and household contacts, and contacts before and during illness.
    - CDC, FDOH, and public health are working with our partners to carefully evaluate the two cases of MERS in the U.S. Through this public health investigation, we hope to gain a better understanding of the virus, risk of transmission, and the spectrum of illness it causes.

- All reported cases have been linked to eight countries in the Arabian Peninsula[1]: Saudi Arabia, Qatar, Jordan, the United Arab Emirates (UAE), Oman, Kuwait, Yemen, and Lebanon.
    - Most infected people either lived in the Arabian Peninsula or recently traveled from the Arabian Peninsula before they became ill.
    - A few people became infected with MERS-CoV after having close contact[2] with an infected person who had recently traveled from the Arabian Peninsula.

- Public health agencies continue to investigate clusters of cases in several countries to better understand how MERS-CoV spreads from person-to-person.

Vaccine and Treatment

- There is no vaccine to prevent MERS-CoV infection at the present time.

- There is no specific antiviral treatment recommended for MERS-CoV infection; medical care can help relieve symptoms. For severe cases, current treatment includes care to support vital organ functions.

- CDC has participated in an interagency working group led by the U.S. National Institutes of Health (NIH) to address the possibility of antiviral treatment, vaccine, and other possible treatments for MERS-CoV infection.
    - NIH has the lead in exploring possibilities for a MERS-CoV vaccine.
    - NIH has supported and conducted foundational work on potential SARS vaccines; this work may be helpful for developing a MERS-CoV vaccine.

- The Food and Drug Administration (FDA) has not approved specific antiviral treatment for people with MERS-CoV infection. Also, CDC, NIH, FDA, and the World Health Organization (WHO) do not currently have recommendations for specific antiviral treatment.

What CDC Has Done to Prepare for MERS Importations to the United States

- CDC continues to closely monitor the MERS situation globally and work with the World Health Organization, health departments and other partners to understand the risks of this virus to the public's health. CDC and FDOH recognize the potential for MERS-CoV to spread further and cause more cases globally and in the United States. In preparation for this, the following has occurred:
    - Enhanced surveillance and laboratory testing capacity in states to detect cases.
    - Developed guidance and tools to conduct public health investigations.
    - Provided recommendations for healthcare infection control and other measures to prevent disease spread.
    - Provided guidance for flight crews, Emergency Medical Service (EMS) units at airports, and U.S. Customs and Border Protection (CPB) officers and health care partners about reporting ill travelers to FDOH.
    - Disseminated up-to-date information to the general public, international travelers, and public health partners.

What the General Public Should do to Protect Themselves

- CDC and FDOH routinely advises that people help protect themselves from respiratory illnesses by taking everyday preventive actions like washing their hands often; avoiding close contact with people who appear sick; avoiding touching the eyes, nose, and mouth with unwashed hands; and disinfecting frequently touched surfaces.

What Recent Travelers From the Arabian Peninsula Should Do

- If you develop a fever and symptoms of respiratory illness, such as cough or shortness of breath, within 14 days after traveling from countries in or near the Arabian Peninsula[1], you should call ahead to a healthcare provider and mention your recent travel. While sick, stay home from work or school and delay future travel to reduce the possibility of spreading illness to others.

What Close Contacts[2] of an Ill Traveler From the Arabian Peninsula Should Do

- If you have had close contact[2] with someone who recently traveled from a country in or near the Arabian Peninsula, and the traveler has/had fever and symptoms of respiratory illness, such as cough or shortness of breath, you should monitor your health for 14 days, starting from the day you were last exposed to the ill person.

- If you develop fever and symptoms of respiratory illness, such as cough or shortness of breath, you should call ahead to a healthcare provider and mention your recent contact with the traveler. While sick, stay home from work or school and delay future travel to reduce the possibility of spreading illness to others.

What People Who Have Had Close Contact[2] With a Confirmed or Probable Case Should Do

- If you have had close contact[2] with someone who has a probable or confirmed MERS-CoV infection, you should contact a healthcare provider for an evaluation and mention your recent close contact with someone known to be infected with MERS-CoV. Your healthcare provider may request laboratory testing and outline additional recommendations, depending on the findings of your evaluation and whether you have symptoms. You most likely will be asked to monitor your health for 14 days, starting from the day you were last exposed to the ill person. Watch for these symptoms:
  - Fever (100°Fahrenheit or 37.7°Celsius, or higher). Take your temperature twice a day.
  - Coughing
  - Shortness of breath
  - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea/vomiting, and runny nose.

