Florida Department of Health - Hillsborough County
Disease Surveillance Newsletter
December 2017

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Articles and Attachments Included This Month

Zika Fever Update (December 28, 2017)

The total number of Zika Cases reported in the state of Florida

Infection Type	Infection Count 2016	Infection Count 2017
Travel-Related Infections of Zika	1,122	207
Locally Acquired Infections of Zika	296	2
Undetermined	49	32
Pregnant Women with Lab-Evidence of Zika	299	125

Note, these categories are not mutually exclusive and cannot be added together. Please visit our website to see the full list of travel-related cases by county.

The total number of Zika Cases reported in Hillsborough County

Infection Type	Hillsborough County 2016	Hillsborough County 2017
Travel-Related Infections of Zika	46	9

Florida Food Recalls (November 21 – December 28)

Brand Names	Food	Date of Recall	Health Risk	Link to Recall
Springfield Smoked Fish	Smoked Salmon Products	12/21/2017	Listeria	Details
Kroger Comforts FOR BABY - FDA Alert	Water with Fluoride 1Gallon bottles - Mold/Allergy risk	12/4/2017	Talaromyces penicillium	Details

Health Advisories and Alerts

- **CDC HAN 409: Seasonal Influenza A(H3N2) Activity and Antiviral Treatment of Patients with Influenza**

- **CDC Travel Notices:**
  - 2018 Winter Olympics (PyeongChang 2018)
  - Lunar New Year
  - Carnival and Mardi Gras
  - Measles in Greece and England

Epi in the News

- Foodborne Illness Source Attribution Estimates for 2013 for Salmonella, Escherichia coli O157, Listeria monocytogenes, and Campylobacter Using Multi-Year Outbreak Surveillance Data, United States

Influenza Season

Week 40 (October 1, 2017) marked the official start of influenza season. During flu season, the Florida Department of Health puts out a weekly publication, the Florida Flu Review, summarizing influenza and other respiratory virus surveillance. A new edition to the Flu Review this year is a monthly summary of statewide varicella (chickenpox) and pertussis data.

As of week 51, Hillsborough County is reporting increasing influenza activity. Five outbreaks of influenza or influenza-like illness have been reported in Hillsborough County so far this season. One influenza-associated pediatric mortality was reported in week 46, the first of this influenza season.

Influenza Vaccine in the News

Vaccine Effectiveness

The seasonal influenza vaccine protects against either three or four different strains of influenza. The vaccine is updated each year based on predictions of what types of influenza virus may be circulating in the next season. During and after each influenza season, vaccine effectiveness (VE) is estimated to determine how much the vaccine reduced the risk of flu illness. In a year when most circulating flu strains are similar to the vaccine strains the VE is usually 40-60%.

News stories have circulated recently regarding a preliminary VE estimate of 10% for the Australian flu season. This VE estimate compared the H3N2 circulating virus to the strain in the vaccine; the VE of the other flu vaccine strains was higher. The CDC estimates the VE of the US flu vaccine for 2017-2018 may be better estimated by the 2016-2017 VE for the US, which was 39% for all circulating strains. More information can be found regarding this estimate from the CDC.

Pregnant Women and the Vaccine

In September an article was published that a study found women who had a miscarriage had a higher likelihood of having received an influenza vaccine both the previous year and the current year (within 1-28 days of their miscarriage). Multiple earlier studies have found that it is safe for pregnant women and their babies to receive the vaccine during pregnancy. CDC is continuing to research into this topic.

Influenza vaccine recommendations from the CDC have not changed. Pregnant women are at a higher risk for serious complications from influenza infection and **are recommended vaccination during any trimester of their pregnancy**. CDC also recommends prompt treatment with antiviral medication for high risk individuals who become ill with influenza-like illness during influenza season, including pregnant women. See the attached CDC HAN 409 for further information (page 7).

Recently Published Influenza Vaccine Research

A 2017 study published in the journal Pediatrics was the first of its kind to show that flu vaccination can significantly reduce a child's risk of dying from influenza, particularly among otherwise healthy children.

A study in the journal Clinical Infectious Diseases (CID) showed that flu vaccination reduced deaths, intensive care unit (ICU) admissions, ICU length of stay, and overall duration of hospitalization among hospitalized flu patients.

