

EpiNotes

Florida Department of Health - Hillsborough County Disease Surveillance Newsletter June 2015

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Cases of shigellosis increase nearly 500% in Hillsborough County in 2015

Mackenzie Tewell, MA, MPH, CPH
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Florida Department of Health in Hillsborough County (FDOH-Hillsborough) has seen an increased number of cases of shigellosis in 2015. Year to date, there have been 168 cases of shigellosis in Hillsborough County, compared with 27 in the same time period of 2014 (Table 1). Locally and nationwide, most cases of shigellosis are caused by *Shigella sonnei*. Shigellosis cases diarrhea, vomiting, fever, abdominal cramping and tenesmus, and the stool may contain blood or mucous. Incubation period ranges from 1 to 7 days, but is typically between 1 and 3 days. The illness generally lasts 4-7 days, and is self-limited.

The majority of cases are due to direct or indirect fecal-oral transmission from a symptomatic person or an asymptomatic carrier. Other shigellosis cases may be the result of eating contaminated food, or drinking or swimming in contaminated water. Child care settings are at high risk for outbreaks of shigellosis due to toddlers who are not fully toilet trained and have imperfect hand hygiene. These bacteria are generally shed in the stool for 1-2 weeks after symptoms subside and can be transmitted to others during that time. Appropriate antibiotic therapy has been shown to shorten the period of communicability.

From 2007-2014, 75% of all shigellosis cases in Hillsborough County occurred among individuals aged 19 and under (see graph on page 2). This trend is also echoed in the cases reported so far in 2015.

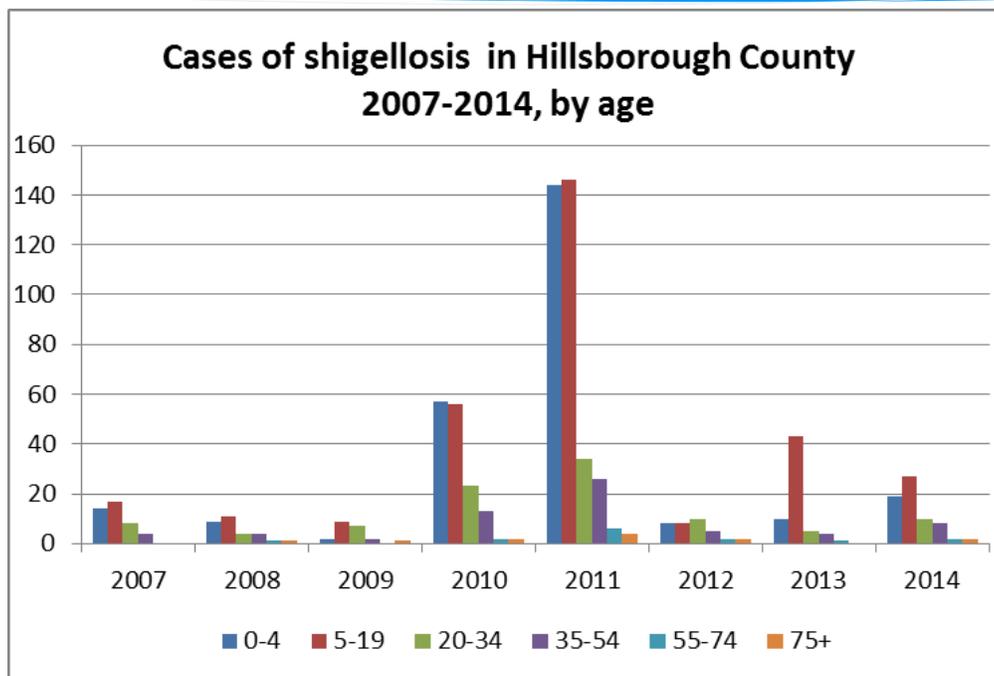
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Mission: To protect, promote & improve the health of all people in Florida through integrated state & community efforts.

Vision: To be **the Healthiest State** in the Nation

Rick Scott
Governor
John H. Armstrong, MD, FACS
State Surgeon General & Secretary





Because shigellosis has a low infective dose, it is easily passed person to person and household attack rates can be as high as 40%. Hillsborough County epidemiologists assess for symptomatic contacts of shigellosis cases during routine interviews, and often find household contacts to be ill. Table 2 displays the total number of shigellosis cases per year, and the percentage of cases that are considered “outbreak associated,” with one or more ill contacts discovered upon interviewing the original case.

Month	2010	2011	2012	2013	2014	2015*
January	3	60	3	0	1	14
February	1	33	4	0	13	25
March	3	55	5	0	5	15
April	1	58	1	0	4	27
May	0	45	3	1	4	74
June	3	39	6	2	0	13
July	6	17	5	1	3	
August	4	17	2	4	4	
September	15	13	5	46	3	
October	20	10	1	6	13	
November	38	12	0	1	12	
December	59	1	0	2	6	

Table 1. Cases of shigellosis in Hillsborough County, by month. *2015 dates calculated through June 25, 2015

Continued on page 3

Year	Total number of shigellosis cases reported	Percentage of cases with at least one additional symptomatic contact upon interview
2007	43	11.6%
2008	30	13.30%
2009	21	0.0%
2010	153	22.2%
2011	360	55.6%
2012	36	44.4%
2013	63	81.0%
2014	68	48.5%
2015*	168	56.5%

Table 2. Total number of cases of shigellosis per year and percentage of cases considered “outbreak associated” in Hillsborough County, 2007-2015.