- If you develop symptoms, call your healthcare provider as soon as possible. Before your medical appointment, call the healthcare provider and tell him or her about your possible exposure to MERS-CoV. This will help the healthcare provider's office take steps to keep other people from getting infected. Ask your healthcare provider to call the local or state health department.

Travel

- At this time, CDC does not recommend that anyone change their travel plans.

- CDC recommends that travelers stay informed by visiting www.cdc.gov/travel and following @CDCtravel for updates and the latest advice.
  - The travel notice for MERS-CoV was upgraded to a level 2 alert. The travel notice advises people traveling to the Arabian Peninsula[1] for health care work to follow CDC's recommendations for infection control and other travelers to the Arabian Peninsula to take general steps to protect their health.

- CDC is continuing to do surveillance by working with our partners at U.S. ports of entry, including Customs and Border Protection, airlines, and Emergency Medical Service units at airports.
  - CDC has developed guidance to educate partners on the symptoms to watch out for and how to report illnesses to CDC's quarantine station staff.
    - CDC is reaching out to these partners to remind them about what to look for and report to CDC.
  - Together with partners at ports of entry, CDC staff continue to assess ill travelers returning from affected areas who have been reported to CDC.
    - The assessment helps determine whether the ill travelers are at risk for MERS-CoV infection and whether any additional public health actions are needed, such as a referral to a healthcare provider or public health department for evaluation and testing.
    - CDC is advising people who develop fever and symptoms of respiratory illness, such as cough or shortness of breath, within 14 days after traveling from countries in or near the Arabian Peninsula[1] to call ahead to a healthcare provider and mention their recent travel.

- CDC is also educating travelers to monitor their own health after returning from countries in or near the Arabian Peninsula[1].
  - Electronic monitors in airport international arrival areas direct people to information about MERS-CoV.
  - Informational cards are provided to ill travelers, which recommend that they monitor their symptoms, call a doctor to make an appointment, and take steps to protect others from infection.
  - Health Advisory posters about MERS displayed for travelers heading to the Arabian Peninsula to raise awareness about MERS and advise travelers to follow general steps to protect their health.

Where people get more information about MERS

- Florida Department of Health: http://flhealth.gov/mers

- CDC will continue to post new information about MERS on the following websites as it becomes available:

- CDC MERS website: www.cdc.gov/coronavirus/mers/index.html
- Travelers' Health: http://wwwnc.cdc.gov/travel/notices/alert/coronavirus-arabian-peninsula-uk

- WHO coronavirus infections website: www.who.int/csr/disease/coronavirus_infections/en/index.html

[1] Countries in and near the Arabian Peninsula include: Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian territories, Qatar, Saudi Arabia, Syria, the United Arab Emirates (UAE), and Yemen.

[2] Close contact is defined as: a) any person who provided care for the patient, including a healthcare worker or family member, or had similarly close physical contact; or b) any person who stayed at the same place (e.g. lived with, visited) as the patient while the patient was ill.

Clinician Screening Tool for Identifying Patients Under Investigation for Middle East Respiratory Syndrome (MERS) 5/21/14

History of fever AND/OR respiratory illness that may include pneumonia, acute respiratory distress syndrome or other serious respiratory conditions of potentially infectious origin

Does patient require hospitalization for respiratory illness? (e.g. low O_2 sats, hypotension, tachycardia)

Does the patient have a history of fever?

NO

YES

And has any of the following?

A history of **travel TO or FROM** a country in or near the Arabian Peninsula[1] within 14 days before symptom onset?

Residency in a country in or near the Arabian Peninsula[1] within 14 days before symptom onset?

Close contact[2] of a symptomatic person who developed fever and acute respiratory illness (not necessarily pneumonia) within 14 days after traveling from countries in or near the Arabian Peninsula[1]?

Is a member of a **cluster of patients with severe acute respiratory illness** (e.g. fever and pneumonia requiring hospitalization) of unknown etiology in which MERS is being evaluated, in consultation with state and local health departments?

Is the patient clinically stable for outpatient management?

And has any of the following?

A history of **health care employment** in or near the Arabian Peninsula[1] within 14 days before symptom onset

A history of **hospital admission** in or near the Arabian Peninsula[1] within 14 days before symptom onset?

Is a **close contact[2] of a confirmed or probable MERS case**?

NO → STOP: No MERS testing ← NO

YES → THEN ← YES

This patient meets the criterion for a Patient Under Investigation for MERS:

- As soon as MERS-CoV infection is suspected, **a mask should be placed on the patient** and the evaluation should continue after the patient has been placed on standard, **contact, and airborne precautions** to prevent any additional exposures. Further information can be found here: www.flhealth.gov/mers and http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html
- Contact your county health department epidemiology program to discuss testing for MERS coronavirus.