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-To-Date	
	2014	2015	2016		Jan-Nov 2016	Jan-Nov 2017
Vaccine Preventable Diseases						
Diphtheria	0	0	0	0.00	0	0
Measles	0	0	0	0.00	0	0
Mumps	1	1	2	1.33	2	5
Pertussis	65	41	72	59.33	62	43
Poliomyelitis	0	0	0	0.00	0	0
Rubella	0	0	1	0.33	1	0
Smallpox	0	0	0	0.00	0	0
Tetanus	0	0	0	0.00	0	0
Varicella	59	74	70	67.67	66	29
CNS Diseases & Bacteremias						
Creutzfeldt-Jakob Disease	1	3	3	2.33	2	1
H. influenzae (Invasive Disease in children <5)	3	2	4	3.00	2	4
Listeriosis	2	2	0	1.33	0	3
Meningitis (Bacterial, Cryptococcal, Mycotic)	12	16	9	12.33	8	6
Meningococcal Disease	2	2	2	2.00	2	0
Staphylococcus aureus (VISA, VRSA)	0	0	0	0.00	0	1
S. pneumoniae (Invasive Disease in children <6)	5	2	3	3.33	3	2
Enteric Infections						
Campylobacteriosis	155	152	261	189.33	238	293
Cholera	0	0	0	0.00	0	0
Cryptosporidiosis	351	101	62	171.33	57	51
Cyclospora	4	1	1	2.00	1	12
Escherichia coli, Shiga toxin-producing (STEC)	6	16	12	11.33	12	14
Giardiasis	64	55	105	74.67	98	70
Hemolytic Uremic Syndrome	1	2	1	1.33	1	3
Salmonellosis	343	287	308	312.67	288	299
Shigellosis	66	216	76	119.33	58	157
Typhoid Fever	0	0	1	0.33	1	2
Viral Hepatitis						
Hepatitis A	5	5	5	5.00	4	8
Hepatitis B (Acute)	59	62	55	58.67	46	61
Hepatitis C (Acute)	29	48	32	36.33	30	29
Hepatitis +HBsAg in Pregnant Women	35	27	23	28.33	23	14
Hepatitis D, E, G	0	1	0	0.33	0	1

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-To-Date	
	2014	2015	2016		Jan-Nov 2016	Jan-Nov 2017
Vectorborne, Zoonoses						
Chikungunya	33	10	1	N/A	1	0
Dengue	6	7	2	5.00	2	0
Eastern Equine Encephalitis	0	0	0	0.00	0	0
Ehrlichiosis/Anaplasmosis	2	0	0	0.67	0	0
Leptospirosis	0	1	0	0.33	0	0
Lyme Disease	11	12	7	10.00	7	11
Malaria	11	2	6	6.33	5	5
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	1
Rabies (Animal)	4	3	3	3.33	3	4
Rabies (Human)	0	0	0	0.00	0	0
Rocky Mountain Spotted Fever	0	0	0	0.00	0	2
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	0	2	0	0.67	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	1	0.33	1	0
Glanders	0	0	0	0.00	0	0
Hansen's Disease (Leprosy)	0	0	1	0.33	1	0
Hantavirus Infection	0	0	0	0.00	0	0
Legionellosis	7	20	25	17.33	24	18
Melioidosis	0	0	0	0.00	0	0
Vibriosis	7	11	11	9.67	10	21