*2015 cases are year to date

FDOH-Hillsborough requests that medical providers complete stool testing for individuals experiencing symptoms of shigellosis, particularly among children who attend daycare and those who present with letters from FDOH stating they have been exposed to others with shigellosis. As always, please contact FDOH-Hillsborough with any questions regarding exclusion, treatment or additional recommendations for cases of shigellosis.



Attachments: The following documents are attached at the end of this newsletter.

1. **CDC HAN 379: Ciprofloxacin- and Azithromycin-Nonsusceptible Shigellosis in the United States** (originally released 6/4/15)
2. **Florida Department of Health Clinician Screening Tool for Identifying Patients Under Investigation for Middle East Respiratory Syndrome (MERS)**—(originally provided on 6/12/15)
Algorithm for medical providers to determine whether testing is warranted in individuals with suspected MERS.
3. **For ED Doctors: Evaluation and Management of patients who lived in or traveled to West Africa in the previous 21 days**—(updated by CDC on 6/17/15) Provides guidance for assessing patients with travel to West Africa, differentiating between travel to Liberia (outbreak over) versus travel to Sierra Leone and/or Guinea (continuing outbreak).
4. **Miltefosine availability reminder letter**—(originally sent 6/9/15) A letter detailing the availability and instructions on obtaining miltefosine, an investigational drug available for treating suspected primary amebic meningoencephalitis (PAM) cases caused by *Naegleria fowleri*, *Balamuthia mandrillaris* and *Acanthamoeba* species.

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-to-date	
	2012	2013	2014		Jan-May 14	Jan-May 15
Vaccine Preventable Diseases						
Diphtheria	0	0	0	0.00	0	0
Measles	0	0	0	0.00	0	0
Mumps	0	0	2	0.67	0	0
Pertussis	119	95	65	93.00	29	18
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	45	65	59	56.33	33	31
CNS Diseases & Bacteremias						
Creutzfeldt-Jakob Disease	3	1	1	1.67	1	2
<i>H. influenzae</i> (Invasive Disease in children <5)	2	2	3	2.33	2	1
Listeriosis	1	5	2	2.67	1	0
Meningitis (Bacterial, Cryptococcal, Mycotic)	5	11	12	9.33	6	5
Meningococcal Disease	3	6	3	4.00	3	2
<i>Staphylococcus aureus</i> (VISA, VRSA)	1	1	0	0.67	0	0
<i>S. pneumoniae</i> (Invasive Disease in children <6)	5	7	5	5.67	4	1
Enteric Infections						
Campylobacteriosis	105	134	189	142.67	56	104
Cholera	1	0	0	0.33	0	0
Cryptosporidiosis	77	59	354	163.33	18	29
Cyclospora	2	9	4	5.00	0	0
<i>Escherichia coli</i> , Shiga toxin-producing (STEC)	22	30	20	24.00	8	14
Giardiasis	54	56	64	58.00	0	15
Hemolytic Uremic Syndrome	1	2	1	1.33	0	1
Salmonellosis	331	303	362	332.00	95	76
Shigellosis	36	63	68	55.67	27	130
Typhoid Fever	0	0	0	0.00	0	0
Viral Hepatitis						
Hepatitis A	5	10	5	6.67	4	3
Hepatitis B (Acute)	39	56	61	52.00	19	22
Hepatitis C (Acute)	26	38	28	30.67	11	18
Hepatitis +HBsAg in Pregnant Women	38	30	35	34.33	12	10
Hepatitis D, E, G	1	0	0	0.33	0	0

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-to-date	
	2012	2013	2014		Jan-May 14	Jan-May 15
Vectorborne, Zoonoses						
Chikungunya	N/A	N/A	36	N/A	0	8
Dengue	5	4	6	5.00	3	2
Eastern Equine Encephalitis	0	1	0	0.33	0	0
Ehrlichiosis/Anaplasmosis	0	2	2	1.33	0	0
Leptospirosis	0	0	0	0.00	0	0
Lyme Disease	9	12	9	10.00	2	3
Malaria	7	8	11	8.67	3	1
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)	5	6	5	5.33	2	1
Rabies (Human)	0	0	0	0.00	0	0
Rocky Mountain Spotted Fever	1	1	0	0.67	0	0
St. Louis Encephalitis	0	0	0	0.00	0	0
Trichinellosis	0	0	0	0.00	0	0
Tularemia	0	0	0	0.00	0	0
Typhus Fever (Epidemic)	0	0	0	0.00	0	0
Venezuelan Equine Encephalitis	0	0	0	0.00	0	0
West Nile Virus	1	0	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	0	0	0	0.00	0	0
Glanders	0	0	0	0.00	0	0
Hansen's Disease (Leprosy)	2	2	0	1.33	0	0
Hantavirus Infection	0	0	0	0.00	0	0
Legionellosis	8	18	8	11.33	5	7
Melioidosis	0	0	0	0.00	0	0
Vibriosis	13	13	7	11.00	3	1

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-to-date	
	2012	2013	2014		Jan-May 14	Jan-May 15
Chemicals/Poisoning						
Arsenic	0	0	0	0.00	0	0
Carbon Monoxide	4	5	22	10.33	5	6
Lead	329	173	246	249.33	133	123
Mercury	0	0	0	0.00	0	0
Pesticide	4	13	42	19.67	1	14
Influenza						
Influenza, Pediatric Associated Mortality	0	1	1	0.67	1	0
Influenza, Novel or Pandemic Strain	0	0	0	0.00	0	0
HIV/AIDS						
AIDS	172	231	178	193.67	75	82
HIV Infection	327	403	443	391.00	190	191
STDs						
Chlamydia	7124	7220	7461	7268.33	3040	2881
Gonorrhea	2160	2023	1848	2010.33	762	671
Syphilis, Congenital	6	3	4	4.33	0	2
Syphilis, Latent	129	189	166	161.33	74	64
Syphilis, Early	117	124	141	127.33	54	43
Syphilis, Infectious	155	156	208	173.00	101	71
Tuberculosis						
TB	51	54	51	52.00	NA	NA
Food and Waterborne Illness Outbreaks						
Food and Waterborne Cases	74	73	55	67.33	4	0
Food and Waterborne Outbreaks	4	4	3	3.67	1	0

This is an official
CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
June 4, 2015, 14:00 EST (2:00 PM EST)
CDCHAN-00379

Ciprofloxacin- and Azithromycin-Nonsusceptible Shigellosis in the United States

Summary: CDC continues to receive new reports of infections with *Shigella* strains that are not susceptible to ciprofloxacin and/or azithromycin, the antimicrobial agents most commonly used to treat shigellosis. Most cases have been reported among gay, bisexual, and other men who have sex with men (collectively referred to as MSM) in Illinois, Minnesota, and Montana and among international travelers, but cases are also occurring among other populations. Shigellosis is very contagious and can spread quickly through communities and across different segments of the population.

CDC recommends meticulous handwashing and other hygiene practices to prevent shigellosis and encourages patients with symptoms of shigellosis such as diarrhea and fever to visit a healthcare provider. Clinicians should obtain stool cultures from patients suspected of having shigellosis, counsel patients about shigellosis prevention, and, when treatment is required, select drugs based on antimicrobial susceptibility test results.

This Health Alert Network (HAN) Advisory provides the following:

- Information about the current status of the outbreaks;
- Recommendations for clinical management, counseling, and follow-up of exposed patients and their contacts;
- Recommendations on general prevention methods for the public, childcare centers, MSM, and international travelers;
- Information about testing and interpretation of azithromycin susceptibility among shigellae; and
- Information about revisions to CDC's *Shigella* website on shigellosis prevention among MSM.

Background

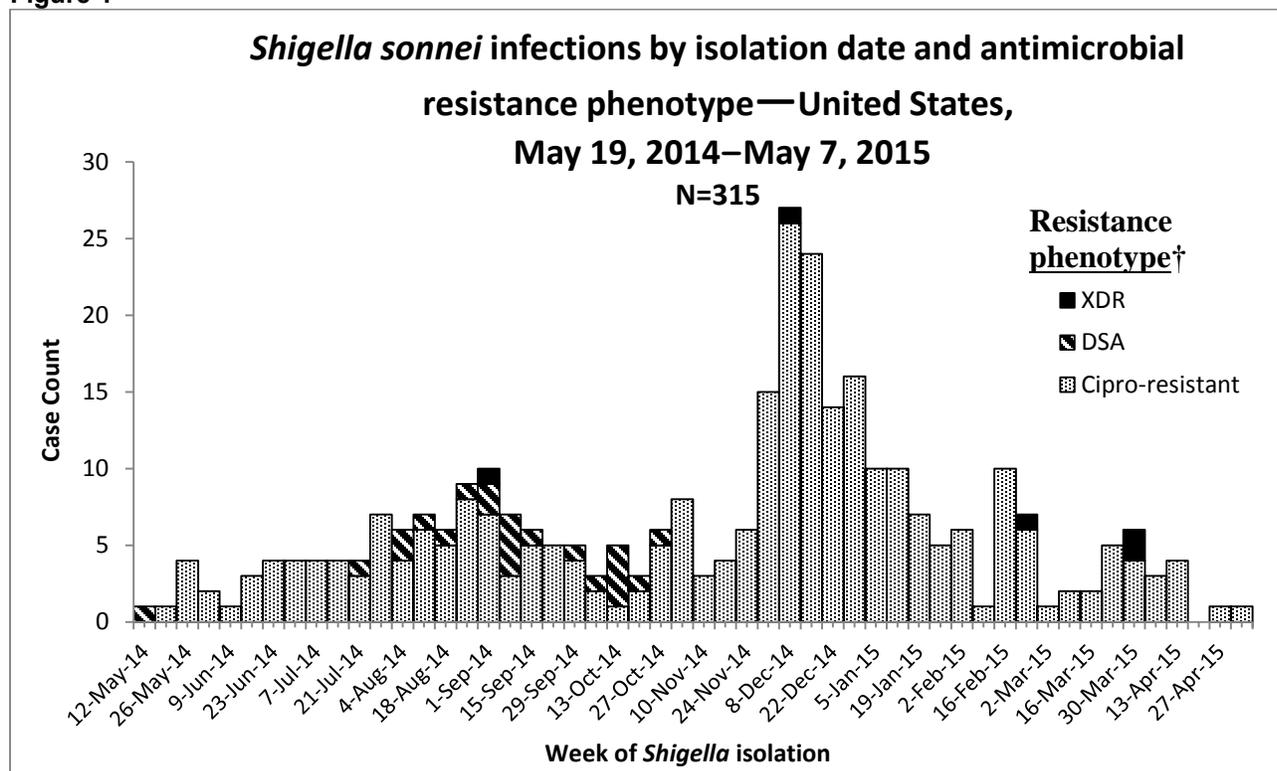
Recent Outbreaks of Multidrug-Resistant *Shigella sonnei* Infections

1. **Extremely drug-resistant (XDR) shigellosis:** As of May 7, 2015, five confirmed cases of XDR shigellosis were identified with onset dates from September 7, 2014 through April 4, 2015, in Illinois and Montana residents. The isolates were tested by CDC's National Antimicrobial Resistance Monitoring System (NARMS) and were resistant to ampicillin, ciprofloxacin, nalidixic acid, streptomycin, sulfisoxazole, tetracycline, and trimethoprim/sulphamethoxazole; had azithromycin minimum inhibitory concentrations >16 µg/ml; and harbored macrolide resistance genes *mphA* and *ermB*. Of the five cases, three self-identified as MSM and two are known to have experienced >14 days of diarrhea. Additionally, in March 2015, a Colorado resident who self-identified as MSM was infected with *S. sonnei* that was resistant to ciprofloxacin, nalidixic acid, and trimethoprim/sulphamethoxazole, and had azithromycin minimum inhibitory concentrations >16 µg/ml. All six of these cases yielded a pulsed-field gel electrophoresis (PFGE) pattern indistinguishable from those associated with an ongoing cluster summarized in 2) below.

2. **Ciprofloxacin-resistant shigellosis:** From May 2014 through April 2015, 179 cases with one of five highly-related PFGE patterns were identified in 34 states and Puerto Rico; approximately half of those who provided information reported international travel before illness onset. Ten of the cases identified by PulseNet, and another 115 cases without PFGE data, were part of an outbreak in San Francisco, California. All San Francisco isolates, and 89% of isolates overall, were resistant to ciprofloxacin. Nineteen cases are known to have occurred among MSM, and several MSM sub-clusters have been reported throughout the United States. A sub-outbreak in a childcare center made 16 people ill. Please see the MMWR report for more information: (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6412a2.htm?s_cid=mm6412a2_e).

3. **Shigellosis with decreased susceptibility to azithromycin (DSA):**¹ MSM in Chicago, Illinois, and metropolitan Minneapolis/St. Paul, Minnesota, were involved in an outbreak from May 13 through December 8, 2014. Twenty-two isolates displayed highly similar PFGE patterns and had DSA; two additional isolates had indistinguishable PFGE patterns but did not undergo antimicrobial susceptibility testing. All 22 patients were adult males; 15 of 17 with information self-identified as MSM, and 12 were known to have HIV infection. An additional case with an indistinguishable PFGE pattern occurred in an MSM in San Francisco in January 2015, but the isolate was not available for azithromycin susceptibility testing. Please see the MMWR report for more information: (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6421a7.htm?s_cid=mm6421a7_w

Figure 1



†DSA, decreased susceptibility to azithromycin. XDR, resistant to at least ampicillin, trimethoprim/sulfamethoxazole, and ciprofloxacin, and with decreased susceptibility to azithromycin

¹ The term decreased susceptibility to azithromycin, or DSA, is used because clinical breakpoints have not been defined for azithromycin susceptibility among shigellae.

General Prevention Recommendations

- Always practice good hygiene, such as washing hands with soap before preparing food or eating and after using the toilet, and follow the recommendations below.
- Childcare centers should:
 - Ensure handwashing stations are at the appropriate height for young children, well-stocked with soap and paper towels, and located near diapering, toilet, food preparation, and dining areas.
 - Require handwashing among children and staff upon arrival at the facility, after diaper changes and toileting, after outdoor play, before eating, and before departing the facility.
 - Follow proper diapering procedures. For more information about this, see: <http://www.cdc.gov/healthywater/pdf/hygiene/Diapering-procedures-childcare-508c.PDF>
 - Assign separate staff to food preparation and diapering.
 - Avoid providing wading pools or basins of water for sensory play.
 - Exclude children and staff with diarrhea as directed by local ordinances.
- MSM should:
 - Avoid sex while ill or while partners are ill with diarrhea and for a few weeks after recovering.
 - Wash hands, genitals, and anus with soap before and after sex.
 - Use barriers such as dental dams and gloves during anal rimming and fisting.
 - Use condoms during anal or oral sex.
 - For more information about *Shigella* infections among MSM, see <http://www.cdc.gov/shigella/msm.html>.
 -
- International travelers should:
 - Strictly observe food, water, and hand hygiene precautions. For more information about this, see <http://www.cdc.gov/shigella/msm.html>.
 - Consider taking bismuth subsalicylate (e.g., Pepto-Bismol, Kaopectate) to prevent travelers' diarrhea.

Recommendations for Shigellosis Patients

Patients infected with *Shigella* can protect others through the following actions:

- All patients should:
 - Wash hands with soap after using the toilet.
 - Not prepare food for others while experiencing diarrhea, if possible.
 - Professional food service workers should follow the guidance of their local health department about exclusion from and return to work.
 - Not swim for 1 week after recovering from diarrhea.
- Children in childcare and childcare staff should:
 - Stay home while ill with shigellosis.
 - Follow the guidance of the local health department about return to the childcare facility.
- MSM should:
 - Avoid sex while ill with diarrhea and for a few weeks after recovering. Shigellae have been documented in stool for as long as 11 weeks after diarrhea has stopped, although most patients are likely to have shigellae in stool for a shorter period of time. Avoid sex for a few weeks after recovering or until a convalescent

stool culture is negative to reduce the likelihood of transmission to sexual partners.

- After resuming sex, protect others by:
 - Washing hands, genitals, and anus with soap before and after sex.
 - Using barriers such as dental dams and gloves during anal rimming and fisting.
 - Using condoms during anal and oral sex.
- For more information about *Shigella* infections among gay and bisexual men, see <http://www.cdc.gov/shigella/msm.html>.

Recommendations for Clinicians

- Obtain stool cultures from patients suspected of having shigellosis.
- Base treatment for shigellosis, when needed, on the antimicrobial susceptibility profile of the individual isolate, or during a local outbreak, that of the outbreak strain.
- Counsel shigellosis patients about the importance of meticulous handwashing after using the toilet, and avoiding activities most likely to transmit the infection to others, such as preparing food for others, swimming, group play among young children, and certain sexual activities (e.g., anal rimming or fisting).
- Recommend symptomatic contacts of shigellosis patients, particularly those suspected to have a multidrug-resistant strain, seek health care.
- For shigellosis patients with treatment failure or prolonged diarrhea, obtain follow-up stool cultures at short intervals (e.g., semi-weekly) until the patient has a negative culture. Shedding of multidrug-resistant shigellae in feces may be prolonged, particularly if the patient was treated with an antimicrobial medication to which the isolate was resistant. Confirming clearance of shigellae from stool will allow more accurate counseling about the timelines appropriate for return to higher-risk activities.

Testing and Interpretation of Azithromycin Susceptibility among Shigellae

Antimicrobial susceptibility testing guidelines and interpretive criteria for azithromycin and *Shigella* have not been published by clinical laboratory organizations, such as the Clinical and Laboratory Standards Institute. CDC's National Antimicrobial Resistance Monitoring System (NARMS) has developed a protocol to test *Shigella* for susceptibility to azithromycin using the disk diffusion method. Health department and clinical laboratories that wish to use the protocol for epidemiologic purposes may contact Davina Campbell at xew9@cdc.gov for more information.

Revisions to CDC's *Shigella* Website, Including Prevention among MSM

CDC recently updated the Frequently Asked Questions page on its *Shigella* website (<http://www.cdc.gov/shigella/general-information.html>). In addition, CDC developed new guidance and a fact sheet on prevention of shigellosis among MSM (<http://www.cdc.gov/shigella/msm.html>).

For More Information

- For more information on *Shigella*, see <http://www.cdc.gov/shigella/index.html> or contact Jacqueline Hurd at xyf2@cdc.gov.

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.

Categories of Health Alert Network messages:

Health Alert Requires immediate action or attention; highest level of importance

Health Advisory May not require immediate action; provides important information for a specific incident or situation

Health Update Unlikely to require immediate action; provides updated information regarding an incident or situation

HAN Info Service Does not require immediate action; provides general public health information

##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##

Clinician Screening Tool for Identifying Patients Under Investigation for Middle East Respiratory Syndrome (MERS)

Only consider persons with:
History of fever *and/or* respiratory illness that may include pneumonia, acute respiratory distress syndrome or other serious respiratory conditions of potentially infectious origin

A
If patient is clinically stable for outpatient management

B
If patient requires hospitalization for respiratory illness (e.g. low O₂ sats, hypotension, tachycardia)

Does the person have any of the following?

- I. A history of health care employment** in or near the Arabian Peninsula¹ or the Republic of Korea in the 14 days before symptom onset
- II. A history of hospital visitation** (e.g. emergency room visit, doctor's appointment, visit someone in the hospital) in or near the Arabian Peninsula¹ or the Republic of Korea in the 14 days before symptom onset
- III. Close contact² of a confirmed or probable MERS case**

Does the person have a history of fever?

NO **YES**

Does the person have any of the following?

- I. History of travel to or from** a country in or near the Arabian Peninsula¹ or the Republic of Korea in the 14 days before symptom onset
- II. Residency** in a country in or near the Arabian Peninsula¹ or the Republic of Korea in the 14 days before symptom onset
- III. Close contact² to a symptomatic person** who developed fever and acute respiratory illness (not necessarily pneumonia) in the 14 days after traveling from countries in or near Arabian Peninsula¹ or the Republic of Korea
- IV. 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

YES **NO**

NO **YES**

STOP: No MERS testing
Continue to treat patient normally and test for influenza.

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 at: flhealth.gov/mers and cdc.gov/coronavirus/mers/infection-prevention-control.html
- Contact your [county health department](#) epidemiology program to discuss testing for MERS coronavirus. Contact list can be found at: flhealth.gov/CHDEpiContact

¹ Countries considered in the Arabian Peninsula and neighboring include: Bahrain, Iraq, Iran, Israel (the West Bank and/or Gaza), Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, the United Arab Emirates, 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) any person who stayed at the same place (e.g. lived with, visited) as the patient while the patient was ill.

For ED Doctors: Evaluation and Management of patients who lived in or traveled to West Africa in the previous 21 days

	Ebola-compatible signs/symptoms (PUIs)	No Ebola-compatible signs/symptoms
Traveled from Sierra Leone/Guinea	<ol style="list-style-type: none"> 1. Isolate (private room) 2. Use Ebola PPE* 3. Notify State/Local DOH and CDC 	<ul style="list-style-type: none"> • Follow standard hospital infection control practices/protocols
Traveled from Liberia only	<ol style="list-style-type: none"> 1. Isolate (private room) 2. Follow standard hospital infection control practices/protocols 3. Notify State/Local DOH and CDC 	<ul style="list-style-type: none"> • Follow standard hospital infection control practices/protocols

For all patients: Clinical judgement is critical. Investigate other potential causes of the patient's signs and symptoms without delay in patient care. Consider acute febrile illnesses, acute upper/lower tract respiratory illnesses and acute gastrointestinal illness. The rapid identification of the cause of an acute illness in a PUI enables rapid treatment and resolution of symptoms.

Person Under Investigation (PUI): Ebola-compatible signs/symptoms AND an epidemiologic risk factor within the 21 days before the onset of symptoms

Ebola-compatible signs/symptoms: Fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal (stomach) pain, unexplained hemorrhage (bleeding or bruising)

***Ebola PPE:**

- **PUIs who do have vomiting, diarrhea, or obvious bleeding includes:** Single-use, impermeable gown or coverall; PAPR hood or NIOSH certified N-95 respirator; If using an N-95 respirator, a disposable surgical hood and disposable full face shield is needed; Two pairs of disposable examination gloves with extended cuffs; Disposable boot covers ; Disposable apron (optional)
- **PUIs who do not have vomiting, diarrhea, or obvious bleeding includes:** Single-use, fluid-resistant gown; Face shield; Face mask; Two pairs of examination gloves where the outer gloves have extended cuffs

<http://www.cdc.gov/vhf/ebola/exposure/risk-factors-when-evaluating-person-for-exposure.html>

<http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html>

<http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html>

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

June 9, 2015

Dear Colleague:

As Florida approaches the warm summer months when swimming activities are more common and when the majority of the primary amebic meningoencephalitis (PAM) cases are diagnosed, the Florida Department of Health (DOH) would like to remind physicians about the availability of the investigational drug, miltefosine, for the treatment of infections caused by free living amebae. The infections include those caused by *Naegleria fowleri*, *Balamuthia mandrillaris* and *Acanthamoeba* species. Physicians who **suspect** they have a patient that has an infection due to a free living amebae are directed to contact the Centers for Disease Control and Prevention (CDC) **immediately** at **770-488-7100**. Confirmatory testing or laboratory evidence of a free living amebae infection is not a prerequisite for contacting CDC. CDC physicians will offer direct consultation services and will release the investigational drug for treatment. The drug can be delivered within hours of the initial consultation in most cases. Additional guidance regarding specimen collection, shipping instructions, and treatment recommendations are also available from CDC during the initial consultation.

After 35 years without a PAM survivor in the United States, during the summer of 2013, two children survived their infections. Their treatment regimens included the drug miltefosine which was provided by CDC.

Amebic encephalitis is a reportable disease in Florida and any suspected case needs to be reported to the county health department or state health department (850-245-4401) within one day. These types of infections should be considered for persons presenting with meningitis like symptoms and a recent history of fresh water exposure. Early diagnosis and reporting are likely critical factors for the effectiveness of any medical treatment regimen. Thank you for your help in keeping our communities safe and healthy.

Sincerely,

Anna Marie Likos, MD, MPH
State Epidemiologist and Director
Division of Disease Control & Health Protection

Reportable Diseases/Conditions in Florida

Practitioner List (Laboratory Requirements Differ)

Effective June 4, 2014



Did you know that you are required* to report certain diseases to your local county health department?

! 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

Birth Defects

+ Congenital anomalies

+ Neonatal abstinence syndrome (NAS)

Cancer

+ Cancer, excluding non-melanoma skin cancer and including benign and borderline intracranial and CNS tumors

HIV/AIDS

+ Acquired immune deficiency syndrome (AIDS)

+ Human immunodeficiency virus (HIV) infection

• HIV, exposed infants <18 months old born to an HIV-infected woman

STDs

• Chancroid

• Chlamydia

• Conjunctivitis in neonates <14 days old

• Gonorrhea

• Granuloma inguinale

• Herpes simplex virus (HSV) in infants <60 days old with disseminated infection and liver involvement; encephalitis; and infections limited to skin, eyes, and mouth; anogenital HSV in children <12 years old

• Human papillomavirus (HPV), associated laryngeal papillomas or recurrent respiratory papillomatosis in children <6 years old; anogenital papillomas in children <12 years old

• Lymphogranuloma venereum (LGV)

• Syphilis

☎ Syphilis in pregnant women and neonates

Tuberculosis

• Tuberculosis (TB)

All Others

! Outbreaks of any disease, any case, cluster of cases, or exposure to an infectious or non-infectious disease, condition, or agent found in the general community or any defined setting (e.g., hospital, school, other institution) not listed that is of urgent public health significance

☎ Amebic encephalitis

! Anthrax

• Arsenic poisoning

• Arboviral diseases not otherwise listed

! Botulism, foodborne, wound, and unspecified

• Botulism, infant

! Brucellosis

• California serogroup virus disease

• Campylobacteriosis

• Carbon monoxide poisoning

• Chikungunya fever

☎ Chikungunya fever, locally acquired

! Cholera (*Vibrio cholerae* type O1)

• Ciguatera fish poisoning

• Creutzfeldt-Jakob disease (CJD)

• Cryptosporidiosis

• Cyclosporiasis

• Dengue fever

☎ Dengue fever, locally acquired

! Diphtheria

• Eastern equine encephalitis

• Ehrlichiosis/anaplasmosis

• *Escherichia coli* infection, Shiga toxin-producing

• Giardiasis, acute

! Glanders

! *Haemophilus influenzae* invasive disease in children <5 years old

• Hansen's disease (leprosy)

☎ Hantavirus infection

☎ Hemolytic uremic syndrome (HUS)

☎ Hepatitis A

• Hepatitis B, C, D, E, and G

• Hepatitis B surface antigen in pregnant women or children <2 years old

☎ Herpes B virus, possible exposure

! Influenza A, novel or pandemic strains

☎ Influenza-associated pediatric mortality in children <18 years old

• Lead poisoning

• Legionellosis

• Leptospirosis

☎ Listeriosis

• Lyme disease

• Malaria

! Measles (rubeola)

! Melioidosis

• Meningitis, bacterial or mycotic

! Meningococcal disease

• Mercury poisoning

• Mumps

☎ Neurotoxic shellfish poisoning

☎ Pertussis

• Pesticide-related illness and injury, acute

! Plague

! Poliomyelitis

• Psittacosis (ornithosis)

• Q Fever

☎ Rabies, animal or human

! Rabies, possible exposure

! Ricin toxin poisoning

• Rocky Mountain spotted fever and other spotted fever rickettsioses

! Rubella

• St. Louis encephalitis

• Salmonellosis

• Saxitoxin poisoning (paralytic shellfish poisoning)

! Severe acute respiratory disease syndrome associated with coronavirus infection

• Shigellosis

! Smallpox

☎ Staphylococcal enterotoxin B poisoning

☎ *Staphylococcus aureus* infection, intermediate or full resistance to vancomycin (VISA, VRSA)

• *Streptococcus pneumoniae* invasive disease in children <6 years old

• Tetanus

• Trichinellosis (trichinosis)

! Tularemia

☎ Typhoid fever (*Salmonella* serotype Typhi)

! Typhus fever, epidemic

! Vaccinia disease

• Varicella (chickenpox)

! Venezuelan equine encephalitis

• Vibriosis (infections of *Vibrio* species and closely related organisms, excluding *Vibrio cholerae* type O1)

! Viral hemorrhagic fevers

• West Nile virus disease

! Yellow fever

*Section 381.0031 (2), *Florida Statutes (F.S.)*, provides that "Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; any hospital licensed under part I of chapter 395; or any laboratory licensed under chapter 483 that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health." Florida's county health departments serve as the Department's representative in this reporting requirement. Furthermore, Section 381.0031 (4), *F.S.* provides that "The department shall periodically issue a list of infectious or noninfectious diseases determined by it to be a threat to public health and therefore of significance to public health and shall furnish a copy of the list to the practitioners..."

Florida Department of Health, Practitioner Disease Report Form



Complete the following information to notify the Florida Department of Health of a reportable disease or condition, as required by Chapter 64D-3, *Florida Administrative Code (FAC)*. This can be filled in electronically.

Print Form

Patient Information

SSN: _____

Last name: _____

First name: _____

Middle: _____

Parent name: _____

Gender: Male Female Unk
 Pregnant: Yes No Unk

Birth date: _____ Death date: _____

Race: American Indian/Alaska Native White
 Asian/Pacific Islander Other
 Black Unk

Ethnicity: Hispanic Non-Hispanic Unk

Address: _____

ZIP: _____ County: _____

City: _____ State: _____

Home phone: _____

Other phone: _____

Emer. phone: _____

Email: _____

Medical Information

MRN: _____

Date onset: _____ Date diagnosis: _____

Died: Yes No Unk

Hospitalized: Yes No Unk

Hospital name: _____

Date admitted: _____ Date discharged: _____

Insurance: _____

Treated: Yes No Unk

Specify treatment:

Laboratory testing: Yes No Unk Attach laboratory result(s) if available.

Provider Information

Physician: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Email: _____

Reportable Diseases and Conditions in Florida

Notify upon suspicion 24/7 by phone **Notify upon diagnosis 24/7 by phone**

HIV/AIDS and HIV-exposed newborn notification should be made using the Adult HIV/AIDS Confidential Case Report Form, CDC 50.42A (revised March 2013) for cases in people ≥13 years old or the Pediatric HIV/AIDS Confidential Case Report, CDC 50.42B (revised March 2003) for cases in people <13 years old. Please contact your local county health department for these forms (visit <http://floridahealth.gov/chdecontact> to obtain CHD contact information). Congenital anomalies and neonatal abstinence syndrome notification occurs when these conditions are reported to the Agency for Health Care Administration in its inpatient discharge data report pursuant to Chapter 59E-7 FAC. Cancer notification should be directly to the Florida Cancer Data System (see <http://fcds.med.miami.edu>). All other notifications should be to the CHD where the patient resides. To obtain CHD contact information, see <http://floridahealth.gov/chdecontact>. See <http://floridahealth.gov/diseasereporting> for other reporting questions.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Amebic encephalitis | <input type="checkbox"/> Glanders | <input type="checkbox"/> Melioidosis | <input type="checkbox"/> Staphylococcal enterotoxin B poisoning |
| <input type="checkbox"/> Anthrax | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Meningitis, bacterial or mycotic | <input type="checkbox"/> Streptococcus pneumoniae invasive disease in child <6 years old |
| <input type="checkbox"/> Arsenic poisoning | <input type="checkbox"/> Granuloma inguinale | <input type="checkbox"/> Meningococcal disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Arboviral disease not listed here | <input type="checkbox"/> Haemophilus influenzae invasive disease in child <5 years old | <input type="checkbox"/> Mercury poisoning | <input type="checkbox"/> Syphilis in pregnant woman or neonate |
| <input type="checkbox"/> Botulism, infant | <input type="checkbox"/> Hansen's disease (leprosy) | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Botulism, foodborne | <input type="checkbox"/> Hantavirus infection | <input type="checkbox"/> Neurotoxic shellfish poisoning | <input type="checkbox"/> Trichinellosis (trichinosis) |
| <input type="checkbox"/> Botulism, wound or unspecified | <input type="checkbox"/> Hemolytic uremic syndrome (HUS) | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Brucellosis | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pesticide-related illness and injury, acute | <input type="checkbox"/> Tularemia |
| <input type="checkbox"/> California serogroup virus disease | <input type="checkbox"/> Hepatitis B, C, D, E, and G | <input type="checkbox"/> Plague | <input type="checkbox"/> Typhoid fever (Salmonella serotype Typhi) |
| <input type="checkbox"/> Campylobacteriosis | <input type="checkbox"/> Hepatitis B surface antigen in pregnant woman or child <2 years old | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Typhus fever, epidemic |
| <input type="checkbox"/> Carbon monoxide poisoning | <input type="checkbox"/> Herpes B virus, possible exposure | <input type="checkbox"/> Psittacosis (ornithosis) | <input type="checkbox"/> Vaccinia disease |
| <input type="checkbox"/> Chancroid | <input type="checkbox"/> Herpes simplex virus (HSV) in infant <60 days old | <input type="checkbox"/> Q Fever | <input type="checkbox"/> Varicella (chickenpox) |
| <input type="checkbox"/> Chikungunya fever | <input type="checkbox"/> HSV, anogenital in child <12 years old | <input type="checkbox"/> Rabies, animal | <input type="checkbox"/> Venezuelan equine encephalitis |
| <input type="checkbox"/> Chikungunya fever, locally acquired | <input type="checkbox"/> Human papillomavirus (HPV), laryngeal papillomas or recurrent respiratory papillomatosis in child <6 years old | <input type="checkbox"/> Rabies, human | <input type="checkbox"/> Vibriosis (infections of Vibrio species and closely related organisms, excluding Vibrio cholerae type O1) |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> HPV, anogenital papillomas in child <12 years old | <input type="checkbox"/> Rabies, possible exposure | <input type="checkbox"/> Viral hemorrhagic fevers |
| <input type="checkbox"/> Cholera (Vibrio cholerae type O1) | <input type="checkbox"/> Influenza A, novel or pandemic strains | <input type="checkbox"/> Ricin toxin poisoning | <input type="checkbox"/> West Nile virus disease |
| <input type="checkbox"/> Ciguatera fish poisoning | <input type="checkbox"/> Influenza-associated pediatric mortality in child <18 years old | <input type="checkbox"/> Rocky Mountain spotted fever or other spotted fever rickettsiosis | <input type="checkbox"/> Yellow fever |
| <input type="checkbox"/> Conjunctivitis in neonate <14 days old | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Rubella | <input type="checkbox"/> Outbreaks of any disease, any case, cluster of cases, or exposure to an infectious or non-infectious disease, condition, or agent found in the general community or any defined setting (e.g., hospital, school, other institution) not listed above that is of urgent public health significance. Please specify: |
| <input type="checkbox"/> Creutzfeldt-Jakob disease (CJD) | <input type="checkbox"/> Legionellosis | <input type="checkbox"/> St. Louis encephalitis | |
| <input type="checkbox"/> Cryptosporidiosis | <input type="checkbox"/> Leptospirosis | <input type="checkbox"/> Salmonellosis | |
| <input type="checkbox"/> Cyclosporiasis | <input type="checkbox"/> Listeriosis | <input type="checkbox"/> Saxitoxin poisoning (paralytic shellfish poisoning) | |
| <input type="checkbox"/> Dengue fever | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Severe acute respiratory disease syndrome associated with coronavirus infection | |
| <input type="checkbox"/> Dengue fever, locally acquired | <input type="checkbox"/> Lymphogranuloma venereum (LGV) | <input type="checkbox"/> Shigellosis | |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Malaria | <input type="checkbox"/> Smallpox | |
| <input type="checkbox"/> Eastern equine encephalitis | <input type="checkbox"/> Measles (rubeola) | <input type="checkbox"/> Staphylococcus aureus infection, intermediate or full resistance to vancomycin (VISA, VRSA) | |
| <input type="checkbox"/> Ehrlichiosis/anaplasmosis | | | |
| <input type="checkbox"/> Escherichia coli infection, Shiga toxin-producing | | | |
| <input type="checkbox"/> Giardiasis, acute | | | |

Comments