1-Countries considered in or near the Arabian Peninsula: Bahrain, Iraq, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian territories, Qatar, Saudi Arabia, Syria, the United Arab Emirates (UAE), and Yemen.

2-Close contact is defined as a) any person who provided care for the patient, including a health care worker or family member, or had similarly close physical contact; or b) stayed at the same place (e.g. lived with, visited) as the patient while the patient was ill.

Florida Department of Health – Hillsborough County

Division of Community Health • Office of Epidemiology
P.O. Box 5135
Tampa, FL 33675-5135
PHONE: (813) 307-8010 • FAX: (813) 276-2981 **After Hours Reporting All Diseases – (813) 307-8000**

Section 381.0031 (1,2), Florida Statutes, provides that "**Any practitioner**, licensed in Florida to practice medicine, osteopathic medicine, chiropractic, naturopathy, or veterinary medicine, who diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health." The DOH county health departments serve as the Department's representative in this reporting requirement. Furthermore, this Section provides that "Periodically the Department shall issue a list of diseases determined by it to be of public health significance…and shall furnish a copy of said list to the practitioners…."

Reportable Diseases/Conditions in Florida Practitioner* Guide 11/24/08

*Reporting requirements for laboratories differ. For specific information on disease reporting, consult Rule 64D-3, *Florida Administrative Code (FAC)*.

AIDS, HIV – (813) 307-8011
DO NOT FAX

- \+ Acquired Immune Deficiency Syndrome (AIDS)
- \+ Human Immunodeficiency Virus (HIV) infection (all, and including neonates born to an infected woman, exposed newborn)

STD – (813) 307- 8022
Fax (813) 307-8027

- • Chancroid
- • Chlamydia
- • Conjunctivitis (in neonates ≤ 14 days old)
- • Gonorrhea
- • Granuloma inguinale
- • Herpes Simplex Virus (HSV) (in infants up to 60 days old with disseminated infection with involvement of liver, encephalitis and infections limited to skin, eyes and mouth; anogenital in children ≤ 12 years old)
- • Human papilloma virus (HPV) (associated laryngeal papillomas or recurrent respiratory papillomatosis in children ≤ 6 years old; anogenital in children ≤ 12 years)
- • Lymphogranuloma venereum (LGV)
- • Syphilis
- ☎ Syphilis (in pregnant women and neonates)

TB CONTROL – (813) 307-8015 x 4758
Fax- (813) 975-2014

- • Tuberculosis (TB)

CANCER – Tumor Registry Database

- \+ Cancer (except non-melanoma skin cancer, and including benign and borderline intracranial and CNS tumors)