Reportable Disease Surveillance Data

Disease Category	Annual Totals			3 Year Average	Year-To-Date	
	2014	2015	2016		Jan-Nov 2016	Jan-Nov 2017
Chemicals/Poisoning						
Arsenic	0	0	0	0.00	0	0
Carbon Monoxide	18	20	20	19.33	19	28
Lead	208	246	154	202.67	150	133
Mercury	0	13	0	4.33	0	3
Pesticide	2	1	2	1.67	2	6
Influenza						
Influenza, Pediatric Associated Mortality	1	0	0	0.33	0	6
Influenza, Novel or Pandemic Strain	0	0	0	0.00	0	0
HIV/AIDS*						
AIDS	167	177	160	172.00	NA	NA
HIV Infection	332	361	330	341.00	NA	NA
STDs						
Chlamydia	7304	7423	8097	7608.00	NA	NA
Gonorrhea	1848	1991	2345	2061.33	NA	NA
Syphilis, Congenital	4	4	2	3.33	NA	NA
Syphilis, Latent	166	199	210	191.67	NA	NA
Syphilis, Early	141	147	198	162.00	NA	NA
Syphilis, Infectious	208	222	223	217.67	NA	NA
Tuberculosis						
TB	49	41	43	44.33	41	25
Food and Waterborne Illness Outbreaks						
Food and Waterborne Cases	58	27	1	28.67	1	NA
Food and Waterborne Outbreaks	3	2	1	2.00	1	NA

"Current HIV Infection data by year of report reflects any case meeting the CDC definition of 'HIV infection' which includes all newly reported HIV cases and newly reported AIDS cases with no previous report of HIV in Florida. If a case is later identified as being previously diagnosed and reported from another state, the case will no longer be reflected as a Florida case and the data will be adjusted accordingly. Data from the most recent calendar years (2016 and 2017) 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.

**Includes confirmed and probable cases reported in Florida residents (regardless of where infection was acquired) by date reported to the Bureau of Epidemiology in Merlin. Data for 2017 are provisional and subject to change until the database closes. Counts are current as of the date and time above, but may change. Please note that counts presented in this table may differ from counts presented in other tables or reports, depending on the criteria used.

Changes in case definitions can result in dramatic changes in case counts. Please see Florida Surveillance Case Definitions on the Bureau of Epidemiology for information on case definition changes (http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/case-def-archive.html).

Reportable Diseases Frequency Report – Also Available in Florida CHARTS
The frequency report is based on reportable disease information received by the Florida Department of Health as mandated under Section 381.0031, Florida Statutes, and Rule 64D-3.029, Florida Administrative Code. Depending on report criteria, counts include confirmed and/or probable cases that have occurred in Florida among Florida residents. This report does not include cases of AIDS, HIV infection, sexually transmitted diseases, or tuberculosis.

This is an official

CDC HEALTH ADVISORY

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CDC HAN-00409

Seasonal Influenza A(H3N2) Activity and Antiviral Treatment of Patients with Influenza

Summary
The Centers for Disease Control and Prevention (CDC) is providing: 1) a notice about increased influenza A(H3N2) activity and its clinical implications; 2) a summary of influenza antiviral drug treatment recommendations; 3) an update about approved treatment drugs and supply this season; and 4) background information for patients about influenza treatment.

Background
In the United States (U.S.), influenza activity has increased significantly over recent weeks with influenza A(H3N2) viruses predominating so far this season. In the past, A(H3N2) virus-predominant influenza seasons have been associated with more hospitalizations and deaths in persons aged 65 years and older and young children compared to other age groups. In addition, influenza vaccine effectiveness (VE) in general has been lower against A(H3N2) viruses than against influenza A(H1N1)pdm09 or influenza B viruses. Last season, VE against circulating influenza A(H3N2) viruses was estimated to be 32% in the U.S. CDC expects that VE could be similar this season, should the same A(H3N2) viruses continue to predominate. For this reason, in addition to influenza vaccination for prevention of influenza, the use of antiviral medications for treatment of influenza becomes even more important than usual. The neuraminidase inhibitor (NAI) antiviral medications are most effective in treating influenza and reducing complications when treatment is started early. Evidence from previous influenza seasons suggests that NAI antivirals are underutilized in outpatients and hospitalized patients with influenza who are recommended for treatment.

This CDC Health Advisory is being issued to—

1) Remind clinicians that influenza should be high on their list of possible diagnoses for ill patients because influenza activity is increasing nationwide, and
2) Advise clinicians that all hospitalized patients and all high-risk patients (either hospitalized or outpatient) with suspected influenza should be treated as soon as possible with a neuraminidase inhibitor antiviral. While antiviral drugs work best when treatment is started within 2 days of illness onset, clinical benefit has been observed even when treatment is initiated later.

Recommendations

1. CDC Antiviral Recommendations for the 2017–2018 Season

CDC recommends antiviral medications for treatment of influenza as an important adjunct to annual influenza vaccination. Treatment with neuraminidase inhibitors has been shown to have clinical and public health benefit in reducing illness and severe outcomes of influenza based on evidence from randomized controlled trials, meta-analyses of randomized controlled trials, and observational studies during past influenza seasons and during the 2009 H1N1 pandemic.[1,2,3,4,5,6]

2. All Hospitalized, Severely Ill, and High-Risk Patients with Suspected or Confirmed Influenza Should Be Treated with Antivirals

Any patient with suspected or confirmed influenza in the following categories should be treated as soon as possible with a neuraminidase inhibitor:

1) Any patient who is hospitalized—treatment is recommended for all hospitalized patients;

2) Any patient who has severe, complicated, or progressive illness—this may include outpatients with severe or prolonged progressive symptoms or who develop complications such as pneumonia but who are not hospitalized;

3) Any patient who is at higher risk for influenza complications but not hospitalized. Patients in this group include—

- children younger than 2 years (although all children younger than 5 years are considered at higher risk for complications from influenza, the highest risk is for those younger than 2 years)
- adults aged 65 years and older
- persons with chronic pulmonary (including asthma), cardiovascular (except hypertension alone), renal, hepatic, hematological (including sickle cell disease), and metabolic disorders (including diabetes mellitus), or neurologic and neurodevelopment conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual disability [mental retardation], moderate to severe developmental delay, muscular dystrophy, or spinal cord injury)
- people with immunosuppression, including that caused by medications or by HIV infection
- women who are pregnant or postpartum (within 2 weeks after delivery)
- people aged younger than 19 years who are receiving long-term aspirin therapy
- American Indians/Alaska Natives
- people with extreme obesity (i.e., body-mass index is equal to or greater than 40)
- residents of nursing homes and other chronic-care facilities

3. Timing of Treatment and Implications for Patient Evaluation, Treatment, and Testing

Clinical benefit is greatest when antiviral treatment is administered as early as possible after illness onset. Therefore, antiviral treatment should be started as soon as possible after illness onset and **should not be delayed** even for a few hours to wait for the results of testing. Ideally, treatment should be initiated within 48 hours of symptom onset. **However, antiviral treatment initiated later than 48 hours after illness onset can still be beneficial for some patients.**

A very large observational study of more than 29,000 hospitalized influenza patients reported that while the greatest clinical benefit was found when antiviral treatment was initiated within 48 hours of illness onset, starting antiviral treatment more than 2 days after onset had survival benefit in adults versus no treatment.[6] Also, a randomized, placebo-controlled study suggested clinical benefit when oseltamivir was initiated 72 hours after illness onset among febrile children with uncomplicated influenza.[7] Clinical judgment, on the basis of the patient's disease severity and progression, age, underlying medical conditions, likelihood of influenza, and time since onset of symptoms, is important when making antiviral treatment decisions for outpatients, particularly those who are not at increased risk for influenza complications.

Because of the importance of early treatment, **decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza**. Therefore, empiric antiviral treatment should generally be initiated as soon as possible when there is known influenza activity in the community. A history of current season influenza vaccination does not exclude a diagnosis of influenza in an ill child or adult. During influenza season especially, high-risk patients should be advised to call their provider promptly if they have symptoms of influenza. It may be useful for providers to implement phone triage lines to enable high-risk patients to discuss symptoms over the phone. To facilitate early initiation of treatment, when feasible, an antiviral prescription can be provided without testing and before an office visit.

4. Influenza Testing

Information to assist clinicians about influenza testing decisions is available at https://www.cdc.gov/flu/professionals/diagnosis/consider-influenza-testing.htm. The most accurate influenza tests are molecular assays. Rapid molecular assays are available in clinical settings that can detect influenza virus nucleic acids in respiratory specimens in 15-30 minutes with high sensitivity and specificity. Other approved molecular assays can yield results in 60-80 minutes or in several hours with very high sensitivity and specificity.

For hospitalized patients with suspected influenza, molecular assays are recommended. Information on influenza molecular assays is available at https://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm. Rapid influenza diagnostic tests (RIDTs) with an analyzer device can detect influenza A and B viral nucleoprotein antigens in respiratory specimens in 10-15 minutes with moderate sensitivity, and RIDTs without an analyzer device have low to moderate sensitivity compared with reverse transcription-polymerase chain reaction (RT-PCR).

Proper interpretation of influenza testing results is important to guide optimal management of influenza patients. An algorithm to assist clinicians in interpreting the results of influenza testing when influenza viruses ARE circulating in the community is available at https://www.cdc.gov/flu/professionals/diagnosis/algorithm-results-circulating.htm. **Clinicians should be aware that a negative RIDT result does not exclude a diagnosis of influenza in a patient with suspected influenza when there is influenza activity in the community.** Other factors such as the quality of the specimen, the source of the specimen in the respiratory tract, and the timing of specimen collection in relationship to illness onset, may also affect test results.

5. Antivirals in Non-High Risk Patients with Uncomplicated Influenza

Neuraminidase inhibitors can benefit other individuals with influenza. While current guidance focuses on antiviral treatment of those with severe illness or at high risk of complications from influenza, antiviral treatment may be prescribed on the basis of clinical judgment for any previously healthy (non-high risk) outpatient with suspected or confirmed influenza who presents within 2 days after illness onset. Neuraminidase inhibitors can reduce the duration of uncomplicated influenza illness by approximately 1 day when started within 2 days after illness onset in otherwise healthy persons. It is possible that antiviral treatment started after 48 hours may offer some benefit. [7]

6. Antiviral Medications

Three prescription neuraminidase inhibitor antiviral medications are approved by the U.S. Food and Drug Administration (FDA) and are recommended for use in the U.S. during the 2017–2018 influenza season: oseltamivir (available as a generic version or under the trade name Tamiflu®), zanamivir (Relenza®), and peramivir (Rapivab®).

- Oral oseltamivir is FDA-approved for treatment of uncomplicated influenza within 2 days of illness onset in persons aged 2 weeks and older, and for chemoprophylaxis to prevent influenza in people 1 year of age and older. Although not part of the FDA-approved indications, use of oral oseltamivir for treatment of influenza in infants younger than 14 days old, and for chemoprophylaxis in infants 3 months to 1 year of age, is recommended by CDC and the

American Academy of Pediatrics. Due to limited data, use of oseltamivir for chemoprophylaxis is not recommended in children younger than 3 months unless the situation is judged critical. CDC recommends oseltamivir treatment as soon as possible for hospitalized patients with suspected or confirmed influenza, high-risk outpatients with suspected or confirmed influenza, and those with progressive disease.

- Inhaled zanamivir is FDA-approved for treatment of uncomplicated influenza within 2 days of illness onset in persons 7 years and older and for prevention of influenza in persons 5 years and older. Inhaled zanamivir is not recommended for treatment of influenza in hospitalized patients due to limited data.

- Intravenous peramivir is FDA-approved for the treatment of acute uncomplicated influenza within 2 days of illness onset in persons aged 2 years and older.

Adamantanes (rimantadine and amantadine) are not currently recommended for antiviral treatment or chemoprophylaxis of influenza A because of high levels of resistance among circulating influenza A viruses.

There are no current national shortages of neuraminidase inhibitors (i.e., oseltamivir, zanamivir and peramivir), and manufacturers report they expect to meet projected seasonal demands. If there is difficulty locating oseltamivir for oral suspension, as there has been in some previous seasons, oral suspension can be compounded by a pharmacy from oseltamivir capsules. However, this compounded suspension should not be used for convenience or when oseltamivir oral suspension is commercially available.

More information about compounding an oral suspension from oseltamivir 75 mg capsules can be found at https://www.gene.com/download/pdf/tamiflu_prescribing.pdf

Additional Considerations for Clinicians

- **Bacterial Infections:** Antibiotics are not effective against influenza virus infection, and early diagnosis of influenza can reduce the inappropriate use of antibiotics if bacterial co-infection is not suspected. However, because certain bacterial infections can produce symptoms similar to influenza and bacterial infections can occur as a complication of influenza, bacterial infections should be considered and appropriately treated, if suspected. In addition, because pneumococcal infections are a serious complication of influenza infection, current pneumococcal vaccine recommendations for adults 65 years of age or older, as well as adults and children at increased risk for invasive pneumococcal disease due to chronic underlying medical conditions, should be followed (see http://www.cdc.gov/vaccines/vpd-vac/pneumo/vac-PCV13-adults.htm and http://www.cdc.gov/vaccines/vpd-vac/pneumo/vacc-in-short.htm for further information).

- **Adverse Events and Antiviral Use**: The most common adverse events associated with oral oseltamivir include a slightly increased risk of nausea and vomiting as compared to placebo, with nausea occurring in 10% of adults with influenza who received oseltamivir and 6% of people who received placebo in controlled clinical trials (3% and 4%, respectively, in children), and vomiting occurring in 9% of adults with influenza who received oseltamivir and 3% of people who received placebo in controlled clinical trials (15% and 9%, respectively, in children). These symptoms are generally transient and can be mitigated if oseltamivir is taken with food. Adverse events for inhaled zanamivir were not increased as compared to placebo in clinical trials, but cases of bronchospasm have been reported during post marketing; inhaled zanamivir is not recommended for persons with underlying airways disease (e.g., asthma or chronic obstructive pulmonary diseases). For people who received peramivir intravenously or intramuscularly in clinical trials, the most common adverse event was diarrhea, occurring in 8% versus 7% in people who received placebo.

Resources for Patient Education

Results from unpublished CDC qualitative research shows that most people interviewed were not aware that drugs to treat influenza illness are available. A fact sheet for patients is available at http://www.cdc.gov/flu/antivirals/whatyoushould.htm.

Note the following important background information for patients:

- If you get the flu, antiviral drugs are a treatment option.
- It is very important that antiviral drugs are used early to treat hospitalized patients, people with severe flu illness, and people who are at high risk for flu complications because of their age, severity of illness, or underlying medical conditions.
- If you have severe illness or are at high risk of serious flu complications, you may be treated with flu antiviral drugs if you get the flu.
- If you have a high-risk condition, treatment with an antiviral drug can mean the difference between having milder illness instead of very serious illness that could result in a hospital stay.
- Other people also may be treated with antiviral drugs by their doctor this season. Most otherwise-healthy people who get the flu, however, do not need to be treated with antiviral drugs.
- Studies show that flu antiviral drugs work best for treatment when they are started within 2 days of getting sick. However, starting antivirals later can still be helpful for some people.
- If your health care provider thinks you have the flu, your health care provider may prescribe antiviral drugs. A test for flu is not necessary.
- Antibiotics are not effective against the flu. Using antibiotics inappropriately can lead to antibiotic resistance and may expose patients to unwanted side effects of the drug.
- Other practices that may help decrease the spread of influenza include respiratory hygiene, cough etiquette, social distancing (e.g., staying home from work and school when ill, staying away from people who are sick) and hand washing.

Additional Resources

- Summary of Influenza Antiviral Treatment Recommendations for Clinicians: http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm
- Clinical Description and Lab Diagnosis of Influenza: http://www.cdc.gov/flu/professionals/diagnosis/index.htm
- Guidance for Clinicians on the Use of RT-PCR and Other Molecular Assays for Diagnosis of Influenza Virus Infection: http://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm
- Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities: http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm
- Influenza Virus Testing in Investigational Outbreaks in Institutional or Other Closed Settings: https://www.cdc.gov/flu/professionals/diagnosis/guide-virus-diagnostic-tests.htm

- FDA Influenza (Flu) Antiviral Drugs and Related Information (including package inserts): http://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm100228.htm

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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##

Reportable Diseases/Conditions in Florida

Practitioner List (Laboratory Requirements Differ)

Per Rule 64D-3.029, Florida Administrative Code, promulgated October 20, 2016

Florida Department of Health

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

You are an invaluable part of disease surveillance in Florida!
Please visit www.FloridaHealth.gov/DiseaseReporting for more information. To report a disease or condition, contact your CHD epidemiology program (www.FloridaHealth.gov/CHDEpiContact). If unable to reach your CHD, please call the Department's Bureau of Epidemiology at (850) 245-4401.

!	**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

- ! **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**
- \+ Acquired immune deficiency syndrome (AIDS)
- ☎ **Amebic encephalitis**
- ! **Anthrax**
- • Arsenic poisoning
- ! **Arboviral diseases not otherwise listed**
- • Babesiosis
- ! **Botulism, foodborne, wound, and unspecified**
- • Botulism, infant
- ! **Brucellosis**
- • California serogroup virus disease
- • Campylobacteriosis
- \+ Cancer, excluding non-melanoma skin cancer and including benign and borderline intracranial and CNS tumors
- • Carbon monoxide poisoning
- • Chancroid
- • Chikungunya fever
- ☎ **Chikungunya fever, locally acquired**
- • Chlamydia
- ! **Cholera (*Vibrio cholerae* type O1)**
- • Ciguatera fish poisoning
- \+ Congenital anomalies
- • Conjunctivitis in neonates <14 days old
- • Creutzfeldt-Jakob disease (CJD)
- • Cryptosporidiosis
- • Cyclosporiasis
- ! **Dengue fever**
- ! **Diphtheria**
- • Eastern equine encephalitis
- • Ehrlichiosis/anaplasmosis
- • *Escherichia coli* infection, Shiga toxin-producing
- • Giardiasis, acute
- ! **Glanders**
- • Gonorrhea
- • Granuloma inguinale
- ! ***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 and children <2 years old
- ☎ **Herpes B virus, possible exposure**
- • 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 immunodeficiency virus (HIV) infection
- • HIV-exposed infants <18 months old born to an HIV-infected woman
- • Human papillomavirus (HPV)-associated laryngeal papillomas or recurrent respiratory papillomatosis in children <6 years old; anogenital papillomas in children ≤12 years old
- ! **Influenza A, novel or pandemic strains**
- ☎ **Influenza-associated pediatric mortality in children <18 years old**
- • Lead poisoning (blood lead level ≥5 µg/dL)
- • Legionellosis
- • Leptospirosis
- ☎ **Listeriosis**
- • Lyme disease
- • Lymphogranuloma venereum (LGV)
- • Malaria
- ! **Measles (rubeola)**
- ! **Melioidosis**
- • Meningitis, bacterial or mycotic
- ! **Meningococcal disease**
- • Mercury poisoning
- • Mumps
- \+ Neonatal abstinence syndrome (NAS)
- ☎ **Neurotoxic shellfish poisoning**
- ☎ **Paratyphoid fever (*Salmonella* serotypes Paratyphi A, Paratyphi B, and Paratyphi C)**
- ☎ **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**
- • Syphilis
- ☎ **Syphilis in pregnant women and neonates**
- • Tetanus
- • Trichinellosis (trichinosis)
- • Tuberculosis (TB)
- ! **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**
- ! **Zika fever**

***Coming soon*: "What's Reportable?" app for iOS and Android**

*Subsection 381.0031(2), Florida Statutes, 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, subsection 381.0031(4), Florida Statutes, 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…"

Practitioner Disease Report Form

Complete the following information to notify the Florida Department of Health of a reportable disease or condition. This can be filled in electronically.

Per Rule 64D 3.029, Florida Administrative Code, promulgated October 20, 2016 (laboratory reporting requirements differ).

Patient Information

SSN: _____

Last name: _____

First name: _____

Middle: _____

Parent name: _____

Gender: ○ Male ○ Female ○ Unknown

If female, pregnant: ○ Yes ○ No ○ Unknown

Birth date: _____ Death date: _____

Race: ○ American Indian/Alaska native ○ Asian/Pacific islander ○ Black ○ White ○ Other ○ Unknown

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown

Address: _____

ZIP: _____ **County:** _____

City: _____ **State:** _____

Home phone: _____

Other phone: _____

Emergency phone: _____

Email: _____

Medical Information

MRN: _____

Date onset: _____ **Date diagnosis:** _____

Died: ○ Yes ○ No ○ Unknown

Hospitalized: ○ Yes ○ No ○ Unknown

Hospital name: _____

Date admitted: _____ Date discharged: _____

Insurance: _____

Treated: ○ Yes ○ No ○ Unknown

Specify treatment: _____

Laboratory testing: ○ Yes ○ No ○ Unknown Attach laboratory result(s) if available

Provider Information

Physician: _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____

Fax: _____

Email: _____

To obtain local county health department contact information, see www.FloridaHealth.gov/CHDEpiContact**. See www.FloridaHealth.gov/DiseaseReporting for other reporting questions. 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 county health department for these forms (visit www.FloridaHealth.gov/CHDEpiContact to obtain 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 (http://fcds.med.miami.edu). All other notifications should be to the CHD where the patient resides.

Reportable Diseases and Conditions in Florida

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

- ☎ ☐ Amebic encephalitis
- **!** ☐ Anthrax
- ☐ Arsenic poisoning
- **!** ☐ Arboviral diseases not otherwise listed
- ☐ Babesiosis
- **!** ☐ Botulism, foodborne, wound, and unspecified
- ☐ Botulism, infant
- **!** ☐ Brucellosis
- ☐ California serogroup virus disease
- ☐ Campylobacteriosis
- ☐ Carbon monoxide poisoning
- ☐ Chancroid
- ☐ Chikungunya fever
- ☎ ☐ Chikungunya fever, locally acquired
- ☐ Chlamydia
- **!** ☐ Cholera (*Vibrio cholerae* type O1)
- ☐ Ciguatera fish poisoning
- ☐ Conjunctivitis in neonates <14 days old
- ☐ Creutzfeldt-Jakob disease (CJD)
- ☐ Cryptosporidiosis
- ☐ Cyclosporiasis
- **!** ☐ Dengue fever
- **!** ☐ Diphtheria
- ☐ Eastern equine encephalitis
- ☐ Ehrlichiosis/anaplasmosis
- ☐ *Escherichia coli* infection, Shiga toxin-producing
- ☐ Giardiasis, acute
- **!** ☐ Glanders
- ☐ Gonorrhea
- ☐ Granuloma inguinale
- **!** ☐ *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 and children <2 years old
- ☎ ☐ Herpes B virus, possible exposure
- ☐ 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
- **!** ☐ Influenza A, novel or pandemic strains
- ☎ ☐ Influenza-associated pediatric mortality in children <18 years old
- ☐ Lead poisoning (blood lead level ≥5 ug/dL)
- ☐ Legionellosis
- ☐ Leptospirosis
- ☎ ☐ Listeriosis
- ☐ Lyme disease
- ☐ Lymphogranuloma venereum (LGV)
- ☐ Malaria
- **!** ☐ Measles (rubeola)
- **!** ☐ Melioidosis
- ☐ Meningitis, bacterial or mycotic
- **!** ☐ Meningococcal disease
- ☐ Mercury poisoning
- ☐ Mumps
- ☎ ☐ Neurotoxic shellfish poisoning
- ☎ ☐ Paratyphoid fever (*Salmonella* serotypes Paratyphi A, Paratyphi B, and Paratyphi C)
- ☎ ☐ Pertussis
- ☐ Pesticide-related illness and injury, acute
- **!** ☐ Plague
- **!** ☐ Poliomyelitis
- ☐ Psittacosis (ornithosis)
- ☐ Q Fever
- ☎ ☐ Rabies, animal or human
- **!** ☐ Rabies, possible exposure
- **!** ☐ Ricin toxin poisoning
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- **!** ☐ Rubella
- ☐ St. Louis encephalitis
- ☐ Salmonellosis
- ☐ Saxitoxin poisoning (paralytic shellfish poisoning)
- **!** ☐ Severe acute respiratory disease syndrome associated with coronavirus infection
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- ☎ ☐ Syphilis in pregnant women and neonates
- ☐ Tetanus
- ☐ Trichinellosis (trichinosis)
- ☐ Tuberculosis (TB)
- **!** ☐ Tularemia
- ☎ ☐ Typhoid fever (*Salmonella* serotype Typhi)
- **!** ☐ Typhus fever, epidemic
- **!** ☐ Vaccinia disease
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- **!** ☐ 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
- **!** ☐ Zika fever
- **!** ☐ 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. Specify in comments below.

Comments: _____

***Coming soon*:**
"What's Reportable?" app for iOS and Android