EPIDEMIOLOGY – (813) 307-8010
Fax (813) 276-2981

- ! Any disease outbreak
- ! Any case, cluster of cases, or outbreak of a disease or condition found in the general community or any defined setting such as a hospital, school or other institution, not listed below that is of urgent public health significance. This includes those indicative of person to person spread, zoonotic spread, the presence of an environmental, food or waterborne source of exposure and those that result from a deliberate act of terrorism.
- • Amebic encephalitis
- • Anaplasmosis
- ! Anthrax
- • Arsenic poisoning
- ! Botulism (foodborne, wound, unspecified, other)
- • Botulism (infant)
- ! Brucellosis
- • California serogroup virus (neuroinvasive and non-neuroinvasive disease)
- • Campylobacteriosis
- • Carbon monoxide poisoning
- ! Cholera
- • Ciguatera fish poisoning (Ciguatera)
- • Congenital anomalies
- • Creutzfeldt-Jakob disease (CJD)
- • Cryptosporidiosis
- • Cyclosporiasis
- • Dengue
- ! Diphtheria
- • Eastern equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
- • Ehrlichiosis
- • Encephalitis, other (non-arboviral)
- ☎ Enteric disease due to: *Escherichia coli*, O157:H7; *Escherichia coli*, other pathogenic; *E. coli* including entero- toxigenic, invasive, pathogenic, hemorrhagic, aggregative strains and shiga toxin positive strains
- • Giardiasis (acute)
- ! Glanders
- ! *Haemophilus influenzae* (meningitis and invasive disease)
- • Hansen's disease (Leprosy)
- ☎ Hantavirus infection
- ☎ Hemolytic uremic syndrome
- ☎ Hepatitis A
- • Hepatitis B, C, D, E, and G
- • Hepatitis B surface antigen (HBsAg) (positive in a pregnant woman or a child up to 24 months old)
- ! Influenza due to novel or pandemic strains
- ☎ Influenza-associated pediatric mortality (in persons < 18 years)
- • Lead Poisoning (blood lead level ≥ 10µg/dL); additional reporting requirements exist for hand held and/or on-site blood lead testing technology, see 64D-3 FAC
- • Legionellosis
- • Leptospirosis
- ☎ Listeriosis
- • Lyme disease
- • Malaria
- ! Measles (Rubeola)
- ! Melioidosis
- • Meningitis (bacterial, cryptococcal, mycotic)
- ! Meningococcal disease (includes meningitis and meningococcemia)
- • Mercury poisoning
- • Mumps
- ☎ Neurotoxic shellfish poisoning
- ☎ Pertussis
- • Pesticide-related illness and injury
- ! Plague
- ! Poliomyelitis, paralytic and non-paralytic
- • Psittacosis (Ornithosis)
- • Q Fever
- ☎ Rabies (human, animal)
- ! Rabies (possible exposure)
- ! Ricin toxicity
- • Rocky Mountain spotted fever
- ! Rubella (including congenital)
- • St. Louis encephalitis (SLE) virus disease (neuroinvasive and non-neuroinvasive)
- • Salmonellosis
- • Saxitoxin poisoning (including paralytic shellfish poisoning)(PSP)
- ! Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease
- • Shigellosis
- ! Smallpox
- ☎ *Staphylococcus aureus* (infection with intermediate or full resistance to vancomycin, VISA, VRSA)
- ☎ Staphylococcus enterotoxin B (disease due to)
- • Streptococcal disease (invasive, Group A)
- • *Streptococcus pneumoniae* (invasive disease)
- • Tetanus
- • Toxoplasmosis (acute)
- • Trichinellosis (Trichinosis)
- ! Tularemia
- ☎ Typhoid fever
- ! Typhus fever (disease due to *Rickettsia prowazekii* infection)
- • Typhus fever (disease due to *Rickettsia typhi*, *R. felis* infection)
- ! Vaccinia disease
- • Varicella (Chickenpox)
- • Varicella mortality
- ! Venezuelan equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
- • Vibriosis (Vibrio infections)
- ! Viral hemorrhagic fevers (Ebola, Marburg, Lassa, Machupo)
- • West Nile virus disease (neuroinvasive and non-neuroinvasive)
- • Western equine encephalitis virus disease (neuroinvasive and non-neuroinvasive)
- ! Yellow fever

! = Report immediately 24/7 by phone upon initial suspicion or laboratory test order

☎ = Report immediately 24/7 by phone

• = Report next business day

\+ = Other reporting timeframe

FLORIDA DEPARTMENT OF HEALTH – PRACTITIONER DISEASE REPORT FORM

(Please complete the following information to report the suspect or diagnosis of a disease which is reportable under *Florida Administrative Code* 64D-3.)

DH2136,10/06

Patient Information:

Last Name | Area Code + Phone Number | ☐ Please check here if you would like more copies of the form

First Name | MI | Date of Birth (MMDDYYYY) | Social Security Number (no dashes)

Address

City | State | Zip Code

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/AlaskaNative ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Other: _____

Disease Specific Information:

Date of Onset: | Disease Fatal? ☐ Yes ☐ No

Patient Hospitalized? ☐ Yes ☐ No | Discharge Date:

Hospital Name:

Medicaid Number or Insurance:

Pregnancy Status: ☐ Not Pregnant ☐ Pregnant Number of Months___

Disease or Condition Reporting: For HIV/AIDS and HIV exposed newborns please report per forms indicated in *F.A.C.* 64D-3.

Report immediately upon:

❗ = Initial suspicion 24/7 by phone

☎ = Diagnosis 24/7 by phone

- ☐ Anthrax ☎❗
- ☐ Botulism, foodborne ☎❗
- ☐ Botulism, infant
- ☐ Botulism, other/wound/unspecified ☎❗
- ☐ Brucellosis ☎❗
- ☐ California serogroup virus disease
- ☐ Campylobacteriosis
- ☐ Chancroid
- ☐ Chlamydia
- ☐ Cholera ☎❗
- ☐ Ciguatera fish poisoning
- ☐ *Clostridium perfringens* epsilon toxin
- ☐ Conjunctivitis, in neonatal ≤14 days
- ☐ Creutzfeldt-Jakob disease (CJD)
- ☐ Cryptosporidiosis
- ☐ Cyclosporiasis
- ☐ Dengue
- ☐ Diphtheria ☎❗
- ☐ Eastern equine encephalitis virus disease
- ☐ Ehrlichiosis, human granulocytic (HEG)
- ☐ Ehrlichiosis, human monocytic (HME)
- ☐ Ehrlichiosis, human other or unspecified species
- ☐ Encephalitis, other (non-arboviral)
- ☐ Enteric disease due to *Escherichia coli* O157:H7 ☎
- ☐ Enteric disease due to other pathogenic *Escherichia coli* ☎
- ☐ Giardiasis (acute)
- ☐ Glanders ☎❗
- ☐ Gonorrhea
- ☐ Granuloma inguinale
- ☐ *Haemophilus influenzae*, meningitis and invasive disease ☎❗
- ☐ Hansen's disease
- ☐ Hantavirus infection ☎
- ☐ Hemolytic uremic syndrome ☎
- ☐ Hepatitis, acute A ☎
- ☐ Hepatitis, acute B, C, D, E, G
- ☐ Hepatitis, chronic B, C
- ☐ Hepatitis B surface antigen positive in pregnant woman or child up to 24 months
- ☐ Herpes simplex virus (HSV) in infants up to six months
- ☐ HSV anogenital in children≤12 yrs
- ☐ Human papilloma virus (HPV) anogenital in children≤12 yrs
- ☐ HPV assocated laryngeal papillomas or recurrent respiratory papillomatosis in children ≤6 yrs
- ☐ HPV cancer associated strains
- ☐ Influenza – due to novel or pandemic strains ☎❗
- ☐ Influenza – assocated pediatric mortality in persons <18 yrs ☎
- ☐ Lead poisoning
- ☐ Legionellosis
- ☐ Leptospirosis
- ☐ Listeriosis ☎
- ☐ Lyme disease
- ☐ Lymphogranuloma Venereum (LGV)
- ☐ Malaria
- ☐ Measles (Rubeola) ☎❗
- ☐ Melioidosis ☎❗
- ☐ Meningitis, bacterial, cryptococcal, other mycotic
- ☐ Meningococcal disease ☎❗
- ☐ Mercury poisoning
- ☐ Mumps
- ☐ Neurotoxic shellfish poisoning
- ☐ Pertussis ☎
- ☐ Pesticide-related illness and injury
- ☐ Plague ☎❗
- ☐ Poliomyelitis ☎❗
- ☐ Psittacosis (Ornithosis)
- ☐ Q Fever
- ☐ Rabies, animal ☎
- ☐ Rabies, human ☎
- ☐ Rabies possible exposure (animal bite) ☎❗
- ☐ Ricin toxicity ☎❗
- ☐ Rocky Mountain spotted fever
- ☐ Rubella ☎❗
- ☐ St. Louis encephalitis virus disease
- ☐ Salmonellosis
- ☐ Saxitoxin poisoning, including paralytic shellfish poisoning (PSP)
- ☐ Severe acute respiratory syndrome (SARS) ☎❗
- ☐ Shigellosis
- ☐ Smallpox ☎❗
- ☐ *Staphylococcus aureus*, intermediate or full resistance to vancomycin ☎
- ☐ Staphylococcus enterotoxin B ☎
- ☐ Streptococcal disease, invasive Group A
- ☐ *Streptococcal pneumoniae*, invasive disease
- ☐ Syphilis
- ☐ Syphilis, pregnancy or neonate ☎
- ☐ Tetanus
- ☐ Toxoplasmosis, acute
- ☐ Trichinellosis (Trichinosis)
- ☐ Tuberculosis (TB)
- ☐ Tularemia ☎❗
- ☐ Typhoid fever ☎
- ☐ Typhus fever, endemic
- ☐ Typhus fever, epidemic ☎❗
- ☐ Vaccinia disease ☎❗
- ☐ Varicella (chickenpox) Date of vaccination __/__/__
- ☐ Varicella mortality
- ☐ Venezuelan equine encephalitis virus disease ☎❗
- ☐ Vibriosis, Vibrio infections
- ☐ Viral hemorrhagic fevers ☎❗
- ☐ West Nile virus disease
- ☐ Western equine encephalitis virus disease
- ☐ Yellow fever ☎❗

☐ Any Outbreak, grouping, or clustering of patients having similar disease, symptoms, syndromes: ☎❗ _____

Provider Information:

Name:

Address:

City, State, Zip:

Phone: ( ) Provider Fax: ( )

Email:

County Health Department Fax: 813-276-2981

CHD After-Hours Phone Number: 813-307-8000

Medical Information:

Diagnosis Date:

Test Conducted? ☐ Yes ☐ No

Please attach lab record (if available)

Lab Name:

Lab Test Date: | Lab Results:

Treatment Provided? ☐ Yes ☐ No | Test Method:

Treatment:

Medical Record Number: