



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Emerging and Acute Infectious Disease Guidelines (EAIDG)

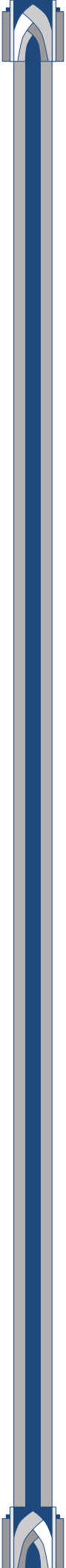
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INTRODUCTION

The purpose of this handbook is to provide a centralized resource for outbreak and reportable disease investigations to local and regional health departments in Texas. This handbook is intended as a tool to help local and regional public health staff with their surveillance activities and investigations. Our hope is that this handbook will continue to grow over the years and highlight some of the best investigation practices in the state.

This handbook will be reviewed annually and updated if needed by the **Texas Department of State Health Services (DSHS) - Emerging and Acute Infectious Disease Branch (EAIDB)**. Disease investigation sections are individually maintained by the following teams (please refer to the table on the next page):

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EAIDB Teams

FB	HCS	HCID	IRID	VPD
Amebiasis	Carbapenem- resistant <i>Enterobacteriaceae</i> (CRE)	Ascariasis	Amebic Meningitis/Encephalitis	Acute Flaccid Myelitis (AFM)
Botulism	Multidrug-resistant <i>Acinetobacter</i> (MDR-A)	Ebola	Influenza A- Novel/Variant	Congenital Rubella Syndrome (CRS)
Campylobacteriosis	Vancomycin- intermediate <i>Staphylococcus aureus</i> (VISA)/ Vancomycin-resistant <i>Staphylococcus aureus</i> (VRSA)	*Hepatitis C, acute	Influenza-Associated Pediatric Mortality	Diphtheria
Cryptosporidiosis		Hookworm (ancylostomiasis)	Legionellosis	<i>Haemophilus influenzae</i>
Cyclosporiasis		Trichuriasis	Novel Coronavirus	Hepatitis A
Fascioliasis		Viral Hemorrhagic Fever (non- Ebola)	<i>Streptococcus pyogenes</i> , Invasive (Group A <i>Streptococcus</i>)	Hepatitis B, acute and perinatal
GI outbreaks			<i>Streptococcus agalactiae</i> , Invasive (Group B <i>Streptococcus</i>)	Measles
Hepatitis E				Meningococcal Disease
Listeriosis				Mumps
Norovirus outbreaks				Pertussis
Paragonimiasis				Polio (paralytic and non- paralytic infection)
Salmonellosis (non- typhoidal)				Rubella
Shiga toxin- producing <i>E. coli</i>				<i>Streptococcus pneumoniae</i> , Invasive
Shigellosis				Tetanus
Typhoid Fever				Varicella
Vibriosis				
Yersiniosis				

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Acute Flaccid Myelitis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

There are multiple infectious agents that can cause acute flaccid myelitis (AFM). Conditions like AFM can be caused by a variety of germs, including several viruses:

- Enteroviruses
- West Nile Virus (WNV) and viruses in the same family as WNV, specifically Japanese encephalitis virus and South Louis encephalitis viruses, and
- Adenoviruses

Transmission

Mode of transmission is dependent on the infectious agent.

Incubation Period

Incubation period is dependent on the infectious agent.

Communicability

Although the underlying infection may be communicable, the condition of AFM is usually a rare complication.

Clinical Illness

Acute flaccid myelitis is a clinical syndrome characterized by sudden limb weakness (weakness or paralysis in one or more extremities, but not generalized to the entire body) and loss of muscle tone and reflexes. Some patients, in addition to the limb weakness, will experience:

- Facial droop/weakness
- Difficulty moving the eyes
- Drooping eyelids
- Difficulty with swallowing or slurred speech

Numbness or tingling is rare in patients with AFM, though some patients have pain in their arms or legs. Some patients with AFM may be unable to pass urine. The most severe symptoms of AFM is respiratory failure that can happen when the muscles involved with breathing become weak. This can require urgent ventilator support (breathing machines).

DEFINITIONS

Clinical Case Definition

An illness with onset of acute focal limb weakness. Multiple etiologic agents may cause acute flaccid myelitis.

Laboratory Criteria for Diagnosis

- A magnetic resonance image (MRI) showing a spinal cord lesion largely restricted to gray matter* and spanning one or more spinal segments
- A specific pathogen is not needed to confirm the diagnosis.

*Terms in the spinal cord MRI report such as “affecting mostly gray matter,” “affecting the anterior horn or anterior horn cells,” “affecting the central cord,” “anterior myelitis,” or “poliomyelitis” would all be consistent with this terminology. If still unsure if this criterion is met, consider consulting the neurologist or radiologist directly.

Case Classification

- **Confirmed:**
 - An illness with onset of acute focal limb weakness, **AND**
 - An MRI showing a spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments.
- **Probable:**
 - An illness with onset of acute focal limb weakness, **AND**
 - Cerebrospinal fluid (CSF) with pleocytosis (white blood cell count >5 cells/mm³, may adjust for presence of red blood cells by subtracting 1 white blood cell for every 500 red blood cells present).

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of AFM. If an etiology is known and is a reportable condition (e.g., West Nile, varicella, or polio) the case should be investigated according to the etiology.

If the etiology is known and due to a non-reportable condition OR if the etiology is unknown, use this chapter for investigation purposes.

Case Investigation Checklist

- Confirm the clinical presentation of the patient.
- Ascertain what testing has been done, including lab testing, lumbar puncture, and MRI.
- Ask the treating physician, preferably the neurologist, to complete the [*Acute Flaccid Myelitis: Patient Summary Form*](#).
 - EAIDB does NOT recommend that the LHD complete the form themselves.
 - Submit the *Acute Flaccid Myelitis: Patient Summary Form* to EAIDB.
- EAIDB will obtain approval from CDC for testing.
- Collect specimens to submit to CDC for testing (Table 1).

Control Measures

Control measures will depend on the causative agent; however, proper hand hygiene will help in controlling spread. Standard precautions in healthcare facilities should be implemented.

Exclusion

Anyone with a fever should be excluded from work or school until 24 hours have passed fever-free without the use of an anti-fever medication. Anyone with diarrhea should be excluded from work or school until 24 hours have passed diarrhea-free without the use of an anti-diarrheal medication.

If the etiology is determined, there may be additional exclusion criteria that apply.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak of AFM is suspected, notify the regional DSHS office or to EAIDB at (512) 776-7676.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Acute flaccid myelitis is not currently a reportable condition in and of itself. However, certain illnesses that cause AFM (e.g., polio, varicella, West Nile) may be reportable and should be reported according to Texas Administrative Code requirements for these conditions.

EAIDB requests that patients with suspected AFM be reported within one week to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at (800) 252-8239 or (512) 776-7676.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Fax the *Acute Flaccid Myelitis: Patient Summary Form* as soon as possible to EAIDB. The form will be needed to facilitate lab testing with CDC.
 - Fax forms to **512-776-7616**
 - Forms should be faxed once enough information has been collected to establish that a patient meets probable or confirmed case status.
- Once the investigation is complete, fax or mail a completed *Acute Flaccid Myelitis: Patient Summary Form* within 30 days to EAIDB.
 - Fax forms to **512-776-7616** or mail to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at 512-776-7676.

LABORATORY PROCEDURES

Clinicians treating patients meeting the AFM case definition should pursue laboratory testing of cerebrospinal fluid (CSF), blood, serum, respiratory, and stool specimens for enteroviruses, West Nile virus, and other known infectious etiologies at their usual clinical and reference laboratories. Clinicians may contact the local health department and/or DSHS for assistance with any testing that is not available locally. Specimens should not be shipped to DSHS or CDC without first consulting with the local health department. Along with the specimens listed below, CDC would also require a copy of the MRI report for patients reported with suspect AFM.

Clinicians should collect specimens from patients suspected of having AFM as early as possible in the course of illness, preferably on the day of onset of limb weakness. Early specimen collection has the best chance to yield a diagnosis of AFM. The specimens which should be collected include the following:

- Cerebrospinal fluid (CSF) **AND**
- Blood (serum and whole blood), **AND**
- Stool (preferably two stool specimens collected as soon after onset of limb weakness and separated by 24 hours)

CDC advised overnight shipment of available clinical specimens, within 24-48 hours of specimen collection if possible, from patients that meet the clinical case definition. Please ship specimens overnight so they arrive at CDC on Tuesday through Friday. Do not ship specimens on Friday or over the weekend.

For specimens that should be frozen, please freeze them at -20°C and make arrangements to ship the specimens overnight to CDC frozen on dry ice.

For specimens that should be sent refrigerated, please store them at 4°C and make arrangements to ship the specimens overnight to CDC on cold packs. Specimens should not have direct contact with the cold packs during shipping.

Specimens from each patient should be shipped with completed hard copies of the following:

- The [Acute Flaccid Myelitis Patient Summary Form](#)
- A CDC [specimen submission form 50.34](#) **FOR EACH SPECIMEN**. Please note that, for the Test Order Name, select “Picornavirus Special Study.”

If ten or more patient specimens are submitted, please provide an electronic line listing by email. Use the following headers in this order: patient ID number; date of birth; sex; onset date; fatal y/n; specimen ID number; specimen collection date; specimen type; if culture isolate—cell line and passage number.

Prior to shipping, coordinate with Central Office staff regarding specimens shipped.

Additional instructions regarding specimen collection, storage, and shipping can be found at: <https://www.cdc.gov/acute-flaccid-myelitis/hcp/instructions.html>

*For stool specimens, CDC recommends that healthcare providers rule out poliovirus infection in cases of acute flaccid paralysis (AFP) that are clinically compatible with polio, including those with anterior myelitis. Recommendations for polio testing can be found at: <http://www.cdc.gov/polio/us/hcp.html>. CDC can do testing for polio if the reporting facility cannot.

TABLES

Table 1: Specimens to Collect from Suspect AFM Cases

Specimen Type		Minimum Amount	Collection	Storage	Shipping	Comments
Required Specimens						
Cerebrospinal fluid (CSF)		2 mL	Unspun; standard cryovial tube; collect at same time or within 24 hours as whole blood	Refrigerate at 4°C	Ship overnight on cold packs. Ship within 24-48 hours of collection*	Tubes should be insulated during shipping to ensure they are not in direct contact with cold pack
Cerebrospinal fluid (CSF)		1 mL	Spun and processed; standard cryovial tube; collect at same time or within 24 hours as whole blood	Freeze at -20°C	Ship on dry ice	
Serum		0.4 mL	Spun and processed; Tiger/red top tube	Freeze at -20°C	Ship on dry ice	
Whole blood		3-5 mL	Unspun; lavender/green top tube (with anticoagulant); collect at same time or within 24 hours as CSF	Refrigerate at 4°C	Ship overnight on cold packs. Ship within 24-48 hours of collection*	Tubes should be insulated during shipping to ensure they are not in direct contact with cold pack
Stool	Whole stool (preferred)	≥1gram	Collect in sterile container, no special medium required	Freeze at -20°C	Ship on dry ice	Two samples total, collected at least 24 hours apart, both collected as early in illness as possible and ideally within 14 days of illness onset
	Rectal swab	≥1gram	Store in viral transport medium	Freeze at -20°C	Ship on dry ice	Two samples total, collected at least 24 hours apart, both collected as early in illness as possible and ideally within 14 days of illness onset

Optional Specimens					
Respiratory - NP/OP swab	1ml	Store in viral transport medium	Freeze at -20°C	Ship on dry ice	Send only if EV/RV positive for typing
<i>In the event of death, please send the following specimens, if possible</i>					
Fresh-frozen tissue		Place directly on dry ice or liquid nitrogen	Freeze at -70°C	Ship on dry ice	Representative sections from various organs are requested, but particularly from brain/spinal cord (including gray and white matter), heart, lung, liver, kidney, and other organs as available.
Formalin-fixed or formalin-fixed, paraffin-embedded tissue		Avoid prolonged fixation—tissues should have been fixed in formalin for 3 days, then transferred to 100% ethanol	Room temperature	Ship at room temperature with paraffin blocks in carriers to prevent breakage	See comment above regarding frozen tissue

** If specimens cannot be shipped within 24-48 hours of collection, consider recollection, if feasible.*

UPDATES

April 2017

- Investigation form updated to fit CDC's case definition
- Links were updated to the most recent patient summary forms from the CDC
- Specimen collection tables were updated to reflect changes to testing procedures at the CDC

Amebiasis rev Jan 2016

BASIC EPIDEMIOLOGY

Infectious Agent

Entamoeba histolytica, a protozoan parasite. The trophozoite is the active form of the parasite which causes symptoms. Cysts are the infectious form which sometimes develops in the lower intestine but does not cause symptoms. Infected persons may shed both trophozoites and cysts in stool.

Transmission

Transmission is person-to-person or through ingestion of amebic cysts in fecally contaminated food or water. Cysts are relatively chlorine-resistant and can survive in moist environmental conditions for weeks to months. Transmission may also occur sexually by oral-anal contact.

Incubation Period

Variable, from a few days to several months or years; usually 2 to 4 weeks

Communicability

A person is infectious as long as they are shedding amebic cysts in their stool. Cysts may be shed intermittently for months or years if the person is not treated.

Clinical Illness

The symptoms are often mild and can include loose stools, stomach pain, and stomach cramping. A severe form of amebiasis causes stomach pain, bloody or mucoid stools, and fever. After becoming symptomatic, it is possible for cases to experience remission or constipation followed by the recurrence of symptoms. Other symptoms include chronic abdominal pain, amebic granulomata in the wall of the large intestine and ulceration of the skin in the perianal region or in the penile region. Liver abscesses and brain or lung infections occur infrequently. Asymptomatic infections are common. Only about 10% to 20% of people who are infected become sick.

DEFINITIONS

Clinical Case Definition

Infection of the large intestine by *Entamoeba histolytica* can vary in severity, ranging from an asymptomatic infection to mild, chronic diarrhea to fulminant dysentery. Extraintestinal infection can occur (e.g., hepatic abscess).

Laboratory Confirmation

- For intestinal amebiasis
 - Demonstration of cysts or trophozoites of *E. histolytica* in stool, **OR**
 - Demonstration of trophozoites in tissue biopsy or ulcer scrapings by culture or histopathology
- For extra-intestinal amebiasis
 - Demonstration of *E. histolytica* trophozoites in extraintestinal tissue

Case Classifications

- **Confirmed, intestinal amebiasis:** A clinically compatible illness that is laboratory confirmed
- Suspect, intestinal amebiasis: A clinically compatible case with *E. histolytica* detected in stool by use of an antigen-based fecal immunoassay
- **Confirmed, extra-intestinal amebiasis:** A person must meet one of the following:
 - A case with demonstration of the organism, *E. histolytica*, in at least one extra-intestinal tissue sample, **OR**
 - A symptomatic person (with clinical or radiographic findings consistent with extra-intestinal infection) and demonstration of specific antibody against *E. histolytica* as measured by reliable immunodiagnostic test (e.g., EIA) and PCR based assays

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

It is recommended that local and regional health departments investigate all reported cases of amebiasis to identify potential sources of infection. Sporadic cases of amebiasis do not require an investigation form be sent to DSHS EAIDB unless they are identified as part of a multi-jurisdictional cluster or outbreak. Any case associated with a cluster or outbreak should be interviewed.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ If time and resources allow or the case is part of an outbreak or cluster, interview the case to identify potential sources of infection. Ask about possible exposures within the incubation period prior to symptom onset, including:
 - Exposure to a known carrier and/or persons with diarrheal illness within the incubation period.
 - Contact with visitors born outside the U.S. or travelled to a developing country within 6 months prior to onset.
 - Sexual contacts within incubation period.
 - Travel outside the area. Obtain travel dates and locations visited.
 - Attendance or work at a child-care facility by the case or a household member.
 - Note: If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
- ☐ Provide education to the case or his/her surrogate regarding modes of transmission and ways to prevent transmission to others. See Prevention and Control Measures.
- ☐ Identify whether there is a public health concern: persons should not work as food handlers, child-care or health care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- ☐ All confirmed and suspect case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.

- Thoroughly wash fruits and vegetables with potable water.
- Avoid unpasteurized milk, cheese, and other dairy products.
- When traveling internationally to areas with poor sanitary conditions:
 - Drink bottled water or water that has been boiled for at least 1 minute.
 - Don't drink fountain drinks or drinks with ice.
 - Don't eat fruits or vegetables that you don't peel yourself.
 - Avoid uncooked foods.
- Practice safer sex measures, such as the use of condoms and dental dams for oral/anal contact.

Exclusions

School/child-care: No exclusions are specified for amebiasis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for amebiasis but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications, OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the DSHS Emerging and Acute Infectious Disease Branch (EAIDB) at (800) 252-8239 or (512) 776-7676.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional cases.
- Work with any implicated facilities to ensure staff and students/residents/volunteers get hand hygiene education and review hygiene and sanitary practices currently in place including:
 - Policies on, and adherence to, hand hygiene.
 - Storage and preparation of food.
 - Procedures for changing diapers and toilet training.
 - Procedures for environmental cleaning.
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** and **suspect** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- If investigation forms are requested, they may be faxed to 512-776-7616 or emailed securely to an EAIDB foodborne epidemiologist.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://www.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

CLINICAL SPECIMENS:

Testing for amebiasis is widely available from most private laboratories. Specimens should not be submitted to the DSHS laboratory unless approved by EAIDB. Submission of specimens to the DSHS laboratory will be considered during outbreak investigations. Contact an EAIDB foodborne epidemiologist to discuss further.

Specimen Collection

- Collect stool during acute phase of illness, if possible.
- Submit a stool specimen in a sterile, leak-proof container.
 - Required volume: >20 g fresh stool.
 - If fresh stool cannot be transported to laboratory within 5 hours, specimens should be placed in PVA and formalin immediately.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check "Outbreak association" and write in name of outbreak.
- Payor source:
 - Check "IDEAS" to avoid bill for submitter

Specimen Shipping

- Transport temperature: May be shipped at ambient temperature.
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.
- Unpreserved specimen received greater than 5 hours after collection.
- Specimen too old.

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *E. histolytica* is NOT available at the DSHS laboratory.

UPDATES

January 2016

- Revised the Exclusion section to provide clarity.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Procedures section to address the unavailability of food and environmental swab testing for *E. histolytica* at the DSHS laboratory.

Amebic Meningitis/Encephalitis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Naegleria fowleri, *Acanthamoeba* spp. and *Balamuthia mandrillaris* are microscopic, free-living amoebae (single-celled living organisms). *Naegleria fowleri* is the causal agent of Primary Amebic Meningoencephalitis (PAM), while *Acanthamoeba* spp. and *Balamuthia mandrillaris* are the causal agents of Granulomatous Amebic Encephalitis (GAE).

- *Naegleria fowleri* is a heat-loving (thermophilic), free-living amoeba (single-celled microbe) commonly found around the world in warm fresh water (e.g., lakes, rivers, hot springs) and soil. *N. fowleri* is the only species of *Naegleria* known to infect people. Most of the time, the amoeba lives in freshwater habitats by feeding on bacteria. However, in rare instances, the amoeba can infect humans by entering the nose during water-related activities.
- *Acanthamoeba* species are found worldwide. Most commonly the amoebae are found in soil, dust, fresh water, brackish water (e.g., a marsh) and sea water. *Acanthamoeba* spp. can also be found in swimming pools, hot tubs and drinking water systems (e.g., slime layers in pipes and taps), as well as in heating, ventilating and air conditioning (HVAC) systems and humidifiers. Several species of *Acanthamoeba*, including *A. culbertsoni*, *A. polyphaga*, *A. castellanii*, *A. astronyxis*, *A. hatchetti*, *A. rhysodes*, *A. divionensis*, *A. lugdunensis* and *A. lenticulata* are implicated in human disease.
- *Balamuthia mandrillaris* is found in soil and believed to enter the body through skin wounds and cuts, or when dust containing *Balamuthia mandrillaris* is breathed in or gets in the mouth. Exposure to *Balamuthia mandrillaris* is likely to be common because of how widespread the amoeba is in the environment. However, very few cases of disease in humans have been found worldwide since *Balamuthia mandrillaris* was discovered.

Transmission

Naegleria fowleri

Transmission of *N. fowleri* to humans occurs when water containing amoebae enters the nose. Trophozoites infect humans or animals by penetrating the nasal tissue and migrating to the brain via the olfactory nerves causing primary amebic meningoencephalitis. Exposure occurs when people go swimming or diving in warm freshwater places, like lakes and rivers. People do not become infected by drinking contaminated water. In very rare instances, *Naegleria* infections may also occur when contaminated water from other sources (e.g., inadequately chlorinated swimming pool water or contaminated tap water) enters the nose. Some examples are when people submerge their heads or cleanse during religious practices, and when people irrigate their sinuses (nose) using contaminated tap water. It is also possible that *Naegleria* infection could be acquired through transplantation of organs from an infected donor.

Acanthamoeba spp.

Acanthamoeba spp. can enter the body through the eye, the nasal passages, cuts or skin wounds or by being inhaled into the lungs. The trophozoites are the infective forms, although both cysts and trophozoites gain entry into the body through various means. When *Acanthamoeba* spp. enter the eye they can cause severe keratitis in otherwise healthy individuals, particularly contact lens users. When the amoeba enters the respiratory system or through the skin, it can invade the central nervous system by hematogenous dissemination causing granulomatous amebic encephalitis (GAE) or disseminated disease, or skin lesions in individuals with compromised immune systems.

Balamuthia mandrillaris

Balamuthia mandrillaris: GAE occurs when the amebae infect the body, possibly through skin wounds and cuts, or when dust containing *Balamuthia* is breathed in through the nose or mouth. The trophozoites are the infective forms, although both cysts and trophozoites gain entry into the body through various means. Entry can occur through the nasal passages to the lower respiratory tract, or through ulcerated or broken skin. When *B. mandrillaris* enters the respiratory system or through the skin, it can invade the central nervous system by hematogenous dissemination causing granulomatous amebic encephalitis (GAE) or disseminated disease. The ameba can also cause skin lesions in individuals who are immune competent as well as those with compromised immune systems. *Balamuthia mandrillaris* infection also may be acquired through transplantation of infected donor organs.

Incubation Period and Illness Duration*Naegleria fowleri*:

- Incubation period: Symptoms start 1-14 days (median 5 days) after exposure
- Duration of illness: Death occurs 1-18 days (median 5 days) after symptoms begin

Balamuthia mandrillaris and *Acanthamoeba* spp.:

- Incubation period: Weeks to months (or longer)
- Duration of illness: Weeks to months

Communicability

Amebic meningitis/encephalitis is not spread person-to-person (except in the case of transmission through transplantation of organs from an infected donor).

Clinical Illness*Primary amebic meningoencephalitis (PAM)*

Infections with *Naegleria fowleri* cause the rare disease PAM, a brain infection that leads to the destruction of brain tissue. Infection can occur in young immune-competent individuals. In its early stages, the infection may be similar to bacterial meningitis. Initial symptoms of PAM start 1 to 14 days after infection. Symptoms may include headache, fever, nausea, vomiting and stiff neck. Later symptoms may include confusion, lack of attention to people and surroundings, a loss of balance, seizures and hallucinations. These symptoms are followed by coma and death. After the start of symptoms, the disease progresses rapidly and death occurs within 18 days, usually on the fifth or sixth day.

Granulomatous amebic encephalitis (GAE)

GAE - caused by *Balamuthia mandrillaris* and *Acanthamoeba* species - often has a slow, insidious onset and then develops into a subacute or chronic disease lasting several weeks to months. However, *B. mandrillaris* infections associated with organ transplantation have an especially rapid clinical course.

GAE caused by *Acanthamoeba* spp. can cause a serious infection of the brain and spinal cord. Symptoms may include headaches, stiff neck, nausea and vomiting, tiredness, confusion, lack of attention to people and surroundings, loss of balance and bodily control, seizures and hallucinations. Symptoms progress over several weeks and death usually occurs. Skin infections do not necessarily lead to disseminated disease.

GAE and disseminated infection are very rare forms of *Acanthamoeba* spp. infection and primarily affect people with compromised immune systems. While unusual, disseminated infection can also affect healthy children and adults. Conditions that may increase a patient's risk for GAE and disseminated infection include AIDS, organ/tissue transplant, steroids or excessive use of antibiotics, diabetes mellitus, cancer, disorders in which white blood cells in the lymphatic tissue are over-produced or abnormal, disorders in which blood cells or blood clotting mechanisms do not function properly or are abnormal, liver cirrhosis and lupus.

Balamuthia mandrillaris infection can cause a wide range of symptoms. Disease can begin with a skin wound on the face, trunk or limbs and can then progress to the brain where it causes GAE. Diagnosis of *Balamuthia mandrillaris* GAE can be difficult, but some early symptoms may include headaches, stiff neck or head and neck pain with neck movement, sensitivity to light, nausea, vomiting, lethargy and low-grade fever. Other signs of *Balamuthia mandrillaris* GAE may include behavioral changes, seizures, weight loss, partial paralysis, speech difficulties and difficulty walking. *Balamuthia* can also cause a widespread infection involving multiple body parts. The disease might appear mild at first but can become more severe over weeks to several months. *Balamuthia mandrillaris* GAE is a very rare but usually fatal disease. Overall, the outlook for people with this disease is poor, although early diagnosis and treatment may increase the chances for survival.

Balamuthia mandrillaris is able to infect anyone, including healthy people. Those at increased risk for infection include people with HIV/AIDS, cancer, liver disease or diabetes mellitus; people taking immune system inhibiting drugs; alcoholics; young children or the elderly and pregnant women.

Severity

More than 95% of PAM and GAE cases are fatal. Only 1 person with PAM has survived out of 123 known infected individuals in the United States from 1962 to 2011.

DEFINITIONS

Amebic meningitis/encephalitis is classified as either Primary Amebic Meningoencephalitis (if it is caused by *Naegleria fowleri*) or as Other Amebic Meningitis/Encephalitis (if it is caused by another ameba). See the case definitions for both conditions below.

Clinical Case Definition of PAM

An infection presenting as meningoencephalitis or encephalitis. The clinical presentation of PAM is like that of acute meningitis caused by other pathogens and symptoms include headache, nausea, vomiting, anorexia, fever, lethargy, and stiff neck. Disorientation, mental status changes, seizure activity, loss of consciousness, and ataxia may occur within hours of initial presentation. After the onset of symptoms, the disease progresses rapidly and usually results in death within 3 to 7 days.

Laboratory Confirmation of PAM

Detection of *Naegleria fowleri* from a clinical specimen via:

- Detection of nucleic acid (e.g., PCR), **OR**
- Detection of antigen (e.g., immunohistochemistry)

Note: When available, molecular characterization (e.g., genotype) should be reported.

Case Classifications for PAM

- **Confirmed:** A clinically compatible case that is laboratory confirmed
- **Probable:** A clinically compatible case that meets at least one of the supportive laboratory criteria (listed below) and does not meet confirmatory lab criteria
 - Supportive laboratory evidence:
 - Visualization of motile amebae in a wet mount of CSF
 - Isolation of *N. fowleri* in culture from a clinical specimen

Clinical Case Definition of Other Amebic Meningitis/Encephalitis

An infection presenting as meningoencephalitis or encephalitis. Granulomatous amebic encephalitis (GAE) can include general symptoms and signs of encephalitis such as early personality and behavioral changes, depressed mental status, fever, photophobia, seizures, nonspecific cranial nerve dysfunction, and visual loss. GAE neurologic infections are generally fatal within weeks or months; however, a few patients have survived.

Laboratory Confirmation of Other Amebic Meningitis/Encephalitis

Detection of *Acanthamoeba*, *Balamuthia*, or another non-*Naegleria* free-living ameba from a clinical specimen or culture via:

- Detection of nucleic acid (e.g., PCR), **OR**
- Detection of antigen (e.g., immunohistochemistry)

Comments: *Acanthamoeba* spp. and *B. mandrillaris* can cause clinically similar illnesses and might be difficult to differentiate using commonly available laboratory procedures. Definitive diagnosis by a reference laboratory might be required. A negative test on CSF does not rule out *Acanthamoeba* spp. or *B. mandrillaris* infection because these organisms are not commonly present in the CSF.

Case Classifications for Other Amebic Meningitis/Encephalitis

- **Confirmed:** A clinically compatible case that is laboratory confirmed
- **Probable:** No probable case definition

Note: *Acanthamoeba* species and *Balamuthia mandrillaris* can also cause disseminated disease (affecting multiple organ systems) or cutaneous disease. For *B. mandrillaris* disease, painless skin lesions appearing as plaques a few millimeters thick and one to several centimeters wide have been observed in some patients, especially patients outside the U.S., preceding the onset of neurologic symptoms by 1 month to approximately 2 years. Skin lesions and sinus disease may be seen in *Acanthamoeba* disease. Disseminated disease and cutaneous disease caused by free-living amebae are only voluntarily reportable in Texas unless they progress to meningitis or encephalitis.

Cluster and Outbreak Definitions for PAM and Other Amebic Meningitis/Encephalitis

- Cluster:
 - Two or more cases linked by place of residence or places visited within 1 year
- Outbreak:
 - Two or more cases associated with the same body of water or other common water exposure event/practice (e.g., Neti pot usage for nasal irrigation) within 1 year

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of suspected amebic meningitis or encephalitis. Primary amebic meningoencephalitis cases tend to receive substantial amounts of attention from the community and the media.

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition.
- ☐ Arrange for specimens to be sent to the Centers for Disease Control and Prevention (CDC) (if specimens have not already been sent).
- ☐ Review medical records or speak to an infection preventionist or physician to verify that the case meets case definition, and to obtain information on underlying health conditions and course of illness.
- ☐ Interview the case (or surrogate) to identify risk factors.
 - If multiple attempts were made to contact the case or surrogate and attempts were unsuccessful, please fill out the case investigation form with as much information as possible and indicate the reason for missing information (e.g., lost to follow-up - patient did not return call; multiple messages left).
- ☐ Ensure that appropriate control measures are implemented (see Control Measures section, below).

- Complete the Free Living Ameba Case Report form (available at <http://www.dshs.state.tx.us/idcu/investigation>) and fax it to DSHS.
- Enter and submit for notification in the NEDSS Base System (NBS) all confirmed and probable case investigations.

Control Measures

Naegleria fowleri

- Provide education on Primary Amebic Meningoencephalitis (PAM) as needed with emphasis on the rarity of disease.
 - Although infections are severe, the risk of *Naegleria fowleri* infection is very low. There have been 30 reported infections in the U.S. during the 10 years from 2000–2009, despite millions of recreational water exposures each year. By comparison, during the 10 years from 1996–2005, there were over 36,000 drowning deaths in the U.S.
 - It is likely that a low risk of *Naegleria fowleri* infection will always exist with recreational use of warm freshwater lakes, rivers and hot springs. The low number of infections makes it difficult to know why some people have been infected compared to the millions of other people using the same or similar waters across the U.S.
 - The only way to prevent *Naegleria fowleri* infections is to refrain from water-related activities. For individuals who plan to take part in water-related activities, provide education on risk reduction (see below).
- Provide education on prevention of exposure.
 - <http://www.cdc.gov/parasites/naegleria/prevention.html>
 - Avoid water-related activities in bodies of warm freshwater during periods of high water temperature and low water levels.
 - Hold the nose shut or use nose clips when taking part in water-related activities in bodies of warm freshwater such as lakes, rivers or hot springs.
 - Avoid digging in or stirring up the sediment while taking part in water-related activities in shallow, warm, freshwater areas.
 - *Naegleria fowleri* infections have been reported when people put their heads underwater, rinse their sinuses through the nose, and cleanse their noses during religious practices (e.g., ritual nasal rinsing and ablution) using contaminated tap or faucet water. If you perform nasal irrigation or sinus flushes (e.g., using a Neti pot) for any reason, be sure to use only sterile, distilled or lukewarm previously boiled water.
- Recommend that anyone experiencing symptoms be evaluated by a physician.
- Posting of signs mentioning the presence of *Naegleria fowleri* in bodies of water is not generally recommended since the *N. fowleri* ameba is ubiquitous in nature. There are no guidelines or supporting evidence for the posting or removal of such signs. Posting of safe swimming practices might be a preferred alternative.
- Several drugs are effective against *Naegleria fowleri* in the laboratory. However, their effectiveness in humans is unclear since almost all infections have been fatal even when people were treated. See the CDC's Primary Amebic Meningoencephalitis (PAM) treatment website for more information on available treatments for patients with free-living ameba infections at <http://www.cdc.gov/parasites/naegleria/treatment-hcp.html>.

Balamuthia mandrillaris and *Acanthamoeba* spp.

- There are no specific prevention and control measures for *B.mandrillaris* and *Acanthamoeba* spp.
- Provide education on Granulomatous Amebic Encephalitis as needed with emphasis on the rarity of disease.
- Recommend that anyone experiencing symptoms be evaluated by a physician.
- Although infections are severe, the risk of *B.mandrillaris* and *Acanthamoeba* spp. infection is very low. It mainly affects those who are immunocompromised.

School/Daycare Exclusion Criteria

No exclusion is required for disease control purposes.

MANAGING SPECIAL SITUATIONS

Multiple Cases Associated with a Single Water Source

If one or more cases occur that are associated with a single water source within a one-year period, notify the DSHS EAIDB at (800) 252-8239 or (512) 776-7676.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable, and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at (800) 252-8239 or (512) 776-7676.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS within 30 days of receiving a report of a confirmed or probable case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completion of the investigation.
- Fax (or mail) a completed investigation form when the NBS notification is submitted.
 - Investigation forms may be faxed to **512-776-7616** or mailed to:
 Infectious Disease Control Unit
 Texas Department of State Health Services
 Mail Code: 1960
 PO Box 149347
 Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- For waterborne outbreaks, submit a completed **National Outbreak Reporting System (NORS)** outbreak form at the conclusion of the outbreak investigation.
 - Enter into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

It is recommended that CSF, serum and tissue specimens (including biopsy, surgical or necropsy specimens) be collected for the detection of free-living amebae (*Naegleria fowleri*, *Balamuthia mandrillaris* and *Acanthamoeba* spp.) and sent directly to the CDC along with the CDC Form for Free-living Amebae (FLA) Testing (request by emailing dpdx@cdc.gov) and the CDC 50.34 Submission Form (available at <http://www.cdc.gov/laboratory/specimen-submission/index.html>).

Clinicians who suspect amebic meningitis/encephalitis (including PAM) should contact their state health department and/or CDC (24/7 Emergency Operation Center - 770-488-1700). CDC can assist with diagnosis and provide treatment recommendations. Telediagnosis can be arranged at CDC by emailing photos through DPDx, CDC's Division of Parasitic Diseases and Malaria telediagnosis tool. Instructions for submitting photos through DPDx are available at the [DPDx Contact Us page](#).

Important note: For CSF samples - Do NOT refrigerate or freeze; Do NOT centrifuge (Refrigeration or freezing will rapidly lyse and kill the amebae, preventing visual detection and identification.)

- The DSHS Parasitology Laboratory may be contacted for assistance and coordination in submitting specimen samples and electronic images to the CDC. The team lead, Cathy Snider, will work with the hospital to coordinate all CSF specimen shipments to the CDC.

Cathy Snider – Team leader – Parasitology

DSHS Parasitology Lab

1100 West 49th Street

Austin, TX 78756

Phone: 512-458-7560

Email: cathy.snider@dshs.state.tx.us

Specimen Collection

The following CDC guidelines are available at <http://www.cdc.gov/parasites/naegleria/diagnosis-hcp.html>.

Tissue specimens - including biopsy, surgical or necropsy specimens - may be collected for the detection of free-living amebae (*Naegleria*, *Balamuthia* and *Acanthamoeba*).

A. Specimens Needed for Pre-Mortem Diagnosis

Clinical Pre-Mortem Specimens for Diagnosis at CDC:

If possible, CDC requests that the following specimens be sent for diagnostic testing at CDC:

- Fresh CSF (Please DO NOT FREEZE and DO NOT REFRIGERATE as this kills the amebae)
- If the patient has had a biopsy, the following are also requested:
 - Fresh brain tissue (Please DO NOT FREEZE and DO NOT REFRIGERATE)
 - Formalin-fixed and paraffin embedded tissues
 - Three stained hematoxylin and eosin (H&E) slides
 - Six unstained slides

B. Specimens Needed for Post-Mortem and Autopsy Diagnosis

To better understand the pathogenesis of PAM and the potential for transmission via organ transplantation, CDC would like to encourage autopsies for PAM case patients whose families consent.

- **CNS Tissue:** *Naegleria fowleri* is most likely detected in biopsy or autopsy tissue collected from the area surrounding the nasal-olfactory bulbs in the brain. However, CDC requests that tissues be collected from other CNS sites in addition to the olfactory bulb to look for other possible locations of ameba entry into the brain, such as around the auditory nerve.
- **Extra-CNS Tissue:** All possible steps should be taken to minimize the possibility of cross-tissue contamination between CNS and extra-CNS tissues. These steps should, at a minimum, include:
 - Completing the gross examination and sample collection from all extra-CNS tissues prior to examination of the CNS tissues
 - Utilizing separate workspaces and dissecting tools for the extra-CNS and CNS tissues
 - Placing recovered samples of extra-CNS and CNS tissues in separate formalin containers
 - Processing all tissues, particularly extra-CNS and CNS, separately
 - Cutting extra-CNS and CNS tissues separately
 - If the same equipment is used to cut the tissue, cut extra-CNS tissues first and include a cleaning step in between different tissues.

Specimens can then be sent to CDC.

Clinical Post-Mortem Specimens for Diagnosis at CDC

If possible, please send the following specimens:

- Fresh CSF (Please **DO NOT FREEZE** and **DO NOT REFRIGERATE** as this kills the amebae)
- Fresh, unfixed brain tissue
- Fresh, unfixed tissue (other than brain)
- Formalin-fixed, paraffin-embedded, tissue
 - Three H&E-stained slides
 - Six unstained slides (for indirect immunofluorescence, or IIF)
 - Paraffin-embedded tissue block
- Photos of gross brain morphology
 - Particularly around olfactory and auditory areas
- Serum

Submission Forms

- The FLA specimen submission form for free-living amebae (FLA) testing can be requested by emailing dpx@cdc.gov. In addition, the CDC 50.34 Specimen Submission Form (available at <http://www.cdc.gov/laboratory/specimen-submission/form.html>) is also required for FLA testing.

Specimen Shipping

- Ship samples according to shipping guidelines and requirements available at <http://www.cdc.gov/dpdx/diagnosticProcedures/other/FLA.html> and <http://www.cdc.gov/dpdx/diagnosticProcedures/other/shipment.html>.
- Unfixed specimens for culture should be sent at ambient temperature by overnight priority mail. For PCR, sterile unfixed specimens or specimens in 70-90% ethanol should be sent by overnight priority mail on ice packs. Care should be taken to pack glass slides securely, as they can be damaged in shipment if not packed in a crush-proof container.
- **Please arrange Monday through Friday delivery only.** Packages cannot be accepted on weekends or federal holidays. Please send any fresh tissue, CSF, whole blood or serum specimens by overnight express:

CDC
SMB/STAT Lab
Attn: Unit 53
1600 Clifton Road, NE
Atlanta, GA 30333
Ph: 404-718-4157; 404-718-1433

- For additional information about tissue specimens or shipping, please contact the CDC Division of Parasitic Diseases at dpdx@cdc.gov or 404-718-4110.

Digital Laboratory and Pathology Image Submission

- Please send your diagnostic request to dpdx@cdc.gov. Attaching several images will assist in making an identification. When submitting a digital image, please include the following information along with your message:
 - Your name
 - Your affiliation
 - Your telephone contact number (optional)
 - Mailing address for final reporting
 - Specimen ID code
 - Type of specimen
 - Date specimen was collected
 - Stain used, and magnification of the microscopic field captured
 - Presumed diagnosis
 - Any other pertinent data (e.g., pre or post treatment, travel history, etc.).
 - If you have other relevant supporting documents or clinical information, please attach them.

UPDATES

April 2017

- Definitions: changed Clinical Case Definition and Laboratory Confirmation for both PAM and Other Amebic Meningitis/Encephalitis to make this document consistent with the Epi Case Criteria Guide (ECCG).
- Surveillance and Case Investigation: separated Control Measures by *Naegleria fowleri* and *Balamuthia mandrillaris* and *Acanthamoeba* spp.
- Reporting and Data Entry Requirements: added that probable cases need to be entered into NBS and a NBS notification submitted
- Laboratory Procedures: edited CDC DPDx laboratory contact information

Ascariasis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Ascariasis is caused by the soil transmitted helminths *Ascaris lumbricoides* and *Ascaris suum*. Both are roundworm intestinal nematodes. *Ascaris lumbricoides* is found in humans and dogs, while *Ascaris suum* is most commonly found in pigs, but can infect humans via consumption of contaminated meat. *Ascaris lumbricoides* is the most prevalent of all human intestinal nematodes worldwide.

Transmission

Transmission is primarily via ingestion of fecal contaminated soil. Eggs are shed in an infected person's feces but do not become infectious until they have incubated in soil for 2-3 weeks. Once they become infectious they can be transmitted via contaminated water, agriculture products, fingers, or other fomites.

Incubation Period

Eggs must incubate in soil for 2-3 weeks before they become infectious to humans. Once ingested it takes approximately 8 weeks for the eggs to develop into an egg-laying adult female worm although symptoms may manifest earlier.

Communicability

Human to human transmission of *Ascaris* spp. does NOT occur because part of the worm's life cycle must be completed in soil before becoming infectious. Soil contamination is perpetuated by fecal contamination from infected humans or dogs for *Ascaris lumbricoides* and humans (rarely) or pigs for *Ascaris suum*. An infected person may shed eggs for as long as they are infected with an egg-laying adult which may be several years.

Clinical Illness

Most infections with *Ascaris* spp. are asymptomatic. Heavier infections may result in gastrointestinal issues, malnutrition, or intestinal obstruction. Severe infections in children resulting in nutrient deficiencies can lead to growth retardation and cognitive impairment. During larval migration through respiratory passages, acute transient pneumonitis and eosinophilia may occur. Adult worms may migrate under stressful conditions (fever, anesthesia, etc.) which may lead to intestinal wall perforation, appendicitis, peritonitis, pancreatitis, cholangitis, or biliary colic. In very rare instances, intestinal obstructions may cause gangrene and if untreated result in death.

DEFINITIONS

Clinical Case Definition

Early symptoms of ascariasis occur during larval migration and include cough, wheezing, pneumonitis and eosinophilia. Minor infections may manifest as minor abdominal discomfort or loss of appetite. Major infections may result in obstruction and/or inflammation of intestinal organs (appendicitis, pancreatitis etc.), vomiting (possibly accompanied by expulsion of adult worms), weight loss, and fatigue. In children, nutrient deficiency, growth retardation, and cognitive impairment may also be present.

Laboratory Confirmation

- Microscopic identification of *Ascaris* eggs in feces, **OR**
- Microscopic identification of ascarid larvae in sputum or gastric washings, **OR**
- Identification of adult worms passed from the anus, mouth or nose

Case Classifications

- **Confirmed:** A case that is laboratory confirmed
- **Probable:** A clinically compatible case with evidence of infection such as
 - An ultrasound showing worms in the pancreas or liver or
 - CT scans or MRI showing worms present in the ducts of the liver or pancreas.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of ascariasis. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the Ascariasis Investigation Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors, and describe course of illness.
- ☐ Interview the case to get detailed exposure history and risk factor information.
 - Use the **Ascariasis Investigation Form** to record information from the interview.
 - If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
 - Provide education to the case or his/her surrogate about effective hand washing, food safety practices, and avoidance of soil contamination. See Prevention and Control Measures.
- ☐ Fax completed forms to DSHS EAIDB at **512-776-7616**
 - For lost to follow-up (LTF) cases, please complete as much information as possible obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/e-mail securely to DSHS EAIDB and indicate the reason for any missing information.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water.
- Proper disposal of human waste products such as feces is necessary to prevent contamination of soil.
- Avoid areas where human waste contamination of soil or water is likely.
- Proper removal and disposal of pet waste from outdoor areas.
- Thoroughly wash fruits and vegetables to remove soil/fertilizer residue.
- Thoroughly cook all fruits and vegetables that may have been in contact with soil produced from human and animal waste.
- Cook all pork products to the appropriate temperature prior to consumption and wash hands thoroughly before and after handling raw meat.

Exclusions

There is no human-to-human transmission of ascariasis therefore no exclusion from work, school or daycare is required for disease control purposes unless the individual has diarrhea. If the individual has diarrhea, the standard exclusion until diarrhea free for 24 hours without the use of diarrhea suppressing medications applies. Diarrhea is defined as 3 or more episodes of loose stools in a 24 hour period.

MANAGING SPECIAL SITUATIONS

Outbreaks/Clusters

If an outbreak or cluster is suspected, notify the DSHS Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky exposures, such as inadequate waste disposal near the home or work, recreational activities in areas with inadequate waste disposal, or travel to an endemic country reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Risks	Notes
1	NT	34	F	White/non-Hispanic	12/4/16	Diarrhea, Anemia	Travel to Vietnam, lives in same neighborhood as ID 2	Brother ill
2	PR	4	M	Unknown	11/30/16	Anemia, bloody stool	Poor sanitation near home, lives in same neighborhood as ID 1	Lost to follow up (LTF)

- If the outbreak was reported in association with an apparent common risk factor (e.g., work or live near a possible site of soil contamination, members of the same household with similar travel), recommend that anyone displaying symptoms seek medical attention from a healthcare provider.
- If several cases in the same family or geographic area are identified and there is a possibility for similar exposures (e.g., travel to the same country, poor sanitation), testing of potentially exposed persons or mass de-worming treatment may be warranted.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB neglected tropical disease epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.

LABORATORY PROCEDURES

Fecal Ova and Parasite testing for ascariasis is widely available from most private laboratories however, specimen submission to DSHS laboratory is advised. Adult worm specimen identification may not be available at private laboratories therefore submission to the DSHS laboratory is available and highly recommended. Contact an EAIDB neglected tropical disease epidemiologist to discuss further if needed.

Specimen Collection

- Submit a stool specimen in a sterile, leak-proof container.
 - Required volume: Stool 15 g solid or 15 mL liquid.
- Specimens that cannot be received by the lab in less than 5 hours should be placed in formalin and PVA immediately.
- Adult worms should be submitted in either 5-10% formalin or 70% ethanol.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name and date of birth or social security number match exactly what is written on the transport tubes.
- Fill in the date of collection, date of onset, and diagnosis/symptoms.

Specimen Shipping

- Transport temperature: May be shipped at ambient temperature.
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Possible Causes for Rejection:

- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.
- Unpreserved specimen received greater than 5 hours after collection– specimen should still be submitted as an attempt will be made to complete testing.
- Transport media was expired.

UPDATES

April 2017

- Basic Epidemiology: revised the Transmission, Incubation Period, and Communicability sections to provide clarity.

Botulism rev Jan 2016

***Initial calls or reports regarding suspect botulism should be referred to EAIDB for immediate evaluation and for approval of testing and/or release of antitoxin, if appropriate. If botulism is highly suspected (e.g., antitoxin is released or testing is approved) then the case will be forwarded to the appropriate regional or local health department for further investigation. ***

Please contact DSHS EAIDB at 512-776-7676 or 512-221-6852 (after hours).

BASIC EPIDEMIOLOGY

Infectious Agent

Botulism is caused by neurotoxins produced by the bacterium *Clostridium botulinum*. *C. botulinum* bacteria form spores which can survive under a wide range of adverse environmental conditions, including high temperatures, such as boiling for less than ten minutes. Bacterial growth, however, (as opposed to spore survival) occurs only under anaerobic conditions and low acid (generally pH>4) and the toxin itself is produced as the bacteria are multiplying. There are seven types of botulinum toxin, designated A– G. Types A, B, and E are the most common sources of human disease. The toxin is heat-labile, and can be inactivated by boiling for ten minutes.

Transmission

Foodborne botulism: caused by ingestion of pre-formed toxin. Most implicated foods are low acid, home-canned items inadequately processed during canning and not heated before consumption. Rarely, commercial products are implicated, usually after a breakdown in standard canning procedures. Examples of implicated foods include:

- Home-canned asparagus, beans, and other vegetables (including low acid tomatoes and salsa), usually processed inadequately by the water-bath method;
- Fish that has been improperly canned, dried, smoked or stored;
- Sausages or other prepared meats, such as jerky, that are improperly processed (inadequate sodium nitrite) and improperly stored;
- Chopped or whole garlic, herbs, olives or vegetables bottled in oil;
- Among Alaskan Natives, traditionally preserved foods including fermented (putrefied) whale blubber, salmon heads, salmon eggs, and other marine products;
- Possibly home-pickled fish, eggs, vegetables and olives that have been inadequately prepared without the correct concentrations of salt and/or vinegar.
- Rare commercial canned products (e.g., commercially canned chili in 2007); products may be recalled even without cases if improper processing carries a risk of botulism.

Wound botulism: results from a local *C. botulinum* infection in devitalized tissue at a wound site, where semi-anaerobic conditions develop. Wound botulism has been rare, but increasingly reported, especially in injectors of "black-tar" heroin.

Infant botulism: occurs when *C. botulinum* spores are ingested in food or soil and germinate in the preformed gut of infants under the age of 1 that have yet to develop mature intestinal flora. The germination of spores results in an intestinal infection in these infants, where the botulinum toxin is produced within the intestine and then enters the bloodstream causing symptoms. This is also known as intestinal botulism.

Inhalational botulism: does not occur naturally. There have been only three reported cases in humans worldwide. Studies done with monkeys have shown that the toxin can be absorbed through the lung mucus membrane into the bloodstream. It is believed that if botulinum toxin were to be used as a bioweapon, it would be by this route.

Iatrogenic botulism: occurs from an accidental overdose or as an adverse event following the therapeutic or cosmetic injection of botulinum neurotoxin. Examples of therapeutic uses of botulinum toxin include treatment for hemifacial muscle spasms, focal dystonia, focal spasticity, autonomic disorders, Frey's syndrome and oculomotor disorders.

Incubation Period

Foodborne botulism: The incubation period for foodborne botulism can vary from 12 hours to several days, but is usually 12–36 hours. A short incubation is associated with more severe disease and larger toxin dose ingested.

Wound and iatrogenic botulism: The incubation period can be up to two weeks or longer.

Infant botulism: The incubation period is unknown.

Inhalational botulism: Thought to be 12–36 hours after inhalation, but may take several days after exposure to low doses of toxin.

Communicability

No instance of secondary person-to-person transmission has been documented.

Clinical Illness

Early symptoms tend to be nonspecific and providers often do not suspect botulism until the symptoms become more severe. The hallmark symptoms of botulism are bilaterally symmetrical cranial nerve palsies, which result in slurred speech (dysarthria), difficulty swallowing (dysphagia), double vision (diplopia), and/or drooping eyelids (ptosis); the symptoms progress in a descending manner, causing weakness and possibly paralysis, including loss of respiratory function.

Botulism is frequently misdiagnosed in adults, most often as polyradiculoneuropathy (Guillain-Barré or Miller-Fisher syndrome), myasthenia gravis, or other diseases of the central nervous system.

The signs and symptoms of infant botulism are constipation, poor feeding and/or weak sucking, drooping eyelids (ptosis), weak cry, dilated and/or sluggishly reactive pupils, poor head control, hypotonia ("floppy baby syndrome"), and respiratory difficulty.

DEFINITIONS

Note: There are 4 different categories of botulism used for reporting cases in NEDSS: Botulism, foodborne; Botulism, wound; Botulism, infant; and Botulism, other unspecified.

BOTULISM, FOODBORNE

Clinical Case Definition

Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis can progress rapidly.

Laboratory Confirmation

- Detection of botulinum toxin in serum, stool, or patient's food, **OR**
- Isolation of *Clostridium botulinum* from stool.

Case Classifications

- **Confirmed:** A clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory confirmed botulism.
- **Probable:** A clinically compatible case with a history of ingestion of a food item known to carry a risk for the botulism toxin.

BOTULISM, WOUND

Clinical Case Definition

An illness resulting from toxin produced by *Clostridium botulinum* that has infected a wound. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis can progress rapidly.

Laboratory Confirmation

- Detection of botulinum toxin in serum, **OR**
- Isolation of *Clostridium botulinum* from wound.

Case Classifications

- **Confirmed:** A clinically compatible case that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms.
- **Probable:** A clinically compatible case in a patient who has no suspected exposure to contaminated food and who has either a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms.

BOTULISM, INFANT

Clinical Case Definition

An illness of infants (<1 year), characterized by constipation, poor feeding, and “failure to thrive” that can be followed by progressive weakness, impaired respiration, and death.

Laboratory Confirmation

- Detection of botulinum toxin in stool or serum, **OR**
- Isolation of *Clostridium botulinum* from stool.

Case Classification

- **Confirmed:** A clinically compatible case that is laboratory confirmed, occurring in a child aged less than 1 year.

BOTULISM, OTHER UNSPECIFIED

Clinical Case Definition

Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis can progress rapidly.

Laboratory Confirmation

- Detection of botulinum toxin in clinical specimen, **OR**
- Isolation of *Clostridium botulinum* from clinical specimen.

Case Classification

- **Confirmed:** A clinically compatible case that is laboratory confirmed in a patient aged greater than or equal to 1 year who has no history of ingestion of suspect food and has no wounds.

SURVEILLANCE AND CASE INVESTIGATION

Note: EAIDB should be directly involved in the evaluation and testing of suspect foodborne botulism cases because antitoxin (H-BAT) can only be released by the CDC after consultation with the central office of a state health department. This is done to ensure that the state health department is aware that there is a suspect case of foodborne botulism, as there is always the possibility of additional cases and a food source still in commerce.

EAIDB does not have to be directly involved in the evaluation of suspect infant botulism cases because these are almost always isolated cases and do not represent public health threats, but should be contacted for approval and coordination of specimens submitted to the DSHS laboratory. Physicians can contact the California Infant Botulism Treatment and Prevention Program directly, and antitoxin will be released without consultation with EAIDB. EAIDB does receive notification of the antitoxin release in these situations and will notify the appropriate regional or local health department for further investigation.

For suspect botulism consultations, please contact DSHS EAIDB at 512-776-7676 or 512-221-6852 (after hours).

*** If botulism is highly suspected (e.g., antitoxin is released or testing is approved) then the case will be forwarded to the appropriate regional or local health department for further investigation.

Case Investigation

Local and regional health departments should investigate all reports of suspect botulism. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the Botulism Foodborne Alert Summary or the Infant Botulism Investigation Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition (may have been done by EAIDB).
- ☐ Verify that the laboratory has sent a specimen to the DSHS laboratory (may have been done by EAIDB).
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to describe course of illness and outcome of case.
- ☐ Interview the case or surrogate to identify potential sources infections:

Foodborne Botulism

- ☐ Interview the case and others who may be able to provide pertinent information about foods eaten.
- ☐ A home visit is strongly recommended when home-canned foods are implicated, or if the source is not readily apparent.
- ☐ Ask about possible exposures 1–10 days before onset of symptoms, including:
 - Home-canned, vacuum-packed, or traditionally preserved foods. Foods to suspect as a source of illness are those eaten less than two days before onset, those that are low in acid (fish, meat, and vegetables), and those that were not eaten by other persons who remain well.
 - Commercially canned, vacuum packed foods or mishandled commercial products (e.g., refrigerated soup not kept cold after purchase); such products are implicated only rarely. For implicated foods, determine the brand, manufacturer, package size, lot number and location/date of purchase.

- Preserved or traditionally prepared fish and marine products.
- Items stored in oil (e.g., onions, garlic) or foil (e.g., baked potatoes.).
- Sausages, preserved or traditionally preserved meats, and inadequately refrigerated meats; such products are implicated only rarely.
- Ask if any leftovers of any reported risky food items are still present in the home. Consult with EAIDB regarding possible testing of identified risky food items.
- Identify other potentially exposed persons. Obtain the name, address, and telephone number of every person who may have eaten the suspected food item, shared an environmental exposure or may have the suspect home-processed food in his or her possession.
- Obtain the organization name, contact telephone number, and attendance lists (particularly email or telephone lists) for every suspected gathering, public event, or other shared environmental exposure.
- Use the Botulism Foodborne Alert Summary to record information from the interview.

Wound Botulism

- Interview the case or surrogate to identify potential sources of infections:
 - Ask the patient about illicit injection drug use. Specifically, ask about the types of drugs used and how the drugs are used (e.g., injected into veins, injected into tissues, snorted, etc.).
 - In addition to illicit drug use, interview regarding potential foodborne exposures.

Infant Botulism

- Interview the case or surrogate to identify potential sources of infections:
 - The most common risk factors are exposure to dirt or dust, as with nearby construction, or the ingestion of unpasteurized honey. Although honey was associated with intestinal botulism in the past, it is rarely implicated in cases.
 - Use the Infant Botulism Investigation Form to record information from the interview.
- Fax completed forms to DSHS EAIDB at 512-776-7616 or email securely to an EAIDB epidemiologist.
- Hospitalized cases should be followed until discharge and patient's outcome recorded.
 - Initial reports can be sent to DSHS prior to discharge.
- In the event of a death, copies of the hospital discharge or death summary should also be faxed to DSHS EAIDB.
- All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Treatment

Treatment for botulism is based on the clinical picture and should never be delayed pending laboratory confirmation of the diagnosis. All patients require close monitoring of ventilatory status, and severe cases need aggressive supportive therapy. Additional therapies depend on the type of botulism and are outlined below:

- **Foodborne, Wound, Other (non-infant):** The Centers for Disease Control and Prevention (CDC) control the distribution of botulinum antitoxin (H-BAT), which is stocked at United States Public Health Service Quarantine Stations throughout the country. If antitoxin treatment is being considered, EAIDB will immediately consult with the CDC.

- **Infant Botulism:** A human-derived hyper immune globulin (BIG-IV or “Baby BIG”) is approved by FDA for treatment of infants. Baby BIG can be obtained from the California Department of Health Services by calling their 24 hour number at 510- 231-7600. Consultations also available. EAIDB should also be contacted to arrange for testing by the DSHS laboratory. Additional information about infant botulism is available at: <http://www.infantbotulism.org/>

Prevention and Control Measures

Foodborne botulism

- Strict hygienic procedures should be followed when home canning or pickling to properly sterilize products and prevent bacterial growth, thus reducing the contamination of foods.
- Oils infused with garlic, vegetables, fresh herbs or similar moist flavoring should be refrigerated.
- Potatoes which have been baked while wrapped in aluminum foil should be kept hot or thoroughly reheated before being served, or refrigerated immediately.
- Because the botulism toxin is destroyed by high temperatures, persons who eat risky home-canned foods (i.e., low acidic, non-pickled foods) should consider boiling the food for a minimum of ten minutes before eating it to ensure safety. However, if a food is suspected or at risk of containing botulinum toxin, it should be discarded immediately, as uniform heating may not occur throughout the product or be of a sufficient temperature and/or length of time to destroy the toxin. Adequate pickling, the addition of sugar syrup, or sufficient brining should prevent the growth of *C. botulinum*.
- Instructions on safe home canning can be obtained from county extension services or from the United States Department of Agriculture.
 - http://nchfp.uga.edu/publications/publications_usda.html

Wound botulism

- Wound botulism can be prevented by promptly seeking medical care for infected wounds and by not using injectable street drugs.
- Injection drug users and healthcare providers serving them should be educated regarding typical symptoms of botulism and the importance of rapid diagnosis and treatment. Potential routes for education include needle exchange programs, urban hospital emergency departments, or free clinics.

Infant botulism

- Honey can contain spores of *Clostridium botulinum* and may be a source of infection for infants, therefore children less than 12 months old should not be fed honey (raw or otherwise). Honey is safe for persons one year of age and older.

Iatrogenic botulism

- Iatrogenic botulism may be prevented by using commercially manufactured therapeutic botulinum toxin from medically approved sources and by avoiding injections above recommended doses.

Exclusions

No exclusion is required.

MANAGING SPECIAL SITUATIONS

Outbreaks

Botulism outbreaks are rare. Outbreaks of foodborne botulism have potential to be a public health emergency because the contaminated food may be eaten by other people. Rapid investigation of cases and outbreaks is critical for prompt treatment of likely cases, and for the identification of contaminated food vehicles and prevention of additional cases.

If an outbreak is suspected, **immediately** notify DSHS EAIDB at **(800) 252-8239 or (512) 776-7676** or **512-221-6852 (after hours)**.

- Outbreak investigations should always be done in a collaborative manner involving local health department(s) with suspected or confirmed cases, the appropriate regional health department(s), an EAIDB botulism epidemiologist, DSHS Regulatory Services staff, and any appropriate federal agencies.
- If a food establishment or a commercial product is implicated, EAIDB will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the case(s).
- Outbreaks of infant botulism are extremely unlikely, but not impossible. A food or formula product containing a high load of spores may be responsible for an outbreak. However, since infant botulism was first recognized in 1976, there has never been an infant botulism outbreak in Texas, and, to our knowledge, there has never been one in the U.S.

The local/regional health department should:

- Review case information collected following the initial notification of any suspect individual case(s) already identified, including laboratory results, Foodborne Botulism Alert Summary forms, clinical histories, food histories, and any other information.
- Contact hospitals and healthcare providers in the appropriate areas of the state, or throughout the state if necessary, to alert them to the possibility of additional cases of foodborne botulism.
- Interview all cases suspected as being part of the outbreak or cluster if not done already.
- Prepare a line list of cases in your jurisdiction. At a minimum, information needed for the line list includes patient name, DSHS specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of botulism, and risky foods eaten or other risky exposures reported by the case or surrogate.
- Encourage anyone with symptoms be evaluated by a healthcare provider.
- Communicate regularly with all parties involved in outbreak investigation
 - Provide Situation Reports through email.
 - Hold conference calls to discuss the outbreak investigation
- Report findings at conclusion of investigation:
 - Create Outbreak Summary Report.
 - Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

Botulinum Toxin as a Biological Weapon

C. botulinum toxin has been classified as a possible agent of bioterrorism due to its ability to be weaponized and because it is extremely potent and lethal. The toxin is also easy to produce and transport, and affected individuals often need extensive and prolonged intensive care. Dissemination through aerosol or food would be the most likely mode of spread. Aerosol dissemination could result in many cases of illness in a geographic area. Therefore, inhalational botulism produced by an act of bioterrorism should be considered for 2 or more botulism cases linked temporally and geographically but without a likely common foodborne or drug exposure. In such situations immediately call DSHS EAIDB at 512-776-7676 or 512-221-6852 (after hours). The cases should be extensively interviewed to identify possible exposures such as gatherings, public events, specific geographic locations, large buildings, shopping areas, and public transportation.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **immediately** to the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Call DSHS EAIDB immediately when a botulism investigation is being conducted.
- Enter the case into NBS and submit an NBS notification on all **confirmed** and **probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks **immediately** to the regional DSHS office or to EAIDB at **512-776-7676**.
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

The DSHS laboratory in Austin is the only lab in Texas that can perform confirmatory testing for botulism. Specimens will be accepted by the DSHS lab only with prior approval by EAIDB. Please contact DSHS EAIDB at 512-776-7676 or 512-221-6852 (after hours).

A preliminary laboratory result may be available in 3-5 days after the specimen arrives and a definitive result may take as long as 3 weeks. The decision to treat is based on the clinical picture and should not wait for laboratory confirmation. Generally, if the physician is not considering treatment with antitoxin, there is no need for laboratory testing.

The laboratory must be notified at 512-689-5537 prior to shipping any specimens.

Specimen Collection

- Stool
 - 10-50 grams recommended for an adult
 - ≥ 5 grams recommended for an infant
 - Keep at 2° - 8° C. Do not freeze
 - A sterile water enema can be used to obtain a specimen from a non-stooling patient
- Vomitus or Gastric Aspirate
 - > 10 mL in sterile, leak-proof container
- Serum
 - 10ml minimum for an adult is recommended
 - Not recommended for infant testing
- Wound
 - Tissue from a biopsy or swab from deep in the wound
- Food
 - Only tested if associated with a confirmed botulism case

Submission Form

- DSHS Laboratory G-27A form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-27A form.
- Fill in the date of collection and select the appropriate test.
- Payor source:
 - Check "IDEAS" to avoid bill for submitter

Specimen Shipping

- Transport temperature:
 - Stools, Vomitus or Gastric Aspirate, and Serum:
 - Keep at 2° - 8° C
 - Should be shipped cold (on cold packs, not dry ice) by overnight courier
 - Wound:
 - Ship tissue in anaerobic atmosphere
 - Ship swab in anaerobic transport for swabs
 - Ship without refrigeration
 - Food:
 - Should be shipped in original container under current storage conditions (e.g., cold storage submitted cold; frozen storage submitted frozen; etc.)
- All specimens must be triple contained in accordance with federal shipping regulations. All clinical specimens must be accompanied by a specimen submission form (G-27A).
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. BioThreat Team (512) 689-5537
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Incorrect source of specimen.
- Insufficient amount of specimen.
- Missing or discrepant information on form/specimen

UPDATES

January 2016

- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.

Campylobacteriosis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Campylobacter species, a Gram-negative bacilli. Most cases are caused by *C. jejuni* and fewer by *C. coli*.

Transmission

Transmission is fecal-oral, through the ingestion of contaminated food or water, or through direct contact with animals. Person-to-person transmission is uncommon. Commonly recognized vehicles or mechanisms include:

- Handling or eating undercooked/raw poultry or meat.
- Unpasteurized (raw) milk or dairy products.
- Contaminated and inadequately treated drinking water.
- Contact with animals, especially young animals with diarrhea.
- Contact with poultry.

Incubation Period

Usually 2 to 5 days (ranges 1-10 days).

Communicability

Infected persons not treated with antibiotics may excrete organism for 2 to 7 weeks, but this shedding is of little epidemiological importance, as person-to-person transmission is uncommon.

Clinical Illness

Illness is characterized by diarrhea, abdominal pain, malaise, and fever. The diarrhea may be bloody and can be accompanied by nausea and vomiting. Symptoms usually persist less than one week. Post-infectious complications may include reactive arthritis, Guillain-Barre Syndrome, and irritable bowel syndrome.

DEFINITIONS

Clinical Case Definition

An illness of variable severity commonly manifested by diarrhea, abdominal pain, nausea and sometimes vomiting. The organism may also rarely cause extra-intestinal infections such as bacteremia, meningitis or other focal infections.

Laboratory Confirmation

- Isolation of *Campylobacter* spp. in a clinical specimen.

Case Classifications

- **Confirmed:** A case that is laboratory confirmed
- **Probable:**
 - A case with *Campylobacter* spp. detected in a clinical specimen using a culture independent diagnostic test (CIDT), **OR**
 - A clinically compatible case that is epidemiologically linked to a case that meets the probable or confirmed laboratory criteria for diagnosis

Note: The use of CIDs as stand-alone tests for the direct detection of *Campylobacter* in stool is increasing. Data regarding their performance indicate variability in the sensitivity, specificity, and positive predictive value of these assays depending on the manufacturer (CDC unpublished data). It is therefore useful to collect information on the laboratory conducting the testing using the laboratory's unique CLIA number, and when possible, type and manufacturer of the CID used to diagnose each case. Culture confirmation of CID-positive specimens is ideal, but not practical to achieve in most jurisdictions.

Note: A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different species

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

It is recommended that local and regional health departments investigate all reported cases of campylobacteriosis to identify potential sources of infection. Sporadic cases of campylobacteriosis do not require an investigation form be sent to DSHS EAIDB unless they are identified as part of a multi-jurisdictional cluster or outbreak. Any case associated with a cluster or outbreak should be interviewed.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ If time and resources allow or the case is part of an outbreak or cluster, interview the case to identify potential sources of infection. Ask about possible exposures 1–10 days before onset, including:
 - Contacts or household members with a similar illness. Obtain the name, phone number or address, and clinical information of the ill person.
 - Source(s) of drinking water and source of any water consumed either purposefully or accidentally during work or sports activity, such as lake or stream.
 - Consumption of unpasteurized (raw) milk or dairy products. Identify type of raw milk (cow, goat or “other”), brand and/or sources, and dates(s) of purchase and consumption.
 - Handling or consumption of raw or undercooked poultry or meat.
 - Meals from restaurants or other food services. Obtain name and location of the facility, and date of the meal.
 - Contact with animals or poultry. Ask whether animal has recently experienced diarrhea.
 - Note: If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
- ☐ Provide education to the case or his/her surrogate about food and pet safety, and effective hand washing. See Prevention and Control Measures.
- ☐ Identify whether there is a public health concern: persons should not work as food handlers, child-care or health care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- ☐ All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water especially:
 - Before preparing, handling or eating any food
 - After going to the bathroom
 - After changing a diaper
 - After caring for someone with diarrhea
 - After handling raw food especially poultry
 - After any contact with animals or their living areas
- Avoid consumption of raw or undercooked poultry and meat. Cook all poultry products thoroughly. Make sure that the meat is cooked throughout (no longer pink) and any juices run clear. All poultry should be cooked to reach a minimum internal temperature of 165 °F.
- Prevent cross contamination in the kitchen by using separate cutting boards for foods of animal origin and other foods and carefully cleaning all cutting boards, countertops, and utensils with soap and hot water after preparing raw food of animal origin.
- Avoid consumption of unpasteurized (raw) milk or dairy products.
- Avoid drinking or swallowing untreated surface water. Untreated water should be boiled or otherwise disinfected before consumption.
- Exercise care when handling or cleaning up after pets with diarrhea. Wash hands afterwards.

Exclusions

School/child-care: No exclusions are specified for campylobacteriosis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for campylobacteriosis but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications, OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional campylobacteriosis cases.
- Isolates can be submitted to the DSHS laboratory for culture confirmation and/or PFGE for *C. jejuni*. See Laboratory Procedures.
- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on and adherence to hand hygiene
 - Storage and preparation of food
 - Procedures for changing diapers and toilet training
 - Procedures for environmental cleaning
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory. The general policy is to test only food samples implicated in suspected outbreaks, not in single cases.

REPORTING AND DATA ENTRY REQUIREMENTS.

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different species. A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- If investigation forms are requested, they may be faxed to 512-776-7616 or emailed securely to an EAIDB foodborne epidemiologist.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

CLINICAL SPECIMENS:

Testing for campylobacteriosis is widely available from most private laboratories. Isolates or specimens from submitters are accepted with prior approval by the DSHS laboratory for culture confirmation and/or PFGE for *C. jejuni*. Contact an EAIDB foodborne epidemiologist to discuss further.

In an outbreak or other special situation, the DSHS Laboratory can culture raw stool or stool in transport medium (e.g., Cary-Blair media) for *Campylobacter* species. Contact an EAIDB foodborne epidemiologist prior to submitting raw stool or stool in transport medium for culture.

Specimen Collection

- Submit pure cultures on an agar slant at ambient temperature or 2-8°C (*ice pack*) as soon as possible to ensure viability.
- For raw stool or stool in transport medium, please refer to table below:

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool	≤24 hours	4°C (ice pack)
Raw stool	>24 hours	Freeze immediately at ≤-70°C. Ship on dry ice.
Stool in transport solution/medium	Time of collection to ≤3 days	Room temp or 4°C (ice pack)
Stool in transport solution/medium	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.
All	*The above transport times are optimal for recovery of pathogenic organisms. In the interest of public health, specimens will be accepted up to 30 days from date of collection.	*The above transport temperatures are optimal for the recovery of pathogenic organisms. In the interest of public health, specimens will be accepted at non-optimal temperature transport.

* Note: Pathogen recovery rates decrease over time. For best results, submit ASAP.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter

Specimen Shipping

- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Missing or discrepant information on form/specimen.
- Transport media was expired.
- Specimen not in correct transport medium.

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Campylobacter* spp. is available at the DSHS laboratory. Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

General policy

- The DSHS lab will only test food samples or environmental swabs from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreaks, the DSHS lab will not test food samples or environmental swabs unless a pathogen has been identified in a clinical specimen.
- Food samples or environmental swabs must be **collected by a registered sanitarian**

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

UPDATES

April 2017

- Updated statement regarding how often to count a case, only counting a case once per 30 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Carbapenem-resistant *Enterobacteriaceae* (CRE)

rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Carbapenemase producing *Enterobacteriaceae* or Carbapenem-resistant *Enterobacteriaceae*, specifically *Klebsiella* species and *E. coli*, are Gram-negative bacilli that have the ability to break down the carbapenem antibiotic rendering it ineffective. Carbapenem resistance by *Enterobacteriaceae* can occur by many mechanisms, including the production of a metallo-beta-lactamase or a carbapenemase (such as *Klebsiella pneumoniae* carbapenemase, KPC) which can be transmitted from one *Enterobacteriaceae* to another. Metallo-beta-lactamases such as New Delhi metallo-beta-lactamase (NDM), are more common outside the United States but, in rare cases, have been identified in American patients with exposure to healthcare in other countries where these strains are endemic. CRE can also have additional resistance mechanisms that enable them to be nonsusceptible to many other classes of commonly used antibiotics.

Transmission

Enterobacteriaceae are a family of bacteria that can be found in a person's gastrointestinal tract that can cause infections both in community and healthcare settings. When found in a clinical culture, CRE can represent an infection or colonization (the organism is present but not causing any symptoms or disease). Colonizing CRE strains can escalate into full blown infections if they gain access to body sites that are usually sterile, like the bloodstream, bone or joints.

Transmission can occur via direct person-to-person contact or secondary contact with contaminated environmental surfaces, medical devices, or equipment. Additionally, the hands of healthcare workers who frequently touch these objects in patient environments often become vectors of transmission if hand hygiene compliance and/or transmission-based precautions are not adhered to.

Incubation Period

There is no set incubation period for exposure-to-illness onset.

Communicability

The period of communicability is unknown and may be as long as the organism is present in the individual. Studies have shown that 39% of individuals may remain colonized with CRE at 1 year from initial test date.

Clinical Illness

CRE can cause infections in almost any part of the body including bloodstream infections, ventilator associated pneumonia, and intra-abdominal abscesses. Based on information from a CDC pilot surveillance system most CRE infections involve the urinary tract, often in people who have a urinary catheter or have urinary retention. Symptoms associated with CRE infections generally vary based on the site that is infected (e.g., cough if in the lungs, urinary symptoms if in the bladder) but can also include general symptoms like fever or chills.

Severity

The case fatality rate of CRE can be as high as 50%, as reported for bloodstream infections.

DEFINITIONS

Clinical Case Definition

When found in a clinical culture, CRE can represent an infection or colonization. There is no set clinical case definition for a CRE as it can cause many types of symptoms.

Laboratory Confirmation

Carbapenem-resistant *Enterobacteriaceae* (CRE):

- *Klebsiella* species or *E.coli* from any body site/source that is laboratory confirmed.

Case Classification

- **Confirmed:** A *Klebsiella* species or *E.coli* from any body site/source that is laboratory confirmed.
 - *Klebsiella* species and *E. coli* that are **resistant** to any carbapenem, including meropenem, imipenem, doripenem, or ertapenem,
 - OR**
 - Production of a carbapenemase (i.e. KPC, NDM, VIM, IMP, OXA-48) demonstrated by a recognized test (i.e. polymerase chain reaction, metallo- β -lactamase test, modified Hodge test, Carba NP).
- **Probable:** there is no probable case definition

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments will promptly address all reports of CRE.

The jurisdiction where the healthcare facility is located conducts the investigation and ensures control measures are promptly taken. The investigation steps below describe the public health activities to be completed when a suspected or confirmed CRE case is reported. Investigations and control measures are required for infection or colonization with any type of CRE.

Case Investigation Checklist

- ☐ The jurisdiction that conducts the investigation is according to the location where the patient tested positive for CRE. (E.g.; patient tested positive for CRE *E.coli* and is in hospital in jurisdiction A but the patient resides in jurisdiction B, jurisdiction A would conduct the investigation).
- ☐ Immediately ensure contact precautions have been implemented for anyone with suspected or confirmed CRE.
- ☐ Confirm that the laboratory results meet the case definition.
 - If it is unclear, call a DSHS Regional HAI Epidemiologist for assistance.
- ☐ Ensure additional control measures are in place for cases and/or facilities. (see “specific control measures” section below)
- ☐ Review the medical records. If needed, speak to an Infection Preventionist (IP) at the healthcare facility to verify demographics, symptoms, and course of illness.
- ☐ If the patient has been discharged from the reporting healthcare facility and the receiving healthcare facility is known, the investigator ensures that the receiving healthcare facility is informed of the CRE case and ensures control measures are in place.
- ☐ Refer to the CRE Investigation form for additional questions to address.
 - The CRE Investigation Form is available on the DSHS Website: <http://www.dshs.state.tx.us/idcu/investigation/>
- ☐ All suspected and confirmed cases of CRE require the investigation form to be completed.

- A paper copy of the investigation form and laboratory report is NOT required to be sent to DSHS EAIDB unless specifically asked.
- Enter all case investigations and submit a notification in NBS within 30 days of the initial report.
 - The jurisdiction that conducted the investigation enters the case in NBS.
 - The jurisdiction is entered as the jurisdiction who conducted the investigation and not the jurisdiction of residency.
 - Once the case is reviewed and approved by DSHS central office, the central office will update the jurisdiction to the jurisdiction of residency for aggregate reporting purposes.

NOTE: if a case is multi-jurisdictional, it is the responsibility of the investigator to notify other jurisdictions of the case.

Prevention and Control Measures

Control measures for Cases

Ideally, the facility is performing control measures for the case and the investigator is communicating directly with the facility, most likely with the IP or the responsible representative over infection prevention. The investigator may also speak with the patient directly if applicable. The investigator ensures the below control measures are addressed but not all specific control measures might be necessary for all case investigations.

Specific Control Measures

- Facilities are responsible for ensuring that healthcare personnel are vigilant with hand hygiene practices and ensure that:
 - Hand hygiene sinks are accessible and free from clutter/supplies;
 - Alcohol-based hand sanitizers are accessible and well stocked.
- Ensure the patient is on contact precautions/ contact isolation. Contact precautions include but are not limited to:
 - Performing hand hygiene before entry into the patient room;
 - Donning (putting on) gown and gloves either before or upon immediate entry into the patient's room; (note some facilities might require more PPE)
 - Doffing (removing) gown, gloves and any other personal protective equipment (PPE) should be removed before exiting or immediately upon exiting the patient's room. Hand hygiene should be performed after removal of PPE.
 - Hand hygiene should be performed before exiting or immediately upon exiting the patient's room.
 - No recommendation currently exists for when to discontinue contact precautions. A facility should consult with an infectious disease physician, the IP, or the other provider that initiated the precautions. The facility may also call a DSHS regional HAI Epidemiologist for assistance.
- Ensure the facility is performing disinfection of reusable equipment before and after each use.
- Recommend single patient rooms if available.
 - If single rooms are not feasible, recommend cohorting like patients (ex: a patient with CRE-E.coli and another patient with CRE-E.coli)
- Recommend staff cohorting if possible.
- Recommend reducing the use of invasive medical devices for patients on the unit where the case was cared for, as invasive devices increase patient's risk of infection.
- Increase the frequency of cleaning of high touch areas.

- Provide education on CRE as needed, with specific emphasis on contact precaution and the above control measures.
 - If additional help is needed regarding providing education, contact your DSHS Regional HAI Epidemiologist. (Education could be provided to: anyone at the facility, family members, and the patient.)

Treatment

Each case will have a unique treatment option. It is recommended that the reporting facility collaborate with a clinical pharmacist, an infectious disease physician, and/or an antibiotic stewardship resource for an individualized treatment plan.

Exclusions

Students (K-12) and daycare age children with CRE wound infection need to be excluded from attendance until drainage from wounds or skin and soft tissue infections is contained and maintained in a clean dry bandage; restrict from situations that could result in the infected area becoming exposed, wet, soiled, or otherwise compromised. No other exclusions apply.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, immediately notify a DSHS Regional HAI Epidemiologist. The DSHS regional HAI Epidemiologist will notify central office and work with central office as needed.

Outbreak Definition

At this time there are no defined criteria for an outbreak. If your health department believes they have detected an outbreak, it is recommended to speak with the DSHS regional HAI Epidemiologist.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School and Child-care Facilities, and General Public Reporting Requirements

Cases of Carbapenem-resistant *Enterobacteriaceae* (CRE) should be reported **within 1 working day** to the local or regional health department. If the jurisdiction is unclear, call a DSHS Regional HAI Epidemiologist or Emerging and Acute Infectious Disease Branch (EAIDB) at 512-776-7676 for assistance.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Promptly investigate all reported cases.
- Ensure control measures are in place and provide education to prevent further spread of disease (see specific control measures section located in this document).
- Enter the case into NBS when the first occurrence is reported and create the NBS notification to DSHS on all cases of CRE. Complete additional case information and enter the remaining information within 30 days of initial report.
 - Please refer to the NBS Data Entry Guide for specific details on how to properly complete an NBS investigation, how to data enter a laboratory report and submit a NBS notification.

When a cluster or an outbreak is investigated, local and regional health departments should:

- Report suspected outbreaks within 24 hours of identification to a DSHS Regional HAI Epidemiologist.
 - Fax the investigation form and all other supporting documents to the DSHS Regional HAI Epidemiologist.
- If labeling a case as part of an outbreak, the outbreak must be named in NBS. Outbreak names must be requested through the NEDSS (NBS) office. The staff can be reached by phone (512) 458-7111 ext. 7729 or email nedss@dshs.state.tx.us

DISEASE REPORTING

Purpose of Reporting and Surveillance

- To prevent transmission of infections with CRE, specifically CRE-*Escherichia coli* (CRE-*E.coli*) and CRE-*Klebsiella* species in healthcare facilities and the community, by decreasing the likelihood of transmission through the investigation process.
- To improve the detection, monitoring and epidemiological characterization of CRE in Texas.
- To develop, implement and evaluate strategies to prevent the emergence, transmission and persistence of CRE.
- To conduct and support epidemiological studies to identify outbreaks and potential sources of ongoing transmission in various populations.
- To identify further trends related to continued antibiotic resistance and the development of MDROs in Texas.

Requested Reporting

- Report CRE *E.coli* and CRE-*Klebsiella* species to your local health jurisdiction **within 1 working day.**

Local Health Jurisdiction Investigation Responsibilities

- Local health departments may request assistance with the investigation of CRE by contacting both the DSHS Lead Epidemiologist and the DSHS Regional HAI Epidemiologist for the health service region (HSR).
- Because of the potential for transmission of CRE to vulnerable patients in healthcare settings, public health action is imperative in controlling further transmission by: instituting control measures, identifying and screening close contacts of cases that could transmit in healthcare settings, if indicated, and ensuring that the facility IP has been notified and that appropriate infection control measures are in place.

LABORATORY PROCEDURES

Clinical laboratories are not required to submit isolates to the DSHS Laboratory at this time. To obtain confirmatory, gene sequencing or phenotypic testing, clinical laboratories should contact a reference laboratory for those services. The reference lab will give guidance on specimen collection, submission form and shipping.

Any specimen sent to the DSHS Laboratory for possible outbreak situations or molecular testing requires prior approval from a DSHS regional HAI epidemiologist.

UPDATES

April 2017

- Added information and clarification about jurisdiction and who should investigate cases and included information about consulting with a DSHS Regional HAI Epidemiologist for more help with an investigation.
- Added more specific information about control measures and isolation.
- Clarified instructions on how to handle an outbreak.

Congenital Rubella Syndrome (CRS) rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Rubella virus (family togaviridae; genus *rubivirus*)

Transmission

Rubella transmission occurs from person to person through contact with infectious nasopharyngeal secretions and droplets and indirectly by objects contaminated with nasopharyngeal secretions of an infected patient, or through contact with the urine of an infant with CRS. In the case of CRS, rubella virus may also be transmitted from mother to fetus during pregnancy.

Incubation Period

CRS is contracted during pregnancy.

Communicability

Infants with CRS can shed the virus in the nasopharyngeal secretions and urine for up to a year or longer. Rubella virus has been recovered from the lens of children with CRS who have congenital cataracts for up to several years. Therefore, it is essential that infected infants be identified as early in life as possible in order to prevent further spread of the virus. Infected infants should be considered infectious until they are at least 1 year old or until two cultures of clinical specimens obtained 1 month apart after the infant is older than 3 months of age are negative for rubella virus.

Clinical Illness

CRS may consist of many problems including low birth weight, eye defects, cardiac defects, central nervous system defects, hepatitis, thrombocytopenic purpura, splenomegaly, and bone lesions. Deafness is the most common manifestation of CRS, and is sometimes the only manifestation. In mild forms of CRS, there may be no obvious clinical manifestations at birth, and the onset of CRS-related symptoms can be delayed until 2-4 years.

The severity of effects on the fetus depends on the period of gestation at which the infection occurs. A fetus infected early in the pregnancy (especially during the first trimester) has a high probability of developing CRS. In symptomatic women infected with rubella during the first 12 weeks (first trimester) of pregnancy, CRS-associated congenital defects occur in up to 85% of infants. The likelihood of congenital defects decreases if the woman's rubella infection occurs later in the gestational period, dropping to 25% when the woman has a rubella infection late in the second trimester.

DEFINITIONS

Clinical Case Definition

An illness of newborns resulting from rubella infection *in utero* and characterized by signs or symptoms from the following categories:

- Cataracts/congenital glaucoma, congenital heart disease (most commonly patent ductus arteriosus, peripheral pulmonary artery stenosis), hearing loss, pigmentary retinopathy
- Purpura, hepatosplenomegaly, jaundice, microcephaly, developmental delay, meningoencephalitis, or radiolucent bone disease

Laboratory Criteria for Diagnosis

- Isolation of the rubella virus, **OR**
- Demonstration of rubella-specific immunoglobulin M (IgM) antibody, **OR**
- Infant rubella antibody level that persists at a higher level and for a longer period than expected from passive transfer of maternal antibody (i.e., rubella titer that does not drop at the expected rate of a two-fold dilution per month), **OR**
- Detection of rubella-virus-specific nucleic acid by PCR

Case Classification

- **Confirmed:** A case that meets clinical case definition and is laboratory confirmed.
- **Probable:** A case that meets one of the following:
 - Is not laboratory confirmed and has any two complications listed in (a) of the clinical case definition above, **OR**
 - Is not laboratory confirmed and has one complication from (a) and one from (b); and lacks evidence of any other etiology

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of congenital rubella immediately.

Case Investigation Checklist

- ☐ Ensure isolation of case and droplet precautions are in place.
- ☐ Confirm that the laboratory results meet the case definition.
- ☐ Request that the laboratory forward viral isolation specimens to the DSHS laboratory. See Laboratory Procedures.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition, clinical picture, treatment history, and vaccination status of both mom and baby.
 - The Rash-Fever Illness Case Track Record can be used to record information collected during the investigation.
- ☐ Identify and follow-up with all exposed contacts.
 - Determine their susceptibility (fully vaccinated or lab evidence of rubella specific IgG).
 - If susceptible, give vaccination as appropriate for age and vaccination status.
 - See control measures below for infants and in the Rubella section for adults and older children.
- ☐ In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be faxed to DSHS EAIDB.

- Fax the hospital records, labs and completed the Rash-Fever Illness Case Track Record to DSHS.
- All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Patients with congenital rubella syndrome should be considered contagious until they are 1 year of age or until two cultures of clinical specimens obtained 1 month apart after the infant is older than 3 months of age are negative for rubella virus.
- Parents should be made aware of the potential hazard of their infants to susceptible, pregnant contacts.

Exclusion

Infants with CRS should be placed in contact isolation. These precautions should be enforced during any hospital admission before the child's first birthday, unless two cultures of clinical specimens obtained 1 month apart are negative for rubella virus after infant is older than 3 months of age.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak of rubella or CRS is suspected, notify EAIDB at (800) 252-8239 or (512) 776-7676.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 work day** to the local or regional health department or to DSHS EAIDB at (800) 252-8239 or (512) 776-7676.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS within 30 days of receiving a report of a confirmed or probable case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at 512-776-7676.

LABORATORY PROCEDURES

Please submit specimens for viral isolation (culture or PCR) to the DSHS laboratory in Austin. Specimens may be submitted for serology if serology is not available from a commercial lab.

Virus Isolation/PCR Specimen Collection and Submission (preferred)

Rubella virus can be isolated from throat, nasopharynx, blood, urine, and cerebrospinal fluid specimens from rubella and CRS cases. Efforts should be made to obtain clinical specimens (particularly pharyngeal swabs) for viral isolation from infants at the time of the initial investigation. Infants with CRS may, however, shed virus for a prolonged period (up to 1 year) so specimens obtained later may also yield rubella virus. Specimens for virus isolation (pharyngeal swabs) should be obtained monthly until cultures are repeatedly negative.

Specimen Collection

- Use a viral culturette or synthetic swab (collection and transport system) to obtain a pharyngeal swab and place in 2-3 mL of viral transport media.
- Label the culturette or specimen tube with the patient's name and date of birth or social security number.

Submission Form

- Use Specimen Submission Form G-2V.
- Make sure the patient's name and date of birth, social security number match exactly what is written on the culturette or specimen tube.
- Mark the laboratory test requested (virus isolation-rubella), disease suspected, date of onset, and date of collection.

Specimen Shipping

- Keep the specimen at 2-8°C and ship overnight on wet ice within 48 hours.
- If the specimen must be held longer, freeze at -70°C and ship on dry ice.
- Send the specimen to the laboratory via overnight delivery on wet or dry ice as noted above.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Serology Specimen Collection and Submission (if needed)

IgM Serology: Single specimen collected soon after birth or soon after suspected diagnosis of CRS is made. Note: IgG is not useful in CRS as baby may have maternal antibodies. Do not use cord blood.

Specimen Collection

Option 1:

- Collect at least 5 mL blood in red top tube.
- Label blood tubes with patient's first and last name, and we recommend a second identifier such as date of birth or medical record number or social security number. If the first and last name is not provided, the specimen will be rejected.
 - Centrifuge the **red top blood** collection tube within 2 hours from the time of collection to separate the serum from the red blood cells (clot).
 - Transfer the serum from the red top tube into a serum transport tube properly labeled with the patient's name and date of birth or social security number and ship cold with cool packs and must be received within 48 hours.
 - If the serum samples will not be delivered to the laboratory within 48 hours of collection, then the samples must be frozen at -20°C (frozen) or lower and shipped frozen with dry ice.
 - Do not freeze whole blood in red top tube for shipping.

Option 2:

- Collect at least 5 mL blood in **gold top** or **tiger top** blood collection tube containing a gel serum separator (Gold top or tiger top tubes are types of serum separator tubes (SST) with the gel that keeps the serum separated from the clot after the centrifugation).
- Label blood tubes with patient's first and last name, and we recommend a second identifier such as date of birth or medical record number or social security number. If the first and last name is not provided, the specimen will be rejected.
 - Centrifuge the gold top blood collection tube within 2 hours from the time of collection to separate the serum from the red blood cells (clot) and ship cold with cool packs and must be received within 48 hours.
 - If more than 48 hours, transfer the serum into a serum transport tube properly labeled with the patient's name and date of birth or social security number and ship frozen with dry ice.
 - Do not freeze serum in SST for shipping. Freezing will cause hemolysis and hemolyzed specimens will be unsatisfactory for testing.

Submission Form

- Use the DSHS Laboratory current version of G-2A form for specimen submission.
- Make sure the patient's first and last name and date of birth/social security number match exactly what is written on the tube.
- Mark the laboratory test requested, date of onset, and date of collection. Be certain that the names on acute and convalescent sera match exactly.
- Call DSHS Laboratory at 512-776-7138 if needing information for specimen submission.

Specimen Shipping

- To avoid specimen rejection, ship separated serum or centrifuged SST Monday through Thursday to the DSHS laboratory via overnight delivery following the above guidelines.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
 - If the serum samples will not be delivered to the DSHS laboratory within 48 hours of collection, transfer into a serum transport tube and freeze on Fridays. Ship frozen specimens with dry ice on Monday. Lone Star service will not deliver specimen to the DSHS lab on Saturday.

- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Discrepancy between name on tube and name on form
- Insufficient quantity of serum for testing specimens received with extended transit time
- Received at incorrect temperature
- No date of collection

UPDATES

April 2017

- Edits made throughout the document to improve clarity

Cryptosporidiosis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Cryptosporidium species, a coccidian, protozoan parasite. *Cryptosporidium hominus* and *Cryptosporidium parvum* are the 2 species most often associated with human illness.

Transmission

Transmission occurs through the fecal-oral route. This is predominantly through the ingestion of sporulated oocysts, which are the infectious stage of the parasite, in contaminated or untreated water sources. Oocysts are shed periodically in high quantities in the stool of infected individuals and are highly resistant to environmental conditions and chemical disinfectants. Transmission can also occur through person-to-person transmission, through contact with an infected animal or contaminated surface, and via the ingestion of contaminated food. A wide array of animals can act as reservoirs and sources of infection without displaying symptoms of illness, including fish, reptiles, birds, and small (rodents, cats, dogs) and large mammals (cattle and sheep).

Incubation Period

Variable; usually 1 to 12 days, with an average of 7 days

Communicability

Oocysts may be shed immediately upon symptom onset and for up to 2 weeks after symptoms resolve. Immunocompromised individuals may shed oocysts for months. *Cryptosporidium* oocysts are infectious immediately upon excretion. Outside of the body the oocysts can remain infectious for 2-6 months and even longer when in a moist environment.

Clinical Illness

Frequent, non-bloody, watery diarrhea lasting 6 to 14 days (less than 30 days) is the predominant symptom. Fever, abdominal cramps, fatigue, vomiting, anorexia and weight loss may also be seen. Asymptomatic infections are common.

Severity

Usually self-limited in healthy individuals. Pregnant women and people with weakened immune systems are at higher risk of severe complications. Rare instances of disseminated infection may occur in immunocompromised individuals. Malnutrition and significant weight loss in immunocompromised individuals with chronic diarrhea can contribute to death.

DEFINITIONS

Clinical Case Definition

A gastrointestinal illness characterized by diarrhea and one or more of the following: diarrhea duration of 72 hours or more, abdominal cramping, vomiting, or anorexia.

Laboratory Confirmation

- Detection of *Cryptosporidium* organisms or DNA in stool, intestinal fluid, tissue samples, biopsy specimens, or other biological sample by certain laboratory methods with a high positive predictive value (PPV), e.g., DFA, PCR, EIA, or light microscopy of stained specimen.

Case Classifications

- **Confirmed:** A case that is laboratory confirmed
- **Probable:** A person must meet one of the following:
 - A case with *Cryptosporidium* antigen detected by a screening test method such as, the immunochromatographic card/rapid card test or a laboratory test of unknown method, **OR**
 - A clinically compatible case that is epidemiologically linked to a confirmed case by one of the following means:
 - Household or other close contact to a lab-confirmed case with onset of symptoms within 1 month (before or after), **OR**
 - Exposure to an outbreak at a body of water or water facility involving at least 2 lab-confirmed cases and onset of symptoms within one month (before or after) of one or more of these cases.

Note: a case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

It is recommended that local and regional health departments investigate all reported cases of cryptosporidiosis to identify potential sources of infection. Sporadic cases of cryptosporidiosis do not require an investigation form be sent to DSHS EAIDB unless they are identified as part of a multi-jurisdictional cluster or outbreak. Any case associated with a cluster or outbreak should be interviewed.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist/healthcare provider to verify case definition, identify possible risk factors, and describe course of illness.
- ☐ If time and resources allow or the case is part of an outbreak or cluster, interview the case to identify potential sources of infection. Ask about possible exposures in the 2 to 12 days before onset, including:
 - Contact with any acquaintances or household member with a similar illness.
 - Attendance or work at a child-care facility by the case or a household member.
 - Source(s) of drinking water, including water at home and work, as well as streams, lakes or other untreated sources.
 - Recreational water exposures: lakes, rivers, swimming pools, water slides, etc. Obtain the date and location of exposure.
 - Travel outside the area. Obtain travel dates and locations visited.

- Contact with livestock and other animals.
- Consumption of high-risk foods (e.g., raw milk or other unpasteurized products).
- Note: If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
- Provide education to the case or his/her surrogate regarding modes of transmission and ways to prevent transmission to others. See Prevention and Control Measures.
- Identify whether there is a public health concern: persons should not work as food handlers, child-care or health care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
 - After any contact with animals or their living areas.
- Swimming at recreational water venues (pools, interactive fountains, lakes, ocean):
 - Prevent transmission to others by not swimming when experiencing diarrhea (this is essential for children in diapers).
 - If diagnosed with cryptosporidiosis, swimming should be avoided for at least 2 weeks after diarrhea stops.
 - Symptomatic individuals should shower prior to entering the water.
 - Children should be washed thoroughly (especially their bottoms) with soap and water after they use the toilet or their diapers are changed and before they enter the water.
 - Children should be taken on frequent bathroom breaks and have their diapers checked often.
 - Change diapers in the bathroom, not near the poolside or water source.
- Contact with animals:
 - Avoid or minimize any contact with the feces of all animals, especially young animals.
 - Wear disposable gloves when cleaning up animal feces and always wash hands when finished.
 - Wash hands after any contact with any animals or their living areas.
- Outside:
 - Wash hands after gardening, even if wearing gloves.
- Immunocompromised persons/at risk populations - cryptosporidiosis can become a life threatening disease for immunocompromised persons:
 - Avoid close contact with any person or animal that has cryptosporidiosis.
 - Do not handle animal feces.
- Avoid sexual practices that can cause oral exposure to stool (e.g., oral-anal contact).

Exclusions

School/child-care: No exclusions are specified for cryptosporidiosis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for cryptosporidiosis but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications, OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the DSHS Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl, D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional cases.

- Work with any implicated facilities to ensure staff and students/residents/volunteers get hand hygiene education and review hygiene and sanitary practices currently in place including:
 - Policies on, and adherence to, hand hygiene
 - Storage and preparation of food
 - Procedures for changing diapers and toilet training
 - Procedures for environmental cleaning
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- When a public recreational or public water source (such as public pools, water parks or lake) is implicated as a source of transmission, educate staff on appropriate measures of environmental cleaning and disinfection.
 - Recommend the disinfection and remediation guidelines at the CDC website:
<http://www.cdc.gov/healthywater/swimming/pools/disinfection-remediation-pools-hot-tubs.html>
 - When a recreational water source has been implicated in an outbreak, recommend hyperchlorination be used for disinfection and remediation:
<http://www.cdc.gov/healthywater/pdf/swimming/pools/hyperchlorination-to-kill-cryptosporidium.pdf>
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** and **probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection. A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- If investigation forms are requested, they may be faxed to 512-776-7616 or emailed securely to an EAIDB foodborne epidemiologist.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

CLINICAL SPECIMENS:

Testing for cryptosporidiosis is widely available from most private laboratories. Specimens should not be submitted to the DSHS laboratory unless approved by EAIDB. Submission of specimens to the DSHS laboratory will be considered during outbreak investigations. Contact an EAIDB foodborne epidemiologist to discuss further.

Specimen Collection

- Submit a stool specimen in a sterile, leak-proof container.
 - Required volume: Stool 15g solid or 15mL liquid.
- Fresh stool that cannot be received by the lab in less than 5 hours should be placed in formalin immediately.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter

Specimen Shipping

- Transport temperature: May be shipped at ambient temperature or 2-8°C.
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.
- Unpreserved specimen received greater than 5 hours after collection.

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Cryptosporidium* is NOT available at the DSHS laboratory.

UPDATES

April 2017

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.

Cyclosporiasis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Cyclospora cayetanensis, a sporulating, protozoan parasite. *Cyclospora* is an oocyst, i.e., it is protected by an outer wall making it resistant to disinfectants. It also has surface adhesions that allow it to adhere to various surfaces, e.g., leafy greens, berries, etc.

Transmission

Transmission occurs through ingestion of oocysts in contaminated food or water.

Incubation Period

Usually 7 days (range 2-14 days)

Communicability

Cyclospora oocysts are not infectious in freshly excreted stool, making person-to-person transmission unlikely. However, indirect transmission can occur if excreted oocysts contaminate the environment and sufficient time/conditions allow them to become infectious (i.e., sporulate).

Clinical Illness

Watery diarrhea is the predominant symptom. Low grade fever, abdominal cramps, prolonged fatigue, nausea, vomiting, anorexia, flatulence, myalgia and weight loss may also be seen. Asymptomatic infections can occur.

DEFINITIONS

Clinical Case Definition

An illness of variable severity caused by the protozoan parasite *Cyclospora cayetanensis*. The most common symptom is watery diarrhea. Other common symptoms include loss of appetite, weight loss, abdominal cramps/bloating, nausea, body aches, and fatigue. Vomiting and low grade fever also may be noted. Relapses and asymptomatic infections can occur.

Laboratory Confirmation

- Detection, in symptomatic or asymptomatic persons, of *Cyclospora*:
 - Oocysts in stool by microscopic examination, or in intestinal fluid/aspirate or intestinal biopsy specimens, **OR**
 - Demonstration of sporulation, or DNA (by PCR) in stool, intestinal fluid/aspirate or intestinal biopsy specimens

Case Classifications

- **Confirmed:** A laboratory-confirmed case with or without clinical symptoms
- **Probable:** A clinically compatible case that is epidemiologically linked to a confirmed case

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of cyclosporiasis. Investigations should include an interview of the case or a surrogate to get a detailed exposure history.

Please use the Cyclosporiasis Investigation Form available on the DSHS website:

<http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ Interview the case to get detailed food history and risk factor information.
 - Use the **Cyclosporiasis Investigation Form** to record information from the interview.
 - If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
 - Provide education to the case or his/her surrogate about effective hand washing, food safety practices, and ways to prevent transmission to others. See Prevention and Control Measures.
- ☐ Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - For lost to follow-up (LTF) cases, please complete as much information obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.
- ☐ Identify whether there is a public health concern: persons should not work as food handlers, child-care or health care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
- Thoroughly wash fruits and vegetables; however, this practice does not eliminate the risk of *Cyclospora*.
- When traveling internationally to areas with poor sanitary conditions:
 - Drink bottled water or water that has been boiled for at least 1 minute.
 - Don't drink fountain drinks or drinks with ice.
 - Don't eat fruits or vegetables that you don't peel yourself.
 - Avoid uncooked foods.
- Avoid swallowing recreational water, especially when traveling.

Exclusions

School/child-care: No exclusions are specified for cyclosporiasis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for cyclosporiasis but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the DSHS Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl, D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional cases.

- Work with any implicated facilities to ensure staff and students/residents/volunteers get hand hygiene education and review hygiene and sanitary practices currently in place including:
 - Policies on, and adherence to, hand hygiene.
 - Storage and preparation of food.
 - Procedures for changing diapers and toilet training.
 - Procedures for environmental cleaning.
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://www.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

CLINICAL SPECIMENS:

Testing for cyclosporiasis is widely available from most private laboratories. Specimens are encouraged to be submitted to the DSHS laboratory for confirmation.

Specimen Collection

- Submit a stool specimen in a sterile, leak-proof container.
 - Required volume: Stool 15 g solid or 15mL liquid.
- Fresh stool that cannot be received by the lab in less than 5 hours should be placed in formalin and PVA immediately.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter.

Specimen Shipping

Transport temperature: May be shipped at ambient temperature or 2-8°C.

- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.
- Unpreserved specimen received greater than 5 hours after collection.
- Transport media was expired.
- Specimen too old.

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Cyclospora* is NOT available at the DSHS laboratory. In outbreak and special situations, food and environmental samples may be submitted to the FDA laboratory.

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

UPDATES

APRIL 2017

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.

Diphtheria rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Toxin-producing strains of *Corynebacterium diphtheriae*

Transmission

Direct person-to-person transmission by intimate respiratory and physical contact. Cutaneous skin lesions are also important in transmission.

Incubation Period

Usually 2-5 days (range 1-10 days)

Communicability

Untreated individuals generally shed bacteria from the respiratory tract or from skin lesions for 2-4 weeks after infection. Infected individuals are infectious for up to 4 days after antibiotic treatment has been initiated. A chronic carrier state is extremely rare, but known to exist, and such a carrier may shed organisms for up to 6 months or longer.

Clinical Illness

Classic diphtheria is an upper respiratory tract illness characterized by sore throat, low-grade fever, and an adherent membrane of the tonsils, pharynx, and/or nose. The disease can involve almost any mucous membrane. Growth of the adherent membrane can cause a potentially fatal airway obstruction. Patients with severe disease can develop a “bullneck” appearance caused by edema of the anterior neck.

Cutaneous diphtheria is either caused by toxigenic or non-toxigenic strains of *C. diphtheriae*. The disease is usually mild, typically consisting of non-distinctive sores or shallow ulcers, and rarely causes toxic complications. Cutaneous infections represent 1-2% of infections with toxigenic strains. Cutaneous diphtheria is not reportable, but should be promptly investigated to determine whether the strain is toxigenic.

DEFINITIONS

Clinical Case Definition

An upper respiratory tract illness typically characterized by sore throat, low-grade fever, and an adherent membrane of the tonsil(s), pharynx, larynx, and/or nose

Laboratory Criteria for Diagnosis

- Isolation of *Corynebacterium diphtheriae* from a clinical specimen, **OR**
- Histopathologic diagnosis of diphtheria.

Case Classification

- **Confirmed:** A clinically compatible case that is:
 - Laboratory confirmed **OR**
 - Epidemiologically linked to a laboratory-confirmed case
- **Probable:** No probable case definition

Note: Cutaneous diphtheria should not be reported. All diphtheria isolates regardless of association with disease, should be sent to the DSHS Laboratory.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should immediately investigate any reported suspect cases of diphtheria.

****If a provider suspects diphtheria, the provider should be instructed to call the Texas Department of State Health Services EAIDB to discuss the case and determine whether diphtheria antitoxin is needed. During business hours, the provider should call 512-776-7616, after hours the number is 512-221-6852****

EAIDB will evaluate and determine the need for antitoxin prior to contacting the Centers for Disease Control and Prevention (CDC) for diphtheria antitoxin, if still required. The current CDC Emergency Operations Center (EOC) protocol has been revised to redirect medical care providers requesting DAT (for treatment of suspected diphtheria) to contact their respective state health departments and discuss their case, if they have not previously done so.

If the CDC releases antitoxin, the following control measures should be implemented immediately. If the CDC does not feel antitoxin is warranted, the control measures can be implemented after laboratory/pathological confirmation.

Case Investigation Checklist

- ☐ If not done already, notify DSHS EAIDB immediately and discuss possible release of antitoxin.
- ☐ If deemed to be a candidate for antitoxin by EAIDB, refer provider to CDC for antitoxin.
- ☐ Isolate patient.
- ☐ Confirm that laboratory results meet the case definition.
- ☐ Verify that the laboratory has forwarded the specimen to the DSHS laboratory. See Laboratory Procedures.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition, underlying health conditions, course of illness, vaccination status and travel history.
 - Request copies of admission and discharge summaries and laboratory results.
- ☐ Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- ☐ Identify and follow-up with all close contacts. See Managing Close Contacts below.
 - Collect specimens and send to the DSHS laboratory.
 - Provide prophylaxis.
 - Monitor for 7 days.
 - Give vaccination or booster as appropriate for age and vaccination status.
- ☐ Submit specimens from case and close contacts to the DSHS laboratory.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Reports of suspected diphtheria should be investigated **immediately**.
- Universal vaccination with a diphtheria toxoid containing vaccine is the best prevention and control measure.
- Identify and follow-up with close contacts of confirmed cases.
 - Only close contacts of a patient with culture-confirmed or suspected diphtheria should be considered at increased risk for acquiring secondary disease. Such contacts include all household members and other persons with a history of habitual close contact with the patient, as well as those directly exposed to oral secretions of the patient.
- Patient should be kept in strict isolation until two cultures from both throat and nose, taken at least 24 hours apart and at least 24 hours after cessation of antimicrobial therapy, are negative for diphtheria bacilli. If cultures are not possible, patient should be kept in isolation for 14 days following appropriate antibiotic treatment.
- Cases should be monitored until hospital discharge, even if all investigation and control measures have been completed.

Managing Close Contacts

- Close contacts should be cultured, receive prompt antimicrobial chemoprophylaxis, and be examined daily for seven days for evidence of disease.
 - Submit specimens from close contacts to the DSHS laboratory.
 - Do not wait for culture results before treating contacts.
- Recommended prophylaxis is a 7-10 day course of oral erythromycin (children 40 mg/kg/day and adults 1 g/day).
- Identified carriers of *C. diphtheriae* should be cultured after they complete antimicrobial therapy. Those who continue to carry the organism should receive an additional 10-day course of oral erythromycin and follow-up cultures.
- All close contacts who have received fewer than 3 doses of diphtheria toxoid or whose vaccination status is unknown should receive an immediate dose of a diphtheria toxoid-containing preparation appropriate for their age and should complete the primary series according to the recommended schedule.
- Close contacts who have completed a primary series of 3 or more doses of diphtheria toxoid and who have not been vaccinated with diphtheria toxoid within the previous 5 years should receive a booster dose appropriate for their age. See Managing Contacts flowchart.

Treatment

The mainstay of treatment of a case of suspected diphtheria is prompt administration of diphtheria antitoxin. This should be given without waiting for laboratory confirmation of a diagnosis. Antitoxin is only available from the CDC, usually through the Quarantine Station in Houston. To determine whether or not the case-patient is approved for antitoxin release, call EAIDB at 512-776-7616 or 512-221-6892 (after hours).

Exclusion

Patient should be excluded until released from isolation by provider.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak of diphtheria is suspected, notify the regional DSHS office or EAIDB at **(800) 252-8239** or **(512) 776-7676**.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Clinically suspected diphtheria cases are required to be reported **immediately** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases to DSHS within 30 days of receiving a report of a confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **(800) 252-8239** or **512-776-7676**.

LABORATORY PROCEDURES

Isolation and identification of *Corynebacterium diphtheriae* is available through the DSHS Laboratory. Specimens should be sent to DSHS from cases and all close contacts. Before shipping specimens, be sure to notify DSHS EAIDB VPD staff at **(512) 776-7676**.

Please refer to the [TAC](#) Title 25, Ch 97, Subchapter A, Rule §97.3 “What Condition to Report and What Isolates to Report or Submit”.

Specimen Collection

- Use a cotton-tipped or polyester-tipped swab.
- Swabs should be taken below the membrane, if possible. (A portion of the membrane may be submitted for culture, but does not always yield *C. diphtheriae* well.)
- Ship swabs in Amie’s or Stuarts Transport or transfer to a Loeffler’s Slant for transport to DSHS Labs.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name and date of birth or social security number match exactly what is written on the transport tubes.
- Fill in the date of collection, date of onset, and diagnosis/symptoms.

Specimen Shipping

- Transport temperature: Keep at 2° - 25° C.
- Ship specimens via overnight delivery on cold packs or wet ice (double bagged) within 48 hours of collection.
- DO NOT mail on a Friday or a day before a state holiday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

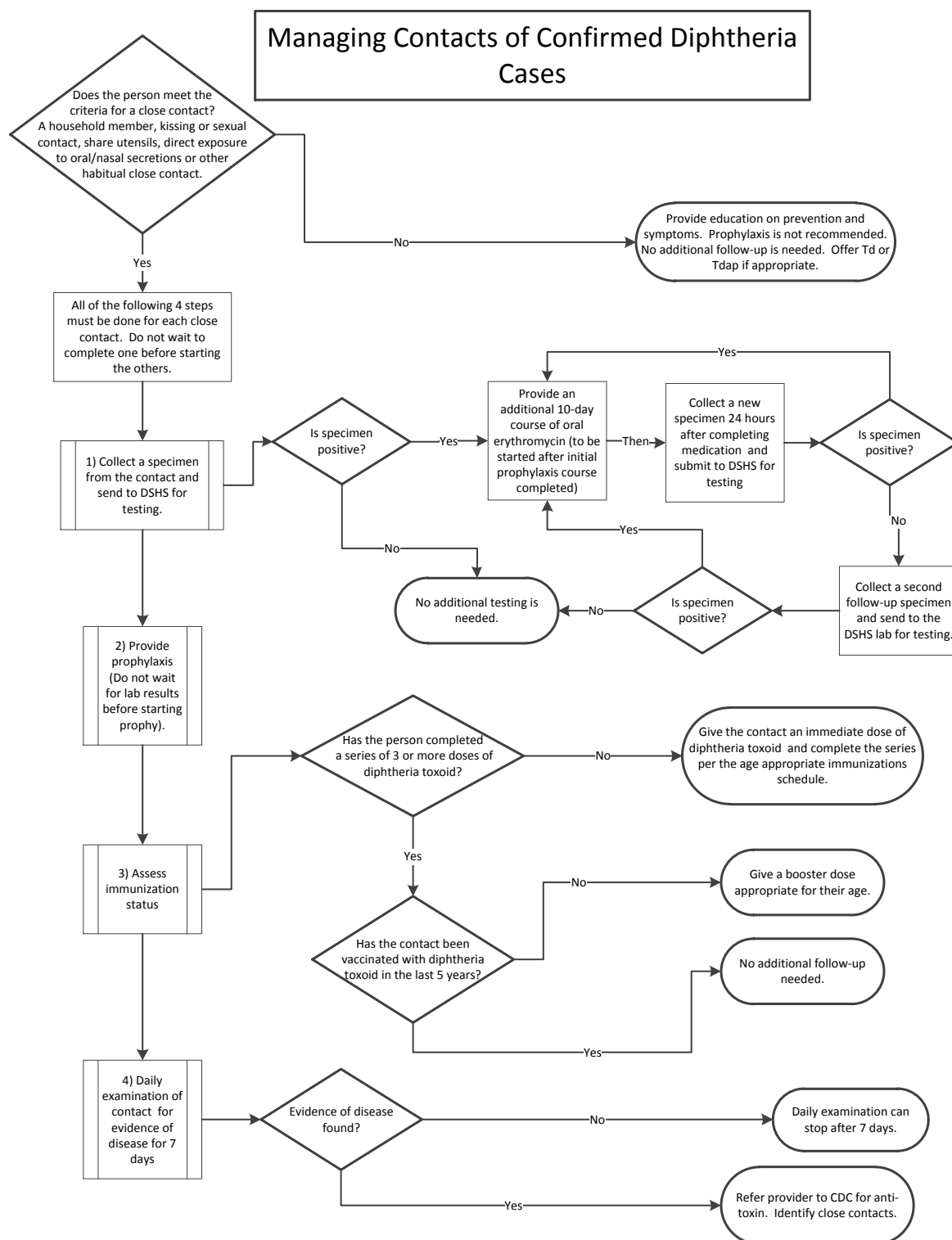
- Incorrect source of specimen
- Specimen > 24 hours not in transport medium
- Missing or discrepant information on form/specimen

UPDATES

April 2017

- Updates made to document to clarify case classification
- Updates made to process for obtaining diphtheria antitoxin

FLOW CHART



Ebola Virus Disease rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

The infectious agent is Ebolavirus, in the family filoviridae. There are five identified Ebola virus species, four of which cause disease in humans: Zaire, Sudan, Taï Forest, and Bundibugyo.

Transmission

Ebola has been found in certain mammals (primates, bats) in Africa. It is thought that fruit bats of the Pteropodidae family are natural Ebola virus hosts. Ebola is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals such as chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest.

Once infection occurs in humans, there are several ways it can spread to others. Ebola is spread through direct contact (through broken skin, mucous membranes - yes, nose, mouth, etc.) with:

- blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, semen) of a person who is sick with Ebola
- objects contaminated with the virus (e.g., needles, syringes)

Risk is highest during the late stages of the illness when the patient is vomiting, having diarrhea, or hemorrhaging, and at death if unprotected contact with the corpse occurs. Post-mortem infection has been linked to the preparation of the body for burial and during burial rituals or funeral services.

Ebola is not spread through the air. It is also not typically spread by water or food except through handling or consumption of contaminated bush meat (wild animals hunted for food).

Incubation Period

Usually 8-10 days after exposure (range 2-21 days)

Communicability

People with Ebola are not infectious until symptoms begin. They are infectious for the duration of the illness. The remains of people that have passed away while sick with Ebola are considered infectious and are a common source of infection in African outbreaks. Ebola virus has been detected in semen up to nine months after illness, and abstinence or condom use are recommended during this period after illness. Ebola virus has been detected in breast milk; unless the baby is already symptomatic for Ebola, breastfeeding should be avoided for eight weeks or until breast milk is PCR negative on 2 separate days.

Clinical Illness

Ebola virus disease (EVD) is a severe acute illness, usually with sudden onset of fever, malaise, muscle pain, severe headache, vomiting, diarrhea, abdominal pain, bruising and bleeding. Complications include liver damage, kidney damage, shock, and central nervous system complications. Recovery from Ebola depends on good supportive clinical care. Case fatality rates as high as 90 percent have been reported. Laboratory findings usually show lymphopenia, severe thrombocytopenia, and transaminase elevation (AST>ALT).

DEFINITIONS

Clinical Case Definition (frequently referred to as Person Under Investigation or PUI)

- Fever and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage; AND
- Epidemiologic risk factors within 21 days prior to the onset of symptoms, such as contact with blood or other body fluids or human remains of a patient known to have or suspected to have Ebola, residence in - or travel to - an area where Ebola transmission is active*, or direct handling of bats or non-human primates from disease-endemic areas.

Laboratory Confirmation

- RT-PCR for Ebola, **OR**
- Virus isolation, **OR**
- IgM ELISA, **OR**
- Antigen-capture ELISA, **OR**
- Immunohistochemistry

Case Classifications

- **Confirmed:** A clinically compatible illness that is laboratory confirmed
- **Suspect:** A clinically compatible illness that meets one or more of the following exposures within 21-days before onset of symptoms:
 - Contact with blood or other body fluids of a patient with EVD, **OR**
 - Residence in - or travel to - an EVD endemic area or area currently classified by CDC as experiencing an Ebola outbreak, **OR**
 - Handling EVD specimens in a laboratory setting, **OR**
 - Work in a laboratory that handles primates, bats, or rodents from endemic areas, **OR**
 - Exposure to semen or breast-milk of an individual who had EVD within the last 9 months.

Exposure Risk Levels

- **High risk** includes any of the following:
 - In any country
 - Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, and semen¹) from a person with Ebola who has symptoms
 - Direct contact with a person with Ebola who has symptoms, or the person's body fluids, **while not wearing appropriate personal protective equipment (PPE)**
 - Laboratory processing of blood or body fluids from a person with Ebola who has symptoms **while not wearing appropriate PPE or without using standard bio-safety precautions**
 - Providing direct care to a person showing symptoms of Ebola in a household setting
 - In countries with widespread transmission or cases in urban settings with uncertain control measures
 - Direct contact with a dead body **while not wearing appropriate PPE.**

¹ Ebola virus can be detected in semen for months after recovery from the disease. Unprotected contact with the semen of a person who has recently recovered from Ebola may constitute a potential risk for exposure. The period of risk is not yet defined.

- **Some risk** includes any of the following:

In any country

- Being in close contact² with a person with Ebola who has symptoms **while not wearing appropriate PPE** (for example, in households, healthcare facilities, or community settings)

In countries with widespread transmission*

- Direct contact with a person with Ebola who has symptoms, or the person's body fluids, **while wearing appropriate PPE**
- Being in the patient-care area of an Ebola treatment unit
- Providing any direct patient care in non-Ebola healthcare settings

- Low (but not zero) risk includes any of the following:

In any country

- Brief direct contact (such as shaking hands) with a person in the early stages of Ebola, **while not wearing appropriate PPE**. Early signs can include fever, fatigue, or headache.
- Brief proximity with a person with Ebola who has symptoms (such as being in the same room, but not in close contact) **while not wearing appropriate PPE**
- Laboratory processing of blood or body fluids from a person with Ebola who has symptoms **while wearing appropriate PPE and using standard biosafety precautions**
- Traveling on an airplane with a person with Ebola who has symptoms and having had no identified **some or high** risk exposures

In countries with widespread transmission, cases in urban settings with uncertain control measures, or former widespread transmission and current, established control measures*

- Having been in one of these countries and having had no known exposures

In any country other than those with widespread transmission

- Direct contact with a person with Ebola who has symptoms, or the person's body fluids, while wearing appropriate PPE
- Being in the patient-care area of an Ebola treatment unit

- **No identifiable risk** includes any of the following:

- Laboratory processing of Ebola-containing specimens in a Biosafety Level 4 facility while wearing appropriate PPE
- Any contact with a person who isn't showing symptoms of Ebola, even if the person had potential exposure to Ebola virus
- Contact with a person with Ebola before the person developed symptoms
- Any potential exposure to Ebola virus that occurred **more than 21 days previously**
- Having been in a country with Ebola cases, but **without** widespread transmission, cases in urban settings with uncertain control measures, or former widespread transmission and now established control measures, and not having had any other exposures
- Having stayed on or very close to an airplane or ship (for example, to inspect the outside of the ship or plane or to load or unload supplies) during the entire time that the airplane or ship was in a country with widespread transmission or a country with cases in urban settings with uncertain control measures, **and** having had no direct contact with anyone from the community
- Having had laboratory-confirmed Ebola and subsequently been determined by public health authorities to no longer be infectious (i.e., Ebola survivors)

² Close contact is defined as being within approximately 3 feet (1 meter) of a person with Ebola while the person was symptomatic for a prolonged period of time **while not using appropriate PPE**.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should IMMEDIATELY investigate all reports of Ebola. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. There are extensive guidelines, forms, and information <http://www.cdc.gov/Ebola> to assist with Ebola investigations. The current case investigation form is available at <http://www.dshs.state.tx.us/idcu/investigation/>.

The likelihood of an Ebola diagnosis depends on the current global situation. A case in the United States is highly unlikely if there is no Ebola circulating in Africa, although laboratory exposures may occur at any time. Testing for Ebola virus by RT-PCR should generally be performed for patients who have symptoms consistent with Ebola virus disease and have had an exposure that puts them at risk. In addition, they should be evaluated for other possible febrile diseases including those that are common in areas where the patient traveled or resided (e.g., malaria, typhoid, influenza).

Case Investigation Checklist

- ☐ Isolate patient.
- ☐ Implement standard, contact, and droplet precautions.
- ☐ Utilize appropriate PPE (<http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html>)
- ☐ Work with hospital to assure adequate PPE training and supervision is in place. To protect healthcare workers during care of a patient with EVD, healthcare facilities must provide onsite management and oversight on the safe use of PPE and implement administrative and environmental controls with continuous safety checks through direct observation of healthcare workers during the PPE donning and doffing processes.
- ☐ Assess Person Under Investigation's (PUI's) risk factors.
- ☐ Contact EAIDB for consultation on symptoms, risk factors, and preliminary lab findings to consider lab testing. EAIDB will coordinate the required consultation with CDC for test approval.
- ☐ Consider observation for progression of symptoms while testing and treating for alternative diagnosis such as malaria prior to testing.
- ☐ Arrange for testing of PUI as needed.
- ☐ Identify all close contacts of PUI during infectious period. Contact tracing should begin as soon as a person with risk factors presents for medical evaluation.
- ☐ A list should be kept of all persons who are in proximity of the patient at the health care facility including time, location, and type of contact.
- ☐ If positive for Ebola
 - ☐ Identify and prioritize Ebola contacts based on the exposure levels outlined above.
 - ☐ Arrange for symptom monitoring for 21 days for all contacts and possible quarantine of high risk contacts.
 - ☐ If patient traveled while possibly infectious, collect information about travel.
 - ☐ Consider a press release and/or a health alert.
 - ☐ Facilitate transfer to a specialized Ebola treatment center.
- ☐ If negative for Ebola and symptoms persist, consider testing travelers to endemic areas for Lassa fever and Marburg virus.

Control Measures

- Evaluate level of exposure of household members and pets to determine level of risk and whether they should be quarantined during the monitoring period.
- Arrange for environmental cleaning of the residence.
- Monitor Contacts - Asymptomatic individuals who have had a possible exposure to Ebola should be monitored so that they can be isolated if signs or symptoms occur; additional restrictions such as quarantine, do not board orders, or restriction letters may also be required, depending upon the type of exposure. For all high, some, and low risk contacts:
 - Make an initial contact to assess level of risk, give LHD contact information, establish an emergency plan for medical evaluation including transportation and medical facility, provide training as needed in use of thermometer and reporting procedures, and establish a reporting method.
 - Monitor for symptoms for 21 days after exposure.
 - For high risk contacts, symptom monitoring should be done twice daily in person by health department staff. For some risk contacts, monitoring should be done twice daily and some form of direct visualization should be utilized. For low risk contacts arrangements should be made to receive daily reports of twice daily self-monitoring results.
- In-person monitoring visits
 - Visit and monitor the contact at a pre-arranged location. Call the contact shortly prior to the in-person visit to ensure they will be at pre-determined location and inquire of their health (feverish, overall general health).
 - If the contact indicates they are experiencing signs or symptoms suggestive of EVD³, obtain a temperature reading over the phone.
 - If the contact does not report a fever ($\geq 100^{\circ}\text{F}$ ⁴), continue with the in-person check.
 - If the contact reports a fever ($\geq 100^{\circ}\text{F}$), **do not** conduct an in-person visit. Make arrangements for enhanced frequency of monitoring or for a medical evaluation if needed.
 - During in-person visits, avoid making physical contact with the person under surveillance. Attempt to maintain a distance of 3 feet.
 - Inquire about any presence or absence of specific symptoms that are associated with EVD and observe whether or not they appear ill. Visually confirm the thermometer temperature reading.
 - Although an in-person visit by a healthcare provider or public health personnel is preferred and recommended, the contact may also be observed via a video conferencing method such as Skype or FaceTime. If video conferencing will be utilized, thermometer reading must be visually confirmed.
- Arrange for medical evaluation as needed
 - When monitoring is initiated, identify an assessment hospital to utilize if needed and communicate with them to assure they are prepared.
(<http://www.cdc.gov/vhf/ebola/healthcare-us/preparing/assessment-hospitals.html>).
 - Create a transport plan to utilize if the contact is unable to transport themselves to the medical facility.
 - If EMS has or will be contacted, assure that they are advised of the Ebola exposure history.
 - Communicate with the medical facility prior to arrival to arrange entry, isolation, and assure appropriate PPE and standard, contact, and droplet precautions are utilized.
- If a contact reports one or more symptoms (not including fever), inquire about possible explanations for the symptom. In addition, it is recommended that a physician or other medical provider conduct a follow-up call to confirm the underlying explanation for the symptom.

³ Symptoms of EVD include fever, severe headache, muscle pain, weakness, diarrhea, vomiting, abdominal (stomach) pain, unexplained hemorrhage or bruising

⁴ Texas Administrative Code definition of fever (Title 25, §97.1-15)

- If no alternative cause or diagnosis is provided for the reported symptom, arrange for a medical evaluation.
- If the contact exhibits symptoms indicative of EVD, the contact is now classified as a “Person Under Investigation” and therefore appropriate PPE is needed. Limit contact and consider the following PPE to minimize further exposure:
 - Gown (fluid resistant or impermeable)
 - Facemask
 - Eye protection (goggles or face shield)
 - Gloves
- Persons at high risk may need to be placed under quarantine to ensure no further transmission occurs.

Outreach Activities

- Coordinate with DSHS and your PIO (Public Information Office) to issue a health alert to all area providers, hospitals, and urgent care clinics.
 - Describe situation.
 - Provide instructions on PPE.
 - List symptoms and risk factors to look for.
 - Instruct on what to do if a PUI is identified.
- Contact all entities likely to have or that have had an exposure (e.g., if patient took bus while sick, or if contacts all attend church).
 - Describe situation.
 - Allay concerns.
 - List symptoms to look for and what to do if anyone with symptoms are identified.
 - Elicit additional contacts, if appropriate.
- Prepare media statements and FAQs.
- Have a 24/7 phone for providers to call
- Inform the police department, EMS, 911, and anyone else who might be called upon to interact or care for PUIs
 - Describe situation.
 - Provide instructions on PPE.
 - List symptoms and risk factors to look for.
 - Instruct on what to do if a PUI is identified.

Exclusion

Patients with Ebola will not be released from isolation until they are no longer considered infectious (symptom resolution and two negative PCR results).

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Any confirmed or clinically suspected cases of Ebola are required to be reported **immediately** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Call DSHS EAIDB immediately when an Ebola investigation is being conducted or considered.
- Enter the case into NBS and submit an NBS notification on all **confirmed** and **suspect** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Ebola PUIs who are laboratory tested for Ebola:
 - Please enter in NBS regardless of whether they are confirmed or ruled out.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - For positives, enter an investigation in NBS and create a notification the same day or, if lab test is completed after-hours, the next day.
 - In comments describe symptoms, risk factors, and test reason
 - A notification can be sent as soon as the lab testing is completed. Additional information from the investigation may be entered upon completing the investigation.

LABORATORY PROCEDURES

Testing for Ebola is only available at select laboratories in the US. The CDC, Texas DSHS, and some LRN laboratories offer Ebola PCR testing. Approval from an EAIDB epidemiologist and the CDC are required **BEFORE** submitting specimens for testing. If available, the unique CDC PUI number should be referenced on all communication related to the sample.

Specimen Collection

- Collect two purple top EDTA **plastic** tubes of blood with a minimum volume of 4 mLs each.
- Do not submit specimens in glass containers or in heparinized tubes.
- It is not necessary to separate and remove serum or plasma from the primary collection container.
- Write the patient's name and another identifier such as date of birth or social security number on the collection tube.
- Specimens should be immediately stored at 2-8°C or transported immediately.
- Specimens other than blood may be submitted upon consult with EAIDB.

Submission Form

- Use DSHS Laboratory G-27A form for specimen submission.
- Make sure the patient's name and date of birth or social security number match exactly what is written on the transport tubes.
- Fill in the date of collection, date of onset, and diagnosis/symptoms.
- Check the box for Other: and write Ebola.
- Write the unique CDC PUI number on the form. (This number is obtained during the EAIDB consult with CDC.)
- For DSHS lab, prior to shipment, fax a copy to 512-776-7431 Attn: Biothreat Team or send via secure email to dshsLRN@dshs.state.tx.us.
- Include a copy with the specimen.

Specimen Shipping

- The DSHS lab will NOT accept specimens for Ebola testing that are not pre-approved. You must contact EAIDB prior to submission. It will be determined at that time whether a specimen needs to be sent directly to CDC simultaneously or whether the LRN laboratory will send one.
- The testing lab must be contacted prior to shipment to arrange receipt and testing of specimen. For the DSHS lab, call the Biothreat team's 24/7 number, 512-689-5537.
- Regions should provide coordination for testing at other LRN laboratories as needed.
- Transport temperature: Keep at 2° - 8° C
- Do not ship any other specimens with Ebola specimens.
- Ship specimens via overnight delivery on cold packs. Couriers are strongly recommended for submission to the DSHS lab. EAIDB can help arrange courier transportation if necessary.
- For the DSHS Laboratory, ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199
- The following must be provided to the laboratory by phone or email (DSHS Biothreat team at 512-689-5537 or dshsLRN@dshs.state.tx.us):
 - Method of delivery
 - Estimated time of arrival
 - Tracking number for the package or courier phone number

Causes for Rejection:

- **Testing not approved by EAIDB and CDC**
- Missing or discrepant information on form/specimen.

UPDATES

April 2017

- Edited Laboratory Confirmation.
- Updated and edited Local and Regional Reporting and Follow-up Responsibilities.
- Removed footnotes related to Ebola outbreak 2014 which no longer apply.

Fascioliasis added Jan 2016

BASIC EPIDEMIOLOGY

Infectious Agent

Fasciola species, a parasitic liver fluke (flat worm). Two *Fasciola* species infect people: *F. hepatica*, known as "the common liver fluke" and "the sheep liver fluke", is most common; *F. gigantica* is less common but can also infect people.

Transmission

Transmission occurs through consumption of uncooked aquatic plants (such as watercress) that are contaminated with infectious larvae (metacercariae). Transmission can also occur by ingesting contaminated water, e.g., by drinking it or by eating vegetables that were washed or irrigated with contaminated water. Infection is not transmitted directly from person to person.

Incubation Period

Acute phase of infection: symptoms, if any, can start 4-7 days after the exposure and can last several weeks or months.

Chronic phase of infection: symptoms, if any, can start months to years after the exposure.

Communicability

Infection is not transmitted directly from person to person. On the basis of limited data, the life span of adult flukes in people might be 5 to 10 years, perhaps even longer.

Clinical Illness

- **Early (acute) phase:** symptoms may include fever, nausea, vomiting, diarrhea, a swollen liver (hepatomegaly), liver function abnormalities, skin rashes, shortness of breath and abdominal pain or tenderness.
- **Chronic phase** (after the parasite settles in the bile ducts) is marked by inflammation and hyperplasia and thickening of the bile ducts and gall bladder, leading to biliary lithiasis or obstruction. The symptoms of this phase, such as biliary colic, nausea, intolerance to fatty food, right upper quadrant pain, epigastric pain, obstructive jaundice, and pruritus, are the result of a blockade in the biliary tract and inflammation in the gall bladder. Inflammation of the liver, gallbladder, and pancreas can also occur.

DEFINITIONS

Clinical Case Definition

Fascioliasis (liver fluke trematode) is transmitted by eating raw watercress or other water plants contaminated with immature larvae, usually from locations around sheep, cattle, or related animals. The immature larval flukes migrate through the intestinal wall, the abdominal cavity, and the liver tissue, into the bile ducts, where they develop into mature adult flukes. In the early (acute) phase, symptoms may include fever; gastrointestinal problems such as nausea, vomiting and diarrhea; a swollen liver (hepatomegaly); liver function abnormalities, skin rashes; shortness of breath; and abdominal pain or tenderness. The chronic phase (after the parasite settles in the bile ducts), is marked by inflammation and hyperplasia and thickening of the bile ducts and gall bladder, leading to biliary lithiasis or obstruction. The symptoms of this phase, such as biliary colic, nausea, intolerance to fatty food, right upper quadrant pain, epigastric pain, obstructive jaundice, and pruritus, are the

result of a blockade in the biliary tract and inflammation in the gall bladder. Inflammation of the liver, gallbladder, and pancreas can also occur.

Laboratory Confirmation

- Microscopic identification of *Fasciola* eggs in feces, duodenal contents, or bile
- Detection of *Fasciola* coproantigens (antigens found in feces) by ELISA

Case Classifications

- **Confirmed:** A case that is laboratory confirmed
- **Probable:** A clinically compatible case with
 - Detection of *Fasciola* antibodies, **OR**
 - History of ingestion of watercress or freshwater plants and eosinophilia

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of fascioliasis. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the Fascioliasis Investigation Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ Interview the case to get detailed exposure history and risk factor information.
 - Use the **Fascioliasis Investigation Form** to record information from the interview.
 - If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
 - Provide education to the case or his/her surrogate about effective hand washing and food safety practices. See Prevention and Control Measures.
- ☐ Fax completed forms to DSHS EAIDB at **512-776-7616**
 - For lost to follow-up (LTF) cases, please complete as much information as possible obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB and indicate the reason for any missing information.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water.
- Avoid eating uncooked watercress and other aquatic plants of wild or unknown origin, especially from grazing areas or places where the disease is known to be endemic.
- Vegetables grown in fields that might have been irrigated with contaminated water should be thoroughly cooked.
- Travelers to areas with poor sanitation should avoid food and water that might be contaminated.

Exclusions

School/child-care: No exclusions are specified for fascioliasis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for fascioliasis but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks/Clusters

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky exposures, such as consumption of watercress or other aquatic plants, recreational water contact or travel to an endemic country reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Risks	Notes
1	NT	34	F	White/non-Hispanic	12/4/16	Fever, epigastric tenderness	Ate watercress on trip to China	Reported travel with 5 other friends
2	PR	4	M	Unknown	11/30/16	Fever, Upper abdomen discomfort, hepatomegaly	Travel companion of Case ID# 1	Lost to follow up (LTF)

- If the outbreak was reported in association with an apparent common risk factor (e.g., food establishment serving watercress or other aquatic plants, recreational body of water, travel), contact hospitals in your jurisdiction to alert them to the possibility of additional fascioliasis cases.
- Determine the source of infection to prevent additional cases.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

Testing for fascioliasis is widely available from most private laboratories. Specimens are encouraged to be submitted to the DSHS laboratory for confirmation. Contact an EAIDB foodborne epidemiologist to discuss further.

Specimen Collection

- Submit a stool specimen in a sterile, leak-proof container.
 - Required volume: Stool 15 g solid or 15mL liquid.
- Fresh stool that cannot be received by the lab in less than 5 hours should be placed in formalin and PVA immediately.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter.

Specimen Shipping

Transport temperature: May be shipped at ambient temperature or 2-8°C.

- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.
- Unpreserved specimen received greater than 5 hours after collection.
- Transport media was expired.
- Specimen too old.

UPDATES

January 2016

- Added in January 2016.

Gastroenteritis Outbreaks rev Apr 2017

Gastroenteritis is common, and so are gastroenteritis outbreaks. Rapid investigation of outbreaks of unknown etiology is critical for the identification of contaminated food vehicles or other possible sources of exposure, as well as the prevention of additional cases.

The purpose of the Gastroenteritis Outbreak Investigation Guidance is to provide basic information to local health department and DSHS regional staff that will enable them to appropriately investigate gastroenteritis outbreaks of undetermined etiology, at least until an etiology is confirmed, and to implement measures that will help reduce the burden of gastroenteritis outbreaks in the future. If an etiologic agent for the outbreak is identified, refer to the investigation guideline for that specific condition.

BASIC EPIDEMIOLOGY

There are many infectious and a few noninfectious agents that can cause gastroenteritis:

- Viruses- e.g., Norovirus, hepatitis A virus, rotavirus
- Bacteria- e.g., *Shigella*, *Salmonella*, Shiga toxin-producing *E. coli*, *Campylobacter jejuni*, *Listeria monocytogenes*, *Yersinia enterocolitica*, *Vibrio* spp.
- Bacterial toxins- e.g., *Bacillus cereus* emetic and diarrheal toxins, *Clostridium perfringens* toxin, *Staphylococcus aureus* toxin, *Clostridium botulinum* toxin
- Parasites- e.g., *Cryptosporidium*, *Cyclospora cayetanensis*, *Giardia*, *Trichinella*
- Noninfectious agents- e.g., metals, scombroid, mushroom and shellfish toxins

Transmission

Transmission can occur through the ingestion of contaminated food or water or through direct contact with an infected person, fomite, animal or an animal's environment.

Incubation Period

It varies depending on the agent. Toxins often cause illness shortly after consumption (less than 24hrs), compared to a longer incubation period due to an infectious agent.

Communicability

Illnesses caused by preformed toxins (e.g., *Bacillus cereus*, *Staphylococcus aureus*, *C. botulinum* toxin) are not communicable. The communicable period varies for those infected with bacteria, viruses or parasites; please see agent specific guidelines.

Clinical Illness

Gastroenteritis is an illness triggered by the infection and inflammation of the digestive system. Typical symptoms include abdominal cramps, diarrhea, and vomiting. Other symptoms may include loss of appetite, bloating, nausea, bloody diarrhea, lethargy and body aches.

A Foodborne Illness Chart of common foodborne disease agents, descriptions of associated symptoms and incubation periods, is available at

http://www.dshs.state.tx.us/idcu/health/foodborne_illness/investigation/

DEFINITIONS

Outbreak Definition

An outbreak is defined as two or more cases with symptoms clustered in time and space.

The most common types of outbreaks reported to local and regional health departments include:

- Common event, or point source outbreaks- occurs as a result of a common exposure at a defined time and place. E.g., the occurrence of gastroenteritis among people who attended an event, such as a wedding reception or party.
- Outbreaks of gastroenteritis in facilities- often caused by viruses such as norovirus (which are most commonly, but not exclusively, spread person-to-person). E.g., long term care facilities, child-care centers.
- Outbreaks of gastroenteritis allegedly related to food or a food premise- can be the result of food items contaminated from nature, by an ill food handler, by cross-contamination with a contaminated food or the environment, or by a combination of these factors. E.g., restaurant outbreak or contaminated food item in circulation.

OUTBREAK INVESTIGATION

Outbreak Investigation

Notification of an outbreak without a known etiology might be sent from a healthcare provider, hospital laboratory, event manager, or anyone else who knows of or suspects an outbreak has occurred.

Outbreak Investigation Checklist

- ☐ Prepare a linelist of all cases. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, any lab results, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- ☐ Administer questionnaires to cases in the outbreak
 - If there is no known event or other possible common exposure for the cases, use the Hypothesis Generating Questionnaire for Gastroenteritis Complaints (http://www.dshs.state.tx.us/idcu/health/foodborne_illness/investigation/). If a common event or other possible common exposure has already been identified, then you would most likely administer a questionnaire that is based on exposures (e.g., menus) for the common event. You will need to work with event coordinators, ill persons, and others (as needed) to obtain information on the food and beverages served at the event, as well as other possible exposures.

- ☐ Request medical records for any case-patients in your jurisdiction who died or were too ill to be interviewed and for whom there are no appropriate surrogates to interview.
- ☐ Characterize the outbreak: Compile all of the available information on all cases in the outbreak.
 - See Characterize the Outbreak below.
- ☐ Attempt to identify additional cases. Methods might include:
 - Contact health care providers/hospitals in your jurisdiction to alert them to the possibility of additional cases with similar symptoms.
 - Contact others potentially exposed to the suspected source (e.g., event attendees).
 - Release a media alert, if indicated.
- ☐ Confirm the outbreak.
 - Confirmation can be made if there are at least two cases with similar symptoms and exposure to a common event, food, or other risk factor within a reasonably short period of time.
- ☐ Create an outbreak definition, which includes an onset date range, and exposure to a common restaurant, event or other risk factor.
 - The outbreak definition will usually specify a geographic area or location, of either residence or exposure (or both).
 - The outbreak definition might be expanded or contracted during the investigation, as additional information is received.
- ☐ Arrange for appropriate laboratory testing, if needed.
 - See Laboratory Procedures section for testing available at the DSHS laboratory.
 - Specimens should not be submitted to the DSHS laboratory unless approved by EAIDB. Contact an EAIDB foodborne epidemiologist to discuss further.
- ☐ Conduct environmental field investigation, if indicated.
 - Facility assessment:
 - Collect information on facility operations.
 - Identify and correct items that may have contributed to the outbreak.
 - Obtain names and contact information of those present at facility during outbreak timeframe, e.g., employees, food workers, customers, residents, students, etc.
 - If food is suspected:
 - Obtain menus.
 - Interview food employees for illness history and job duties.
 - Restrict individuals from handling food until they are free from symptoms for at least 24 hours without the use of symptom suppressing medications.
 - Collect food samples or embargo food, if necessary.
 - Decisions about testing implicated food items can be made in consultations with an EAIDB foodborne epidemiologist and the DSHS Laboratory.
 - Provide food safety education. See Control Measures Section.
- ☐ Implement facility control measures. See Control Measures Section.
- ☐ Consider testing hypotheses with an epidemiological study (i.e. case control or cohort).
- ☐ Communicate regularly with all parties involved in outbreak investigation:
 - Provide Situation Reports through email.
 - Hold conference calls to discuss the outbreak investigation
- ☐ Report findings at conclusion of investigation:
 - Create Outbreak Summary Report.
 - Enter outbreak into **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

Characterize the Outbreak

Provide descriptive information in narrative, tabular, and graphic form, for the outbreak:

- Calculate or estimate the number of persons at risk.
- Calculate or estimate the number of ill persons, including primary ill, and secondary ill persons.
- Calculate or estimate the attack rate.
- Calculate or estimate the mean, median, and range for the illness incubation period.
- Calculate the number and frequency of symptoms expressed by ill persons.
- Calculate the number and percentage of ill persons who sought medical care.
- Calculate the number and percentage of ill persons hospitalized overnight.
- Calculate the number and percentage of ill persons who visited an emergency room for their illness.
- Calculate the number and percentage of ill persons who died.
- Calculate the percentage of total cases in the age groups:
 $<1y$, $1-4y$, $5-9y$, $10-19y$, $20-49y$, $50-74y$, $\geq 75y$.
- Calculate the median age and the age range.
- Calculate the gender distribution of illness (% female, % male).
- Document the illness onset dates and range of dates.
- Prepare an epi-curve for the outbreak.
- Prepare a geographic map or table for outbreak cases.

Characterize the outbreak setting, event, or food item:

- Document the likely location of exposure for the cases (e.g., food eaten at home, food eaten in a restaurant, food eaten at a hospital, etc.).
- Document any confirmed or suspected source of the outbreak (*Note:* More than one suspect source can be entered into NORS).
- Collect any documentation from regulatory partners regarding tracebacks they conducted.
- Document characteristics of the setting, event, or food that might have contributed to the outbreak.
- Document any food or environmental specimens that were tested for pathogens.

Exclusions

School/child-care: The standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: The standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

CONTROL MEASURES

Control measures should be implemented as soon as a potential outbreak is recognized. Specific recommendations for the prevention of additional cases should be based on the findings of the epidemiologic investigation.

General Control Measures at Facilities:

- **Hand washing**
 - Hands should be washed with warm water and soap for 15-20 seconds, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
- **Environmental Disinfection**
 - If the facility does not have an Environmental Protection Agency-registered commercial virucide, use bleach. The CDC recommends the use of a chlorine bleach solution with a concentration of 1000–5000 ppm (5–25 tablespoons of household bleach (5.25%) per gallon of water) on all surfaces. Leave the surface wet for ≥ 5 minutes or follow the directions on the commercial cleaner to allow sufficient time for the bleach to kill the pathogen.
- **Exclusion and Isolation**
 - Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care until they are free from symptoms for at least 24 hours without the use of symptom suppressing medications.

Recommended Control Measures for Schools and Child-Care Centers:

- **Hand Washing**
 - Encourage children and adults to wash their hands frequently, especially before handling or preparing foods and after wiping noses, diapering, using toilets, or handling animals.
 - Wash hands with soap and water long enough to sing the “Happy Birthday” song twice.
 - Sinks, soap, and disposable towels should be easy for children to use.
 - If soap and water are not available, clean hands with gels or wipes with alcohol in them.
- **Diapering**
 - Keep diapering areas near hand washing areas.
 - Keep diapering and food preparation areas physically separate. Keep both areas clean, uncluttered, and dry.
 - The same staff member should not change diapers and prepare food.
 - Cover diapering surfaces with intact (not cracked or torn) plastic pads.
 - If the diapering surface cannot be easily cleaned after each use, use a disposable material such as paper on the changing area and discard the paper after each diaper change.
 - Sanitize the diapering surface after each use and at the end of the day.
 - Wash hands with soap and water or clean with alcohol-based hand cleaner after diapering.
- **Environmental Surfaces and Personal Items**
 - Regularly clean and sanitize all food service utensils, toys, and other items used by children.
 - Discourage the use of stuffed toys or other toys that cannot be easily sanitized.
 - Discourage children and adults from sharing items such as combs, brushes, jackets, and hats.
 - Maintain a separate container to store clothing and other personal items.
 - Keep changes of clothing on hand and store soiled items in a nonabsorbent container that can be sanitized or discarded after use.
 - Provide a separate sleeping area and bedding for each child, and wash bedding frequently.

General Food Safety:

- **Clean-** wash hands and surfaces often.
 - Wash hands properly for 15-20 seconds.
 - Wash surfaces and utensils after each use.
 - Wash fruits and veggies - but not meat, poultry, or eggs.
- **Separate-** don't cross-contaminate.
 - Use separate cutting boards and plates for produce and for meat, poultry, seafood, and eggs.
 - Keep meat, poultry, seafood, and eggs separate from all other foods at the grocery.
 - Keep meat, poultry, seafood, and eggs separate from all other foods in the fridge.
- **Cook** - cook to the right temperature
 - Use a food thermometer. For a chart of safe cooking temperatures, visit <http://www.foodsafety.gov/keep/charts/mintemp.html>
 - Keep food hot after cooking (at 140 °F or above).
 - Microwave food thoroughly (to 165 °F).
- **Chill-** refrigerate promptly
 - Refrigerate perishable foods within two hours.
 - Never thaw or marinate foods on the counter.
 - Know when to throw food out.

For more information on food safety, please visit <http://www.foodsafety.gov/>

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Cases or suspected cases of illness considered being **public health emergencies, outbreaks, exotic diseases**, and unusual group expressions of disease must be reported to the local health department or DSHS **immediately**. Other diseases for which there must be a quick public health response must be reported **within one working day**.

Local and Regional Reporting and Follow-up Responsibilities

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dsht.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

CLINICAL SPECIMENS

Available testing at DSHS laboratory for clinical specimens includes:

- Viral
 - Real time RT-PCR: Norovirus
- Bacterial
 - Enteric pathogen isolation and ID
 - EIA: Shiga-toxin producing *E. coli*
 - EHEC, shiga-like toxin assay
 - Real time RT-PCR: STEC
 - PFGE
- Parasitic
 - Ova and Parasite detection and ID

Specimen Collection

Plain raw stool is best for viral testing, but most specimens should also be subdivided into Cary-Blair transport media. This will greatly enhance the possibility of bacterial recovery should the viral tests be negative.

- Viral
 - Only raw stool is acceptable for norovirus testing.
- Bacterial
 - Transfer raw stool to Cary-Blair transport media, for optimal recovery of bacterial pathogens.
 - Raw stool also acceptable up to 30 days from time of collection but not it is not the preferred specimen.
- Parasitic
 - Transfer raw stool to O & P collection vials.
 - 10% formalin & Z-PVA

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Select appropriate test(s):
 - Molecular Studies
 - Check “PCR” and “Norovirus”
 - Bacteriology
 - Check “Culture, stool” under Clinical Specimen
 - Parasitology
 - Check “Fecal ova and parasite examination”
- Check “Outbreak association” and write in name of outbreak, (bottom of Section 2)
- Payor source (Section 6):
 - Check “IDEAS” to avoid bill for submitter

Specimen Shipping

- Norovirus testing (only raw stool accepted)
 - Transport temperature: 2-8°C (ice pack)
 - Transport time: as soon as possible
- Enteric pathogen isolation:

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool	≤24 hours	4°C (ice pack)
Raw stool	>24 hours	Freeze immediately at ≤-70°C. Ship on dry ice.
Stool in transport solution/medium	Time of collection to ≤3 days	Room temp or 4°C (ice pack)
Stool in transport solution/medium	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.
All	*The above transport times are optimal for recovery of pathogenic organisms. In the interest of public health, specimens will be accepted up to 30 days from date of collection.	*The above transport temperatures are optimal for the recovery of pathogenic organisms. In the interest of public health, specimens will be accepted at non-optimal temperature transport.

* Note: Pathogen recovery rates decrease over time. For best results, submit ASAP.

** For suspected *Vibrio* species submit at room temperature.

- Parasitic testing
 - Raw stool should be transferred within a few hours to 10% Formalin & Z-PVA vials.
 - Can be shipped at Room Temp or 2-8°C (ice pack).
 - Do Not Freeze
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

FOOD SAMPLES

Food is tested only upon prior approval

- Contact an EAIDB foodborne epidemiologist to discuss further.

General Policy

- Test only food samples implicated in a suspected outbreak (not associated with single cases).
- In outbreak settings, food items will not be tested unless a pathogen has been identified in a clinical specimen.
- Food samples must be **collected by a registered sanitarian.**

Available Tests

- Aerobic Plate Count
- *Bacillus cereus* Enumeration
- *Campylobacter* spp.
- *Cronobacter sakazakii*
- *Clostridium perfringens* Enumeration
- Coliform Count
- *Escherichia coli* O157:H7
- *Escherichia coli* count
- non-O157 STEC in meat products (O26; O45; O103; O111; O121; and O145)
- *Listeria monocytogenes*
- *Salmonella* spp.
- *Shigella* spp.
- *Staphylococcus aureus* enterotoxin
- *Staphylococcus aureus* Enumeration
- *Vibrio cholerae*, *Vibrio parahaemolyticus*, *Vibrio vulnificus*
- Yeast & Mold Count
- *Yersinia enterocolitica*

Submission Form

Complete the G-23 form for each food sample submitted.

Specimen Collection and Handling

- Food samples must be **collected by a registered sanitarian.**
- Food items should be refrigerated and maintained at 0° to 4° Celsius, until arrival at the laboratory.
- Whenever possible, submit samples to the laboratory in the original, unopened containers.
- If the original container is too large, transfer representative portions to sterile containers using aseptic technique.
- Dry or canned foods that are not perishable should be collected and shipped at ambient temperature. Frozen foods should be shipped frozen.
- Do not freeze refrigerated foods.
- Collect at least 100 grams of each sample unit. (100 grams = 3.53 ounces or 0.22 pounds).

ENVIRONMENTAL SWABS

Environmental swabs are tested only upon prior approval

- Contact an EAIDB foodborne epidemiologist to discuss further.

General policy

- Test environmental swabs only from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreak settings, environmental swabs will not be tested unless a pathogen has been identified in a clinical specimen.
- Environmental swabs **must be collected by a registered sanitarian.**

Submission Form

Complete the G-23 form for each environmental swab submitted.

Specimen Collection and Handling

- Swabs must be tested within 48 hours of collection and prior to their expiration dates.
 - Acceptable swabs include Quik-Swabs (3M) or Spongesicles (Various providers).

Specimen Shipping for Clinical Samples, Food Samples, and Environmental Swabs:

- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

UPDATES

April 2017

- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Haemophilus influenzae rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Haemophilus influenzae (*H.flu*) is a small, Gram-negative bacillus, a bacterium capable of causing a range of diseases including ear infections, cellulitis (soft tissue infection), upper respiratory infections, pneumonia, and such serious invasive infections as meningitis with potential brain damage and epiglottitis with airway obstruction. There are at least 6 serotypes of *H. influenzae* (designated a-f) distinguished by their capsular antigens, as well as unencapsulated (nontypable) strains. *Haemophilus influenzae*, type b (Hib), however, often causes the most severe disease and is the only type which is preventable by vaccine. Despite its name, this bacterium has nothing to do with the influenza viruses. (Note also that it is spelled differently.)

Transmission

Haemophilus influenzae bacteria are found in the nose and throat, usually without causing symptoms, and are spread mainly by breathing, coughing and sneezing. *H.flu* is transmitted by direct contact with respiratory droplets and discharges from the nose and throat of infected/colonized persons.

Incubation Period

The incubation period is hard to define, because most persons who acquire *Haemophilus influenzae* infections are asymptomatically colonized. Those who become ill following exposure to a case usually do so within 10 days, although the risk may be slightly elevated for up to 60 days.

Communicability

As long as the organism is present in discharges from the nose or throat. Communicability ends within 24 hours of initiation of appropriate chemoprophylaxis. Note, however, that treatment of invasive disease does not necessarily eradicate the organism from the nose/throat. Those exposed more than 7 days before onset of illness in the case are not at significantly increased risk. Hib cases are probably most infectious during the 3 days prior to onset of symptoms.

Clinical Illness

All types of *Haemophilus influenzae* can cause illness, although Hib is the most common cause of severe illness. Disease can take many forms, including:

- Meningitis- brain swelling
- Bacteremia- blood infection
- Periorbital or other cellulitis- skin lesions
- Septic arthritis- joint infection
- Osteomyelitis- bone infection
- Pericarditis- infection of the sac around the heart
- Pneumonia- lung infection
- Epiglottitis - Swelling of the windpipe

Onset of symptoms is usually abrupt, and may include:

- Fever
- Headache
- Lethargy
- Anorexia
- Nausea
- Vomiting
- Irritability

Progressive stupor or coma is common with meningitis. Infections spread via the bloodstream after penetration of the mucous membranes of the nasopharynx. The exact mechanism allowing the penetration is unknown, but a recent upper respiratory tract infection may facilitate invasion. Recently, having a cochlear implant procedure has been identified as a possible risk factor for invasive disease. Asymptomatic carriage of Hib is not uncommon; in the pre-vaccine era the organism was recovered from the upper respiratory tract of 2–5% of healthy children. Thus, isolates from sputum or other not-normally-sterile sites are *not* indicative of invasive disease. Neonatal sepsis and non-invasive upper respiratory tract disease, including otitis media, sinusitis, and bronchitis are often caused by other, non-encapsulated strains (non-type b) of *H. influenzae*. These organisms are extremely common and can be recovered from the nasopharynx of 40% to 80% of healthy children.

DEFINITIONS

Clinical Case Definition

Invasive *Haemophilus influenzae* may manifest as meningitis, bacteremia/septicemia, pneumonia, endocarditis, epiglottitis, pericarditis, osteomyelitis, septic arthritis, and cellulitis.

Laboratory Criteria for Diagnosis

- Isolation of *Haemophilus influenzae* from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF] or, less commonly, joint fluid, or pericardial fluid), **OR**
- Detection of *Haemophilus influenzae* specific nucleic acid from a normally sterile site using a validated PCR assay.

Note: Serotyping of isolates can be performed at the DSHS laboratory. Serotyping is recommended for all *H. flu* isolates from sterile sites and required on isolates from children under 5 years old.

Case Classification

- **Confirmed:** A case that is laboratory confirmed
- **Probable:** Meningitis with detection of *H. influenzae* type b antigen in cerebrospinal fluid (CSF). (Antigen test results in urine or serum are unreliable for diagnosis of *H. influenzae* disease).

Note: Conjunctivitis, otitis media, and bronchitis caused by *H. influenzae* are not invasive infections, and do not need to be reported.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate any reported cases of invasive *H. flu*. Health departments should also facilitate the typing of untyped specimens (from sterile sites) as soon as possible. Submission of *H. flu* isolates on children under 5 for serotyping is mandated by the Texas Administrative Code. Investigations of *H. flu* type b should include rapid identification and evaluation of close contacts.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
 - See the Sterile Site and Invasive Disease Determination Flowchart for confirming a specimen meets the criteria for sterile site.
- ☐ If *Haemophilus influenzae* was isolated from a sterile site but the type is unknown, request that the laboratory forward the isolate to the DSHS laboratory for typing and molecular analysis.
 - If an isolate is not available but *Haemophilus influenzae* is suspected, forward any specimen from a sterile site that is available.
- ☐ Review medical records or speak to an infection preventionist or physician to verify demographics, symptoms, underlying health conditions, and course of illness.
- ☐ Complete the *Haemophilus influenzae* Investigation Form by interviewing the case (or surrogate) to identify close contacts, risk factors and other pertinent information.
 - All cases of *H. flu*, type b should have a full investigation completed.
 - Children under 5 should have a full investigation completed, regardless of serotype result.
 - Cases that are 5 or older only need to have serogroup, sterile site, and disease manifestation confirmed to complete an investigation EXCEPT if the patient has type b.
- ☐ Ensure appropriate control measures are implemented (see Control Measures below).
- ☐ Refer household or close contacts that meet the prophylaxis criteria to their healthcare provider for appropriate chemoprophylaxis (See Prophylaxis Criteria below).
- ☐ Send the completed *Haemophilus influenzae* form to DSHS.
- ☐ In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be faxed to DSHS.
- ☐ All confirmed and probable *Haemophilus influenzae* case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Control measures are primarily needed for Hib cases (see Managing Close Contacts section below). For all other *H. flu* cases, appropriate antibiotic treatment for the patient and good hand hygiene are the only control measures needed.
- Appropriate vaccination is the best control measure.
- Children <24 months of age who have had invasive Hib disease (culture confirmed) should still receive Hib vaccine, since many children of that age fail to develop adequate immunity following natural disease.
- Rifampin prophylaxis should be instituted as rapidly as possible, to eligible contacts (see below).

Managing Close Contacts

- If the case is part of a household with a child younger than 12 months of age who has not received the three-dose primary series of Hib conjugate vaccine, all household members should receive rifampin prophylaxis.
- If the case is part of a household with at least one contact that is younger than 48 months of age and unvaccinated or incompletely vaccinated against Hib, rifampin prophylaxis is recommended for all household contacts regardless of age.
- If the case is part of a household with an immunocompromised child, even if the child is older than 48 months and fully vaccinated, all members of the household should receive rifampin because of the possibility that the vaccination may not have been effective.
- Chemoprophylaxis is not recommended for occupants of households that do not have children younger than 48 months of age (other than the index case) or when all household contacts 12 to 48 months of age are immunocompetent and have completed their Hib vaccination series.
- In childcare facilities, prophylaxis is recommended when there have been 2 or more cases in a 60 day period AND there are under or unimmunized children at the daycare. Attendees and providers should receive rifampin prophylaxis. Additionally, under or unimmunized children should receive a dose of vaccine and should be scheduled to complete the recommended series.
- Index patients younger than 2 years or that live with a susceptible contact, should also receive rifampin prophylaxis preferably just before hospital discharge, if the patient was not treated with cefotaxime or ceftriaxone.
- The recommended dose of rifampin is 20 mg/kg as a single daily dose (maximum daily dose 600 mg) for 4 days. Some providers recommend that neonates (<1 month of age) receive 10 mg/kg once daily for 4 days.
- Hospital personnel exposed to a child with invasive Hib disease do not need prophylaxis.

Treatment

Antibiotic treatment is available to treat infection with *Haemophilus influenzae*.

Exclusion

Children with a fever from any infectious cause should be excluded from school/daycare for at least 24 hours after fever has subsided without the use of fever suppressing medications. Do not exclude exposed asymptomatic children and staff as long as they have no other reasons for exclusion.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak of *Haemophilus influenzae* is suspected, notify EAIDB at (800) 252-8239 or (512) 776-7676.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS within 30 days of receiving a report of a confirmed or probable case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:
Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347
 - **Cases (Hib and children under 5) should be monitored until hospital discharge**, even if all investigation and control measures have been completed.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at 512-776-7676.

LABORATORY PROCEDURES

Serotyping of *H. flu* isolates is an important part of the diagnostic process, but also to aid in understanding the epidemiology of *H. flu* in Texas. The Texas Administrative Code mandates the submission of *H. flu* isolates on children under 5 years old. *H. flu* isolates from patients of any age can be submitted to the DSHS lab and we encourage the submission of all *H. flu* isolates. Serotyping of *H. flu* isolates allows us to understand the epidemiology of *H. flu* and how the vaccine has affected Hib and all *H. flu* in Texas. The DSHS laboratory can perform serotyping for *H. flu* isolates collected from sterile sites. **DO NOT** submit isolates from sputum for serotyping.

Isolate submission

- Submit isolates of *H. influenzae* on chocolate agar slants (or media that has the necessary growth requirements for *Haemophilus*) at ambient temperature.
- Ship isolate to the DSHS laboratory via overnight delivery. The viability of the organism is short lived; therefore, isolate must arrive at the DSHS lab in Austin within 48 hours after subculture.
- If a delay of more than 48 hours in transport is anticipated, use a CO₂ generator bag.
- Use Specimen Submission form G-2B.

Specimen Shipping

- DO NOT mail on a Friday or a day before a state holiday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

H. influenzae is considered an infectious agent, biosafety level 2. The isolate should be triple contained in accordance with federal regulations.

Causes for Rejection

- Discrepant or missing information between isolate and paperwork
- Expired media used

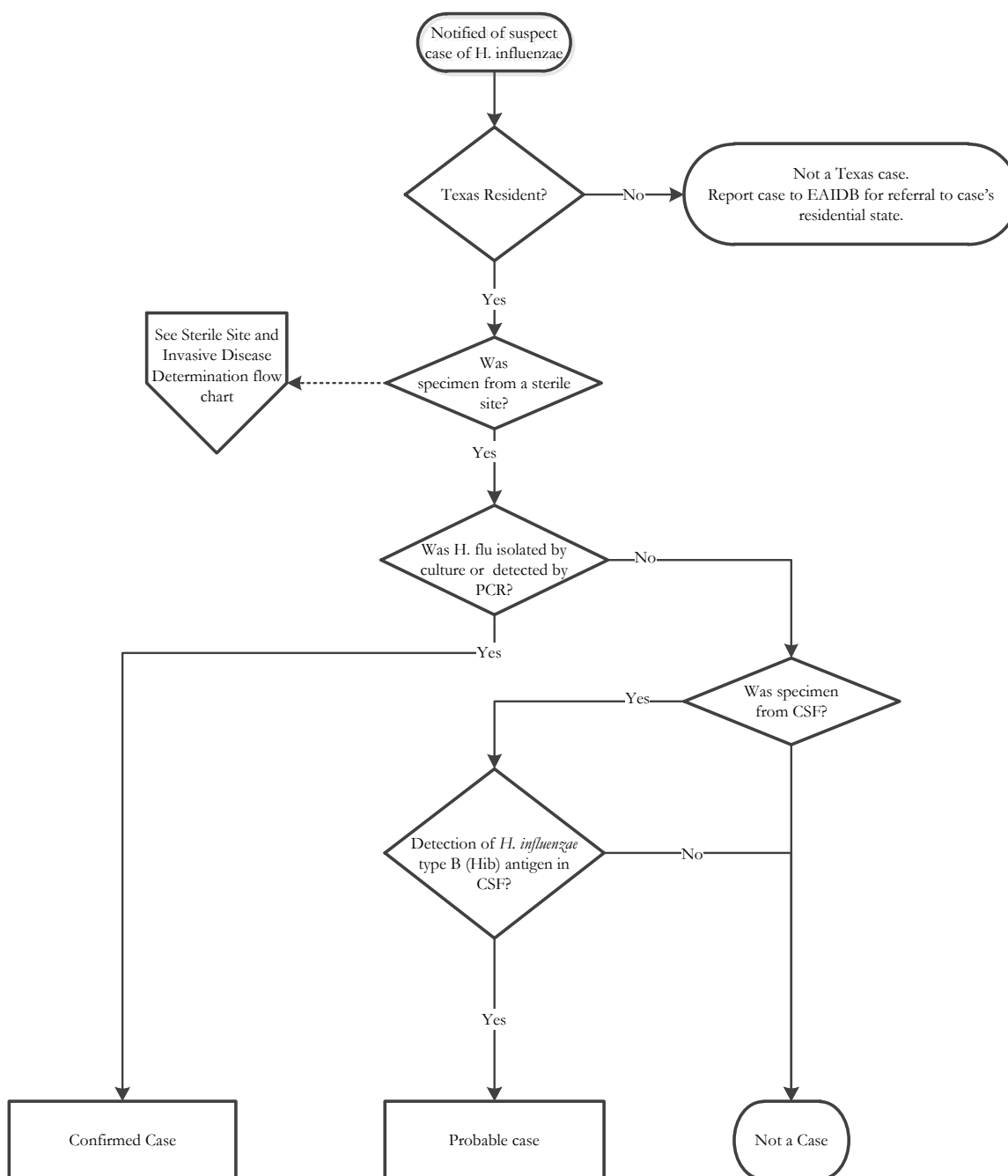
UPDATES

April 2017

- The phase “clinically compatible” has been removed from the case definition to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
- Edits made throughout the document to improve clarity

FLOW CHART rev Apr 2017

Haemophilus influenzae Case Status Classification



Hepatitis A_{rev Apr 2017}

BASIC EPIDEMIOLOGY

Infectious Agent

Hepatitis A virus (HAV), a picornavirus

Transmission

Hepatitis A virus is transmitted from person to person through the fecal-oral route. Common source outbreaks are rare but have been linked to contaminated water, food contaminated by infected persons where the food was not properly cooked or handled after cooking, raw or undercooked mollusks harvested from contaminated waters, and contaminated produce.

Incubation Period

Average of 28-30 days (range 15-50 days)

Communicability

Persons with HAV shed the most virus during the 1-2 weeks prior to symptom onset. In most cases, persons are no longer infectious after the first week of jaundice, although not all patients experience jaundice.

Clinical Illness

The clinical course of illness is indistinguishable from the other types of acute viral hepatitis. The illness typically has an abrupt onset of fever, malaise, anorexia, nausea, abdominal discomfort, jaundice and dark urine. Clinical illness does not usually last longer than two months.

Up to 70% of illness in children younger than 6 years old is likely to be asymptomatic. In older children and adults, infection is usually symptomatic, with up to 70% having jaundice.

Unlike some of the other viral hepatitis infections, hepatitis A does not create a chronic carrier state. Some patients, however, may have prolonged symptoms or relapse up to six months, during which the virus may be shed.

DEFINITIONS

Clinical Case Definition

An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), **AND**

- Jaundice, **OR**
- Elevated serum alanine aminotransferase (ALT) or aspartate aminotransferase (AST) levels.

Laboratory Criteria for Diagnosis

- Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV IgM) positive

Case Classification

- **Confirmed:**
 - A case that meets the clinical case definition and is laboratory confirmed **OR**
 - A case that meets the clinical case definition and occurs in a person who has an epidemiological link with a person who has laboratory-confirmed hepatitis A (i.e., household or sexual contact with an infected person during the 15-50 days before the onset of symptoms).
- **Probable:** No probable case definition for Hepatitis A

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of acute Hepatitis A. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use DSHS Viral Hepatitis Case Track form available on the DSHS website:

<http://www.dshs.state.tx.us/idcu/investigation/>

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or physician to verify demographics, symptoms, underlying health conditions, and course of illness.
- ☐ Complete the Viral Hepatitis Case Track form by interviewing the case (or surrogate) to identify close contacts, risk factors and other pertinent information.
 - During the interview provide education on control measure including proper hand hygiene.
- ☐ Ensure appropriate control measures are implemented (see Control Measures below).
- ☐ Exclude children and cases that are food-handlers from work, if within 7 days of symptom onset.
- ☐ Refer household and sexual contacts who are still within 2 weeks of exposure to their healthcare providers for appropriate chemoprophylaxis.
 - See Prophylaxis Guidance.
- ☐ Send the completed Viral Hepatitis Case Track form to DSHS.
- ☐ All confirmed acute HAV case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.
- ☐ In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be faxed to DSHS EAIDB.

Control Measures

- Routine hand washing with soap and warm water especially:
 - Before preparing, handling or eating any food
 - After going to the bathroom
 - After changing a diaper
 - After caring for someone with diarrhea
- Get the Hepatitis A vaccine as recommended.
- Post-exposure prophylaxis is available for at risk close contacts. See Prophylaxis Guidance.
- Patients infected with hepatitis A should adhere to strict hand hygiene for the first two weeks of symptoms and up to 1 week after the onset of jaundice and should not handle food for other people for 1 week after onset of jaundice.

Managing Close Contacts

- Household and sexual contacts should be identified immediately and those that are unvaccinated should be offered post-exposure prophylaxis with immune globulin (IG) or vaccine as follows:
 - For persons 1-40 years of age, offer vaccine within 2 weeks of exposure.
 - For persons <1 or >40, immunocompromised, diagnosed with liver disease, or cannot receive vaccine, provide IG within 2 weeks of exposure.
 - Contact DSHS EAIDB if vaccine or IG is needed.
- Contacts who have received one dose of hepatitis A vaccine at least one month prior to exposure do not need post-exposure prophylaxis.
- The patient should be educated on enteric precautions, which should be undertaken the first two weeks of symptoms and up to 1 week after the onset of jaundice.
- Generally, IG and vaccine are not recommended for school or work contacts with the following exceptions:
 - At day care centers, IG and/or vaccine should be offered if a day care attendee or employee is IgM-positive or if two household contacts of an employee or attendee are IgM-positive.
 - If a food-handler is diagnosed with hepatitis A, the other food handlers should be offered IG and/or vaccine. Patrons generally do not need prophylaxis although it may be considered if the food-handler prepared food that was not heated, had diarrhea, and IG and vaccine can be provided within 2 weeks of exposure.

Treatment

There is no specific treatment available for hepatitis A infection.

Exclusion

Food-handlers and school children should be kept out of work or school for 7 days after the onset of symptoms.

MANAGING SPECIAL SITUATIONS

Daycare exposures

- Vaccinate or provide IG to unvaccinated staff and attendees if
 - One or more cases of hepatitis A is diagnosed in the attendees or staff, **OR**
 - Two or more households of attendees have cases diagnosed in them.
- If the daycare does not provide care to children in diapers, then vaccine/IG only needs to be given to classroom contacts of an index-case patient.
- Post-exposure prophylaxis should also be considered for household contacts of daycare attendees that have children in diapers.

Food handler exposures

- If a food-handler is diagnosed with hepatitis A, the other food handlers should be offered IG and/or vaccine. Patrons generally do not need prophylaxis although it may be considered if the food-handler prepared food that was not heated, had diarrhea, and IG and vaccine can be provided within 2 weeks of exposure.

Common source exposures

- Common source outbreaks are generally identified too late for PEP to be effective, but it should be considered if still within the 2 week PEP window.
- The common source should be removed from circulation.

The Hepatitis A Communication Toolkit can be found at

http://www.dshs.state.tx.us/idcu/disease/hepatitis/hepatitis_a/links/ and can be used if health alerts, press releases, exposure notifications, etc. are needed to manage Hepatitis A outbreaks/exposures.

Outbreaks

If an outbreak of hepatitis A is suspected, notify EAIDB at **(800) 252-8239 or (512) 776-7676**.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Confirmed and clinically suspected cases are required to be reported **within 1 work day** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases to DSHS within 30 days of receiving a report of confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at 512-776-7676.

LABORATORY PROCEDURES

Testing for hepatitis A is widely available from most hospital or commercial laboratories. If hepatitis A testing is needed through the DSHS State Laboratory, please contact the EAIDB VPD team at **(800) 252-8239 or (512) 776-7676**.

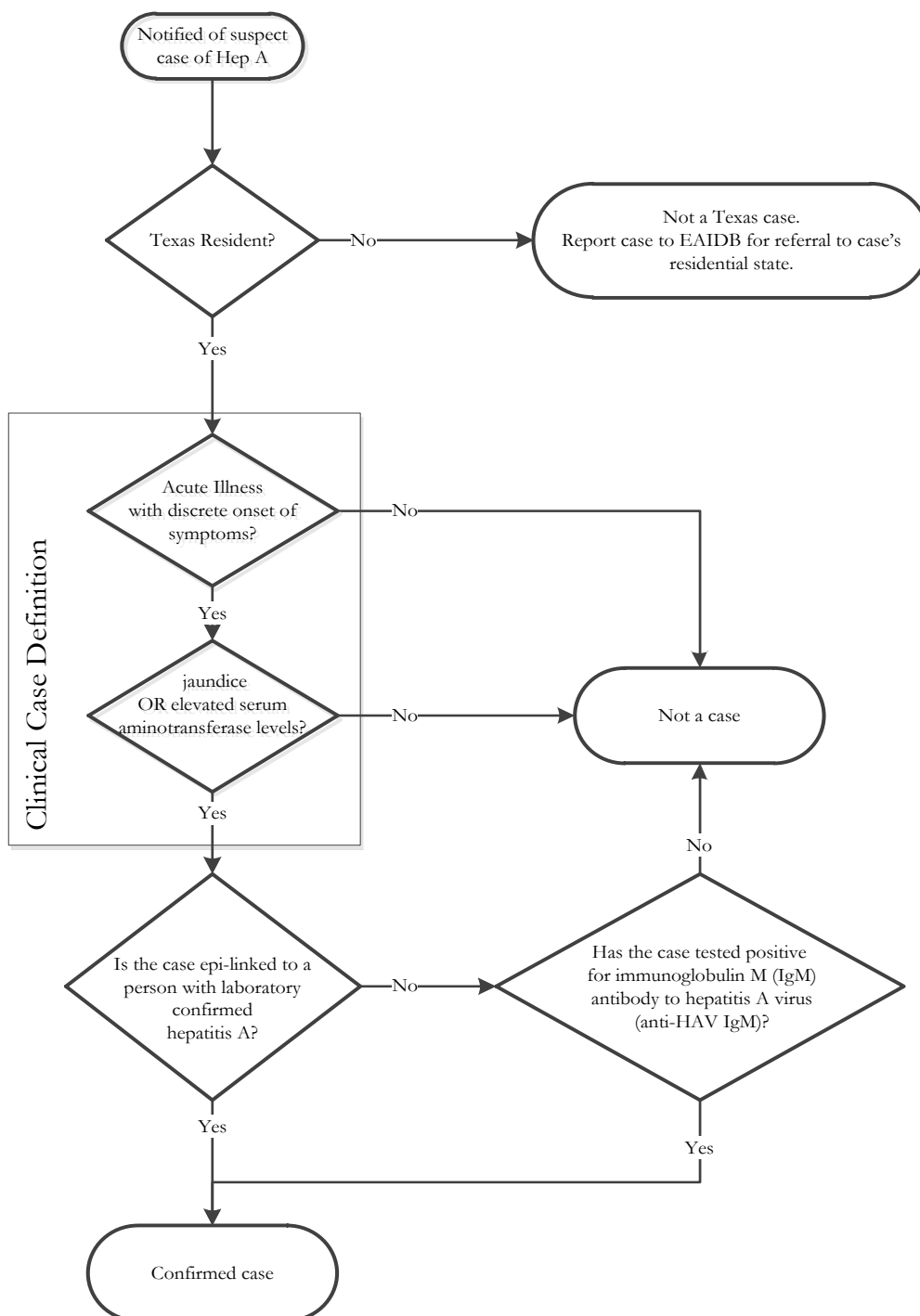
UPDATES

April 2017

- The clinical case definition has been updated to require both the discrete onset of symptoms and either jaundice or elevated liver enzymes to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
- Parenthetical note added about epi linkage, discussing sexual and household contacts

FLOW CHART rev Apr 2017

Hepatitis A (HAV): Case Status Classification



Hepatitis B, Acute & Perinatal rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Hepatitis B virus (HBV), a hepadnavirus

Transmission

- Sexual activity with an infected person
- Transfusion of contaminated blood or blood products
- Perinatally (either in utero or at delivery)
- Sharing or reusing non-sterilized needles, syringes, razors, toothbrushes, manicure equipment, or any other items which may contain the blood or body fluid of an infected person
- Percutaneous or mucous membrane exposure to blood or body fluids of an infected person
- Tattooing and/or body piercing

Incubation Period

The incubation period is 45–180 days with an average of 60–90 days

Communicability

The blood of infected persons is infective many weeks before the onset of symptoms and remains infective through the acute clinical course of the disease and during the chronic carrier state, which may persist for life. The younger a person is when infected, the more likely it is he or she will become chronic disease carriers. Additionally, persons who are hepatitis B e antigen (HBeAg, also referred to as “little e antigen”) positive are highly infectious.

Clinical Illness

The clinical course of acute hepatitis B is indistinguishable from that of other types of acute viral hepatitis. Clinical signs and symptoms occur more often in adults than in infants or children, who usually have an asymptomatic acute course. However, approximately 50% of adults who have acute infections are asymptomatic.

The prodromal phase from initial symptoms to onset of jaundice usually lasts from 3 to 10 days. It is non-specific and is characterized by a slow onset of malaise, anorexia, nausea, vomiting, right upper quadrant abdominal pain, fever, headache, myalgia, skin rashes, arthralgia and arthritis, and dark urine. The icteric phase is variable but usually lasts from 1 to 3 weeks and is characterized by jaundice, light or gray stools, hepatic tenderness and hepatomegaly (splenomegaly is less common). During convalescence, malaise and fatigue may persist for weeks or months, while jaundice, anorexia, and other symptoms disappear.

Most acute HBV infections in adults result in complete recovery with elimination of hepatitis B surface antigen (HBsAg) from the blood and the production of hepatitis B surface antibody (anti-HBs), creating immunity to future infection.

DEFINITIONS

Note: Refer to Table 1 for hepatitis B diagnostic test definitions and abbreviations and Table 2 for interpretation of hepatitis B serological tests.

Hepatitis B, Acute

Clinical Case Definition

An acute illness with a discrete onset of any sign or symptom* consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), **AND**

- Jaundice, **OR**
- Elevated serum alanine aminotransferase levels (ALT) >100 IU/L.

* A documented negative hepatitis B surface antigen (HBsAg) laboratory test result within 6 months prior to a positive test result (i.e., HBsAg, hepatitis B “e” antigen [HBeAg], or hepatitis B virus nucleic acid testing [HBV NAT] including genotype) does not require an acute clinical presentation to meet the surveillance case definition.

Laboratory Criteria for Diagnosis

- Hepatitis B surface antigen (HBsAg) positive **AND**
- IgM antibody to hepatitis B core antigen (anti-HBc IgM) positive (if done)

Case Classification

- **Confirmed:**
 - A case that meets the clinical case definition, is laboratory-confirmed, and is known not to have chronic hepatitis B**
- **Probable:**
 - There is no probable case definition for acute hepatitis B

** A person should be considered chronically infected if the hepatitis B surface antigen (HBsAg) has been positive for 6 months or longer or if the patient has a history of chronic hepatitis B diagnosis.

Note: Persons with chronic hepatitis B virus (HBV) infection may have no evidence of liver disease or may have a spectrum of disease ranging from chronic hepatitis to cirrhosis or liver cancer. Persons with chronic infection may be asymptomatic. **Please note that chronic hepatitis B is not a reportable condition in Texas.**

Hepatitis B, Perinatal

Clinical Case Definition

Perinatal hepatitis B (HBV) in the newborn may range from asymptomatic to fulminant hepatitis.

Laboratory Criteria for Diagnosis

- Hepatitis B surface antigen (HBsAg) positive*** **OR**
- Hepatitis B e antigen (HBeAg) positive **OR**
- Detectable hepatitis B virus DNA (HBV DNA)

*** HBsAg must be tested more than 4 weeks after last dose of hepatitis B vaccine to be considered confirmatory

Case Classification

- **Confirmed:**
 - Child born in the US to a HBV-infected mother **AND**
 - Positive for HBsAg at ≥ 1 month of age and ≤ 24 months of age **OR**
 - Positive for HBeAg or HBV DNA ≥ 9 months of age and ≤ 24 months of age.
- **Probable:**
 - Child born in the US whose mother's hepatitis B status is unknown (i.e. epidemiologic linkage not present) **AND**
 - Positive for HBsAg at ≥ 1 month of age and ≤ 24 months of age **OR**
 - Positive for HBeAg or HBV DNA ≥ 9 months of age and ≤ 24 months of age.

Notes:

- If the mother is known to NOT be infected with HBV, refer to the case definition for acute hepatitis B.
- These definitions are used for surveillance purposes only, not for perinatal hepatitis B prevention case management purposes.
- A pregnant woman with hepatitis B should NOT be entered into NBS as a perinatal case. Perinatal cases must be 24 months of age or younger. Positive pregnant women with acute hepatitis B should be entered as acute cases. If a pregnant woman has chronic hepatitis B, she can be entered as a chronic case of hepatitis B if the jurisdiction chooses to maintain a database of chronic hepatitis B patients, but NBS notifications should not be submitted for chronic hepatitis B cases since this is not a reportable condition. She should be case managed through the Perinatal Hepatitis B Prevention Program.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Acute hepatitis B surveillance is used to 1) identify contacts of case-patients who may require testing or prophylaxis; 2) detect outbreaks; 3) identify infected persons who need counseling and referral for medical management; 4) monitor disease incidence and prevalence; and 5) determine the epidemiologic characteristics of infected persons, including the source of their infection, to assess and reduce missed opportunities for vaccination. See *Getting the Most Out of Surveillance* below for more information on conducting hepatitis B surveillance activities.

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition.
 - See *Evaluating Suspected Cases* below.
 - If the case is pregnant, refer to the Perinatal Hepatitis B Program regardless of acute or chronic infection. See *Perinatal Hepatitis B Investigations in the Managing Special Situations* section for more information.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition, underlying health conditions, course of illness, vaccination status and travel history.
 - Use the *Viral Hepatitis Case Tracking Form* to record information.
 - See *Information to Collect for Acute Hepatitis B* below.
- ☐ Interview the case (See *Interviewing the Patient* below).
- ☐ Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- ☐ Identify and follow-up with all close contacts. See *Contact Investigations* below.
 - Provide education on hepatitis B.
 - Recommend testing.
 - Evaluate susceptibility status.
 - Offer or recommend vaccination as appropriate.
- ☐ If an acute case is a healthcare worker, a recent blood donor, a transplant recipient, suspected to have been infected in a healthcare setting, less than 2 years old or pregnant see the *Managing Special Situations*.
- ☐ Send the completed *Viral Hepatitis Case Tracking Form* to DSHS.

All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Information to Collect For Acute Hepatitis B

The following information is epidemiologically important to collect in a case investigation for acute hepatitis B. The Viral Hepatitis Case Tracking Form includes spaces to record most of this information. All information collected during investigation should be entered into NBS.

- Demographic information
- Clinical details
 - Date of illness onset
 - Symptoms, including jaundice
 - Hospitalization
 - Provider information
- Laboratory results
- Vaccination status
- Risk behaviors and exposures
 - Sexual
 - Drug use
 - Tattoos/piercings
 - Healthcare
 - Receipt of organs/blood products
 - Accidental needle stick
 - Medical/dental procedures
 - Hospitalization/residents in long term care facilities
 - Other blood exposure
 - Occupational
 - Incarceration
- Contact investigation and prophylaxis
 - Sexual contacts
 - Household contacts
 - Pregnancy status
 - Bloodborne exposures (e.g., recently donated blood or an organ)

Evaluating Suspected Cases of Acute Hepatitis B

- Evaluate the diagnosis
 - Review laboratory tests
 - Identify all HBsAg+ and/or anti-Hep B IgM+ results in NBS or received via fax.
 - Check patient's name in NBS to see if patient has already been identified as a hepatitis B case or has previous (> 6 mos) positive lab results for hepatitis B.
 - If patient has a previous positive hep lab result or a hep B investigation, mark lab as reviewed. **HBsAg+ lab results that were not submitted via NBS should be shared with the perinatal program for women 13-50.**
 - Contact provider
 - If patient is not identified as previously reported acute or chronic case, contact the healthcare provider for additional laboratory and clinical information, and pregnancy status if age/gender appropriate.
 - If patient is pregnant, refer to perinatal program.
 - If patient is not pregnant and the provider indicates the patient is a known chronic case OR the patient's clinical information is not consistent with acute hepatitis B, investigation can be closed.
 - Mark lab as reviewed in NBS, OR
 - If an acute investigation was opened in NBS, close as "not a case" (and do not send a notification), OR
 - If desired and appropriate, enter the case in NBS as a chronic hep B case. Do not submit a notification.
 - If patient is identified as acute by provider or has a clinical presentation consistent with acute hepatitis B, continue investigation.
 - Contacting the provider can be done by fax, phone, e-mail or mail.
 - Some health departments find it useful to initiate contact with a form letter that the provider completes with information on pregnancy status, clinical information, chronic status, and any additional liver test results.

Control Measures

- Identify the source of infection.
 - Obtain information on high risk behaviors, medical/dental/commercial procedures in 45-180 days prior to onset.
 - Close contact with any household or sexual contact with acute or chronic hepatitis B infection
 - Receipt of blood transfusion or other blood products
 - History of dental or surgical care including renal dialysis
 - Blood exposure through needles, tattooing, piercing or acupuncture
 - Accidental exposure of skin, eyes, mucous membranes, or a wound to blood of another person
 - Work in occupational settings with elevated risk of exposures (e.g., medical, dental, or clinical laboratory work, or employment in facilities for mentally disabled persons)
 - Sexual contact with multiple sex partners or a sex partner with a risk factor
 - Possible sources should be pursued if additional exposures may be prevented (e.g., illegal tattooing, likely healthcare transmission, etc.).
- Identify potentially exposed persons.
 - Household members
 - Sexual contacts
 - Needle-sharing contacts
 - Others potentially exposed to blood/sexual fluids
 - Evaluation special situations (see Managing Special Situations below)
 - If patient is a healthcare worker, evaluate potential for exposing patients.
 - If patient has recently donated blood/plasma, notify the blood bank.
 - If patient is pregnant, refer patient to perinatal program.

Managing Close Contacts

- Evaluate immunization and disease history of household and sexual contacts.
 - **Susceptible:** persons who are not immune to HBV or who have not been appropriately vaccinated against HBV.
 - **Protected:** persons with adequate antibody response (anti-HBs $\geq$ 10 milli-IUs/mL) due to vaccination or natural infection.
 - **Primary non-responder:** persons who do not demonstrate adequate antibody response after three doses of hepatitis B vaccine.
 - **Non-responder:** persons who have received two complete series of the hepatitis B vaccine but still do not demonstrate adequate antibody response.
 - **Unknown:** persons whose anti-HBs status is unknown are always considered susceptible.
- Test or refer for testing as appropriate.
- Offer vaccine or refer to provider for vaccine, if susceptible (see the Red Book for current recommendations).
- Offer education on preventing hep B.
- Refer to prevention and/or treatment resources.
- Refer acute cases to provider for follow-up testing to establish resolution or carrier status.
 - Offer education on reducing risk of further transmission.
 - Refer to treatment.

Exclusion

There is no exclusion for cases of acute hepatitis B.

MANAGING SPECIAL SITUATIONS

Perinatal Hepatitis B Investigations

Any woman that has a positive hepatitis B laboratory result AND is known to be pregnant must be referred to the Perinatal Hepatitis B Prevention Program for case management. Any woman age 13-50 that has an unknown pregnancy status and a positive hepatitis B lab result should also be referred to the Perinatal Hepatitis B Prevention Program for further investigation of pregnancy status.

- Currently all positive hepatitis B surface antigen results for women aged 13-50 that are reported electronically to NBS are reviewed for pregnancy status by EAIDB each week.
- Labs that are connected to prenatal or obstetric care are shared with the Perinatal Hepatitis B Prevention Program for review and case management.
- Lab resultss that belong to women aged 13-50 with unclear pregnancy status are also referred to the Perinatal Hepatitis B Prevention Program for follow up in determining pregnancy status.

Preventing perinatal transmission is perhaps the most important part of hep B surveillance, and for this reason DSHS has an official Perinatal Hepatitis B Prevention Program for Texas. The program has extensive information on diagnosis, case management, and follow-up of pregnant women with hepatitis B and their infants. Their program can be accessed at:

<https://www.dshs.texas.gov/immunize/perinatal-hepatitis-B/> or at 512-776-6634

Even though pregnant HBsAg + women and their infants are case managed by the perinatal program, infants infected perinatally with hep B are reported to the CDC through NBS.

The information provided below is the information that is needed for perinatal hepatitis B surveillance information that is shared with the CDC via NBS. This information should be available on the perinatal hepatitis B prevention program's case management forms, a separate investigation/reporting form is not needed.

- Demographic information
 - Infant
 - Mother
- Clinical details
 - Laboratory results and dates for mother
 - Laboratory results and dates for infant
- Vaccination
 - Dates
 - HBIG information including date and time
 - Was series given more than once

All information collected for confirmed perinatal hepatitis B investigations should be entered into NBS within 30 days of the report of a positive hepatitis B lab on the infant. Investigation forms (or a copy of the infant and mother's perinatal program case management forms) should be submitted to EAIDB.

Positive Lab Results Received on a Child Under 2 years old

All positive laboratory results indicative of hepatitis B infection in children under 2 should be investigated to ensure the child is not a case of perinatal hepatitis B.

- Ascertain if additional laboratory results exist in NBS.
- Contact the submitting laboratory or provider to find additional laboratory results and information on the mother's hepatitis B status.

- If mother is positive and child has acute or chronic infection, investigate as a potential missed perinatal case.

Case is a Health Care Worker (HCW)

If the case is a dentist, physician, nurse, or other health care worker (HCW) with potential for exposing patients by blood or other body fluids:

- The HCW should be discouraged from working until the acute clinical illness has resolved.
- Upon returning to work, special precautions should be practiced until the HCW is no longer infectious, including:
 - Wearing gloves for all procedures during which the hands will be in contact with the patients' mucosal surfaces or broken skin
 - Avoiding situations involving sharps that could lead to exposures of susceptible individuals to blood or objects contaminated with blood of the case
 - Careful and frequent hand washing

Health Care Associated Infection is Suspected

If two or more iatrogenic (health care associated) cases occur in patients of the same dental or health care provider, residential care facility, or non-hospital health care facility (e.g., dialysis center); and the cases have no other identified plausible source of infection; or if other circumstances suggest the possibility of iatrogenic infection, notify EAIDB at **(800) 252-8239 or (512) 776-7676**.

Case is a Recent Blood Donor

If the case has donated blood or plasma within the eight weeks prior to onset of symptoms, the agency that received the blood or plasma should be notified so that any unused product can be recalled.

Case is a Recent Transfusion Recipient

If transfused blood or blood products are suspected as the possible source of infection, the blood bank or other agency that provided the implicated lot should be notified so that aliquots of the blood still on hand (or the donors themselves) can be retested for HBsAg or tested for anti-HBc. Lot numbers for tracking are usually available through the blood bank at the hospital where the units were transfused.

Getting the Most Out of Surveillance

- Provider education
 - Providers should be educated about the importance of performing appropriate serologic tests to determine the etiology of viral hepatitis and reporting all cases of acute and perinatal HBV. Providers are required by Texas law to test pregnant women for hepatitis B.
 - Hospitals and infection control practitioners should be encouraged to report all persons with acute viral hepatitis (ICD-10 code B16), and all births to HBsAg-positive women. This is required by Texas Administrative Code (TAC).
- Case investigation
 - Case investigation is essential for determining contacts who are eligible for prophylaxis and for collection of risk factor data.
 - Analysis of risk factor data can identify populations where targeted interventions may be needed.

- Laboratory reporting
 - Laboratories should be encouraged to report all persons with serologic markers of acute or chronic hepatitis to the state or local health department.
 - Currently Texas receives over 50,000 hepatitis B laboratory results through NBS. At this time, only IgM anti-HBc and HBsAg results populate the “Documents Requiring Review” queue (where all electronic laboratory results first appear). All other hepatitis B laboratory results are automatically “swept” off that queue by the system. They are still stored in NBS and can be located by searching for a specific patient or by running a report for one or more specific laboratory results.
 - All IgM anti-HBc and HBsAg positive results should be reported.
 - To facilitate reporting, these laboratory results are included in the state’s list of laboratory-reportable conditions.
- Monitoring surveillance indicators
 - Regular monitoring of surveillance indicators, including date of report, timeliness, and completeness of reporting, may identify specific areas of the surveillance and reporting system that need improvement. Important program indicators that can be monitored through the surveillance, reporting and case investigation system include the following:
 - Characteristics of cases of acute hepatitis B that occur in children and adolescents younger than 20 years of age and missed opportunities for vaccination
 - Characteristics of cases of acute hepatitis in which death has occurred
 - Characteristics of cases of acute hepatitis B in persons reporting a history of vaccination
 - Characteristics of cases of acute hepatitis B in persons over 70 years of age
 - Characteristics of cases of acute hepatitis B associated with healthcare transmission
- Registries/databases for HBsAg-positive persons
 - NBS can serve as a de facto chronic B registry and the positive hepatitis B results can be used to distinguish newly reported cases of infection from previously identified cases.

Outbreaks

If an outbreak of hepatitis B is suspected, notify EAIDB at **(800) 252-8239** or **(512) 776-7676**.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Perinatal hepatitis B cases are required to be reported **within one work day**. Confirmed acute hepatitis B cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed or probable perinatal hepatitis B as well as confirmed acute hepatitis B** cases to DSHS within 30 days of receiving a report of a confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
 - Please do not send a notification on chronic hepatitis B cases entered into NBS.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, autopsy report and death investigation form should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347
- HBsAg-positive pregnant women (acute and chronic infections) should also be reported to the DSHS Perinatal Hepatitis B Prevention Program at **(512) 776-6634**.
 - For information on perinatal hepatitis B prevention activities, please refer to the Perinatal Hepatitis B Prevention Program Manual at: <https://www.dshs.texas.gov/immunize/perinatal-hepatitis-B/publications.aspx>

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at 512-776-7676.

LABORATORY PROCEDURES

Testing for hepatitis B is widely available from most hospital and commercial laboratories. If hepatitis B testing is needed through the DSHS State Laboratory, please contact the EAIDB VPD Team at **(800) 252-8239 or (512) 776-7676**.

For testing in regard to a possible perinatal case, please contact the Perinatal Hepatitis B Prevention Program at **(512) 776-6634**.

UPDATES

April 2017

- **Hepatitis B, acute**
 - The laboratory criteria for diagnosis has been updated to require a hepatitis B surface antigen (HBsAg) positive test results and, if done, an IgM antibody to hepatitis B core antigen (anti-HBc IgM) positive laboratory result
 - The clinical case definition has been updated to require both the discrete onset of symptoms and either jaundice or elevated liver enzymes to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
- **Hepatitis B, perinatal**
 - The laboratory criteria for diagnosis has been updated to include hepatitis B e antigen (HBeAg) and hepatitis B virus DNA (HBV DNA) to the laboratory confirmed definition
 - A probable case definition has been added to perinatal hepatitis B to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
 - Notes were added to laboratory criteria for diagnosis as well as case definition

TABLES

Table 1. Diagnostic Tests for Hepatitis B Virus (HBV) Antigens and Antibodies

Abbreviation	HBV Antigen or Antibody	Use
HBsAg	Hepatitis B surface antigen	Detection of acutely or chronically infected people; antigen used in hepatitis B vaccine
Anti-HBs	Antibody to HBsAg	Identification of people who have resolved infections with HBV; determination of immunity after immunization
HBeAg	Hepatitis B e antigen	Identification of infected people at increased risk of transmitting HBV
Anti-HBe	Antibody to HBeAg	Identification of infected people with lower risk of transmitting HBV
Anti-HBc (total)	Antibody to HBcAg	Identification of people with acute, resolved, or chronic HBV infection (not present after immunization); passively transferred maternal anti-HBc is detectable for as long as 24 months among infants born to HBsAg-positive women
IgM anti-HBc	IgM antibody to HBcAg	Identification of people with acute or recent HBV infections (including HBsAg-negative people during the "window" phase of infection)

Source: American Academy of Pediatrics. Hepatitis B. In: Pickering LK, Baker CJ, Long SS, McMillan JA, eds. *Red Book: 2012 Report of the Committee on Infectious Diseases*. 29th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2012: 373.

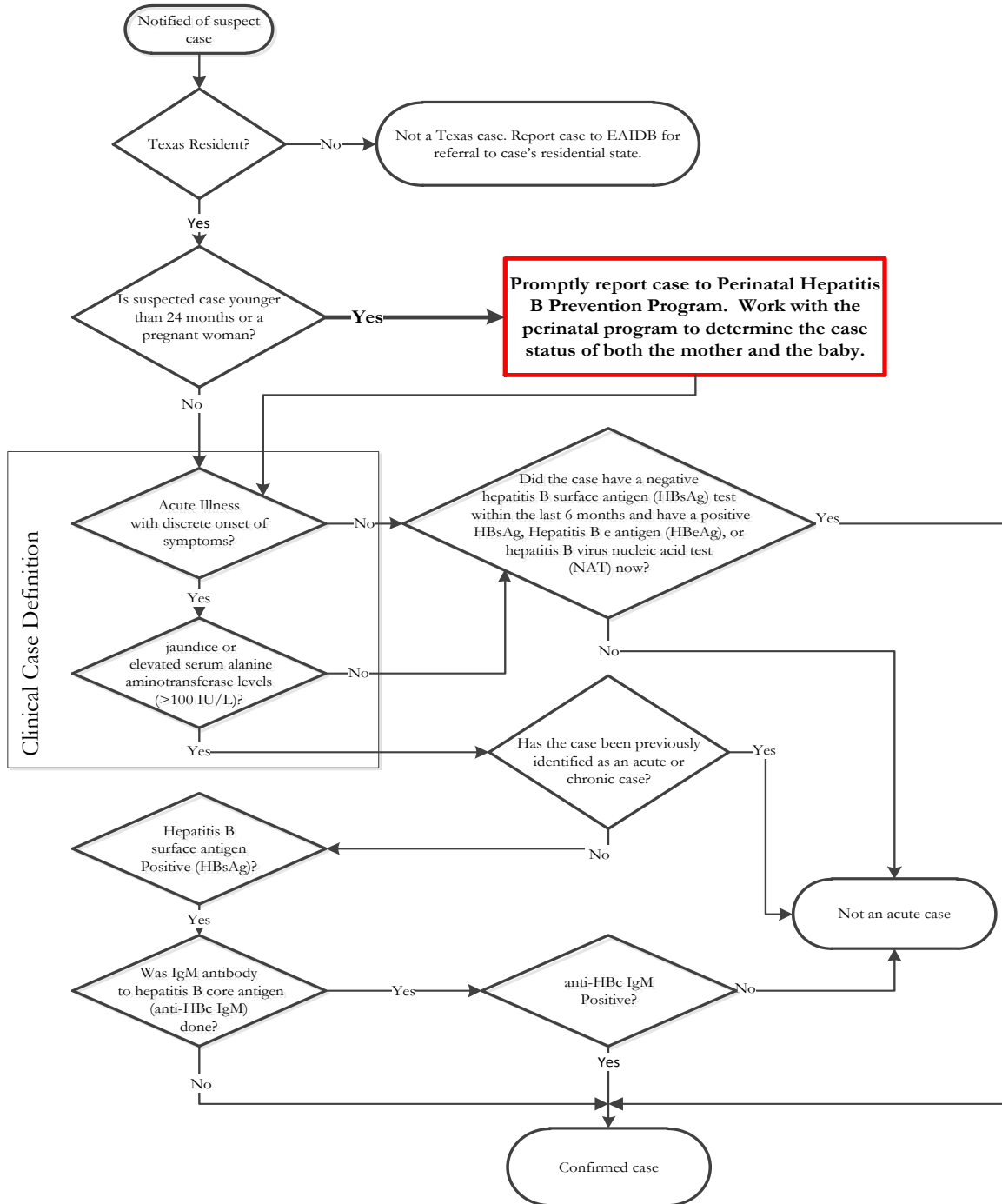
Table 2. Interpretation of Hepatitis B Serological Tests and Health Department Response

Tests	Results	Interpretation	Health Department Response
HBsAg Anti-HBc Anti-HBs	Negative Negative Negative	Susceptible (Never infected or vaccinated)	Vaccinate or refer for vaccine if appropriate
HBsAg Anti-HBc Anti-HBs	Negative Negative Positive	Immune due to vaccination	No further action needed
HBsAg Anti-HBc Anti-HBs	Negative Positive Positive	Immune due to past infection	No further action needed
HBsAg Anti-HBc IgM anti-HBc Anti-HBs	Positive Positive Positive Negative	Acutely Infected	Initiate case investigation. If case is pregnant, refer to Perinatal Hepatitis B program. Enter case into NBS if meets confirmed case status (no probable case status for acute hepatitis b).
HBsAg Anti-HBc IgM anti-HBc Anti-HBs	Positive Positive Negative Negative	Chronically Infected	Follow-up to determine if patient may be pregnant. If pregnant, refer case to Perinatal hepatitis B program. If case is chronic, it is not required to be reported. No NBS entry required. If entry is made, please do not submit notification.
HBsAg Anti-HBc Anti-HBs	Negative Positive Negative	Four interpretations possible*	Recommend patient follow-up with physician and/or recommend more testing be completed if applicable.
*1. May be recovering from acute HBV infection. 2. May be distantly immune and test not sensitive enough to detect very low level of anti-HBs in serum 3. May be susceptible with a false positive anti-HBc. 4. May be undetectable level of HBsAg present in the serum and the person is actually a carrier.			

Source: Adapted from Centers for Disease Control and Prevention (CDC).

FLOW CHART rev Apr 2017

Acute Hepatitis B (HBV): Case Status Classification



Hepatitis C, Acute rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Hepatitis C virus (HCV), a single-stranded RNA virus, is the causative agent.

Transmission

- Transfusion of contaminated blood or blood products
- Sharing or reusing non-sterilized needles, syringes, razors, toothbrushes, manicure equipment, or any other items which may contain the blood or body fluid of an infected person
- Percutaneous or mucous membrane exposure to blood or body fluids of an infected person
- Sexual activity with an infected person, especially among HIV- infected partners
- Tattooing and/or body piercing
- Perinatally (either in utero or at delivery)

Incubation Period

The incubation period is 2 weeks to 6 months with an average of 4 to 12 weeks.

Communicability

The blood of infected persons is infective many weeks before the onset of symptoms and remains infective through the acute clinical course of the disease and during the chronic carrier state, which may persist for life.

Clinical Illness

The clinical course of acute hepatitis C is indistinguishable from that of other types of acute viral hepatitis. Most infections are asymptomatic with symptoms of acute hepatitis C infection only present approximately 20% to 30% of the time. Chronic hepatitis will subsequently develop in 75% to 85% of acute HCV infected individuals.

DEFINITIONS

Clinical Case Definition

- **Acute:** An acute illness with discrete onset of symptoms* consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), and a) jaundice or b) abnormal serum alanine aminotransferase levels (ALT level >400 IU/L).

*A documented negative HCV laboratory test result of any type (antibody, antigen, NAT/PCR) followed within 12 months by a positive test result of any type does not require an acute clinical presentation to meet the surveillance case definition.

Laboratory Confirmation

- Nucleic acid test (NAT) or PCR test for HCV RNA positive (including qualitative, quantitative or genotype testing) **OR**
- A positive test indicating presence of hepatitis C viral antigen (HCV antigen)*

* When and if a test for HCV antigen(s) is approved by FDA and available

Case Classification

- **Confirmed:**
 - A case that meets clinical criteria and is laboratory confirmed **OR**
 - A documented negative HCV test result (antibody/anti-HCV, antigen, or NAT/PCR) followed within 12 months by a positive result of any of these tests (test conversion – does not require acute clinical presentation).
- **Probable:**
 - A case that meets clinical criteria and has a positive anti-HCV antibody test, but has no reports of a positive HCV NAT or positive HCV antigen tests, **AND** does not have evidence of test conversion within 12 months or has no report of test conversion.

SURVEILLANCE AND CASE INVESTIGATION

Local and regional health departments should investigate all reports of acute hepatitis C. Most reports of hepatitis C do not require in-depth investigations beyond verifying the case definition and establishing risk factors in acute cases. However, if healthcare transmission is suspected, then a more thorough investigation must be done and EAIDB should be notified at (800) 252-8239 or (512) 776-7676.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
 - Most HCV results reported through electronic laboratory reports (ELRs) will not have enough information to meet the case definition for acute cases. If time and resources allow, then health departments should attempt to determine likelihood of cases being acute.
- ☐ If the case is found to be acute:
 - Review medical records or speak to an Infection Preventionist or healthcare provider to verify case definition, identify underlying health conditions and describe course of illness.
 - The Viral Hepatitis Case Tracking Form should be used to assess risk factors and record information collected during the investigation and the information should be entered into NBS. Complete forms may be faxed to 512-776-7616.
 - If the case is 12 months or younger, a follow-up test should be done after 12 months of age to confirm the diagnosis.
- ☐ If an acute case is a healthcare worker, a recent blood donor, a transplant recipient, a pregnant woman, or suspected to be a healthcare acquired infection see Managing Special Situations.
- ☐ All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

MANAGING SPECIAL SITUATIONS

Case is a Health Care Worker (HCW)

If the case is a dentist, physician, nurse, or other health care worker (HCW) with potential for exposing patients by blood or other body fluids:

- The HCW should be discouraged from working until the acute clinical illness has resolved.
- Upon returning to work, special precautions should be practiced until the HCW is no longer infectious, including:
 - Wearing gloves for all procedures during which the hands will be in contact with the patients' mucosal surfaces or broken skin
 - Avoiding situations involving sharps that could lead to exposures of susceptible individuals to blood or objects contaminated with blood of the case
 - Careful and frequent hand washing

Case is a Recent Blood Donor

If the case has donated blood or plasma within the 8 weeks prior to onset of symptoms, the agency that received the blood or plasma should be notified so that any unused product can be recalled.

Case is a Recent Transfusion Recipient

If transfused blood or blood products are suspected as the possible source of infection, the blood bank or other agency that provided the implicated lot should be notified so that aliquots of the blood still on hand (or the donors themselves) can be retested for HCV. Lot numbers for tracking are usually available through the blood bank at the hospital where the units were transfused.

Case is a Pregnant Woman

According to CDC approximately 6 out of every 100 infants born to HCV-infected mothers will become infected with HCV. Likelihood of transmission is increased if the mother is viremic at the time of delivery or is coinfecting with HIV. There is no prophylaxis treatment available to prevent transmission during birth. Infants born to infected mothers should be tested after 18 months of age because maternal antibodies to HCV may persist until this time. If a diagnosis is desired before 18 months testing for HCV RNA may be done at or after the first well child visit at 1-2 months. HOWEVER follow up HCV RNA testing is recommended at a later visit regardless of the first results. There is no evidence that breastfeeding can result in HCV transmission from mother to child, however, nursing mothers with cracked or bleeding nipples should consider abstaining from breastfeeding due to the possibility of bloodborne transmission.

Health Care Associated Infection is Suspected

If 2 or more iatrogenic (health care associated) cases occur in a hospital, patients of the same dental or health care provider, residential care facility, or nonhospital health care facility (e.g., dialysis center) and the cases have no other identified plausible source of infection, or if other circumstances suggest the possibility of iatrogenic infection, notify EAIDB at (800) 252-8239 or (512) 776-7676.

Possible Common-Source Outbreaks

Report immediately to EAIDB at (800) 252-8239 or (512) 776-7676.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Clinically suspected acute hepatitis C cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS within 30 days of receiving a report of confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- If investigation forms are requested, they may be faxed to 512-776-7616 or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.

LABORATORY PROCEDURES

Testing for hepatitis C is widely available from most hospital and commercial laboratories. If hepatitis C testing is needed through the DSHS State Laboratory, please contact the EAIDB at **(800) 252-8239 or (512) 776-7676**.

UPDATES

April 2017

- Updated laboratory criteria.
- Updated case definition to reflect new case criteria including the addition of “probable” case classification.
- Updated Basic Epidemiology information to reflect latest information from CDC including probability of symptom manifestation and probability of progression to Chronic Hepatitis C infection.
- Added information for Acute HCV infected pregnant women to the “Managing Special Situations” section.

Hepatitis E rev Jan 2016

BASIC EPIDEMIOLOGY

Infectious Agent

Hepatitis E virus (HEV), is the only member of the genus *Hepevirus* in the family *Hepeviridae*. It is a spherical, nonenveloped, single-stranded RNA virus. There are four genotypes of HEV.

Transmission

Hepatitis E virus is usually spread by the fecal-oral route. The most common source of infection, particularly in developing countries, is fecally contaminated drinking water. Fecal-oral transmission probably can occur from person-to-person, though secondary household cases are not common during outbreaks. Unlike the other major hepatitis viruses, recent studies have suggested that hepatitis E is the only member of the group to have animal reservoirs and is likely a zoonotic infection transmitted from domestic pigs and other wild animal species. Sporadic outbreaks have occurred in developed countries in association with the consumption of raw/undercooked animal products, mainly pork and venison. Hepatitis E genetic material has been detected from the meat and organs of domestic pigs, wild boar, and deer. The consumption of contaminated shellfish has also been considered a risk for transmission.

Incubation Period

The range is 15-64 days; the mean incubation period has ranged from 26 to 42 days in various epidemics.

Communicability

Not known. Hepatitis E virus has previously been detected in stools 14 days after onset of jaundice and approximately 4 weeks after consuming contaminated food or water, persisting for about 2 weeks.

Clinical Illness

The signs and symptoms of Hepatitis E are similar to those of other types of acute viral hepatitis: fever, fatigue, jaundice (skin or whites of eyes turning yellow), loss of appetite, nausea, vomiting, abdominal pain, dark urine, joint pain, and clay colored stools. Children are usually asymptomatic or have mild disease. Pregnant women are at risk for severe outcomes, e.g., liver failure and death (mortality in this population in their third trimester is about 20%).

DEFINITIONS

Clinical Case Definition

Typical clinical signs and symptoms of acute hepatitis E virus (HEV) are similar to those of other types of acute viral hepatitis and include abdominal pain, anorexia, dark urine, fever, hepatomegaly, jaundice, malaise, nausea, and vomiting. Other less common symptoms include arthralgia, diarrhea, pruritus, and urticarial rash. The period of infectivity following acute infection has not been determined but virus excretion in stools has been demonstrated up to 14 days after illness onset. In most hepatitis E outbreaks, the highest rates of clinically evident disease have been in young to middle-age adults; lower disease rates in younger age groups can be the result of anicteric and/or subclinical HEV infection.

No evidence of chronic infection has been detected in long-term follow-up of patients with hepatitis E. The case fatality rate is low except in pregnant women where it can reach 20% among those infected during the third trimester of pregnancy.

Laboratory Confirmation

- IgM anti-HEV from CDC laboratory or PCR positive from reference laboratory

Note: No FDA approved tests to diagnose HEV infection are available in the United States.

Case Classifications

- **Confirmed:** A case that meets the clinical case description and is laboratory confirmed
- **Probable:**
 - A case that meets the clinical case description with supportive laboratory evidence (positive IgM antibody from labs other than CDC), **OR**
 - Negative tests for other acute hepatitis markers and an epidemiological link to other confirmed cases or travel history to an endemic area during exposure period

SURVEILLANCE AND CASE INVESTIGATION

Local and regional health departments should promptly investigate all reports of Hepatitis E. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use DSHS Viral Hepatitis Case Track form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ Interview the case to identify potential sources of infection.
 - Use the **DSHS Viral Hepatitis Case Track** to record information from the interview.
- ☐ Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - For lost to follow-up (LTF) cases, please complete as much information obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.
- ☐ Identify whether there is a public health concern: persons should not work as food handlers, child-care or health care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Prevention of Hepatitis E relies primarily on good sanitation and the availability of clean drinking water.
- When traveling internationally to areas with poor sanitary conditions:
 - Drink bottled water or water that has been boiled for at least 1 minute.
 - Don't drink fountain drinks or drinks with ice.
 - Don't eat fruits or vegetables that you don't peel yourself.
 - Avoid uncooked foods.
- Routine hand washing with soap and warm water, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.

Exclusions

School/child-care: No exclusions are specified for hepatitis E but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for hepatitis E but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

Outbreaks of Hepatitis E in the United States are rare and are usually associated with contaminated water supply in countries with poor sanitation.

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.

- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional cases.
- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on and adherence to hand hygiene.
 - Storage and preparation of food.
 - Procedures for changing diapers and toilet training.
 - Procedures for environmental cleaning.
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable, and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.

- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

- Hepatitis E testing is not available at the DSHS State Laboratory.
- Testing for hepatitis E is widely available at most private laboratories.
- Testing is also available at the CDC laboratory:
 - <http://www.cdc.gov/hepatitis/HEV/LabTestingRequests.htm>

UPDATES

January 2016

- Revised the Exclusion section to provide clarity.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.

Hookworm (ancylostomiasis) rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Hookworm is a soil transmitted helminth. Human infections are caused by the nematode parasites *Necator americanus* and *Ancylostoma duodenale*.

Transmission

Transmission primarily occurs via direct contact with fecal contaminated soil. Soil becomes contaminated with eggs shed in the feces of an individual infected with hookworm. The eggs must incubate in the soil for several days before they become infectious and are able to be transmitted to another person. Oral transmission can sometimes occur from consuming improperly washed food grown or exposed to fecal contaminated soil. Transmission can also occur (rarely) between a mother and her fetus/infant via infected placental or mammary tissue.

Incubation Period

Eggs must incubate in the soil for 5-10 days before they mature into infectious filariform larvae that can penetrate the skin. Within the first 10 days following penetration of the skin filariform larvae will migrate to the lungs and occasionally cause respiratory symptoms. Three to five weeks after skin penetration the larvae will migrate to the intestinal tract where they will mature into an adult worm. Adult worms may live in the intestine for 1-5 years depending on the species.

Communicability

Human to human transmission of Hookworm does NOT occur because part of the worm's life cycle must be completed in soil before becoming infectious. However, vertical transmission of dormant filariform larvae can occur between a mother and neonate via contaminated breast milk. These dormant filariform larvae can remain within in a host for months to years. Soil contamination is perpetuated by fecal contamination from infected individuals who can shed eggs in feces for several years after infection.

Clinical Illness

Hookworm infection is often asymptomatic. Immediately following infection a pruritic, erythematous, papular rash commonly known as "ground itch" can develop at the penetration site, typically the feet or hands. In the first two weeks of infection, minor cough and throat irritation may occur as a result of larval migration but these symptoms are rare. Light infections produce few or no symptoms but can include abdominal discomfort, diarrhea, and/or blood in the stool. Severe infections can be characterized by more severe symptoms stemming primarily from intestinal blood loss resulting in anemia. Symptoms can include: nausea, fatigue, pale skin, and rarely congestive heart failure and death. In children, anemia resulting from infection can cause impaired growth and delayed mental development.

DEFINITIONS

Clinical Case Definition

Necator americanus and *Ancylostoma duodenale* are the cause of most hookworm infections worldwide. Most patients with hookworm are asymptomatic but severe and chronic cases are often characterized by hypochromic, microcytic anemia and hypoproteinemia. Complications due to anemia can result in severe fatigue, paleness, nausea, and diarrhea and can cause growth impairment and mental retardation in children.

Laboratory Confirmation

- Microscopic identification of *Ancylostoma* or *Necator* eggs in feces, **OR**
- Microscopic identification of *Ancylostoma* or *Necator* species of larvae cultured from the feces, **OR**
- Identification of adult worms expelled after treatment

Case Classifications

- **Confirmed:** A case that is laboratory confirmed

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of hookworm (ancylostomiasis). Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the Hookworm (ancylostomiasis) Investigation Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ Interview the case to get detailed exposure history and risk factor information.
 - Use the **Hookworm (ancylostomiasis) Investigation Form** to record information from the interview.
 - If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
 - Provide education to the case or his/her surrogate about effective hand washing, food safety practices, and avoidance of soil contamination. See Prevention and Control Measures.
- ☐ Fax completed forms to DSHS EAIDB at **512-776-7616**
 - For lost to follow-up (LTF) cases, please complete as much information as possible obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/e-mail securely to DSHS EAIDB and indicate the reason for any missing information.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water.
- Proper disposal of human waste products such as feces is necessary to prevent contamination of soil.
- Avoid areas where human waste contamination of soil or water is likely.
- Wear shoes or other clothing to prevent contact with soil.
- Thoroughly wash fruits and vegetables to remove soil/fertilizer residue.

Exclusions

Because human-to-human transmission is rare and has only been documented from nursing mothers to neonates via breast milk, no exclusion from work, school or daycare is required for disease control purposes unless the individual has diarrhea. If the individual has diarrhea, the standard exclusion until diarrhea free for 24 hours without the use of diarrhea suppressing medications applies. Diarrhea is defined as 3 or more episodes of loose stools in a 24 hour period.

MANAGING SPECIAL SITUATIONS

Outbreaks/Clusters

If an outbreak or cluster is suspected, notify the DSHS Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky exposures, such as inadequate waste disposal near the home or work, recreational activities in areas with inadequate waste disposal, or travel to an endemic country reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Risks	Notes
1	NT	34	F	White/non-Hispanic	12/4/16	Diarrhea, Anemia	Lived in Vietnam last 5 years, currently lives in same neighborhood as ID 2	Brother ill
2	PR	4	M	Unknown	11/30/16	Anemia, bloody stool	Poor sanitation near home, lives in same neighborhood as ID 1	Lost to follow up (LTF)

- If the outbreak was reported in association with an apparent common risk factor (e.g., work or live near a possible site of soil contamination, members of the same household with similar travel), recommend that anyone displaying symptoms seek medical attention from a healthcare provider.
- If several cases in the same family or geographic area are identified and there is a possibility for similar exposures (e.g., travel to the same country, poor sanitation), testing of potentially exposed persons or mass de-worming treatment may be warranted.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB neglected tropical disease epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.

LABORATORY PROCEDURES

Fecal Ova and Parasite testing for hookworm is widely available from most private laboratories however, specimen submission to DSHS laboratory is advised. Adult worm specimen identification may not be available at private laboratories therefore submission to the DSHS laboratory is available and highly recommended. Contact an EAIDB neglected tropical disease epidemiologist to discuss further.

Specimen Collection

- Submit a stool specimen in a sterile, leak-proof container.
 - Required volume: Stool 15 g solid or 15 mL liquid.
- Specimens that cannot be received by the lab in less than 5 hours should be placed in formalin and PVA immediately.
- Adult worms should be submitted in either 5-10% formalin or 70% ethanol.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name and date of birth or social security number match exactly what is written on the transport tubes.
- Fill in the date of collection, date of onset, and diagnosis/symptoms.

Specimen Shipping

- Transport temperature: May be shipped at ambient temperature.
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.

- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Possible Causes for Rejection:

- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.
- Unpreserved specimen received greater than 5 hours after collection– specimen should still be submitted as an attempt will be made to complete testing.
- Transport media was expired.

UPDATES

April 2017

- Basic Epidemiology: revised the Transmission, Incubation Period, and Communicability sections to provide clarity.

Influenza A-Novel/Variant rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Novel or variant influenza is caused by an influenza virus that is not known to circulate in humans. Some animals (avian and swine populations) are considered higher risk for transmitting a novel/variant influenza strain to humans.

Transmission

The transmission route of novel/variant influenza viruses is likely to be similar to seasonal influenza which is primarily by droplet spread. Transmission may also occur by direct or indirect contact with oral secretions or fecal material from infected animals.

Incubation Period

The incubation period is likely to be similar to seasonal influenza with an incubation period of 1 to 4 days.

Communicability

The communicability of novel/variant influenza viruses is unknown and strain specific. It may range from low to high communicability depending on how well adapted the strain is to humans. Susceptibility is considered to be universal since by definition a novel/variant influenza strain is one that is not known to circulate in humans.

Clinical Illness

Symptoms are likely to be similar to seasonal influenza with fever, chills, muscle aches, headache, sore throat and cough. Many novel/variant influenza infections have had increased incidence of gastrointestinal symptoms such as vomiting and diarrhea.

Severity

The severity of illness is unknown and may vary from mild to severe depending on the specific strain and characteristics of the population.

DEFINITIONS

National Case Definition: Novel Influenza A Virus Infections (2014)

Clinical Case Definition

An illness compatible with influenza virus infection such as fever >100 degrees Fahrenheit with cough and/or sore throat

Laboratory Confirmation

Identification of an influenza A virus subtype or strain that is different from currently circulating human influenza H1 and H3 strains as confirmed by the Centers for Disease Control and Prevention's (CDC) influenza laboratory, by public health laboratories using CDC-approved protocols for that specific strain or by labs using Food and Drug Administration (FDA)-authorized tests for specific strains

- Novel/variant subtypes include, but are not limited to, H2, H5, H7 and H9 subtypes.
- Influenza H1 and H3 subtypes originating from a non-human species or from genetic reassortment between animal and human viruses are also novel/variant subtypes or strains.
- Methods available for detection of currently circulating human influenza viruses at public health laboratories (e.g., RT-PCR) will also detect suspected novel/variant subtypes and strains.
- Initial confirmation that a specific influenza A virus represents a novel/variant virus will be performed by CDC's influenza laboratory.
- Currently, only viral isolation, RT-PCR, gene sequencing or a 4-fold rise in strain-specific serum antibody titers are considered confirmatory for case classification purposes.

Case Classifications

- **Confirmed:** A case of human infection with a laboratory confirmed novel/variant influenza A virus
- **Probable:** A case meeting the clinical criteria and epidemiologically linked to a confirmed case, but for whom no confirmatory laboratory testing for novel/variant influenza virus infection has been performed or test results are inconclusive for a novel/variant influenza A virus infection
- **Suspect:** A case meeting the clinical criteria in which influenza A has been detected but is pending laboratory confirmation. Any case of human infection with an influenza A virus that is different from currently circulating human influenza H1 and H3 viruses is classified as a suspect case until the confirmation process is complete.
 - Typically, sporadic novel/variant influenza cases will have a history of either
 - Close contact with ill animals known to transmit novel/variant subtypes of influenza A (such as wild birds or poultry, swine or other mammals)
 - OR**
 - Travel within 14 days of onset, to any country where a novel/variant influenza A virus (such as highly pathogenic avian influenza A H5N1) has been recently identified in animals or people.

Criteria for Epidemiologic Linkage

- The patient has had contact with one or more persons who either have or had the disease **AND** transmission of the agent by the usual modes of transmission is plausible.
- A case may be considered epidemiologically linked to a laboratory confirmed case if at least one case in the chain of transmission is laboratory confirmed.

Interim Case Definitions for Novel Influenza A (H5N1) and A (H7N9), and Novel Influenza A Viruses with the Potential to Cause Severe Disease in Humans (e.g., H5N2)

Novel influenza virus knowledge is constantly evolving; therefore, CDC publishes interim definitions for novel influenza viruses that are currently associated with severe disease in humans (e.g., H5N1, H7N9) or have the potential to cause severe disease in humans (e.g., H5N2). The case definitions for these novel influenza viruses may differ from the published national case definition for novel influenza A virus infections. Please consult the CDC websites for the most up-to-date definitions.

Novel Influenza A Viruses **Associated with Severe Disease in Humans:**

<http://www.cdc.gov/flu/avianflu/h7n9/specimen-collection.htm>

For case definitions, see: H5N1: <https://www.cdc.gov/flu/avianflu/h5n1/case-definitions.htm>;

H7N9: <https://www.cdc.gov/flu/avianflu/h7n9/case-definitions.htm>

- **Case Under Investigation:** Illness compatible with influenza in a patient meeting any of the exposure criteria below and for whom laboratory confirmation is not known or pending.
 - Exposure criteria:
 - Patients with recent travel (within <10 days of illness onset) to areas where human cases of avian influenza A (H5N1) or (H7N9) virus infection have become infected or to areas where avian influenza A (H5N1) or (H7N9) viruses are known to be circulating in animals¹.
OR
 - Patients who have had recent close contact (within <10 days of illness onset) with confirmed or suspected² cases of human infection with avian influenza A (H5N1) or (H7N9) virus. Close contact may be regarded as coming within about 6 feet (2 meters) of a confirmed or suspected case while the case was ill (beginning 1 day prior to illness onset and continuing until resolution of illness). This includes healthcare personnel providing care for a confirmed case, family members of a confirmed case, persons who lived with or stayed overnight with a confirmed or suspected case, and others who have had similar close physical contact³.
OR
 - Unprotected exposure to live avian influenza A (H5N1) or (H7N9) virus in a laboratory.

Footnotes:

¹H5N1: See [Outbreaks of Highly Pathogenic Avian Influenza \(subtype H5N1\) in poultry notified to the OIE from the end of 2003 to 28 November 2016](#) and [Cumulative Number of Confirmed Human Cases for Avian Influenza A \(H5N1\) Reported to WHO, 2003-2016](#). H7N9: (1/26/16) China is the only country where avian influenza A (H7N9) viruses are known to be circulating in animals (poultry) or where human cases have become infected.

²Patients suspected of having infection with a novel influenza A virus can include probable cases, cases under investigation for infection with avian influenza A (H5N1) or (H7N9) virus, and other patients for whom available clinical and epidemiologic information support a diagnosis of infection with avian influenza A (H5N1) or (H7N9) virus.

³Limited, non-sustained, person-to-person transmission of highly pathogenic avian influenza A (H5N1) virus has been reported in several countries following close, prolonged unprotected contact with a severely ill H5N1 patient, including in household and hospital settings. Limited data are available for avian influenza A (H7N9) virus in which limited, non-sustained, person-to-person transmission could not be excluded in some family clusters.

Novel Influenza A Viruses **with the Potential to Cause** Severe Disease in Humans:

<http://www.cdc.gov/flu/avianflu/severe-potential.htm>

- **Case Under Investigation:** Illness compatible with influenza¹ in a patient meeting any of the exposure criteria below and for whom laboratory test results are not known or are pending²:
 - Patients who have had recent contact³ (within 10 days of illness onset) with birds potentially infected with avian influenza (AI) viruses (i.e., sick or dead birds [domestic poultry, wild aquatic birds, or captive birds of prey that have had contact with wild aquatic birds]⁴, or flocks where AI virus infection has been confirmed)

OR
 - Patients who have had recent close contact (within 10 days of illness onset) with confirmed or suspected⁵ cases of human infection with AI or other novel influenza viruses. Close contact may be regarded as coming within about 6 feet (2 meters) of a confirmed or suspected case while the case was ill (beginning 1 day prior to symptom onset and continuing until resolution of illness). This includes healthcare personnel providing care for a confirmed or suspected case, family members of a confirmed or suspected case, persons who lived with or stayed overnight with a confirmed or suspected case, and others who have had similar close physical contact in a community or workplace environment.

OR
 - Unprotected exposure to live AI virus in a laboratory.

Footnotes:

¹Illness compatible with influenza may present as influenza-like illness (ILI) [fever $\geq 100^{\circ}\text{F}$ plus cough or sore throat] or other signs and symptoms associated with influenza such as rhinorrhea, fatigue, myalgia, arthralgia, headache, and difficulty breathing. Note that influenza may not cause fever in all patients (especially in patients under 5 years of age, over 65 years of age, or patients with immune-suppression), and the absence of fever should not supersede clinical judgment when evaluating a patient for illness compatible with influenza. Atypical presentations of influenza may include nausea, vomiting, or diarrhea. While a rare sign of seasonal influenza, conjunctivitis has been reported as a sign of avian influenza virus infection.

²Note that commercially available rapid influenza diagnostic tests (RIDTs) cannot distinguish between influenza A virus subtypes (i.e., they do not differentiate between human and animal influenza A viruses); thus, a positive RIDT test result cannot confirm AI virus infections. Commercially available RIDTs also may not detect AI viruses in clinical specimens; therefore a negative RIDT result does not exclude infection with AI virus.

³Contact may include: direct contact with birds (e.g., handling, slaughtering, defeathering, butchering, preparation for consumption) or direct contact with surfaces contaminated with feces or bird parts (carcasses, internal organs, etc.) or prolonged exposure to birds in a confined space.

⁴Exposures that occur in geographic regions in the United States where newly detected avian influenza viruses have been identified are of most concern.

⁵Suspected cases of AI virus infection include probable cases, cases under investigation, and other patients for whom available clinical and epidemiologic information support a diagnosis of infection with AI virus.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of suspected novel/variant influenza. Please use the General Influenza Investigation Form and the Influenza Investigation Form Supplemental Pages (if applicable) which are available on the DSHS website at <http://www.dshs.texas.gov/idcu/investigation/>. Healthcare providers may report suspected cases of novel/variant influenza. Only the state laboratory or the CDC can identify a confirmed or probable case of novel/variant influenza.

Case Investigation Checklist for Suspect Cases Pending Confirmatory Testing

- ☐ Determine why the healthcare provider suspects novel/variant influenza and evaluate the patient as a candidate for testing.
 - ☐ Consult the Definitions section (above), particularly the “Interim Case Definitions for Novel Influenza A (H5N1) and (H7N9), and Novel Influenza A Viruses with the Potential to Cause Severe Disease in Humans (e.g., H5N2)”.
 - ☐ **Patients who meet the “Case Under Investigation” criteria should be tested for novel influenza.**
- ☐ Use the current influenza season’s DSHS Influenza Laboratory Surveillance Protocol to give instructions for the collection and submission of specimens. Also, follow instructions in the Laboratory Procedures section (below).
- ☐ Ensure that appropriate infection control measures have been implemented (see Control Measures section, below).
- ☐ Complete and fax a copy of the General Influenza Investigation Form to DSHS.
- ☐ Do not enter suspect cases into NBS unless specifically requested.

Case Investigation Checklist for Confirmed, Probable and Suspect (Unsubtypeable Influenza A Pending Subtyping) Cases

- ☐ Ensure that appropriate infection control measures have been implemented (see Control Measures section, below).
- ☐ Confirm that the laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or physician to verify underlying health conditions and course of illness.
- ☐ Notify the State Influenza Surveillance Coordinator in DSHS EAIDB about the case under investigation as soon as enough information is available to determine that the case meets case definition.
- ☐ Interview the case (or surrogate) to identify travel history, animal contact and other risk factors.
- ☐ Identify close contacts and determine if secondary cases have occurred.
- ☐ See Contact Tracing section below.
- ☐ Enhance surveillance for ILI and influenza:
 - ☐ Ensure that all regular influenza reporters are reporting ILI data to public health.
 - ☐ If the case occurs outside of flu reporting season, contact regular flu reporters and request that they report ILI for at least 4 weeks.
- ☐ Contact local hospitals and large clinics to see if any increases in ILI activity have occurred.
 - ☐ Follow-up with hospitals and large clinics weekly for at least 4 weeks.
- ☐ Contact local schools to see if any increases in ILI activity have occurred.
 - ☐ Follow-up with schools weekly for at least 4 weeks.

- When non–travel-related novel/variant influenza cases are detected, health departments should work with providers to increase specimen submissions for influenza surveillance (PCR) testing.
- Refer to the state pandemic influenza plan (*Public Health Preparedness, Surveillance, and Response Plan for Texas: Respiratory Viruses Having Pandemic Potential*) for a list of responsibilities by department and program area.
- If applicable, complete the steps in the Managing Special Situations section.
- Complete the General Influenza Investigation Form and the Influenza Investigation Form Supplemental Pages and fax these forms to DSHS.
- DSHS may also request completion of other novel/variant influenza investigation forms, if needed.
- Enter and submit for notification in the NEDSS Base System (NBS) all confirmed and probable case investigations.

Control Measures

- Provide education on influenza to contacts of the case as needed.
- Provide guidance on infection control in healthcare settings.
 - **Standard, contact, and airborne precautions** are recommended when managing patients who may be infected with novel influenza A viruses, including confirmed cases, probable cases, cases under investigation for infection with a novel influenza A virus, and other patients for whom available clinical and epidemiologic information strongly support a diagnosis of infection with a novel influenza A virus.
 - See CDC’s “Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease” at <http://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm> for more information.
- Recommend that anyone with risk factors experiencing symptoms or anyone with severe illness be evaluated by a healthcare provider.
- Remind local healthcare providers to consider influenza and report suspected cases.
- Antivirals may be used to treat and prevent influenza according to CDC guidance.
 - The Texas Medical Board recently changed its rules (Texas Administrative Code, Title 22, Part 9, Chapter 190, Subchapter B, §190.8) regarding the prescribing of prophylaxis for close contacts of patients with certain infectious diseases. Physicians can now prescribe antiviral medications to contacts of influenza cases without first medically evaluating the contacts.

School/Daycare Exclusion Criteria

Children are required to be excluded from school and daycare for at least 24 hours after fever has subsided without the use of fever suppressing medications. It is recommended that adults not return to work for at least 24 hours after fever has subsided without the use of fever suppressing medications. In the event of a pandemic or unusually severe presentation the exclusion period may be extended.

CONTACT TRACING

Contact tracing for close contacts is required for all confirmed and probable novel/variant influenza cases. The extent of follow-up required may depend on the number of cases identified, the severity of illness or interest from public health leaders or media. Contract tracing requirements may cease in specific situations (e.g., in the case of an ongoing pandemic), as specified by DSHS Austin.

Routine contact tracing:

- Routine contact tracing should be done for all suspected (i.e., unsubtypeable influenza A pending subtyping), probable and confirmed novel/variant influenza cases.
- Complete the Respiratory Contact Tracking Form located on the DSHS website at <http://www.dshs.texas.gov/idcu/investigation> and provide a copy to DSHS.
- Advise contacts of signs and symptoms of illness and refer them to their healthcare providers if they experience any symptoms compatible with influenza or ILI within 10 days of their last contact with the confirmed/probable case.
- Prioritize contacts for laboratory testing and collect specimens.
 - Collect specimens from any contacts with influenza or ILI symptoms within 10 days of last contact with the confirmed/probable case.
 - Prioritize specimen collection from symptomatic contacts according to degree and frequency of contact (e.g., prioritize household contacts over coworkers).
 - Do not delay specimen collection or testing to wait for more specimens to become available (i.e., do not batch specimens!).
- Provide close contacts with a Novel/Variant Influenza fact sheet.
 - A fact sheet will be developed by DSHS EAIDB.
- Close contacts of persons with confirmed or suspected cases can be counseled about the early signs and symptoms of influenza and advised to contact their healthcare providers immediately if clinical signs or symptoms develop. Healthcare providers may choose to provide an influenza antiviral prescription to exposed persons at higher risk for complications of influenza virus infection. Prophylaxis recommendations will likely vary with the severity of disease. Guidance will be provided by CDC or DSHS.
 - The Texas Medical Board recently changed its rules (Texas Administrative Code, Title 22, Part 9, Chapter 190, Subchapter B, §190.8) regarding the prescribing of prophylaxis for close contacts of patients with certain infectious diseases. Physicians can now prescribe antibiotics to contacts of influenza cases without first medically evaluating the contacts.

Enhanced contact tracing:

- Enhanced contact tracing should be performed when DSHS EAIDB advises.
- Enhanced contact tracing includes all routine contact tracing requirements plus:
 - Close contacts should be actively monitored for symptoms of ILI for a minimum of 10 days (i.e., follow-up should be performed at regular intervals).
 - Consider testing asymptomatic close contacts in addition to symptomatic close contacts.

Close contacts definition: Close contacts are defined as persons who were within about 6 feet of a suspected (i.e., unsubtypeable influenza A pending subtyping), probable or confirmed case while the case was ill (beginning 1 day prior to the case's illness onset and continuing until the case's resolution of illness). This includes household and family contacts, healthcare personnel, laboratory workers and other persons who were known to be within about 6 feet of the case. Assess workplace, school and social settings for close contacts as well.

MANAGING SPECIAL SITUATIONS

Animal (Swine or Avian) Exposure Identified

If the influenza case is determined to be a novel/variant strain and if exposure to domestic or wild animals is identified during the investigation, DSHS EAIDB should be notified immediately so that partners in DSHS Zoonosis Control, the Texas Animal Health Commission (TAHC) and/or Texas Parks and Wildlife (TPW) can be included in the investigation.

Extensive efforts should be made to identify all animal contacts in the 2 weeks prior to onset of illness. Zoonosis Control, TAHC or TPW will conduct trace backs and investigations on animal contacts.

Multiple Cases of Novel/Variant Influenza Identified

If more than one case of novel/variant influenza is identified, enhanced surveillance will be expanded.

The local/regional health department should:

- Alert all acute care healthcare providers in the area to be cognizant of possible cases and encourage reporting of suspected cases.
- Continue to work with existing influenza surveillance partners and hospitals/large clinics in the area to track influenza-like illness and identify new cases.
- Investigate common exposures among the cases and work with any identified facilities or entities.
 - Recommend control measures based on the type of entity or setting.
 - Recommendations should be jointly developed with TAHC/TPW if animals are present.
- Encourage anyone with symptoms to be evaluated by a healthcare provider.
- Perform enhanced contact tracing for close contacts of confirmed/probable cases.
- Ensure specimen submission at an adequate level from the local/regional area to determine the prevalence of the novel/variant influenza virus in Texas according to Influenza Virologic Surveillance Right Size guidelines. DSHS will provide guidance on specimen volume and representativeness required to achieve this objective.
- See the Texas Influenza Surveillance Handbook for more information on control measures and outbreak response.
- Refer to the state pandemic influenza plan (*Public Health Preparedness, Surveillance, and Response Plan for Texas: Respiratory Viruses Having Pandemic Potential*) for a list of responsibilities by department and program area.

Pandemic

During a pandemic, DSHS will determine what information should be collected on individual cases of pandemic influenza or if only aggregate data will be collected. It is anticipated that a complete novel/variant influenza investigation will be performed on initial cases. A specific investigation form will be provided for this purpose. As the case count increases, a General Influenza Investigation Form should be completed for all or a subset of cases.

Once a pandemic influenza strain becomes widespread in Texas it is likely that individual investigations will no longer be performed for all cases and only aggregate reporting of cases or full investigation of a subset of cases will be needed. Individual investigations may continue for a subset of cases such as influenza-associated deaths among pregnant/postpartum women or other groups of interest.

Refer to the state pandemic influenza plan (*Public Health Preparedness, Surveillance, and Response Plan for Texas: Respiratory Viruses Having Pandemic Potential*) for a list of responsibilities by department and program area. Investigation and reporting guidance specific to the pandemic will be shared by DSHS.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Clinically suspected cases are required to be reported **immediately** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**. Healthcare providers are encouraged to report suspected cases of influenza with a recent history of international travel or with recent contact with swine or poultry.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** and **probable** cases within 30 days of receiving a report of a confirmed or probable case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completion of the investigation.
- **Investigation forms should be faxed as soon as an investigation has been completed.**
 - Investigation forms may be faxed to **512-776-7616**.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Submit a completed **Respiratory Disease Outbreak Summary Form** at the conclusion of the outbreak investigation.
 - Fax a copy to the DSHS regional office and/or to EAIDB at 512-776-7676.
 - The Respiratory Disease Outbreak Summary Form is available at <http://www.dshs.texas.gov/idcu/investigation>.

LABORATORY PROCEDURES

Specimens associated with suspected novel/variant influenza cases should be submitted to the DSHS Laboratory or Laboratory Response Network (LRN) laboratory following the protocol for seasonal influenza surveillance. The protocol is available by request from DSHS EAIDB or from the regional influenza surveillance coordinator.

Specimen Collection

- For H5N1, H7N9, and novel influenza A viruses with the potential to cause severe disease in humans (e.g., H5N2), follow CDC's specimen collection guidance at <http://www.cdc.gov/flu/avianflu/h7n9/specimen-collection.htm> and <http://www.cdc.gov/flu/avianflu/severe-potential.htm>
 - Ensure that proper infection control precautions are followed when collecting specimens from persons with suspected or known infection with a novel influenza A virus (<http://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm>).
 - The following should be collected as soon as possible after illness onset: (i) a nasopharyngeal swab, or (ii) a nasal aspirate or wash, or (iii) two swabs combined into one viral transport media vial (e.g., nasal or nasopharyngeal swab combined with an oropharyngeal swab). If these specimens cannot be collected, a single nasal, or oropharyngeal swab is acceptable.
 - For patients with lower respiratory tract illness, a lower respiratory tract specimen (e.g., an endotracheal aspirate or bronchoalveolar lavage fluid) is preferred for suspected H5N1 or H7N9 infection because these specimens have a higher yield for detecting avian influenza H5N1 and H7N9 viruses. For novel influenza A viruses with the potential to cause severe disease in humans (e.g., H5N2), a lower respiratory tract specimen may be preferred.
 - Specimens should be placed into sterile viral transport media and immediately placed on refrigerant gel-packs or at 4°C (refrigerator) for transport to the laboratory.
 - If possible, in order to increase the potential for novel influenza virus detection, multiple respiratory specimens from different sites should be obtained from the same patient on at least two consecutive days.
- The current influenza season's DSHS Influenza Laboratory Surveillance Protocol should be consulted for storage, packaging, and shipping instructions.
- Refer to situation-specific guidance from DSHS EAIDB, if provided.

Submission Form (if submitting specimen(s) to DSHS Austin)

- Use the DSHS Laboratory G-2V Specimen Submission Form for specimen submission.
 - On the form, under the Virology section, check the box for “Influenza surveillance {Influenza real-time RT-PCR}”. In the blank space to the right of “Influenza surveillance {Influenza real-time RT-PCR}”, write “suspect novel influenza”.

Section 4. VIROLOGY	
☐ Electron Microscopy	
☒ Influenza surveillance {Influenza real-time RT-PCR}	<i>Suspect novel influenza</i>
Vaccine received: ☐ Yes ☐ No	
Date vaccine received: _____	
Travel history (if known): _____	<i>No international travel</i>
☐ Measles, real-time RT-PCR	
☐ Mumps, real-time RT-PCR	<i>Animal contact: Contact with pigs</i>
☐ MERS Coronavirus (Novel coronavirus)	
**** Prior authorization required. **** Call Infectious Disease (512) 776-7676 for authorization	
☐ Other: _____	

- Indicate the patient’s flu vaccination status for the current season and the date of vaccination, if known.
- Indicate the patient’s travel history.
- In the blank space to the right of “Influenza surveillance {Influenza real-time RT-PCR}”, write “Animal contact” and the type of animal contact with which the patient had contact, if applicable.
- Make sure the patient's name and approved secondary identifier on the form exactly match what is written on the specimen tube.
 - An approved secondary identifier should be one of the following: date of birth, medical record number, social security number, Medicaid number, or CDC number.
- Make sure to fill in the date and time of collection in addition to the patient demographics on the form.
- Follow the submission form instructions found in the current influenza season’s DSHS Influenza Laboratory Surveillance Protocol.

Specimen Shipping

- **Notify the laboratory that you will be shipping the specimen and provide the shipment date and tracking number.**
- Transport temperature: Store the specimen at 2°-8°C if the specimen will be received at the laboratory within 72 hours of collection; ship the specimen on cold or freezer packs. Otherwise, the specimen must be stored frozen (-70°C) and shipped on dry ice.
- Ship specimens for overnight delivery.
DO NOT mail specimens on a Friday or the day before a holiday unless special arrangements have been made in advance with the DSHS or LRN Laboratory.

- If shipping specimens to DSHS Austin, ship specimens to:
Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Common Causes for Rejection:

- There is a discrepancy between the patient name on the specimen tube and the name on submission form.
- The specimen is not shipped in viral transport medium or the medium is expired.
- The specimen is received more than 72 hours after collection (if refrigerated).
- The specimen is received at ambient temperature.

UPDATES

April 2017

- Definitions: modified the Case Under Investigation definition and footnote number 1 for the “Novel Influenza A Viruses **Associated with** Severe Disease in Humans” subsection
- Laboratory Procedures: changes made to Submission Form instructions to reflect updates to the DSHS Laboratory G-2V Specimen Submission Form and the DSHS Laboratory submission procedure

Influenza-Associated Pediatric Mortality

rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Influenza A, B or C virus

Transmission

Transmission occurs via droplet spread. After a person infected with influenza coughs, sneezes, or talks, influenza viruses contained in the respiratory droplets travel through the air; other persons nearby can become infected if these droplets land in their noses or mouths. These droplets can also contaminate surfaces, and people can become infected when they touch an object or a surface on which these droplets have landed and then touch their noses or mouths. Transmission may also occur by direct contact, such as kissing.

Incubation Period

The incubation period is 1 to 4 days with most infections occurring within 2 days of exposure to an infected individual.

Communicability

Influenza is easily transmitted from person to person. Infected persons can start shedding virus up to 24 hours before the onset of symptoms. Shedding of the virus is greatest during the first 3 days of illness. The duration of virus shedding may be longer in young children and immunocompromised persons. Additionally, some persons who become infected with influenza remain asymptomatic.

Clinical Illness

Symptoms of influenza may include fever, cough, sore throat, myalgia (muscle aches), headaches and fatigue. Among children, otitis media, nausea, vomiting and diarrhea are also commonly reported. Influenza is usually a self-limiting infection, but in people with chronic medical conditions such as heart or lung disease, it can lead to pneumonia and other life-threatening complications.

Severity

An estimated 23,607 (range: 3,349-48,614) deaths (all ages) associated with influenza occur every year in the United States.

DEFINITIONS

Clinical Case Definition

An influenza-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and death. Influenza-associated deaths in all persons aged <18 years should be reported.

A death should not be reported if there is

- No laboratory confirmation of influenza virus infection,
- The influenza illness is followed by full recovery to baseline health status prior to death,
- The death occurs in a person 18 years of age or older, or
- After review and consultation there is an alternative agreed upon cause of death which is unrelated to an infectious process.
 - For example, a child with a positive influenza test whose death clearly resulted from trauma after a car accident would not qualify as a case. However, a child with a respiratory illness and a positive influenza test whose death is attributed to another infectious cause such as staphylococcal pneumonia would still qualify as a case.

Laboratory Confirmation

Laboratory testing for influenza virus infection may be done on pre- or post-mortem clinical specimens, and may include identification of influenza A or B virus infections by a positive result by at least one of the following:

- Influenza virus isolation in tissue cell culture from respiratory specimens
- Reverse-transcriptase polymerase chain reaction (RT-PCR) testing of respiratory specimens
- Immunofluorescent antibody staining (direct or indirect) of respiratory specimens
- Rapid influenza diagnostic testing of respiratory specimens
- Immunohistochemical (IHC) staining for influenza viral antigens in respiratory tract tissue from autopsy specimens
- Four-fold rise in influenza hemagglutination inhibition (HI) antibody titer in paired acute and convalescent sera

Case Classifications

- **Confirmed:** A death meeting the clinical case definition that is laboratory confirmed
- **Probable:** No probable case definition

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of suspected influenza-associated death in any person under 18 years of age. Please use the Influenza-Associated Pediatric Mortality Case Report Form available on the DSHS website at

<http://www.dshs.texas.gov/idcu/investigation/>. Please use the most recent version of the form (the form is updated annually, usually in September before the coming flu season).

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition, underlying health conditions and course of illness.
- ☐ Notify the State Influenza Surveillance Coordinator in DSHS EAIDB about the case under investigation as soon as enough information is available to determine that the case meets case definition.
- ☐ Complete the Influenza-Associated Pediatric Mortality Case Report Form using medical records and information from healthcare providers, and by interviewing the case's parent/guardian or surrogate to identify vaccination status and risk factors.
- ☐ Sources of vaccination status include parent/guardian, school, primary care provider and ImmTrac. All sources of vaccination history should be explored before deciding that vaccination status is unknown.
- ☐ If multiple attempts were made to contact the parent/guardian or surrogate and attempts were unsuccessful, please fill out the case investigation form with as much information as possible and indicate the reasons for missing information (e.g., "lost to follow-up – parent did not return call; multiple messages left").
- ☐ Ensure that any available (pre- or post-mortem) respiratory specimens and autopsy specimens are forwarded to the DSHS lab for influenza testing.
- ☐ If the case is associated with an outbreak, see the Managing Special Situations section.
- ☐ Fax the completed Influenza-Associated Pediatric Mortality Case Report Form to DSHS.
- ☐ The initial report should be submitted within 2 weeks of death.
- ☐ The final completed report should be submitted upon conclusion of the investigation.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS).
- ☐ Copies of the death certificate and autopsy report should be faxed to DSHS when they become available. Copies of the medical records (admission report, history and physical, progress notes, laboratory results, radiology reports, discharge summary, etc.) are also appreciated.

Control Measures

- Provide education on influenza as needed:
 - Get vaccinated for influenza every year.
 - Wash hands frequently with soap and water, especially after coughing or sneezing.
 - Use alcohol-based hand sanitizers when facilities are not available for hand washing.
 - Cover coughs and sneezes with disposable tissues or your arm/sleeve.
 - Avoid touching your eyes, nose or mouth.
 - Avoid close contact with people who are sick.
 - When you are sick, limit contact with others and stay home until fever free for 24 hours without the use of fever-reducing medications.

- Take antiviral medications if prescribed by your doctor.
 - The Texas Medical Board recently changed its rules (Texas Administrative Code, Title 22, Part 9, Chapter 190, Subchapter B, §190.8) regarding the prescribing of prophylaxis for close contacts of patients with certain infectious diseases. Physicians can now prescribe antiviral medications to contacts of influenza cases without first medically evaluating the contact.
- Recommend that anyone with risk factors experiencing symptoms or anyone with severe illness be evaluated by a healthcare provider.
- See the [Texas Influenza Surveillance Handbook](#) for additional influenza control measures.

School/Daycare Exclusion Criteria

Children with influenza are required to be excluded from school and daycare for at least 24 hours after fever has subsided without the use of fever suppressing medications. It is recommended that adults with influenza not return to work for at least 24 hours after fever has subsided without the use of fever suppressing medications.

MANAGING SPECIAL SITUATIONS

Outbreaks

Influenza-associated pediatric deaths may result in high levels of media and public attention. If the death is linked to an influenza outbreak, then the outbreak investigation may also be subject to additional media or public attention. If an outbreak of influenza is suspected, notify DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should:

- Work with the facility to ensure that staff and students/residents get hand hygiene and respiratory etiquette education.
- Recommend that staff with influenza be restricted from working until 24 hours after fever has subsided without the use of fever suppressing medications.
- Recommend that anyone with risk factors experiencing symptoms or anyone with severe illness be evaluated by a healthcare provider.
- See the Texas Influenza Surveillance Handbook for more information on control measures and responding to influenza outbreaks.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed and clinically suspected cases are required to be reported **within 1 work day** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Notify DSHS EAIDB of the case by phone or e-mail as soon as enough information is collected to confirm a case.
- Enter the case into NBS and submit an NBS notification on all **confirmed** cases within 30 days of receiving a report of a confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completion of the investigation.
- **Fax an investigation form (may be incomplete) within 2 weeks of death.**
 - Document any reasons for delays in reporting the death (e.g., found during death certificate review, delayed reporting the health department, etc.).
- Fax a completed investigation form upon conclusion of the investigation.
 - Investigation forms may be faxed to **512-776-7616**.

When an outbreak of influenza or an influenza-like illness is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Submit a completed **Respiratory Disease Outbreak Summary Form** at the conclusion of the outbreak investigation.
 - Fax a copy to the DSHS regional office and/or to EAIDB at 512-776-7676.
 - The Respiratory Disease Outbreak Summary Form is available at <http://www.dshs.state.tx.us/idcu/investigation/>.

LABORATORY PROCEDURES

Specimens for influenza testing **should** be submitted to the DSHS Laboratory (or a Texas Laboratory Response Network [LRN] laboratory) for all influenza-associated pediatric mortality cases. It is especially important to submit specimens if influenza was suspected but not confirmed or only confirmed with a rapid influenza test.

If available, respiratory specimens collected pre- or post-mortem (e.g., nasopharyngeal swabs, throat swabs, lower respiratory tract specimens, etc.), and post-mortem (autopsy) specimens should be submitted for influenza testing. The DSHS Austin Laboratory and the Texas Laboratory Response Network (LRN) laboratories can perform influenza PCR testing on respiratory specimens; post-mortem tissue specimen testing is performed by the CDC Pathology Laboratory.

Specimen Collection

Pre- or Post-Mortem Respiratory Specimens/Swabs

- Follow the specimen collection instructions in the current influenza season's DSHS Influenza Laboratory Surveillance Protocol. The protocol is available by request from DSHS EAIDB or from the regional influenza surveillance coordinator.
- A nasopharyngeal swab is the preferred specimen type. Other respiratory specimens may be accepted as described in the current protocol.
- Refrigerate (2°–8 °C) or freeze (–70°C) specimen vials immediately after collection.

Post-mortem tissue specimens/slides collected during autopsy

- CDC can test post-mortem specimens collected during an autopsy for influenza, other viruses (upon request), and bacterial co-infections.
- Contact EAIDB at (800) 252-8239 or (512) 776-7676 for instructions on post-mortem autopsy specimen collection and submission.

Submission Form (if submitting specimen(s) to DSHS Austin)

Pre- or Post-Mortem Respiratory Specimens/Swabs

- Use the DSHS Laboratory G-2V Specimen Submission Form for specimen submission. On the form, under the Virology section, check the box for “Influenza surveillance {Influenza real-time RT-PCR}”. In the blank space to the right of “Influenza surveillance {Influenza real-time RT-PCR}”, write “pediatric flu death”.

Section 4. VIROLOGY	
☐	Electron Microscopy
☒	Influenza surveillance {Influenza real-time RT-PCR}
	Vaccine received: ☐ Yes ☐ No
	Date vaccine received: _____
	Travel history (if known): _____
☐	Measles, real-time RT-PCR
☐	Mumps, real-time RT-PCR
☐	MERS Coronavirus (Novel coronavirus)
	++++ Prior authorization required. +++++
	Call Infectious Disease (512) 776-7676 for authorization
☐	Other: _____

Pediatric flu death

- Indicate the patient's flu vaccination status for the current season and the date of vaccination, if known.
- If applicable, indicate the patient's travel history and/or animal contact history.
 - For animal contact history, write “Animal contact” and the type of animal contact with which the patient had contact in the blank space to the right of “Influenza surveillance {Influenza real-time RT-PCR}”.
- Make sure the patient's name and approved secondary identifier on the form exactly match what is written on the specimen tube.
 - An approved secondary identifier should be one of the following: date of birth, medical record number, social security number, Medicaid number, or CDC number.
- Make sure to fill in the date and time of collection in addition to the patient demographics on the form.

Post-mortem tissue specimens/slides collected during autopsy

- Contact EAIDB at (800) 252-8239 or (512) 776-7676 for instructions on post-mortem autopsy specimen collection and submission.

Specimen Shipping

Pre- or Post-Mortem Respiratory Specimens/ Swabs

- Transport temperature: Store the specimen at 2°-8°C if the specimen will be received at the laboratory within 72 hours of collection; ship the specimen on cold or freezer packs. Otherwise, the specimen must be stored frozen (-70°C) and shipped on dry ice.
- Ensure that the specimen is triple-contained and that the outer shipping container is properly labeled for “Biological Substance, Category B” shipments.
- Ship specimens for overnight delivery.
- DO NOT mail specimens on a Friday or the day before a holiday unless special arrangements have been made in advance with the DSHS or LRN Laboratory.
- If shipping specimens to DSHS Austin, ship specimens to:
Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Post-mortem tissue specimens/slides collected during autopsy

- Contact EAIDB at (800) 252-8239 or (512) 776-7676 for instructions on post-mortem autopsy specimen collection and submission.

Common Causes for Rejection

- There is a discrepancy between the patient name on the specimen tube and the name on submission form.
- The specimen is not shipped in viral transport medium or the medium is expired.
- The specimen is received more than 72 hours after collection (if refrigerated).
- The specimen is received at ambient temperature.

UPDATES

April 2017

- Laboratory Procedures: changes made to Submission Form instructions to reflect updates to the DSHS Laboratory G-2V Specimen Submission Form and the DSHS Laboratory submission procedure.

Legionellosis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Legionella species are Gram-negative bacilli commonly found in water. There are over 50 species and approximately 70 serogroups currently recognized. *L. pneumophila* serogroup 1 is primarily responsible for human disease followed by *L. micdadei*, *L. bozemanii*, *L. dumoffi*, and *L. longbeachae*.

Transmission

Transmission occurs by inhaling aerosols from a water source contaminated with the *Legionella* bacteria. An example is breathing in steam or mist from a contaminated hot tub. Transmission may also occur by aspirating contaminated water. (See [Legionella Ecology and an Introduction to Environmental Health and Engineering](#) video for more information.)

Incubation Period

The incubation period for Legionnaires' disease is 2–10 days with most infections occurring 5–6 days after exposure. Pontiac Fever can occur in 5–72 hours after exposure, but most often occurs 24–48 hours after exposure.

(Note: The incubation period for Legionnaires' disease is most commonly 2–10 days, with an average of 5–6 days, but has been reported to be up to 19 days in rare cases. For routine surveillance purposes, exposure histories are collected for the 10 days prior to onset. However, in outbreak settings where it is important to consider a wide range of possible sources, use of a 14-day incubation period is often desirable.)

Communicability

No human-to-human transmission occurs.

Clinical Illness

- **Legionnaires' disease** is a common cause of pneumonia. Symptoms may include a high fever, shortness of breath, chills, non-productive cough, muscle aches and headache. Chest pain, altered mental status, abdominal pain, nausea, vomiting and diarrhea are also common.
- **Pontiac Fever** presents as a self-limited febrile illness that does not result in pneumonia. Symptoms may include fever, cough, headaches and muscle aches. Complete recovery usually occurs within a week without antibiotics.

Severity

Almost all patients with Legionnaires' disease require hospitalization, and the case fatality rate of Legionnaires' disease is 5% to 30%. The case fatality rate is often higher in nosocomial cases. Pontiac fever does not result in death and hospitalization is rarely required.

DEFINITIONS

Clinical Case Definition

Legionellosis is associated with two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is characterized by fever, myalgia, cough and clinical or radiological pneumonia; and Pontiac Fever, a milder illness without pneumonia.

Laboratory Confirmation

A clinically compatible case that meets at least one of the confirmatory laboratory criteria:

- Isolation (culture) of any *Legionella* organism from respiratory secretions, lung tissue, pleural fluid or other normally sterile fluid
- Detection of *Legionella pneumophila* serogroup 1 antigen in urinary using validated reagents
- Demonstration of seroconversion by a fourfold or greater rise in specific serum antibody titer between paired acute and convalescent phase serum specimens to *Legionella pneumophila* serogroup 1 using validated reagents

Note: DFA and PCR tests for *Legionella* are not considered confirmatory for determining the case classification of Legionellosis cases.

Case Classifications

- **Confirmed:** A clinically compatible case that meets at least one of the confirmatory laboratory criteria
- **Probable:** No probable case definition for Legionellosis

Case Categories (Confirmed cases of Legionellosis may be further categorized to describe type of exposure.)

- Travel-associated case
 - Definitely: A case that has a history of spending the entire 10-day incubation period away from home, either in the same country of residence or abroad
 - Possibly: A case that has a history of spending at least one night away from home, either in the same country of residence or abroad, in the 10-day incubation period
- Healthcare-associated (nosocomial) case
 - Definitely: A case that has a history of spending the entire 10-day incubation period in a hospital or a long-term care facility
 - Possibly: A case that had exposure to a healthcare facility for any portion of the 10-day incubation period

Cluster and Outbreak Definitions

- Cluster:
 - Two or more cases linked by areas of residence (building, street block, neighborhood, etc.), work or places visited, with sufficient closeness in dates of onset of illness to warrant further investigation
- Outbreak:
 - Two or more cases associated with the same facility (e.g., hotel, gym, etc.) or other common location (e.g., amusement park) within 1 year, OR
 - One definitely healthcare-associated case or two or more possibly healthcare-associated cases within 1 year associated with the same healthcare facility

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of clinically suspected Legionellosis. Investigations should **always** include an interview of the case-patient or a surrogate to obtain a detailed exposure history. Please use the Legionellosis Investigation Report Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm that the laboratory results meet the case definition.
 - Urinary antigen and respiratory culture are preferred testing methods for clinical *Legionella* confirmation.
 - If only one antibody test was performed and symptoms are consistent with Legionellosis, consider requesting that the attending physician order a convalescent antibody test or a urinary antigen test, especially in an outbreak setting.
- ☐ Review medical records or speak to an infection preventionist or physician to verify demographics, symptoms, underlying health conditions and course of illness.
- ☐ Interview the case-patient (or surrogate).
 - Use the Legionellosis Investigation Report Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.
 - If cruise ship exposure is reported during the incubation period, interview the patient with the DSHS Legionellosis Investigation Report Form AND the Legionellosis Cruise Ship Questionnaire at <http://www.cdc.gov/legionella/health-depts/inv-tools-single/index.html>.
 - Jurisdictions that are experiencing a significant increase in Legionellosis cases should interview patients with the DSHS Legionellosis Investigation Report Form AND also consider completing the Legionellosis Hypothesis-Generating Questionnaire (<http://www.cdc.gov/legionella/health-depts/inv-tools-single/index.html>)
 - Determine the patient's onset date. This may be difficult for patients with complex medical histories or those with atypical symptoms. When onset date is uncertain for these reasons, consult all of the following sources:
 - Patient or surrogate interview
 - Medical summaries and progress reports, consultations, radiology (chest x-ray) reports, and medication records (specifically antibiotics) for all medical facilities visited in the 2-4 weeks prior to suspected symptom onset
 - For the 10 days prior to illness onset, identify risk factors, travel history and other potential exposures such as hospital, dental and long-term care facility visits/stays or visits to any other location where aerosolization of water may have occurred (e.g., gyms, saunas, restaurants with outdoor misters or fountains, truck stops with showers, etc.).
 - Obtain detailed information on travel or facility exposures including exact dates, room numbers, the name of the facility, and the facility's complete physical address (since facilities may have similar names and multiple locations).
 - If at least three, unsuccessful attempts were made to contact the case-patient or surrogate, please complete the case investigation form with available information and indicate the reason for missing information (e.g., lost to follow-up – patient did not return call; multiple messages left).
 - If initially the patient is unable to communicate for interview due to severity of illness, conduct the initial interview with the patient's surrogate and interview the patient when the patient is able to communicate.
- ☐ Implement control measures for cases, contacts and/or facilities in the assigned jurisdiction (see list of control measures below).

- If suspected healthcare-associated, travel-related or other exposures are identified, notify DSHS and other jurisdictions, if necessary, in which the possible exposure occurred, using appropriate notification channels.
 - **Notify DSHS within 1 business day of when a healthcare-associated or travel-related exposure is identified.**
 - DSHS tracks potential Legionellosis exposures in Texas.
 - DSHS will share all out-of-state exposures and in-state exposures that may affect out-of-state residents with the Centers for Disease Control and Prevention (CDC) who will notify other states/jurisdictions as needed.
- When cases report travel or exposure to healthcare facilities or other institutions during their incubation periods, or in the event of a cluster or outbreak, complete the applicable steps in the Managing Special Situations section.
- In the event of a death, a copy of the discharge summary, death certificate, or autopsy report should be obtained.
- Complete the investigation form(s) and fax it to DSHS.
- Enter all confirmed Legionellosis case investigations and submit a notification in the NEDSS Base System (NBS).
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.

Prevention and Control Measures

Cases, contacts and the general public

- Provide education on Legionellosis as needed. Emphasize the following:
 - Low risk of Legionnaires' disease for most healthy individuals
 - No human-to-human transmission
 - Close contacts of the case at risk only if exposed to the same source as the case
 - Increased risk of infection for individuals who are immunosuppressed, have chronic obstructive pulmonary disease (COPD) or have other risk factors such as diabetes or history of smoking
- Recommend using sterile water for respiratory therapy devices. Do not use tap water.
- Recommend that high risk sources such as hot tubs are maintained properly including:
 - Maintenance of appropriate pH (7.2–7.8) and disinfectant levels
 - Removal of slime or biofilm
 - Replacement of filters as recommended by the manufacturer
 - For more information see <http://www.cdc.gov/legionella/about/prevention.html> and www.cdc.gov/healthywater/swimming/rwi/illnesses/legionella.html.
- Recommend that anyone experiencing symptoms be evaluated by a medical provider.
 - Collect demographic information and symptom history on ill contacts.
- No environmental testing of water is recommended for a single case that is only possibly associated with a facility/exposure.
- General prevention messages include:
 - Don't smoke.
 - Don't use hot tubs or whirlpools that are not well maintained.
 - Don't use tap water in humidifiers or respiratory therapy devices.
 - Thoroughly clean and maintain any humidifiers, respiratory therapy devices, hot tubs, fountains or other devices or equipment that can aerosolize water per the manufacturer's directions.

- Women planning a water birth
 - Women who are planning a water birth should educate themselves on the process, carefully considering the documented benefits and risks of water birth at different stages of labor.
 - Research birth providers and facilities to ensure that infection prevention plans are in place for water births and are actively in use to protect patients.
 - Read the DSHS Midwifery Board's Waterbirth Guidelines: "Information for Client Discussion Regarding the use of Water during Labor and Birth", "Guidelines for Water Immersion and Waterbirth", and "Pool Setup and Cleaning Recommendations" (combined document) at <https://www.dshs.state.tx.us/midwife/waterbirth/>.

Healthcare providers and facilities (healthcare and non-healthcare)

- Remind local healthcare providers to consider Legionellosis as a cause of pneumonia and report confirmed or clinically suspected cases.
 - Indications for Legionella testing (<http://www.cdc.gov/legionella/clinicians/clinical-features.html>):
 - Patients who have failed outpatient antibiotic therapy for community-acquired pneumonia
 - Patients with severe pneumonia, in particular those requiring intensive care
 - Immunocompromised patients with pneumonia
 - Patients with pneumonia in the setting of a Legionellosis outbreak
 - Patients with a travel history in the two weeks prior to illness onset
 - Patients suspected of healthcare-associated pneumonia
- Notify the director of any facility that the case-patient stayed at or visited during the incubation period.
- Request that the facility notify the health department if any guest/customer/resident/patient complains of respiratory illness or pneumonia after staying/visiting there.
 - If there were additional complaints of illness, collect suspected case-patient names, room numbers and contact information.
- Remind the facility of the importance of proper maintenance.
 - See CDC's Water Systems Maintenance website: <http://www.cdc.gov/legionella/water-system-maintenance.html>
 - Facilities should take steps to minimize the risk of Legionellosis associated with building water systems. Refer to the American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. (ASHRAE) current guidance (ASHRAE Guideline 12-2000 and ANSI/ASHRAE Standard 188-2015) and the CDC toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards" for more information.
 - Recommend review of maintenance procedures of hot tubs, pools, whirlpools, birthing tubs, cooling towers, decorative fountains or any other sources of possible aerosolization of water. Important features in maintenance plans include procedures for:
 - Maintaining appropriate hot and cold water temperatures
 - Maintaining and monitoring pH and disinfectant levels including residual free chlorine
 - Replacing filters per manufacturer's recommendations
 - Performing emergency disinfection/remediation as needed
 - For more information, see www.cdc.gov/legionella/about/prevention.html.
 - Encourage the facility to hire a professional maintenance company for their equipment (e.g., hot tubs, pools) if the facility employees are unfamiliar with proper maintenance procedures.
- Remind the facility to enforce the maximum bather load for pools and hot tubs/spas.

- Encourage facilities to educate physicians to heighten their suspicion for cases of healthcare-associated Legionellosis and to use appropriate methods for its diagnosis. Facilities should also educate patient-care, infection-control and engineering personnel about measures to control healthcare-associated Legionellosis.
- Facilities should ensure that nebulizers and other semicritical respiratory care equipment are cleaned with sterile water. Enteral tubes should be flushed with sterile water and enteral feedings should be diluted with sterile water.
 - Providers should make sure that patients who use these devices are aware of these recommendations.
- Each hospital and long-term care facility should form a team of representatives from various departments to develop and write a Legionellosis control plan. The team should be led by a hospital epidemiologist or an infection control professional.
 - This operational plan should encompass several components including:
 - Surveillance strategies
 - Whether environmental culturing is recommended
 - Remediation strategies (if and when necessary)
 - Reporting procedures
 - Hospitals and long-term care facilities should regularly review and update their Legionellosis control plans.
 - For more information, see the Report of the 'Texas Legionnaires' Disease Task Force.
- Point-of-use filtration (0.2 micrometer) may be used at specific faucets, showerheads and other outlets as an added control measure. (This is more commonly recommended in an outbreak setting.)
- Water testing is generally not recommended in response to single cases that are only possibly associated with a facility.
- For additional information specific to facilities review the Managing Special Situations section.

Providers and facilities that offer water birthing

- For a complete list of recommendations see the DSHS Midwifery Board's Waterbirth Guidelines at <https://www.dshs.state.tx.us/midwife/waterbirth/>
- Be aware of the potential risks of water birth-associated infections and educate expectant parents on these risks.
- Provide written procedures and guidelines to expectant parents regarding water birth, and document acknowledgment of procedures.
- Ensure the use of proper equipment for water birthing.
- Create written procedures for cleaning and maintaining birthing tubs and associated components.
- Maintain, disinfect, and properly store equipment used for water birthing.
- Maintain recommended water quality of tubs utilized by the facility during water birthing. Water quality measures should be guided by the instructions provided by the manufacturer.
- Document equipment maintenance, chemical additives used to maintain water quality, and preparation and use of equipment for each birth.
- Train all staff midwives and anyone involved in the use of water during labor and/or birth on all facility specific procedures developed for waterbirth and retain records of employee training.

School/Daycare Exclusion Criteria

No exclusion from work, school or daycare is required for disease control purposes.

MANAGING SPECIAL SITUATIONS

TRAVEL-ASSOCIATED CASES

One travel-associated case

If a **single** confirmed case of Legionellosis reported staying at a hotel for at least one day/night during the incubation period, the hotel should be notified. Do not share the patient's name or exact date of stay. With only one confirmed case, the exposure may or may not have occurred at the hotel.

For a **single** confirmed case, the local/regional health department should:

- Notify the hotel in writing of the case and
 - Request that the hotel notify the health department if any guest complains of respiratory illness or pneumonia after staying there.
 - Recommend that the hotel review their maintenance procedures for their cooling system, decorative fountains, pools and any hot tubs/whirlpools.
 - Recommend review of American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. (ASHRAE) Guideline 12-2000, ANSI/ASHRAE Standard 188-2015, the Model Aquatic Health Code, and other resources at <http://www.cdc.gov/legionella/water-system-maintenance.html>
 - A sample letter is available on the CDC website at <http://www.cdc.gov/legionella/downloads/sample-hotel-letter.pdf>.
 - Note: Do not share enough details for the hotel to identify the case.
- Environmental (water) sampling and testing is not recommended for a single case staying at a hotel.

Multiple travel-associated cases

If **two or more** unrelated, confirmed cases of Legionellosis reported staying at least one night/day at the same hotel within a one-year period, notify the EAIDB at (800) 252-8239 or (512) 776-7676. (Cases are considered related if they are members of the same household, traveling together, staying in the same room and otherwise spending significant amounts of time together outside of suspected travel exposure. For example, a husband and wife staying in the same room and traveling together would count as related but members of the same sports team staying in different rooms would not be related.)

For **two or more** unrelated confirmed cases, the local/regional health department should:

- Notify the hotel in writing of the cases and
 - Request that the hotel notify the health department if any guest complains of respiratory illness or pneumonia after staying there.
 - Recommend that the hotel review their maintenance procedures for their cooling system, decorative fountains, pools and any hot tubs/whirlpools.
 - Recommend review of ASHRAE Guideline 12-2000, ANSI/ASHRAE Standard 188-2015, the Model Aquatic Health Code, and other resources at <http://www.cdc.gov/legionella/water-system-maintenance.html>
 - A sample letter is available on the CDC website at <http://www.cdc.gov/legionella/downloads/sample-hotel-letter.pdf>.
 - Note: Do not share enough details for the hotel to identify the cases.
- Consider posting an Epi-X call for cases to notify other state and local health departments of the cluster and to encourage reporting of additional cases.

- Work with the hotel to conduct an environmental assessment to determine possible sources of exposure and to verify maintenance procedures are being followed. The environmental assessment should be completed by the health department or by an independent contractor familiar with water systems and with documented *Legionella* remediation experience.
 - Note: the environmental assessment is a way to gain a thorough understanding of a facility's water systems and assist facility management with minimizing the risk of Legionellosis. It is not the same as environmental sampling.
 - Use the CDC's *Legionella* Environmental Assessment Form (<http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/environmental-inv-tools.html>) to conduct the assessment. The form should be completely filled out. (Videos providing information and instruction on environmental assessment and sampling are available at <http://www.cdc.gov/legionella/videos.html>).
 - Ask the facility to provide maps of the hotel and water system in order to identify exposure locations and to select sites for environmental sampling (if planned).
- Recommend that the hotel take measures to reduce/eliminate *Legionella* from its water system.
 - The hotel should follow ASHRAE Guideline 12-2000 and ANSI/ASHRAE Standard 188-2015 for controlling and preventing Legionellosis associated with building water systems. The CDC developed a toolkit aimed to provide an easy-to-understand interpretation of ASHRAE Standard 188 (<https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html>).
 - Recommend that the hotel hire an environmental consultant familiar with water system assessment and with documented *Legionella* remediation experience.
 - The hotel owner should work with the consultant to minimize any risks of *Legionella* colonization and transmission associated with the facility, including addressing any modifiable issues identified by public health or the consultant.
 - CDC's instructions on "Disinfection of Hot Tubs Contaminated with *Legionella*" may be found at <http://www.cdc.gov/legionella/downloads/hot-tub-disinfection.pdf>.
- Recommend environmental sampling (i.e., collection of water and biofilm swab samples to test for *Legionella*), if warranted.
 - Environmental sampling should be considered when more than one case of Legionellosis is associated with a hotel within a one-year period and the epidemiological investigation or environmental assessment identifies potential exposures or sources of infection.
 - Environmental sampling should be done if remediation efforts were implemented and a new case is identified with exposure occurring after remediation was done.
 - Please see the Environmental Sampling and Testing section near the end of this chapter for sample sites, collection protocols, and testing instructions.
 - Do not delay interventions necessary to prevent additional cases of Legionellosis (e.g., closing a hot tub to bathers) pending the results of environmental sampling.
 - If environmental sampling is done, the hotel should provide a copy of the testing results to the health department.

HEALTHCARE-ASSOCIATED CASES

One possibly healthcare-associated case

If **one confirmed, possibly healthcare-associated case** of Legionellosis reported exposure to a healthcare facility during his/her incubation period, the healthcare facility should be notified. With only one possibly healthcare-associated case, the exposure may or may not have occurred at the facility. Consult with EAIDB if it is an outpatient exposure at (800) 252-8239 or (512) 776-7676.

Note: The healthcare-associated Legionellosis recommendations may be used for cases associated with closed, non-healthcare institutions (e.g., correctional facilities). Recommendations may need to be modified slightly to reflect differences in healthcare facilities and non-healthcare facilities.

For **one possibly healthcare-associated case**, the local/regional health department should:

- Notify (in writing) the infection preventionist or medical director of the healthcare facility at which the case-patient stayed to verify that the facility is aware of the case and
 - Request that the facility notify the health department if additional nosocomial Legionellosis cases are suspected or identified.
 - Recommend that the facility implement active surveillance to identify new cases if the confirmed case reported an inpatient/resident stay at the facility (during the incubation period).
 - At minimum, active surveillance should include daily review of chest x-rays, sputum cultures and new diagnoses of pneumonia.
 - All patients who develop pneumonia two or more days after admission over the next 60 days should be tested by urinary antigen test; culture testing is also recommended in addition to urinary antigen testing.
 - Once implemented in response to a possible or definite case, active surveillance should continue for at least six months.
 - Recommend that the facility review their maintenance procedures for any possible sources of aerosolized water (including cooling towers, evaporative condensers, water heaters, pools/hot tubs/whirlpools, decorative fountains, respiratory therapy equipment, etc.).
 - Review of the American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. (ASHRAE) Guideline 12-2000 ANSI/ASHRAE Standard 188-2015, and the CDC toolkit “Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards,” is also recommended (see <http://www.cdc.gov/legionella/water-system-maintenance.html>).
 - Recommend that the facility review and update (if necessary) the facility’s Legionellosis control plan (see Report of the Texas Legionnaires' Disease Task Force for more information).
- Environmental (water) testing is not recommended when a facility has only one possibly healthcare-associated case.

One or more definitely healthcare-associated case OR multiple possibly healthcare-associated cases

If **one or more definitely healthcare-associated or two or more possibly healthcare-associated cases** occur in patients of the same dental or healthcare provider, hospital, residential care facility or other long-term care facility AND the cases have no other identified plausible source of infection OR if other circumstances suggest the possibility of healthcare-associated infection, notify the EAIDB at (800) 252-8239 or (512) 776-7676. If there are outpatient visits in the cluster, please consult with EAIDB before declaring it a cluster.

For **≥ 1 definitely healthcare-associated case or ≥ 2 possibly healthcare-associated cases**, the local/regional health department should:

- Notify the infection preventionist or medical director of the healthcare facility at which the case-patients stayed to verify that the facility is aware of the cases.
 - If any of the patients reported exposures to multiple facilities during their incubation periods, make sure that all facilities are notified.
 - Notify facilities of cases and public health recommendations, in writing.
- Work with the facility to conduct retrospective and prospective surveillance to identify potentially missed or new cases for a minimum of 6 months before the earliest onset date and after the most recent onset date, respectively.
 - Retrospective surveillance should include a review of patient medical records and laboratory results from the past 6 months to identify clinically compatible cases.

- Active surveillance should include daily review of chest x-rays, sputum cultures and new diagnoses of pneumonia.
- Once implemented in response to a possible or definite case, active surveillance should continue for at least 6 months following the onset date of the most recent healthcare-associated case.
- Request that the facility notify the health department if additional healthcare-associated Legionellosis cases are suspected or identified.
- Recommend testing of patients with compatible symptoms at least 60 days before the earliest onset date of a healthcare-associated case and at least 60 days after the onset date of the most recent healthcare-associated case.
 - All patients who developed pneumonia in the last 60 days should be tested with a urinary antigen test.
 - All patients who develop pneumonia two or more days after admission over at least 60 days after the latest onset date of a health-care associated case should be tested by both culture **and** urinary antigen. This testing should be extended beyond 60 days when there is evidence of ongoing transmission or when recommended prevention and control measures have not been completed.
 - Testing may be done in-house or by a commercial laboratory.
 - Clinical *Legionella* isolates/cultures should be retained (not discarded) by the hospital/lab or sent to the state public health lab (with approval form the public health lab).
- Remind the facility to report to its regulatory authority as appropriate.
- Notify facility staff about the outbreak so that medical personnel consider Legionellosis in the differential diagnosis for patients with nosocomial and community-acquired pneumonia, and test and report suspected cases as directed.
- Consider clinically-compatible illnesses in facility staff.
- Review the facility's infection control measures to prevent Legionellosis exposures and work with the facility to identify potential gaps.
 - Review and update (if necessary) the facility's Legionellosis control plan. Refer to the Report of the Texas Legionnaires' Disease Task Force for detailed Legionellosis response measures in acute care hospitals and long-term care facilities.
- Recommend that the facility review their maintenance procedures for any possible sources of aerosolized water (including cooling towers, evaporative condensers, water heaters, pools/hot tubs/whirlpools, decorative fountains, respiratory therapy equipment, etc.).
- Review of the ASHRAE Guideline 12-2000 and ANSI/ASHRAE Standard 188-2015 is also recommended.
- Work with the facility to conduct an environmental assessment to determine possible sources of exposure and to verify that maintenance procedures are being followed. The environmental assessment should be completed by the health department or by an independent contractor familiar with water systems and with documented *Legionella* remediation experience.
 - Note: the environmental assessment is a way to gain a thorough understanding of a facility's water systems and assist facility management with minimizing the risk of Legionellosis. It is not the same as environmental sampling.
 - Use and complete the CDC's *Legionella* Environmental Assessment Form (<http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/environmental-inv-tools.html>) to conduct the assessment. (Videos providing information and instruction on environmental assessment and sampling are available at <http://www.cdc.gov/legionella/videos.html>).
 - Ask the facility to provide maps of the facility and water system (if available) in order to identify exposure locations and to select sites for environmental sampling (if planned).

- Consider using methods to limit exposure of high-risk patients to potentially contaminated water sources, pending successful reduction in levels of *Legionella* colonization within the facility's water system including:
 - Restrictions on showering
 - Restrictions on use of potable hot water: shift to using sterile water for bathing, drinking, oral hygiene, wound care, and dilution of drinks (bottled water may also be an option for some activities)
 - Installing point-of-use filtration at faucets and showerheads
 - Suspending water births (until water restrictions are lifted)
- Recommend that the facility take measures to reduce/eliminate *Legionella* from its water system.
 - The facility should follow ASHRAE Guideline 12-2000 and ANSI/ASHRAE Standard 188-2015 for controlling and preventing Legionellosis associated with building water systems. The CDC developed a toolkit aimed to provide an easy-to-understand interpretation of ASHRAE Standard 188 (<https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html>).
 - Recommend that the facility hire an environmental consultant familiar with water system assessment and with documented *Legionella* remediation experience. The facility owner should work with the consultant to minimize any risks of *Legionella* colonization and transmission associated with the facility, including addressing any modifiable issues identified by public health or the consultant.
- Recommend environmental sampling (i.e., collection of water and biofilm swab samples to test for *Legionella*), if warranted.
 - Water testing should be considered when one definite healthcare-associated case or two or more possible healthcare-associated cases of Legionellosis are associated with a facility within a one-year period.
 - Sampling should only be performed after a thorough environmental assessment has been done and a sampling plan has been made. The sampling plan should be approved by the health department.
 - Water testing should be done if remediation efforts were implemented and a new case is identified with exposure occurring after remediation was done.
 - Please see the Environmental Sampling and Testing section near the end of this chapter for sample sites, collection protocols, and testing instructions.
 - Do not delay interventions necessary to prevent additional cases of Legionellosis (e.g., cleaning equipment, implementing water restrictions, installing point-of-use filters) pending the results of environmental sampling.
 - If environmental sampling is done, the healthcare facility should provide a copy of the testing results to the health department.
- If needed, conduct a case-control study to identify specific exposures within the facility.

CASES ASSOCIATED WITH A GYM, SPA, OR OTHER “OPEN” FACILITY

One facility-associated case

If **one confirmed case** of Legionellosis reported exposure to a source of aerosolized water (pool, whirlpool, hot tub, mister, etc.) at a public/communal facility during at least one day/night during the incubation period, the facility should be notified. Do not share the patient's name or exact date of exposure. With only one confirmed, possibly facility-associated case, the exposure may or may not have occurred at the facility.

For a **single case**, the local/regional health department should:

- Notify the facility in writing of the case and
 - Request that the facility notify the health department if any customer complains of pneumonia after visiting the facility.
 - Recommend that the facility review their maintenance procedures for any possible sources of aerosolized water (including pools, hot tubs/whirlpools, misters, etc.).

- Recommend review of American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. (ASHRAE) Guideline 12-2000, ANSI/ASHRAE Standard 188-2015, the Model Aquatic Health Code, the CDC toolkit “Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards,” and other resources at <http://www.cdc.gov/legionella/water-system-maintenance.html>
 - A sample letter for hotels is available on the CDC website at <http://www.cdc.gov/legionella/downloads/sample-hotel-letter.pdf>. This letter can be modified for any facility.
 - Note: Do not share enough details for the facility to identify the case.
- Environmental (water) sampling and testing is not recommended for a single case reporting exposure to the facility.

Multiple facility-associated cases

If **two or more confirmed cases** of Legionellosis reported exposure to a source of aerosolized water (pool, whirlpool, hot tub, mister, etc.) at a facility during at least one day/night during the incubation period* within a one-year period, notify the EAIDB at (800) 252-8239 or (512) 776-7676.

For **multiple cases**, the local/regional health department should:

- Notify the facility in writing of the cases and
 - Request that the facility notify the health department if any customer complains of pneumonia after visiting the facility.
 - Recommend that the facility review their maintenance procedures for any possible sources of aerosolized water (including pools, hot tubs/whirlpools, misters, etc.).
 - Recommend review ASHRAE Guideline 12-2000, ANSI/ASHRAE Standard 188-2015, the Model Aquatic Health Code, the CDC toolkit “Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards,” and other resources at <http://www.cdc.gov/legionella/water-system-maintenance.html>
 - A sample letter for hotels is available on the CDC website at <http://www.cdc.gov/legionella/downloads/sample-hotel-letter.pdf>. This letter can be modified for any facility.
 - Note: Do not share enough details for the facility to identify the case.
- Contact local hospital infection control staff and emergency room staff to determine whether they have observed an increase in community-acquired pneumonia patients admitted to the facility.
 - If cultures/isolates or respiratory specimens are available on potential cases, these should be held (i.e., not discarded) in case further testing is requested.
- Inform primary care physicians, emergency room staff and radiologists in the potential outbreak area and any other locations necessary of the following:
 - That there is a cluster of Legionellosis cases
 - The signs and symptoms of Legionellosis
 - The recommended lab tests to confirm Legionellosis
 - Reporting requirements and contact information for the health department
- Consider clinically-compatible illnesses in staff of the affected facility.
- Work with the facility to conduct an environmental assessment to determine possible sources of exposure and to verify maintenance procedures are being followed. The environmental assessment should be completed by the health department or by an independent contractor familiar with water systems and with documented *Legionella* remediation experience.
 - Note: the environmental assessment is a way to gain a thorough understanding of a facility’s water systems and assist facility management with minimizing the risk of Legionellosis. It is not the same as environmental sampling.

- Use and complete the CDC's *Legionella* Environmental Assessment Form (<http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/environmental-inv-tools.html>) to conduct the assessment. (Videos providing information and instruction on environmental assessment and sampling are available at <http://www.cdc.gov/legionella/videos.html>).
- Ask the facility to provide maps of the facility and water system (if available) in order to pinpoint exposure locations and to select sites for environmental sampling (if planned).
- Recommend that the facility take measures to reduce/eliminate *Legionella* from the water system.
 - The facility should follow ASHRAE Guideline 12-2000 and ANSI/ASHRAE Standard 188-2015 for controlling and preventing Legionellosis associated with building water systems.
 - CDC's toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards" is an easy-to-understand interpretation to ASHRAE 188 (<https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html>).
 - Recommend that the facility hire an environmental consultant familiar with water system assessment and with documented *Legionella* remediation experience. The facility owner should work with the consultant to minimize any risks of *Legionella* colonization and transmission associated with the facility, including addressing any modifiable issues identified by public health or the consultant.
 - CDC's instructions on "Disinfection of Hot Tubs Contaminated with *Legionella*" may be found at <http://www.cdc.gov/legionella/downloads/hot-tub-disinfection.pdf>.
- Recommend environmental sampling (i.e., collection of water and biofilm swab samples to test for *Legionella*), if warranted.
 - Environmental sampling should be considered when more than one case of Legionellosis is associated with a facility within a one-year period and the epidemiological investigation or environmental assessment identifies potential exposures or sources of infection.
 - Sampling should only be performed after a thorough environmental assessment has been done and a sampling plan has been made. The sampling plan should be approved by the health department.
 - Environmental sampling should be done if remediation efforts were implemented and a new case is identified with exposure occurring after remediation was done.
 - Please see the Environmental Sampling and Testing section near the end of this chapter for sample sites, collection protocols, and testing instructions.
 - Do not delay interventions necessary to prevent additional cases of Legionellosis (e.g., closing a hot tub to bathers) pending the results of environmental sampling.
 - If environmental sampling is done, the hotel should provide a copy of the testing results to the health department.

CASES ASSOCIATED WITH A COMMUNITY

If **multiple confirmed cases** of Legionellosis (e.g., in residents, visitors/travelers, etc.) are reported within a one-year period with exposure to the same community AND no potential common source has been identified, notify the EAIDB at (800) 252-8239 or (512) 776-7676.

A cluster of Legionellosis cases with a common exposure can involve both Legionnaires' disease and Pontiac fever and health departments should be alert to this possibility. Questions regarding ill contacts of Legionnaires' disease case patients should not be limited to persons with symptoms of pneumonia.

The local/regional health department should:

- Identify the investigation team and available resources
 - Contact DSHS if assistance is needed.
- Establish the existence of an outbreak
 - Acquire and examine baseline data, if available
 - Verify that the “outbreak” is not a reporting or surveillance artifact
- Verify the diagnosis
 - Obtain clinical records and lab reports
 - Conduct additional clinical testing if needed
 - Ask facilities to retain *Legionella* isolates/cultures (if culture was performed)
- Construct a case definition (define person, place and time)
- Find cases systematically and develop a line listing
 - Promptly initiate case finding in the community.
 - Inform primary care physicians, emergency room staff and radiologists in the potential outbreak area and any other locations necessary of the following:
 - That there is a cluster of Legionellosis cases
 - The signs and symptoms of Legionellosis
 - How a case of Legionellosis is diagnosed
 - Preferred testing methods to identify Legionellosis cases
 - Recommendations for which patients to test (e.g., patients with community-acquired pneumonia)
 - Reporting requirements and contact information for the health department
 - Contact local hospital infection control staff and emergency room staff to determine whether they have observed an increase in community-acquired pneumonia patients admitted to the facility.
 - Cultures should be requested to be sent to the public health laboratory and held appropriately.
 - Consider notifying state and national partners, providers and healthcare facilities of the increase (e.g., Epi-X notification).
 - Case finding will involve passive and active surveillance.
 - All cases should be interviewed* with the Legionellosis Investigation Report Form or with a Legionellosis hypothesis-generating form.
- Perform descriptive epidemiology/develop hypotheses
 - Interview the cases with a hypothesis-generating questionnaire or other extensive, open-ended questionnaire in order to identify common exposures.
 - The CDC’s hypothesis-generating questionnaire for Legionellosis is available at <http://www.cdc.gov/legionella/health-depts/inv-tools-single/index.html>.
 - Map cases to identify commonalities in location or proximity to possible environmental sources.
 - Create an epidemic curve.
- Evaluate hypotheses/perform additional studies as necessary
 - Conduct epidemiologic studies (e.g., case-control study) necessary to identify the source(s) of the outbreak.
 - Conduct an environmental investigation
 - Assess the community to identify possible sources of exposure (e.g., cooling towers, chiller units, supermarket/restaurant misters, swamp coolers, decorative fountains, whirlpool spas, municipal water system, wells and streams)
 - Collect and test environmental samples for *Legionella* as appropriate.
 - Ask environmental testing labs to retain cultures/isolates that are outbreak-related so that these may be compared to clinical isolates.

- Implement control measures
 - General control measures should be implemented immediately.
 - Control measures for source control should be implemented as soon as a likely source is identified.
 - Do not wait for laboratory results on suspected sources before implementing control measures.

*Note: The incubation period for Legionnaires' disease is most commonly 2-10 days, with an average of 5-6 days, but has been reported to be up to 19 days in rare cases. For routine surveillance purposes, exposure histories are collected for the 10 days prior to onset. However, in outbreak settings where it is important to consider a wide range of possible sources, use of a 14-day incubation period is often desirable.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed and clinically suspected cases of Legionellosis should be reported **within 1 week** of suspicion to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- **Notify DSHS within 1 business day of when a healthcare-associated or travel-related exposure is identified.**
- Notify facilities (e.g., hotels, long-term care facilities, hospitals, etc.) within the LHD/HSR's jurisdiction when these facilities are identified by an investigation of a confirmed Legionellosis case-patient as possible sources of exposure during the case's incubation period.
- Enter the case into NBS and submit an NBS notification on all confirmed cases to DSHS within 30 days of receiving a report of confirmed Legionellosis.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
- Fax (or mail) a completed investigation form **as soon as the investigation is complete**.
 - DSHS compares reported exposure information on investigation forms to that of previously reported Legionellosis cases in order to identify clusters and outbreaks. Since exposure history is not captured in NBS, the investigation form is the only way in which this information is usually reported.
 - Investigation forms may be faxed to 512-776-7616 or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Submit a completed **National Outbreak Reporting System (NORS)** outbreak form at the conclusion of the outbreak investigation.
 - Enter into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
 - To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password and instructions for logging in.
- Submit a completed **Respiratory Disease Outbreak Summary Form** at the conclusion of the outbreak investigation.
 - Please include a copy of the completed environmental assessment and *Legionella* environmental testing results, if done.
 - Fax a copy to the DSHS regional office and/or to EAIDB at 512-776-7676.
 - The Respiratory Disease Outbreak Summary Form is available at <http://www.dshs.state.tx.us/idcu/investigation/>.

CLINICAL LABORATORY PROCEDURES

Specimens and isolates associated with Legionellosis cases are not routinely submitted to the DSHS laboratory in Austin. When multiple Legionellosis cases are associated with a single facility, DSHS will accept **isolates** from other laboratories conducting environmental testing if patient isolates (*Legionella* culture from clinical specimens) are available for comparison.

Contact EAIDB at 512-776-7676 for approval:

- When submitting clinical or environmental isolates to the DSHS Austin lab that are related to an outbreak
- To request molecular typing at CDC's lab to confirm that isolates from cases are identical (case-patients are exposed to the same source)

Specimen Collection

Clinical specimen

- Acceptable specimens: sputum, bronchial washing, tracheal aspirate, or lung biopsy
- Bronchial washing or tracheal aspirate:
 - Collect washing or aspirate using sterile water, not saline
 - 2mL minimum volume needed
 - Refrigerate at 2°–8 °C. Do not freeze.
- Sputum, expectorated:
 - Collect in a sterile container
 - Collect specimen under the direct supervision of a nurse or physician
 - Have patient rinse or gargle with water first to remove excess oral flora
 - Instruct patient to cough deeply to produce a lower respiratory specimen (not postnasal fluid)
 - For pediatric patients unable to produce a sputum specimen, a respiratory therapist should collect a specimen via suction. The best specimen should have <10 squamous cells/100X field (10X objective and 10X ocular).
 - Refrigerate at 2 °–8 °C. Do not freeze.
- Sputum, induced:
 - Collect in a sterile container
 - Have patient rinse mouth with water after brushing gums and tongue
 - With the aid of a nebulizer, have patient inhale approximately 25 ml of 3-10% sterile saline
 - Refrigerate at 2 °–8 °C. Do not freeze.
- Lung biopsy:
 - Collect during surgery or cutaneous biopsy procedure
 - Place in an anaerobic transport system or sterile, screw-cap container
 - Add several drops of sterile saline to keep small pieces of tissue moist
 - Always submit as much tissue as possible. If excess tissue is available, save a portion of surgical tissue at -70°C in case further studies are needed. Never submit a swab that has been rubbed over the surface of a tissue.
 - Refrigerate at 2°–8°C. Do not freeze.
 - Do not suspend the specimen in formalin or other preserving liquid.

Clinical isolates (pure cultures)

- Submit a pure culture on a BCYE slant
- May be kept at ambient temperature

Laboratory Submission Form

- For clinical specimens and isolates, use the DSHS Laboratory G-2B Submission Form.
 - For clinical specimens: On the form under “Section 5. BACTERIOLOGY” check the box for “Aerobic isolation” under “*Clinical Specimen*” and write “*Legionella*” in the open space.

Section 5. BACTERIOLOGY	
<u>Clinical specimen:</u> ☒ Aerobic isolation ☐ Anaerobic isolation ☐ Culture, stool ☐ Diphtheria Screen ☐ GC/CT, amplified RNA probe ☐ Haemophilus, isolation ☐ Toxic shock syndrome toxin I assay (TSST 1) <u>Pure culture:</u> ☐ Anaerobic identification ☐ Organism suspected: _____	<u>Definitive Identification:</u> ☐ Bacillus ☐ Campylobacter ☐ Enteric Bacteria ☐ Gram Negative Rod ☐ Gram Positive Rod ☐ Group B Streptococcus (Beta Strep) ☐ Haemophilus ☐ Legionella ☐ Neisseria ☐ Pertussis / Bordetella ☐ Staphylococcus ☐ Streptococcus ☐ Other:

- For clinical isolates: On the form under “Section 5. BACTERIOLOGY” check the box for “*Legionella*” under “*Definitive Identification*”.

Section 5. BACTERIOLOGY	
<u>Clinical specimen:</u> ☐ Aerobic isolation ☐ Anaerobic isolation ☐ Culture, stool ☐ Diphtheria Screen ☐ GC/CT, amplified RNA probe ☐ Haemophilus, isolation ☐ Toxic shock syndrome toxin I assay (TSST 1) <u>Pure culture:</u> ☐ Anaerobic identification ☐ Organism suspected: _____	<u>Definitive Identification:</u> ☐ Bacillus ☐ Campylobacter ☐ Enteric Bacteria ☐ Gram Negative Rod ☐ Gram Positive Rod ☐ Group B Streptococcus (Beta Strep) ☐ Haemophilus ☒ Legionella ☐ Neisseria ☐ Pertussis / Bordetella ☐ Staphylococcus ☐ Streptococcus ☐ Other:

- For clinical specimens and isolates, make sure the patient's name and approved secondary identifier on the form exactly match what is written on the specimen tube. Make sure to fill in the date of collection, date of onset and diagnosis/symptoms.
 - An approved secondary identifier should be one of the following: date of birth, medical record number, social security number, Medicaid number, or CDC number.

Specimen Shipping

- Transport temperature for clinical specimens: Keep at 2°–8°C (refrigerated/ice packs). Do not use dry ice.
- Transport temperature for isolates (pure culture): May be shipped at ambient temperature. Do not use dry ice.
- Ship specimens via overnight delivery on cold packs or wet ice (double bagged) within 24 hours of collection if possible.
 - Note: While *Legionella* may survive extended transport, their isolation may be compromised by overgrowth of commensal bacteria in the specimens; therefore, specimens should arrive at the laboratory as soon as possible for the best results.
- DO NOT ship specimens on a Friday or the day before a state holiday unless special arrangements have been made with the DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Frequent Causes for Rejection:

- Sputum specimen consists of saliva only
- Insufficient quantity submitted for testing
- Discrepancy between name on specimen container and name on submission form
- Container broken in transport
- Expired media used

Results Available:

- Culture results typically available in 3–21 days (15 days of no growth = negative result)

ENVIRONMENTAL SAMPLING AND TESTING

Inhalation of aerosols containing *Legionella* is presumed to be the primary means of acquiring Legionellosis. Aerosolized waters from cooling towers, evaporative condensers, showers and humidifiers have been identified as sources of infection. *Legionella* species have been recovered from a wide variety of domestic water systems and are ubiquitous in freshwater environments. Domestic water systems are complex environments in which concentrations of legionellae can fluctuate considerably depending upon water temperature, biocide levels and presence of natural hosts (i.e., protozoa) for legionellae to parasitize.

Recommendations for Environmental Sampling

When to Sample:

- Hotels, gyms, spas and other similar facilities
 - Baseline environmental sampling (in the absence of associated cases) is not recommended.
 - Environmental testing is not recommended for a single case whose illness may be associated with a hotel or similar facility.
 - Environmental sampling should be considered when more than one case of Legionellosis is associated with a hotel or similar facility within a one-year period and the epidemiological investigation or environmental assessment identifies potential exposures or sources of infection.
 - Environmental sampling should be done if remediation efforts were implemented and a new case is identified with exposure occurring after remediation was done.

- Sampling should only be performed after a thorough environmental assessment has been done and a sampling plan has been made. The sampling plan should be approved by the health department.
- Healthcare facilities
 - Baseline environmental sampling for *Legionella* (no patient cases detected)
 - All healthcare facilities should, in implementing their Legionellosis control plan, assess their risk of *Legionella* transmission. Each facility should evaluate environmental, engineering and patient population factors to determine whether there is a reasonable potential for nosocomial transmission.
 - Baseline water distribution system cultures should be performed if the results of the risk assessment indicate the facility has a significant risk of *Legionella* transmission.
 - For more information on assessing a facility's risk of *Legionella* transmission, see the Report of the Texas Legionnaires' Disease Task Force (www.dshs.state.tx.us/idcu/disease/legionnaires/taskforce/) and ANSI/ASHRAE Standard 188-2015.
 - Environmental sampling in the context of a patient case(s)
 - Water testing should be considered when one definite healthcare-associated case or two or more possible healthcare-associated cases of Legionellosis are associated with a facility within a one-year period.
 - Water testing should be done if remediation efforts were implemented and a new case is identified with exposure occurring after remediation was done.

Sampling Considerations and Procedures:

- Purpose of sampling: To determine the source of transmission and extent of colonization
- Sampling should only be performed after a thorough environmental assessment has been done and a sampling plan has been made. The sampling plan should be approved by the health department.
- If environmental sampling is pursued, the samples should be collected and processed in a way that maximizes the recovery of *Legionella*.
- Instructional/training videos: “How to Make a Sampling Plan”, “How to Sample Potable Water”, “How to Sample Cooling Towers”, and “How to Sample Spas and Fountains” at <http://www.cdc.gov/legionella/videos.html>
- **Choosing Sites for Sampling:**
 - See CDC's “Sampling Procedure and Potential Sampling Sites” document: <http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/environmental-inv-tools.html>
 - Potential sampling sites for hotels include hot tubs/whirlpools (including filters, jets, tanks, water lines, etc.); swimming pools (including skimmer baskets); showerheads and faucets in pool showering facilities, if applicable; decorative fountains; potable water supply to and within the facility (including hot water heaters, holding tanks, water returns, etc.); cooling towers; sprinkler systems; and potential sources of exposure in guest rooms (faucets, showerheads, etc.).
 - Potential sampling sites for healthcare facilities include potable water supply to and within the facility (including hot water heaters, holding tanks, water returns, etc.); potable water outlets (faucets, showers, etc.), especially those in or near patient rooms; ice machines; cooling towers and evaporative condensers; humidifiers (e.g., nebulizers) and other respiratory therapy equipment; and other potential sources of exposure (e.g., decorative fountains, whirlpools, safety showers and eyewash stations, etc.).
 - All showers and faucets in all case rooms (primary room where case stayed and other rooms where case exposures may have occurred [e.g., surgical recovery rooms]) should be sampled, along with showers and sink faucets in additional rooms.

- Choose rooms proximal and distal to risers or hot water heaters and on various floors based on the results of the environmental assessment.
- Ideally, sample at least a couple of outlets on every floor and/or wing. Some sites should also be selected at random for sampling.
- In most situations, it is appropriate to sample only the hot water. However, there are situations where taking some cold water samples is helpful.
 - For example, in hot climates (like Texas!), the cold water may be warm enough for rapid *Legionella* amplification (>77°F).
 - Note: In most recent *Legionella* outbreak investigations in Texas, some cold water samples were collected in addition to hot water samples.
 - Desalination may elevate cold water temperature.
 - Cold water could be warm due to lack of insulation between hot and cold water pipes.
 - The results of the environmental assessment (if done properly/completely) can help to determine if cold water samples should be collected.
- **Number of Samples to Collect:**
 - The number of samples to be collected should be based on a plan (to limit the expense and time associated with sample collection and testing)
 - The sampling plan should be based on the findings of the environmental assessment and available epidemiologic data (i.e., water sources and locations where patients may have been exposed)
 - The number of samples to collect may depend on:
 - The size and design of the facility (e.g., number of floors, wings, rooms, buildings, etc.)
 - The design and configuration of the water system including the presence of dead legs, number and type of components, types of heating systems, etc.
 - The facility's sources of possible aerosolized or aspirated water (e.g., cooling towers, air handling systems, showers, faucets, decorative fountains, ice machines, whirlpools, etc.)
 - The number of Legionellosis cases associated with the facility and their reported exposures in/near the facility
 - The facility's patient population
 - Other factors specific to the facility
 - In the smallest facilities, at least 10 environmental samples should be collected; however, in most cases 10 samples will not be sufficient for representative sampling. In larger or more complex facilities, 100+ samples may need to be collected in order to be representative and increase the odds of detection of *Legionella* that may be in the water system.
 - See CDC's "Sampling Procedure and Potential Sampling Sites":
<http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/environmental-inv-tools.html>
 - DSHS Austin and CDC can offer assistance in determining the number of samples and locations of sample sites.

- **Collection Recommendations and Procedures:**

- Environmental sampling should be a joint effort by the facility (particularly building systems staff/facilities engineers), the facility's *Legionella* consultant, the testing laboratory and the local health department (epidemiologist and environmental health specialist).
- Environmental sampling should be well planned in advance to ensure that all required staff and supplies are present.
- For sample collection procedures, please refer to CDC's "Sampling Procedure and Potential Sampling Sites" document (<http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/environmental-inv-tools.html>). This document covers:
 - Materials (required and optional)
 - Safety precautions
 - Sampling procedures:
 - Potable water at the points of use
 - Additional note on collection of water from handheld showerheads:
 - Handheld showerheads differ from traditional fixed showerheads because water may stagnate in the tubing increasing the risk for *Legionella* growth.
 - If the facility has handheld showerheads, collect a sample from the handheld showerhead tubing before collecting the bulk water sample. Collect a swab sample (if feasible) from the tubing and collect a water sample by capturing the water from the tubing.
 - Sampling from handheld showerheads will result in additional samples (2 biofilm swabs [1-flexible tubing, 1-water pipe], 2 bulk water [1-tubing residual, 1-bulk water from pipe]).
 - Potable water at the hot water heaters
 - Whirlpool spas
 - List of potential sampling sites (from potable water, cooling towers, whirlpool spas, and other sources)
- Collection of 1 (one) liter (1 L) of water is preferred.
 - If a liter cannot be collected from a sample source, the **minimum acceptable sample size during an active investigation is 250 ml**.
 - Larger volumes of water (1 to 10 liters) are needed to detect legionellae in water that has very low concentrations of these bacteria such as municipal water supplies.
- In addition to water samples, biofilm swabs should be taken from most sites, when possible.
- The sampling team should also test the water quality (i.e., residual chlorine, temperature and pH) at sampling sites.
- All samples should be transported to the laboratory in insulated coolers as protection against extreme heat or cold.
 - Samples that will not reach the laboratory within 72 hours should be refrigerated before shipping.
 - Samples that reach the laboratory but cannot be processed within 72 hours of collection should be refrigerated.
- For more information see <http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/lab-inv-tools/procedures-manual.html>

- Recommended minimum frequency of (environmental) retesting, in an outbreak setting:
 - Once interventions are in place, culture water to detect any legionellae:
 - Every 2 weeks for 3 months; if cultures are negative, then
 - Once per month for the next 3 months
 - If legionellae are detected the 6 month process must be restarted.

Laboratory Testing of Environmental Specimens

- Testing of environmental samples should be performed by an ELITE-certified laboratory capable of culturing *Legionella* species. A list of ELITE-certified laboratories is available at <https://wwwn.cdc.gov/elite/Public/MemberList.aspx>.
- Inform the testing laboratory that the testing is being performed as part of an outbreak investigation. (Some laboratories have different protocols for collecting and testing specimens for non-outbreak purposes.)
- The traditional ISO spread plate method should be used for testing during outbreak investigations (i.e., during initial detection and throughout remediation and repeat testing cycles).
- *Legionella* isolates from environmental testing related to clusters or outbreaks should be speciated, serotyped and retained for future studies.
 - If isolates cannot be retained by the testing laboratory, they may be forwarded to the DSHS Austin lab once approval is received from EAIDB.
- The DSHS laboratory will accept isolates (for speciation and serogrouping) from environmental sources if there is also an isolate available from a human case associated with the facility for comparison.
- Molecular typing of *Legionella* isolates is available from CDC (contact DSHS to request this testing) and can be helpful to:
 - Confirm that isolates from cases are identical (i.e., case-patients were exposed to the same source)
 - Compare clinical to environmental isolates to narrow down the list of potential environmental sources

ADDITIONAL RESOURCES

Training and Informational Videos

- CDC's *Legionella* Environmental Investigation Videos (<http://www.cdc.gov/legionella/videos.html>):
 - *Legionella* Ecology and an Introduction to Environmental Health and Engineering
 - Conducting and Interpreting the Environmental Assessment
 - How to Make a Sampling Plan
 - How to Sample Potable Water
 - How to Sample Cooling Towers
 - How to Sample Spas and Fountains
- CDC *Legionella* training videos and presentations that were part of the Water, Sanitation, and Hygiene (WASH) webinar series in 2010 are available from DSHS upon request:
 - WASH Webinar #1: Legionellosis Outbreak Investigations; Environmental Assessment
 - WASH Webinar #3: Public Health Response; Importance of Molecular Typing

National Guidance for Environmental and Laboratory Investigation

- Additional resources for environmental sampling and testing are available from CDC's *Legionella* Epidemiologist Investigation Tools website at <http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/index.html>.
- Occupational Safety and Health Administration (OSHA) Legionnaires' disease eTool (sources identification and control procedure, and water sampling guidelines for *Legionella*—Section II): <https://www.osha.gov/dts/osta/otm/legionnaires/>

Water System Maintenance

- CDC's Water System Maintenance website: <http://www.cdc.gov/legionella/water-system-maintenance.html>
- Model Aquatic Health Code (for swimming pools, hot tubs/whirlpool spas, interactive fountains, waterparks): <http://www.cdc.gov/healthywater/swimming/pools/mahc/>
- American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. (ASHRAE)-Guideline 12-2000--Minimizing the Risk of Legionellosis Associated with Building Water Systems: www.techstreet.com/cgi-bin/detail?product_id=232891
- ANSI/ASHRAE Standard 188-2015--Legionellosis: Risk Management for Building Water Systems: <http://www.earthwiseenvironmental.com/sites/default/files/188FINAL-ASHRAE-D-86603.pdf>
- CDC's FAQ for ASHRAE 188-2015: <http://www.cdc.gov/legionella/health-depts/ashrae-faqs.html>
- CDC's toolkit -- Developing a Water Management Program to Reduce *Legionella* Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards: <https://www.cdc.gov/legionella/downloads/toolkit.pdf>
- Operating Public Hot Tubs: <http://www.cdc.gov/healthywater/pdf/swimming/resources/operating-public-hot-tubs-factsheet.pdf>
- Disinfection of Hot Tubs Contaminated with *Legionella*: <http://www.cdc.gov/legionella/downloads/hot-tub-disinfection.pdf>
- Other pool and hot tub operation recommendations: <http://www.cdc.gov/healthywater/swimming/pools/design-operation-pools-hot-tubs.html>
- EPA's -- Technologies for *Legionella* Control in Premise Plumbing Systems: Systematic Review: <https://www.epa.gov/ground-water-and-drinking-water/technologies-legionella-control-premise-plumbing-systems>

UPDATES

April 2017

- Basic Epidemiology: added additional species of *Legionella* to Infectious Agents. Added additional symptoms to Legionnaires' disease under clinical Illness.
- Surveillance and Case Investigation
 - Case Investigation Checklist: corrected urine antigen to urinary antigen, changed multiple attempts to at least three attempts, added information about what to do in the event of a death.
 - Prevention and Control Measures: changed physician to medical provider, added information about the CDC Toolkit, minor grammatical changes.
 - School/Daycare Exclusion Criteria: no changes
- Managing Special Situations
 - Travel-associated cases: added additional information about the environmental assessment; added CDC toolkit link; updated web links; clarified that environmental sampling should be informed by environmental assessment and needs to be approved by health department
 - Healthcare-associated cases: added information about what to do if it involves outpatients; added additional information about the environmental assessment; added CDC toolkit link; updated web links; added clarification about the retrospective and prospective surveillance dates; added clarification about clinical *Legionella* isolates; clarified that environmental sampling should be informed by environmental assessment and needs to be approved by health department
 - Cases associated with a gym, spa, or other “open” facility: added additional information about the environmental assessment; added CDC toolkit link; updated web links; clarified that environmental sampling should be informed by environmental assessment and needs to be approved by health department
 - Cases associated with a community: no changes
- Reporting and Data Entry Requirements: no changes
- Clinical Laboratory Procedures: updated section number on Laboratory Submission Form; added information about name and approved secondary identifier
- Environmental Sampling and Testing: added that the sampling plan should be approved by the health department
- Additional Resources: added links to CDC's toolkit Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards and EPA's -- Technologies for Legionella Control in Premise Plumbing Systems: Systematic Review; updated web links

Listeriosis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Listeria monocytogenes, a Gram-positive, rod-shaped bacterium.

Transmission

Transmission primarily occurs through ingestion of contaminated food. Transmission also occurs *in utero* from mother to fetus.

Incubation Period

Typically, 2 or 3 weeks. However, cases have occurred up to 70 days after a single exposure to a contaminated food. Median incubation period is longer among pregnant women.

Communicability

Transplacental infections and nosocomial transmission to newborns are the mostly likely sources of direct human to human transmission. Though infected individuals can shed the bacteria in stools for months, secondary cases among household contacts are rare to nonexistent.

Clinical Illness

Usually consist in a mild illness with fever, malaise, headache, back pain, and gastrointestinal symptoms. Most severe cases occur in immunocompromised, elderly or pregnant individuals. Invasive manifestations are less common and include meningitis and septicemia.

Severity

Illness in pregnant women can cause miscarriage, preterm delivery and/or infection of the fetus/newborn. Case fatality is 20% - 30% in newborns.

DEFINITIONS

Clinical Case Definition

In adults, invasive disease caused by *Listeria monocytogenes* manifests most commonly as meningitis or bacteremia; infection during pregnancy can result in fetal loss through miscarriage or stillbirth, or neonatal meningitis or bacteremia. Other manifestations can also be observed.

Laboratory Confirmation

- Isolation of *L. monocytogenes* from a normally sterile site*, e.g., blood, cerebrospinal fluid (CSF), or less commonly, joint, pleural, or pericardial fluid, **OR**
- In the setting of miscarriage or stillbirth, isolation of *L. monocytogenes* from placental or fetal tissue, **OR**
- In the setting of pregnancy or live birth, isolation of *L. monocytogenes* from mother's or neonate's blood or other sterile site, or from placental or amniotic fluid.

*See the Sterile Site and Invasive Disease Determination Flowchart in Appendix A, for confirming a specimen meets the criteria for sterile site.

Note: As required by TAC, all *Listeria monocytogenes* isolates must be submitted to the DSHS laboratory.

Case Classifications

- **Confirmed:** A clinically compatible case that is laboratory confirmed
- **Probable:** No probable case definition

Notes:

- For fetal or neonatal (≤ 1 month of age) infections, only the mother is counted as the case.
- A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of listeriosis. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the *Listeria* Case Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Verify that the laboratory has forwarded the isolate to the DSHS laboratory, as required. If an isolate has not been sent, please request a specimen be submitted.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
 - Use information from medical records to complete the Supplemental Medical History Form of the *Listeria* Case Form.
- ☐ Interview the case to get detailed food history and risk factor information.
 - Use the **Listeria Case Form** to record information from the interview.
 - For fetal or neonatal (≤ 1 month of age) infections, only the mother is counted as the case and is the one that should be interviewed.
 - If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
 - Provide education to the case or his/her surrogate about effective hand washing and food safety practices. See Prevention and Control Measures.
- ☐ Fax completed forms to DSHS EAIDB at 512-776-7616 or email securely to an EAIDB epidemiologist.
 - An EAIDB foodborne epidemiologist will fax or email the form (deidentified) to the CDC.
 - Please note that the CDC measures the proportion of interviews reported to CDC within 7 days of interview date, so please send the form as soon as possible.
 - For lost to follow-up (LTF) cases, please complete as much information, obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.), on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.
- ☐ Hospitalized cases should be followed until discharge and patient's outcome recorded on the *Listeria* Case Form
 - Initial reports can be sent to DSHS prior to discharge.
- ☐ In the event of a death, copies of the hospital discharge or death summary should also be faxed to DSHS EAIDB.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Avoid consuming raw milk and other unpasteurized dairy products.
- Rinse raw produce, such as fruits and vegetables, thoroughly under running tap water before eating, cutting, or cooking.
- Scrub the surface of melons, such as cantaloupes, with a clean produce brush under running water and dry them with a clean cloth or paper towel before cutting.
- Follow food safety principles in the kitchen, especially:
 - Cook or reheat meat thoroughly. Reheated meats should be steaming hot (165°F).
 - Prevent cross-contamination in food preparation areas by thoroughly washing hands, counters, cutting boards, and utensils after they touch raw meat.
 - Separate uncooked meats, hot dogs and other meat packaging from vegetables, uncooked food and ready to eat foods.
 - Keep the refrigerator at 40°F or lower and the freezer at 0°F or lower.
 - Clean up all spills in your refrigerator right away—especially juices from hot dog and lunch meat packages, raw meat, and raw poultry.
- Pregnant women and immunocompromised individuals should avoid high risk food items, such as:
 - Smoked fish
 - Soft cheeses such as feta, queso blanco, queso fresco, brie, Camembert, blue-veined, or panela
 - Refrigerated pâté or meat spreads
 - Ready to eat meat, hot dogs, luncheon meats, cold cuts, deli meats, fermented/dry sausage, or leftover food unless heated until steaming hot.
- Routine hand washing with soap and warm water, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
 - After any contact with animals or their living areas.

Exclusions

School/child-care: No exclusions are specified for listeriosis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for listeriosis but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional listeriosis cases.
- If isolates have not already been submitted to the DSHS laboratory for confirmation and PFGE, request hospital/clinical labs submit isolates for confirmation and PFGE testing. See Laboratory Procedures.
- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on and adherence to hand hygiene.
 - Storage and preparation of food.
 - Procedures for changing diapers and toilet training.
 - Procedures for environmental cleaning.
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

PFGE clusters:

- For clusters of cases with indistinguishable PFGE patterns detected by CDC/PulseNet and/or the DSHS laboratory, a member of the DSHS EAIDB foodborne team will notify appropriate DSHS regional epidemiologists, usually by email, who will then notify appropriate local health departments of cases within their jurisdiction.
- Local/regional health departments with cases in their jurisdiction should:
 - Interview the case patient, even if they have already been interviewed as part of a routine disease investigation, using the cluster specific questionnaire attached in the email notification.
 - Fax the completed questionnaire promptly within timeframe designated in cluster notification to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - If the health department having jurisdiction of a case is unable to reach a case-patient after 3 attempts during normal working hours, and they are not able to call after hours, please call the DSHS regional office or DSHS EAIDB to discuss further.
 - If an interview is unattainable or the case is lost to follow-up, fax/email securely medical records and any case information to DSHS EAIDB.
 - Please complete as much information obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.
- Local/regional health department with cases will be notified by the EAIDB foodborne team of any CDC or DSHS conference calls and may participate, if able.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory. The general policy is to test only food samples implicated in suspected outbreaks, not in single cases.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection. A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed *Listeria* case forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - An EAIDB foodborne epidemiologist will fax the form (de-identified) to the CDC.
 - Please note that the CDC measures the proportion of interviews reported to CDC within 7 days of interview date, so please send the form as soon as possible.
 - For lost to follow-up (LTF) cases, please complete as much information, obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.), on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

All *Listeria monocytogenes* isolates must be submitted to the DSHS laboratory.

CLINICAL SPECIMENS:

Specimen Collection

- Submit pure culture on an agar slant.
- If a pure culture is not available, you may submit:
 - Blood, CSF, amniotic fluid, placental tissue or fetal tissue, shipped on wet ice within 48 hours of collection.
 - Blood should be collected in tiger or red top vacutainer.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check "Outbreak association" and write in name of outbreak.
- Payor source:
 - Check "IDEAS" to avoid bill for submitter

Specimen Shipping

- Transport temperature: Submit pure cultures on an agar slant at ambient temperature. Blood should be kept at 2° - 25° C (refrigerated or at room temperature); tissue must be kept refrigerated at 2°-8° C.
- Ship specimens via overnight delivery on cold packs or wet ice (double bagged). Pure isolates and blood may be shipped without ice or cold packs.
- Do NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Incorrect source of specimen.
- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Listeria monocytogenes* is available at the DSHS laboratory. Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

General policy

- The DSHS lab will only test food samples or environmental swabs from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreaks, the DSHS lab will not test food samples or environmental swabs unless a pathogen has been identified in a clinical specimen.
- Food samples or environmental swabs must be **collected by a registered sanitarian**

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

UPDATES

April 2017

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.

Measles rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

The measles virus—a single-stranded, RNA-encoded paramyxovirus

Transmission

Virus is spread directly from person to person by inhalation of suspended droplet nuclei or by contact with infective nasopharyngeal secretions. It can also be transmitted indirectly by objects (fomites) contaminated with nasopharyngeal secretions. Measles is one of the most contagious of all infectious diseases, with >90% attack rates among susceptible close contacts.

Incubation Period

The incubation period ranges from 7–21 days (average 10–12 days) from exposure to the onset of prodromal symptoms.

Communicability

Measles is most communicable during the 3–4 days preceding rash onset. Persons with measles have been shown to shed virus between 4–5 days prior to rash onset (with the onset of prodromal symptoms) and for 4 days after the rash has appeared.

Clinical Illness

Measles is characterized by a generalized maculopapular rash (a flat, red area on the skin that is covered with small confluent bumps), fever, and one or more of the following: cough, coryza (runny nose), conjunctivitis (eye inflammation or red eyes). There are three stages of illness:

- **Prodrome**
 - Measles has a distinct prodromal stage that begins with a mild to moderate fever and malaise. Usually within 24 hours there is an onset of conjunctivitis, photophobia (sensitivity to light), coryza (sneezing, nasal congestion, and nasal discharge), an increasingly severe cough, swollen lymph nodes (occipital, postauricular and cervical at the angle of the jaw), and Koplik's spots (seen only for a day or two before and after onset of rash). These spots are seen as bluish-white specks on a rose-red background appearing on the cheek and lip mucosa usually opposite the molars.
- **Rash**
 - The rash begins with flat, faint eruptions usually on the upper lateral parts of the neck, behind the ears, along the hairline and on the posterior parts of the cheeks. The rash may appear from 1–7 days after the onset of the prodromal symptoms, but usually appears within 3–4 days. Individual lesions become more raised as the rash rapidly spreads over the entire face, neck, upper arms and chest. In severe cases, the lesions may merge together to form large rash masses. In mild cases, the rash may be macular and more nearly pinpoint, resembling that of scarlet fever.
- **Fever**
 - Fever is mild to moderate early in the prodrome, and goes up when the rash appears. Temperatures may exceed 40°C (104°F), and usually falls 2–3 days after rash onset. High fever persisting beyond the third day of the rash suggests that a complication (e.g., ear infection) may have occurred.

DEFINITIONS

Clinical Case Definition

An illness characterized by all of the following criteria:

- A generalized maculopapular rash lasting at least 3 days, **AND**
- A temperature $\geq 101.0^{\circ}\text{F}$ ($\geq 38.3^{\circ}\text{C}$), **AND**
- Cough, coryza, or conjunctivitis.

Laboratory Criteria for Diagnosis

- IgG seroconversion or a significant rise in measles immunoglobulin G antibody level by any standard serologic assay*, **OR**
- Isolation of measles virus from a clinical specimen*, **OR**
- Detection of measles-virus-specific nucleic acid by PCR*, **OR**
- Positive serological test for measles immunoglobulin M* not otherwise ruled out by other confirmatory testing or more specific measles testing in a public health laboratory.

*Not explained by MMR vaccination during the previous 6-45 days.

Case Classification

- **Confirmed:** An acute febrile rash illness (temperature can be lower than 101° and rash < 3 days) that is:
 - Laboratory confirmed, **OR**
 - Epidemiologically linked to a laboratory confirmed measles case.
- **Probable:** No probable case definition

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

In the current setting of measles elimination in the United States, rapid investigation and reporting of all suspected measles cases is extremely important to ensure that measles remains controlled.

Measles investigations are high priority and time sensitive. The investigation steps below describe public health activities that should be completed when a suspect measles case is reported.

Case Investigation Checklist

- ☐ Immediately isolate anyone with suspected measles.
 - Isolate either at home or in the hospital under airborne precautions (respiratory isolation in negative air pressure room, if possible).
- ☐ Initiate the investigation and contact the provider **AND** case patient (or proxy) the same day the report is received.
- ☐ Confirm that clinical presentation and laboratory results meet the case definition.
 - If laboratory specimens have not been collected, make arrangements to have them collected as soon as possible.
 - Vaccinated individuals may have atypical symptoms.
 - Someone with known exposure and prodromal symptoms without a rash should be considered a measles suspect.
 - If the suspect case was reported within 3 days of rash onset, there should be appropriate follow-up to establish a rash duration of at least 3 days.
 - See Testing of Suspect Cases Who Have Recently Received Measles-containing Vaccine below.

- ☐ Notify DSHS EAIDB and/or your regional office immediately.
- ☐ Verify that the laboratory has forwarded viral and serology specimens to the DSHS laboratory. See Laboratory Procedures.
 - Testing at a public health laboratory (e.g., DSHS lab in Austin) is preferred.
 - PCR is not currently available at commercial laboratories.
 - Collection of throat (preferred), NP, and/or urine specimens for PCR are strongly encouraged.
 - Measles IgM may be falsely positive due to previous vaccination or the use of less accurate tests used in most commercial laboratories.
 - Serum tested at commercial labs can be forwarded to the DSHS lab for confirmatory testing. If this needs to be done notify EAIDB to facilitate this process.
 - Measles IgM may be falsely negative if collected within the first three days after rash onset.
 - Only viral specimens can be genotyped.
 - PCR is fast, unlike culture.
- ☐ If a private provider/hospital cannot or will not collect specimens, public health staff should make every arrangement to collect specimens instead.
- ☐ Interview patient and review medical records or speak to an infection preventionist or physician to verify case exposure, underlying health conditions, course of illness, vaccination status and travel history.
 - Request copies of admission and discharge summaries and laboratory results.
- ☐ Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school records, primary care provider, etc.
- ☐ Determine possible **risk factors** and timeframes (within 3 weeks prior to symptom onset):
 - Exposure to a confirmed measles case
 - Travel to a measles endemic/outbreak area or contact with a traveler from a measles endemic/outbreak area
 - Transit through an international airport
 - Exposure to international visitors or venues that may attract international visitors.

Previous outbreaks have been identified at:

 - US tourist venues (e.g., Disneyland or Orlando, FL)
 - International sports competitions (e.g., Olympics, Little League World Series)
 - Conferences (e.g., international trade show)
 - Use of public transit in a major U.S. city
 - Check the news or with the VPD team to identify any current outbreaks that the patient may have been exposed to.
- ☐ Alert other health departments of exposures that may have occurred in their jurisdictions as soon as possible.
 - Notify EAIDB if other states/counties need to be notified.
- ☐ Determine whether a contact investigation should be initiated (See the Determine Whether to Initiate a Contact Investigation Section).

- If applicable, identify all close contacts and manage based on risk level and susceptibility. PEP needs to be given in a short time period, so assess contacts quickly.
 - See Managing Contacts of Confirmed or Highly Suspicious Measles Cases flowchart at the end of this chapter.
 - For details on identification and prioritization of contacts see the following segments:
 - Identify Contacts
 - Prioritize Contacts
 - For details on prophylaxis see the following segments:
 - Provide Post Exposure Prophylaxis for Susceptible Contacts
 - Control Measures
 - Recommendations for Prophylaxis, Quarantine and Monitoring of Measles Contacts table
 - For details on monitoring contacts for development of symptoms, see Monitor Measles Contacts.
- If the case is confirmed, conduct activities outlined in Outreach Activities.
- If more than one case is identified or an outbreak occurs, see Managing Special Situations.
- All confirmed and suspect case investigations must be entered in NBS. Suspect cases should be updated to “not a case” or “confirmed” once status is determined. Confirmed cases should be submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Susceptible contacts to suspected cases should be vaccinated with measles vaccine within 72 hours of exposure OR should have IG administered within six (6) days of exposure. Contact DSHS EAIDB if IG/vaccine is needed.
- If vaccination of exposed contact is contraindicated (or the PEP window has passed), exclude exposed contact from school or work for at least 21 days after last rash onset. Exclusion from school or daycare of unvaccinated, exposed children for 21 days from last rash onset is required by Texas Administrative Code.
- Table 1 (and its extensive footnotes) has contact and setting specific recommendations for prophylaxis, testing, quarantine/exclusion, and symptom monitoring.

Testing of Suspect Cases Who Have Recently Received Measles-Containing Vaccine

Ten percent of recipients of measles-containing vaccine may develop fever and rash approximately 1 week after vaccination. Vaccination causes production of IgM antibody that cannot be distinguished from the antibody resulting from natural infection.

A positive measles IgM test cannot be used to confirm the diagnosis of measles in persons with measles-like illness who received measles vaccine 6–45 days before onset of rash. A negative test would exclude the diagnosis, however. A viral specimen should be collected for those vaccinated more than 14 days before illness onset to confirm measles diagnosis. For persons receiving vaccine 6–14 days prior to rash onset, testing is not recommended unless the patient is known to be exposed.

Outreach Activities

When health departments confirm a case of measles, they should conduct the following outreach activities. Materials to assist with these activities can be found in the Measles Communication Toolkit at <http://www.dshs.state.tx.us/idcu/disease/measles/links/>

- Issue a health alert to all area providers, hospitals and urgent care clinics.
 - Describe the situation.
 - Provide instructions on ensuring staff immunity.
 - List symptoms to look for.
 - Instruct on what to do if a suspect case is identified (e.g., isolation, testing, reporting, etc.).
- Contact all entities likely to have exposure (e.g., if measles case is school-aged, notify schools).
 - Describe the situation.
 - Provide instructions on checking vaccine records.
 - List symptoms to look for.
 - Instruct on what to do if symptomatic persons are identified.
- Issue a press release if wide-spread community exposure is suspected.
- Have a 24/7 phone for providers to call if measles is suspected (existing reporting/afterhours/on call numbers can be used).
- Initiate active surveillance for additional cases and continue for a minimum of 6 weeks after the onset of the last case.
 - Contact healthcare providers in the jurisdiction to notify them of the situation and request reporting of any suspect case.
- Provide a daily line list of suspects and cases to DSHS EAIDB (during an outbreak).

Determine Whether to Initiate a Contact Investigation

- If a case is highly suspicious for measles (e.g., clinically compatible illness in an under/unvaccinated person with exposure or history of travel), a contact investigation should be initiated even if laboratory confirmation of the case is not yet available.
- If a suspect measles case is not strongly suspicious for measles (e.g., clinically compatible illness in a person who has received two doses of MMR vaccine and does not have measles exposure), the results of laboratory testing should be obtained before initiating a contact investigation.
- If an IgM positive test result has already been obtained on a *vaccinated* suspect case that is not strongly suspicious for measles, repeat IgM testing or additional measles testing (PCR) can be performed at a public health laboratory before a contact investigation is initiated.
- Contact the VPD team
 - if assistance is needed determining whether a contact investigation should be initiated.
 - if a contact investigation is initiated.

Identify Contacts

- A contact of a measles case is anyone who has shared the same airspace with a person who is infectious with measles.
 - Anyone in the same airspace (same room, no minimum amount of time) as the suspected case up to 2 hours after the case has left should be considered exposed,
 - The infectious period is four days before rash onset through four days after rash onset [day of rash onset is day 0].
- No minimum time period has been established for exposure, but it is presumed that longer exposures are more likely to result in measles transmission than brief, transient exposures.

- When exposures have occurred in venues in which it is not possible to identify individuals, it is helpful to notify local health care providers so that they can be on the alert for possible cases. In addition, some health jurisdictions have issued press releases to notify the public.
- If the case was traveling by plane, ship, bus or train during the infectious period, obtain all travel information (obtain boarding pass or e-reservation, if possible) and call EAIDB, who will contact the CDC.
 - Appendix B has more information on how these types of exposures/notifications are handled.

Determine Susceptibility of Contacts

Non high-risk people† can be presumed to be immune to measles for the purposes of measles case investigations if they:

- were born prior to 1957; or
- have written documentation with dates of receipt of at least one dose of measles-containing vaccine given on or after their first birthday in 1968 or later; or
- have documented IgG+ test for measles; or
- laboratory confirmation of previous disease; or
- served in the U.S. armed forces; or
- were born in the U.S. in 1970 or later and attended a U.S. elementary school;‡ or
- entered the U.S. in 1996 or later with an immigrant visa or have a green card.‡

†Additional evidence of immunity is required for exposed high-risk persons, e.g., healthcare personnel of any age, pregnant women, immunocompromised people, household contacts of a case, or persons in settings with known unvaccinated persons (e.g., childcare settings). Additional evidence of immunity may also be required during an outbreak. Immunity can be presumed if the exposed person:

- has documentation of a positive measles IgG test; or
- has documentation of two doses of measles vaccine given in 1968 or later, separated by at least 28 days, with the first dose on or after the first birthday

‡Unless known to be unvaccinated for measles, e.g., having a medical contraindication to vaccination or being philosophically or religiously opposed to vaccinations.

Prioritize Contacts for Investigation

In the event that contacts have to be prioritized, please contact your Regional Office and ask for assistance. Measles is considered a public health emergency and every effort should be made to assess all contacts to interrupt transmission.

However, if it is not feasible to investigate all possible contacts in an exposure setting, possible contacts should be prioritized for investigation.

The following contacts, if susceptible to measles, are at the greatest risk of infection or severe disease, or are more likely to transmit measles to others and should be prioritized for investigation:

- Household contacts
- Healthcare personnel of any age or others with occupations that require interaction with high risk populations (e.g., daycare workers)
- Pregnant women
- Immunocompromised people

- Persons under five years of age in settings with known unvaccinated persons (e.g., childcare settings)
- Infants

There are scant data on factors that make transmission of measles more likely, however if it is necessary to prioritize the investigation further, possible information to consider includes the following:

- Length of time of exposure to case
- Proximity to case
- Ventilation in the exposure setting, and
- The time of exposure related to when the case left the setting

In addition, the infectiousness of the case at the time of exposure may increase or decrease the possibility of transmission. Persons with measles are most infectious at the late prodromal phase of illness immediately prior to rash onset when cough and coryza are at their peak. The presence and frequency of cough in the case may affect the possibility of transmission. Cases who have received measles-containing vaccine in the past may be less symptomatic and also less infectious.

Managing Close Contacts

Provide Post-Exposure Prophylaxis for Susceptible Contacts

- The MMR vaccine may be given within 72 hours of exposure to persons ≥ 6 months of age with 1 or no documented doses of MMR, if not contraindicated.
- Children under 1 year of age that receive MMR will still need to have two doses of MMR after 1 year of age.
- Pregnant women should not be given MMR. Give IVIG instead (arrangements will need to be made with the woman's healthcare provider).
- Immune globulin (IG) may be given to exposed susceptible people of any age through day 6 after exposure.
 - The recommended dose of IG is 0.5 mL/kg (maximum dose=15 mL) intramuscularly (IM).
 - Pregnant women and immunocompromised individuals should get IVIG.
 - For persons already receiving IVIG therapy prior to exposure, ≥ 400 mg/kg < 3 weeks before measles exposure should be sufficient to prevent measles infection.
 - It is unknown if administration of IG prolongs the incubation period. If symptoms consistent with measles occur within 28 days of exposure, persons who have received IG should be instructed to isolate themselves immediately and notify their health department.
- DSHS has IG for measles exposures. DSHS does NOT have IVIG.
- Additional information about measles PEP can be found here:
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm>

Administer Immune Globulin

- Screen for contraindications.
 - Immunoglobulin A deficiency (IgA)
 - Severe thrombocytopenia or any coagulating disorder that prevents intramuscular injections
 - History of anaphylactic reaction to a previous dose of IG.
- Provide product information, available at: <http://www.fda.gov/downloads/BiologicsBloodVaccines/BloodBloodProducts/ApprovedProducts/LicensedProductsBLAs/FractionatedPlasmaProducts/UCM371376.pdf>
- Give immune globulin (IG) intramuscularly (IM) to children and adults with a 1 to 2 inch needle, depending on recipient's weight.
 - Regardless of age, the dose is 0.5 ml/kg.
 - The maximum dose is 15 ml IM (anyone over 66 pounds will get the max dose).
 - Pregnant women and immunocompromised persons should receive intravenous IG from their healthcare provider.
- Select a large muscle mass that can support the administration of a large volume of IG.
 - For children <3 years of age, administer IG into the vastus lateralis (outer thigh) muscle with a 7/8 to 1 inch needle. For certain very small infants a 5/8 inch needle may be adequate.
 - For persons ≥3 years of age, administer IG into the ventrogluteal or dorsogluteal muscle with a 1-2 inch needle.
 - For adults with sufficient deltoid muscle mass, the deltoid muscle may be used.
- Do not administer more than 3 ml of IG per injection site in children or more than 5 ml of IG per injection site in adults.
- IG and measles vaccine should not be given at the same time
- IG can be administered simultaneously with, or at any interval before or after, any inactivated vaccine.
- Anyone that receives IG should not receive a live virus vaccine (MMR or varicella vaccine) for at least 6 months.

Monitor Measles Contacts

Measles contacts, even vaccinated contacts, should monitor themselves for measles symptoms from day 5 after first exposure through day 21 after last exposure (day of exposure is day 0). Information containing the recommended follow-up of measles contacts for both low-risk (Table 2) and high-risk (Table 3) contacts is available in the tables portion of the measles Investigation Guidance document. Contacts should be instructed to isolate themselves immediately if measles symptoms develop and notify their health department. If they plan to seek medical care, they should contact the hospital or doctor's office ahead of time to notify them that they might have measles.

Contacts that are unvaccinated should be asked to stay home (children at school or daycare must stay home) and monitored by the health department in addition to self-monitoring. The contacts should be called every few days to ensure they are still feeling well.

Exclusion

According to the Texas Administrative Code (TAC), children in school and childcare shall be excluded for 4 days from rash onset. In an outbreak, unvaccinated children should be excluded for at least 21 days after last rash onset.

Susceptible adults should be instructed to stay home from work and any other activities.

MANAGING SPECIAL SITUATIONS

Cases among Employees or Attendees at Schools Exclude persons with suspected measles from school until 4 days have passed since rash onset if not immunocompromised.

- All students and school staff born in or after 1957 who cannot provide adequate evidence of immunity should be vaccinated, regardless of exposure status. A first dose should be given to those who are unvaccinated. Recommend a second MMR to persons who have previously received only one MMR as long as 28 days have passed since the first dose.
- Identify all persons at the school who were potentially exposed to the case.
 - Recommend that susceptible, unimmunized persons receive the MMR vaccine within 72 hours of exposure (or if immunocompromised, pregnant or under one year of age, IGIV or IG within 6 days). Exclude all exposed persons who were susceptible and unimmunized at the time of exposure unless they received PEP (see Table 1).
 - Exposed persons who had received one dose of measles-containing vaccine prior to the exposure can return to school after they receive their second dose of MMR, but should be educated about symptoms of measles and told to stay home if symptoms develop.
 - Susceptible, unimmunized persons who continue to refuse the recommended measles vaccination(s) following exposure to measles should be asked to stay home from school or child care until 21 days after rash onset in the last cases of measles.
- Maintain daily active surveillance of all school contacts to assess for prodromal signs and symptoms of rash illnesses compatible with measles for 21 days from the last possible exposure in the school.

Cases among Employees or Attendees at Childcare Facilities

Exclude persons with suspected measles from child care until 4 days have passed since rash onset if not immunocompromised.

- All students and staff born in or after 1957 who cannot provide adequate evidence of immunity should be vaccinated, regardless of exposure status (assuming they are old enough for MMR). A first dose should be given to those who are unvaccinated. Recommend a second MMR to persons who have previously received only one MMR as long as 28 days have passed since the first dose.
- Identify all persons at the childcare facility who were potentially exposed to the case.
 - Recommend that susceptible, unimmunized persons receive the MMR vaccine within 72 hours of exposure (or if immunocompromised, pregnant or under one year of age, IGIV or IG within 6 days).
 - Exclude all exposed persons who were susceptible and unimmunized at the time of exposure (see Table 1), *regardless of PEP*.
 - Exposed persons who had received one dose of measles-containing vaccine prior to the exposure cannot return to child care after they receive their second dose of MMR.
 - Susceptible, unimmunized persons who continue to refuse the recommended measles vaccination(s) following exposure to measles should be asked to stay home from child care until 21 days after rash onset in the last cases of measles.
- Maintain daily active surveillance of all child care contacts to assess for prodromal signs and symptoms of rash illnesses compatible with measles for 21 days from the last possible exposure in the school.

Case(s) in a Medical Setting

- To prevent measles outbreaks in health care settings, health care workers (defined as anyone who works, studies or volunteers in a healthcare facility of any kind) should have documented immunity to measles *before* exposure, ideally as a condition of employment.
 - Health care facilities should maintain readily available documentation of immunity.
 - Acceptable evidence of immunity to measles in health care workers includes (MMWR 1998; 47[No. RR-8]:11):
 - Documented administration of 2 doses of live measles virus vaccine given on or after the first birthday (inactivated measles vaccines were in use from 1963–1967), or
 - Laboratory evidence of immunity, or
 - Born before January 1, 1957 – Healthcare facilities should consider recommending measles, mumps, rubella (MMR) vaccination for unvaccinated workers born before 1957 without a history of measles disease or laboratory evidence of immunity, or
 - Documentation of health care provider-diagnosed measles.
- If a person with measles is treated in a health care setting during the contagious period, identify all potentially exposed patients, visitors, health care workers, volunteers and other staff and assess status of their immunity to measles.
- If an exposed healthcare worker has had only one documented dose of measles-containing vaccine, give an additional dose of vaccine. If the second dose can be given within 72 hours of the exposure, consider the person immune. If vaccine cannot be administered within 72 hours, the healthcare facility can test for measles IgG serology and consider the person immune if the test is positive for measles specific IgG. If the serology is not done or negative, the worker should be furloughed for an incubation period.
- If the exposed healthcare worker was born on or after January 1, 1957 and has no documented evidence of immunity, a dose of measles-containing vaccine should be given immediately and no more than 72 hours after exposure. At the same time, a serologic test for measles IgG should be done to verify immunity. If immunity to measles is not serologically confirmed, the person must be furloughed from day 5 after the first exposure to day 21 after the last exposure.
- If the exposed healthcare worker was born before January 1, 1957 and has no documented evidence of immunity, a serologic test for measles IgG should be considered to verify immunity. If immunity is not confirmed, the person must be furloughed from day 5 after the first exposure to day 21 after the last exposure.
- If the exposed healthcare worker has had two documented doses of measles vaccine given on or after the first birthday and at least 28 days apart, consider the person immune.
- In summary, exposed **susceptible** health care workers should be immunized immediately and no more than 72 hours after exposure, and furloughed from day 5 after the first exposure to day 21 after their last exposure. This includes healthcare workers born at any time who have no documented evidence of immunity, and workers born in 1957 or later with only one previous dose of measles-containing vaccine documented who did not receive a second dose within 72 hours of exposure. (If furloughing of this second group is not possible due to large numbers exposed, these staff should have their temperatures taken and be assessed for prodromal symptoms when they come to work on the 5th through 21st day after the exposure. Anyone with a fever, cough, coryza, or conjunctivitis should be furloughed for the duration of symptoms and assessed for measles if a rash develops. This screening procedure must be followed rigorously to prevent staff members with prodromal measles from infecting others.)
- Healthcare workers who develop measles must avoid patient contact until 4 days have passed since the rash onset.

- Only health care workers with documented immunity to measles should enter the room of a suspected measles patient.
- Exposed patients should likewise have their immune status assessed and be given vaccine if they are not immune; school and work restrictions of unimmunized contacts apply.

Activities that a health department may want to do prior to identification of any measles case or outbreak:

- Review measles investigation guidance (this document. Good job!).
- Have a supply of MMR vaccine on hand for outbreak response (check with your department's immunizations staff).
- Have a supply of viral transport media (e.g., Remel) and shipping containers on hand. (See Appendix C Laboratory Resources.)
- Have a DSHS laboratory submitter ID and G2A and G2V forms on hand. (See Appendix C Laboratory Resources.)
- Have draft exposure letters on hand (See Measles Toolkit at <http://www.dshs.state.tx.us/idcu/disease/measles/links/>).
- Ensure epidemiology, surveillance, preparedness, and field staffs are all immune to measles and that such immunity is documented

Airline Exposures

Occasionally, Texas residents are exposed to measles in other states, often on airplanes. Typically, those notifications will come from the CDC to the Central Office. Central Office will notify each jurisdiction of any residents that have potentially been exposed to measles. Each jurisdiction is expected to make contact with all exposed individuals to verify vaccination history, ascertain or monitor symptoms, provide education on measles, and provide prophylaxis if warranted.

Alternately, Texas measles cases may have exposed people from other states while in transit. All information about the patient's travel (obtain the boarding documents, if possible) should be collected as soon as possible and forwarded to Central Office. Central Office staff will share the information with CDC so exposed passengers can be identified and shared with other states. For more information on these types of situations, please see Appendix B.

Outbreaks

If an outbreak of measles is suspected, notify the regional DSHS office or EAIDB at **(800) 252-8239** or **(512) 776-7676**.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Confirmed and clinically suspected cases are required to be reported **immediately** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases to DSHS within 30 days of receiving a report of confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.

- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, autopsy report and death investigation form should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at (800) 252-8239 or 512-776-7676.

LABORATORY PROCEDURES

Laboratory confirmation is essential because in a setting of measles elimination, most cases that meet the clinical case definition are not measles. Additionally, because measles IgM assays may be falsely positive, collection of respiratory and/or urine specimens for PCR are encouraged. Testing at a public health laboratory is preferred. **If a private provider/hospital cannot or will not collect specimens, public health staff should make every arrangement to collect specimens instead.** Collect both virology specimens as well as serology specimens. To obtain testing kits, contact the DSHS Laboratory at **(512) 776-7661**. Before shipping specimens, be sure to notify DSHS EAIDB VPD staff at **(512) 776-7676**. The specimen tracking number (e.g., FedEx or LSO number) should be provided to the DSHS EAIDB VPD staff. This helps to ensure that specimens are received in satisfactory condition and tested as soon as possible.

PCR Assay Specimen Collection and Submission

PCR can confirm the diagnosis of measles, especially in vaccinated persons. The DSHS lab performs measles PCR. Currently, PCR testing for measles is not available at commercial or hospital labs. Additionally, molecular epidemiologic techniques are used to genetically type measles viruses and identify the source of wild viruses and establish chains of transmission. Positive PCR specimens will be forwarded to CDC or other designated public health lab for molecular testing. Viral isolation (i.e. culture) is not needed to perform strain typing.

Serology Specimen Collection and Submission

IgM Serology: A single specimen should be collected as soon as possible. A negative IgM result from a specimen collected before the fifth day of rash onset may not, however, rule out the diagnosis of measles (false negative results). While we encourage early testing of patients with a rash-fever illness, testing may need to be repeated if specimen was collected before the fifth day of rash onset.

IgG Serology: Acute AND convalescent samples are needed. Collect acute sample early in the course of illness and convalescent sample 10-14 days later. DSHS Laboratory can only conduct acute/convalescent testing if the first sample is negative (usually an unvaccinated individual). Otherwise, the acute/convalescent testing will need to be conducted through laboratory commercial or hospital laboratory, or referred to the CDC.

 Measles VIRAL Specimen Collection	
Specimen Type	PCR TESTING ** Measles Specimens **
Materials 	• Viral transport media (VTM) and tubes • Specimen submission forms (G2V) • Personal protective equipment • Tongue depressors • Polyester fiber tipped swabs - either Dacron or Rayon • NO cotton tipped or wooden shaft swabs or any that contain calcium alginate
Proper Specimen Collection	• Do not use expired media – be sure to check the expiration date • With mouth open, depress tongue • Swab posterior pharynx, avoiding the tonsils • Put tip of swab in the VTM, breaking applicator stick • Seal properly • Freeze or refrigerate • Prepare for shipment • Throat swabs are the preferred specimens for DSHS testing • Nasopharyngeal swabs and urine are also acceptable specimens for measles testing
Specimen Handling	• Transport specimens to the laboratory as soon as possible • Specimens should be placed in a biohazard bag and stored at 4°C or -70° C • If specimens are shipped the same day of collection, ship at 4°C • If specimens will be stored and shipped after the date of collection, freeze at -70° C • DO NOT store samples in a standard freezer – this inactivates the virus • DO NOT have repeated freeze thaw cycles – this inactivates the virus
Specimen Shipping	• Do not ship on Fridays or before federal holidays • Specimens stored at 4°C are shipped using cold packs • Specimens stored at -70° C are shipped on dry ice • Complete the G2V form for each specimen • Check the “Measles PCR” box in Section 4 of the G2V • The name on the tube should match the name on the form exactly • Ship to the physical address ATTN: Lab Services • Record the shipping tracking number and notify IDCU that a specimen is being shipped
Additional Information	• Collect as soon as possible after rash onset • Preferably within five days • Not more than ten days after onset Centers for Disease Control and Prevention– Measles PCR http://www.cdc.gov/measles/lab-tools/rt-pcr.html

 Measles SERUM Specimen Collection	
Specimen Type	IgM and IgG Antibody Testing ** Measles Specimens **
Materials	• Red top tubes and serum separator tubes OR gold top OR tiger top tubes • Specimen Submission forms (G2A) • Personal Protective Equipment • Centrifuge
Proper Specimen Collection	• Do not use expired tubes – be sure to check the expiration date • RED TOP TUBE ○ Collect at least 5mL of blood in red top tube ○ Centrifuge the red top tube ○ Transfer the serum into a serum transport tube • GOLD/TIGER TOP TUBE ○ Collect at least 5mL of blood in gold/tiger top tube ○ Centrifuge the gold/tiger top tube • Seal properly • Refrigerate or freeze (do not freeze serum separator tubes, gold top tubes or whole blood) • Prepare for shipment
Specimen Handling	• Transport specimens to the laboratory as soon as possible • Specimens should be placed in a biohazard bag and stored at 4°C or -20° C • If specimens are shipped the same day of collection, ship at 4°C • If specimens will be stored and shipped after the date of collection, freeze at -20° C • Do not freeze whole blood in red top tube for shipping • Do not freeze serum in gold top or serum separator tube for shipping
Specimen Shipping	• Do not ship on Fridays or before federal holidays • Do not ship whole blood • Specimens that will arrive at the lab within 48 hours of collection can be stored at 4°C and should be shipped using cold packs • Specimens that will arrive at the lab more than 48 hours after collection should be stored at -20° C and shipped on dry ice • Complete the G2A form for each specimen • Check “Rubeola screen” and “Rubeola IgM” in Section 7 of the G2A • The name on the tube should match the name on the form exactly • Ship to the physical address ATTN: Lab Services • Record the shipping tracking number and notify IDCU that a specimen is being shipped
Additional Information	• Collect as soon as possible after rash onset, up to 30 days • Patients with an MMR vaccine in the past 6-45 days are not recommended for serology testing. Centers for Disease Control and Prevention– Measles serology http://www.cdc.gov/measles/lab-tools/serology.html

UPDATES

April 2017

- Edits made throughout the document to improve clarity.

TABLES

Table 1: Measles Serology Results and Interpretation

IgM result	IgG result	Previous infection history	Current infection/vaccination status	Comments
+	+ or -	Not vaccinated, no history of measles	Wild-type measles	Seroconversion†, classic measles
+	+ or -	Previously vaccinated, primary vaccine failure	Recent 2nd MMR	Seroconversion†
-	+	Previously vaccinated, IgG+	Recent 2nd MMR	IgG level may stay same or boost
+	+	Previously vaccinated, IgG+	Wild-type measles	May have few or no symptoms‡
+	+	Recently vaccinated	Exposed to wild-type measles	Cannot distinguish if vaccine or wild-type, evaluate on epidemiologic grounds§

† IgG response depends on timing of specimen collection.

‡ If so, do not consider contagious unless clinical presentation is consistent with measles.

§ If IgM negative, helpful to rule out wild-type measles infection

Table 2: Recommended Follow-up of Measles Low-Risk Contacts (borrowed from California DPH)

<i>Measles immunity assessment for <u>low-risk</u> contacts (NOT immunocompromised, infant <12 months, pregnant, healthcare worker or household contact)</i>	IgG testing	MMR PEP¹	IG PEP²	Quarantine if no PEP³	Exclusion if no PEP⁴	Symptom watch
Two documented doses of MMR vaccine (~1% will be susceptible)	No	No	No	No	No	Passive
Known to be measles IgG positive (<1% will be susceptible)	No	No	No	No	No	Passive
Born before 1957 (5% will be susceptible)	No	No	No	No	Yes	Passive
Have 1 documented dose of MMR vaccine (5% will be susceptible)	If desired	Yes	No	No	Yes	Passive
Measles IgG negative ⁵ or known to be unvaccinated	-	Yes	No ⁶	Yes	Yes	Active
Unknown or no documentation of vaccination or immune status, with presumption of immunity ⁷	If desired	Yes	No	No	Yes	Passive
History of measles disease (not documented)	Yes	Yes	No	Yes	Yes	Active
Unknown or no documentation of vaccination or immunity status, without presumption of immunity ⁷	Yes	Yes	No	Yes	Yes ⁸	Active

1 Postexposure prophylaxis (PEP) with MMR vaccine can be given <72 hours of exposure to persons without contraindications for the vaccine.

2 Contacts at high risk of severe infection (severely immunocompromised people, unvaccinated infants, and susceptible pregnant women) should receive IG (IM or IV) PEP ≤6 days of first exposure to measles. If it can be done rapidly, it is recommended that pregnant women be tested for measles IgG prior to administering IGIV if there is a possibility they may have received vaccine or had disease.

3 Quarantine for 21 days after last exposure unless the exposed person: is measles IgG positive, meets a presumption of immunity, or MMR<72 hours of first exposure. If symptoms consistent with measles develop, exposed person should be isolated. If there is concern about whether measles symptoms will be reported or if there will be compliance with quarantine, active monitoring with periodic calls to the exposed person to monitor for development of measles symptoms is recommended.

4 Unless found to be measles IgG positive or to have two documented MMR, exclude from high-risk settings (e.g., childcare facility with infants or healthcare facility) for 21 days after last exposure. Some jurisdictions may choose to exclude from other settings with large numbers of unvaccinated persons.

5 If patient has two documented MMR and an IgG negative result, base public health decisions on the two documented doses of MMR vaccine.

6 IG can be considered for persons in this category weighing <30 kg (66 lbs).

7 Immunity may be presumed in persons who have served in the U.S. Armed Forces; or were born in the U.S. in 1970 or later and attended a U.S. elementary school; or entered the U.S. in 1996 or later with an immigrant visa or have a green card, unless known to be unvaccinated.

8 If MMR vaccine is given ≥72 hours of first exposure or IG is given > 6 days of first exposure, exclude from high-risk settings.

Table 3: Recommended Follow-up of Measles High-Risk Contacts (borrowed from California DPH)

<i>Measles immunity assessment for <u>high-risk</u> contacts (immunocompromised, infant <12 months, pregnant, healthcare worker or household contact)</i>	IgG testing	MMR PEP⁹	IG PEP¹⁰	Quarantine if no PEP¹¹	Exclusion if no PEP¹²	Symptom watch
Unvaccinated infants <12 months of age	No	No ¹³	Yes	Yes	Yes	Active
Pregnant women without 2 documented MMR or serologic evidence of immunity	Yes ¹⁴	No	Yes ¹⁵	Yes	Yes	Active
Severely immunocompromised people	No	No	Yes	See footnote ¹⁶	Yes	Active
Household or other contact with prolonged exposure without 2 documented MMR or serologic evidence of immunity	Yes	Yes	No	Yes	Yes	Active

⁹ Postexposure prophylaxis (PEP) with MMR vaccine can be given <72 hours of exposure to persons without contraindications for the vaccine.

¹⁰ Contacts at high risk of severe infection (severely immunocompromised people, unvaccinated infants, and susceptible pregnant women) should receive IG (IM or IV) PEP ≤6 days of first exposure to measles. If it can be done rapidly, it is recommended that pregnant women be tested for measles IgG prior to administering IGIV if there is a possibility they may have received vaccine or had disease.

¹¹ Quarantine for 21 days after last exposure unless the exposed person: is measles IgG positive, meets a presumption of immunity, or MMR<72 hours of first exposure. If symptoms consistent with measles develop, exposed person should be isolated. If there is concern about whether measles symptoms will be reported or if there will be compliance with quarantine, active monitoring with periodic calls to the exposed person to monitor for development of measles symptoms is recommended.

¹² Unless found to be measles IgG positive or to have two documented MMR, exclude from high-risk settings (e.g., childcare facility with infants or healthcare facility) for 21 days after last exposure. Some jurisdictions may choose to exclude from other settings with large numbers of unvaccinated persons.

¹³ Infants ≥ 6 months of age can receive MMR PEP.

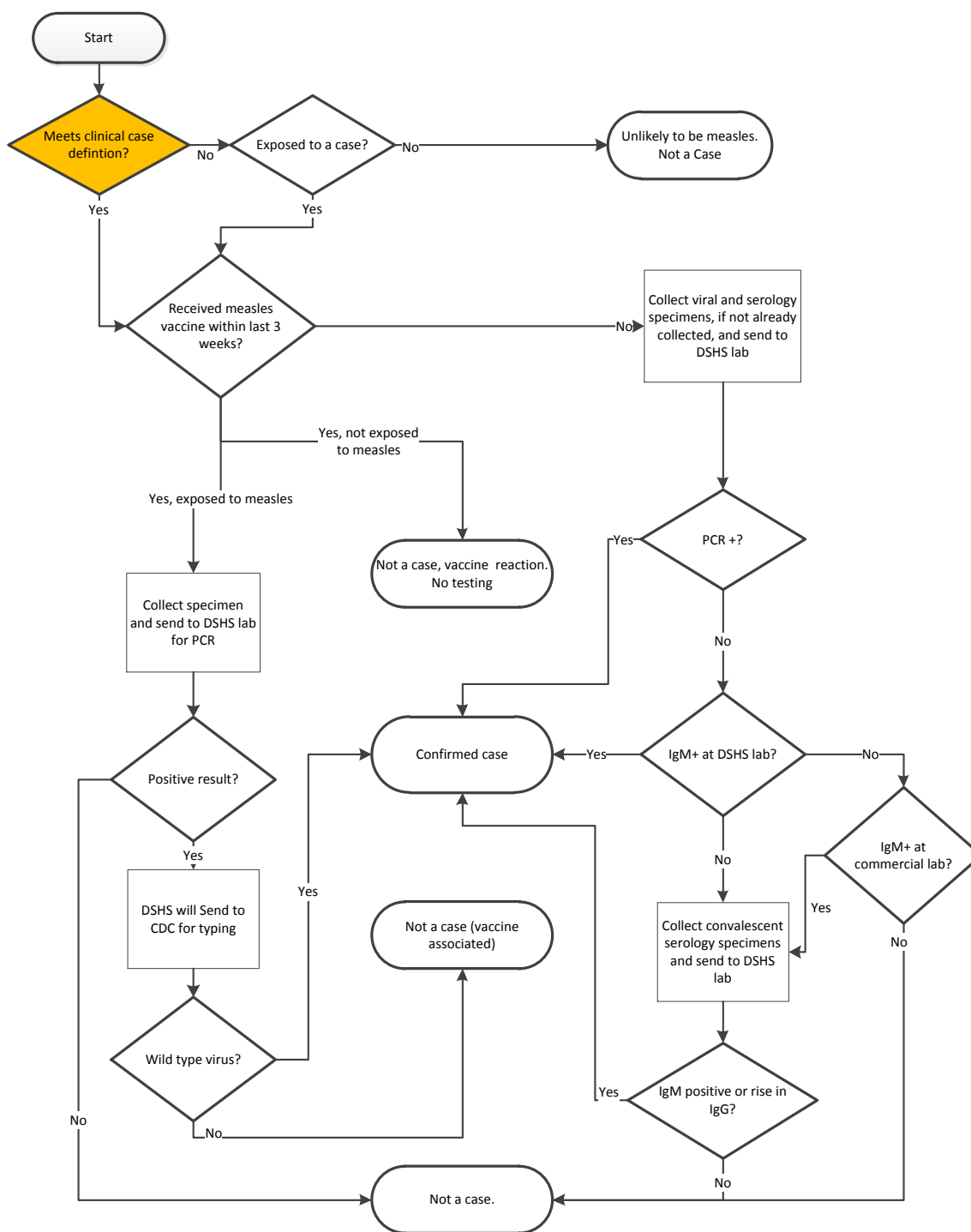
¹⁴ If no documentation of 2 doses of MMR vaccine or measles IgG positivity is available.

¹⁵ If patient is IgG negative, or if patient has unknown status and testing cannot be completed by day 6 after exposure, administer IGIV.

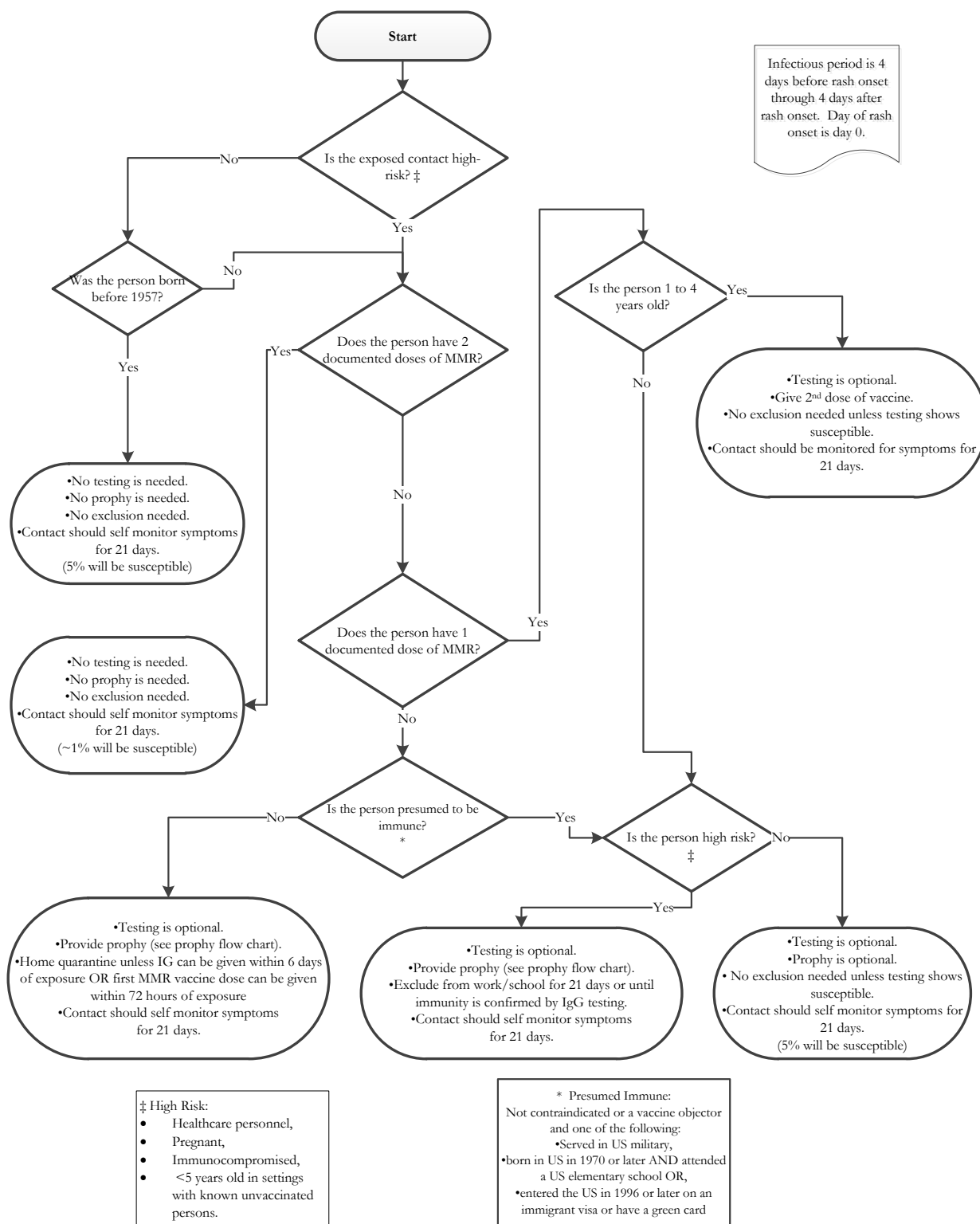
¹⁶ EAIDB should be consulted about severely immunocompromised measles contacts to assess the need for quarantine.

FLOW CHARTS rev Apr 2017

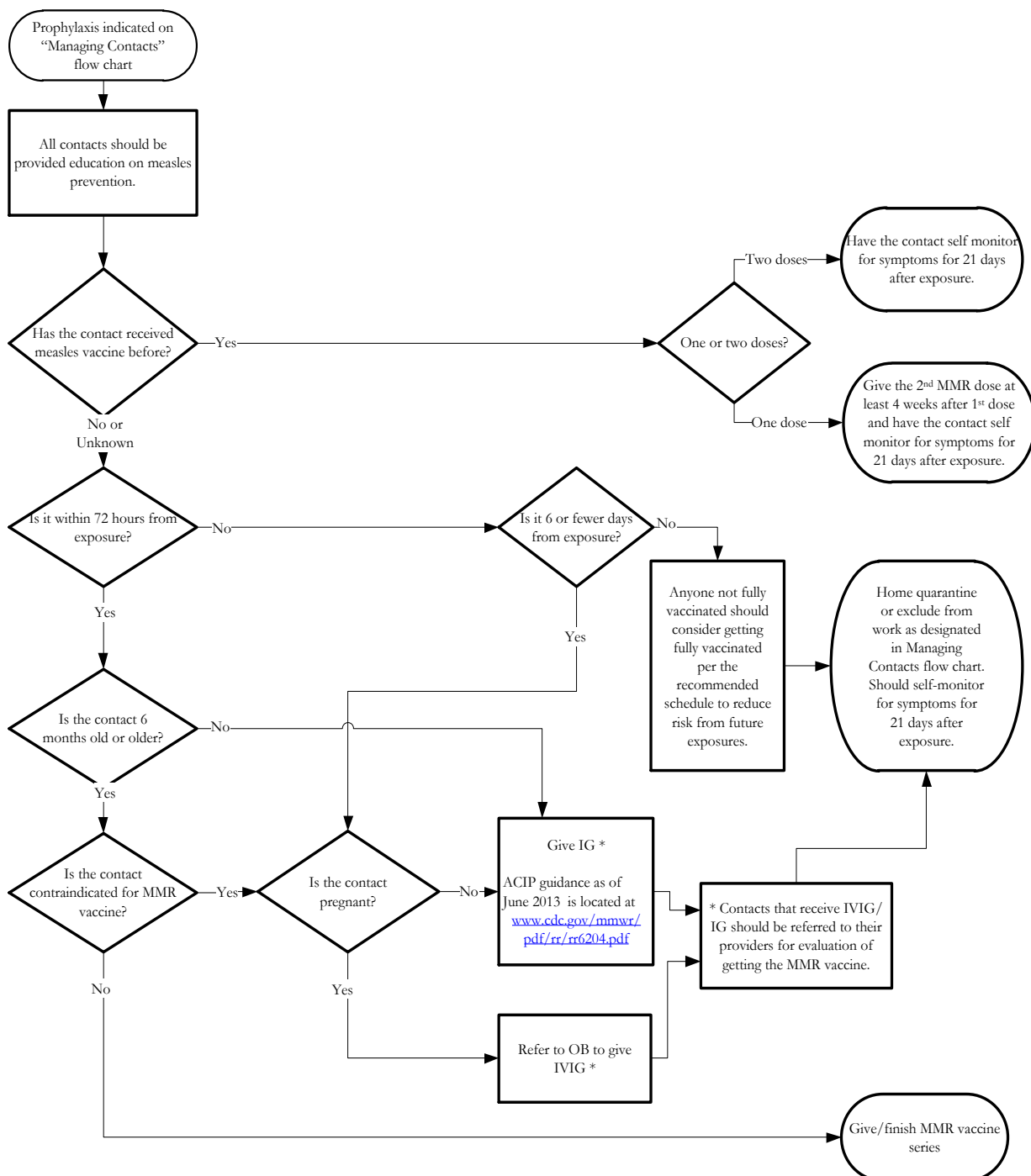
Measles: Case Status Classification

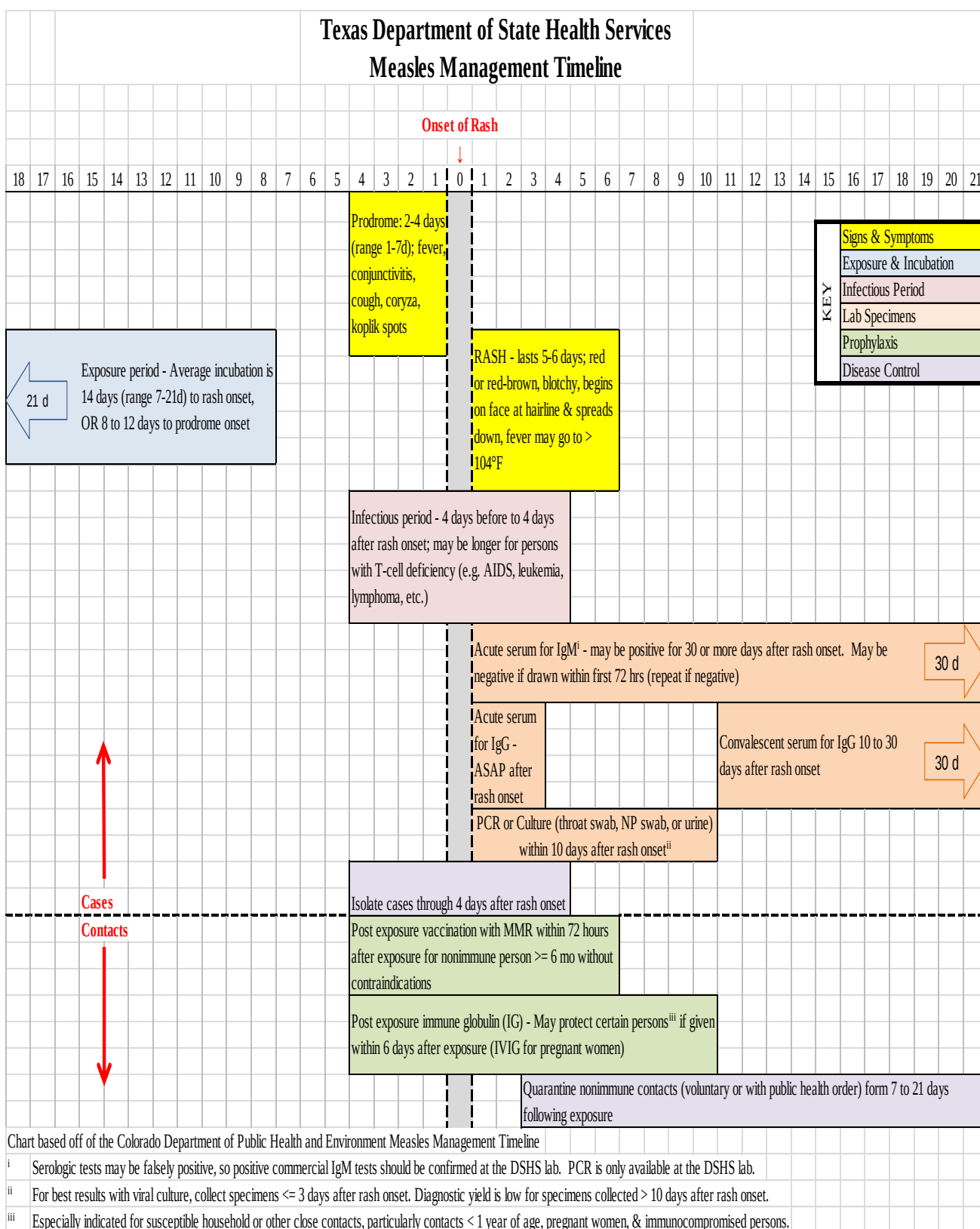


Managing Contacts of Confirmed or Highly Suspicious Measles Cases



Prophylaxis for Contacts of Confirmed or Highly Suspicious Measles Cases





Meningococcal Infection, Invasive rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Neisseria meningitidis is a Gram-negative, aerobic diplococcus with at least 13 serogroups. Serogroups A, B, C, Y, W-135 and X are all capable of causing outbreaks. In the United States and in Texas, B, C and Y are the most common serogroups.

Transmission

N. meningitidis spreads from person to person either by direct contact with respiratory secretions (e.g., kissing), indirect contact (e.g., sharing of eating utensils), or by aerosol droplets (e.g., coughing and sneezing). Up to 10%-20% of people can be asymptomatic nasopharyngeal carriers of *N. meningitidis*. Less than 1% of those will progress to invasive disease.

Incubation Period

The incubation period is usually 3 - 4 days, but it can range from 1 - 10 days.

Communicability

A person can pass the infection to others for as long as the bacteria are present in discharges from the nose and mouth. A person is no longer infectious after 24 hours of appropriate antimicrobial treatment. (Antimicrobial treatment should be continued for the full duration that it is prescribed.)

Clinical Illness

- **Meningitis** is the most common presentation of invasive meningococcal disease. Meningococcal infection is similar to other forms of meningitis, with sudden onset of fever, headache and stiff neck, often accompanied by nausea, vomiting, photophobia (sensitivity to light) or altered mental status.
- **Meningococcal sepsis (meningococcemia or bacteremia)** is the most severe form and can occur without meningitis in 5%-20% of invasive infections. Sepsis is characterized by abrupt onset of fever and a petechial or purpuric (red or purplish spots caused by bleeding under the skin) rash, and is often associated with hypotension, shock, acute adrenal hemorrhage and multiorgan failure.
- Less common presentations of meningococcal disease include pneumonia, arthritis, otitis media and epiglottitis.
- Texas invasive meningococcal disease cases from 2010-2014 reported the following clinical illness manifestations: meningococcal meningitis (48%), meningococcal sepsis (34%), pneumonia (3%), septic arthritis (2%), peritonitis (1%), multiple manifestations (5%), and unknown manifestation (7%).

Severity

The case fatality rate is 8%-15% even with appropriate antibiotic treatment. Sequelae occur in 11%-19% of people and may include hearing loss, neurologic disability, amputation or loss of limb use.

DEFINITIONS

Clinical Case Definition

Invasive meningococcal disease manifests most commonly as meningitis and/or meningococcemia that may progress rapidly to purpura fulminans, shock and death. However, other manifestations might be observed.

Laboratory Criteria for Diagnosis

- **Confirmed:**
 - Isolation of *Neisseria meningitidis* from a normally sterile site
 - Isolation of *Neisseria meningitidis* from purpuric lesions
 - Detection of *N. meningitidis*-specific nucleic acid in a specimen obtained from a normally sterile site, using a validated polymerase chain reaction (PCR) assay
- **Probable:**
 - *N. meningitidis* antigen detection by immunohistochemistry (IHC) on formalin-fixed tissue
 - *N. meningitidis* antigen detection by latex agglutination of CSF
- **Suspect:**
 - Gram negative diplococci, not yet identified, isolated from a normally sterile site (e.g., blood or CSF)

Case Classification

- **Confirmed:** A case that meets at least one of the confirmed laboratory criteria
- **Probable:** A case that meets at least one of the probable laboratory criteria
- **Suspect:** A case that meets the suspect laboratory criteria, or a case with clinical purpura fulminans in the absence of a positive blood culture

Note: All *Neisseria meningitidis* isolates from normally sterile sites and/or purpuric lesions must be submitted to the DSHS laboratory for typing and molecular analysis.

See the Sterile Site and Invasive Disease Determination Flowchart in Appendix A for confirming that a specimen meets the criteria for sterile site.

See the Meningococcal Infection: Case Status Classification Flowchart at the end of this section for assistance with case classification.

Other Definitions

For a definition of “close contacts” see the Case Investigation section (subsection: Control Measures). For cluster and outbreak definitions see the Managing Special Situations section.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of invasive meningococcal infections. Investigations should include an interview of the case or a surrogate to obtain a detailed exposure history. Please use the Meningococcal Infection Investigation Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ An investigation should begin immediately for any person, living or deceased, who is suspected of having invasive meningococcal disease.
 - ☐ Immediately inform the Regional Health Department and DSHS EAIDB when an investigation is being done or considered.
- ☐ Confirm that laboratory results indicate invasive disease.
 - ☐ See the Sterile Site and Invasive Disease Determination Flowchart in Appendix A.
- ☐ Review medical records or speak to an infection preventionist or physician to obtain demographics and case-patient symptoms.
- ☐ Ensure that appropriate control measures are implemented (see Control Measures below).
- ☐ Interview the case (or surrogate) to identify close contacts (see “close contacts” definition in Control Measures section, below).
 - ☐ Obtain detailed information on close contacts including address, place of work, occupation and daycare or school information.
 - ☐ If needed, the Respiratory Contact Tracking Form may be used to document contacts (available at <http://www.dshs.state.tx.us/idcu/investigation/>).
- ☐ Ensure that close contacts are offered and receive appropriate chemoprophylaxis.
- ☐ Ensure that all other appropriate control measures are implemented (see Control Measures).
- ☐ Within 24 hours of starting the investigation, contact the testing laboratory to ensure that the isolate has been forwarded to the DSHS laboratory (see Laboratory Procedures).
 - ☐ If an isolate (culture) is not available but invasive meningococcal disease is suspected, forward any specimen from a sterile site that is available.
 - ☐ If an isolate is available but no longer viable, please contact EAIDB at 512-776-7676 to discuss testing options.
- ☐ Complete the Meningococcal Infection Investigation Form using all of the following sources:
 - ☐ Medical records
 - ☐ Alternate or supplemental source: infection preventionist or physician responsible for the patient’s care during the meningococcal illness
 - ☐ Patient (or surrogate) interview
 - ☐ All possible sources of vaccination status including patient, parent/guardian, school, hospital records, primary care provider, and ImmTrac
- ☐ If applicable, complete steps in the Managing Special Situations section.
- ☐ Fax the completed investigation form and lab results to DSHS.
- ☐ Enter and submit for notification all suspect, probable, and confirmed invasive meningococcal cases in the NEDSS Base System (NBS).

Control Measures

Cases

- Investigate reports of suspected invasive meningococcal disease promptly to identify at-risk contacts.
- Start appropriate antibiotic treatment immediately upon diagnosis.
- Ensure that patients remain in respiratory isolation for 24 hours after the start of appropriate antibiotic therapy.
- Verify that school/daycare exclusion criteria are followed (see below).
- Disinfect any clothing or bedding that is soiled from nose or throat discharges. A patient's hospital room should be terminally cleaned upon discharge.

Contacts

- Advise contacts of signs and symptoms of illness, and refer them to their healthcare providers if they experience any symptoms compatible with invasive meningococcal disease.
- Recommend antibiotic postexposure prophylaxis for close contacts (regardless of meningococcal immunization status) who were exposed to the case in the 7 days before onset of disease in the case and until the case has had 24 hours of effective antibiotic therapy. Postexposure prophylaxis for close contacts should be initiated as soon as possible, ideally within 24 hours of identification of the index case and up to 14 days from the last exposure.
 - **Close Contacts Definition:** Close contacts of a patient who has meningococcal disease include household members (including dormitory room, barracks), child care center contacts, and persons directly exposed to the patient's oral/nasal secretions (e.g., by kissing, mouth-to-mouth resuscitation, unprotected endotracheal intubation, or unprotected endotracheal tube management).
 - The *Red Book: 2015 Report of the Committee on Infectious Diseases* lists the following categories of risk for contacts of people with meningococcal disease:

Managing Close Contacts

High risk: chemoprophylaxis recommended (close contacts)
• Household contacts, especially children younger than 2 years of age • Child care or preschool contact at any time during 7 days before onset of illness • Direct exposure to the index patient's secretions through kissing or through sharing toothbrushes or eating utensils—markers of close social contact—at any time during 7 days before onset of illness • Mouth-to-mouth resuscitation, unprotected contact during endotracheal intubation at any time 7 days before onset of illness • Frequently slept in same dwelling as index patient during 7 days before onset of illness • Passengers seated directly next to the index case during airline flights lasting more than 8 hours
Low risk: chemoprophylaxis not recommended
• Casual contact: no history of direct exposure to index patient's oral secretions (e.g., school or work) • Indirect contact: only contact is with a high-risk contact, no direct contact with the index patient • Health care personnel without direct exposure to patient's oral secretions ○ Note: Hospital personnel should receive prophylaxis only if they were directly exposed to the patient's nasal or throat secretions and failed to correctly use appropriate personal protective equipment (PPE).
In outbreak or cluster
• Chemoprophylaxis for people other than people at high risk should be administered only after consultation with local public health authorities.

- The Texas Medical Board recently changed its rules (Texas Administrative Code, Title 22, Part 9, Chapter 190, Subchapter B, §190.8) regarding the prescribing of prophylaxis for close contacts of patients with certain infectious diseases. Physicians can now prescribe antibiotics to contacts of invasive meningococcal disease cases without first medically evaluating the contact.
- Monitor close contacts for signs of illness, especially fever, for up to 10 days.
- Provide close contacts with meningococcal disease fact sheets and other information.
 - A fact sheet for meningococcal meningitis is available on the IDCU (Infectious Disease Control Unit) web site:
http://www.dshs.state.tx.us/idcu/disease/meningococcal_invasive/faqs/
 - Information is also available on all types of meningococcal disease:
<http://www.cdc.gov/meningococcal/about/>

Schools or Institutions

- When a case of invasive meningococcal disease is identified in a school or other institution, public health should immediately contact facility administrators to recommend that the institution rapidly communicate with its population, and to help guide messaging.
 - Information communicated should include:
 - Notification about the case (obtain consent if the name of the case is to be released)
 - Reassurance that the chance of another case is remote
 - Signs and symptoms of invasive meningococcal disease and instructions to seek care promptly if they occur

- Chemoprophylaxis is not needed unless individuals have been contacted by public health authorities.
- Vaccination with available meningococcal vaccines offers longer-term protection and is routinely recommended for adolescents and others at increased risk.

General Public

- Provide education, when needed:
 - There are 3 vaccines available in the US that provide protection against 4 of the 5 most common serogroups of *N. meningitidis* (serogroups A, C, W, and Y). These are meningococcal conjugate (Menactra® and Menveo®) and polysaccharide (Menomune®) vaccines. Additional meningococcal vaccines approved for use in the US include MenHibrix® (serogroups C and Y) and the recently approved serogroup B vaccines, Trumenba® and Bexsero®. For more information about these vaccines call the DSHS Immunization Division at 512-776-7284.
 - Routine hand washing and practicing respiratory etiquette (e.g., covering mouth and nose while sneezing or coughing) are essential to prevent the spread of bacteria.
 - Limit sharing food, eating utensils and other personal belongings.

Exclusion

Children with meningitis and bloodstream infections caused by *N. meningitidis* should be excluded from school and daycare until written permission is provided by their healthcare provider. Children with a fever from any infectious cause should be excluded from school and daycare for at least 24 hours after fever has subsided without the use of fever suppressing medications.

MANAGING SPECIAL SITUATIONS

If there are ≥ 2 suspected cases in the same institution or social group, an area or organization has met the outbreak threshold, and for guidance about other unusual situations, immediately notify EAIDB at (800) 252-8239 or (512) 776-7676.

Attack Rate Calculations

Attack rates are calculated to determine the risk for disease among the general population and to determine whether overall rates have increased.

- Determine if any cases are secondary or co-primary cases. If the two cases are determined not to be co-primary or secondary, evaluation should continue to see if the cases represent an organizational outbreak.
 - Primary case: A primary case of invasive meningococcal disease is one that occurs in the absence of previous known close contact with another patient with invasive meningococcal disease.
 - Secondary case: A secondary case of invasive meningococcal disease is one that occurs among close contacts of a primary case-patient 24 hours or more after onset of illness in the primary patient. (Note: Occurrence of secondary cases will be rare if chemoprophylaxis is administered as recommended.)
 - Co-primary case: Co-primary cases are two or more cases that occur among a group of close contacts with onset of illness separated by less than 24 hours.
 - Close contacts: Close contacts of a patient who has invasive meningococcal disease include household members (including dormitory room, barracks), child care center contacts, and persons directly exposed to the patient's oral/nasal secretions (e.g., by kissing, mouth-to-mouth resuscitation, unprotected endotracheal intubation, or unprotected endotracheal tube management).

- To calculate a primary attack rate all confirmed cases of the same serogroup should be summed, secondary cases should be excluded, and each set of co-primary cases should be counted as one case.

$$\text{Attack rate/100,000} = \frac{\text{Number of primary confirmed or probable cases occurring during a 3-month period}}{\text{Number of population at risk during the same time period}} \times 100,000$$

Population at risk: Persons who are considered to be at increased risk for invasive meningococcal disease compared with historical rates of disease in the same group of the general US population. Population at risk is usually defined on the basis of community of residence or organizational affiliation. In organization-based outbreaks, the population at risk can be defined as the group of persons that best represent the affiliation. In community-based outbreaks, patients do not share any common affiliation besides an area of residence.

Two or More Cases with the Same or Similar PFGE Patterns

DSHS EAIDB monitors molecular laboratory data for invasive meningococcal disease cases whose isolates have indistinguishable (matching) or similar pulsed-field gel electrophoresis (PFGE) patterns.

EAIDB defines a **PFGE cluster** as one of the following:

- At least 2 cases with matching pulsed-field gel electrophoresis (PFGE) patterns in a county in a 1-year period
- At least 2 cases with matching PFGE patterns anywhere in Texas in a 3-month period

When a PFGE cluster is identified:

- EAIDB will inform the Health Service Region (HSR); the HSR should inform the local health department(s) (LHDs) with jurisdiction over the cases (if applicable).
- If not already submitted, completed case report forms will be requested on cases that are part of the cluster.
- Case report forms for the clustered cases should be reviewed for common exposures.
- The investigating jurisdiction(s) may be asked to re-interview the cases or complete a supplemental case form.
- Threshold calculations may be conducted.
- Enhanced surveillance may be considered if cases are sufficiently temporally and/or geographically clustered or if they occur in a defined population and outbreak thresholds are not met.

Two or More Cases Associated with a School, Daycare, Nursing Home, Correctional Facility or Closed Setting

When ≥ 2 invasive meningococcal disease cases are associated with an organization, the local/regional health department:

- Should thoroughly investigate links between the cases
 - LHDs should work closely with HSRs and EAIDB to coordinate information on invasive meningococcal disease cases from different jurisdictions.
- Should recommend basic control measures including hand hygiene, and respiratory etiquette education for residents/patients and staff
- Should conduct active surveillance for new cases of disease for a minimum of 2 weeks after the onset of the last case
- Should take steps to reduce overcrowding (if applicable)

- Should determine the population of the organization or affiliation and calculate attack rates for the organization by classroom, grade, unit or other grouping.
 - Organization-based outbreak: The occurrence of ≥ 3 confirmed or probable cases of invasive meningococcal disease of the same serogroup in a period of ≤ 3 months among persons who have a common affiliation but no close contact with each other, resulting in a primary disease attack rate of >10 cases per 100,000 persons.
 - Organization-based outbreaks may occur among children, students, residents and/or staff at a university, school, daycare, nursing home, correctional facility, church, employer, club, sports team or other organizational or closed setting.
- May consider mass antibiotic chemoprophylaxis for limited or closed populations (e.g., a single school or residential facility)
 - If mass chemoprophylaxis is undertaken, it should be administered to all targeted persons at the same time.
 - It is possible that even in a vaccine-preventable, organization-based outbreak, antibiotic distribution may be a more timely intervention, since preventive antibodies take 7-10 days to develop after vaccination.
- Should vaccinate the population at risk if the attack rate is >10 cases per 100,000 population
 - In some instances the attack rate will be >10 cases per 100,000 population with only 2-3 cases. In these situations, vaccination may be considered after only 2 primary cases are identified.
 - The actual attack rate at which the decision to vaccinate is made may vary and the following factors should be considered:
 - Completeness of case reporting and number of possible cases of invasive meningococcal disease for which bacteriologic confirmation or serogroup data are not available
 - Occurrence of additional cases of invasive meningococcal disease after recognition of a suspected outbreak
 - Logistic and financial considerations
 - Consult with EAIDB and the DSHS Immunization Branch to determine the need for and availability of vaccine.

Note: In the United States, measures that have not been recommended for control of invasive meningococcal disease outbreaks include restricting travel to areas with an outbreak, closing schools or universities, or canceling sporting or social events.

Two or More Cases Located within a Community

When multiple cases occur in a community, the local/regional health department should:

- Thoroughly investigate links between the cases
 - LHDs should work closely with HSRs and EAIDB to coordinate information on meningococcal disease cases from different jurisdictions.
- Consider enhanced surveillance to detect additional cases in the community
- Determine the population of the community and calculate attack rates with the outbreak strain among the population at risk, as described in the *Control of Communicable Diseases Manual, Epidemiology and Prevention of Vaccine-Preventable Diseases* (“Pink book”) and *Manual for the Surveillance of Vaccine-Preventable Diseases*.
 - Community-based outbreak: The occurrence of ≥ 3 confirmed or probable primary cases of invasive meningococcal disease in a period of ≤ 3 months among persons residing in the same area who are not close contacts and who do not share a common affiliation, with a primary attack rate of >10 cases per 100,000 population.
 - Examples of settings for a community-based outbreak include neighborhood, zip code, school district, city or county.

Note: For outbreak threshold calculations, population-based rates are used, and not age-specific attack rates, as have been calculated for college students.

When a community-based outbreak (based on calculations) is occurring:

- Conduct active surveillance to detect other cases in the population.
- Conduct a public education campaign.
- Immunize unvaccinated members of the at-risk population.
 - The actual attack rate at which the decision to vaccinate is made may vary and the following factors should be considered:
 - Completeness of case reporting and number of possible cases of invasive meningococcal disease for which bacteriologic confirmation or serogroup data are not available
 - Occurrence of additional cases of invasive meningococcal disease after recognition of a suspected outbreak
 - Logistic and financial considerations
 - Consult with EAIDB and the DSHS Immunization Branch to determine the need for and availability of vaccine.

Note: Mass chemoprophylaxis (with antibiotics) is not usually effective for widespread communities but may be considered for small sub-populations (e.g., schools) that are directly experiencing cases. If mass chemoprophylaxis is undertaken, it should be administered to all targeted persons at the same time.

Outbreaks

If an outbreak of meningococcal disease is suspected, notify the regional DSHS office or EAIDB at (800) 252-8239 or (512) 776-7676.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Laboratory confirmed and clinically suspected cases are required to be reported **immediately** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Call DSHS EAIDB immediately when an investigation is being done or considered.
- Enter the case into NBS and submit an NBS notification on all **confirmed, probable, and suspect** cases to DSHS within 30 days of receiving a report of a confirmed, probable, or suspect case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules (for link to NBS guidelines see Appendix D).
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completion of the investigation.
- Fax (or mail) a completed investigation form when the NBS notification is submitted.
 - **In the event of a death, copies of the hospital discharge summary, death certificate and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at (800) 252-8239 or 512-776-7676.
- Submit a completed **Respiratory Disease Outbreak Summary Form** at the conclusion of the outbreak investigation.
 - Fax a copy to the DSHS regional office and/or to EAIDB at 512-776-7676.
 - The Respiratory Disease Outbreak Summary Form is available at <http://www.dshs.state.tx.us/idcu/investigation/>.

LABORATORY PROCEDURES

Neisseria meningitidis isolates from normally sterile sites and/or purpuric lesions are required to be submitted to the DSHS Laboratory for typing and molecular analysis. Before shipping specimens, be sure to notify DSHS EAIDB staff at (512) 776-7676.

Specimen Collection

- Submit isolates of *N. meningitidis* (preferred specimen) on blood or chocolate agar at ambient temperature.

Note: Isolates that are no longer viable can still be tested. Please contact EAIDB to discuss testing options. If an isolate/culture is not available, EAIDB recommends sending blood, CSF, or any other available specimen from a sterile site or purpuric lesions (for PCR testing at CDC).

- Submit blood in a red or tiger-top vacutainer. Transport at ambient temperature.
- Submit spinal fluid. Transport at room temperature. **DO NOT REFRIGERATE.**

Laboratory Submission Form

- Use the DSHS Laboratory G-2B Specimen Submission Form.
- For isolates of *N. meningitidis*:
 - On the G-2B Form in “Section 4. BACTERIOLOGY,” check “Neisseria meningitidis” under “Serotyping” (see below).

Section 4. BACTERIOLOGY	
<u>Clinical specimen:</u>	<u>Pure culture:</u>
☐ Aerobic isolation	☐ Anaerobic identification
☐ Anaerobic isolation	☐ Organism suspected: _____
☐ Culture, stool	<u>Definitive Identification:</u>
☐ Diphtheria Screen	☐ Bacillus
☐ EHEC, shiga-like toxin assay	☐ Campylobacter
☐ GC/CT, amplified RNA probe	☐ Enteric Bacteria
☐ GC Screen	☐ Gram Negative Rod
☐ Group B Strep Screen	☐ Gram Positive Rod
☐ Haemophilus, isolation	☐ Group B Streptococcus (Beta Strep)
☐ Toxic shock syndrome toxin I assay (TSST 1)	☐ Haemophilus
<u>Serotyping:</u>	☐ Legionella
☐ E.coli	☐ Neisseria
☐ Haemophilus influenzae	☐ Pertussis / Bordetella
☒ Neisseria meningitidis	☐ Staphylococcus
☐ Salmonella	☐ Streptococcus
☐ Shigella	☐ Vibrio
☐ Vibrio cholera	☐ Other:

- For blood or spinal fluid specimens:
 - On the G-2B Form in “Section 4. BACTERIOLOGY,” check “Aerobic isolation” under “Clinical specimen”. Also, please write “*N. meningitidis*” in the white space next to “Aerobic isolation” (see below).

Section 4. BACTERIOLOGY	
<u>Clinical specimen:</u>	<u>Pure culture:</u>
☒ Aerobic isolation	☐ Anaerobic identification
☐ Anaerobic isolation	☐ Organism suspected: _____
☐ Culture, stool	<u>Definitive Identification:</u>
☐ Diphtheria Screen	☐ Bacillus
☐ EHEC, shiga-like toxin assay	☐ Campylobacter
☐ GC/CT, amplified RNA probe	☐ Enteric Bacteria
☐ GC Screen	☐ Gram Negative Rod
☐ Group B Strep Screen	☐ Gram Positive Rod
☐ Haemophilus, isolation	☐ Group B Streptococcus (Beta Strep)
☐ Toxic shock syndrome toxin I assay (TSST 1)	☐ Haemophilus
<u>Serotyping:</u>	☐ Legionella
☐ E.coli	☐ Neisseria
☐ Haemophilus influenzae	☐ Pertussis / Bordetella
☐ Neisseria meningitidis	☐ Staphylococcus
☐ Salmonella	☐ Streptococcus
☐ Shigella	☐ Vibrio
☐ Vibrio cholera	☐ Other:

Specimen Shipping

- Provide a shipment tracking number to DSHS if possible.
- DO NOT ship specimens on a Friday or the day before a state holiday unless special arrangements have been made with the DSHS Laboratory.
- *N. meningitidis* is considered an infectious agent, biosafety level 2. The isolate should be triple-contained in accordance with federal regulations.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Frequent Causes for Rejection:

- Discrepancy between patient name on tube and name on submission form
- Expired media used

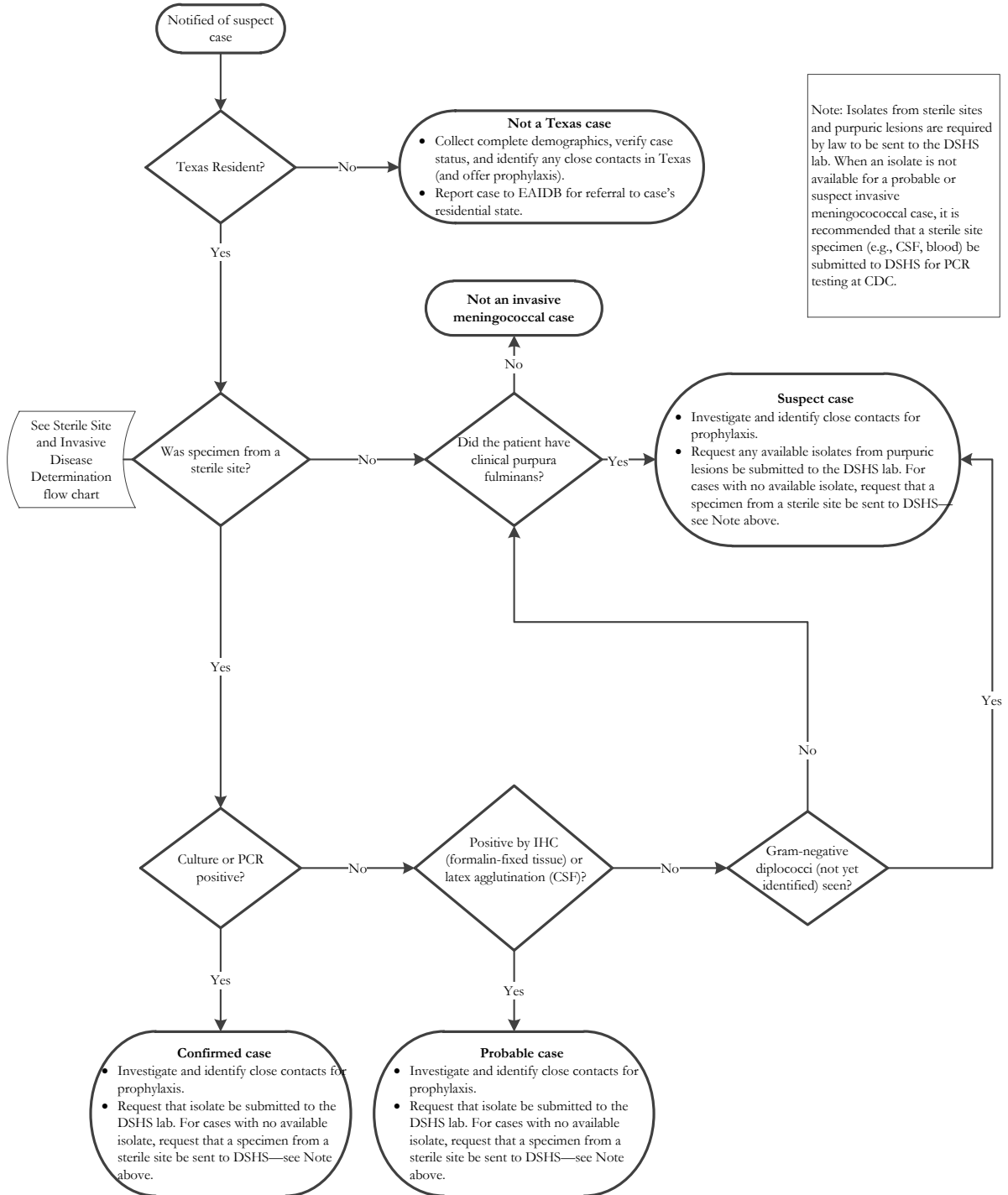
UPDATES

April 2017

- Edits made throughout the document to improve clarity

FLOW CHART rev Apr 2017

Invasive Meningococcal Infection: Case Status Classification



Multidrug-resistant *Acinetobacter* (MDR-A)

rev April 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Acinetobacter are strictly aerobic Gram negative coccobacilli of the Moraxellaceae family and have more than 25 species within the genus. They have an intrinsic resistance factor that enables them to hydrolyze carbapenem, causing resistance to carbapenems and penicillins. Multidrug-resistant *Acinetobacter* strains can also circumvent antibiotics by producing porins, modifying penicillin-binding proteins and producing aminoglycoside modifying enzymes, among other ways.

Transmission

Acinetobacter species are ubiquitous in nature and have been found in soil, water, animals and humans. In humans, it has been isolated from the skin, throat and rectum, and has been reported to be a colonizer of the respiratory tract in healthcare settings.

Transmission can occur via direct person-to-person contact or secondary contact with contaminated environmental surfaces, medical devices, or equipment. Additionally, the hands of healthcare workers who frequently touch these objects in patient environments often become vectors of transmission if hand hygiene compliance and/or transmission-based precautions are not adhered to.

Incubation Period

There is no set incubation period for exposure-to-illness onset.

Communicability

Acinetobacter is capable of surviving on inanimate surfaces for extended periods of time, from a few weeks to a month or more. When outbreaks occur, often due to incomplete surface cleaning of the environment and medical instrument, and *Acinetobacter* becomes endemic to a healthcare setting, implementing successful and sustainable elimination can prove to be extremely challenging.

Clinical Illness

Healthcare-associated *Acinetobacter* respiratory tract infections, including ventilator associated pneumonia, catheter related urinary tract infections, bloodstream infections, and wound infections have all been well documented in medical literature. There have also been reports of *Acinetobacter* meningitis, endocarditis, osteomyelitis, corneal perforation and infection associated with peritoneal dialysis. Symptoms associated with MDR-A infections generally vary based on the site that is infected (e.g., cough if in the lungs, urinary symptoms if in the bladder) but can also include general symptoms like fever or chills.

Severity

MDR-A patients, per one study, showed higher in-hospital mortality rates up to 26% infected patients were more likely to have both longer hospital and ICU lengths of stay than uninfected patients.

DEFINITIONS

Clinical Case Definition

When found in a clinical culture MDR-A can represent an infection or colonization. There is no set clinical case definition as MDR-A can cause many types of symptoms.

Laboratory Confirmation

Acinetobacter species from any body site/source that is laboratory confirmed.

Case Classification

- **Confirmed:**
 - *Acinetobacter* species from any body site/source that:
 - test non-susceptible (i.e., intermediate or resistant) to at least one of the antibiotics listed below, in at least three of the following six antimicrobial classes.

Note: no other antibiotics can meet case definition, only the one's listed in the table below.

Beta-Lactam	Aminoglycosides	Carbapenems	Fluoroquinolones	Cephalosporins	Sulbactam
Piperacillin Piperacillin/ Tazobactam	Amikacin Gentamicin Tobramycin	Imipenem Meropenem Doripenem	Ciprofloxacin Levofloxacin	Cefepime Ceftazidime	Ampicillin/ Sulbactam

- **Probable:** there is no probable case definition

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments will promptly address all reports of MDR-A. The jurisdiction where the healthcare facility is located conducts the investigation and ensures control measures are promptly taken. The investigation steps below describe the public health activities to be completed when a suspected or confirmed MDR-A case is reported. Investigations and control measures are required for infection or colonization with any type of MDR-A.

Case Investigation Checklist

- ☐ The jurisdiction that conducts the investigation is according to the location where the patient tested positive for MDR-A. (E.g.; patient tested positive for MDR-A, and is in hospital in jurisdiction A, but the patient resides in jurisdiction B, jurisdiction A would conduct the investigation).
- ☐ Immediately ensure contact precautions have been implemented for anyone with suspected or confirmed MDR-A.
- ☐ Confirm that the laboratory results meet the case definition.
 - If it is unclear, call a DSHS Regional HAI Epidemiologist for assistance.
- ☐ Ensure additional control measures are in place for cases and/or facilities. (see “specific control measures” section below)
- ☐ Review the medical records. If needed, speak to an Infection Preventionist (IP) at the healthcare facility to verify demographics, symptoms, and course of illness.
- ☐ If the patient has been discharged from the reporting healthcare facility and the receiving healthcare facility is known, the investigator ensures that the receiving healthcare facility is informed of the MDR-A case and ensures control measures are in place.

- Refer to the MDR-A Investigation form for additional questions to address.
 - The MDR-A Investigation Form is available on the DSHS Website: <http://www.dshs.state.tx.us/idcu/investigation/>
- All suspected and confirmed cases of MDR-A require the investigation form to be completed.
- A paper copy of the investigation form and laboratory report is NOT required to be sent to DSHS EAIDB unless specifically asked.
- Enter all case investigations and submit a notification in NBS within 30 days of the initial report.
 - The jurisdiction that conducted the investigation enters the case in NBS.
 - The jurisdiction is entered as the jurisdiction who conducted the investigation and not the jurisdiction of residency.
 - Once the case is reviewed and approved by DSHS central office, the central office will update the jurisdiction to the jurisdiction of residency for aggregate reporting purposes.
 - NOTE: if a case is multi-jurisdictional, it is the responsibility of the investigator to notify other jurisdictions of the case.

Prevention and Control Measures

Control measures for Cases

Ideally, the facility is performing control measures for the case and the investigator is communicating directly with the facility, most likely with the IP or the responsible representative over infection prevention. The investigator may also speak with the patient directly if applicable. The investigator ensures the below control measures are addressed but not all specific control measures might be necessary for all case investigations.

Specific Control Measures

- Facilities are responsible for ensuring that healthcare personnel are vigilant with hand hygiene practices and ensure that:
 - Hand hygiene sinks are accessible and free from clutter/supplies;
 - Alcohol-based hand sanitizers are accessible and well stocked.
- Ensure the patient is on contact precautions/ contact isolation. Contact precautions include but are not limited to:
 - Performing hand hygiene before entry into the patient room;
 - Donning (putting on) gown and gloves either before or upon immediate entry into the patient's room; (note some facilities might require more PPE)
 - Doffing (removing) gown, gloves and any other personal protective equipment (PPE) should be removed before exiting or immediately upon exiting the patient's room. Hand hygiene should be performed after removal of PPE.
 - Hand hygiene should be performed before exiting or immediately upon exiting the patient's room.
 - No recommendation currently exists for when to discontinue contact precautions. A facility should consult with an infectious disease physician, the IP, or the other provider that initiated the precautions. The facility may also call a DSHS regional HAI Epidemiologist for assistance.
- Ensure the facility is performing disinfection of reusable equipment before and after each use.
- Recommend single patient rooms if available.
 - If single rooms are not feasible, recommend cohorting like patients (ex: a patient with MDR-A and another patient with MDR-A)

- Recommend staff cohorting if possible.
- Recommend reducing the use of invasive medical devices for patients on the unit where the case was cared for, as invasive devices increase patient's risk of infection.
- Increase the frequency of cleaning of high touch areas.
- Provide education on MDR-A as needed, with specific emphasis on contact precaution and the above control measures.
 - If additional help is needed regarding providing education, contact your DSHS Regional HAI Epidemiologist. (Education could be provided to: anyone at the facility, family members, and the patient.)

Treatment

Each case will have a unique treatment option. It is recommended that the reporting facility collaborate with a clinical pharmacist, an infectious disease physician, and/or an antibiotic stewardship resource for an individualized treatment plan.

Exclusions

Students (K-12) and daycare age children with MDR-A wound infection need to be excluded from attendance until drainage from wounds or skin and soft tissue infections is contained and maintained in a clean dry bandage; restrict from situations that could result in the infected area becoming exposed, wet, soiled, or otherwise compromised. No other exclusions apply.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, immediately notify a DSHS Regional HAI Epidemiologist. The DSHS regional HAI Epidemiologist will notify central office and work with central office as needed.

Outbreak Definition

At this time there are no defined criteria for an outbreak. If your health department believes they have detected an outbreak, it is recommended to speak with the DSHS Regional HAI Epidemiologist.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School and Child-care Facilities, and General Public Reporting Requirements

Cases of Multidrug-resistant *Acinetobacter* (MDR-A) should be reported **within 1 working day** to the local or regional health department. If jurisdiction is unclear, call a DSHS Regional HAI Epidemiologist or Emerging and Acute Infectious Disease Branch (EAIDB) at 512-776-7676 for assistance.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Promptly investigate all reported cases.
- Ensure control measures are in place and provide education to prevent further spread of disease (see specific control measures section located in this document).
- Enter the case into NBS when the first occurrence is reported and create the NBS notification to DSHS on all cases of MDR-A. Complete additional case information and enter the remaining information within 30 days of initial report.
 - Please refer to the NBS Data Entry Guide for specific details on how to properly complete an NBS investigation, how to data enter a laboratory report and submit a NBS notification.

When a cluster or an outbreak is investigated, local and regional health departments should:

- Report suspected outbreaks within 24 hours of identification to the Regional DSHS Regional HAI Epidemiologist
 - Fax the investigation form and all other supporting documents to the DSHS Regional HAI Epidemiologist.
- If labeling a case as part of an outbreak, the outbreak must be named in NBS. Outbreak names must be requested through the NEDSS (NBS) office. The staff can be reached by phone (512) 458-7111 ext. 7729 or email nedss@dshs.state.tx.us

DISEASE REPORTING

Purpose of Reporting and Surveillance

- To prevent transmission of infections with MDR-A in healthcare facilities and the community, by decreasing the likelihood of transmission through the investigation process.
- To improve the detection, monitoring and epidemiological characterization of MDR-A in Texas.
- To develop, implement and evaluate strategies to prevent the emergence, transmission and persistence of MDR-A.
- To conduct and support epidemiological studies to identify outbreaks and potential sources of ongoing transmission in various populations.
- To identify further trends related to continued antibiotic resistance and the development of MDROs in Texas.

Requested Reporting

- Report to your local health jurisdiction *within 1 working day*.

Local Health Jurisdiction Investigation Responsibilities

- Local health departments may request assistance with the investigation of MDR-A by contacting both the DSHS Lead Epidemiologist and the DSHS Regional HAI Epidemiologist for the health service region (HSR). Because of the potential for transmission of MDR-A to vulnerable patients in healthcare settings, public health action is imperative in controlling further transmission by: instituting control measures, identifying and screening close contacts of cases that could transmit in healthcare settings, if indicated, and ensuring that the facility IP has been notified and that appropriate infection control measures are in place.

LABORATORY PROCEDURES

Clinical laboratories are not required to submit isolates to the DSHS Laboratory at this time. To obtain confirmatory, gene sequencing or phenotypic testing, clinical laboratories should contact a reference laboratory for those services. The reference lab will give guidance on specimen collection, submission form and shipping.

Any specimen sent to the DSHS Laboratory for possible outbreak situations or molecular testing requires prior approval from a DSHS Regional HAI epidemiologist.

UPDATES

April 2017

- Added information and clarification about jurisdiction and who should investigate cases and included information about consulting with a DSHS regional HAI Epidemiologist for more help with an investigation.
- Added more specific information about control measures and isolation.
- Clarified instructions on how to handle an outbreak.

Mumps rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Mumps virus, a single-stranded RNA paramyxovirus

Transmission

Transmission occurs through respiratory droplets or through direct contact with nasopharyngeal secretions.

Incubation Period

Average of 16-18 days (range 12-25 days)

Communicability

Mumps virus has been found in respiratory secretions as early as 3 days before the start of symptoms and up to 9 days after onset. However, the patient is most infectious within the first 5 days after symptom onset.

Clinical Illness

Prodromal symptoms are nonspecific; they include myalgia (muscle pain), anorexia, malaise, headache, and low-grade fever, and may last 3–4 days. Parotitis (inflammation and swelling of the parotid glands) is the most common manifestation of clinical mumps, affecting 30–40% of infected persons. Parotitis can be unilateral (one side of cheek) or bilateral (both sides of cheek); other combinations of single or multiple salivary glands may be affected. Parotitis usually occurs within the first 2 days of symptom onset and may present as an earache or tenderness on palpation of the angle of the jaw. Symptoms usually decrease within 1 week and generally resolve within 10 days.

Up to 20% of infections are asymptomatic; an additional 40–50% may have only nonspecific or primarily respiratory symptoms.

The most common complication is orchitis (inflammation of the testicles), affecting up to 50% of infected males who have reached puberty. While painful, only rarely does this lead to infertility. Other complications are rare, but may include encephalitis (inflammation of the brain), meningitis, oophoritis (inflammation of an ovary), mastitis (inflammation of the breast), pancreatitis (inflammation of the pancreas), myocarditis (inflammation of heart muscle), arthritis (inflammation of joints), and nephritis (inflammation of the kidneys). Spontaneous abortion (miscarriage) can result if an infection occurs during pregnancy, particularly in the first trimester. Rarely (~1 in 20,000), mumps infection can cause deafness, which is usually permanent.

Not all cases of parotitis are caused by mumps virus. Parotitis can also occur as a result of infection with other viruses such as cytomegalovirus, parainfluenza virus, influenza A, Coxsackie A, echovirus, lymphocytic choriomeningitis virus, and HIV as well as *Staphylococcus aureus*, and other bacteria. Non-infectious causes of parotitis include drugs, tumors, immunologic diseases, and obstruction of the salivary duct. Mumps, however, is the only agent that causes outbreaks (i.e., multiple cases at once) of parotitis.

DEFINITIONS

Clinical Case Definition

Acute parotitis or other salivary gland swelling lasting at least 2 days, or orchitis or oophoritis unexplained by another more likely diagnosis

Laboratory Criteria for Diagnosis

- Isolation of mumps virus from a clinical specimen, **OR**
- Detection of mumps-virus-specific nucleic acid by PCR.

Note: An elevated serum amylase is **not** confirmatory for mumps.

Case Classification

- **Confirmed:**
 - A case that meets the laboratory criteria for diagnosis **AND**
 - Meets clinical case definition **OR**
 - Has aseptic meningitis, encephalitis, hearing loss, mastitis, or pancreatitis.
- **Probable:**
 - A case that meets the clinical case definition **AND**
 - Has a positive test for serum anti-mumps immunoglobulin M (IgM) antibody, **OR**
 - Has an epidemiologic link to another probable or confirmed case or linkage to a group/community defined by public health during an outbreak of mumps.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of mumps. Local and regional health authorities should provide education to prevent further spread of disease, discuss exclusion criteria with reporters and encourage timely vaccinations.

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition.
- ☐ Request that the laboratory forward viral specimens to the DSHS laboratory. If viral specimens are not available, consider serology specimens. See laboratory procedures.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition and vaccination status.
 - The Mumps Investigation Form should be used to record information collected during the investigation.
- ☐ Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- ☐ Identify close contacts and ensure appropriate control measures are implemented (see control measures below).
- ☐ In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be faxed to DSHS EAIDB.
- ☐ Send the complete Mumps Investigation Form to DSHS.

- All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Although vaccination after exposure to mumps may not prevent disease, the vaccine will protect persons from subsequent exposures. If ongoing exposure is expected, quarantine and/or vaccinating contacts may be of use.
- Persons who are unsure of their mumps disease history or mumps vaccination history should be vaccinated.
- IG is not effective and not recommended.
- A 3rd dose of MMR should be considered in ongoing outbreaks of highly vaccinated persons in certain congregate settings. See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm>

Exclusion

Children should be excluded from school or daycare for 5 days after onset of swelling.

MANAGING SPECIAL SITUATIONS

If there are ≥ 2 suspected cases in the same institution or social group, an area or organization has met the outbreak threshold, and for guidance about other unusual situations, immediately notify EAIDB at (800) 252-8239 or (512) 776-7676.

Outbreaks

If an outbreak of mumps is suspected, notify the regional DSHS office or EAIDB at **(800) 252-8239** or **(512) 776-7676**.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Confirmed and clinically suspected cases are required to be reported **within 1 work day** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS within 30 days of receiving a report of a confirmed or probable case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.

- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, autopsy report and death investigation form should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at (800) 252-8239 or 512-776-7676.

LABORATORY PROCEDURES

Diagnosing Mumps

Serologic tests should be interpreted with caution, as false-positive and false-negative results are possible with IgM tests for mumps. Mumps cases should not be ruled out by negative serology results. With previous contact with mumps virus either through vaccination (particularly with two doses) or natural infection, serum mumps IgM test results may be negative; IgG test results may be positive at initial blood draw and viral detection in RT-PCR or culture may have low yield.

PCR Specimen Collection and Submission (preferred)

Specimens should be obtained early in the course of illness when the quantity of virus shed is highest. Collect buccal or oral swab samples as soon as mumps disease is suspected. Samples collected when the patient first presents with symptoms have the best chance of having a positive result by RT-PCR.

Specimen Collection

Processing the swabs within 24 hours of collection will enhance the sensitivity of both the RT-PCR and virus isolation techniques.

- Using a buccal or oral swab, massage the parotid gland area for 30 seconds prior to swabbing the area around Stensen's duct.
 - A commercial product designed for the collection of throat specimens or a flocked polyester fiber swab can be used. Synthetic swabs are preferred. Do not use cotton swabs, which may contain substances that are inhibitory to enzymes used in RT-PCR. Flocked synthetic swabs appear to be more absorbent and elute samples more efficiently.
- Swabs should be placed in 2 ml of standard viral transport medium (DSHS uses Remel media)

Submission Form

- Use specimen submission form G-2V.
- If more than 1 swab is submitted, a G-2V must be provided for each swab.
- Check mumps PCR on the G2V form.

Specimen Shipping

- All clinical specimens for PCR should be kept at 2-8°C during storage and shipment. Ship specimens on ice via overnight delivery.
- If there is a delay in shipment or the specimen will not be received at the laboratory within 48 hours of collection, the sample should be frozen at -70°C. Frozen samples should be shipped on dry ice.
- Notify EAID VPD staff about the specimens to ensure prompt testing and satisfactory receipt of the specimen.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Specimens submitted on a preservative, such as formalin
- Specimens received at room temperature or cold greater than 48 hours of collection

Serology Specimen Collection and Submission (If needed)

The first (acute-phase) serum sample should be collected as soon as possible upon suspicion of mumps disease. Convalescent-phase serum samples should be collected about 2-3 weeks after the acute-phase sample.

The DSHS Laboratory does not offer mumps IgM testing. Mumps PCR and IgG testing is available at the DSHS Laboratory.

Persons with a history of mumps vaccination may not have detectable mumps IgM antibody regardless of timing of specimen collection.

Specimen Collection

Option 1:

- Collect at least 5 mL blood in red top tube.
- Label blood tubes with patient's first and last name, and we recommend a second identifier such as date of birth or medical record number or social security number. If the first and last name is not provided, the specimen will be rejected.
 - Centrifuge the **red top blood** collection tube within 2 hours from the time of collection to separate the serum from the red blood cells (clot).
 - Transfer the serum from the red top tube into a serum transport tube properly labeled with the patient's name and date of birth or social security number and ship cold with cool packs and must be received within 48 hours.
 - If the serum samples will not be delivered to the laboratory within 48 hours of collection, then the samples must be frozen at -20°C (frozen) or lower and shipped frozen with dry ice.
 - Do not freeze whole blood in red top tube for shipping.

Option 2:

- Collect at least 5 mL blood in **gold top** or **tiger top** blood collection tube containing a gel serum separator (Gold top or tiger top tubes are types of serum separator tubes with the gel that keeps the serum separated from the clot after the centrifugation).
- Label blood tubes with patient's first and last name, and we recommend a second identifier such as date of birth or medical record number or social security number. If the first and last name is not provided, the specimen will be rejected.
 - Centrifuge the gold top blood collection tube within 2 hours from the time of collection to separate the serum from the red blood cells (clot) and ship cold with cool packs and must be received within 48 hours.
 - If more than 48 hours, transfer the serum into a serum transport tube properly labeled with the patient's name and date of birth or social security number and ship frozen with dry ice.
 - Do not freeze serum in serum separator tube (SST) for shipping. Freezing will cause hemolysis and hemolyzed specimens will be unsatisfactory for testing.

Submission Form

- Use the DSHS Laboratory current version of G-2A form for specimen submission.
- Make sure the patient's first and last name and date of birth/social security number match exactly what is written on the tube.
- Mark the laboratory test requested, date of onset, and date of collection. Be certain that the names on acute and convalescent sera match exactly.
- Call DSHS Laboratory at 512-776-7138 if needing information for specimen submission.

Specimen Shipping

- Notify EAIDB VPD staff about the specimens to ensure prompt testing and satisfactory receipt of the specimen.
- To avoid specimen rejection, ship separated serum or centrifuged serum separator tubes Monday through Thursday to the DSHS laboratory via overnight delivery following the above guidelines.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
 - If the serum samples will not be delivered to the DSHS laboratory within 48 hours of collection, transfer into a serum transport tube and freeze on Fridays. Ship frozen specimens with dry ice on Monday. Lone Star service will not deliver specimen to the DSHS lab on Saturday.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

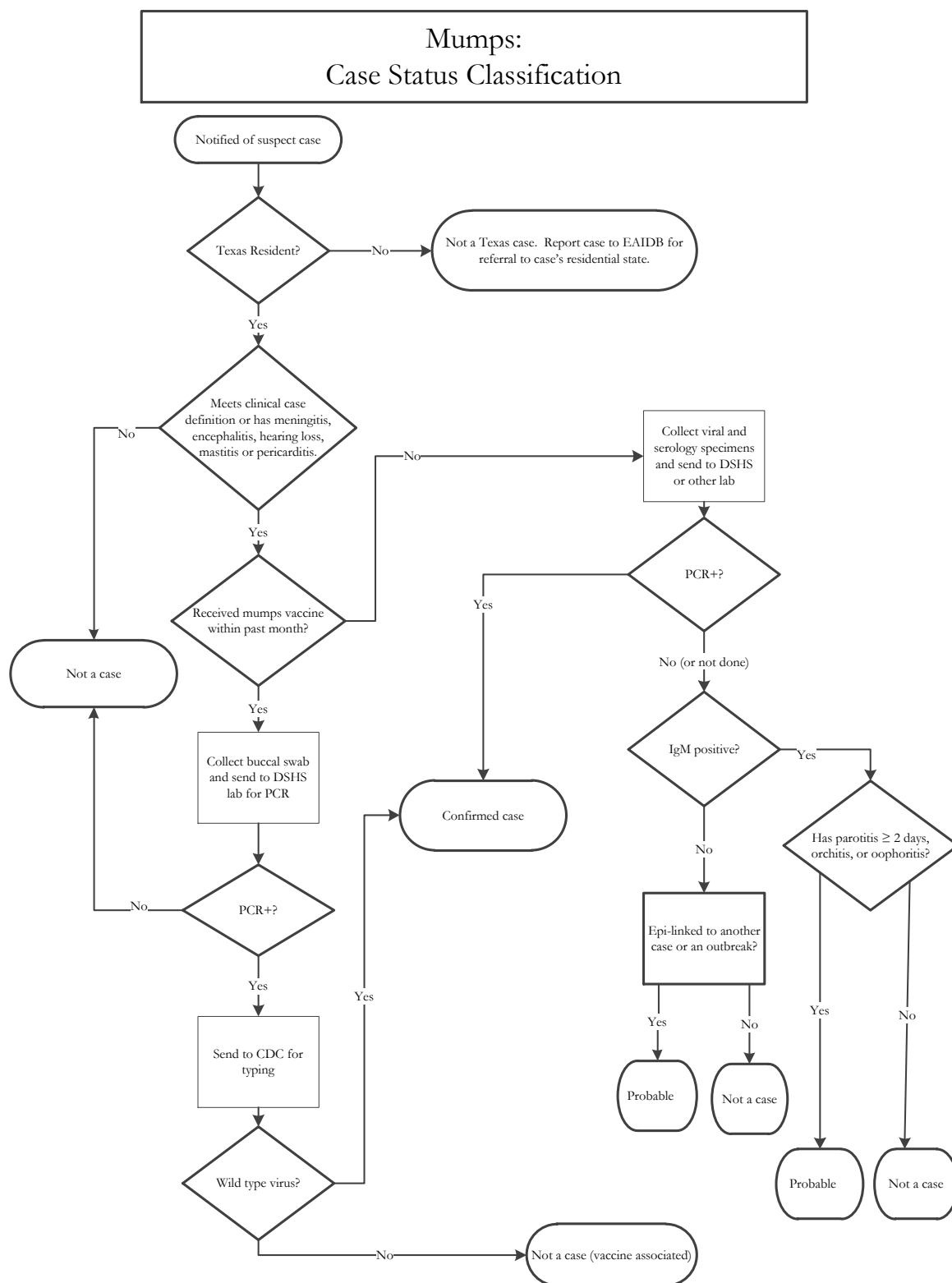
- Discrepancy between name on tube and name on form
- Insufficient quantity of serum for testing
- Specimens received with extended transit time, received at incorrect temperature, or no date of collection

UPDATES

April 2017

- Updated reporting time frame from “within 1 week” to “within 1 work day”
- Added clarifying language to the case classification

FLOW CHART rev Apr 2017



Norovirus Outbreaks rev Jan 2016

Norovirus is the most common cause of gastrointestinal illness, estimated to cause more than half of all cases and outbreaks recorded annually. Outbreaks of norovirus are common as viral particles are readily transmitted person-to-person due to a low infectious dose required to cause illness. While sporadic cases are not reportable, norovirus outbreaks are reported to DSHS and to the CDC.

BASIC EPIDEMIOLOGY

Infectious Agent

Noroviruses are small, structured RNA viruses that belong to the Caliciviridae family. There are six genogroups (G) of norovirus, of which GI, GII, and GIV infect humans. Due to its genetic diversity, infection with one genogroup does not provide immunity against any other norovirus genogroup. GII norovirus strains account for the majority of norovirus outbreaks in long-term care facilities, and the GII.4 Sydney strain has been predominant in recent years.

Transmission

Transmission occurs through the fecal-oral route, including direct person-to-person contact and indirect transmission through contaminated food, water, or environmental surfaces. Vomitus-oral transmission, via aerosolization, is possible.

Incubation Period

Norovirus symptoms typically present 12–48 hours after exposure to the virus.

Communicability

Norovirus is most communicable during the acute stage of disease, but the virus may be shed in stool for 2-3 weeks after symptom resolution.

Clinical Illness

Norovirus illness is generally self-limited and lasts 1-3 days in healthy individuals, and 4-6 days in the very young, elderly, and hospitalized. Primary symptoms include: vomiting and diarrhea (typically watery and without blood). Additional symptoms include: nausea, low-grade fever, abdominal cramps, and malaise. Deaths can occur, especially in the elderly in long-term care facilities.

DEFINITIONS

Outbreak Definition

An outbreak is defined as two or more cases with symptoms clustered in time and space.

Laboratory Criteria for Diagnosis

- Polymerase chain reaction (PCR) can be used to test stool and emesis samples, as well as environmental swabs in special studies. (Identification of norovirus can best be made from stool specimens taken within 48 to 72 hours after onset of symptoms. Virus can sometimes be found in stool samples taken as late as 2 weeks after recovery.), **OR**
- Detection of norovirus by direct and immune electron microscopy of fecal specimens, **OR**
- Fourfold increase of norovirus antibodies in acute- and convalescent-phase blood samples

Note: The etiology of GI outbreaks should be confirmed by submitting specimens to the DSHS Laboratory. Sequencing of norovirus strains found in clinical and environmental samples has greatly helped in conducting epidemiologic investigations.

Case Classification

- **Confirmed:**
 - A clinically compatible case that is laboratory confirmed
- **Probable:** Norovirus can be established as the probable cause of an outbreak if:
 - The mean (or median) illness duration is 12 to 60 hours, **AND**
 - The mean (or median) incubation period is 24 to 48 hours, **AND**
 - More than 50% of people have vomiting, **AND**
 - No bacterial or parasitic agent is found.

OUTBREAK INVESTIGATION

Outbreak Investigation

Suspect norovirus outbreaks should be investigated in order to determine the agent, characterize the scope, and prevent additional cases.

Outbreak Investigation Checklist

- Prepare a linelist of all cases. Minimal information needed for the line list might include patient name or other identifier; age and sex; category or group (e.g., patient, preschooler, resident, staff, or student), room number, if applicable; onset of symptoms (date & time), signs & symptoms, duration of illness; lab specimen collected, lab results; treatments and outcome of case; and foods eaten or other risky exposures leading up to illness reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Category	Room #	Onset	Symptoms	Hospitalized	Lab specimen
1	NT	34	F	resident	4c	2/4/16	Bl. D, F	Yes	stool
2	PR	2	M	staff	Wing A	1/30/16	V, D, F	None	none

- Systematically collect information from cases to characterize the outbreak.
 - Interview ill persons (as many as possible).
 - Use a questionnaire based on the Hypothesis Generating Questionnaire http://www.dshs.state.tx.us/idcu/health/foodborne_illness/investigation/ that includes information specific to the outbreak, such as a calendar and building floor plans.
- Characterize the outbreak: Compile all of the available information on all cases in the outbreak. See Characterize the Outbreak below.
- Arrange for appropriate laboratory testing.
 - Attempt to collect stool specimens from at least 3, but not more than 12, ill persons. Coordinate specimen submission and testing with EAIDB and DSHS or local laboratory. See Laboratory Procedures.
 - Ensure that specimens negative for norovirus are tested for bacterial pathogens.
- Conduct environmental field investigation, if indicated.
 - Facility assessment:
 - Collect information on facility operations.
 - Identify and correct items that may have contributed to the outbreak.
 - Obtain names and contact information of those present at facility during outbreak timeframe, e.g., employees, food workers, customers, residents, students, etc.
- Implement facility control measures. See Control Measures Section.
- Communicate regularly with all parties involved in outbreak investigation
 - Provide Situation Reports through email.
 - Hold conference calls to discuss the outbreak investigation.
- Monitor the outbreak until the last case has been symptom free for 48 hours
- Report findings at conclusion of investigation:
 - Create Outbreak Summary Report.
 - Enter outbreak into **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

Characterize the outbreak

- Provide descriptive information, in narrative, tabular, and graphic form, for the outbreak:
 - Calculate or estimate the number of persons at risk.
 - Calculate or estimate the number of ill persons.
 - Calculate or estimate the attack rate.
 - Calculate or estimate the mean, median, and range for the illness incubation period.
 - Calculate the number and frequency of symptoms expressed by ill persons.
 - Calculate the number and percentage of ill persons who sought medical care.
 - Calculate the number and percentage of ill persons hospitalized overnight.
 - Calculate the number and percentage of ill persons who died.
 - Calculate the percentage of total cases in the age groups <1y, 1-4y, 5-19y, 20-24y, ≥50y.
 - Calculate the gender distribution of illness (% female, % male).
 - Document the number of persons who provided stool specimens and the number of these that tested positive for norovirus.
 - Document the strain of norovirus, if determined.
- Characterize the outbreak setting:
 - Document any ill health care, food, or other workers at the facility or other setting.
 - Document the percentage of ill staff who had illness onset >24 hours before residents/others.

- Document any suspected source of the outbreak (*Note:* More than one suspect source can be entered into the National Outbreak Reporting System or NORS).
- Document characteristics of the setting that might have contributed to the outbreak (crowding, construction, water issues, recent movement of people into setting, etc.).
- Document any food or environmental specimens that tested positive for noroviruses and the viral strain identified, if known.
- Characterize the time frame of the outbreak.
- Document the illness onset dates for the first and last ill persons in the outbreak, and the peak date of illness.
- Prepare an epi-curve for the outbreak.

Exclusions

School/child-care: No exclusion specified for norovirus but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications

Food Employees: Symptomatic food employees infected with Norovirus are to be excluded from work. Asymptomatic food employees diagnosed with an infection from Norovirus are to be excluded from working in a food establishment serving a highly susceptible population or restricted if they do not serve a highly susceptible population.

Food employees can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met:

- Medical documentation stating that the food employee is free of infection from Norovirus, OR
- More than 48 hours have passed since the food employee became asymptomatic (without the use of diarrhea suppressing medications), OR
- The food employee did not develop symptoms and more 48 hours have passed since being diagnosed.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

CONTROL MEASURES

Control measures should be implemented as soon as a potential outbreak is recognized. Specific recommendations for the prevention of additional cases should be based on the findings of the epidemiologic investigation.

General Control Measures include:

- **Hand hygiene**
 - Hands should be washed with warm water and soap for 15-20 seconds, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
 - No bare-hand contact with ready-to-eat foods is also helpful.
 - Alcohol-based and other sanitizers are of questionable efficacy and should not be a substitute for hand washing when soap and water are available.
- **Environmental Disinfection**
 - If the facility does not have an Environmental Protection Agency-registered commercial virucide, use bleach. The CDC recommends the use of a chlorine bleach solution with a concentration of 1000–5000 ppm (5–25 tablespoons of household bleach (5.25%) per gallon of water) on all surfaces. Leave the surface wet for ≥5 minutes or follow the directions on the commercial cleaner to allow sufficient time for the bleach to kill the pathogen.
 - Bathrooms and “high-touch” surfaces (door knobs, hand rails, etc.) should be targeted.
Refer to bleach cleaning recommendations: <http://www.disinfect-for-health.org/resources> and http://www.disinfect-for-health.org/wp-content/themes/disinfect/pdfs/NorovirusIncident_8.5x11_English_Color.pdf
- **Exclusion and Isolation**
 - Recommend segregation of ill persons, perhaps also with exposed persons, if appropriate.
 - Recommend restriction of movement and visitors, if a group setting and if appropriate.
 - Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care until they are free from symptoms for at least 24-48 hours without the use of symptom suppressing medications.

For more information on norovirus prevention, please see:

<http://www.cdc.gov/norovirus/preventing-infection.html>

Recommended Control Measures for Schools and Child-Care Centers:

- **Hand Washing**
 - Encourage children and adults to wash their hands frequently, especially before handling or preparing foods and after wiping noses, diapering, using toilets, or handling animals.
 - Wash hands with soap and water long enough to sing the “Happy Birthday” song twice.
 - Sinks, soap, and disposable towels should be easy for children to use.
 - If soap and water are not available, clean hands with gels or wipes with alcohol in them.

- **Diapering**
 - Keep diapering areas near hand washing areas.
 - Keep diapering and food preparation areas physically separate. Keep both areas clean, uncluttered, and dry.
 - The same staff member should not change diapers and prepare food.
 - Cover diapering surfaces with intact (not cracked or torn) plastic pads.
 - If the diapering surface cannot be easily cleaned after each use, use a disposable material such as paper on the changing area and discard the paper after each diaper change.
 - Sanitize the diapering surface after each use and at the end of the day.
 - Wash hands with soap and water or clean with alcohol-based hand cleaner after diapering.
- **Environmental Surfaces and Personal Items**
 - Regularly clean and sanitize all food service utensils, toys, and other items used by children.
 - Discourage the use of stuffed toys or other toys that cannot be easily sanitized.
 - Discourage children and adults from sharing items such as combs, brushes, jackets, and hats.
 - Maintain a separate container to store clothing and other personal items.
 - Keep changes of clothing on hand and store soiled items in a nonabsorbent container that can be sanitized or discarded after use.
 - Provide a separate sleeping area and bedding for each child, and wash bedding frequently.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Cases or suspected cases of illness considered being **public health emergencies, outbreaks, exotic diseases**, and unusual group expressions of disease must be reported to the local health department or DSHS **immediately**. Other diseases for which there must be a quick public health response must be reported **within one working day**.

Local and Regional Reporting and Follow-up Responsibilities

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>

- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request.
 - Information needed from requestor: name, email address, and agency name.
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

Real time RT-PCR for norovirus is available at the DSHS laboratory for clinical specimen testing. Coordinate shipping, specimen submission, and testing of specimens with EAIDB and the DSHS laboratory staff. Specimens should not be submitted to the DSHS laboratory unless approved by EAIDB. Contact an EAIDB foodborne epidemiologist to discuss further.

CLINICAL SPECIMENS

Specimen Collection

- Only raw stool is accepted for norovirus testing.
- Transport temperature: 2-8°C (ice pack).
- Transport time: as soon as possible.

Submission Form

- Use the DSHS Laboratory G-2B form for specimen submission.
 - Select appropriate test:
 - Molecular Studies
 - Check “PCR” and “Norovirus”.
 - Check “Outbreak association” and write in name of outbreak, (bottom of Section 2).
 - Payor source
 - Check “IDEAS” to avoid bill for submitter.

Specimen Shipping

- Transport temperature: 2-8°C (ice pack)
- Transport time: as soon as possible.
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

ENVIRONMENTAL AND FOOD SAMPLES

- Testing of food or other environmental specimens is generally NOT done for norovirus outbreaks, because appropriate laboratory protocols are not available.
 - Food testing is not routine, except for shellfish (by FDA).
 - Detection in water and other food items requires special protocols; if indicated, EAIDB will call CDC or FDA to discuss further.

UPDATES

January 2016

- Added an Exclusion sub-section to address child-care/school and food employee exclusions. The food employee exclusions reflect the New Texas Food Establishment Rules (TFER) which went into effect on October 11, 2015.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.

Novel Coronavirus rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Coronaviruses are named for the crown-like spikes on their surface. There are four main sub-groupings of coronaviruses - alpha, beta, gamma and delta. Human coronaviruses were first identified in the mid-1960s. The six coronaviruses that can infect people are alpha coronaviruses 229E and NL63, and beta coronaviruses OC43, HKU1, severe acute respiratory syndrome coronavirus (SARS-CoV) and Middle East Respiratory Syndrome coronavirus (MERS-CoV). Both SARS-CoV and MERS-CoV are considered new coronaviruses: the first known SARS-CoV illness occurred in 2002 and MERS-CoV was identified in 2012. Both novel coronaviruses cause acute severe respiratory illness. Since 2004, there have not been any known cases of SARS reported anywhere in the world.

Transmission

Studies have been conducted to determine the transmission of SARS-CoV. The studies suggest that the most likely modes of transmission for SARS-CoV are droplet and direct person-to-person contact. However, there is evidence that indirect contact and aerosol spread also exist. MERS-CoV has been spread from ill people to others through close contact, such as caring for or living with an infected person. Infected people have spread MERS-CoV to others in healthcare settings, such as hospitals. There has been limited spread of MERS-CoV from person to person.

Incubation Period

The incubation period of a novel coronavirus causing severe acute respiratory disease depends on the type of novel coronavirus. The incubation period for SARS is estimated to be 1 to 14 days with a median of 4 to 5 days. The incubation period for MERS is usually 5 or 6 days, but it can range from 2 to 14 days.

Communicability

The period of communicability for the novel coronaviruses causing severe respiratory disease, SARS-CoV and MERS-CoV, is not completely understood. For SARS-CoV, epidemiologic and virologic studies and clinical follow-up during the 2003 epidemic indicated that transmission does not occur before the onset of clinical signs and symptoms and the maximum period of communicability is less than 21 days. The period of communicability of MERS-CoV is unknown.

Clinical Illness

The two novel coronaviruses, SARS-CoV and MERS-CoV, can cause acute respiratory illness. SARS-CoV caused severe acute respiratory syndrome or SARS, a respiratory illness that mostly affected adults. Typical symptoms included fever, myalgia, headache, malaise and chills followed by a nonproductive cough and dyspnea generally 5 to 7 days later. It also caused diarrhea in approximately 10%-20% of the cases. SARS had a mortality rate of 10% with a case fatality rate approaching 50% in people who were 60 years of age and older.

MERS-CoV causes Middle East Respiratory Syndrome or MERS, a severe acute respiratory illness. Typical symptoms include fever, cough and shortness of breath. Some people may develop gastrointestinal symptoms including diarrhea or nausea/vomiting. For many people with MERS, more severe complications follow, such as pneumonia and kidney failure. About 3-4 out of every 10 people reported with MERS have died. Most MERS-related deaths have been in persons with underlying health conditions such as diabetes or cancer.

DEFINITIONS

Case definitions for novel coronaviruses evolve as clinical and epidemiologic information on these viruses changes. Please refer to the novel coronavirus information on CDC's website for the most recent definitions. The CDC MERS-CoV case definitions may be found here:

<http://www.cdc.gov/coronavirus/mers/case-def.html>.

Clinical Case Definition

Limited data on the clinical presentation of MERS are available; most published clinical information to date is from critically ill patients. At hospital admission, common signs and symptoms include fever, chills/rigors, headache, non-productive cough, dyspnea and myalgia. Other symptoms can include sore throat, coryza, sputum production, dizziness, nausea and vomiting, diarrhea and abdominal pain. Atypical presentations including mild respiratory illness without fever and diarrheal illness preceding development of pneumonia have been reported. Clinical judgment should be used to guide testing of patients for MERS-CoV infection. Healthcare providers should maintain awareness of the need to detect patients who should be evaluated for Middle East Respiratory Syndrome Coronavirus (MERS-CoV) infection; this requires clinical judgment as information on modes of transmission of MERS-CoV, and clinical presentation of MERS, is limited and continues to evolve.

Laboratory Confirmation

- Identification of a novel coronavirus that is different from currently circulating human coronaviruses as confirmed by CDC's laboratory, by public health laboratories using CDC-approved protocols for a specific novel strain or by labs using an FDA-approved test for a specific novel strain
- Confirmatory laboratory testing requires a positive PCR on at least two specific genomic targets or a single positive target with sequencing on a second.
- Other laboratory confirmation criteria may be defined by CDC for the specific novel coronavirus.

Case Classifications

- **Confirmed:** A confirmed case is a person with laboratory confirmation of MERS-CoV infection.
- **Probable:** A probable case is a Patient Under Investigation (PUI) with absent or inconclusive laboratory results for MERS-CoV infection who is a close contact¹ of a laboratory-confirmed MERS-CoV case. Examples of laboratory results that may be considered inconclusive include a positive test on a single PCR target, a positive test with an assay that has limited performance data available, or a negative test on an inadequate specimen.
- **Suspect (Patient Under Investigation [PUI]):** A person who has both clinical features and an epidemiologic risk should be considered a Patient Under Investigation (PUI) based on one of the following scenarios:
 - Fever² AND pneumonia or acute respiratory distress syndrome (based on clinical or radiological evidence) AND EITHER:
 - A history of travel from countries in or near the Arabian Peninsula³ within 14 days before symptom onset, **OR**
 - Close contact with a symptomatic traveler who developed fever and acute respiratory illness (not necessarily pneumonia) within 14 days after traveling from countries in or near the Arabian Peninsula **OR**
 - 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-CoV is being evaluated, in consultation with state and local health departments.
 - OR**
 - Fever AND symptoms of respiratory illness (not necessarily pneumonia; e.g., cough, shortness of breath) AND a history of being in a healthcare facility (as a patient, worker or visitor) within 14 days before symptom onset in a country or territory in or near the Arabian Peninsula in which recent healthcare-associated cases of MERS have been identified.
 - OR**
 - Fever OR symptoms of respiratory illness (not necessarily pneumonia; e.g., cough, shortness of breath) AND close contact with a confirmed MERS case while the case was ill.

The above criteria serve as guidance for testing; however, patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain history of health care exposure).

Footnotes:

¹ Close contact is defined as a) being within approximately 6 feet (2 meters), or within the room or care area, of a confirmed MERS case for a prolonged period of time (such as caring for, living with, visiting, or sharing a healthcare waiting area or room with, a confirmed MERS case) while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); or b) having direct contact with infectious secretions of a confirmed MERS case (e.g., being coughed on) while not wearing recommended personal protective equipment. Data to inform the definition of close contact are limited; considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with MERS (e.g., coughing likely increases exposure risk). Transient interactions, such as walking by a person with MERS, are not thought to constitute an exposure; however, final determination should be made in consultation with public health authorities. For guidance on recommended PPE please see [Interim Infection Prevention and Control Recommendations for Hospitalized Patients with Middle East Respiratory Syndrome Coronavirus \(MERS-CoV\)](#).

²Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations.

³Countries considered in the Arabian Peninsula and neighboring include: Bahrain; Iraq; Iran; Israel, the West Bank, and Gaza; Jordan; Kuwait; Lebanon; Oman; Qatar; Saudi Arabia; Syria; the United Arab Emirates (UAE); and Yemen.

Note: CDC may require that patients undergo testing for alternate causes of infection including all clinically indicated tests for community acquired pneumonia, before being considered a probable or suspect case.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of novel coronavirus including SARS and MERS. Investigations should include an interview of the case or surrogate to obtain a detailed exposure history. The current investigation form is the Middle East Respiratory Syndrome (MERS) Patient Under Investigation (PUI) Short Form available at <http://www.dshs.texas.gov/idcu/investigation/>. Completion of a more detailed investigation form may be required for probable or confirmed cases or in the event of an outbreak or other special situation. This more detailed investigation form will be provided by DSHS, if needed.

Suspect (Patient Under Investigation [PUI]) Case Investigation Checklist

- ☐ Any suspected novel coronavirus case should be investigated immediately.
- ☐ Ensure that appropriate control measures have been implemented (see Prevention and Control Measures, below). If the patient is under evaluation for MERS-CoV (e.g., differential diagnosis includes MERS-CoV, healthcare provider is requesting testing for MERS-CoV, etc.), then MERS-CoV control measures should be implemented.
- ☐ Determine whether the patient meets the case definition.
 - Obtain medical records, interview the suspected case-patient or surrogate and interview the patient's healthcare provider.
- ☐ Notify DSHS immediately of suspect (PUI) cases of novel coronavirus.
- ☐ Collect and ship specimens to the DSHS laboratory or another public health laboratory qualified to perform novel coronavirus testing using CDC-approved protocols for a specific novel strain.
 - Inform the testing laboratory (i.e., DSHS or a qualified Laboratory Response Network [LRN] lab) when specimens have been shipped and provide a shipment tracking number.
 - Note: Only persons who meet case definition or have been approved by the local health department epidemiologist or DSHS EAIDB will be tested for novel coronavirus.
 - If novel coronavirus testing is performed at a laboratory other than DSHS Austin, inform the Regional Health Department and DSHS EAIDB within 24 hours of initiating testing.
- ☐ For any patient who is tested for MERS-CoV, complete the novel coronavirus-specific PUI Short Form.
- ☐ Fax the completed PUI form to DSHS within 48 hours of testing.
- ☐ Suspect case investigations may be entered in the NEDSS Base System (NBS).

Confirmed/Probable Case Investigation Checklist

- ☐ Any confirmed or probable novel coronavirus cases should be investigated immediately.
- ☐ Ensure that appropriate control measures have been implemented (see Prevention and Control Measures, below).
- ☐ Confirm that laboratory results (if available) meet the case definition.
 - For confirmed cases, verify that the laboratory that performed the confirmatory testing is a public health laboratory using CDC-approved protocols for a specific novel strain.
- ☐ For probable cases, verify that epidemiologic linkages meet the case definition.
- ☐ Notify DSHS immediately of probable or confirmed cases of novel coronavirus.
- ☐ For probable cases, collect and ship specimens to the DSHS laboratory or another public health laboratory qualified to perform novel coronavirus testing using CDC-approved protocols for a specific novel strain.
 - Inform the testing laboratory (i.e., DSHS or a qualified LRN lab) when specimens have been shipped and provide a shipment tracking number.
 - Note: Only persons who meet case definition or have been approved by the local health department epidemiologist or DSHS EAIDB will be tested for novel coronavirus.
 - If novel coronavirus testing is performed at a laboratory other than DSHS Austin, inform the Regional Health Department and DSHS EAIDB within 24 hours of initiating testing.
- ☐ Complete the novel coronavirus-specific PUI Form using medical records and by interviewing the case-patient or surrogate to identify close contacts, risk factors, and other pertinent information.
 - Completion of a more detailed investigation form may be required and will be provided by DSHS, if needed.
- ☐ Identify close contacts and determine if secondary cases have occurred.
 - See the Contact Tracing section below.
 - Inform DSHS EAIDB immediately if the case-patient used public transportation (bus, train, airplane, ship, etc.) while symptomatic.
- ☐ Be prepared to enhance surveillance in the local area for respiratory illnesses and respiratory viruses, if requested by DSHS.
 - Refer to the *Public Health Preparedness, Surveillance, and Response Plan for Texas: Respiratory Viruses Having Pandemic Potential* for a list of responsibilities by department and program area, and for action triggers.
- ☐ If applicable, complete the steps in the Managing Special Situations section.
- ☐ Fax the novel coronavirus-specific PUI Form and other investigation forms (if provided) to DSHS. The PUI form must be faxed to DSHS within 48 hours of testing.

Confirmed and probable case investigations must be entered in the NEDSS Base System (NBS).

Prevention and Control Measures

Prevention and control guidelines for MERS are subject to change as disease knowledge evolves. Please refer to the CDC websites provided below for the most recent recommendations.

Healthcare Facilities and Healthcare Personnel

Please see “Interim Infection Prevention and Control Recommendations for Hospitalized Patients with Middle East Respiratory Syndrome Coronavirus (MERS-CoV)” available at <http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html>. These recommendations are intended for healthcare settings (excluding air or ground medical transport, and laboratory settings) and for healthcare personnel (HCP) who may come into contact with people confirmed to have, or being evaluated for, a novel coronavirus illness such as MERS. HCP refers to all persons, paid and unpaid, working in healthcare settings whose activities potentially place them at risk for exposures to a patient with MERS-CoV. Examples of such activities include those that require direct contact with patients and exposure to the patient-care environment.

To complement the guidance below, CDC has developed two checklists that identify key actions that can be taken to enhance preparedness for MERS-CoV infection control:

- Healthcare Provider Preparedness Checklist:
<http://www.cdc.gov/coronavirus/mers/preparedness/checklist-provider-preparedness.html>
- Healthcare Facility Preparedness Checklist:
<http://www.cdc.gov/coronavirus/mers/preparedness/checklist-facility-preparedness.html>

Infection Control Recommendations

- Minimize Chance for Exposures
Ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including MERS-CoV. Measures should be implemented before patient arrival, upon arrival, and throughout the duration of the affected patient’s presence in the healthcare setting.
- Before Arrival
 - When scheduling appointments, instruct patients and persons who accompany them to call ahead or inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever) and to take appropriate preventive actions (e.g., wear a facemask upon entry to contain cough, follow triage procedure).
- Upon Arrival and During the Visit
 - Take steps to ensure all persons with symptoms of a respiratory infection adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit. Consider posting visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use facemasks or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.
 - Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible. If available, facilities may wish to place these patients in a separate area while waiting for care.

- Ensure rapid triage and isolation of patients who might have MERS-CoV infection
 - Identify patients at risk for having MERS-CoV infection before or immediately upon arrival to the hospital
 - Implement triage procedures to detect patients at risk for having MERS-CoV infections during or before patient triage or registration (e.g., at the time of patient check-in) and ensure that all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of MERS-CoV or contact with possible MERS-CoV patients. See the “Interim Guidance for Healthcare Professionals” (<http://www.cdc.gov/coronavirus/mers/interim-guidance.html>) for which patients to evaluate for MERS-CoV.
 - Immediately isolate those identified as at risk for having MERS-CoV infection
 - Implement Respiratory Hygiene and Cough Etiquette (i.e., placing a facemask over the patient's nose and mouth) and isolate those at risk for MERS-CoV infection in an Airborne Infection Isolation Room (AIIR). See recommendations for “Patient Placement” below. Additional guidance for evaluating patients in U.S. for MERS-CoV infection can be found at the CDC [Middle East Respiratory Syndrome \(MERS\) website](#).
- Provide supplies to perform hand hygiene to all patients upon arrival to facility (e.g., at entrances of facility, waiting rooms, at patient check-in) and throughout the entire duration of the visit to the healthcare setting.
- Ensure Adherence to Standard, Contact and Airborne Precautions

Standard precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of standard precautions that apply to patients with respiratory infections, including those caused by MERS-CoV, are summarized below. Attention should be paid to training and proper donning, doffing and disposal of any personal protective equipment. All aspects of standard precautions (e.g., injection safety) are not emphasized in this document but can be found in the guideline titled Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. All HCP who enter the room of a patient with suspected or confirmed MERS-CoV should adhere to Standard, Contact, and Airborne precautions, including the following:
- Hand Hygiene
 - HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene in healthcare settings can be performed by washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled, use soap and water, not alcohol-based hand rubs. Healthcare facilities should ensure that facilities and supplies for performing hand hygiene are readily available to all personnel.

- Personal Protective Equipment

Employers should select appropriate PPE and provide it to workers in accordance with OSHA's PPE standards (29 CFR 1910 Subpart I). Workers must receive training on and demonstrate an understanding of when to use PPE; what PPE is necessary; how to properly don (put on), use, doff (take off) PPE; how to properly dispose of or disinfect and maintain PPE; and the limitations of PPE. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.

 - Gloves
 - Put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated.
 - Remove and discard gloves immediately upon leaving the patient room or care area. Please see section below on "Using More than one Kind of Personal Protective Equipment (PPE)" for recommended sequence of PPE removal.
 - Gowns
 - Put on a clean disposable gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown immediately upon leaving the patient room or care area.
 - Respiratory Protection
 - Use respiratory protection (i.e., a respirator) that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator upon entry to the patient room or care area.
 - The respirator should be the last part of the PPE ensemble to be removed. If reusable respirators are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. If disposable respirators are used, they should be removed and discarded after leaving the patient room or care area and closing the door.
 - Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard ([29 CFR 1910.134](#)). Staff should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
 - More information on respirators and facemasks is available in Appendix A of CDC's Interim Infection Prevention guidance for MERS-CoV: <http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html>
 - Eye Protection
 - Put on eye protection (e.g., a disposable face shield) upon entry to the patient room or care area. Remove and discard eye protection immediately upon leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
 - Using More than one Kind of Personal Protective Equipment (PPE)
 - Different types of PPE are used together to prevent multiple routes of transmission.
 - The following sequence is a general approach to putting on this PPE combination for respiratory pathogens: first gown; then respirator; then goggles or face shield; then gloves.

- The following sequence is a general approach to removing PPE for respiratory pathogens: first gloves; then goggles or face shield; then gown; then respirator.
 - Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing door.
 - Careful attention should be given to prevent contamination of clothing and skin during the process of removing PPE.
 - Perform hand hygiene as described above immediately before putting on and after removing all PPE.
- Patient Placement
 - Place a patient who might be infected with MERS-CoV in an Airborne Infection Isolation Room (AIIR) that has been constructed and maintained in accordance with current guidelines.
 - AIIRs are single patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.
 - If an AIIR is not available, the patient should be transferred as soon as is feasible to a facility where an AIIR is available. Pending transfer, place a facemask on the patient and isolate him/her in an examination room with the door closed. The patient should not be placed in any room where room exhaust is recirculated without high-efficiency particulate air (HEPA) filtration.
 - Once in an AIIR, the patient's facemask may be removed; the facemask should remain on if the patient is not in an AIIR. Limit transport and movement of the patient outside of the AIIR to medically-essential purposes. When outside of the AIIR, patients should wear a facemask to contain secretions.
 - Only essential personnel should enter the AIIR. Implement staffing policies to minimize the number of HCP who enter the room.
 - Facilities should consider caring for these patients with dedicated HCP to minimize risk of transmission and exposure to other patients and other HCP.
 - Facilities should keep a log of all persons who care for OR enter the rooms or care area of these patients.
 - Once the patient vacates a room, unprotected individuals, including HCP, should not be allowed in that room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. More information on clearance rates under differing ventilation conditions is available here: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e%20-%20tab1. In addition, the room should undergo appropriate cleaning and surface disinfection before unprotected individuals are allowed to reenter it.

- Use Caution When Performing Aerosol-Generating Procedures
 - Some procedures performed on MERS-CoV patients may be more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing. These procedures potentially put HCP and others at an increased risk for MERS-CoV exposure. Although not quantified, procedures that might post such a risk include: cough-generating procedures, bronchoscopy, sputum induction, intubation and extubation cardiopulmonary resuscitation, and open suctioning of airways.
 - Ideally, a combination of measures should be used to reduce exposures from these aerosol-generating procedures when performed on patients with suspected or confirmed MERS-CoV. Precautions for aerosol-generating procedures include:
 - Only performing these procedures if they are medically necessary and cannot be postponed.
 - Limiting the number of HCP present during the procedure to only those essential for patient care and support.
 - Conducting the procedures in an AIIR when feasible. Such rooms are designed to reduce the concentration of infectious aerosols and prevent their escape into adjacent areas using controlled air exchanges and directional airflow.
 - HCP should wear gloves, a gown, and either a face shield that fully covers the front and sides of the face or goggles, and respiratory protection at least as protective as an N95 filtering face piece respirator during aerosol-generating procedures.
 - Unprotected HCP should not be allowed in a room where an aerosol-generating procedure has been conducted until sufficient time has elapsed to remove potentially infectious particles. More information on [clearance rates under differing ventilation conditions](#) is available.
 - Conduct environmental surface cleaning following procedures described in the section on environmental infection control below.
- Duration of Infection Control Precautions
 - At this time, information is lacking to definitively determine a recommended duration for keeping patients in isolation precautions.
 - Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.
 - Factors that should be considered include: presence of symptoms related to MERS-CoV, date symptoms resolved, other conditions that would require specific precautions (e.g., tuberculosis, *Clostridium difficile*) and available laboratory information.
- Manage Visitor Access and Movement Within the Facility
- Establish procedures for monitoring, managing and training visitors.
- All visitors should follow respiratory hygiene and cough etiquette precautions while in the common areas of the facility.
- Restrict visitors from entering the MERS-CoV patient's room. Facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's emotional well-being and care.
- Visitors who have been in contact with the patient before and during hospitalization are a possible source of MERS-CoV for other patients, visitors, and staff.

- Visitors to MERS-CoV patients should be scheduled and controlled to allow for:
 - Screening visitors for symptoms of acute respiratory illness before entering the hospital.
 - Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for MERS-CoV) and ability to comply with precautions.
 - Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient's room.
 - Facilities should maintain a record (e.g., log book) of all visitors who enter patient rooms.
 - Visitors should not be present during aerosol-generating procedures.
 - Visitors should be instructed to limit their movement within the facility.
 - Exposed visitors (e.g., contact with symptomatic MERS-CoV patient prior to admission) should be advised to report any signs and symptoms of acute illness to their health care provider for a period of at least 14 days after the last known exposure to the sick patient.
- Implement Engineering Controls
- Consider designing and installing engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include physical barriers or partitions to guide patients through triage areas, curtains between patients in shared areas, closed suctioning systems for airway suctioning for intubated patients, as well as appropriate air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are installed and properly maintained.
- Monitor and Manage Ill and Exposed Healthcare Personnel
- HCP who care for patients with MERS-CoV should be monitored. They should immediately report any signs (e.g., fever) or symptoms (e.g., cough, shortness of breath) of acute illness to their supervisor or a facility designated person (e.g., occupational health services) for a period of 14 days after the last known contact with a MERS CoV patient, regardless of their use of PPE.
- HCP who develop any respiratory symptoms after an unprotected exposure (i.e., not wearing recommended PPE at the time of contact) to a patient with MERS-CoV should not report for work or should immediately stop working. These HCP should notify their supervisor, implement respiratory hygiene and cough etiquette, seek prompt medical evaluation, and comply with work exclusion until they are no longer deemed infectious to others.
- For asymptomatic HCP who have had an unprotected exposure (i.e., not wearing recommended PPE at the time of contact) to a patient with MERS-CoV, exclude from work for 14 days to monitor for signs and symptoms of respiratory illness and fever¹.
 - If necessary to ensure adequate staffing of the facility, the asymptomatic provider could be considered for continuing patient care duties after discussion with local, state, and federal public health authorities.
- Facilities and organizations providing healthcare should:
 - Implement sick leave policies for HCP, including contract staff and part-time personnel, that are non-punitive, flexible and consistent with public health guidance (e.g., policies should ensure ill HCP who may have MERS-CoV infection stay home, unless hospital admission for isolation and treatment is recommended).
 - Ensure that all HCP are aware of the sick leave policies.
- Provide employee health services that:
 - Ensure that HCP have ready access, including via telephone, to medical consultation and, if needed, prompt treatment.
- Train and Educate Healthcare Personnel

- Provide all HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- HCP must be medically cleared, trained, and fit tested for respiratory protection device use (e.g., N95 filtering facepiece respirators), or medically cleared and trained in the use of an alternative respiratory protection device (e.g., Powered Air-Purifying Respirator, PAPR) whenever respirators are required. OSHA has a number of respiratory training videos (https://www.osha.gov/SLTC/respiratoryprotection/training_videos.html).
- Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.
- Implement Environmental Infection Control
- Ensure that cleaning and disinfection procedures are followed consistently and correctly.
- Standard cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for MERS-CoV in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed. If there are no available EPA-registered products that have a label claim for MERS-CoV, products with label claims against human coronaviruses should be used according to label instructions. Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
 - Detailed information on environmental infection control in healthcare settings can be found in CDC's "Guidelines for Environmental Infection Control in Health-Care Facilities" (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm>) and "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" [section IV.F. Care of the environment] (http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html).
- Establish Reporting within Hospitals and to Public Health Authorities
 - Implement mechanisms and policies that promptly alert key facility staff including infection control, healthcare epidemiology, hospital leadership, occupational health, clinical laboratory, and frontline staff about suspected or known MERS-CoV patients.
 - Communicate and collaborate with public health authorities.
 - Promptly notify public health authorities of suspected or known patients with MERS-CoV.
 - Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.

Laboratory Settings

Laboratory workers should follow the guidelines in the CDC's "Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Middle East Respiratory Syndrome Coronavirus (MERS-CoV) – Version 2", available at <http://www.cdc.gov/coronavirus/mers/guidelines-lab-biosafety.html>.

General Guidelines (for working with potentially infectious materials)

- Laboratory workers should wear personal protective equipment (PPE) which includes disposable gloves, laboratory coat/gown, respirator, and eye protection when handling potentially infectious specimens.
- Acceptable respiratory protection devices include: a properly fit-tested, NIOSH-approved filtering facepiece respirator (N-95 or higher level) or a powered air-purifying respirator

(PAPR) equipped with high-efficiency particulate air (HEPA) filters. Accurate fit-testing is a key component of a respiratory protection program (RPP) and will assist with effective respirator use. An RPP includes medical clearance, training, fit-testing, and fit-checking to ensure appropriate respiratory selection and use. To be effective, respirators must provide a proper sealing surface on the wearer's face. Personnel who cannot wear fitted respirators because of facial hair or other fit limitations should wear loose-fitting hooded or helmeted PAPRs. See detailed information on a respiratory protection program [here](https://www.osha.gov/SLTC/etools/respiratory/) <https://www.osha.gov/SLTC/etools/respiratory/>.

- Any procedure with the potential to generate fine-particulate aerosols (e.g., vortexing or sonication of specimens in an open tube) should be performed in a Class II Biological Safety Cabinet (BSC). Appropriate physical containment devices (e.g., centrifuge safety buckets; sealed rotors) should be used for centrifugation. Ideally, rotors and buckets should be loaded and unloaded in a BSC. Perform any procedures outside a BSC in a manner that minimizes the risk of exposure to an inadvertent sample release.
- After specimens are processed, decontaminate work surfaces and equipment with appropriate disinfectants. Use any EPA-registered hospital disinfectant. Follow manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling.
- Autoclave all disposable waste.

Specific Guidelines

- The following activities may be performed in BSL-2 facilities using standard BSL-2 work practices:
 - Pathologic examination and processing of formalin-fixed or otherwise inactivated tissues
 - Molecular analysis of extracted nucleic acid preparations
 - Electron microscopic studies with glutaraldehyde-fixed grids
 - Routine examination of bacterial and mycotic cultures
 - Routine staining and microscopic analysis of fixed smears
 - Final packaging of specimens for transport to diagnostic laboratories for additional testing. Specimens should already be in a sealed, decontaminated primary container.
 - Inactivated specimens (e.g., specimens in nucleic acid extraction buffer)
- The following activities involving manipulation of potentially infected specimens should be performed as above and in a Class II BSC:
 - Aliquoting and/or diluting specimens
 - Inoculating bacterial or mycological culture media
 - Performing diagnostic tests that do not involve propagation of viral agents in vitro or in vivo
 - Nucleic acid extraction procedures involving potentially infected specimens
 - Preparation and chemical- or heat-fixing of smears for microscopic analysis
- The following activities must be performed in a BSL-3 facility using BSL-3 work practices:
 - MERS-CoV propagation in cell culture
 - Initial characterization of viral agents recovered in cultures of MERS-CoV specimens
- The following activities must be performed in Animal BSL-3 facilities using Animal BSL-3 work practices:
 - Inoculation of animals for potential recovery of virus from MERS-CoV samples
 - Protocols involving animal inoculation for characterization of putative MERS-CoV agents

Clinical Laboratory Testing

- Clinical laboratories performing routine hematology, urinalysis, and clinical chemistry studies, and microbiology laboratories performing diagnostic tests on serum, blood, or urine specimens should follow standard laboratory practices, including Standard Precautions, when handling potential MERS-CoV specimens. For additional information, see [Biosafety in Microbiological and Biomedical Laboratories \(BMBL\) - Fifth Edition](#) (page 225).

Packing, Shipping and Transport

- Follow IATA Dangerous Goods Regulations for packaging, shipping and transport of specimens from suspect cases of MERS-CoV infection.
- Follow shipping regulations for UN 3373 Biological Substance, Category B when sending potential MERS-CoV specimens.
- More packaging resources (checklist, packing instructions, labels, and packaging schematic) can be found at <http://www.cdc.gov/coronavirus/mers/guidelines-lab-biosafety.html>.

Air or Ground Medical Transport

Air medical transport (AMT) service providers transporting MERS patients should follow the guidance at <http://www.cdc.gov/coronavirus/mers/hcp/air-transport.html>.

CDC has not written emergency medical services (EMS) or first responder ground transport guidelines specifically for MERS; however, the guidance in CDC's "Infection Control for Prehospital Emergency Medical Services (EMS)" guidance for Severe Acute Respiratory Syndrome (SARS) (<http://www.cdc.gov/sars/guidance/I-infection/prehospital.html>) can be adapted for MERS, with the **addition of airborne precautions**. See AMT guidance above for more information on cleaning and disinfection.

Confirmed, Probable or Suspected (PUI) Case-Patients

People who are confirmed to have, or being evaluated for, MERS-CoV infection and do not require hospitalization for medical reasons may be cared for and isolated in a residential setting after a healthcare professional determines that the setting is suitable.

- To assess the suitability of the home setting, see <http://www.cdc.gov/coronavirus/mers/hcp/home-care.html>.
- Providers should contact their state or local health department to discuss home isolation, home quarantine, or other measures for close contacts, especially for patients who test positive for MERS-CoV, and to discuss criteria for discontinuing any such measures.
- See [Interim Guidance for Health Professionals](#) for more information.
- Provide guidance below on "Preventing MERS-CoV from Spreading to Others in Homes and Communities" (<http://www.cdc.gov/coronavirus/mers/hcp/home-care-patient.html>) to anyone confirmed to have, or being evaluated for, MERS-CoV infection who will be cared for and isolated in a residential setting, <http://www.cdc.gov/coronavirus/mers/hcp/home-care-patient.html>

The following prevention steps are recommended for people confirmed to have MERS-CoV infection who can receive care at home and do not need to be hospitalized for medical reasons; people being evaluated by a healthcare provider for MERS-CoV infection; caregivers and household members of a person confirmed to have, or being evaluated for, MERS-CoV infection; and other people who have had close contact with a person confirmed to have, or being evaluated for, MERS-CoV infection:

Note: If you are confirmed to have, or being evaluated for, MERS-CoV infection you should follow the prevention steps below until a healthcare provider or local or state health department says you can return to your normal activities.

- Stay home
 - You should restrict activities outside your home, except for getting medical care. Do not go to work, school, or public areas, and do not use public transportation or taxis.
- Separate yourself from other people in your home
 - As much as possible, you should stay in a different room from other people in your home. Also, you should use a separate bathroom, if available.
- Call ahead before visiting your doctor
 - Before your medical appointment, call the healthcare provider and tell him or her that you have, or are being evaluated for, MERS-CoV infection. This will help the healthcare provider's office take steps to keep other people from getting infected.
- Wear a facemask
 - You should wear a facemask when you are in the same room with other people and when you visit a healthcare provider. If you cannot wear a facemask, the people who live with you should wear one while they are in the same room with you.
- Cover your coughs and sneezes
 - Cover your mouth and nose with a tissue when you cough or sneeze, or you can cough or sneeze into your sleeve. Throw used tissues in a lined trash can, and immediately wash your hands with soap and water.
- Wash your hands
 - Wash your hands often and thoroughly with soap and water. You can use an alcohol-based hand sanitizer if soap and water are not available and if your hands are not visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid sharing household items
 - You should not share dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items with other people in your home. After using these items, you should wash them thoroughly with soap and water.
- Monitor your symptoms
 - Seek prompt medical attention if your illness is worsening (e.g., difficulty breathing). Before going to your medical appointment, call the healthcare provider and tell him or her that you have, or are being evaluated for, MERS-CoV infection. 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.

Caregivers and Household Members

<http://www.cdc.gov/coronavirus/mers/hcp/home-care-patient.html>

- The following prevention steps are recommended for anyone who lives with or provides care at home for a person confirmed to have, or being evaluated for, a novel coronavirus infection such as MERS-CoV infection:
- Make sure that you understand and can help the person follow the healthcare provider's instructions for medication and care. You should help the person with basic needs in the home and provide support for getting groceries, prescriptions, and other personal needs.

- Have only people in the home who are essential for providing care for the person.
 - Other household members should stay in another home or place of residence. If this is not possible, they should stay in another room or be separated from the person as much as possible. Use a separate bathroom, if available.
 - Restrict visitors who do not have an essential need to be in the home.
 - Keep elderly people and those who have compromised immune systems or certain health conditions away from the person. This includes people with chronic heart, lung or kidney conditions and diabetes.
- Make sure that shared spaces in the home have good air flow, such as by an air conditioner or an opened window, weather permitting.
- Wash hands often and thoroughly with soap and water, or with an alcohol-based hand sanitizer if hands are not visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.
- Wear a disposable facemask, gown, and gloves when you touch or have contact with the person's blood, body fluids and/or secretions, such as sweat, saliva, sputum, nasal mucus, vomit, urine or diarrhea.
 - Throw out disposable facemasks, gowns, and gloves after using them. Do not reuse them.
 - Wash your hands immediately after removing your facemask, gown and gloves.
- Avoid sharing household items.
 - Do not share dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items with a person who is confirmed to have, or being evaluated for, a novel coronavirus infection such as MERS-CoV infection. After the person uses these items, he or she should be wash them thoroughly (see below "Wash laundry thoroughly").
- Clean all "high-touch" surfaces, such as counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets and bedside tables, every day. Also, clean any surfaces that may have blood, body fluids and/or secretions or excretions on them.
 - Read label of cleaning products and follow recommendations provided on product labels.
 - Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves or aprons and making sure you have good ventilation during use of the product.
 - Use a diluted bleach solution or a household disinfectant with a label that says "EPA-approved."
 - To make a bleach solution at home, add 1 tablespoon of bleach to 1 quart (4 cups) of water. For a larger supply, add ¼ cup of bleach to 1 gallon (16 cups) of water.
- Wash laundry thoroughly.
 - Immediately remove and wash clothes or bedding that have blood, body fluids and/or secretions or excretions on them.
 - Wear disposable gloves while handling soiled items. Wash hands immediately after removing your gloves.
 - Read and follow directions on labels of laundry or clothing items and detergent. In general, wash and dry with the warmest temperatures recommended on the clothing label.
- Place all used gloves, gowns, facemasks, and other contaminated items in a lined container before disposing them with other household waste. Wash hands immediately after handling these items.

- Monitor the person's symptoms. If he or she is getting sicker, call his or her medical provider and tell him or her that the person has, or is being evaluated for a novel coronavirus infection. This will help the healthcare provider's office take steps to keep other people from getting infected. Ask the healthcare provider to call the local or state health department.
- Caregivers and household members who do not follow precautions when in close contact³ with a person who is confirmed to have, or being evaluated for, a novel coronavirus infection, are considered "close contacts" and should monitor their health. Follow the prevention steps for close contacts below.

Close Contacts

<http://www.cdc.gov/coronavirus/mers/hcp/home-care-patient.html>

The following prevention steps are recommended for anyone who has had close contact with someone who is confirmed to have, or being evaluated for, a novel coronavirus infection:

- Monitor your health starting from the day you were first exposed to the person and continue for 14 days after you were last exposed to the person. Watch for these signs and symptoms:
 - Fever. 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, follow the prevention steps described above for Confirmed, Probable or Suspected (PUI) Case-Patients, and call your healthcare provider as soon as possible.
 - Before going to 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.

If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.

Travelers to the Arabian Peninsula and Airline Crew

<http://wwwnc.cdc.gov/travel/notices/alert/coronavirus-saudi-arabia-qatar>

- General prevention measures for all travelers:
 - Wash your hands often with soap and water. If soap and water are not available, use an alcohol-based hand sanitizer.
 - Avoid touching your eyes, nose, and mouth. Germs spread this way.
 - Avoid close contact with sick people.
 - Be sure you are up-to-date with all of your shots, and if possible, see your health care provider at least 4–6 weeks before travel to get any additional shots.
 - Visit CDC's Travelers' Health website (<http://wwwnc.cdc.gov/travel/>) for more information on healthy travel.
 - CDC does not recommend that travelers change their plans because of MERS. Most instances of person-to-person spread have occurred in health care workers and other close contacts (such as family members and caregivers) of people sick with MERS. If you are concerned about MERS, you should discuss your travel plans with your doctor.

- Travelers who are ill:
 - Cover your mouth with a tissue when you cough or sneeze, and throw the tissue in the trash.
 - Avoid contact with other people to keep from infecting them. This might mean delaying your travel until you are well.
 - Call a doctor if you develop a fever and symptoms of lower respiratory illness, such as cough or shortness of breath, within 14 days after traveling from countries in or near the Arabian Peninsula⁴. You should tell the doctor about your recent travel before you go in for an appointment.
 - Tell people who have been in close contact with you to monitor their health for 14 days after the last time they were around you.
 - They should call a doctor and tell them about your illness and travel history and their current symptoms.
 - If you get sick while you are traveling, see “Getting Health Care Abroad” (<http://wwwnc.cdc.gov/travel/page/getting-health-care-abroad>) for information about how to locate medical services overseas.
- Persons considering exposure or exposed to camels during travel:
 - The MERS virus has been found in some camels, and some MERS patients have reported contact with camels. However, we do not know exactly how people become infected with the virus - many people with MERS have had close contact with a person sick with MERS.
 - The World Health Organization (WHO) has posted a general precaution for anyone visiting farms, markets, barns, or other places where animals are present. Travelers should practice general hygiene measures, including regular hand washing before and after touching animals, and avoid contact with sick animals. Travelers should also avoid consumption of raw or undercooked animal products. For more information, see http://www.who.int/csr/disease/coronavirus_infections/faq/en/.
 - The WHO considers certain groups to be at high risk for severe MERS; these groups include people with diabetes, kidney failure, or chronic lung disease and people who have weakened immune systems. The WHO recommends that these groups take additional precautions (for more information see http://www.who.int/csr/disease/coronavirus_infections/MERS_CoV_RA_20140613.pdf?ua=1):
 - Avoid contact with camels.
 - Do not drink raw camel milk or raw camel urine.
 - Do not eat undercooked meat, particularly camel meat.
- Healthcare workers
 - People who are traveling to provide health care services in the Arabian Peninsula should review [CDC’s recommendations for infection control of confirmed or suspected MERS cases](#).
- Airline crew (<http://www.cdc.gov/quarantine/air/managing-sick-travelers/mers-airline-crew.html>)
 - Please follow your company's policy for personal protection.
 - Please report to CDC ill travelers (with symptoms below) arriving from the Republic of Korea or countries in and near the Arabian Peninsula.
 - Report to CDC if the ill person:
 - Feels warm to the touch, gives a history of feeling feverish, or has an actual measured temperature of 100° F (37.8° C) or higher, **PLUS**
 - Has a cough or difficulty breathing.

- Please report as soon as possible - before arrival - by one of the methods described in the “Guidance for Airlines on Reporting Onboard Deaths or Illnesses to CDC” (<http://www.cdc.gov/quarantine/air/reporting-deaths-illness/guidance-reporting-onboard-deaths-illnesses.html>).
- CDC will update the airline about the results of the testing and any need for follow-up or treatment of exposed crew members or passengers.

General Population

- CDC advises that people follow prevention steps to help reduce their risk of getting infected with respiratory viruses, like MERS-CoV:
 - Wash your hands often with soap and water for 20 seconds, and help young children do the same. If soap and water are not available, use an alcohol-based hand sanitizer.
 - Cover your nose and mouth with a tissue when you cough or sneeze, then throw the tissue in the trash.
 - Avoid touching your eyes, nose and mouth with unwashed hands.
 - Avoid personal contact, such as kissing, or sharing cups or eating utensils, with sick people.
 - Clean and disinfect frequently touched surfaces such as toys and doorknobs.
- You are not considered to be at risk for MERS-CoV infection if you have not had close contact with someone who is confirmed to have, or being evaluated for, MERS-CoV infection.
- If you are caring for or living with a person confirmed to have, or being evaluated for, MERS-CoV infection, see “Interim Guidance for Preventing MERS-CoV from Spreading in Homes and Communities” at <http://www.cdc.gov/coronavirus/mers/hcp/home-care-patient.html>.
- Currently, there is no vaccine to prevent MERS-CoV infection. The U.S. National Institutes of Health is exploring the possibility of developing one.

School/Daycare Exclusion Criteria

Children with a fever from any infectious disease cause should be excluded from school and daycare for at least 24 hours after fever subsides without the use of fever-suppressing medications. It is recommended that adults not return to work for at least 24 hours after fever has subsided without the use of fever suppressing medications. Do not exclude close contacts from daily activities such as work or school as long as they have no other reasons for exclusion. In the event of a pandemic the exclusion period may be extended.

CONTACT TRACING

For all confirmed and probable cases of novel coronavirus infection, contact tracing for close contacts (see CDC's close contact definition below) is required. In addition, because MERS-CoV and other novel coronaviruses are not fully understood, DSHS Austin may request that contact tracing activities for confirmed and probable cases include healthcare workers who were wearing recommended PPE but otherwise meet the definition of close contact.

The extent of follow-up required for close contacts of confirmed or probable cases may depend on the number of cases identified, the severity of illness or interest from public health leaders or media. Contract tracing requirements may cease in specific situations (e.g., in the case of an ongoing pandemic), as specified by DSHS Austin.

Contact tracing

- Contact tracing should be done for all probable and confirmed cases.
- Complete the Respiratory Disease Contact Tracking Form found at <http://www.dshs.texas.gov/idcu/investigation/> and provide a copy to DSHS.
- Advise contacts of signs and symptoms of illness, and refer them to their healthcare providers if they experience any symptoms compatible with novel coronavirus infection within 14 days of their last contact with the confirmed or probable case.
 - Advise ill close contacts to call ahead prior to visiting their healthcare provider and inform their healthcare provider about recent contact with a confirmed or probable case.
 - Close contacts with respiratory or other compatible symptoms should be tested for novel coronavirus.
- Close contacts should be actively monitored for symptoms of novel coronavirus infection for a minimum of 14 days after last contact with the confirmed/probable case (i.e., follow-up should be performed at regular intervals).
- Collect serum specimens or other laboratory specimens on asymptomatic close contacts, when requested (See Laboratory Procedures section)
- Provide close contacts with a disease fact sheet, if available.

Close contacts definition for MERS:

Close contact is defined as a) being within approximately 6 feet (2 meters), or within the room or care area, of a confirmed MERS case for a prolonged period of time (such as caring for, living with, visiting, or sharing a healthcare waiting area or room with, a confirmed MERS case) while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); or b) having direct contact with infectious secretions of a confirmed MERS case (e.g., being coughed on) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection).

Data to inform the definition of close contact are limited; considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with MERS (e.g., coughing likely increases exposure risk). At this time, transient interactions, such as walking by a person with MERS, are not thought to constitute an exposure; however, final determination should be made in consultation with public health authorities. For guidance on appropriate PPE please see [Interim Infection Prevention and Control Recommendations for Hospitalized Patients with Middle East Respiratory Syndrome Coronavirus \(MERS-CoV\)](#).

MANAGING SPECIAL SITUATIONS

Clusters of Patients with Severe Acute Respiratory Illness

- Clusters of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) without recognized links to a case of MERS-CoV infection or to travelers from countries in or near the Arabian Peninsula should be evaluated for common respiratory pathogens.
- If the illnesses remain unexplained, providers should consider testing for MERS-CoV, in consultation with state and local health departments.
- In accordance with the World Health Organization's guidance for MERS-CoV, a cluster is defined as two or more persons with onset of symptoms within the same 14 days period, and who are associated with a specific setting such as a classroom, workplace, household, extended family, hospital, other residential institution, military barracks or recreational camp.
- If a cluster of patients with severe acute respiratory illness is identified, notify EAIDB **immediately** at **(800) 252-8239** or **(512) 776-7676**.

Multiple Cases/Outbreaks of Novel Coronavirus

If there is more than one case of novel coronavirus in a jurisdiction, local area or facility, or an outbreak is suspected, notify EAIDB **immediately** at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Investigate common exposures among the cases and work with any identified facilities or entities.
 - Recommend appropriate control measures for the specific entity or setting.
- Perform contact tracing and monitoring for close contacts of confirmed/probable cases.
 - Collect specimens from close contacts, if requested.
- Encourage persons with compatible symptoms to be evaluated by a healthcare provider.
- Alert all healthcare providers in the area to be cognizant of possible cases and encourage immediate reporting of suspected cases.
- Collect and ship specimens on all suspected or probable cases to the DSHS laboratory or another public health laboratory qualified to perform novel coronavirus testing using CDC-approved protocols for a specific novel strain.
- Enhance respiratory virus surveillance (e.g., case reporting and laboratory testing) in the facility or in a defined geographic area (depending on the specific outbreak situation)
- Refer to the *Public Health Preparedness, Surveillance, and Response Plan for Texas: Respiratory Viruses Having Pandemic Potential* for a list of responsibilities by department and program area.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases of novel coronavirus infection are required to be reported immediately to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at (800) 252-8239 or (512) 776-7676.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** and **probable** cases to DSHS within 30 days of receiving a report of such a case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- **Investigation forms should be faxed as soon as an investigation has been completed.**
 - Investigation forms may be faxed to DSHS EAIDB at **512-776-7616**.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks immediately to the regional DSHS office or to DSHS EAIDB at **512-776-7676**
- Submit a completed **Respiratory Disease Outbreak Summary Form** at the conclusion of the outbreak investigation.
 - Fax a copy to the DSHS regional office and/or to EAIDB at 512-776-7676.
 - The Respiratory Disease Outbreak Summary Form is available at <http://www.dshs.state.tx.us/idcu/investigation/>.

LABORATORY PROCEDURES

Identification of a novel coronavirus such as MERS-CoV is available in Texas through the DSHS Austin Laboratory. Additionally, some Texas Laboratory Response Network (LRN) laboratories are able to test for novel coronavirus. For a list of laboratories in Texas currently qualified to perform novel coronavirus testing, please contact DSHS EAIDB at 512-776-7676.

Specimens should be sent on all cases that meet the current definitions of suspected (PUI), probable or confirmed cases.

Specimen Collection

Please see <http://www.cdc.gov/coronavirus/mers/guidelines-clinical-specimens.html> for the most up-to-date guidelines.

Specimen Type and Priority

To date, little is known about pathogenic potential and transmission dynamics of MERS-CoV. To increase the likelihood of detecting infection, CDC recommends collecting multiple specimens from different sites at different times after symptom onset, if possible.

Points to consider when determining which specimen types to collect from a patient under investigation for MERS include:

- The number of days between specimen collection and symptom onset
- Symptoms at the time of specimen collection

Additional points to consider:

- Maintain proper infection control when collecting specimens
- Use approved collection methods and equipment when collecting specimens
- Handle, store, and ship specimens following appropriate protocols

Collection of all three specimen types (not just one or two of the three)—lower respiratory, upper respiratory and serum specimens—for testing using the CDC MERS rRT-PCR assay is recommended. Lower respiratory specimens are preferred, but collecting nasopharyngeal and oropharyngeal (NP/OP) specimens, and serum, is strongly recommended depending upon the length of time between symptom onset and specimen collection. Respiratory specimens should be collected as soon as possible after symptoms begin – ideally within 7 days. However, if more than a week has passed since symptom onset and the patient is still symptomatic, respiratory samples should still be collected, especially lower respiratory specimens since respiratory viruses can still be detected by rRT-PCR. For example,

- If symptom onset for a PUI with respiratory symptoms was less than 14 days ago, a single serum specimen (see Serum section, below), an NP/OP specimen, and a lower respiratory specimen (see Respiratory Specimens section, below) should be collected for CDC MERS rRT-PCR testing at an authorized state or local public health laboratory.
- If symptom onset for a PUI with an ongoing respiratory tract infection (especially a lower respiratory tract infection) was 14 or more days ago, a single serum specimen for **serologic testing at CDC** (see Serum section, below) in addition to a lower respiratory specimen and an NP/OP specimen (see Respiratory Specimens section, below) are recommended.

General Guidelines

For short periods (≤ 72 hours), most specimens should be held at 2-8°C rather than frozen. For delays exceeding 72 hours, freeze specimens at -70°C as soon as possible after collection (with exceptions noted below). Label each specimen container with the patient's ID number, specimen type and the date the sample was collected.

Respiratory Specimens

A. Lower respiratory tract

- Bronchoalveolar lavage, tracheal aspirate, or pleural fluid
 - Collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
 - Refrigerate specimen at 2-8°C if the specimen will arrive at the testing laboratory within 72 hours of collection; if exceeding 72 hours, freeze at -70°C and ship on dry ice.
- Sputum
 - Have the patient rinse his/her mouth with water and then expectorate (deep cough) sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
 - Refrigerate specimen at 2-8°C if the specimen will arrive at the testing laboratory within 72 hours of collection; if exceeding 72 hours, freeze at -70°C and ship on dry ice.

B. Upper respiratory tract

- Nasopharyngeal AND oropharyngeal swabs (NP/OP swabs)
 - Collection of both nasopharyngeal and oropharyngeal swabs, or a combined NP/OP specimen, is recommended.
 - Use only synthetic fiber swabs with plastic shafts. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing.
 - Collection technique
 - Nasopharyngeal swabs: Insert a swab into the nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions. Swab both nasopharyngeal areas.
 - Oropharyngeal swabs: Swab the posterior pharynx, avoiding the tongue.
 - Place swabs immediately into sterile tubes containing 2-3 ml of viral transport media. NP/OP specimens can be combined, placing both swabs in the same vial.
 - Refrigerate specimen at 2-8°C if the specimen will arrive at the testing laboratory within 72 hours of collection; if exceeding 72 hours, freeze at -70°C and ship on dry ice.
- Nasopharyngeal wash/aspirate or nasal aspirates
 - Collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
 - Refrigerate specimen at 2-8°C if the specimen will arrive at the testing laboratory within 72 hours of collection; if exceeding 72 hours, freeze at -70°C and ship on dry ice.

Serum

- Serum (for serologic testing at CDC) [Note: Use this serum guidance if the only serum specimen available would be collected 14 or more days after illness onset]
 - Because we do not want to delay detection of MERS infection and since the prevalence of MERS in the US is low, serologic testing on a single serum sample collected 14 or more days after symptom onset may still be beneficial. This is in contrast to serologic testing for many other respiratory pathogens which require collection and testing of acute and convalescent serum specimens. Serologic testing is currently available at CDC upon request and approval. Please be aware that the MERS-CoV serologic test is for research/surveillance purposes and not for diagnostic purposes - it is a tool developed in response to the MERS-CoV outbreak. Contact CDC's Emergency Operations Center (EOC) (770-488-7100) for consultation and approval if serologic testing is being considered.
- Serum (for rRT-PCR testing at authorized state or local public health lab) [Note: Use this serum guidance for specimens collected during the first two weeks of the patient's illness onset]
 - For rRT-PCR testing (i.e., detection of the virus and not antibodies), a single serum specimen collected optimally during the first 10-12 days after symptom onset is recommended. Note: The kinetics of MERS-CoV are not well understood. Once additional data become available, these recommendations will be updated as needed.
 - The minimum amount of serum required for MERS-CoV testing (either serologic or rRT-PCR) is 200 μ L. If both MERS-CoV serology and rRT-PCR tests are planned, the minimum amount of serum required is 400 μ L (200 μ L for each test). Serum separator tubes should be stored upright for at least 30 minutes, and then centrifuged at 1000–1300 relative centrifugal force (RCF) for 10 minutes before removing the serum and placing it in a separate sterile tube for shipping (such as a cryovial). Refrigerate the serum specimen at 2–8°C and ship on ice-pack; freezing and shipment of serum on dry ice is permissible.
 - Children and adults
 - Collect 1 tube (5-10 mL) of whole blood in a serum separator tube.
 - Infants
 - A minimum of 1 mL of whole blood is needed for testing pediatric patients.
 - If possible, collect 1 mL in a serum separator tube.

Submission Form

- Use DSHS Laboratory G-2V Specimen Submission Form for specimen submission. On the form, under the Virology section, check the box "MERS Coronavirus (Novel coronavirus)".

Section 4. VIROLOGY	
☐	Electron Microscopy
☐	Influenza surveillance {Influenza real-time RT-PCR} Vaccine received: ☐ Yes ☐ No Date vaccine received: _____ Travel history (if known): _____
☐	Measles, real-time RT-PCR
☐	Mumps, real-time RT-PCR
☒	MERS Coronavirus (Novel coronavirus) ++++ Prior authorization required. ++++ Call Infectious Disease (512) 776-7676 for authorization
☐	Other: _____

- Make sure the patient's name and approved secondary identifier on the form exactly match what is written on the specimen tube.
 - An approved secondary identifier should be one of the following: date of birth, medical record number, social security number, Medicaid number, or CDC number.
- Fill in the patient's first name, last name, address, city, state, zip code, sex, date of birth, date and time of collection, date of onset and diagnosis/symptoms.
- The submitter will not incur a cost for novel coronavirus testing when patients meet testing criteria as long as the appropriate payor source is selected on the submission form. Contact DSHS EAIDB at 512-776-7676 for instructions on filling out the Payor Source section of the G-2V Specimen Submission Form.

Specimen Shipping

- **Notify the testing laboratory that you will be shipping the specimen and provide the shipment date and tracking number.**
- Transport temperature: Store the specimen at 2-8°C if the specimen will be received at the laboratory within 72 hours of collection; ship the specimen on cold or freezer packs. Otherwise, the specimen must be frozen at -70°C and shipped on dry ice.
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday or the day before a holiday unless special arrangements have been made in advance with the DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Incorrect source of specimen
- The specimen is received at an incorrect temperature
- The specimen is received more than 72 hours after collection (if refrigerated)
- Missing or discrepant information on form/specimen
- Patient does not meet testing criteria or has not been approved for testing by epidemiology

UPDATES

April 2017

- Definitions: updated the footnotes.
- Contact Tracing: updated the close contact definition for MERS.
- Laboratory Procedures: updated DSHS lab submission G-2V form picture; updated what type of information needs to match between the DSHS lab G-2V submission form and the specimen tube.

Paragonimiasis added Jan 2016

BASIC EPIDEMIOLOGY

Infectious Agent

Paragonimus species, a parasitic lung fluke (flat worm). More than 30 species of trematodes (flukes) of the genus *Paragonimus* have been reported which infect animals and humans; the most important is *P. westermani*, which occurs primarily in Asia. Although rare, human paragonimiasis from *P. kellicotti* has been acquired in the United States.

Transmission

Transmission occurs through consumption of raw, salted, pickled, or partially cooked freshwater crabs or crayfish (crawfish) containing infectious larvae (metacercariae). The larvae are released when the crab or crayfish is digested and they migrate within the body, most often ending up in the lungs. Infection can also be acquired by ingestion of raw meat from other infected vertebrate hosts that contain young flukes (e.g., wild boars). Transmission has also been implicated from contaminated utensils, such as knives or cutting boards. Infection is not transmitted directly from person to person.

Incubation Period

Variable; approximately 7-12 weeks after ingestion of the infectious larvae (when flukes mature and begin to lay eggs). The long, variable, poorly defined interval until symptoms appear depends on the organ invaded and the number of worms involved.

Communicability

Eggs may be discharged by those infected for up to 20 years. Duration of infection in mollusk and crustacean hosts is not well defined. Animals, such as pigs, dogs and a variety of feline species, can also harbor *P. westermani*.

Clinical Illness

Disease most frequently involves the lungs as adult flukes living in the lung cause lung disease. Initial signs and symptoms may be diarrhea and abdominal pain followed several days later by fever, chest pain, and fatigue. The symptoms may also include a dry cough, which later becomes productive with rusty-colored or blood-tinged sputum on exertion, and pleuritic chest pain. Extrapulmonary disease is not uncommon, with flukes found in such sites as the CNS, subcutaneous tissues, intestinal wall, peritoneal cavity, liver, lymph nodes and genitourinary tract. Infection usually lasts for years, and the infected person may be asymptomatic. The symptoms of paragonimiasis can be similar to those of tuberculosis, clinically and on chest X-rays.

DEFINITIONS

Clinical Case Definition

Paragonimiasis (lung fluke trematode) is transmitted by eating inadequately cooked crustaceans (primarily crayfish in the US) that are infected with the parasite. Disease most frequently involves the lungs. Initial signs and symptoms may be diarrhea and abdominal pain followed several days later by fever, chest pain, and fatigue. The symptoms may also include a dry cough, which later becomes productive with rusty-colored or blood-tinged sputum on exertion, and pleuritic chest pain. X-ray findings may include diffuse and/or segmental infiltrates, nodules, cavities, ring cysts and/or pleural effusions. Extrapulmonary disease is not uncommon, with flukes found in such sites as the CNS,

subcutaneous tissues, intestinal wall, peritoneal cavity, liver, lymph nodes and genitourinary tract. Infection usually lasts for years, and the infected person may be asymptomatic. Paragonimiasis may be mistaken for tuberculosis, clinically and on chest X-rays.

Laboratory Confirmation

- Microscopic identification of *Paragonimus* eggs in feces, sputum, pleural fluid, CSF, or pus
- Identification of worms or eggs in biopsies of pulmonary, cerebral, subcutaneous, or intra-abdominal nodules or cystic lesions

Case Classifications

- **Confirmed:** A case that is laboratory confirmed
- **Probable:** A clinically compatible case with
 - Detection of *Paragonimus* antibodies by CF, EIA, or immunoblot, **OR**
 - Positive skin test for *Paragonimus*, **OR**
 - History of ingestion of inadequately cooked crustaceans and marked eosinophilia with total WBC count in the normal range or supportive x-ray findings

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of paragonimiasis. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the Paragonimiasis Investigation Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ Interview the case to get detailed exposure history and risk factor information.
 - Use the **Paragonimiasis Investigation Form** to record information from the interview.
 - If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
 - Provide education to the case or his/her surrogate about effective hand washing and food safety practices. See Prevention and Control Measures.
- ☐ Fax completed forms to DSHS EAIDB at **512-776-7616**
 - For lost to follow-up (LTF) cases, please complete as much information as possible obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/e-mail securely to DSHS EAIDB and indicate the reason for any missing information.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water.
- Never eat raw freshwater crabs or crayfish. Cook crabs and crayfish to at least 145°F (~63°C).
- Travelers should be advised to avoid traditional meals containing undercooked freshwater crustaceans.

Exclusions

School/child-care: No exclusions are specified for paragonimiasis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for paragonimiasis but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks/Clusters

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky exposures, such as consumption of freshwater crustaceans, recreational water contact or travel to an endemic country reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Risks	Notes
1	NT	34	F	White/non-Hispanic	12/4/16	Diarrhea, Chest Pain, Dry cough	Ate crayfish that brother purchased at a festival	Brother ill
2	PR	4	M	Unknown	11/30/16	Blood in sputum, chest pain	Attended The Crayfish festival in October	Lost to follow up (LTF)

- If the outbreak was reported in association with an apparent common risk factor (e.g., food establishment serving freshwater crustaceans, recreational body of water or travel), contact hospitals in your jurisdiction to alert them to the possibility of additional paragonimiasis cases.
- Determine the source of infection to prevent additional cases.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>

- Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

Testing for paragonimiasis is widely available from most private laboratories. Specimens are encouraged to be submitted to the DSHS laboratory for confirmation. Contact an EAIDB foodborne epidemiologist to discuss further.

Specimen Collection

- Submit a stool specimen in a sterile, leak-proof container.
 - Required volume: Stool 15g solid or 15mL liquid.
- Fresh stools that cannot be received by the lab in less than 5 hours should be placed in formalin and PVA immediately.
- For sputum and any other specimen types (e.g., tissue section), please contact the DSHS Parasitology Lab: **512-776-7560**.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter

Specimen Shipping

- Transport temperature: May be shipped at ambient temperature or 2-8°C.
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.
- Unpreserved specimen received greater than 5 hours after collection.
- Transport media was expired.
- Specimen too old.

UPDATES

January 2016

- Added in January 2016

Pertussis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Bordetella pertussis (*B. pertussis*), a fastidious Gram-negative bacillus

Transmission

Transmitted from person to person through direct contact with respiratory secretions, most commonly through direct contact with airborne droplets from infectious individuals

Incubation Period

Average of 7-10 days (range 4-21 days)

Communicability

Pertussis is highly contagious. Persons with pertussis are most infectious during the catarrhal period and for 21 days after cough onset. Persons with pertussis are no longer contagious after appropriate antibiotic treatment has been completed, usually 5 days.

Clinical Illness

The clinical course of illness is divided into the following three stages:

- The **catarrhal stage** is characterized by the onset of a runny nose, sneezing, low-grade fever, and a slight cough. The cough gradually becomes more severe and after 1-2 weeks, the next stage develops.
- The **paroxysmal stage** is characterized by coughing fits (paroxysms), which may be followed by an inspiratory whooping sound, apnea, or vomiting. This usually lasts 1-6 weeks, but may continue for 10 weeks.
- In the **convalescent stage**, there is a gradual resolution of the paroxysmal coughing. The coughing may resolve after a few weeks, but may continue for months.

Regardless of vaccination history, pertussis can occur at any age. In infants less than 12 months of age, apnea may be the initial or most important symptom. An indication to the diagnosis **in infants only** is an elevated white blood count (over 15,000/mm³). In infants pertussis symptoms can include apnea, pneumonia, pulmonary hypertension, seizures, and encephalopathy. Pertussis can cause serious complications and even death in infants. Among older children, adolescents, and adults pertussis symptoms are usually milder.

Other *Bordetella* infections

B. parapertussis is a less common, non-reportable infection requiring no public health action. Parapertussis symptoms are similar but milder than pertussis, and serious complications are rare. *B. pertussis* infections provide little cross-protection against subsequent infection with the *B. parapertussis* and vice versa; pertussis vaccine does not prevent parapertussis. *Bordetella holmesii* has been associated most often with sepsis in patients with underlying conditions.

B. bronchiseptica is rare in humans. We recommend that reports of parapertussis, holmesii and bronchiseptica infection not be investigated further, except in certain outbreak instances. We do not recommend chemoprophylaxis for close contacts to be given. The decision to treat patients with these non-pertussis *Bordetella* infections may be left to the clinician's judgment.

DEFINITIONS

Clinical Case Definition

A cough illness lasting at least 14 days **AND** at least one of the following additional symptoms and without other apparent cause:

- Paroxysmal coughing, **OR**
- Inspiratory “whoop,” **OR**
- Post-tussive vomiting, **OR**
- **If under 1 year old**, apnea with or without cyanosis.

Laboratory Criteria for Diagnosis

- Isolation (culture) of *Bordetella pertussis* from a clinical specimen, **OR**
- Positive PCR assay for *Bordetella pertussis*.

Note:

- Because *B. pertussis* can be difficult to culture, a negative culture result does not rule out pertussis.
- Negative PCR results do not require investigation unless reported as a suspected case by a health professional.
- Direct fluorescent antibody (DFA) staining of a patient’s specimen and serological laboratory results (pertussis IgA, IgG or IgM) are NOT considered confirmatory for pertussis, but should be investigated as soon as possible.

Case Classification

- **Confirmed:** Must meet one of the following criteria:
 - A person with an acute cough illness of any duration who is culture positive, **OR**
 - A person who meets the clinical case definition and is PCR positive, **OR**
 - A person who meets the clinical case definition and is epidemiologically linked to a laboratory-confirmed case.
- **Probable:** A person must meet one of the following criteria (in the absence of a more likely diagnosis):
 - A person who meets the clinical case definition but is not laboratory confirmed (not tested, tests are negative, or tested by serology or DFA), and is not epidemiologically linked to a laboratory-confirmed case.
 - **Is under 1 year old** with an acute cough illness of any duration with at least one of the additional symptoms from the clinical criteria **AND** is either
 - PCR positive, **OR**
 - Epidemiologically linked to a laboratory-confirmed case.

Note:

- An illness meeting the clinical case definition should be classified as "probable" rather than "confirmed" if it occurs in a patient who has contact with an infant aged <1 year who is PCR positive for pertussis and has ≥1 sign or symptom and cough duration <14 days (classified as "probable" case).

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of pertussis. Investigation should include identification and evaluation of close contacts.

All positive lab results should be investigated, even non-confirmatory ones (e.g., DFA, serology results). Priority for investigating lab results should be culture/PCR, DFA, serology. Serology results can be further prioritized into pertussis toxin IgG, toxin/FHA IgG total antibody, IgA results, IgM results, everything else.

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition and vaccination status.
 - The Pertussis Investigation Form should be used to record information collected during the investigation.
- ☐ Interview patient (or surrogate).
- ☐ Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- ☐ Identify close contacts and ensure appropriate prophylaxis is provided as appropriate (see Close Contacts below).
- ☐ Notify school/daycare if the case attended while infectious.
- ☐ In the event of a death, notify EAIDB immediately. Copies of the hospital discharge summary, death certificate, and autopsy report should also be faxed to DSHS EAIDB.
 - The Pertussis Death Investigation Form must also be completed and submitted to EAIDB
- ☐ Hospitalized cases should be followed until discharge, especially if the case is an infant.
 - NBS data entry/initial reports can be sent to DSHS prior to discharge.
- ☐ Maternal vaccination history should be obtained for all pertussis cases under one year of age.
- ☐ Fax or mail the completed the Pertussis Investigation Form and if applicable, the Pertussis Death Investigation Form to DSHS.
- ☐ All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS) within 30 days of report. Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Managing Close Contacts

- Close contacts are defined to include immediate family members (those who spend many hours together or sleep under the same roof) and anyone who had direct contact with respiratory secretions.
- Apart from household contacts, the definition of close contact can vary. The following are options of how to define a close contact:
 - Those within close proximity (2 feet) for 2 hours or longer at any one period of time
 - Those who shared confined space (within ~6 feet) for >1 hour during the communicable period.
 - Healthcare workers caring for a case without wearing a mask.
 - Schoolchildren sitting within ~3 feet of a case (i.e., adjacent seating) can also be included.

- Identify all exposed contacts including the following:
 - Household contacts
 - Other high risk contacts including:
 - Infants
 - Women in their third trimester of pregnancy
 - All persons with pre-existing health conditions that may be exacerbated by a pertussis infection (such as immunocompromised persons or moderate to severe medically-treated asthma)
 - People who routinely come into contact with any of the above are classified as high risk
- Not all contacts need prophylaxis, some may just need to be evaluated for symptoms and educated about pertussis. **High risk contacts should be prophylaxed.**
- Antibiotic prophylaxis is recommended if initiated within 21 days of exposure for all household and high risk contacts.
 - Within families, secondary attack rates have been demonstrated to be high, even when household contacts are current with immunizations. Administration of antimicrobial prophylaxis to asymptomatic household contacts within 21 days of onset of cough in the index patient can prevent symptomatic infection.
 - Initiating antibiotic treatment more than 3 weeks after exposure has limited benefit and is not recommended, except for high-risk contacts that may benefit from antibiotic prophylaxis up to 6 weeks after exposure.
 - For more information, see CDC Postexposure antimicrobial prophylaxis page: <http://www.cdc.gov/pertussis/outbreaks/PEP.html>.
- The Texas Medical Board recently changed its rules (Texas Administrative Code, Title 22, Part 9, Chapter 190, Subchapter B, §190.8) regarding the prescribing of prophylaxis for close contacts to infectious disease. Physicians can now prescribe pertussis antibiotics to contacts of pertussis cases without first medically evaluating the contact.
- Anyone age 11 or older who has not received Tdap should get vaccinated.
- Children who received their third dose of DTaP vaccine 6 months or more before exposure should be given a fourth dose at this time.
- Children who have had at least 4 doses of DTaP should receive a booster dose of DTaP unless a dose has been given within the last 3 years or they are 7 years of age or older.
- Close contacts younger than 7 years who are unvaccinated or who have fewer than 4 doses of DTaP vaccine should be vaccinated according to the recommended schedule.
- Exposed children should be observed for 14 days after last contact with the exposed person.
- For health departments that do not maintain their own supply of antibiotics, DSHS has limited quantities of antibiotics available for prophylaxis of high risk and household contacts that cannot otherwise obtain them.
 - Contact your regional office to obtain antibiotics

The current CDC guidelines for treatment and postexposure prophylaxis of pertussis are summarized in the table below and can also be found at

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5414a1.htm>.

Recommended Antimicrobial Treatment and Postexposure Prophylaxis for Pertussis, by Age Group

Age Group	Primary Agents			Alternate Agent*
	Azithromycin	Erythromycin	Clarithromycin	TMP-SMZ
<1 month	Recommended agent. 10 mg/kg per day in a single dose for 5 days (only limited safety data available)	Not preferred. Erythromycin is associated with infantile hypertrophic pyloric stenosis Use if azithromycin is unavailable; 40 to 50 mg/kg per day in 4 divided doses for 14 days	Not recommended (safety data unavailable)	Contraindicated for infants aged <2 months (risk for kernicterus)
1-5 months	10 mg/kg per day in a single dose for 5 days	40 to 50 mg/kg per day in 4 divided doses for 14 days	15 mg/kg per day in 2 divided doses for 7 days	Contraindicated at age <2 months. For infants aged ≥2 months, TMP 8 mg/kg per day, SMZ 40 mg/kg per day in 2 divided doses for 14 days
Infants (aged ≥6 months) and children	10 mg/kg in a single dose on day 1 then 5 mg/kg per day (maximum: 500 mg) on days 2-5	40 to 50 mg/kg per day (maximum: 2 g per day) in 4 divided doses for 14 days	15 mg/kg per day in 2 divided doses (maximum: 1 g per day) for 7 days	TMP 8 mg/kg per day, SMZ 40 mg/kg per day in 2 divided doses for 14 days
Adults	500 mg in a single dose on day 1 then 250 mg per day on days 2-5	2 g per day in 4 divided doses for 14 days	1 g per day in 2 divided doses for 7 days	TMP 320 mg per day, SMZ 1,600 mg per day in 2 divided doses for 14 days

* Trimethoprim sulfamethoxazole (TMP-SMZ) can be used as an alternative agent to macrolides in patients aged ≥2 months who are allergic to macrolides, who cannot tolerate macrolides, or who are infected with a rare macrolide-resistant strain of *Bordetella pertussis*

Treatment

Pertussis infection can be treated through appropriate antibiotic usage as prescribed by a health care provider.

Exclusion

Until completion of 5 days of antibiotic therapy if cough onset is within past 21 days. If more than 21 days have passed since cough onset, no exclusion is necessary.

MANAGING SPECIAL SITUATIONS

Communication Toolkits can be found at <http://www.dshs.state.tx.us/idcu/disease/pertussis/links/> and provide examples of letters used to complete the following activities.

Outbreaks

- Three cases of pertussis that overlap in time (cough onsets within 21 days of each other) and place is considered an outbreak in Texas.
- Outbreak names should be requested from the NEDSS office and entered into NBS for each case associated with the outbreak.
- Even in the event of an outbreak, antibiotic prophylaxis is still only recommended for household and high risk contacts.
- If an outbreak of pertussis is suspected, notify the regional DSHS office or EAIDB at **(800) 252-8239 or (512) 776-7676**.

Healthcare exposures:

- Any healthcare exposures that involve high-risk contacts (e.g., NICU, OB/GYN offices) should be investigated. High risk individuals should be identified and referred for evaluation and possible PEP.
- If the case is a healthcare worker, the infection control practitioner (ICP) of the affected facility should identify and refer all symptomatic contacts (patients and coworkers) for medical evaluation and presumptive treatment immediately. In addition, chemoprophylaxis should be given to exposed healthcare personnel (HCP) who have not had Tdap; or are likely to expose a neonate or a pregnant woman (even if they have had Tdap).
- In addition, unvaccinated HCW should be given Tdap, regardless of age; and all exposed HCW should be monitored daily for 21 days and treated promptly should symptoms of pertussis ensue.
- The asymptomatic contacts may remain in the workplace if they comply with prophylaxis and lack respiratory symptoms; they should be under surveillance for 21 days past their last known exposure.
- Health care workers should contact the facility ICP if respiratory symptoms develop and not work until pertussis is excluded. If the facility has no ICP, the health department may need to coordinate these activities.

Schools:

- PEP is not recommended by the CDC in school settings. School nurses or administration should be made aware of the exposure and should monitor classroom contacts for symptoms. Coughing contacts should be referred to their healthcare provider for evaluation. If two or more cases are identified in a classroom DSHS recommends sending letters home (from the HD or school) to parents of exposed children.

Daycares:

- If the exposure involves children under one year of age, PEP is recommended. Otherwise follow the instructions for schools. Daycares may be required to notify parents in accordance with DFPS licensure.

Infant cases and contacts:

- Infant cases are treated differently than older pertussis cases. Infants are the most vulnerable age group, especially for adverse outcomes, hospitalization and death.
- Additional information is required when investigating infant cases of pertussis.
 - Hospitalized infants must have dates of admission and discharge recorded in NBS. If the investigation is complete, but the child remains hospitalized, please enter the case in NBS and continue to monitor the child's hospital stay until discharge (or death) and then update NBS accordingly.
 - Vaccination status of the mothers of infant cases is also required. Please use the patient interview, hospital records, Immtrac, and even prenatal care records to determine the mother's pre/perinatal vaccination history.
 - If the mother does not remember, please ask leading questions such as if she received any vaccines while pregnant or if she any received prenatal care.
 - Any information obtained about maternal vaccination should be recorded in NBS.
- Much of pertussis investigation now focuses on preventing adverse effects in infants.
 - Pertussis contacts that are infants, are pregnant, or are household contacts of infants or pregnant women should be prioritized.
 - Post-exposure prophylaxis and appropriate vaccination (if indicated) of these contacts should be done immediately.
- Infants may also have a different clinical picture and to that end, a different case definition is used for infant cases only (see the case definition at the beginning of this chapter).

REPORTING AND DATA ENTRY REQUIREMENTS**Provider, School & Child-Care Facilities, and General Public Reporting Requirements**

Confirmed, probable and clinically suspected cases are required to be reported **within 1 work day** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS within 30 days of receiving a report of a confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at (800) 252-8239 or 512-776-7676.
- All outbreaks should be recorded in NBS.
 - Outbreak names must be requested through the NEDSS (NBS) office.

LABORATORY PROCEDURES

Isolation of the organism by culture is ideal; however, it is not readily available. Culture is highly specific, but relatively insensitive. Culture confirmation is recommended for outbreaks. Pertussis culture testing is complicated, so please contact EAIDB for further information during outbreaks. Direct fluorescent antibody (DFA) testing of nasopharyngeal secretions has been shown to have low sensitivity and variable specificity; therefore, it should only be used for screening and not relied upon for laboratory confirmation. DFA is not available from the DSHS Laboratory.

The preferred laboratory test for pertussis is Polymerase Chain Reaction (PCR). PCR testing can be a rapid, sensitive, and specific method for diagnosing pertussis. Pertussis PCR is now widely available at commercial hospitals and laboratories. DSHS performs the testing, usually for a fee.

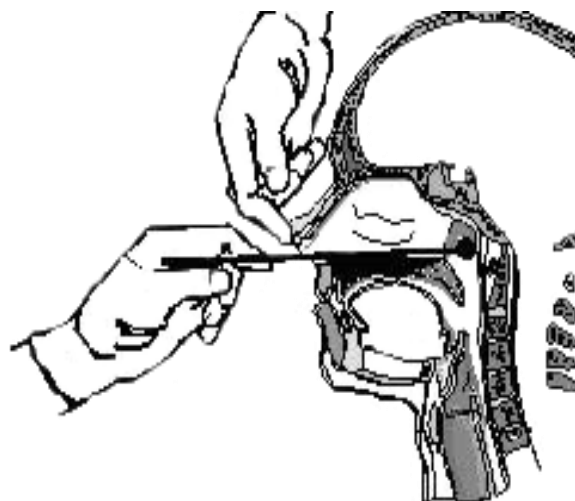
To obtain pertussis PCR testing kits, contact the DSHS Laboratory at **(512) 776-7661**.

Specimen Collection and Submission

Nasopharyngeal Swab for PCR Testing

Appropriate positioning of a nasopharyngeal swab

- Use a Rayon or Dacron nasopharyngeal swab with aluminum or plastic handles.
 - If you are not using swabs provided through the DSHS testing kit, be sure the swab you are using is a “mini-tip” Rayon or Dacron swab.
- Immobilize the patient’s head.
- Gently insert nasopharyngeal swab into a nostril until the posterior nares is reached.
- Leave the swab in place for up to 10 seconds. This procedure may induce coughing and tearing.
- If resistance is encountered during insertion of the swab, remove it and attempt insertion on the opposite nostril.
- Remove the swab slowly.
- After collection, the swab should be inserted back into the dry transport tube. Store at 2-8°C until shipment at refrigerated temperature (2-8°C).



Submission Form

- Use a G-2B Specimen Submission Form.
- Make sure the patient's name and date of birth or social security number match exactly what is written on the transport tubes.
- Fill in the date of collection, date of onset, and diagnosis/symptoms.
- On the DSHS Specimen Submission Form G-2B, in section 6: Molecular Studies, check PCR Bordetella Pertussis.

Section 6. MOLECULAR STUDIES		
☐ <u>PCR:</u>	☐ Eastern Equine Encephalitis (EEE)	☐ PFGE for:
☒ Bordetella Pertussis, Parapertussis, & Bordetella holmesli detection, real-time	☐ St. Louis Encephalitis (SLE)	
☐ Malaria identification	☐ Western Equine Encephalitis (WEE)	☐ Other:
☐ Norovirus	☐ West Nile Virus (WNV)	
☐ Shiga Toxin Producing E. Coli		

Specimen Shipping

- Transport temperature: Keep at 2-8°C (refrigerated).
- Ship specimens via overnight delivery on cold packs or wet ice (double bagged) within 48 hours of collection.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Discrepancy between name on tube and name on form
- Incorrect swab (must use nasopharyngeal swab)
- Obvious contamination with blood
- Tube broken in transport
- Received at ambient temperature

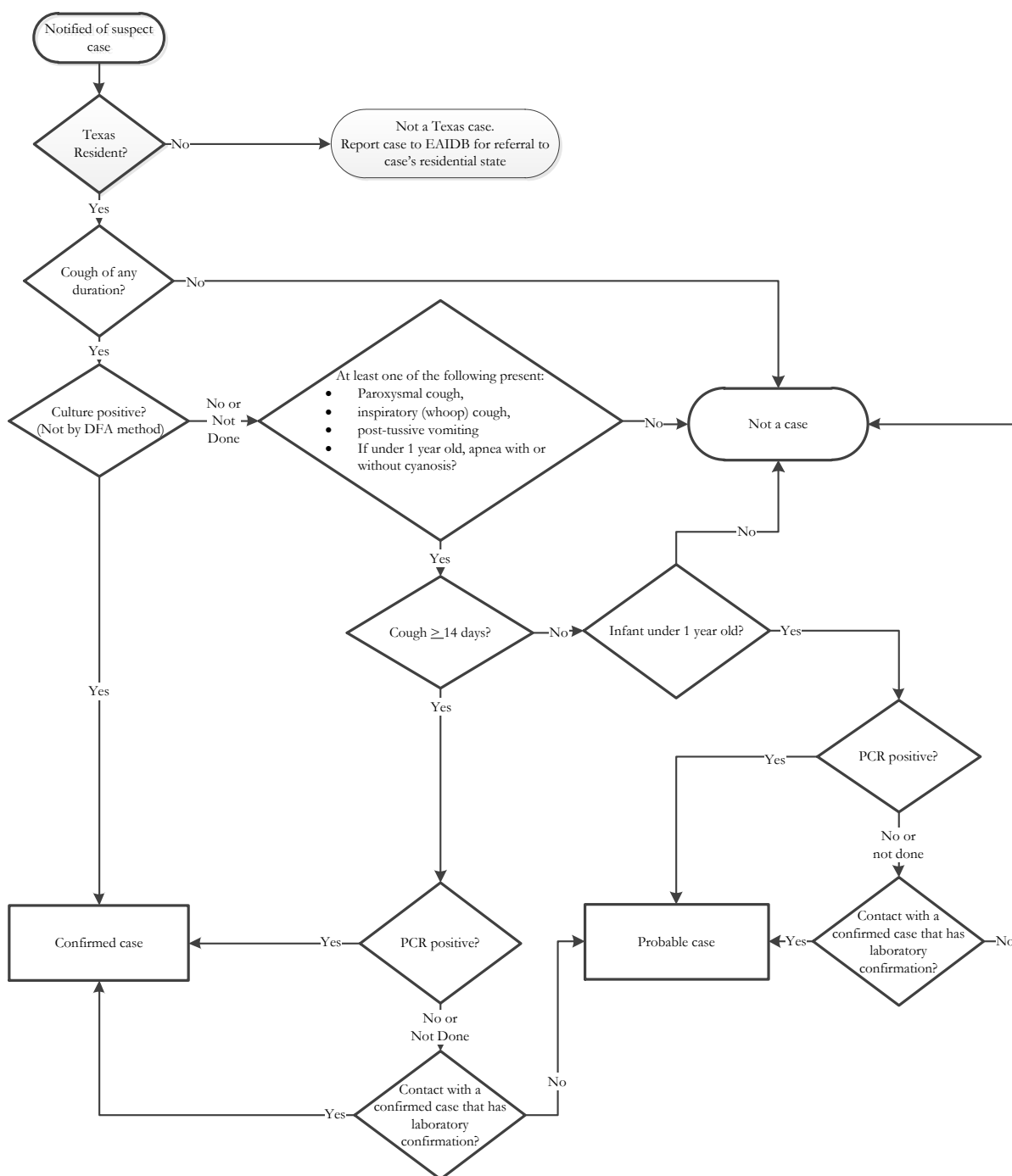
UPDATES

April 2017

- Updates made throughout the document to improve clarity

FLOW CHART rev Apr 2017

Pertussis: Case Status Classification



Polio (Paralytic and Non-paralytic Infection) rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Poliovirus (genus *Enterovirus*) types, 1, 2, and 3.

Transmission

Poliovirus is transmitted by person-to-person contact, primarily via the fecal-oral route. Virus proliferates in both the pharynx (throat) and intestines. Infection may occur following inhalation of contaminated salivary droplets or ingestion of contaminated food products. It should be made clear that poliovirus is disseminated via droplet spread and is not airborne. Virus may persist in the feces of those with and without symptoms for 3-6 weeks post-infection.

Incubation Period

Commonly 7-14 days for paralytic cases; reported range of up to 35 days.

Communicability

Not precisely defined, but transmission is possible as long as the virus is excreted.

Clinical Illness

The virus infects the throat and intestine, with invasion of local lymph nodes. Up to 95% of polio infections are asymptomatic or unapparent. Some persons have nonspecific mild illnesses including fever, sore throat, or gastrointestinal symptoms. In rare cases poliovirus infects the spinal cord or brain stem resulting in aseptic meningitis or acute asymmetric flaccid paralysis.

DEFINITIONS

Poliomyelitis, paralytic

Clinical Case Definition

Acute onset of a flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs, without other apparent cause, and without sensory or cognitive loss.

Laboratory Criteria for Diagnosis

- Isolation of poliovirus type 1, 2, or 3 from a clinical specimen (stool or CSF)

Case Classification

- **Confirmed*:**
 - A case that meets the clinical case definition in which the patient has a neurological deficit 60 days after onset of initial symptoms, has died, or has unknown follow-up status
- **Probable*:**
 - A case that meets the clinical case definition

* All suspected cases of paralytic poliomyelitis are reviewed by a panel of expert consultants at the Centers for Disease Control and Prevention (CDC) before final case classification occurs.

Poliovirus infection, nonparalytic

Clinical Case Definition

Most poliovirus infections are asymptomatic or cause mild febrile disease.

Laboratory Criteria for Diagnosis

- Poliovirus isolate identified in an appropriate clinical specimen, with confirmatory typing and sequencing performed by the CDC Poliovirus Laboratory

Case Classification

- **Confirmed:**
 - Laboratory confirmed poliovirus infection in a person without symptoms of paralytic poliomyelitis
- **Probable:**
 - There is no probable case definition for poliovirus infection, nonparalytic

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should immediately investigate any reported suspect cases of polio. Identify and evaluate close contacts. Implement control measures and provide education to prevent further spread of disease. Report all cases of paralytic polio immediately to DSHS EAIDB.

Case Investigation Checklist

- ☐ Notify DSHS EAIDB immediately.
- ☐ Confirm that the clinical and laboratory results meet the case definition. See Polio Reports among a Recently Vaccinated Child below.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition, underlying health conditions, course of illness, vaccination status and travel history.
 - Collect full demographics (name, age, sex, race, complete address, and occupation of patient).
 - Request copies of admission and discharge summaries and laboratory results.
 - Clinical summary should include sites of paralysis and any complications of illness.
 - If patient dies, request copies of the autopsy report, death summary and death certificate.
 - Record information on the Suspected Polio Case Worksheet available at <http://www.cdc.gov/vaccines/pubs/surv-manual/appx/appendix14-2-polio-wrsht.pdf>
- ☐ Determine vaccination history of the case.
 - Collect the dates, and lot numbers of all previous doses of polio vaccine
 - Sources of vaccination status that should be checked include: case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- ☐ Verify immunologic status
 - If any doubt exists about the patient's status, an immunologic evaluation of quantitative immunoglobulin, T and B cell quantification, lymphocyte transformation, etc. should be considered.
- ☐ Interview the case to get a detailed exposure history.
 - Recent travel of patient or a close contact outside of the US.
 - Contact with any known case of poliomyelitis.

- Please note that polio only occurs in very limited locations throughout the world.
 - Contact within previous 30 days with any person who received oral poliovirus vaccine (OPV) within the last 60 days (include date of contact, nature of contact, date contact received OPV, lot number of vaccine, age of contact, and relationship to patient). Please note that OPV is no longer used in the United States, but is routinely used in other countries.
- Identify and follow-up with all close contacts.
 - Monitor the close contacts for symptoms.
 - If the contact was exposed to the case's stool or may be exposed to the case's stool then vaccinate as appropriate.
- Submit specimens from case and close contacts to the DSHS laboratory.
 - Testing will be performed at CDC for case confirmation.
- Obtain copy of 60-day follow-up report to ascertain if there is any residual paralysis.
- Fax a detailed summary report along with hospital records, vaccination records, laboratory results and the Suspected Polio Case Worksheet to DSHS EAIDB.
- All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Educate the public on the advantages of immunization in early childhood.

Polio Reports among a Recently Vaccinated Child

It is not uncommon for a poliovirus to be identified in a clinical specimen from an infant or young child who has recently received a dose of OPV. If you receive a laboratory report indicating that a poliovirus has been identified, obtain the following information on the patient:

- Complete immunization history (the number, dates, and lot numbers of all previous doses of OPV and inactivated poliovirus vaccine (IPV) vaccine)
- Clinical history (were there any clinical signs of paralysis?), and
- Diagnosis
- Obtain isolate to submit to CDC for further testing.

If the patient is suspected of having paralytic poliomyelitis, investigate case according to paralytic poliomyelitis guidelines.

Treatment

Treatment for polio is supportive only.

Exclusion

There is no exclusion in Texas Administrative Code for polio.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak of polio is suspected, notify the regional DSHS office or EAIDB at **(800) 252-8239 or (512) 776-7676**.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Confirmed, probable, and clinically suspected cases of acute paralytic poliomyelitis are required to be reported **immediately** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**. Confirmed, probable, and clinically suspected non-paralytic poliovirus infections are required to be reported **within 1 work day** to the local or regional health department or to DSHS EAIDB.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Call DSHS EAIDB immediately when a polio investigation is being done or considered.
- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS within 30 days of receiving a report of confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
 - **Final confirmation of case status can only be done by the CDC. Cases may be in NBS pending case status designation until CDC makes a ruling on the case status.**
- Fax (or mail) the Suspected Polio Case Worksheet, all hospital records, vaccination records and laboratory results within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **(800) 252-8239 or 512-776-7676**.

LABORATORY PROCEDURES

Before shipping specimens, be sure to notify DSHS EAIDB VPD staff at **(512) 776-7676**. The CDC will conduct all poliovirus testing but specimen submission is coordinated through the DSHS laboratory. It is essential to notify DSHS EAIDB VPD staff before sending specimens because the CDC may request additional types of specimens.

Virus Isolation Specimen Collection and Submission Enterovirus Culture - Isolation

- Preferred specimen and quantity:
 - CSF - 2-5 mL
 - Stool - 2-4g - place in viral transport media.
 - Nasopharyngeal (NP) Swab - in viral transport media
 - Tissue in enough viral transport media to prevent drying

Submission Form

- Use a G-2V Specimen Submission Form.
- Make sure the patient's name and date of birth or social security number match exactly what is written on the transport tubes.
- Fill in the date of collection, date of onset, and diagnosis/symptoms.

Specimen Shipping

- Transport temperature: Keep at 2-8°C (refrigerated).
- If specimen will arrive at lab > 48 hours from collection, store at -70° C and send on dry ice.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Specimen submitted on a preservative, such as formalin
- Discrepancy between name on tube and name on form

UPDATES

April 2017

- Updated definitions section to differentiate between paralytic and non-paralytic polio cases
- Updated reporting requirements for paralytic and non-paralytic polio

Rubella

rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Rubella virus (family togaviridae; genus *rubivirus*)

Transmission

Rubella is spread from person to person via droplets shed from the respiratory secretions of infected persons. Rubella may be transmitted by persons with subclinical or asymptomatic cases (up to 50% of all rubella virus infections). Perinatal transmission also occurs, see next chapter (CRS).

Incubation Period

From 14-18 days with a range of 12-23 days.

Communicability

Rubella is only moderately contagious. The disease is most contagious when the rash first appears, but virus may be shed from 7 days before rash to 5–7 days or more after rash onset.

Clinical Illness

Symptoms are often mild, and up to 50% of infections may be subclinical or inapparent. In children, rash is usually the first manifestation and a prodrome (early symptom indicating onset of disease) is rare. In older children and adults, there is often a 1 to 5 day prodrome with low-grade fever, malaise, lymphadenopathy (disease of the lymph nodes), and upper respiratory symptoms preceding the rash. The rash of rubella is maculopapular (rash characterized by flat, red on the skin that is covered with small confluent bumps) and occurs 14 to 17 days after exposure. The rash usually occurs initially on the face and then progresses from head to foot. It lasts about 3 days and is occasionally pruritic (intensely itchy). The rash is fainter than measles rash and does not come together to form one massive rash. The rash is often more prominent after a hot shower or bath. Lymphadenopathy may begin a week before the rash and last several weeks. Postauricular, posterior cervical, and suboccipital nodes are commonly involved.

Arthralgia (joint pain) and arthritis (inflammation and stiffness of joints) occur so frequently in adults that they are considered by many to be an integral part of the illness rather than a complication. Other symptoms of rubella include conjunctivitis (pink eye), testalgia (testicular pain), or orchitis (inflammation of the testicles). Forchheimer spots may be noted on the soft palate but are not diagnostic for rubella. A rubella rash may be confused or mistaken to be parvovirus B19 (Fifth's disease) because the rashes are similar in appearance.

DEFINITIONS

Clinical Case Definition

An illness that has all of the following characteristics:

- Acute onset of generalized maculopapular rash, **AND**
- Temperature $\geq 99^{\circ}\text{F}$, if measured, **AND**
 - Arthralgia/arthritis **OR**
 - Lymphadenopathy **OR**
 - Conjunctivitis

Laboratory Criteria for Diagnosis

- Isolation of rubella virus, **OR**
- Significant rise between acute-and convalescent-phase titers in serum rubella immunoglobulin G (IgG) antibody level* by any standard serologic assay, **OR**
- Positive serologic test for rubella-specific IgM antibody* not otherwise ruled out by more specific testing in a public health laboratory, **OR**
- Detection of rubella-virus-specific nucleic acid by PCR.

* Not explained by MMR vaccination during the previous 6–45 days.

Case Classification

- **Confirmed:** A case that is clinically compatible and is:
 - Laboratory confirmed, **OR**
 - Epidemiologically linked to a laboratory-confirmed case.
- **Probable:** There is no probable case definition.

Serum rubella IgM test results that are false positives have been reported in persons with other viral infections (e.g., acute infection with Epstein-Barr virus [infectious mononucleosis], recent cytomegalovirus infection, and parvovirus infection) or in the presence of rheumatoid factor. Patients who have laboratory evidence of recent measles infection are excluded.

Note: IgM results from specimens collected within 45 days of MMR vaccination do not count as laboratory confirmation.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of congenital rubella. For infants exposed in utero, see the Congenital Rubella Section.

Case Investigation Checklist

- ☐ Ensure isolation is in place if within 7 days of rash onset.
- ☐ Confirm that the laboratory results meet the case definition.
- ☐ Request that the laboratory forward viral isolation specimens to the DSHS laboratory. See laboratory procedures.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition, clinical picture, treatment history, and vaccination status.
 - The Rash-Fever Illness Case Track Record should be used to record information collected during the investigation.

- Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- Identify and follow-up with all exposed contacts.
 - Determine their susceptibility (fully vaccinated or lab evidence of rubella specific IgG).
 - If susceptible, give vaccination as appropriate for age and vaccination status.
 - See control measures below.
 - For infants, see the control measures in the Congenital Rubella section.
- In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be faxed to DSHS EAIDB.
- Fax the completed the Rash-Fever Illness Case Track Record to DSHS.
- All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Determine vaccine status of exposed contacts. If not up-to-date with vaccination, vaccinate with MMR according to the recommended immunization schedule.
- Persons ≥ 1 year of age should have a history of 1 dose of MMR or serologic evidence of immunity to rubella.
- Persons who cannot readily provide laboratory evidence of rubella or a documented history of vaccination on or after their first birthday should be considered susceptible and should be vaccinated if there are no contraindications.
- If vaccination of exposed contact is contraindicated, exclude exposed contact from school or child-care facility for at least 3 weeks after last rash onset.
- If a pregnant woman is exposed to rubella, evidence of rubella immunity should be obtained as soon as possible. If rubella IgG antibodies are not detected, a second specimen should be obtained 3-4 weeks later and tested again for rubella IgM and rubella IgG antibodies. If IgG is present, infection is assumed to have occurred and precautions will need to take place at delivery as the infant may be infectious (see next section: CRS).

Treatment

No specific treatment for rubella infection is available.

Exclusion

Seven days after onset of rash. In an outbreak, unvaccinated children and pregnant women should be excluded for at least three weeks after rash onset.

MANAGING SPECIAL SITUATIONS

If an outbreak of rubella is suspected, notify the regional DSHS office or EAIDB at (800) 252-8239 or (512) 776-7676.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 work day** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases to DSHS within 30 days of receiving a report of confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at (800) 252-8239 or 512-776-7676.

LABORATORY PROCEDURES

Please submit specimens for viral isolation (culture or PCR) to the DSHS laboratory in Austin. Specimens may be submitted for serology if serology is not available from a commercial lab.

Virus Isolation/PCR Specimen Collection and Submission (preferred)

Rubella virus isolates are critical in the diagnosis of acute rubella and CRS, and are needed to establish the molecular epidemiology of rubella and to distinguish rubella from other viral rash illnesses.

Specimen Collection

- Use a synthetic swab such as polyester or rayon swab. Flocked synthetic swabs are acceptable. Do not use cotton swabs. Place the swab in 2-3 mL of viral transport media.
- Obtain a pharyngeal swab within 4 days of rash onset.
- Label the specimen tube with the patient's name and date of birth or social security number.

Submission Form

- Use Specimen Submission Form G-2V.
- Make sure the patient's name and date of birth/social security number match exactly what is written on the specimen tube.

Write in rubella PCR or check virus isolation-rubella, disease suspected, date of onset, and date of collection.

Specimen Shipping

- Transport temperature:
 - Keep the specimen at 2-8°C and ship overnight on wet ice within 48 hours.
 - If the specimen must be held longer, freeze at -70°C and ship on dry ice.
 - Send the specimen to the laboratory via overnight delivery on wet or dry ice as noted above.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Serology Specimen Collection and Submission (if needed)

IgM Serology: Single specimen collected early in the course of illness. Because rubella IgM antibodies rise more slowly in some individuals, a negative rubella IgM result on a specimen collected within 5 days of rash onset will NOT rule out a diagnosis of rubella; the only exception to this is when the specimen is IgG positive, indicating prior immunity. Therefore if the patient is an unvaccinated infant, a specimen for IgM testing should be collected at least 5 days post rash onset. All other specimens should be collected as soon as possible. Rubella IgM may cross-react with other viruses, especially parvovirus.

IgG Serology: Acute AND convalescent samples required. Collect acute early in course of illness and convalescent 10-14 days later. Evidence of rubella immunity by measuring IgG antibody (e.g., in an exposed pregnant woman) can be determined with a single blood specimen.

Specimen Collection

Option 1:

- Collect at least 5 mL blood in red top tube.
- Label blood tubes with patient's first and last name, and we recommend a second identifier such as date of birth or medical record number or social security number. If the first and last name is not provided, the specimen will be rejected.
 - Centrifuge the **red top blood** collection tube within 2 hours from the time of collection to separate the serum from the red blood cells (clot).
 - Transfer the serum from the red top tube into a serum transport tube properly labeled with the patient's name and date of birth or social security number and ship cold with cool packs and must be received within 48 hours.
 - If the serum samples will not be delivered to the laboratory within 48 hours of collection, then the samples must be frozen at -20°C (frozen) or lower and shipped frozen with dry ice.
 - Do not freeze whole blood in red top tube for shipping.

Option 2:

- Collect at least 5 mL blood in **gold top** or **tiger top** blood collection tube containing a gel serum separator (Gold top or tiger top tubes are types of serum separator tubes with the gel that keeps the serum separated from the clot after the centrifugation).
- Label blood tubes with patient's first and last name, and we recommend a second identifier such as date of birth or medical record number or social security number. If the first and last name is not provided, the specimen will be rejected.
 - Centrifuge the gold top blood collection tube within 2 hours from the time of collection to separate the serum from the red blood cells (clot) and ship cold with cool packs and must be received within 48 hours.
 - If more than 48 hours, transfer the serum into a serum transport tube properly labeled with the patient's name and date of birth or social security number and ship frozen with dry ice.
 - Do not freeze serum in serum separator tube (SST) for shipping. Freezing will cause hemolysis and hemolyzed specimens will be unsatisfactory for testing.

Submission Form

- Use the DSHS Laboratory current version of G-2A form for specimen submission.
- Make sure the patient's first and last name and date of birth/social security number match exactly what is written on the tube.
- Mark the laboratory test requested, date of onset, and date of collection. Be certain that the names on acute and convalescent sera match exactly.
- Call DSHS Laboratory at 512-776-7138 if needing information for specimen submission.

Specimen Shipping

- To avoid specimen rejection, ship separated serum or centrifuged SST Monday through Thursday to the DSHS laboratory via overnight delivery following the above guidelines.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
 - If the serum samples will not be delivered to the DSHS laboratory within 48 hours of collection, transfer into a serum transport tube and freeze on Fridays. Ship frozen specimens with dry ice on Monday. Lone Star service will not deliver specimen to the DSHS lab on Saturday.

- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

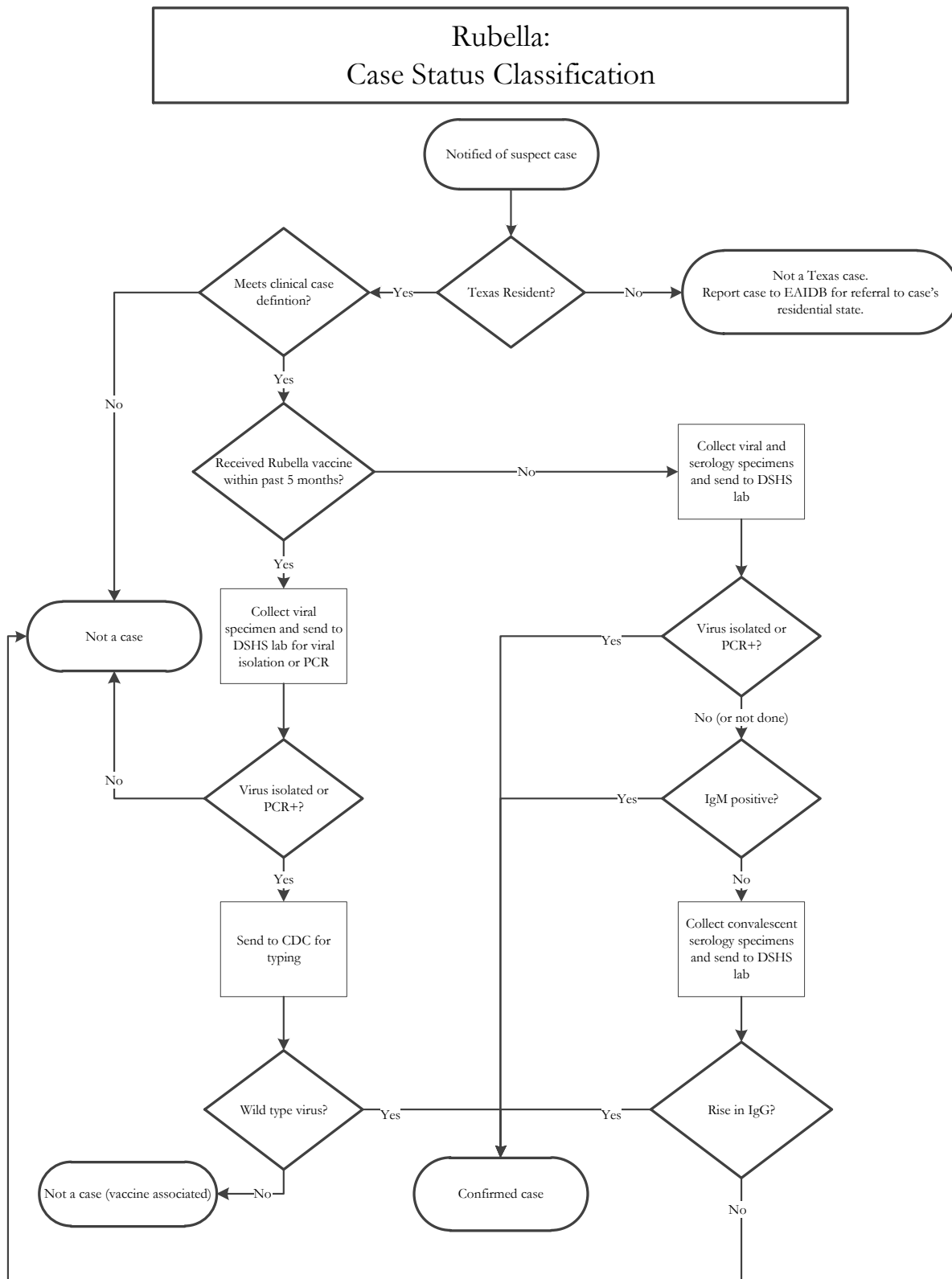
- Discrepancy between name on tube and name on form
- Insufficient quantity of serum for testing specimens received with extended transit time
- Received at incorrect temperature or no date of collection

UPDATES

April 2017

- Updates made throughout the investigation guide to improve clarity

FLOW CHART rev Apr 2017



Salmonellosis (Non-typhoidal) rev Apr 2017

Note that typhoid infections (caused by *S. Typhi*) are reported in NEDSS as Typhoid Fever and will be covered in the Typhoid Fever section. Paratyphoid infections (caused by *S. Paratyphi* A, B, and C) are reported in NEDSS as Salmonellosis and will be covered in this section. See Table 1, at the end of this section.

BASIC EPIDEMIOLOGY

Infectious Agent

Salmonella species, a Gram-negative bacilli. There are two species of *Salmonella*, with the most common cause of human illness being *S. enterica*. The two species are further separated into subspecies and then serotypes based on defining antigens. Due to most human illness being attributed to the same species and subspecies, they are commonly referred to and distinguished by their defined serotype, such as *S. Heidelberg* (*Salmonella enterica* subsp. *enterica* subtype Heidelberg).

Transmission

Transmission is fecal-oral and can occur through the ingestion of fecally contaminated food or water, or improperly cooked or prepared food. Transmission may also occur via direct contact with an infected person, fomite, animal or an animal's environment.

Incubation Period

Usually 12-36 hours (ranges 6 to 72 hours). Longer incubations, up to 16 days, have been documented. For *S. Paratyphi*, usually 1–10 days but may be as long as 2–3 weeks.

Communicability

People are infectious as long as bacteria are shed in their stool. On average bacteria can be shed in stool through the course of infection, usually several days to several weeks, with a small percentage of cases excreting the organism for many months. Antibiotic use during the acute illness can prolong the carrier state.

Clinical Illness

Non-typhoidal salmonellosis is characterized by diarrhea, nausea, headache, and sometimes vomiting. Fever is almost always present. Bloody diarrhea and invasive disease may occur, particularly with certain serotypes. Invasive infection may present as urinary tract infection, septicemia, abscess, arthritis, cholecystitis and rarely as endocarditis, pericarditis, meningitis, or pneumonia. A carrier state may develop.

S. Paratyphi can cause a milder systemic illness similar to typhoid fever including fever, anorexia, lethargy, and/or malaise.

DEFINITIONS

Clinical Case Definition

An illness of variable severity commonly manifested by diarrhea, fever, abdominal pain, nausea, and sometimes vomiting. Asymptomatic infections can occur, and the organism can cause extra-intestinal infections.

Laboratory Confirmation

- Isolation of *Salmonella* (except *S. Typhi*)* from a clinical specimen.
 - **S. Typhi* is reportable as Typhoid Fever

Case Classifications

- **Confirmed:** A case that meets the laboratory criteria for diagnosis. When available, *Salmonella* serotype characterization should be reported.
- **Probable:**
 - A case with *Salmonella* sp. detected, in a clinical specimen, by use of culture independent laboratory methods (non-culture based), **OR**
 - A clinically compatible case that is epidemiologically linked to a case that meets the probable or confirmed laboratory criteria for diagnosis

Note: Both asymptomatic infections and infections at sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.

Note: A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different serotype

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

It is recommended that local and regional health departments investigate all reported cases of salmonellosis to identify potential sources of infection. Sporadic cases of salmonellosis do not require an investigation form be sent to DSHS EAIDB unless they are cases of *S. Paratyphi* infection or identified as part of a cluster or outbreak. Paratyphoid fever cases and any case associated with a cluster or outbreak should be interviewed.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ If an isolate has not been sent to the DSHS laboratory, request the laboratory to forward the isolate to the DSHS laboratory for serotyping and PFGE.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ **Paratyphoid Fever cases:** Interview paratyphoid fever cases, using the CDC Typhoid and Paratyphoid Fever Surveillance Report (available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>) to record information from the interview.
- ☐ **Salmonellosis cluster or outbreak cases:** Use the TXDSHS/CDC Hypothesis Generating Questionnaire or an outbreak specific form provided by DSHS EAIDB to interview salmonellosis cluster cases. See Managing Special Situations.
- ☐ **Salmonellosis cases:** If time and resources allow, interview the case to identify potential sources of infection. Take a food history. Note brand and purchase or source information for high risk foods. Ask about potential exposures during at least the 5 days before onset including:

- ☐ Any contacts or household members with a similar illness. Obtain the name, phone number or address and clinical information of the ill person.
- ☐ Restaurant meals. Obtain the name of the restaurant, date and location of the meal, and food/drinks consumed.
- ☐ Public gathering where food was consumed. Obtain the date, location, sponsor of the event, and food/drinks consumed.
- ☐ Consumption of raw or undercooked meat, poultry, or eggs.
- ☐ Consumption of raw milk or other unpasteurized dairy products.
- ☐ Travel within and outside Texas or outside the United States, or contact with others who have traveled outside the United States. Determine dates of travel.
- ☐ Contact with reptiles or amphibians (snakes, lizards, turtles, frogs, etc.).
- ☐ Contact with pets, livestock, or other animals (including farms and petting zoos).
- ☐ Note: If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
- ☐ Provide education to the case or his/her surrogate about effective hand washing, food safety practices, and animal contact/handling precautions. See Prevention and Control Measures.
- ☐ Identify whether there is a public health concern: persons should not work as food handlers, child-care or health care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- ☐ Fax completed forms for paratyphoid fever or cluster related cases to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - For lost to follow-up (LTF) cases, please complete as much information obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed, probable, and suspect case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
 - After handling raw food, especially poultry and other raw meat products.
 - After any contact with an animal, their living area, or their food.
- Avoid consuming raw milk, unpasteurized dairy products, and undercooked eggs.
- Follow food safety principles in the kitchen, especially:
 - Cook meat thoroughly. Poultry should be cooked to an internal temperature of 165°F.
 - Prevent cross-contamination in food preparation areas by thoroughly washing hands, counters, cutting boards, and utensils after they touch raw meat.
 - Separate uncooked meats, hot dogs and other meat packaging from vegetables, uncooked food and ready to eat foods.
 - Keep the refrigerator at 40°F or lower and the freezer at 0°F or lower.
 - Clean up all spills in your refrigerator right away—especially juices from raw meat, raw poultry, and hot dog and lunch meat packages.

Exclusions

School/child-care: No exclusion specified for salmonellosis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employees: Symptomatic food employees infected with non-typhoidal *Salmonella* are to be excluded from work. Asymptomatic food employees diagnosed with an infection from non-typhoidal *Salmonella* are to be restricted from work.

Food employees can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met:

- Medical documentation stating that the food employee is free of infection from non-typhoidal *Salmonella* based on test results showing two consecutive, negative stool specimen cultures. The stool specimens should be collected at least 24 hours apart and not sooner than 48 hours after the last dose of antibiotics, if antibiotics were given.
- More than 30 days have passed since the food employee became asymptomatic (without the use of diarrhea suppressing medications) or
- The food employee did not develop symptoms and more than 30 days have passed since being diagnosed.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional salmonellosis cases.
- If isolates have not already been submitted to the DSHS laboratory for serotyping and PFGE, request hospital/clinical labs submit isolates for serotyping and PFGE testing. See Laboratory Procedures.
- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on, and adherence to, hand hygiene
 - Storage and preparation of food
 - Procedures for changing diapers and toilet training
 - Procedures for environmental cleaning
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

PFGE clusters:

- For clusters of cases with indistinguishable PFGE patterns detected by CDC/PulseNet and/or the DSHS laboratory, a member of the DSHS EAIDB foodborne team will notify appropriate DSHS regional epidemiologists, usually by email, who will then notify appropriate local health departments of cases within their jurisdiction.
- Local/regional health departments with cases in their jurisdiction should:
 - Interview the case patient, even if they have already been interviewed as part of a routine disease investigation, using the cluster specific questionnaire attached in the email notification.
 - Fax the completed questionnaire promptly within timeframe designated in the cluster notification to DSHS EAIDB at **512-776-7616** or e-mail securely to an EAIDB foodborne epidemiologist.
 - If the health department having jurisdiction of a case is unable to reach a case-patient after 3 attempts during normal working hours, and they are not able to call after hours, please call the DSHS regional office or DSHS EAIDB to discuss further.
 - If an interview is unattainable or the case is lost to follow-up, fax the completed cover sheet and any case information to DSHS EAIDB.
- Local/regional health department with cases will be notified by the EAIDB foodborne team of any CDC or DSHS conference calls and may participate, if able.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory. The general policy is to test only food samples implicated in suspected outbreaks, not in single cases.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed and probable cases are required to be reported **within 1 week** to the local or regional health department or the DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different serotype. A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- If investigation forms are requested, they may be faxed to 512-776-7616 or emailed securely to an EAIDB foodborne epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

CLINICAL SPECIMENS:

Salmonella isolates are required to be submitted to the DSHS Laboratory for typing and molecular analysis.

Please refer to the [TAC](#) Title 25, Ch 97, Subchapter A, Rule §97.3 “What Condition to Report and What Isolates to Report or Submit”.

In an outbreak or other special situation, the DSHS Laboratory can culture raw stool or stool in transport medium (e.g., Cary-Blair media) for *Salmonella* species. Contact an EAIDB foodborne epidemiologist prior to submitting raw stool or stool in transport medium for culture.

Specimen Collection

- Submit pure cultures on an agar slant at ambient temperature or 2-8°C (*ice pack*) as soon as possible to ensure viability.
- For raw stool or stool in transport medium, please refer to table below:

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool	≤24 hours	4°C (ice pack)
Raw stool	>24 hours	Freeze immediately at ≤-70°C. Ship on dry ice.
Stool in transport solution/medium	Time of collection to ≤3 days	Room temp or 4°C (ice pack)
Stool in transport solution/medium	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.
All	*The above transport times are optimal for recovery of pathogenic organisms. In the interest of public health, specimens will be accepted up to 30 days from date of collection.	*The above transport temperatures are optimal for the recovery of pathogenic organisms. In the interest of public health, specimens will be accepted at non-optimal temperature transport.

* Note: Pathogen recovery rates decrease over time. For best results, submit ASAP.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter

Specimen Shipping

- Ship specimens via overnight delivery.
- DO NOT mail on Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Missing or discrepant information on form/specimen.
- Transport media was expired.
- Specimen not in correct transport medium

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Salmonella* spp. is available at the DSHS laboratory. Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

General policy

- The DSHS lab will only test food samples or environmental swabs from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreaks, the DSHS lab will not test food samples or environmental swabs unless a pathogen has been identified in a clinical specimen.
- Food samples or environmental swabs must be **collected by a registered sanitarian**

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

Salmonellosis, TABLE 1:

Guide to Salmonellosis, Paratyphoid Fever, Typhoid Fever Reporting and Surveillance Forms

<i>Salmonella</i> serotype	Reported in NEDSS as	Surveillance Form
<i>Salmonella</i> Typhi	Typhoid Fever	CDC Typhoid and Paratyphoid Fever Surveillance Report requested
<i>Salmonella</i> Paratyphi A, B*, or C	Salmonellosis	CDC Typhoid and Paratyphoid Fever Surveillance Report requested
all other <i>Salmonella</i> serotypes	Salmonellosis	no CDC or DSHS form requested unless part of outbreak investigation

**Salmonella* Paratyphi B var L(+) tartrate + (formerly var. Java) is associated with routine GI illness and is reported as Salmonellosis and no CDC or DSHS form is requested unless part of an outbreak investigation.

UPDATES

April 2017

- Updated case definition to match the Epi Case Criteria Guide for 2017
 - CIDT methods now included in Probable case definition
- Added statement in Laboratory Procedures section regarding new *Salmonella* isolate submission requirement.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Shiga toxin-producing *Escherichia coli*_{rev Apr 2017}

BASIC EPIDEMIOLOGY

Infectious Agent

Shiga toxin-producing *Escherichia coli* (STEC) bacteria. *E. coli* are Gram-negative, rod-shaped bacteria that naturally exist in the mammalian digestive system. Pathogenic strains can be identified by the presence of at least one of two Shiga toxin-producing genes, *stx1* and *stx2*.

The most common serogroups isolated from person with diarrheal illness in North America are O157, O26, O111, O103, O45, O145, and O121.

Transmission

Transmission is fecal-oral and can occur through the ingestion of fecally contaminated food or water. Transmission can also occur via direct contact with an infected person, fomite, animal or an animal's environment. Person to person spread is common within households and daycare centers.

Incubation Period

Incubation can range from as short as 1 day to as long as 10 days; *E. coli* O157:H7 is usually 3 to 4 days, with 6% of infections developing hemolytic uremic syndrome (HUS) within 3 weeks of infection.

Communicability

The duration of excretion of the pathogen is typically 1 week or less in adults, but 3 weeks in one-third of children. Prolonged carriage is uncommon.

Clinical Illness

Symptoms can vary but predominant symptoms include severe abdominal pain and non-bloody diarrhea which can become bloody after 3 to 4 days.

Severity

Hemolytic uremic syndrome (HUS) is a serious complication of STEC infections and can begin as symptoms resolve, usually within 3 weeks of infection. About 15% of young children and a smaller proportion of adults with STEC O157 diarrhea develop HUS. HUS typically requires dialysis and death can occur in 3 to 5% of cases.

DEFINITIONS

Clinical Case Definition

An infection of variable severity characterized by diarrhea (often bloody) and abdominal cramps. Illness can be complicated by hemolytic uremic syndrome (HUS) or thrombotic thrombocytopenic purpura (TTP); asymptomatic infections can also occur and the organism can cause extra-intestinal infections.

Laboratory Confirmation

- Isolation of Shiga toxin-producing *Escherichia coli* from a clinical specimen
 - *Escherichia coli* O157:H7 isolates are assumed to be Shiga toxin-producing. Therefore, isolation alone qualifies a case as “confirmed.”
 - *Escherichia coli* non-O157:H7 isolates must also have Shiga toxin-production verified in order to qualify the case status as “confirmed.” Shiga toxin can be demonstrated by EIA or PCR testing.
 - EIA and/or PCR positive results for Shiga toxin-production, in the absence of an isolate, can only qualify a case as “probable.”

Note: As required by TAC, all *E. coli* O157:H7, isolates or specimens from cases where Shiga-toxin activity is demonstrated must be submitted to the DSHS laboratory.

Case Classifications

- **Confirmed:** A case that meets the laboratory criteria for diagnosis; when available, O and H antigen serotype characterization should be reported.
- **Probable:**
 - A case with isolation of *E. coli* O157 from a clinical specimen, without confirmation of the H antigen or Shiga toxin-production, **OR**
 - A clinically compatible case that is epidemiologically linked to a confirmed or probable case, **OR**
 - Identification of an elevated antibody titer to a known Shiga toxin-producing *E. coli* serotype from a clinically compatible case, **OR**
 - Identification of Shiga toxin in a specimen from a clinically compatible case without the isolation of the Shiga toxin-producing *E. coli*.
- **Suspect:** A case of post-diarrheal HUS or TTP. [Should be investigated but not required to be entered unless it meets criteria for confirmed or probable.]

Note: Cases meeting confirmed or probable criteria for both STEC and HUS should be reported under each condition.

Note: a case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of Shiga toxin-producing *E. coli* infections. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the Shiga Toxin-Producing *Escherichia coli* (*E. coli*) and/or Hemolytic Uremic Syndrome (HUS) Investigation Form available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Verify that the laboratory has forwarded an isolate or specimen from cases where Shiga toxin activity is demonstrated to the DSHS laboratory. If an isolate has not been sent, please request a specimen be submitted as required.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ Interview the case to get detailed food history and risk factor information.
 - Use the **Shiga Toxin-Producing *Escherichia coli* (*E. coli*) and/or Hemolytic Uremic Syndrome (HUS) Investigation Form** to record information from the interview.
 - If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
 - Provide education to the case or his/her surrogate about effective hand washing, food safety practices, and animal contact/handling precautions. See Prevention and Control Measures.
- ☐ Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - For lost to follow-up (LTF) cases, please complete as much information obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB, noting case is LTF.
- ☐ Identify whether there is a public health concern: persons should not work as food handlers, child-care or health-care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
 - After handling raw food, especially poultry and beef.
 - After any contact with animals, their living areas or their food.
- Avoid consuming raw milk, unpasteurized dairy products, and unpasteurized juices (like fresh apple cider). Prolonged heat treatment is required to destroy Shiga toxin.
- Avoid consumption of raw sprouts, especially by those most susceptible to severe complications of foodborne diseases (young children, the elderly, pregnant women, and person with compromised immune system).

- Follow food safety principles in the kitchen, especially:
 - Cook meat thoroughly. Ground beef and meat that has been needle-tenderized should be cooked to a temperature of at least 160°F (70°C). Use a thermometer to verify the temperature, as color is not a very reliable indicator of how thoroughly meat has been cooked.
 - Prevent cross-contamination in food preparation areas by thoroughly washing hands, counters, cutting boards, and utensils after they touch raw meat.
 - Thoroughly wash fresh leafy greens, fruits and vegetables with water.
- Avoid swallowing water when swimming and when playing in lakes, ponds, streams, swimming pools, and backyard "kiddie" pools.
- Do not participate in recreational water activities such as swimming while diarrhea is present and for two weeks after diarrhea has resolved.

Exclusions

School/child-care: No exclusion specified for shiga toxin-producing *E. coli* but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications

Food Employees: Symptomatic food employees infected with shiga toxin-producing *E. coli* are to be excluded from work. Asymptomatic food employees diagnosed with an infection from shiga toxin-producing *E. coli* are to be excluded from working in a food establishment serving a highly susceptible population or restricted if they do not serve a highly susceptible population.

Food employees can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met:

- Medical documentation stating that the food employee is free of infection from shiga toxin-producing *E. coli* based on test results showing two consecutive, negative stool specimen cultures. The stool specimens should be collected at least 24 hours apart and not sooner than 48 hours after the last dose of antibiotics, if antibiotics were given. (Antibiotics are not recommended for treating illness due to STEC or asymptomatic carriage of STEC.) OR
- More than 7 days have passed since the food employee became asymptomatic (without the use of diarrhea suppressing medications) OR
- The food employee did not develop symptoms and more than 7 days have passed since being diagnosed.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional STEC cases.
- If isolates have not already been submitted to the DSHS laboratory for confirmation and PFGE, request hospital/clinical labs submit isolates for confirmation and PFGE testing. See Laboratory Procedures.
- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on, and adherence to, hand hygiene
 - Storage and preparation of food
 - Procedures for changing diapers and toilet training
 - Procedures for environmental cleaning
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

PFGE clusters:

- For clusters of cases with indistinguishable PFGE patterns detected by CDC/PulseNet and/or the DSHS laboratory, a member of the DSHS EAIDB foodborne team will notify appropriate DSHS regional epidemiologists, usually by email, who will then notify appropriate local health departments of cases within their jurisdiction.

- Local/regional health departments with cases in their jurisdiction should:
 - Interview the case patient, even if they have already been interviewed as part of a routine disease investigation, using the cluster specific questionnaire attached in the email notification.
 - Fax the completed questionnaire promptly within timeframe designated in the cluster notification to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - If the health department having jurisdiction of a case is unable to reach a case-patient after 3 attempts during normal working hours, and they are not able to call after hours, please call the DSHS regional office or DSHS EAIDB to discuss further.
 - If an interview is unattainable or the case is lost to follow-up, fax the completed cover sheet and any case information to DSHS EAIDB.
 - Local/regional health department with cases will be notified by the EAIDB foodborne team of any CDC or DSHS conference calls and may participate, if able.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory. The general policy is to test only food samples implicated in suspected outbreaks, not in single cases.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable, and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created, a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

All *E. coli* 0157:H7 isolates or specimens from cases where Shiga toxin activity is demonstrated must be submitted to the DSHS laboratory.

In an outbreak or other special situation, the DSHS Laboratory can culture raw stool or stool in transport medium (e.g., Cary-Blair media) for Shiga toxin-producing *E. coli*. Contact an EAIDB foodborne epidemiologist prior to submitting raw stool or stool in transport medium for culture.

Specimen Collection

- Submit pure cultures on an agar slant at ambient temperatures.
- If a pure culture is not available but Shiga toxin activity is demonstrated,
 - Submit stool specimen in Cary-Blair, Aimes, or Stuarts transport, on wet ice packs, OR
 - Submit stool specimens on broth or MacConkey broth, < 7 days old on wet ice packs, > 7 days old on dry ice.
- For raw stool or stool in transport medium, please refer to table below:

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool	≤24 hours	4°C (ice pack)
Raw stool	>24 hours	Freeze immediately at ≤-70°C. Ship on dry ice.
Stool in transport solution/medium	Time of collection to ≤3 days	Room temp or 4°C (ice pack)
Stool in transport solution/medium	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.
All	*The above transport times are optimal for recovery of pathogenic organisms. In the interest of public health, specimens will be accepted up to 30 days from date of collection.	*The above transport temperatures are optimal for the recovery of pathogenic organisms. In the interest of public health, specimens will be accepted at non-optimal temperature transport.

* Note: Pathogen recovery rates decrease over time. For best results, submit ASAP.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter.

Specimen Shipping

- Ship specimens via overnight delivery.
- DO NOT mail on Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Incorrect source of specimen
- Specimen not in correct transport medium
- Missing or discrepant information on form/specimen
- Transport media was expired
- Specimen too old

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *E.coli* 0157:H7 and non-O157 STEC in meat products is available at the DSHS laboratory. Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

General policy

- Test only food samples or environmental swabs from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreaks, the DSHS lab will not test food samples or environmental swabs unless a pathogen has been identified in a clinical specimen.
- Food samples or environmental swabs must be **collected by a registered sanitarian.**

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

UPDATES

April 2017

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Shigellosis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Shigella species, a Gram negative bacilli. Shigellosis can be caused by four species of *Shigella*: *S. dysenteriae*, *S. flexneri*, *S. boydii*, and *S. sonnei*. *S. sonnei* is the most common cause for shigellosis in the US (72%), per the CDC.

Transmission

Mainly by direct or indirect fecal-oral transmission from a symptomatic patient or asymptomatic carrier. The infectious dose can be as low as 10–100 organisms. Transmission can occur through ingestion of contaminated food or water, direct contact with a contaminated inanimate object (fomites) or sexual contact, including oral-anal contact. Person-to-person transmission is common within households and child-care facilities or other close contacts, especially when hand washing is inadequate. Care givers are also at risk of infection if there is fecal contamination of hands.

Incubation Period

Usually 1-3 days (ranges 12 to 96 hours).

Communicability

People are infectious as long as bacteria are shed in their stool. Shedding may last 1 to 4 weeks after onset of illness. Rarely, individuals can remain carriers for several months. The period of excretion is usually shortened by appropriate antibiotic therapy.

Clinical Illness

Symptoms include acute onset of diarrhea, usually accompanied by moderate to high fever, abdominal pain, cramping, nausea, and tenesmus. Diarrhea is often watery, but may contain blood and mucus (dysentery). Mild and asymptomatic infections also occur.

Severity

Infections can be severe, particularly in young children and the elderly. Complications from shigellosis can include pseudomembranous colitis, toxic megacolon, intestinal perforation, hemolysis, and hemolytic uremic syndrome (HUS).

DEFINITIONS

Clinical Case Definition

An illness of variable severity characterized by diarrhea, fever, nausea, cramps, and tenesmus. Asymptomatic infections can occur.

Laboratory Confirmation

- Isolation of *Shigella* from a clinical specimen.

Case Classifications

- **Confirmed:** A case that meets the laboratory criteria for diagnosis. When available, *Shigella* serogroup or species and serotype characterization should be reported.
- **Probable:**
 - A case with *Shigella* spp. or *Shigella*/EIEC detected, in a clinical specimen, by use of culture independent laboratory methods (non-culture based), **OR**
 - A clinically compatible case that is epidemiologically linked to a case that meets the probable or confirmed laboratory criteria for diagnosis

Note: Both asymptomatic infections and infections at sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.

Note: A case should not be counted as a new case if laboratory results were reported within 90 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different serotype

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

It is recommended that local and regional health departments investigate all reported cases of shigellosis to identify potential sources of infection. Sporadic cases of shigellosis do not require an investigation form to be sent to DSHS EAIDB unless they are identified as part of a multi-jurisdictional cluster or outbreak. Any case associated with a cluster or outbreak should be interviewed.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ If time and resources allow or the case is part of an outbreak or cluster, interview the case to identify potential sources of infection. Ask about possible exposures 1–7 days before onset of symptoms, including:
 - Contacts or household members with a diarrheal illness. Obtain the name, phone number or address, and clinical information of the ill person.
 - Attendance or employment at a child-care facility by the case or a household member of the case. If the case or a household member attends or works at a child-care facility, see Managing Special Situations.
 - Restaurant or other food service meals. Obtain the name of the restaurant, and date and location of the meal.
 - Public gathering where food was consumed. Obtain the date, location, and sponsor of the event.

- Recreational water exposure, including lakes, streams, swimming pools, water parks or wading pools. Obtain the date and location of exposure.
- Source(s) of drinking water as well as water from streams or lakes (either consumed purposefully or accidentally during work or sports activity). Water used only after boiling need not be included.
- Travel within Texas, outside Texas or outside the United States, or contact with others who have traveled outside the United States. Determine dates of travel.
- Sexual contact involving potential oral-fecal exposure.
- Note: If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
- Provide education to the case or his/her surrogate about effective hand washing, particularly after using the toilet, changing diapers, and before preparing or eating food. Meticulous hand washing is required to prevent transmission. See Prevention and Control Measures.
- Identify whether there is a public health concern: persons should not work as food handlers, child-care or health care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- All confirmed, probable, and suspect case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
- Do not participate in recreational water activities such as swimming while diarrhea is present and for one week after diarrhea has resolved.
- Avoid fecal exposure during sexual contact.
- When traveling, drink only treated or boiled water and eat only cooked hot foods or fruits you peel yourself.

Recommended Control Measures for Schools and Child-Care Centers:

- **Hand Washing**
 - Encourage children and adults to wash their hands frequently, especially before handling or preparing foods and after wiping noses, diapering, using toilets, or handling animals.
 - Wash hands with soap and water long enough to sing the “Happy Birthday” song twice.
 - Sinks, soap, and disposable towels should be easy for children to use.
 - If soap and water are not available, clean hands with gels or wipes with alcohol in them.
- **Diapering**
 - Keep diapering areas near hand washing areas.
 - Keep diapering and food preparation areas physically separate. Keep both areas clean, uncluttered, and dry.
 - The same staff member should not change diapers and prepare food.
 - Cover diapering surfaces with intact (not cracked or torn) plastic pads.
 - If the diapering surface cannot be easily cleaned after each use, use a disposable material such as paper on the changing area and discard the paper after each diaper change.
 - Sanitize the diapering surface after each use and at the end of the day.
 - Wash hands with soap and water or clean with alcohol-based hand cleaner after diapering.

- **Environmental Surfaces and Personal Items**

- Regularly clean and sanitize all food service utensils, toys, and other items used by children.
- Discourage the use of stuffed toys or other toys that cannot be easily sanitized.
- Discourage children and adults from sharing items such as combs, brushes, jackets, and hats.
- Maintain a separate container to store clothing and other personal items.
- Keep changes of clothing on hand and store soiled items in a nonabsorbent container that can be sanitized or discarded after use.
- Provide a separate sleeping area and bedding for each child, and wash bedding frequently.

Exclusions

School/child-care: No exclusion specified for shigellosis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications

Food Employees: Symptomatic food employees infected with *Shigella spp.* are to be excluded from work. Asymptomatic food employees diagnosed with an infection from *Shigella spp.* are to be excluded from working in a food establishment serving a highly susceptible population or restricted if they do not serve a highly susceptible population.

Food employees can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met:

- Medical documentation stating that the food employee is free of infection from *Shigella spp.* based on test results showing two consecutive, negative stool specimen cultures. The stool specimens should be collected at least 24 hours apart and not sooner than 48 hours after the last dose of antibiotics, if antibiotics were given.
- More than 7 days have passed since the food employee became asymptomatic (without the use of diarrhea suppressing medications) or
- The food employee did not develop symptoms and more than 7 days have passed since being diagnosed.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Case Attends or Works at a Child-Care Facility

- Interview the director and review written attendance records to identify other possible cases among staff or attendees during the previous month.
- Review food handling, hand washing techniques, and diaper changing practices with the director and staff.
- If other cases are suspected, recommend that they seek medical attention from a healthcare provider.
- Cases should be excluded until free from diarrhea and/or fever. See Exclusions in Case Investigation section.
 - Recommendations can be made to exclude cases until they have two negative stool cultures collected at least 24 hours apart and at least 48 hours after discontinuation of antibiotics
- Parents of children in the same child-care group as a case should be notified of the occurrence of shigellosis in the group. Notification letters should include following elements:

- Children should be monitored carefully for signs of illness such as diarrhea, abdominal pain, nausea, vomiting and fever.
- Notify the daycare operator or local health jurisdiction should symptoms occur.
- A symptomatic child should not be brought to the daycare facility or placed in any other group of children.
- Information on the illness and how transmission can be prevented.
- If indicated, conduct an inspection of the facility.
- Instruct the facility director to call immediately if new cases of illness occur.
- Follow-up with the child-care center to ensure that surveillance and appropriate prevention measures are being carried out (see Prevention and Control Measures).

Outbreaks

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl, D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional shigellosis cases.
- Isolates can be submitted to the DSHS laboratory for serotyping and PFGE. See Laboratory Procedures.
- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on, and adherence to, hand hygiene
 - Storage and preparation of food
 - Procedures for changing diapers and toilet training
 - Procedures for environmental cleaning
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.

- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

PFGE clusters:

- For clusters of cases with indistinguishable PFGE patterns detected by CDC/PulseNet and/or the DSHS laboratory, a member of the DSHS EAIDB foodborne team will notify appropriate DSHS regional epidemiologists, usually by email, who will then notify appropriate local health departments of cases within their jurisdiction.
- Local/regional health departments with cases in their jurisdiction should:
 - Interview the case patient, even if they have already been interviewed as part of a routine disease investigation, using the cluster specific questionnaire attached in the email notification.
 - Fax the completed questionnaire promptly within timeframe designated in the cluster notification to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - If the health department having jurisdiction of a case is unable to reach a case-patient after 3 attempts during normal working hours, and they are not able to call after hours, please call the DSHS regional office or DSHS EAIDB to discuss further.
 - If an interview is unattainable or the case is lost to follow-up, fax the completed cover sheet and any case information to DSHS EAIDB.
- Local/regional health department with cases will be notified by the EAIDB foodborne team of any CDC or DSHS conference calls and may participate, if able.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory. The general policy is to test only food samples implicated in suspected outbreaks, not in single cases.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed, and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 90 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different serotype. A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- If investigation forms are requested, they may be faxed to 512-776-7616 or emailed securely to an EAIDB foodborne epidemiologist.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

CLINICAL SPECIMENS:

Testing for shigellosis is widely available from most private laboratories. Isolates are encouraged to be submitted to the DSHS laboratory for serotyping and PFGE.

In an outbreak or other special situation, the DSHS Laboratory can culture raw stool or stool in transport medium (e.g., Cary-Blair media) for *Shigella* species. Contact an EAIDB foodborne epidemiologist prior to submitting raw stool or stool in transport medium for culture.

Specimen Collection

- Submit pure cultures on an agar slant at ambient temperature or 2-8°C (*ice pack*) as soon as possible to ensure viability.
- For raw stool or stool in transport medium, please refer to table below:

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool	≤24 hours	4°C (ice pack)
Raw stool	>24 hours	Freeze immediately at ≤-70°C. Ship on dry ice.
Stool in transport solution/medium	Time of collection to ≤3 days	Room temp or 4°C (ice pack)
Stool in transport solution/medium	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.
All	*The above transport times are optimal for recovery of pathogenic organisms. In the interest of public health, specimens will be accepted up to 30 days from date of collection.	*The above transport temperatures are optimal for the recovery of pathogenic organisms. In the interest of public health, specimens will be accepted at non-optimal temperature transport.

* Note: Pathogen recovery rates decrease over time. For best results, submit ASAP.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check "Outbreak association" and write in name of outbreak.
- Payor source:
 - Check "IDEAS" to avoid bill for submitter

Specimen Shipping

- Ship specimens via overnight delivery.
- DO NOT mail on Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Missing or discrepant information on form/specimen.
- Specimen not in correct transport medium
- Transport media was expired

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Shigella* spp. is available at the DSHS laboratory. Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

General policy

- The DSHS lab will only test food samples or environmental swabs from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreaks, the DSHS lab will not test food samples or environmental swabs unless a pathogen has been identified in a clinical specimen.
- Food samples or environmental swabs must be **collected by a registered sanitarian**

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

UPDATES

April 2017

- Updated case definition to match the Epi Case Criteria Guide for 2017
 - CIDT methods now included in Probable case definition
- Updated statement regarding how often to count a case, only counting a case once per 90 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

***Streptococcus pyogenes*, Invasive (Group A *Streptococcus*)** rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Streptococcus pyogenes (group A *Streptococcus* [GAS]) are beta-hemolytic, Gram-positive cocci. There are over 130 serotypes.

Transmission

Spread occurs via large respiratory droplets and direct contact. Spread via indirect contact with objects is rare. Foodborne spread has been associated with milk, milk products and egg products. Food products are contaminated by an infected individual. Raw milk may be contaminated if GAS is transmitted to the cow.

Incubation Period

The incubation period is 1 to 5 days.

Communicability

Untreated cases may be infectious for 10–21 days, and longer if purulent discharges are present. The infectious period ends 24 hours after start of appropriate treatment. Asymptomatic carriage is possible.

Clinical Illness

Group A Streptococcal disease has multiple invasive and non-invasive presentations. Non-invasive presentations include strep throat, scarlet fever, impetigo, cellulitis, otitis media and wound infections. Invasive presentations include meningitis, septicemia, septic arthritis, necrotizing fasciitis, peritonitis, osteomyelitis and toxic-shock syndrome.

Severity

Severity varies by clinical presentation. Mortality of invasive infections ranges from 12%–13% and can be as high as 40% in cases with toxic shock syndrome. The Centers for Disease Control and Prevention estimates that 0.4 deaths per 100,000 people occur annually.

DEFINITIONS

Clinical Case Definition

Invasive group A streptococcal infections may manifest as any of several clinical syndromes, including pneumonia, bacteremia in association with cutaneous infection (e.g., cellulitis, erysipelas or infection of a surgical or nonsurgical wound), deep soft-tissue infection (e.g., myositis or necrotizing fasciitis), meningitis, peritonitis, osteomyelitis, septic arthritis, postpartum sepsis (i.e., puerperal fever), neonatal sepsis and non-focal bacteremia.

Laboratory Confirmation

- Isolation of group A *Streptococcus* (*Streptococcus pyogenes*) by culture from a normally sterile site
- Isolation of group A *Streptococcus* (*Streptococcus pyogenes*) by culture from any site when toxic-shock syndrome or necrotizing fasciitis is present

Normally sterile site: Invasive diseases typically cause significant morbidity and mortality. Normally sterile sites include:

- Blood (excluding cord blood)
- Cerebrospinal fluid (CSF)
- Pericardial fluid
- Pleural fluid
- Peritoneal fluid
- Bone or bone marrow

The following are also considered sterile sites when certain other criteria are met:

- Joint fluid when the joint surface is intact (no abscess or significant break in the skin).
- Internal body sites (brain, heart, liver, spleen, vitreous fluid, kidney, pancreas, lymph node or ovary) when the specimen is collected aseptically during a surgical procedure.

Normally sterile sites do *not* include:

- Anatomical areas of the body that normally harbor either resident or transient flora (bacteria) including mucous membranes (throat, vagina), sputum, and skin, or abscesses or localized soft tissue infections.

See the Sterile Site and Invasive Disease Determination Flowchart in Appendix A for confirming that a specimen meets the criteria for sterile site.

Case Classifications

- **Confirmed:** A case that is laboratory confirmed
- **Probable:** No probable case definition

Note: A person with group A *Streptococcus* isolated 2 or more times within a 6-month timeframe (regardless of calendar year) should only be counted once as a case unless additional information is available to indicate a distinct infection, e.g., different serotype, etc.

See the Streptococcal Infection: Case Status Classification Flowchart in Appendix A for assistance with case classification.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of suspected group A *Streptococcus*. In-depth investigation involving patient interviews is not required **but confirmation of case status is necessary**.

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition.
 - See the Sterile Site and Invasive Disease Determination Flowchart for confirming that a specimen meets the criteria for sterile site.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify that the case meets case definition, identify underlying health conditions and describe the course of illness.
 - The Invasive Streptococcal Case Report Form is available at <http://www.dshs.texas.gov/idcu/investigation/> and can be used to record information. This form does not need to be sent to DSHS.
- ☐ If applicable, see the Managing Special Situations section.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Provide education on invasive group A *Streptococcus* as needed.
- Use appropriate food safety practices.
- Recommend only pasteurized milk be consumed.
- Prohibit infected people from handling milk and prohibit people with uncontained skin lesions from handling prepared food.
- Recommend that anyone experiencing symptoms including signs of a wound infection (redness, swelling, drainage, pain) be evaluated by a healthcare provider.
- Promote basic control measures which include:
 - Keep cuts, scratches, sores and wounds clean and covered.
 - Cover your mouth and nose when you sneeze and cough.
 - Wash your hands often using hot water and soap.
 - Don't share toothbrushes or eating utensils.
 - Vaccinate children over 1 year of age against chickenpox. (Some children get invasive GAS infection right after they've had chickenpox.)

Note: For household contacts of persons with invasive GAS infection, routine screening for GAS colonization and chemoprophylaxis is not recommended.

Exclusion

Children with streptococcal sore throat or scarlet fever should be excluded from school and daycare until 24 hours after initiation of antibiotic treatment and until fever subsides. Children with a fever from any infectious cause should be excluded from school and daycare for at least 24 hours after fever has subsided without the use of fever-suppressing medications.

MANAGING SPECIAL SITUATIONS

Case is a Suspected Healthcare-Associated Infection

If one or more healthcare-associated (nosocomial) cases occur in patients of the same dental or healthcare provider, acute care hospital, residential care facility or other long-term care facility; and the cases have no other identified plausible source of infection; or if other circumstances suggest the possibility of nosocomial infection, notify EAIDB at **(800) 252-8239 or (512) 776-7676**. A single case of postpartum or post-surgical GAS infection requires prompt epidemiologic investigation and assessment of potential nosocomial spread from an asymptomatic carrier may be required.

The local/regional health department should:

- Review infection prevention practices at the facility.
- Request the facility to conduct enhanced surveillance for GAS for 6 months before and after the first (and last) case is identified.
- Work with the DSHS EAIDB Healthcare-Associated Infections (HAI) Team or the regional HAI epidemiologist to rule out transmission within the healthcare setting.

Outbreaks

If an outbreak is suspected, notify EAIDB at **(800) 252-8239 or (512) 776-7676**. Outbreaks of invasive disease in children or of rheumatic fever require immediate public health attention.

The local/regional health department should:

- Rule out foodborne exposure.
- Work with the facility to ensure staff and students/residents get hand hygiene and respiratory etiquette education.
- Recommend that staff with streptococcus infections be restricted from working until 24 hours after appropriate antibiotic treatment is initiated.
- Encourage anyone with symptoms to be evaluated by a healthcare provider.
- In childcare settings, limit transfers of children to other childcare settings.
- If cases continue to occur after basic control measures are implemented and the contacts are at high risk for complications or the presentation of illness is severe (rheumatic fever, acute nephritis, toxic-shock syndrome, necrotizing fasciitis, etc.), consider testing to identify carriers.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases to DSHS within 30 days of receiving a report of a confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completion of the investigation.
- If the investigator filled out an investigation form, fax (or mail) it when the NBS notification is submitted.
 - Investigation forms may be faxed to **512-776-7616** or mailed to:
Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to the EAIDB at **512-776-7676**.
- Submit a completed **Respiratory Disease Outbreak Summary Form** at the conclusion of the outbreak investigation.
 - Fax a copy to the DSHS regional office and/or to EAIDB at 512-776-7676.
 - The Respiratory Disease Outbreak Summary Form is available at <http://www.dshs.texas.gov/idcu/investigation/>.

LABORATORY PROCEDURES

Testing for group A *Streptococcus* is widely available from most private laboratories. In general, specimens should not be submitted to the DSHS laboratory. However, if prior approval is obtained from DSHS EAIDB, isolates may be submitted to DSHS for genotyping (PFGE) in cluster or outbreak investigations.

UPDATES

April 2017

- Definitions: minor change to the confirmed Case Classification, added an additional note about case counting to match the change made in the Epi Case Criteria Guide (ECCG)

***Streptococcus agalactiae*, Invasive (Group B *Streptococcus*)** rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Streptococcus agalactiae (group B *Streptococcus* [GBS]) are beta-hemolytic, Gram-positive cocci.

Transmission

Transmission of group B *Streptococcus* from mother to infant occurs just before or during delivery. After delivery, infants are occasionally infected via person-to-person transmission in the nursery. In adults, GBS can be acquired through person-to-person transmission from healthy carriers (colonized but asymptomatic) in the community.

Incubation Period

The incubation period for early onset GBS disease in neonates is <7 days. The incubation period for late onset GBS disease in infants, children and adults is unknown.

Communicability

An estimated 10%–30% of women are carriers. GBS colonization occurs primarily in the gastrointestinal and genital tracts. Colonization is most often asymptomatic and does not require treatment. About half the infants born to colonized mothers are also colonized on the skin and mucosal surfaces as a result of passage through the birth canal or as a result of GBS ascending into the amniotic fluid. The majority of colonized infants, 98%, are asymptomatic.

Clinical Illness

In neonates two syndromes exist: early-onset disease (<7 days old) and late-onset disease (7-90 days old). Both syndromes can include sepsis, pneumonia and meningitis. Pregnancy-related infections include sepsis, amnionitis, urinary tract infection and stillbirth. In adults, pneumonia, bacteremia, meningitis, joint infections or soft tissue infections can occur.

Severity

The Centers for Disease Control and Prevention estimates that 0.53 deaths per 100,000 people occur annually. GBS is the leading cause of neonatal sepsis in the US. The case fatality rate in term infants is 1%–3% and as high as 20% in pre-term infants. The case fatality rate in adults is 8%.

DEFINITIONS

Clinical Case Definition

Group B *Streptococcus* is the most common cause of life-threatening infections, sepsis (blood infection) and meningitis (infection of the fluid and lining around the brain) in newborns. In infants, group B *Streptococcus* is characterized by sepsis, respiratory distress, apnea, shock, pneumonia and meningitis. GBS is acquired in utero or during delivery, and occurs more frequently in low birth weight infants.

Group B *Streptococcus*, invasive disease can present in a number of different ways in adults. The most common problems in adults are: bloodstream infections, pneumonia, skin and soft-tissue infections and bone and joint infections. Rarely, group B *Streptococcus* can cause meningitis in adults.

Laboratory Confirmation

- Isolation of group B *Streptococcus* (*Streptococcus agalactiae*) by culture from a normally sterile site
- Isolation of group B *Streptococcus* (*Streptococcus agalactiae*) by culture from placenta or amniotic fluid from an intact amnion

Normally sterile site: Invasive diseases typically cause significant morbidity and mortality. Normally sterile sites include:

- Blood (excluding cord blood)
- Cerebrospinal fluid (CSF)
- Pericardial fluid
- Pleural fluid
- Peritoneal fluid
- Bone or bone marrow

The following are also considered sterile sites when certain other criteria are met:

- Joint fluid when the joint surface is intact (no abscess or significant break in the skin).
- Internal body sites (brain, heart, liver, spleen, vitreous fluid, kidney, pancreas, lymph node or ovary) when the specimen is collected aseptically during a surgical procedure.

Normally sterile sites do *not* include:

- Anatomical areas of the body that normally harbor either resident or transient flora (bacteria) including mucous membranes (throat, vagina), sputum, and skin, or abscesses or localized soft tissue infections.

See the Sterile Site and Invasive Disease Determination Flowchart in Appendix A for confirming that a specimen meets the criteria for sterile site.

Case Classifications

- **Confirmed:** A case that is laboratory confirmed
- **Probable:** No probable case definition

Note: Only count one GBS case for a mother/baby pair unless both mother and baby have GBS isolated/cultured from a sterile site (for this consideration, placenta and amniotic fluid are not sterile sites). In the event of a stillbirth or fetal death, if GBS is isolated from the placenta or amniotic fluid and there is no GBS culture available from a sterile site, count once as a maternal case.

Note: A person with group B *Streptococcus* isolated 2 or more times within a 6-month timeframe (regardless of calendar year) should only be counted once as a case unless additional information is available indicating a distinct infection, e.g., different serotype, etc.

See the Streptococcal Infection: Case Status Classification Flowchart in Appendix A for assistance with case classification.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of suspected group B *Streptococcus*. In-depth investigation involving patient interviews is not required **but confirmation of case status is necessary**.

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition.
 - See the Sterile Site and Invasive Disease Determination Flowchart for confirming that a specimen meets the criteria for sterile site.
- ☐ Review medical records or speak to an infection preventionist or physician to verify that the case meets case definition, identify underlying health conditions and describe the course of illness.
 - The Invasive Streptococcal Case Report Form is available at <http://www.dshs.texas.gov/idcu/investigation/> and can be used to record information. This form does not need to be sent to DSHS.
- ☐ If applicable, see the Managing Special Situations section.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Provide education on invasive group B *Streptococcus* as needed.
- Recommend that anyone experiencing symptoms be evaluated by a healthcare provider.
- Promote routine hand washing with soap and warm water.
- Pregnant women should undergo vaginal-rectal screening for GBS colonization at 35-37 weeks.
- Use standard precautions. In the case of a nursery outbreak, use contact precautions.
- Antibiotic prophylaxis during non-cesarean section labor is recommended if the mother:
 - Has a positive GBS screen between weeks 35 and 37
 - Has a positive GBS urine result anytime during the current pregnancy
 - Delivered a previous baby with invasive GBS disease
 - Develops fever ($\geq 100.4^{\circ}\text{F}$) during labor
 - Has not delivered her baby within 18 hours of her water breaking
 - Goes into labor before 37 weeks and has not been tested for GBS

Exclusion

Children with a fever from any infectious cause should be excluded from school and daycare for at least 24 hours after fever has subsided without the use of fever-suppressing medications.

MANAGING SPECIAL SITUATIONS

Case is a Suspected Healthcare-Associated (Nosocomial) Infection

If one or more nosocomial (healthcare-associated) cases occur in patients of the same labor and delivery facility, residential care facility or other long-term care facility; and the cases have no other identified plausible source of infection; or if other circumstances suggest the possibility of nosocomial infection, notify the IRID team lead in EAIDB at **(800) 252-8239 or (512) 776-7676**. The DSHS EAIDB Healthcare-Associated Infections (HAI) Team or the regional HAI epidemiologist should also be notified and should work with the local health department to investigate the possibility of transmission within the healthcare setting.

Outbreaks

If an outbreak is suspected, notify EAIDB at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should:

- Review infection prevention practices currently in place.
- Work with the facility to ensure that everyone gets hand hygiene education.
- Recommend cohorting of ill and colonized infants together and the use of contact precautions in nursery settings.
- Encourage anyone with symptoms to be evaluated by a healthcare provider.

Note: Treatment of asymptomatic carriers is considered ineffective.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases to DSHS within 30 days of receiving a report of a confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completion of the investigation.
- If the investigator filled out an investigation form, fax (or mail) it when the NBS notification is submitted.
 - Investigation forms may be faxed to **512-776-7616** or mailed to:
Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.
- Submit a completed **Respiratory Disease Outbreak Summary Form** at the conclusion of the outbreak investigation.
 - Fax a copy to the DSHS regional office and/or to EAIDB at 512-776-7676.
 - The Respiratory Disease Outbreak Summary Form is available at <http://www.dshs.texas.gov/idcu/investigation/>.

LABORATORY PROCEDURES

Testing for group B *Streptococcus* is widely available from most private laboratories. In general, specimens should not be submitted to the DSHS laboratory. However, if prior approval is obtained from DSHS EAIDB, isolates may be submitted to DSHS for genotyping (PFGE) in cluster or outbreak investigations.

UPDATES

April 2017

- Definitions: minor change to the confirmed Case Classification, added additional notes about case counting to match the change made in the Epi Case Criteria Guide (ECCG)

***Streptococcus pneumoniae*, Invasive (Pneumococcal Disease)** rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Streptococcus pneumoniae (*S. pneumoniae*) are beta-hemolytic, Gram-positive cocci.

Transmission

Transmission of *S. pneumoniae* occurs as a result of direct person-to-person contact via respiratory droplets and by autoinoculation in persons carrying the bacteria in their upper respiratory tract.

Incubation Period

The incubation period varies by type of infection and can be as short as 1 to 3 days.

Communicability

The period of communicability is unknown. It may be as long as the organism is present in respiratory tract secretions but is probably less than 24 hours after effective antimicrobial therapy is begun.

Clinical Illness

The major clinical manifestations of invasive pneumococcal disease are bacteremia and meningitis. Pneumonia is the most common clinical presentation of pneumococcal disease among adults. Symptoms generally include an abrupt onset of fever and chills or rigors. Other common symptoms include pleuritic chest pain, productive cough, shortness of breath, rapid breathing, hypoxia, rapid heart rate, malaise and weakness.

Bacteremia without a known site of infection is the most common invasive clinical presentation of pneumococcal infection among children 2 years of age and younger.

Severity

The case fatality rate of pneumococcal pneumonia is 5%-7% and may be much higher among elderly persons. Bacteremia occurs in about 25%-30% of patients with pneumococcal pneumonia. The case fatality rate of pneumococcal bacteremia is about 20%, but may be as high as 60% among elderly persons. The case fatality rate of pneumococcal meningitis is about 30% and may be as high as 80% among elderly persons. *S. pneumoniae* disease is estimated to cause 175,000 hospitalizations annually.

DEFINITIONS

Clinical Case Definition

Streptococcus pneumoniae cause many clinical syndromes depending on the site of infection (e.g., acute otitis media, pneumonia, bacteremia, or meningitis). Only invasive *Streptococcus pneumoniae* disease is reportable.

Laboratory Criteria for Diagnosis

- Isolation of *S. pneumoniae* from a normally sterile site.

Normally sterile sites do *not* include:

- Anatomical areas of the body that normally harbor either resident or transient flora (bacteria) including mucous membranes (throat, vagina), sputum and skin, or abscesses or localized soft tissue infections.

See the Sterile Site and Invasive Disease Determination Flowchart in Appendix A for confirming that a specimen meets the criteria for sterile site.

Case Classification

- **Confirmed:** A case that is laboratory confirmed
- **Probable:** A case with detection of *S. pneumoniae* from a normally sterile site using a culture independent diagnostic test (CIDT) (e.g., PCR, antigen based tests) without isolation of the bacteria

See the Streptococcal Infection: Case Status Classification Flowchart in Appendix A for assistance with case classification.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of suspected *Streptococcus pneumoniae*. In-depth investigation involving patient interviews is not required, but **it is necessary to confirm case status and vaccination status.**

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition. Only specimens from sterile sites are accepted as evidence of invasive disease.
 - See the Sterile Site and Invasive Disease Determination Flowchart for confirming that a specimen meets the criteria for sterile site.
- ☐ Review medical records or speak to an infection preventionist or physician to verify that the case meets case definition, identify underlying health conditions and describe the course of illness.
 - The Invasive Streptococcal Case Report Form is available at <http://www.dshs.state.tx.us/idcu/investigation/> and can be used to record information. This form does not need to be sent to DSHS.
- ☐ Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- ☐ For children <5 years of age, ask the laboratory to forward the specimen to DSHS for serotyping (voluntary activity, see Laboratory Procedures below).

- If applicable, see the Managing Special Situations section.
- All confirmed *Streptococcus pneumoniae* case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- Provide education on *Streptococcus pneumoniae* as needed.
- Recommend that anyone experiencing symptoms be evaluated by a healthcare provider.
- Promote respiratory etiquette and hand hygiene.
- Encourage vaccination per ACIP guidance.
 - Pneumococcal conjugate vaccine (PCV13) is recommended for all children younger than 5 years old, all adults 65 years or older, and people 6 years or older with certain risk factors.
 - Pneumococcal polysaccharide vaccine (PPSV23) is recommended for all adults 65 years or older. People 2 years through 64 years of age who are at high risk of pneumococcal disease should also receive PPSV23.

Managing Close Contacts

Special management of close contacts has no significant value for routine situations.

Treatment

Certain antibiotics are effective at treating *S. pneumoniae* infection.

Exclusion

Children with a fever from any infectious cause should be excluded from school and daycare for at least 24 hours after fever has subsided without the use of fever-suppressing medications.

MANAGING SPECIAL SITUATIONS

Case is a Suspected Healthcare-Associated (Nosocomial) Infection

If one or more nosocomial (healthcare-associated) cases occur in patients of the same hospital, residential care facility, or other long-term care facility; and the cases have no other identified plausible source of infection; or if other circumstances suggest the possibility of nosocomial infection, notify the IRID team lead in EAIDB at **(800) 252-8239 or (512) 776-7676**. The DSHS EAIDB Healthcare-Associated Infections (HAI) Team or the regional HAI epidemiologist should also be notified and should work with the local health department to investigate the possibility of transmission within the healthcare setting.

Outbreaks

If an outbreak of *S. pneumoniae* is suspected, notify the regional DSHS office or EAIDB at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should work with the facility to:

- Review infection prevention practices currently in place.
- Ensure everyone gets hand hygiene and respiratory etiquette education.
- Ensure that symptomatic staff members are excluded from work.
- Ensure an adequate supply of personal protective equipment (PPE) (e.g., gowns, masks).
- Ensure that staff members wear PPE for all respiratory illnesses without an identified etiology.
- Cohort ill patients/residents together.

- Encourage anyone with symptoms to be evaluated by a healthcare provider.
- Review vaccination status of exposed persons and recommend vaccination per ACIP guidance.

Note: Treatment of asymptomatic carriers is considered ineffective.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School & Child-Care Facilities, and General Public Reporting Requirements

Confirmed cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases to DSHS within 30 days of receiving a report of a confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completion of the investigation.
- If the investigator filled out an investigation form, fax (or mail) it when the NBS notification is submitted.
 - Investigation forms may be faxed to **512-776-7616** or mailed to:
Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at (800) 252-8239 or 512-776-7676.
- Submit a completed **Respiratory Disease Outbreak Summary Form** at the conclusion of the outbreak investigation.
 - Fax a copy to the DSHS regional office and/or to EAIDB at 512-776-7676

The Respiratory Disease Outbreak Summary Form is available at

<http://www.dshs.state.tx.us/idcu/investigation/>.

LABORATORY PROCEDURES

Testing for pneumococcal disease is widely available from most hospital or private laboratories. The only exception is serotyping of isolates to determine if the strain was vaccine-preventable or not. Currently, serotyping of isolates is only available through the DSHS Laboratory and only offered for cases less than five years of age. Isolates must be from a sterile site.

Please refer to the [TAC](#) Title 25, Ch 97, Subchapter A, Rule §97.3 “What Condition to Report and What Isolates to Report or Submit”.

Isolate submission

- Submit isolates of *S. pneumoniae* on appropriate media such as blood or chocolate agar slants (or media that has the necessary growth requirements for *S. pneumoniae*) at ambient temperature.
- Ship isolates to the DSHS laboratory via overnight delivery.
- Use Specimen Submission form G-2B. Under Section 4, Bacteriology, write in “S. pneumo” next to Serotyping.

Section 4. BACTERIOLOGY	
<u>Clinical specimen:</u>	<u>Pure culture:</u>
☐ Aerobic isolation	☐ Anaerobic identification
☐ Anaerobic isolation	☐ Organism suspected: _____
☐ Culture, stool	<u>Definitive Identification:</u>
☐ Diphtheria Screen	☐ Bacillus
☐ EHEC, shiga-like toxin assay	☐ Campylobacter
☐ GC/CT, amplified RNA probe	☐ Enteric Bacteria
☐ GC Screen	☐ Gram Negative Rod
☐ Group B Strep Screen	☐ Gram Positive Rod
☐ Haemophilus, isolation	☐ Group B Streptococcus (Beta Strep)
☐ Toxic shock syndrome toxin I assay (TSST 1)	☐ Haemophilus
<u>Serotyping:</u> <i>S. pneumo</i>	☐ Legionella
☐ E.coli	☐ Neisseria
☐ Haemophilus influenzae	☐ Pertussis / Bordetella
☐ Neisseria meningitidis	☐ Staphylococcus
☐ Salmonella	☐ Streptococcus
☐ Shigella	☐ Vibrio
☐ Vibrio cholera	☐ Other:

Specimen Shipping

- DO NOT mail on a Friday or the day before a state holiday unless special arrangements have been made in advance with the DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection

- Discrepant or missing information between isolate and paperwork
- Expired media used

UPDATES

April 2017

- The case classification for confirmed cases has been updated to remove the requirement for being clinically compatible to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
- A case classification for probable cases has been added to reflect the current addition in case definition from the Council of State and Territorial Epidemiologists
- A note regarding the timeframe for counting new cases has been added

Tetanus

rev Jan 2014

BASIC EPIDEMIOLOGY

Infectious Agent

Clostridium tetani, a Gram-positive, spore-forming drumstick-shaped bacilli

Reservoir

Tetanus spores are found in soil and in the intestines and feces of many domestic animals and fowl. Spores have also been reported in contaminated heroin.

Transmission

Transmission is primarily by contaminated wounds (severe or minor, even those unapparent to the injured). In recent years, however, a higher proportion of patients had minor wounds, probably because severe wounds are more likely to be properly managed. Tetanus may follow elective surgery, burns, deep puncture wounds, crush wounds, otitis media (ear infections), dental infection, animal bites, abortion, and pregnancy.

Incubation Period

Usually 3–21 days, although it may range from 1 day to several months, depending on the type, severity and location of the wound; average 10 days. Most cases occur within 14 days. In general, shorter incubation periods are associated with more heavily contaminated wounds, more severe disease and a worse prognosis.

Communicability

Tetanus is not transmitted from one person to another. A person with tetanus is not infectious to others.

Clinical Illness

Tetanus is a neurological disease caused by tetanus toxin. Three different clinical forms have been described; generalized (~80%), local and cephalic tetanus. Symptoms of generalized tetanus include rigidity and painful spasms of skeletal muscles. Initial muscles affected are often in the jaw and neck (leading to the common name for the disease: “lockjaw”) followed by involvement of larger muscles in a descending pattern. Seizures may occur. Less common forms of tetanus are local tetanus which is localized to the anatomic area of injury and cephalic tetanus which involves the cranial nerves. In countries with poor hygiene, neonatal tetanus causes significant mortality when infants born to unimmunized women have infection of the umbilical stump that was contaminated with soil or alternative medical treatment.

Complications of tetanus include fractures, difficulty breathing (due to spasms of the respiratory muscles), and abnormal heart rhythms. In addition, nosocomial infections related to prolonged hospitalization can occur. Death results in approximately 11% of affected persons. The case fatality rate ranges from 10% to over 80%, it is highest in infants and the elderly, and varies inversely with the length of the incubation period and the availability of experienced intensive care unit personnel and resources.

Attempts at laboratory confirmation are of little help. The organism is rarely recovered from the site of infection, and usually there is no detectable antibody response.

DEFINITIONS

Clinical Case Definition

Acute onset of hypertonia and/or painful muscular contractions (usually of the muscles of the jaw and neck) and generalized muscle spasms without other apparent medical cause

Laboratory Confirmation

- None, there is no laboratory criteria for tetanus

Case Classification

- **Confirmed:** No confirmed case definition
- **Probable:** A clinically compatible case, as reported by a health-care professional

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate all reports of tetanus.

Case Investigation Checklist

- ☐ Confirm that clinical picture meets the case definition.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition, clinical picture, treatment history and vaccination status.
 - The Tetanus Investigation Form should be used to record information collected during the investigation.

Tetanus Immune Globulin (TIG) is used to treat tetanus cases (and certain wounds, see Table 1). Hospitals usually have this available but if TIG is needed, DSHS has limited quantities. Contact your regional immunization program manager or EAIDB DSHS VPD team.

- ☐ Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- ☐ Follow-up with the status of the case until death or resolution of symptoms (e.g., mechanical ventilation no longer needed).
 - Case can be submitted in NBS prior to symptom resolution if investigation is otherwise complete.
- ☐ In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be faxed to DSHS EAIDB.
- ☐ Send the complete the Tetanus Investigation Form to DSHS.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

- The best method for controlling tetanus is preventing tetanus through active immunization with adsorbed tetanus toxoid; combined Tetanus-diphtheria-pertussis vaccine (Tdap) is recommended.
- Tdap is recommended for universal use above age seven, especially for persons employed in occupations which put them in contact with soil, sewage, or domestic animals; military personnel, policeman, firefighters, and others with greater than usual risk of traumatic injury; the elderly; and international travelers.
- Children under seven should receive DTaP according to current ACIP recommendations.

Table 1. Guide to Tetanus Prophylaxis in Routine Wound Management

History of Adsorbed Tetanus Toxoid (Doses)	Clean, Minor Wounds		All Other Wounds ^a	
	DTaP, Tdap, or Td ^b	TIG ^c	DTaP, Tdap, or Td ^b	TIG ^c
Fewer than 3 or unknown	Yes	No	Yes	Yes
3 or more	No if <10 y since last tetanus-containing vaccine dose	No	No ^d if <5 y since last tetanus-containing vaccine dose	No
	Yes if 10 y since last tetanus-containing vaccine dose	No	Yes if 5 y since last tetanus-containing vaccine dose	No

Tdap indicates booster tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine; DTaP, diphtheria and tetanus toxoids and acellular pertussis vaccine; Td, adult-type diphtheria and tetanus toxoids vaccine; TIG, Tetanus Immune Globulin (human).

^aSuch as, but not limited to, wounds contaminated with dirt, feces, soil, and saliva; puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns, and frostbite.

^bDTaP is used for children younger than 7 years of age. Tdap is preferred over Td for underimmunized children 7 years of age and older who have not received Tdap previously.

^cImmune Globulin Intravenous should be used when TIG is not available.

^dMore frequent boosters are not needed and can accentuate adverse effects.

Source: American Academy of Pediatrics. Tetanus. In: Pickering LK, Baker CJ, Long SS, McMillan JA, eds. *Red Book: 2012 Report of the Committee on Infectious Diseases*. 29th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2012: 709.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Probable and clinically suspected tetanus cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **probable** cases to DSHS within 30 days of receiving a report of a confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be sent to DSHS EAIDB.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

LABORATORY PROCEDURES

Laboratory confirmation is not necessary for case confirmation.

UPDATES

April 2017

- No updates were made to this section

Trichuriasis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Trichuriasis is caused by infection with the intestinal nematode *Trichuris trichiura*. *Trichuris trichiura* is the second most common soil transmitted helminth in the world.

Transmission

Transmission is primarily via ingestion of fecal contaminated soil. Eggs are shed in an infected person's feces but do not become infectious until they have incubated in soil for at least 10 days. Once they become infectious they can be transmitted via contaminated water, agriculture products, fingers, or other fomites.

Incubation Period

Eggs must incubate in the soil for at least 10 days before they become infectious to humans. Once ingested it takes approximately 10 weeks for eggs to develop into egg-laying adults. Adult worms can live in the human intestine for greater than five years.

Communicability

Human to human transmission of *T. trichiura* does NOT occur because part of the worm's life cycle must be completed in soil before becoming infectious. Soil contamination is perpetuated by fecal contamination from infected individuals. An infected person may shed eggs for as long as they are infected with an egg-laying adult which may be several years.

Clinical Illness

Clinical manifestations of trichuriasis tend to be dependent on the severity of the infection. Minor infections may only result in peripheral blood eosinophilia. Individuals with moderate to severe infections may develop symptoms such as frequent, painful and/or bloody stool, rectal prolapse, or anemia. Children with prolonged or severe anemia may develop significant growth or mental impairment.

DEFINITIONS

Clinical Case Definition

While most cases are asymptomatic severe cases may develop symptoms similar to inflammatory bowel disease. Dysentery including frequent passage of stool that is painful or bloody with mucus or rectal prolapse may be present. Children with severe infection may be developmentally impaired and/or anemic.

Laboratory Confirmation

- Microscopic identification of *Trichuria* eggs or worms in feces, **OR**
- Observation during sigmoidoscopy, proctoscopy, or colonoscopy of *Trichuria* worms characterized by a threadlike form with an attenuated, whip-like end, **OR**
- Identification of worms on prolapsed rectal mucosa

Case Classifications

- **Confirmed:** A case that is laboratory confirmed

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of trichuriasis. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the Trichuriasis Investigation Form available on the DSHS website:

<http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
- ☐ Interview the case to get detailed exposure history and risk factor information.
 - Use the **Trichuriasis Investigation Form** to record information from the interview.
 - If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
 - Provide education to the case or his/her surrogate about effective hand washing, food safety practices, and avoidance of soil contamination. See Prevention and Control Measures.
- ☐ Fax completed forms to DSHS EAIDB at **512-776-7616**
 - For lost to follow-up (LTF) cases, please complete as much information as possible obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/e-mail securely to DSHS EAIDB and indicate the reason for any missing information.
- ☐ If case is part of an outbreak or cluster, see Managing Special Situations section.
- ☐ All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water.
- Proper disposal of human waste products such as feces is necessary to prevent contamination of soil.
- Avoid areas where human waste contamination of soil or water is likely.
- Thoroughly wash fruits and vegetables to remove soil/fertilizer residue.
- Thoroughly cook all fruits and vegetables that may have been in contact with soil produced from human and animal waste.

Exclusions

There is no human-to-human transmission of trichuriasis therefore no exclusion from work, school or daycare is required for disease control purposes unless the individual has diarrhea. If the individual has diarrhea, the standard exclusion until diarrhea free for 24 hours without the use of diarrhea suppressing medications applies. Diarrhea is defined as 3 or more episodes of loose stools in a 24 hour period.

MANAGING SPECIAL SITUATIONS

Outbreaks/Clusters

If an outbreak or cluster is suspected, notify the DSHS Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky exposures, such as inadequate waste disposal near the home or work, recreational activities in areas with inadequate waste disposal, or travel to an endemic country reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Risks	Notes
1	NT	34	F	White/non-Hispanic	12/4/16	Diarrhea, Anemia	Travel to Vietnam, lives in same neighborhood as ID 2	Brother ill
2	PR	4	M	Unknown	11/30/16	Anemia, bloody stool	Poor sanitation near home, lives in same neighborhood as ID 1	Lost to follow up (LTF)

- If the outbreak was reported in association with an apparent common risk factor (e.g., work or live near a possible site of soil contamination, members of the same household with similar travel), recommend that anyone displaying symptoms seek medical attention from a healthcare provider.
- If several cases in the same family or geographic area are identified and there is a possibility for similar exposures (e.g., travel to the same country, poor sanitation), testing of potentially exposed persons or mass de-worming treatment may be warranted.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB neglected tropical disease epidemiologist.

When an outbreak is being investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**.

LABORATORY PROCEDURES

Fecal Ova and Parasite testing for trichuriasis is widely available from most private laboratories however, specimen submission to DSHS laboratory is advised. Adult worm specimen identification may not be available at private laboratories therefore, submission to the DSHS laboratory is available and highly recommended. Contact an EAIDB neglected tropical disease epidemiologist to discuss further if needed.

Specimen Collection

- Submit a stool specimen in a sterile, leak-proof container.
 - Required volume: Stool 15 g solid or 15 mL liquid.
- Specimens that cannot be received by the lab in less than 5 hours should be placed in formalin and PVA immediately.
- Adult worms should be submitted in either 5-10% formalin or 70% ethanol.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name and date of birth or social security number match exactly what is written on the transport tubes.
- Fill in the date of collection, date of onset, and diagnosis/symptoms.

Specimen Shipping

- Transport temperature: May be shipped at ambient temperature.
- Ship specimens via overnight delivery.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Possible Causes for Rejection:

- Specimen not in correct transport medium.
- Missing or discrepant information on form/specimen.
- Unpreserved specimen received greater than 5 hours after collection– specimen should still be submitted as an attempt will be made to complete testing.
- Transport media was expired.

UPDATES

April 2017

- Basic Epidemiology: revised the Transmission, Incubation Period, and Communicability sections to provide clarity.

Typhoid Fever rev Apr 2017

Note that typhoid infections (caused by *S. Typhi*) are reported in NEDSS as Typhoid Fever and will be covered in this section. Paratyphoid infections (caused by *S. Paratyphi* A, B, and C) are reported in NEDSS as Salmonellosis. See Table 1, at the end of this section.

BASIC EPIDEMIOLOGY

Infectious Agent

Salmonella enterica serovar Typhi (*S. Typhi*) is the etiologic agent of typhoid fever.

Transmission

Transmission primarily occurs through ingestion of food or water contaminated with the stool and sometimes urine of a typhoid fever case or an asymptomatic carrier of the organism. It has been documented that typhoid fever has been transmitted sexually from an asymptomatic carrier. Most cases of typhoid fever are travel-related and involve an exposure that occurred in an endemic region (i.e., primarily Asia, Africa, and Latin America). Humans are the only known reservoir of *S. Typhi*.

Incubation Period

Typically, ranges from 8 to 14 days. However, incubation can range from 3 to 60 days.

Communicability

Humans are infectious as long as bacteria are shed in their stool and/or urine. Shedding in stool occurs throughout the course of infection, usually lasting several days to several weeks, with 2-5% of cases becoming chronic carriers capable of excreting the organism for many months. Urinary shedding is less common than fecal shedding. Antibiotic use during the acute illness can prolong the carrier state. Both treated and untreated patients may become chronic carriers of the organism. The most common population for chronic carriers are middle-aged women with a history of biliary duct abnormalities, such as gallstones.

Clinical Illness

Symptoms typically include sustained fever (may reach 103-104 °F), headache, and malaise. Most adults experience constipation, rather than diarrhea. Additional symptoms include anorexia, bradycardia, splenomegaly, non-productive cough, rose spots on the trunk, mental dullness, slight deafness, parotitis, or the development of Peyer patches in the ileum, which may ulcerate and result in intestinal hemorrhage or perforation in 3% of cases. Despite antimicrobial treatment, relapses causing milder illness occur in 15-20% of cases.

Severity

The severity of Typhoid Fever is dependent on multiple factors; e.g., age, prior exposure (via illness or vaccination), number of organisms ingested, virulence of the strain ingested, duration of illness (including time until treatment is initiated). Cases with mental or neurological symptoms have been associated with higher mortality rates. Mortality rates range from 10%-20% without treatment to 1% with access to antimicrobials.

DEFINITIONS

Clinical Case Definition

An illness caused by *Salmonella* Typhi that is often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and nonproductive cough. However, many mild and atypical infections occur. Carriage of *S. Typhi* can be prolonged.

Laboratory Confirmation

- Isolation of *S. Typhi* from blood, stool, or other clinical specimen.

Case Classifications

- **Confirmed:** A clinically compatible case that is laboratory confirmed.
- **Probable:** A clinically compatible case that is epidemiologically linked to a confirmed case in an outbreak

Note: a case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of Typhoid Fever. Investigations should include an interview of the case or a surrogate to get a detailed exposure history.

Please use the **CDC Typhoid and Paratyphoid Fever Surveillance Report** available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Contact laboratory to determine if an isolate has been sent to the DSHS laboratory. If an isolate has not been sent, please request a specimen be submitted.
 - Note: The submission of *S. Typhi* isolates is not required by state law, but it is critical for the detection and investigation of outbreaks.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
 - Use information from medical records to complete the CDC Typhoid and Paratyphoid Fever Surveillance Report.
- ☐ Interview the case to get travel history and other risk factor information.
 - Make special note of the case's travel history. If the case-patient does not report travel outside of the U.S., ask again about travel. If the answer is still negative, inquire about any visitors from a country where typhoid fever is endemic, especially any who might have stayed in the case-patient's household, prepared food, cared for, or had close contact with the case-patient. Ask about prior cases of typhoid fever among members of the household, extended family, or friends. Ask about consumption of raw or undercooked shellfish or bivalves (oysters, scallops etc.) If no history of travel to an endemic country, exposure to an imported case or history of consumption of raw or undercooked seafood is identified, call an EAIDB epidemiologist immediately to discuss the case.

- Make special note if the case is a food worker. Food workers who are diagnosed with typhoid fever are subject to work exclusion requirements. See Exclusions.
- Use the **CDC Typhoid and Paratyphoid Fever Surveillance Report** to record information from the interview.
- If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
- Provide education to the case or his/her surrogate about effective hand washing and food safety practices. See Prevention and Control Measures.
- Fax completed forms to DSHS EAIDB at 512-776-7616 or email securely to an EAIDB epidemiologist.
 - An EAIDB foodborne epidemiologist will fax the form (de-identified) to the CDC.
 - Please note that the CDC measures the proportion of interviews reported to CDC within 7 days of interview date, so please send the form as soon as possible.
 - For lost to follow-up (LTF) cases, please complete as much information as possible obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on the investigation form and fax/email securely to DSHS EAIDB noting case is LTF.
- Hospitalized cases should be followed until discharge and patient's outcome recorded on the Typhoid and Paratyphoid Fever Surveillance Report.
 - Initial reports can be sent to DSHS prior to discharge.
- In the event of a death, copies of the hospital discharge or death summary should also be faxed to DSHS EAIDB.
- If the case is part of an outbreak or cluster, see Managing Special Situations section.
- All confirmed case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- For those traveling to an endemic region:
 - Receive the Typhoid Fever immunization (1 to 2 weeks prior to travel, time frame varies based on type of vaccine).
 - Only eat fresh raw fruit and vegetables that can be peeled, peel them yourself, don't eat the peels, and wash your hands before and after handling.
 - Avoid food and drinks sold from street vendors.
 - Avoid ice, frozen drinks, or other items made from an unknown water source.
 - Drink bottled water (or boil non-bottled water for >1min) and avoid swallowing tap water while showering and brushing teeth..
 - Carbonated water is safer to drink than non-carbonated water.
- Practice routine hand washing with soap and warm water, especially:
 - Before preparing or after handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
 - After handling raw food.
- Avoid consuming raw or undercooked shellfish and bivalves (oysters, scallops, mussels etc.), especially in endemic countries.
- Avoid consuming raw milk, unpasteurized dairy products, and undercooked eggs.

Exclusions

School/child-care:

Children with Typhoid Fever should be excluded from school/child-care until they are free from fever and diarrhea for 24 hours without the use of fever or diarrhea suppressing medications.

Children must have three consecutive negative stools before being allowed to return to school. The stool specimens should be collected at least 24 hours apart and not sooner than 48 hours after the last dose of antibiotics, if antibiotics were given.

Food Employees: Symptomatic food employees infected with *Salmonella* Typhi are to be excluded from work.

Food employees can be reinstated with approval from the Regulatory Authority and if the following condition is met:

- Medical documentation by a health practitioner stating that the food employee is free of infection from *Salmonella* Typhi.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If a Typhoid Fever outbreak is suspected, immediately notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional Typhoid Fever cases.

- If isolates have not already been submitted to the DSHS laboratory for confirmation and PFGE, request hospital/clinical labs submit isolates for confirmation and PFGE testing. See Laboratory Procedures.
- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on and adherence to hand hygiene
 - Storage and preparation of food
 - Procedures for changing diapers and toilet training
 - Procedures for environmental cleaning
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, per the “Exclusions” portion of the Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

PFGE clusters:

- For clusters of cases with indistinguishable PFGE patterns detected by CDC/PulseNet and/or the DSHS laboratory, a member of the DSHS EAIDB foodborne team will notify appropriate DSHS regional epidemiologists, usually by email, who will then notify appropriate local health departments of cases within their jurisdiction.
- The local/regional health department with cases in their jurisdiction should:
 - Interview the case patient, even if they have already been interviewed as part of a routine disease investigation, using the cluster specific questionnaire attached in the email notification.
 - Fax the completed questionnaire promptly within timeframe designated in cluster notification to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - If the health department having jurisdiction of a case is unable to reach a case-patient after 3 attempts during normal working hours, and they are not able to call after hours, please call the DSHS regional office or DSHS EAIDB to discuss further.
 - If an interview is unattainable or the case is lost to follow-up, fax/securely email medical records and any case information to DSHS EAIDB.
 - Please complete as much information obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.
- Local/regional health department with cases will be notified by the EAIDB foodborne team of any CDC or DSHS conference calls and may participate, if able.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory. The general policy is to test only food samples implicated in suspected outbreaks, not in single cases.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed** and **probable** cases,
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection. A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed Typhoid and Paratyphoid Fever Surveillance Report to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

CLINICAL SPECIMENS:

Submission of *Salmonella* isolates for serotyping and pulse-field gel electrophoresis (PFGE) is available through the DSHS Laboratory and is highly encouraged but not required.

In an outbreak or other special situation, the DSHS Laboratory can culture raw stool or stool in transport medium (e.g., Cary-Blair media) for *Salmonella* Typhi. Contact an EAIDB foodborne epidemiologist prior to submitting raw stool or stool in transport medium for culture.

Specimen Collection

- Submit pure cultures on an agar slant at ambient temperature or 2-8°C (*ice pack*) as soon as possible to ensure viability.
- For raw stool or stool in transport medium, please refer to table below:

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool	≤24 hours	4°C (ice pack)
Raw stool	>24 hours	Freeze immediately at ≤-70°C. Ship on dry ice.
Stool in transport solution/medium	Time of collection to ≤3 days	Room temp or 4°C (ice pack)
Stool in transport solution/medium	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.
All	*The above transport times are optimal for recovery of pathogenic organisms. In the interest of public health, specimens will be accepted up to 30 days from date of collection.	*The above transport temperatures are optimal for the recovery of pathogenic organisms. In the interest of public health, specimens will be accepted at non-optimal temperature transport.

* Note: Pathogen recovery rates decrease over time. For best results, submit ASAP.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter

Specimen Shipping

- Ship specimens via overnight delivery.
- DO NOT mail on Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Missing or discrepant information on form/specimen.
- Specimen not in correct transport medium
- Transport media was expired

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Salmonella* Typhi is available at the DSHS laboratory. Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

General policy

- The DSHS lab will only test food samples or environmental swabs from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreaks, the DSHS lab will not test food samples or environmental swabs unless a pathogen has been identified in a clinical specimen.
- Food samples or environmental swabs must be **collected by a registered sanitarian**

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

Table 1: Guide to Salmonellosis, Paratyphoid Fever, Typhoid Fever Reporting and Surveillance Forms

<i>Salmonella</i> serotype	Reported in NEDSS as	Surveillance Form
<i>Salmonella</i> Typhi	Typhoid Fever	CDC Typhoid and Paratyphoid Fever Surveillance Report requested
<i>Salmonella</i> Paratyphi A, B*, or C	Salmonellosis	CDC Typhoid and Paratyphoid Fever Surveillance Report requested
all other <i>Salmonella</i> serotypes	Salmonellosis	no CDC or DSHS form requested unless part of outbreak investigation

**Salmonella* Paratyphi B var L(+) tartrate + (formerly var. Java) is associated with routine GI illness and is reported as Salmonellosis and no CDC or DSHS form is requested unless part of an outbreak investigation.

UPDATES

April 2017

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Varicella

rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Human (alpha) herpesvirus 3 (varicella-zoster virus, VZV) a member of the *Herpesvirus* group

Transmission

Direct contact with patient with varicella (chickenpox) or zoster (shingles); droplet or airborne spread of vesicle fluid (chickenpox and zoster) or secretions of the respiratory tract (chickenpox); indirectly by contaminated fomites. Scabs are not infectious.

Incubation Period

Usually 14-16 days (range 10-21 days). May be prolonged after receipt of Varicella-Zoster Immune Globulin (VariZIG) and in the immunodeficient.

Communicability

Communicable 5 days before rash onset (especially 1-2 days before rash onset) and for up to 5 days after onset of lesions (until crusting). Communicability may be prolonged in persons with altered immunity.

Clinical Illness

Varicella, the primary infection with VZV, is an acute, generalized disease that occurs most commonly in children and is characterized by a maculopapular rash (few hours), then vesicular rash (3-4 days), often accompanied by fever. Lesions are typically more abundant on trunk; but sometimes present on scalp, mucous membranes of mouth and upper respiratory tract. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. Lesions are discrete, scattered and pruritic. Mild, atypical and unapparent infections also occur.

Vaccinated persons with varicella may not have fever and may only have a few lesions that may resemble bug bites. Successive crops of lesions are unusual in vaccinated individuals. "Breakthrough" varicella which can be seen in previously vaccinated persons, is usually a mild illness characterized by few lesions, most of which are papular or papulovesicular.

DEFINITIONS

Clinical Case Definition

An illness with acute onset of diffuse (generalized) maculopapulovesicular rash without other apparent cause. In vaccinated persons who develop varicella more than 42 days after vaccination (breakthrough disease), the disease is almost always mild with fewer than 50 skin lesions and shorter duration of illness. The rash can also be atypical in appearance (maculopapular with few or no vesicles).

Laboratory Criteria for Diagnosis

- Isolation of VZV from a clinical specimen, **OR**
- Varicella antigen detected by direct fluorescent antibody (DFA), **OR**
- Varicella-specific nucleic acid detected by polymerase chain reaction (PCR), **OR**
- Significant rise in serum varicella immunoglobulin G (IgG) antibody level by any standard serologic assay.

Case Classification

- **Confirmed:** A case that meets the clinical case definition **AND**
 - Is either laboratory confirmed **OR**
 - Is epidemiologically linked to another probable or confirmed case
- **Probable:** A case that meets the clinical case definition **without** epidemiologic linkage or laboratory confirmation.

Note: Two or more patients that meet clinical case definition and are epidemiologically linked to one another meet the confirmed case definition. See Varicella case status classification flow chart.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should investigate most laboratory reports of varicella. Confirmation of clinical case definition and ascertainment of vaccine history is needed for patients reported via lab result only. However, the following lab results do not require any follow up as they are almost always indicative of immunity or shingles:

- Any VZV lab result for people over 50 years of age.
- VZV IgG results for patients over 20 years of age.

Note: Children entering the state of Texas with varicella or developing varicella within 2 weeks of entering the state of Texas should not be considered Texas varicella cases. The jurisdiction for these cases is considered to be the location in which the individual was exposed. Appropriate control measures will still need to be implemented regardless of the case's origin.

Reports made via the varicella reporting form generally do not need investigation, unless the jurisdiction chooses to do so. There are some exceptions, however.

- Investigation into vaccination status should be done for any patients that are reported without vaccination history, especially for those that are school age.
- Deaths from varicella should be investigated.
- Hospitalized cases of varicella should be investigated.
- Outbreaks of varicella should be investigated.

Providing education to patients to prevent further spread of disease and encouraging timely vaccinations are also worthwhile activities. And discussing reporting requirements and exclusion criteria with healthcare providers, schools, and daycares is always encouraged.

Case Investigation Checklist

- ☐ Confirm that laboratory results meet the case definition.
- ☐ Confirm clinical case definition.
- ☐ Review medical records or speak to an infection preventionist or physician to verify case definition and vaccination status.
 - The Varicella (Chickenpox) Reporting Form can be used to record information collected during the investigation.
- ☐ Determine vaccination status of the case. Sources of vaccination status that should be checked include:
 - Case (or parent), ImmTrac, school nurse records, primary care provider, etc.
- ☐ Identify close contacts and ensure appropriate control measures are implemented (see control measures below).
- ☐ In the event of a death, copies of the hospital discharge summary, death certificate, and autopsy report should also be faxed to DSHS EAIDB.
 - The Varicella Death Investigation Form must also be completed and submitted to EAIDB.
- ☐ The Varicella (Chickenpox) Reporting Form does not need to be submitted to EAIDB.
- ☐ All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Control Measures

If VariZIG is indicated, it will need to be purchased by the provider. VariZIG can be ordered from one of two distributors: FFF Enterprises (California), 800-843-7477 www.fffenterprises.com and ASD Healthcare (Texas), 800-746-6273, www.asdhealthcare.com. DSHS does not stock variZIG.

- **Healthy Persons**
 - Varicella vaccine is recommended for post-exposure administration for unvaccinated persons, 12 months of age or older, without other evidence of immunity.
 - The varicella vaccine should be administered within three days after exposure in order to be effective.
 - Persons who have not received 2 doses should be brought up to date.
 - VariZIG is not recommended for healthy, full-term infants who are exposed postnatally, even if their mothers have no history of varicella.
- **Pregnant women**
 - Women known to be pregnant or attempting to become pregnant should not receive a varicella-containing vaccine.
 - Evidence of varicella immunity should be obtained as soon as possible. If no varicella antibody is detectable, VariZIG should be strongly considered for pregnant women who have been exposed.
 - VariZIG should be given as soon as possible and within 10 days of exposure.
 - Administration of VariZIG to these women has not been found to prevent viremia, fetal infection, congenital varicella syndrome, or neonatal varicella.
 - The primary indication for VariZIG in pregnant women is to prevent complications of varicella in the pregnant mother rather than to protect the fetus. Susceptible pregnant women are at risk for associated complications when they contract varicella. Varicella causes severe maternal morbidity, and 10%-20% of infected

women develop varicella pneumonia, with mortality reported as high as 40%. Their babies may also develop Congenital Varicella Syndrome, which may lead to severe complications, even death of the newborn.

- **Newborn infants:**
 - CDC recommends VariZIG to newborns infants whose mothers develop chickenpox with 5 days before delivery up to 48 hours after delivery.
- **Premature neonates exposed post-natally:**
 - CDC recommends VariZIG to hospitalized premature infants born at greater or equal to 28 weeks of gestation, whose mothers do not have evidence of immunity to varicella.
 - VariZIG is also recommended for hospitalized premature infants born less than 28 weeks of gestation or who weigh $\leq 1,000$ g at birth, regardless of their mother's evidence of immunity to varicella.
- **Health-Care Personnel (HCP):**
 - Nosocomial transmission of varicella is well recognized. To prevent disease and nosocomial spread, vaccination is recommended routinely for all health care personnel without evidence of immunity and is the preferred method for preventing varicella in health-care settings. Preferably, HCP should be vaccinated when they begin employment. Routine testing for varicella immunity after 2 doses of vaccine is not recommended for the management of those fully vaccinated.
 - HCP who have received 2 doses of vaccine and who are exposed should be monitored daily during days 10-21 after exposure through the employee health program or by an infection control nurse to determine clinical status.
 - HCP who have received 1 dose of vaccine and who are exposed should receive the second dose with single-antigen varicella vaccine within 3-5 days after exposure.
 - Unvaccinated HCP who have no other evidence of immunity who are exposed to VZV are potentially infective from days 10-21 after exposure and should not have patient contact during this period. They should receive post-exposure vaccination as soon as possible.
- **Immunocompromised patients:**
 - This category is comprised of persons who have primary and acquired immune-deficiency disorders, neoplastic diseases and those who are receiving immunosuppressive treatment. Most immunocompromised persons should not receive varicella vaccine.
 - Patients receiving monthly high-dose (≥ 400 mg/kg) Immune Globulin Intravenous (IGIV) are likely to be protected and probably do not require VariZIG if the most recent dose of IGIV was administered ≤ 3 weeks before exposure.
 - CDC recommends VariZIG to immunocompromised patients without evidence of immunity.
- **Child-care facility setting:**
 - Varicella vaccine (or history of prior disease) is required for all children (≥ 12 months of age) to enroll in any licensed child-care facility in Texas, and vaccine is recommended for all susceptible children (≥ 12 months of age).
- **Persons who have contraindications to vaccination:**
 - Persons with a severe allergic reaction to a vaccine component or following a prior dose of vaccine should not receive varicella vaccine. Women known to be pregnant or attempting to become pregnant should not receive a varicella-containing vaccine. Vaccinations of persons with moderate or severe acute illness should be postponed until the condition has improved.

Exclusion

- Exclude from work, school, and health care facilities until vesicles become dry OR, if lesions are not vesicular, until 24 hours have passed without new lesions.
- In the hospital, strict isolation is appropriate because of the risk of serious varicella complications in immunocompromised susceptible patients.

MANAGING SPECIAL SITUATIONS

Outbreaks

In general, the threshold for an outbreak investigation should be 3 or more cases related in location (e.g., school, church, etc.) within a 3-week period. In the presence of nosocomial varicella of known or suspected concurrent streptococcal infections, or among populations at high risk for complications (e.g., immunocompromised or susceptible adolescents or adults), the threshold for response should be 2 cases.

If an outbreak of varicella is suspected, notify the regional DSHS office or EAIDB at **(800) 252-8239** or **(512) 776-7676**.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or to DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS within 30 days of receiving a report of confirmed case.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax (or mail) a completed investigation form within 30 days of completing the investigation.
 - **In the event of a death, copies of the hospital discharge summary, death certificate, autopsy report and death investigation form should also be sent to DSHS EAIDB. Please notify EAIDB when the death is reported.**
 - Investigation forms may be faxed to **512-776-7616** or mailed to:

Infectious Disease Control Unit
Texas Department of State Health Services
Mail Code: 1960
PO Box 149347
Austin, TX 78714-9347

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **(800) 252-8239** or **512-776-7676**.

LABORATORY PROCEDURES

Specimens associated with varicella cases are not routinely submitted to the DSHS laboratory in Austin. However, PCR (preferred) and viral testing (not preferred) are available through the DSHS laboratory. Serology testing is not currently available at DSHS. Before shipping specimens, be sure to notify DSHS EAIDB VPD staff at **(512) 776-7676**.

The CDC also does varicella PCR testing and providers can usually ship directly to CDC for varicella (unlike other diseases). Information about submitting to CDC can be found here:

<http://www.cdc.gov/chickenpox/lab-testing/collecting-specimens.html>

PCR Specimen Collection and Submission (preferred)

Specimen Collection

- The preferred specimens are scabs, vesicle fluids or skin scrapings.
 - Specimens should be collected as close to onset date as possible and no later than 1 week from onset date.
 - Do NOT use any media. Specimens should be submitted in a dry tube.
 - Synthetic swabs should be used. Do not use cotton swabs for specimen collection.
- Instructions for how to collect different types of varicella specimens for PCR can be found here: <http://www.cdc.gov/chickenpox/lab-testing/collecting-specimens.html>

Submission Form

- Use Specimen Submission Form G-2V.
- Make sure the patient's name and date of birth/social security number match exactly what is written on the container.
- Mark the date of onset and date of collection. Write in VZV PCR as the test to be performed.

Specimen Shipping

- Specimens should be sent at ambient temperature.
- Specimens can be sent regular mail, but ensure they will not arrive on a weekend or holiday.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Specimen submitted on a preservative such as formalin or submitted in viral transport media.

Viral Isolation Specimen Collection and Submission (not preferred)

Specimen Collection

- The preferred specimens are vesicle fluids or skin scrapings.
- Specimens should be collected as close to onset date as possible and no later than 1 week from onset date.
- Place swab in 1-2 mL of viral transport media. Synthetic swabs should be used. Do not use cotton swabs for specimen collection.

Submission Form

- Use Specimen Submission Form G-2V.
- Make sure the patient's name and date of birth/social security number match exactly what is written on the container.
- Mark the laboratory test requested (viral isolation), date of onset, and date of collection. List the suspected virus or disease in the Virology section.

Specimen Shipping

- Maintain specimens at 2-8°C immediately after collection. Specimens not received at the lab within 12 hours of collection should be frozen at -70°C. Specimens should be shipped on dry ice.
- DO NOT mail on a Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

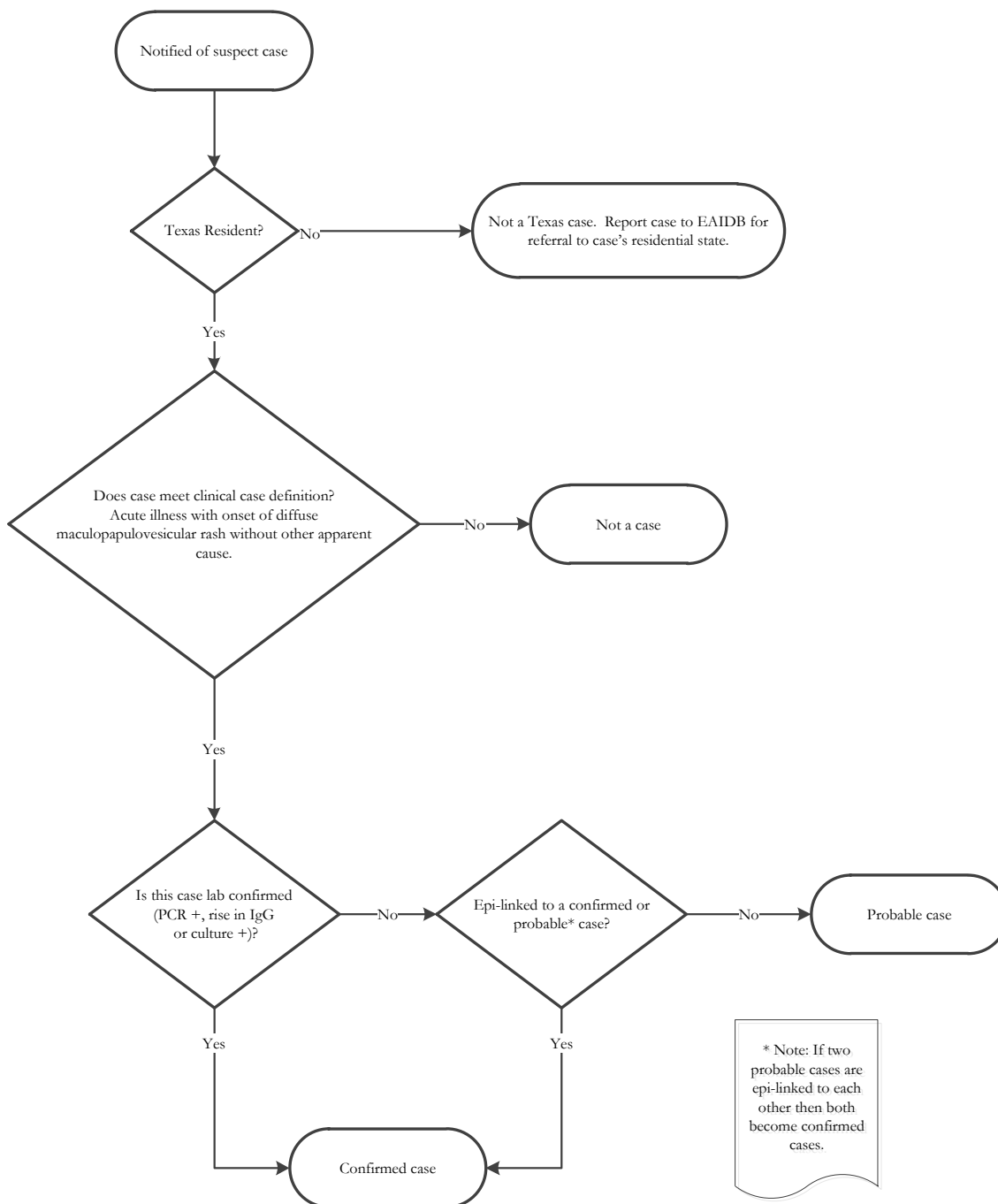
Causes for Rejection:

- Specimen submitted on a preservative such as formalin or submitted in viral transport media.

UPDATES

April 2017

- Edits made to clarify investigation aspects of confirmed and probable cases
- Updates made to provide instruction in handling varicella cases who have crossed the border into the United States within the last two weeks
- Number of days added for providing varicella vaccine as post-exposure prophylaxis

FLOW CHART rev Apr 2017**Varicella:
Case Status Classification**

Vibrio Infections including Cholera rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Vibrio species, a Gram-negative, curve-shaped bacterium.

Transmission

Transmission occurs through the ingestion of fecally contaminated food or water, ingestion of raw/undercooked seafood or exposure of wounds to contaminated water.

Incubation Period

- *V. cholerae* serogroups O1 and O139:
 - Usually 2 to 3 days (ranges from a few hours to 5 days)
- *V. cholerae* serogroups other than O1 and O139:
 - Usually 12 to 24 hours (range 5.5 to 96 hours)
- *V. parahaemolyticus*:
 - Usually 12 to 24 hours (range 4 to 96 hours)
- *V. vulnificus*:
 - Usually 12 to 72 hours

Communicability

There is no evidence of person-to-person transmission; fecal contamination of food or water is possible.

Clinical Illness

Symptoms and severity of illness may vary. Illness can range from a mild ear infection, usually caused by *V. alginolyticus* to gastrointestinal infections of varying severity caused by *V. parahaemolyticus* and other species, to life-threatening invasive disease caused by *V. vulnificus*, and profuse watery diarrhea caused by cholera toxin-producing strains of *V. cholerae*.

DEFINITIONS

Note: There are 4 different categories of vibriosis used in NEDSS: Cholera (toxin-producing only), *V. parahaemolyticus*, *V. vulnificus*, and Vibriosis, other or unspecified.

CHOLERA (toxigenic *Vibrio cholerae* O1 or O139)

Clinical Case Definition

An illness characterized by diarrhea and/or vomiting; severity is variable.

Laboratory Confirmation

- Isolation of toxigenic (i.e., cholera toxin-producing) *Vibrio cholerae* O1 or O139 from stool or vomitus
- Serologic evidence of recent infection (of cholera)

Case Classifications

- **Confirmed:** A clinically compatible illness that is laboratory confirmed

Note: Illnesses caused by strains of *V. cholerae* other than toxigenic *V. cholerae* O1 or O139 should not be reported as cases of cholera.

VIBRIO PARAHAEMOLYTICUS

Clinical Case Definition

An intestinal disorder characterized by watery diarrhea and abdominal cramps in the majority of cases, and sometimes with nausea, vomiting, fever and headache. Occasionally, a dysentery-like illness is observed with bloody or mucoid stools, high fever and high WBC count. Typically, it is a disease of moderate severity lasting 1-7 days; systemic infection and death rarely occur.

Laboratory Confirmation

- Isolation of *Vibrio parahaemolyticus* from a clinical specimen

Case Classifications

- **Confirmed:** A case that meets the laboratory criteria for diagnosis
- **Probable:**
 - A case with *Vibrio parahaemolyticus* detected, in a clinical specimen, by use of culture independent laboratory methods (non-culture based), **OR**
 - A clinically compatible case that is epidemiologically linked to a case that meets the probable or confirmed laboratory criteria for diagnosis

Note: A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different species

VIBRIO VULNIFICUS**Clinical Case Definition**

Infection with *Vibrio vulnificus* produces septicemia in persons with chronic liver disease, chronic alcoholism or hemochromatosis, or those who are immunosuppressed. The disease appears 12 hours to 3 days after eating raw or undercooked seafood, especially oysters. One third of patients are in shock when they present for care or develop hypotension within 12 hours after hospital admission. Three quarters of patients have distinctive bullous skin lesions; thrombocytopenia is common and there is often evidence of disseminated intravascular coagulation. *V. vulnificus* can also infect wounds sustained in coastal or estuarine waters; wounds range from mild, self-limited lesions to rapidly progressive cellulitis and myositis that can mimic clostridial myonecrosis in the rapidity of spread and destructiveness.

Laboratory Confirmation

- Isolation of *Vibrio vulnificus* from a clinical specimen

Case Classifications

- **Confirmed:** A case that meets the laboratory criteria for diagnosis
- **Probable:**
 - A case with *Vibrio vulnificus* detected, in a clinical specimen, by use of culture independent laboratory methods (non-culture based), **OR**
 - A clinically compatible case that is epidemiologically linked to a case that meets the probable or confirmed laboratory criteria for diagnosis

Note: A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different species

VIBRIOSIS, OTHER OR UNSPECIFIED**Clinical Case Definition**

An infection of variable severity characterized by diarrhea and vomiting, primary septicemia, or wound infections. Asymptomatic infections can occur, and the organism can cause extraintestinal infections.

Laboratory Confirmation

- Isolation of a species of the family *Vibrionaceae* (other than *Vibrio parahaemolyticus*, *Vibrio vulnificus*, and toxigenic *Vibrio cholerae*) from a clinical specimen
 - Genera in the family *Vibrionaceae* currently include *Aliivibrio*, *Allomonas*, *Catenococcus*, *Enterovibrio*, *Grimontia*, *Listonella*, *Photobacterium*, *Salinivibrio*, and *Vibrio*.

Case Classifications

- **Confirmed:** A case that meets the laboratory criteria for diagnosis
- **Probable:**
 - A case with a species of the family *Vibrionaceae* (other than *Vibrio parahaemolyticus*, *Vibrio vulnificus*, and toxigenic *Vibrio cholerae* O1 or O139) detected, in a clinical specimen, by use of culture independent laboratory methods (non-culture based), **OR**
 - A clinically compatible case that is epidemiologically linked to a case that meets the probable or confirmed laboratory criteria for diagnosis

Note: as required by TAC all *Vibrio* species isolates must be submitted to the DSHS laboratory.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should promptly investigate all reports of *Vibrio* infections. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Please use the **Cholera and Other *Vibrio* Illnesses Surveillance (COVIS) Report** form. The form is available on the DSHS website <http://www.dshs.state.tx.us/idcu/investigation/>.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Verify that the laboratory has forwarded the isolate to the DSHS laboratory, as required. If an isolate has not been sent, please request a specimen be submitted.
 - Note: *Vibrio* bacteria are difficult to speciate, and it is not uncommon for the DSHS laboratory to identify a different species from an isolate than a hospital laboratory. EAIDB consider speciation conducted by the DSHS laboratory to be definitive.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition, identify possible risk factors and describe course of illness.
 - Use information from medical records to complete the Clinical Information section of the COVIS form.
- ☐ Interview the case to identify potential sources of infection and risk factor information.
 - Use the **Cholera and Other *Vibrio* Illnesses Surveillance (COVIS) Report** form to record information from the interview.
 - Provide education on effective hand washing, food safety, and the risk of consuming raw/undercooked shellfish. See Prevention and Control Measures.
- ☐ If the case consumed any raw oysters during his/her incubation period, contact any restaurants or points of service where the case reported consuming this food item.
 - Obtain, or have a sanitarian obtain, oyster tags from all restaurants or points of service for the dates appropriate for the case's consumption dates.
 - If the restaurant is out of your jurisdiction, please contact an EAIDB foodborne epidemiologist and they will request oyster tags from the health department with jurisdiction.
 - Complete Section IV: Seafood Investigation Section of the COVIS form
- ☐ Fax or email securely the COVIS form and if applicable, copies of the oyster tag (both sides) information to the EAIDB foodborne epidemiology team at 512-776-7616.
 - A member of the EAIDB foodborne team will fax this information to the DSHS Seafood Safety office and the regional office of the FDA for follow-up.
 - An EAIDB foodborne epidemiologist will fax the form (deidentified) to the CDC.
 - Please note that the CDC measures the proportion of interviews reported to CDC within 7 days of interview date, so please send the form as soon as possible.
 - For lost to follow-up (LTF) cases, please complete as much information obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.
- ☐ Hospitalized cases should be followed until discharge and patient's outcome recorded on the COVIS form.
 - Initial reports can be sent to DSHS prior to discharge.
- ☐ In the event of a death, copies of the hospital discharge or death summary should also be faxed to DSHS EAIDB.

- If case is part of an outbreak or cluster, see Managing Special Situations section.
- All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Do not eat raw oysters or other raw shellfish, particularly if you are immunocompromised or have chronic liver disease.
- Cook shellfish (oysters, clams, mussels) thoroughly. Do not eat shellfish that do not open during cooking.
 - For shellfish in the shell either:
 - boil until the shells open and continue boiling for five more minutes, or
 - steam until the shells open and continue cooking for nine minutes;
 - For shucked oysters, boil for at least three minutes or fry them in oil for at least 10 minutes at 350°F degrees.
- Avoid cross-contamination between cooked seafood and other foods with raw seafood and their juices.
- Eat shellfish promptly after cooking and immediately refrigerate leftovers.
 - Eat refrigerated left-over cooked shellfish within 2 days.
- Wear protective clothing (e.g., gloves) when handling raw shellfish.
- Avoid exposure of open wounds or broken skin to warm salt or brackish water, or to raw shellfish harvested from such waters.
- When traveling internationally to areas with poor sanitary conditions:
 - Drink bottled water or water that has been boiled for at least 1 minute.
 - Don't drink fountain drinks or drinks with ice.
 - Don't eat fruits or vegetables that you don't peel yourself.
 - Avoid uncooked foods.
- Routine hand washing with soap and warm water, especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.

Exclusions

School/child-care: No exclusions are specified for *Vibrio* infections but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for *Vibrio* infections but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239 or (512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional vibriosis cases.
- If isolates have not already been submitted to the DSHS laboratory for confirmation and PFGE, request hospital/clinical labs submit isolates for confirmation and PFGE testing. See Laboratory Procedures.
- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on and adherence to hand hygiene.
 - Storage and preparation of food.
 - Procedures for changing diapers and toilet training.
 - Procedures for environmental cleaning.
- If shellfish is identified as a possible source of infection, determine the source of shellfish and how the shellfish were handled prior to consumption.
 - Obtain, or have a sanitarian obtain, oyster tags from all points of service for the appropriate time frame.
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

PFGE clusters:

- For clusters of cases with indistinguishable PFGE patterns detected by CDC/PulseNet and/or the DSHS laboratory, a member of the DSHS EAIDB foodborne team will notify appropriate DSHS regional epidemiologists, usually by email, who will then notify appropriate local health departments of cases within their jurisdiction.
- Local/regional health departments with cases in their jurisdiction should:
 - Interview the case patient, even if they have already been interviewed as part of a routine disease investigation, using the cluster specific questionnaire attached in the email notification.
 - Fax the completed questionnaire promptly within timeframe designated in cluster notification to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - If the health department having jurisdiction of a case is unable to reach a case-patient after 3 attempts during normal working hours, and they are not able to call after hours, please call the DSHS regional office or DSHS EAIDB to discuss further.
 - If an interview is unattainable or the case is lost to follow-up, fax medical records and any case information to DSHS EAIDB.
- Local/regional health department with cases will be notified by the EAIDB foodborne team of any CDC or DSHS conference calls and may participate, if able.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory. The general policy is to test only food samples implicated in suspected outbreaks, not in single cases.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 work day** to the local or regional health department or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases to DSHS.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection, e.g., different species. A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- Fax completed COVIS forms to DSHS EAIDB at **512-776-7616** or email securely to an EAIDB foodborne epidemiologist.
 - An EAIDB foodborne epidemiologist will fax the form (de-identified) to the CDC.
 - Please note that the CDC measures the proportion of interviews reported to CDC within 7 days of interview date, so please send the form as soon as possible.
 - For lost to follow-up (LTF) cases, please complete as much information obtained from medical/laboratory records (e.g., demographics, symptomology, onset date, etc.) on investigation form and fax/email securely to DSHS EAIDB noting case is LTF.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in

LABORATORY PROCEDURES

CLINICAL SPECIMENS:

All *Vibrio* species isolates must be submitted to the DSHS laboratory.

In an outbreak or other special situation, the DSHS Laboratory can culture raw stool or stool in transport medium (e.g., Cary-Blair media) for *Vibrio* species. Contact an EAIDB foodborne epidemiologist prior to submitting raw stool or stool in transport medium for culture.

Specimen Collection

- Submit pure cultures on an agar slant at ambient temperature or 2-8°C (*ice pack*) as soon as possible to ensure viability.
- For raw stool or stool in transport medium, please refer to table below:

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool	≤24 hours	4°C (ice pack)
Raw stool	>24 hours	Freeze immediately at ≤-70°C. Ship on dry ice.
Stool in transport solution/medium	Time of collection to ≤3 days	Room temp or 4°C (ice pack)
Stool in transport solution/medium	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.
All	*The above transport times are optimal for recovery of pathogenic organisms. In the interest of public health, specimens will be accepted up to 30 days from date of collection.	*The above transport temperatures are optimal for the recovery of pathogenic organisms. In the interest of public health, specimens will be accepted at non-optimal temperature transport.

* Note: Pathogen recovery rates decrease over time. For best results, submit ASAP.

** For suspected *Vibrio* species submit at room temperature.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter

Specimen Shipping

- Ship specimens via overnight delivery.
- DO NOT mail on Friday unless special arrangements have been pre-arranged with DSHS Laboratory.
- Ship specimens to:

Laboratory Services Section, MC-1947
Texas Department of State Health Services
Attn. Walter Douglass (512) 776-7569
1100 West 49th Street
Austin, TX 78756-3199

Causes for Rejection:

- Missing or discrepant information on form/specimen.
- Specimen not in correct transport medium
- Transport media was expired

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Vibrio cholera*, *Vibrio parahaemolyticus* and *Vibrio vulnificus* is available at the DSHS laboratory. Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

General policy

- The DSHS lab will only test food samples or environmental swabs from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreaks, the DSHS lab will not test food samples or environmental swabs unless a pathogen has been identified in a clinical specimen.
- Food samples or environmental swabs must be **collected by a registered sanitarian.**

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

UPDATES

April 2017

- Updated case definition to match the Epi Case Criteria Guide for 2017
 - CIDT methods now included in Probable case definition
- Updated statement regarding how often to count a case, only counting a case once per 30 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Viral Hemorrhagic Fever (non-Ebola) rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

There are multiple types of viral hemorrhagic fever (VHF) including Ebola, Crimean-Congo, Lassa, Lujo, Marburg, Nipah Valley and many more. This chapter will cover VHFs in general but will NOT cover VHFs caused by Ebola (see Ebola chapter), Yellow Fever, Dengue or Hantavirus. There are five families of viruses that cause VHFs: arenaviruses, bunyaviruses, filoviruses, flaviviruses, and paramyxoviruses. Even though most viruses in these families cause different VHFs, they also cause other diseases that are not hemorrhagic in nature.

Transmission

Transmission of VHFs are specific to each disease. Most are zoonotic illnesses, spread by contact with infected animals (e.g., rats) or animal vectors (e.g., mosquitos). Human to human transmission is possible, however, usually through direct contact (through a mucous membrane or non-intact skin) with the body fluids of an infected individual.

Incubation Period

Variable. See <http://www.cdc.gov/ncezid/dhcpp/vspb/diseases.html> for more specific information.

Communicability

Variable. Unknown for some diseases. See <http://www.cdc.gov/ncezid/dhcpp/vspb/diseases.html> for more specific information.

Clinical Illness

Variable. See <http://www.cdc.gov/ncezid/dhcpp/vspb/diseases.html> for more specific information.

DEFINITIONS

The following case definition applies to Crimean-Congo Hemorrhagic Fever virus, Lassa virus, Lujo virus, Marburg virus, and New World Arenaviruses: Guanarito virus, Junin virus, Machupo virus, and Sabia virus.

Clinical Case Definition

An illness with acute onset with the following clinical findings:

- A fever **AND**
- One or more of the following clinical findings:
 - Severe headache
 - Muscle pain
 - Erythematous maculopapular rash on the trunk with fine desquamation 3–4 days after rash onset
 - Vomiting
 - Diarrhea
 - Abdominal pain
 - Bleeding not related to injury
 - Thrombocytopenia
 - Pharyngitis (arenavirus only)
 - Retrosternal chest pain (arenavirus only)
 - Proteinuria (arenavirus only)

Laboratory Confirmation

- Detection of VHF* viral antigens in blood by enzyme-linked immunosorbent assay (ELISA) antigen detection, **OR**
- Isolation of VHF virus in cell culture for blood or tissues, **OR**
- Detection of VHF viral genes using reverse transcriptase with polymerase chain reaction amplification (RT-PCR) from blood or tissues, **OR**
- Detection of VHF viral antigens in tissues by IHC

*Viral hemorrhagic fever (VHF) agents include:

- Crimean-Congo hemorrhagic fever viruses
- Ebola virus (see Ebola case definition)
- Lassa virus
- Lujo virus
- Marburg virus
- New world arenaviruses (Guanarito, Machupo, Junin, Sabia viruses)

Case Classifications

- **Confirmed:** A clinically compatible illness that is laboratory confirmed
- **Suspect:** A clinically compatible illness that meets one or more of the following exposures within 21-days before onset of symptoms:
 - Contact with blood or other body fluids of a patient with VHF, **OR**
 - Residence in - or travel to - an VHF endemic area, **OR**
 - Work in a laboratory that handles VHF specimens, **OR**
 - Work in a laboratory that handles primates, bats, or rodents from endemic areas, **OR**
 - Exposure to semen or breast-milk of an individual who had VHF within the last 9 months.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments should IMMEDIATELY investigate all reports of viral hemorrhagic fever. Investigations should include an interview of the case or a surrogate to get a detailed exposure history. Initial investigation of a VHF can be conducted in alignment with the recommendations for investigating a suspected case of Ebola (see Ebola Virus Disease guidelines)."

The likelihood of a VHF diagnosis depends on the epidemiology of that disease. Cases of VHF will most likely be imported from a country with endemic VHFs or outbreaks of VHFs. Exposures in laboratories may also occur in the US, but should be rare.

Case Investigation Checklist

- ☐ Isolate patient.
- ☐ Implement standard, contact, and droplet precautions until a diagnosis is confirmed.
- ☐ Assess exposure history.
- ☐ Contact EAIDB to arrange for testing.
- ☐ Identify contacts for monitoring (may or may not be necessary, depending on type of VHF).
- ☐ All confirmed and suspect case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Exclusion

People with fever should be directed to stay home until fever free for 24 hours without use of anti-fever medications. This is required for children attending school and childcare institutions in Texas.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed or clinically suspected cases of viral hemorrhagic fever are required to be reported **immediately** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) **at (800) 252-8239 or (512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Call DSHS EAIDB immediately when a VHF investigation is being conducted or considered.
- Enter the case into NBS and submit an NBS notification on all **confirmed** and **suspect** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.

LABORATORY PROCEDURES

Testing for VHF will most likely need to be done at the CDC. Approval from CDC is required BEFORE submitting specimens for testing. Contact EAIDB to arrange for testing.

Specimen collection and submission information will be provided based on the individual case presentation.

UPDATES

April 2017

- Updated case classification information to align with Epi Case Criteria Guide
- Added reference to Ebola guidelines for suspect case investigation.

VISA/VRSA_{rev Apr 2017}

BASIC EPIDEMIOLOGY

Infectious Agent

Vancomycin Intermediate *Staphylococcus aureus* (VISA) and Vancomycin Resistant *Staphylococcus aureus* (VRSA) are specific types of the bacteria called *Staphylococcus aureus* that have become resistant to the antibiotic Vancomycin. *Staphylococcus aureus*, also called staph, is a bacterium commonly found on the skin and in the nose of about 30% of individuals and most of the time does not cause any harm. Occasionally, staph can cause infection and is one of the most common causes of skin infections in the United States. These skin infections can look like pimples, boils, or other skin conditions and most are able to be treated. In rare circumstances, staph bacteria can cause serious infections and even be fatal.

Transmission

Transmission of this organism can occur via direct person-to-person contact or secondary contact with contaminated environmental surfaces, medical devices, or equipment. Additionally, the hands of healthcare workers who frequently touch these objects in patient care environments often become vectors of transmission. Implementation of hand hygiene compliance and/or transmission-based precautions can reduce the risk of transmission.

Incubation Period

There is no set incubation period for exposure-to-illness onset.

Communicability

The period of communicability is unknown and may be as long as the organism is present in the individual.

Clinical Illness

VISA/VRSA can cause infections in almost any part of the body including bloodstream infections, ventilator-associated pneumonia, intra-abdominal abscesses, osteomyelitis (bone infection), and endocarditis (infection of the heart valves). Symptoms associated with VISA and VRSA infections generally vary based on the site that is infected (e.g., cough if in the lungs, urinary symptoms if in the bladder) but can also include general symptoms like fever or chills.

Severity

Texas has never confirmed a case of VRSA. As of May 2015, there have been 14 VRSA cases reported in the USA since 2002. Thus, identification of a VRSA is extremely rare and should be treated as a highly unusual event.

DEFINITIONS

Clinical Case Definition

When identified in a clinical culture, VISA and/or VRSA can represent an infection or a colonization. There is no set clinical case definition for *S. aureus* as it can cause many different types of symptoms.

Laboratory Confirmation

Vancomycin Intermediate *Staphylococcus aureus* (VISA):

- A vancomycin- intermediate *Staphylococcus aureus* from any body site/source that is laboratory confirmed. (MIC: 4-8 µg/ml)

Vancomycin Resistant *Staphylococcus aureus* (VRSA):

- A vancomycin-resistant *Staphylococcus aureus* from any body site/source that is laboratory confirmed. (MIC: ≥ 16 µg/ml)

Case Classification

VISA

- **Confirmed:**
 - Isolation of *Staphylococcus aureus* from any body site,
 - AND**
 - Intermediate-level resistance (MIC: 4-8 µg/ml) of the *Staphylococcus aureus* isolate to vancomycin, detected and defined according to CLSI approved standards and recommendations.

VRSA

- **Confirmed:**
 - Isolation of *Staphylococcus aureus* from any body site,
 - AND**
 - High-level resistance of the *Staphylococcus aureus* isolate to vancomycin (MIC: ≥ 16 µg/ml), detected and defined according to CLSI approved standards and recommendations.

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

Local and regional health departments will address all reports of VISA/VRSA immediately. The jurisdiction where the healthcare facility is located conducts the investigation and ensures control measures are promptly taken. The investigation steps below describe the public health activities to be completed when a suspected or confirmed VISA/VRSA case is reported. Investigations and control measures are required for infection or colonization by VISA/VRSA.

Case Investigation Checklist

- ☐ The jurisdiction that conducts the investigation is according to the location where the patient tested positive for VISA/VRSA. (Ex: patient tested positive for VISA and is in hospital in jurisdiction A but the patient resides in jurisdiction B, jurisdiction A would conduct the investigation).
- ☐ Immediately ensure contact precautions have been implemented for anyone with suspected or confirmed VISA/VRSA.
- ☐ Confirm that the laboratory results meet the case definition.
 - If it is unclear, call a DSHS Regional HAI Epidemiologists for assistance.
- ☐ Ensure additional control measures are in place for cases and/or facilities. (see “specific control measures” section below)
- ☐ Immediately notify the DSHS Regional HAI Epidemiologist or the DSHS HAI Epidemiologist for Texas (central office) by phone.
- ☐ Immediately verify that the healthcare facility laboratory has sent the VISA/VRSA isolate to the DSHS laboratory for confirmation testing. (see laboratory procedures below)
- ☐ Review the medical records. If needed, speak to an Infection Preventionist (IP) at the healthcare facility to verify demographics, symptoms, and course of illness.
- ☐ If the patient has been discharged from the reporting healthcare facility and the receiving healthcare facility is known, the investigator ensures that the receiving healthcare facility is informed of the VISA/VRSA case and ensures control measures are in place.
- ☐ Refer to the VISA/VRSA Investigation form for additional questions to address.
 - The VISA/VRSA Investigation Form is available on the DSHS Website: <http://www.dshs.state.tx.us/idcu/investigation/>
- ☐ All suspected and confirmed cases of VISA/VRSA require the investigation form to be completed and a copy of the laboratory report be sent to DSHS EAIDB.
- ☐ Enter all case investigations and submit a notification in NBS within 30 days of the initial report.
 - The jurisdiction that conducted the investigation enters the case in NBS.
 - The jurisdiction is entered as the jurisdiction who conducted the investigation and not the jurisdiction of residency.
 - Once the case is reviewed and approved by DSHS central office, the central office will update the jurisdiction to the jurisdiction of residency for aggregate reporting purposes.

NOTE: if a case is multi-jurisdictional, it is the responsibility of the investigator to notify other jurisdictions of the case.

Prevention and Control Measures

Control measures for Cases

Ideally, the facility is performing control measures for the case and the investigator is communicating directly with the facility, most likely with the IP or the responsible representative over infection prevention. The investigator may also speak with the patient directly if applicable. The investigator ensures the below control measures are addressed but not all specific control measures might be necessary for all case investigations.

Specific Control Measures

- Facilities are responsible for ensuring that healthcare personnel are vigilant with hand hygiene practices and ensure that:
 - Hand hygiene sinks are accessible and free from clutter/supplies;
 - Alcohol-based hand sanitizers are accessible and well stocked.
- Ensure the patient is on contact precautions/contact isolation. Contact precautions include but are not limited to:
 - Performing hand hygiene before entry into the patient room;
 - Donning (putting on) gown and gloves either before or upon immediate entry into the patient's room; (note some facilities might require more PPE)
 - Doffing (removing) gown, gloves and any other personal protective equipment (PPE) should be removed before exiting or immediately upon exiting the patient's room. Hand hygiene should be performed after removal of PPE.
 - Hand hygiene should be performed before exiting or immediately upon exiting the patient's room.
 - No recommendation currently exists for when to discontinue contact precautions. A facility should consult with an infectious disease physician, the IP, or the other provider that initiated the precautions. The facility may also call a DSHS HAI Epidemiologists for assistance.
- Ensure the facility is performing disinfection of reusable equipment before and after each use.
- Specifically for VRSA cases: during the investigation there might be a need to identify other contacts to the VRSA patient. Contacts should be categorized based on their level of interaction (i.e., extensive, moderate, or minimal) with the VRSA colonized or infected patient.
 - Priority should be given to identifying contacts who have had **extensive interaction** with the VRSA patient during a defined period before the VRSA culture date.
 - Recommend culturing multiple (e.g., 2 to 3) frequently colonized sites, such as anterior nares, throat, groin, axilla, or peri-rectal area, plus any skin lesions (e.g., abscess or dermatitis, open wounds).
 - Work with your DSHS Regional HAI Epidemiologist to further identify a plan.
- Recommend single patient rooms if available.
 - If single rooms are not feasible, recommend cohorting like patients (e.g., a patient with VISA and another patient with VISA)
- Recommend staff cohorting if possible.
- Recommend reducing the use of invasive medical devices for patients on the unit where the case was cared for, as invasive devices increase patient's risk of infection.
- Increase the frequency of cleaning of high touch areas.

- Provide education on VISA/VRSA as needed, with specific emphasis on contact precaution and the above control measures.
 - If additional help is needed regarding providing education, contact your DSHS Regional HAI Epidemiologist. (Education could be provided to: anyone at the facility, family members, and the patient.)

Treatment

Each case will have a unique treatment option. It is recommended that the reporting facility collaborate with a clinical pharmacist, an infectious disease physician, and/or an antibiotic stewardship resource for an individualized treatment plan.

Exclusions

Students (K-12) and daycare age children with VISA/VRSA wound infection need to be excluded from attendance until drainage from wounds or skin and soft tissue infections is contained and maintained in a clean dry bandage; restrict from situations that could result in the infected area becoming exposed, wet, soiled, or otherwise compromised. No other exclusions apply.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, immediately notify a DSHS Regional HAI Epidemiologist. The DSHS Regional HAI Epidemiologist will notify central office and work with central office as needed.

Outbreak Definition

VISA - at this time there is no defined criteria for an outbreak of VISA. If your health department believes they have detected an outbreak, it is recommended to speak with the DSHS Regional HAI Epidemiologist.

VRSA - one case of VRSA would be considered an outbreak and should be reported immediately by phone to the DSHS Regional HAI Epidemiologist.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School and Child-care Facilities, and General Public Reporting Requirements

Cases of Vancomycin Intermediate *Staphylococcus aureus* (VISA) and Vancomycin Resistant *Staphylococcus aureus* (VRSA) should be reported ***immediately*** to the local or regional health department. If jurisdiction is unclear, call the DSHS Regional HAI Epidemiologist or Emerging and Acute Infectious Disease Branch (EAIDB) at 512-776-7676 for assistance.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Immediately investigate any suspect or confirmed cases.
- Immediately notify a DSHS Regional HAI Epidemiologist by phone. The DSHS Regional HAI Epidemiologist should report the case to central office.
- Ensure control measures are in place and provide education to prevent further spread of disease (see specific control measures section located in this document).
- Enter the case into NBS when the first occurrence is reported and create the NBS notification to DSHS on all cases of VISA/VRSA. Complete additional case information and enter the remaining information within 30 days of initial report.
 - Please refer to the NBS Data Entry Guide for specific details on how to properly complete an NBS investigation, how to data enter a laboratory report and submit a NBS notification.

When a cluster or an outbreak is investigated, local and regional health departments should:

- Report suspected outbreaks immediately to a DSHS Regional HAI Epidemiologist.
 - Fax the investigation form and all other supporting documents to the DSHS Regional HAI Epidemiologist.
- If labeling a case as part of an outbreak, the outbreak must be named in NBS. Outbreak names must be requested through the NEDSS (NBS) office. The staff can be reached by phone (512) 458-7111 ext. 7729 or email nedss@dshs.state.tx.us

DISEASE REPORTING

Purpose of Reporting and Surveillance

- To prevent transmission of infections with VISA/VRSA in healthcare facilities and the community by decreasing the likelihood of transmission through the investigation process.
- To improve the detection, monitoring and epidemiological characterization of VISA/VRSA in Texas.
- To develop, implement and evaluate strategies to prevent the emergence, transmission and persistence of VISA/VRSA.
- To conduct and support epidemiological studies to identify outbreaks and potential sources of ongoing transmission in various populations.
- To identify further trends related to continued antibiotic resistance and the development of MDROs in Texas.

Requested Reporting

- Report VISA/VRSA to your local health jurisdiction **immediately**.

Local Health Jurisdiction Investigation Responsibilities

- Local health departments may request assistance with the investigation of VISA/VRSA by contacting both the DSHS Lead Epidemiologist and the DSHS Regional HAI Epidemiologist for the health service region (HSR).
- Because of the potential for transmission of VISA/VRSA to vulnerable patients in healthcare settings, public health action is imperative in controlling further transmission by: instituting control measures, identifying and screening close contacts of cases that could transmit the organism in healthcare settings, if indicated, and ensuring the facility's IP has been notified and that appropriate infection control measures are in place.

LABORATORY PROCEDURES

As required by the Texas Administrative Code (TAC), all *Staphylococcus aureus* isolates with a vancomycin MIC greater than 2 µg/ml must be submitted to the DSHS laboratory.

The DSHS laboratory uses the Etest for confirmation of resistance. Etest generates MIC values from a continuous scale and can give results in-between conventional twofold dilutions. According to manufacturer's protocol, a value which falls between standard two-fold dilutions is rounded up to the next upper two-fold value before categorization so that a MIC of 3 µg/ml is reported as intermediate resistance. These protocols are also in accordance with CLIA defined protocols.

If you are suspecting a possible outbreak situation and need molecular testing, prior approval from a DSHS HAI Epidemiologist is required.

UPDATES

April 2017

- Minor grammatical corrections.
- Clarified instructions for who conducts an investigation.

Yersiniosis rev Apr 2017

BASIC EPIDEMIOLOGY

Infectious Agent

Yersinia species, a Gram negative bacilli. *Y. enterocolitica* is the species most commonly associated with human infection. *Y. pseudotuberculosis* infection is much less common.

Note *Y. pestis* is separately notifiable as Plague.

Transmission

Transmission is fecal-oral and occurs through ingestion of contaminated food or water.

Transmission may also occur via direct contact with an animal and less commonly with an infected person.

Incubation Period

Probably 3 to 7 days, generally under 10 days.

Communicability

Although fecal shedding occurs with diarrhea and may persist for a prolonged period after symptoms resolve, secondary transmission is rare.

Clinical Illness

Fever with diarrhea (which may or may not contain blood, leukocytes, or mucus) is common in young children. Older children and adults can have fever, abdominal pain, and tenderness in the right lower quadrant of the abdomen (often mistaken with appendicitis) and leukocytosis.

DEFINITIONS

Clinical Case Definition

An illness characterized by diarrhea (sometimes bloody), fever, and abdominal pain; appendicitis-like syndrome and systemic infections can occur

Laboratory Confirmation

- Isolation of *Yersinia* (except *Y. pestis*)* in a clinical specimen.

*For *Yersinia pestis* isolates, see Plague.

Case Classifications

- **Confirmed:** A case that meets the laboratory criteria for diagnosis.
- **Probable:** A clinically compatible case that is epidemiologically linked to a confirmed case.

Note: a case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection

SURVEILLANCE AND CASE INVESTIGATION

Case Investigation

It is recommended that local and regional health departments investigate all reported cases of yersiniosis to identify potential sources of infection. The Yersiniosis Case Investigation Form can be used to record information from the interview. The form is available on the DSHS website: <http://www.dshs.state.tx.us/idcu/investigation/>. Sporadic cases of yersiniosis do not require an investigation form be sent to DSHS EAIDB unless they are identified as part of a multi-jurisdictional cluster or outbreak. Any case associated with a cluster or outbreak should be interviewed.

Case Investigation Checklist

- ☐ Confirm laboratory results meet the case definition.
- ☐ Review medical records or speak to an infection preventionist or healthcare provider to verify case definition and describe course of illness.
- ☐ Interview the case to get detailed food history and risk factor information.
 - Use the Yersiniosis Case Investigation Form to record information from the interview.
 - Note: If the case is not available or is a child, conduct the interview with a surrogate who would have the most reliable information on the case, such as a parent or guardian.
- ☐ Provide education to the case or his/her surrogate about effective hand washing, particularly after using the toilet, changing diapers, and before preparing or eating food. Meticulous hand washing is required to prevent transmission. See Prevention and Control Measures.
- ☐ Identify whether there is a public health concern: persons should not work as food handlers, child-care or health care workers, or attend child-care as long as they have diarrhea. See Exclusions.
- ☐ All confirmed and probable case investigations must be entered and submitted for notification in the NEDSS Base System (NBS). Please refer to the *NBS Data Entry Guidelines* for disease specific entry rules.

Prevention and Control Measures

- Routine hand washing with soap and warm water especially:
 - Before preparing, handling or eating any food.
 - After going to the bathroom.
 - After changing a diaper.
 - After caring for someone with diarrhea.
 - After handling raw food, especially pork.
 - After any contact with animals or their living areas.
- Avoid consuming raw milk or unpasteurized products.
- Follow food safety principles in the kitchen, especially:
 - Cook meat thoroughly
 - Prevent cross-contamination in food preparation areas by thoroughly washing hands, counters, cutting boards, and utensils after they touch raw meat.
 - Separate uncooked meats, hot dogs and other meat packaging from vegetables, uncooked food, and ready to eat foods.
 - Keep the refrigerator at 40°F or lower and the freezer at 0°F or lower.
 - Clean up all spills in your refrigerator right away, especially juices from meat packages, raw meat, and raw poultry.

Exclusions

School/child-care: No exclusions are specified for yersiniosis but the standard exclusion for diarrhea or fever applies:

- Children with diarrhea should be excluded from school/child-care until they are free from diarrhea for 24 hours without the use of diarrhea suppressing medications.
- Children with a fever from any infection should be excluded from school/child-care for at least 24 hours after fever has subsided without the use of fever suppressing medications.

Food Employee: No exclusions are specified for yersiniosis but the standard exclusion for vomiting or diarrhea applies:

- Food employees are to be excluded if symptomatic with vomiting or diarrhea until:
 - Asymptomatic for at least 24 hours without the use of diarrhea suppressing medications OR
 - Medical documentation is provided stating that symptoms are from a noninfectious condition.

Please see Guide to Excluding and Restricting Food Employees in Appendix A.

MANAGING SPECIAL SITUATIONS

Outbreaks

If an outbreak is suspected, notify the appropriate regional DSHS office or DSHS EAIDB at **(800) 252-8239** or **(512) 776-7676**.

The local/regional health department should:

- Interview all cases suspected as being part of the outbreak or cluster.
- Request medical records for any case in your jurisdiction that died, was too ill to be interviewed, or for whom there are no appropriate surrogates to interview.
- Prepare a line list of cases in your jurisdiction. Minimal information needed for the line list might include patient name or other identifier, DSHS or laboratory specimen identification number, specimen source, date of specimen collection, date of birth, county of residence, date of onset (if known), symptoms, underlying conditions, treatments and outcome of case, and risky foods eaten, foods eaten leading up to illness, or other risky exposures, such as animal contact and travel, reported by the case or surrogate.

Line list example:

ID	Name	Age	Sex	Ethnicity	Onset	Symptoms	Food	Animal	Notes
1	NT	34	F	W/N	2/4/16	Bl. D, F	Chicken, eggs	Dog	Dog food
2	PR	2	M	U/U	1/30/16	V,D,F	Chicken, spinach	None	Brother ill

- If the outbreak was reported in association with an apparent common local event (e.g., party, conference, rodeo), a restaurant/caterer/home, or other possible local exposure (e.g., pet store, camp), contact hospitals in your jurisdiction to alert them to the possibility of additional cases.

- Work with any implicated facilities to ensure staff, students, residents, and volunteers receive hand hygiene education, and review hygiene and sanitary practices currently in place including:
 - Policies on and adherence to hand hygiene
 - Storage and preparation of food
 - Procedures for changing diapers and toilet training
 - Procedures for environmental cleaning
- Recommend that anyone displaying symptoms seeks medical attention from a healthcare provider.
- Restrict individuals from handling food, engaging in child-care, healthcare work, or attending child-care, as long as they are symptomatic. See Exclusions in Case Investigation section.
- Enter outbreak into NORS at the conclusion of the outbreak investigation. See Reporting and Data Entry Requirements section.

Note:

- If a food item or food establishment is implicated, the lead epidemiologist for foodborne diseases will notify the DSHS Division of Regulatory Services about the outbreak and the possibility of a common contaminated food source for the cases.
- Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory. The general policy is to test only food samples implicated in suspected outbreaks, not in single cases.

REPORTING AND DATA ENTRY REQUIREMENTS

Provider, School, Child-Care Facility, and General Public Reporting Requirements

Confirmed, probable and clinically suspected cases are required to be reported **within 1 week** to the local or regional health department or the Texas Department of State Health Services (DSHS), Emerging and Acute Infectious Disease Branch (EAIDB) at **(800) 252-8239** or **(512) 776-7676**.

Local and Regional Reporting and Follow-up Responsibilities

Local and regional health departments should:

- Enter the case into NBS and submit an NBS notification on all **confirmed and probable** cases.
 - Please refer to the *NBS Data Entry Guidelines* for disease-specific entry rules.
 - A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual, unless additional information is available indicating a separate infection. A notification can be sent as soon as the case criteria have been met. Additional information from the investigation may be entered upon completing the investigation.
- If investigation forms are requested, they may be faxed to 512-776-7616 or emailed securely to an EAIDB foodborne epidemiologist.

When an outbreak is investigated, local and regional health departments should:

- Report outbreaks within 24 hours of identification to the regional DSHS office or to EAIDB at **512-776-7676**
- Enter outbreak information into the **National Outbreak Reporting System (NORS)** at the conclusion of the outbreak investigation.
 - For NORS reporting, the definition of an outbreak is two or more cases of similar illness associated with a common exposure.
 - The following should be reported to NORS:
 - Foodborne disease, waterborne disease, and enteric illness outbreaks with person-to-person, animal contact, environmental contact, or an indeterminate route of transmission.
 - Outbreaks as indicated above with patients in the same household.
 - Enter outbreaks into NORS online reporting system at <https://wwwn.cdc.gov/nors/login.aspx>
 - Forms, training materials, and other resources are available at <http://www.cdc.gov/nors/>
- To request a NORS account, please email FoodborneTexas@dshs.state.tx.us
 - Please put in Subject Line: NORS User Account Request
 - Information needed from requestor: name, email address, and agency name
 - After an account has been created a reply email will be sent with a username, password, and instructions for logging in.

LABORATORY PROCEDURES

Testing for yersiniosis is widely available from most private laboratories.

In an outbreak or other special situation, the DSHS Laboratory can culture raw stool or stool in transport medium (e.g., Cary-Blair media) for *Yersinia* species. Contact an EAIDB foodborne epidemiologist prior to submitting raw stool or stool in transport medium for culture.

Specimen Collection

- Submit pure cultures on an agar slant at ambient temperature or 2-8°C (*ice pack*) as soon as possible to ensure viability.
- For raw stool or stool in transport medium, please refer to table below:

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool	≤24 hours	4°C (<i>ice pack</i>)
Raw stool	>24 hours	Freeze immediately at ≤-70°C. Ship on dry ice.
Stool in transport solution/medium	Time of collection to ≤3 days	Room temp or 4°C (<i>ice pack</i>)
Stool in transport solution/medium	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.
All	*The above transport times are optimal for recovery of pathogenic organisms. In the interest of public health, specimens will be accepted up to 30 days from date of collection.	*The above transport temperatures are optimal for the recovery of pathogenic organisms. In the interest of public health, specimens will be accepted at non-optimal temperature transport.

* Note: Pathogen recovery rates decrease over time. For best results, submit ASAP.

Specimen type	Transport time to lab from time of collection	Transport temperature
Raw stool (<i>not preferred specimen</i>)	Accepted up to 30 days (<i>ASAP for optimal recovery of bacterial pathogens</i>)	2-8°C (<i>ice pack</i>)
Stool in transport solution/medium (<i>preferred specimen</i>)	≤24 hours	Room Temp or 2-8°C (<i>ice pack</i>)
Stool in transport solution/medium (<i>preferred specimen</i>)	>24 hours but ≤3 days	2-8°C (<i>ice pack</i>)
Stool in transport solution/medium (<i>preferred specimen</i>)	>3 days	Freeze immediately at ≤-70°C. Ship on dry ice.

Submission Form

- Use DSHS Laboratory G-2B form for specimen submission.
- Make sure the patient's name, date of birth and/or other identifier match exactly what is written on the transport tubes and on the G-2B form.
- Fill in the date of collection and select the appropriate test.
- If submitting as part of an outbreak investigation, check “Outbreak association” and write in name of outbreak.
- Payor source:
 - Check “IDEAS” to avoid bill for submitter

Specimen Shipping

- Ship specimens to:

Laboratory Services Section, MC-1947
 Texas Department of State Health Services
 Attn. Walter Douglass (512) 776-7569
 1100 West 49th Street
 Austin, TX 78756-3199

Causes for Rejection:

- Missing or discrepant information on form/specimen.
- Transport media was expired.
- Specimen not in correct transport medium.

FOOD SAMPLES AND ENVIRONMENTAL SWABS:

Testing of food and environmental swabs for *Yersinia enterocolitica* is available at the DSHS laboratory. Decisions about testing implicated food items can be made after consultation with an EAIDB foodborne epidemiologist and the DSHS Laboratory.

General policy

- The DSHS lab will only test food samples or environmental swabs from facilities implicated in a suspected outbreak (not associated with single cases).
- In outbreaks, the DSHS lab will not test food samples or environmental swabs unless a pathogen has been identified in a clinical specimen.
- Food samples or environmental swabs must be **collected by a registered sanitarian**

For further questions, please contact an EAIDB foodborne epidemiologist to discuss further.

UPDATES**April 2017**

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Appendix A: Additional Flowcharts and Tables rev Jan 2016

- Normally Sterile Sites Definition
- Sterile Site and Invasive Disease Determination
- Responding to Positive IgM Results for Mumps, Measles and Rubella
- Streptococcal Infection Case Status Classification
- Guide to Food Employee Exclusions and Restrictions

NORMALLY STERILE SITES

Normally sterile site: Invasive diseases typically cause significant morbidity and mortality. Sterile sites include:

- Blood (excluding cord blood)
- Bone or bone marrow
- Cerebrospinal fluid (CSF)
- Pericardial fluid
- Peritoneal fluid
- Pleural fluid

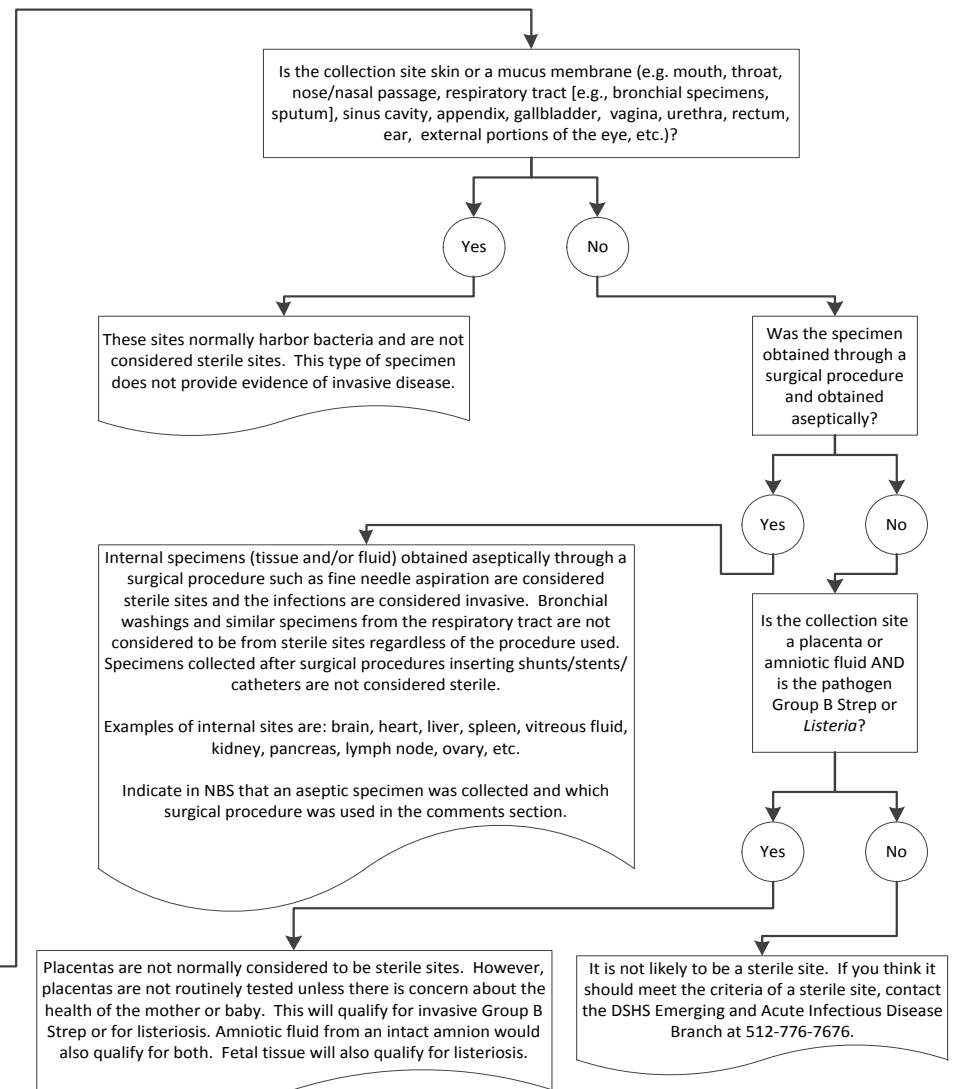
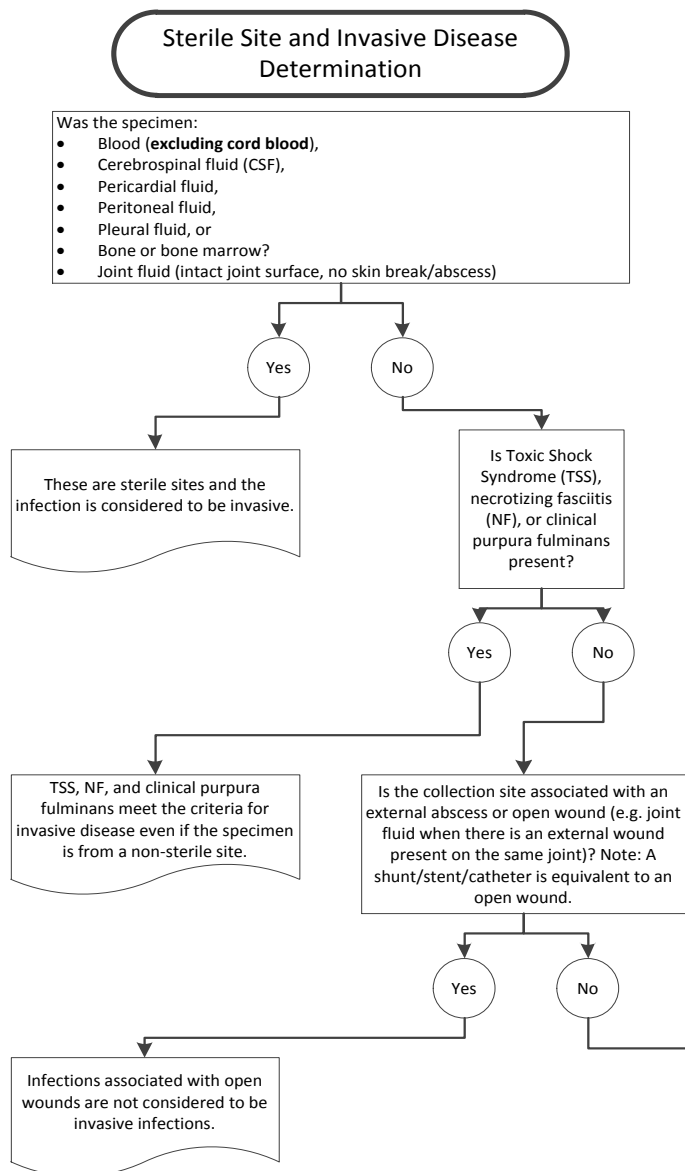
The following are also considered sterile sites when certain other criteria are met:

- Internal body sites (brain, heart, liver, spleen, vitreous fluid, kidney, pancreas, lymph node or ovary) when the specimen is collected aseptically during a surgical procedure
- Joint fluid when the joint surface is intact (no abscess or significant break in the skin)

Although placentas and amniotic fluid from an intact amnion are not considered sterile sites, isolation of Group B streptococci or *Listeria* from these sites may qualify as invasive disease. Consult the Sterile Site and Invasive Disease Determination flowchart on the next page for more information.

Normally sterile sites do not include:

- Anatomical areas of the body that normally harbor either resident or transient flora (bacteria) including mucous membranes (e.g., throat, vagina), sputum, and skin; abscesses; or localized soft tissue infections

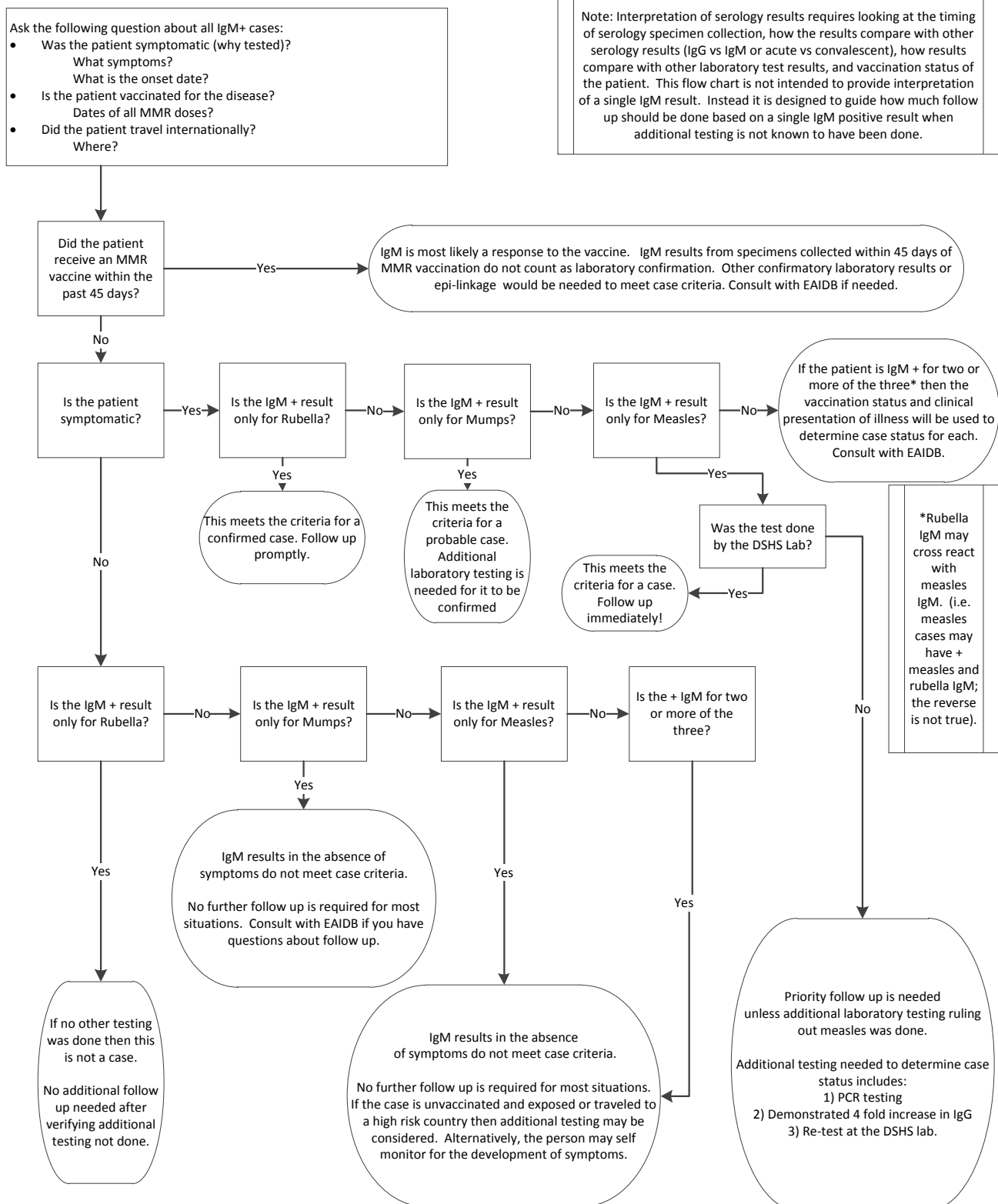


Flow chart for use with *Streptococcus pneumoniae*, Group A Strep (*S. pyogenes*), Group B Strep (*S. agalactiae*), *Neisseria meningitidis*, *Listeria monocytogenes* and *Haemophilus influenzae*. See "Normally Sterile Sites" definition on previous page.

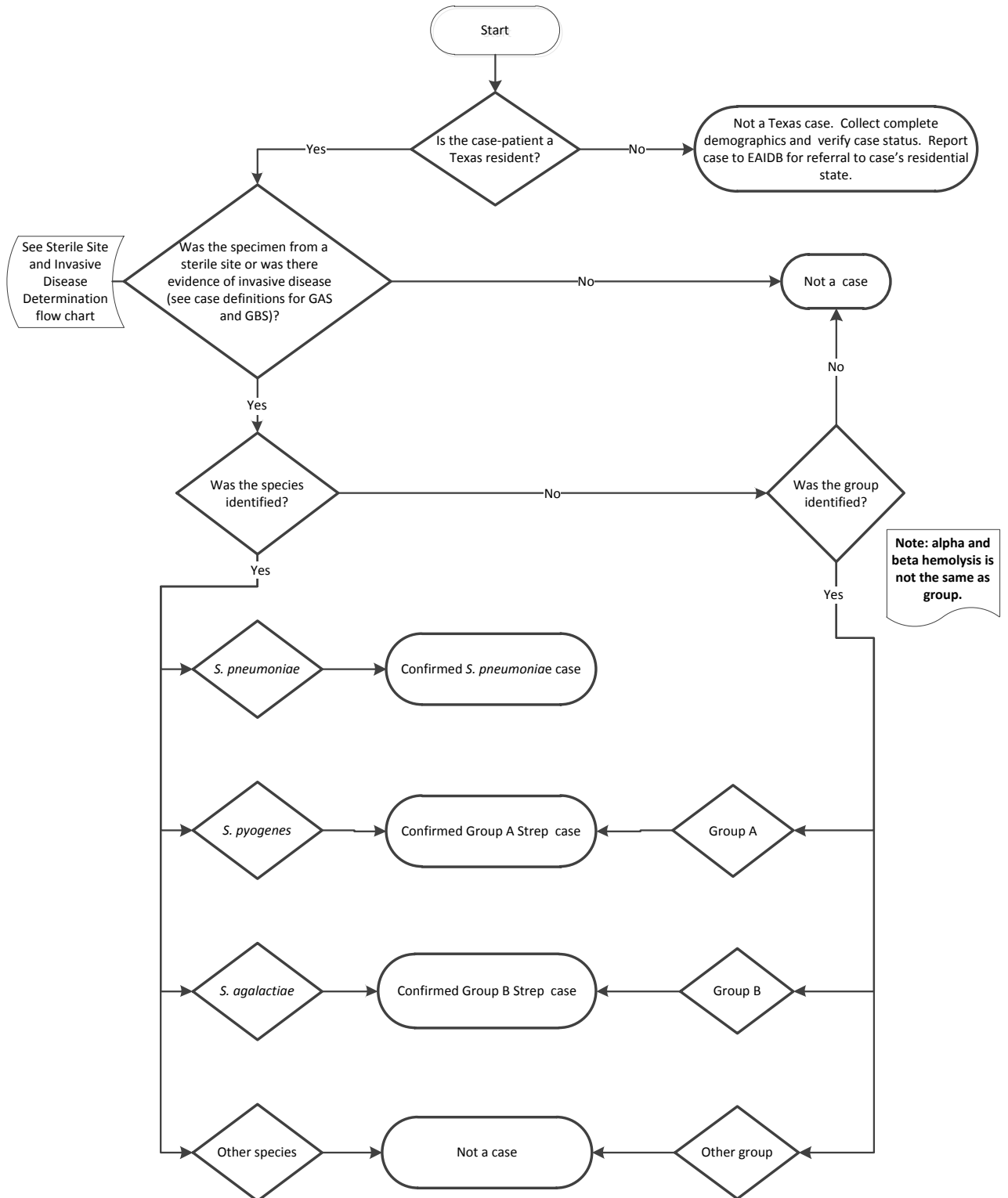
Last updated Jan 2016

Responding to Positive IgM results for Mumps, Measles, and Rubella When More Confirmatory Testing is Not Yet Available or Known

Not for use in evaluating IgM results when testing was requested by public health for contact or outbreak investigations or when more confirmatory testing has been done.



Invasive Streptococcal Infection: Case Status Classification



GUIDE TO FOOD EMPLOYEE EXCLUSIONS AND RESTRICTIONS

- This guide summarizes food employee exclusions and restrictions of interest and serves as a resource for local and regional health departments and accompanies the EAIDB Investigation Guidelines.
- For the complete Texas Food and Establishment Rules (TFER), go to:
<https://www.dshs.state.tx.us/foodestablishments/laws-rules.aspx>

Condition	Health Status of Food Employee	Food Establishment	Exclude or Restrict?	Return-to-Work Criteria for Food Employee
Norovirus	Symptomatic	any food establishment	Exclude	Food employee can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met: • Medical documentation stating that the food employee is free of infection from Norovirus; • More than 48 hours have passed since the food employee became asymptomatic (without the use of diarrhea suppressing medications) or • The food employee did not develop symptoms and more than 48 hours have passed since being diagnosed.
	Asymptomatic	serves a highly susceptible population	Exclude	
		does NOT serve a highly susceptible population	Restrict	
Salmonellosis (non-typhoidal <i>Salmonella</i> sp.)	Symptomatic	any food establishment	Exclude	Food employee can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met: • Medical documentation stating that the food employee is free of infection from non-typhoidal <i>Salmonella</i> based on test results showing two consecutive, negative stool specimen cultures. The stool specimens should be collected at least 24 hours apart and not sooner than 48 hours after the last dose of antibiotics, if antibiotics were given; • More than 30 days have passed since the food employee became asymptomatic (without the use of diarrhea suppressing medications) or • The food employee did not develop symptoms and more than 30 days have passed since being diagnosed.
	Asymptomatic	any food establishment	Restrict	

Condition	Health Status of Food Employee	Food Establishment	Exclude or Restrict?	Return-to-Work Criteria for Food Employee
Shigellosis (<i>Shigella</i> sp.)	Symptomatic	any food establishment	Exclude	Food employee can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met: - Medical documentation stating that the food employee is free of infection from <i>Shigella</i> sp. based on test results showing two consecutive, negative stool specimen cultures. The stool specimens should be collected at least 24 hours apart and not sooner than 48 hours after the last dose of antibiotics, if antibiotics were given; - More than 7 days have passed since the food employee became asymptomatic (without the use of diarrhea suppressing medications) or - The food employee did not develop symptoms and more than 7 days have passed since being diagnosed.
	Asymptomatic	serves a highly susceptible population	Exclude	
		does NOT serve a highly susceptible population	Restrict	
STEC (Shiga toxin-producing <i>E. coli</i>)	Symptomatic	any food establishment	Exclude	Food employee can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met: Medical documentation stating that the food employee is free of infection from Shiga toxin-producing <i>E. coli</i> based on test results showing two consecutive, negative stool specimen cultures. The stool specimens should be collected at least 24 hours apart and not sooner than 48 hours after the last dose of antibiotics, if antibiotics were given;
	Asymptomatic	serves a highly susceptible population	Exclude	

Condition	Health Status of Food Employee	Food Establishment	Exclude or Restrict?	Return-to-Work Criteria for Food Employee
		does NOT serve a highly susceptible population	Restrict	- More than 7 days have passed since the food employee became asymptomatic (without the use of diarrhea suppressing medications) or - The food employee did not develop symptoms and more than 7 days have passed since being diagnosed.
Typhoid Fever (<i>Salmonella Typhi</i>)	Symptomatic or Asymptomatic	any food establishment	Exclude	Food employee can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met: Medical documentation by a health practioner stating that the food employee is free of S. Typhi infection.
Hepatitis A or jaundiced (the onset of jaundice occurred within the last 7 calendar days)	Symptomatic or Asymptomatic	any food establishment	Exclude	Food employee can be reinstated with approval from the Regulatory Authority and if one of the following conditions is met: - The food employee has been jaundiced for more than 7 calendar days; - The anicteric food employee has been symptomatic with symptoms other than jaundice for more than 14 calendar days or - Medical documentation by a health practioner stating that the food employee is free of hepatitis A infection.

Condition	Health Status of Food Employee	Food Establishment	Exclude or Restrict?	Return-to-Work Criteria for Food Employee
Below are Criteria for Reportable Symptoms with No Diagnosis				
	vomiting or diarrhea	any food establishment	Exclude	Food employee can be reinstated if one of the following conditions is met: • Is asymptomatic for at least 24 hours (without the use of diarrhea suppressing medications) or • Medical documentation that states symptom is from a noninfectious condition
	sore throat with fever (acute onset)	serves a highly susceptible population	Exclude	Food employee can be reinstated with medical documentation stating one of the following conditions has been met: • Antibiotic therapy for <i>Streptococcus pyogenes</i> infection for more than 24 hours; • at least one negative throat specimen culture for <i>S. pyogenes</i> infection or • determined free of a <i>S. pyogenes</i> infection by a health practitioner.
		does NOT serve a highly susceptible population	Restrict	
	uncovered infected wound or pustular boil	any food establishment	Restrict	Food employee can be reinstated if the wound or boil is properly covered with one of the following: • An impermeable cover such as a finger cot or stall and a single-use glove over the impermeable cover if the wound or boil is on the hand, finger, or wrist; • And impermeable cover on the arm if the wound or boil is on the arm or • A dry, durable, tight-fitting bandage if the wound or boil is on another part of the body

Definitions of Interest from the Texas Food Establishment Rules (TFER):

Food employee--An individual working with unpackaged food, food equipment or utensils, or food-contact surfaces.

Asymptomatic--Not showing obvious symptoms, not producing indications of a disease or other medical condition. An individual infected with a pathogen but not exhibiting or producing any signs or symptoms of vomiting, diarrhea, or jaundice. Symptoms are not shown because the symptoms have been resolved or have subsided, or because the symptoms never manifested.

Exclude--To prevent a person from working as a food employee or entering a food establishment except for those areas open to the general public.

Restrict--To limit the activities of a food employee so that there is no risk of transmitting a disease that is transmissible through food and the food employee does not work with exposed food, clean equipment, utensils, linens; and unwrapped single-service or single-use articles.

Highly susceptible population--Persons who are more likely than other people in the general population to experience foodborne disease because they are immunocompromised, preschool aged children, or older adults and are obtaining food at a facility that provides services such as custodial care, health care, or assisted living. Examples of custodial or health care facilities or of assisted living facilities include but are not limited to child or adult day care centers, kidney dialysis centers, hospitals, nursing homes, or senior centers providing nutritional or socialization services.

Food establishment--A food establishment means an operation that stores, prepares, packages, serves, vends, or otherwise provides food for human consumption as follows:

- a restaurant, retail food store, satellite or catered feeding location, catering operation if the operation provides food directly to a consumer or to a conveyance used to transport people, market, vending location, (machine), self-service food market, conveyance used to transport people, institution, or food bank;
- an establishment that relinquishes possession of food to a consumer directly, or indirectly through a delivery service such as home delivery of grocery orders or restaurant takeout orders, or delivery service that is provided by common carriers; and
- includes an element of the operation such as a transportation vehicle or a central preparation facility that supplies a vending location or satellite feeding location unless the vending or feeding location is permitted by the regulatory authority and an operation that is conducted in a mobile, stationary, temporary, or permanent facility or location; where consumption is on or off the premises; and regardless of whether there is a charge for the food.
- food establishment does not include an establishment that offers only prepackaged foods that are not time / temperature controlled for safety food, a produce stand that only offers whole, uncut fresh fruits and vegetables, a food processing plant, a cottage food industry, an area where cottage food is prepared, sold or offered for human consumption, a Bed and Breakfast Limited facility as defined in this chapter, or a private home that receives catered or home-delivered food.

Regulatory authority--The local, state, or federal enforcement body or authorized representative having jurisdiction over the food establishment.

UPDATES

April 2017

- No updates were made to this section

Appendix B: Out of State Exposure Notifications rev Apr 2017

- Background
- Basic Notification Process
- Regional and Local Health Department Expectations

BACKGROUND

Out of state exposure notifications include identification of passengers on airlines, ships, buses, or trains who were exposed to selected infectious diseases. These types of exposure notifications are typically received through the Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ) to the Texas Department of State Health Services (DSHS) via special Epi-X DGMQ reports. DSHS Emerging and Acute Infectious Disease Branch (EAIDB) staff in Central Office primarily receives these alerts and notifies the appropriate regional and local health departments. Some local or regional health departments may also receive the Epi-X DGMQ reports directly.

In addition to the formal notifications described above, other exposure notifications can include attendees at conferences, guests of hotels, or participants of group gatherings. These other exposure lists are generated by a state health department or a specific disease program within CDC and are distributed to the applicable disease leads in EAIDB. Distribution from EAIDB to the regional and local health departments is the same.

The contact information available is often limited. Presumed jurisdiction is often determined by the area code of a person's phone number if the person's address is not immediately available. Sometimes the provided contact information is for a travel office or business rather than the individual. In these instances, the health department should contact the travel agency, explain the situation, and ask for the passenger's contact information. If the travel agency will not provide information, ask them to contact the passenger and instruct passenger to contact health department as soon as possible.

Diseases for which exposure notifications have occurred in the past:

- Contaminated healthcare products/devices
- Ebola
- Healthcare associated infections
- Hepatitis A
- Hepatitis B and C (usually healthcare associated)
- HIV* (usually healthcare associated)
- Legionellosis
- Measles
- Meningococcal meningitis
- Novel coronavirus
- Novel/variant influenza
- Rubella
- Tuberculosis*
- Zoonoses*

*TB, zoonoses, and HIV notifications are handled through the TB/HIV/STD program or the Zoonosis Control Branch and may not follow the process outlined here. EAIDB is not involved in these investigations, except in instances when hepatitis B or C exposure may have also occurred with HIV exposure. In those instances, EAIDB and DSHS HIV staff will attempt to coordinate response.

Information on the CDC DGMQ:

<http://www.cdc.gov/quarantine/contact-investigation.html>

BASIC NOTIFICATION PROCESS

Basic Process

- The CDC or other state health department collates a list of people (e.g., passengers on a flight, patients at a medical practice) exposed to selected infectious diseases by presumed state of residence. The list is shared via Epi-X DGMQ reports as part of the airline notification process or via phone, email or fax from selected infectious disease program areas.
- EAIDB reviews the list and subdivides it based on regional (or local) health jurisdictions. The list is forwarded to appropriate jurisdictions by email or fax along with instructions for response and follow-up.
- If applicable, the regional DSHS office will further subdivide the list and share with their local health departments.

REGIONAL AND LOCAL HEALTH DEPARTMENT EXPECTATIONS

When an exposure notification is received, the regional and local health departments should:

- Review the instructions and guidance provided by DSHS, CDC and/or the reporting jurisdiction (e.g., another state).
 - Instructions and guidance will include
 - Timeframe and priority level for follow-up
 - Contact management instructions
 - If an interview form must be completed
 - If prophylaxis is indicated
 - Other necessary actions
- Expect that multiple lists may be received, or multiple (updated) versions of the same list
- Attempt to contact every person on the provided list within the timeframe provided by DSHS, CDC and/or the reporting jurisdiction.
 - Multiple call attempts should be made at different times of the day.
 - A wide variety of contact information may be provided. All phone numbers and emails should be tried at least once.
 - Some diseases may require home visits.
 - If the health department is unable to contact the persons on the list or would like to request assistance for any other reason (e.g., staffing shortage), the health department should request assistance from their regional office or DSHS EAIDB.
 - For some diseases, additional assistance, such as wellness checks by police or other agency, may be required to ensure the contact is okay if the contact cannot be reached by telephone and does not answer the door.
 - If the health department reaches a contact that turns out to live in another jurisdiction, this process should still be completed. Once the notification is complete, the information should be returned to DSHS for transfer to the appropriate jurisdiction.
- Document the outcome of all the attempts to communicate with the contact. Include outcome of communication attempts and how communication was established (e.g., specify correct phone number), and control measures implemented (if any).
- Assess if the person is currently symptomatic. Symptomatic individuals should be managed according to the investigation guidelines for that disease.
- Provide basic education on the condition to all of the exposed persons.
 - Education should include signs and symptoms as well as basic prevention.
 - Basic education should be provided even if the person resides outside of the health jurisdiction performing the follow-up.
- Ask about additional exposed persons (e.g., an unticketed baby sitting on exposed airline passenger's lap)
- If applicable, interview the person using a provided interview form.
 - The interview should be completed even if the person resides outside of the health jurisdiction performing the follow-up. When the interview is complete, notify DSHS about the contact, so appropriate transfer can occur.
- If applicable, recommend or provide prophylaxis.
 - Notify DSHS immediately of out-of-jurisdiction contacts who need prophylaxis.

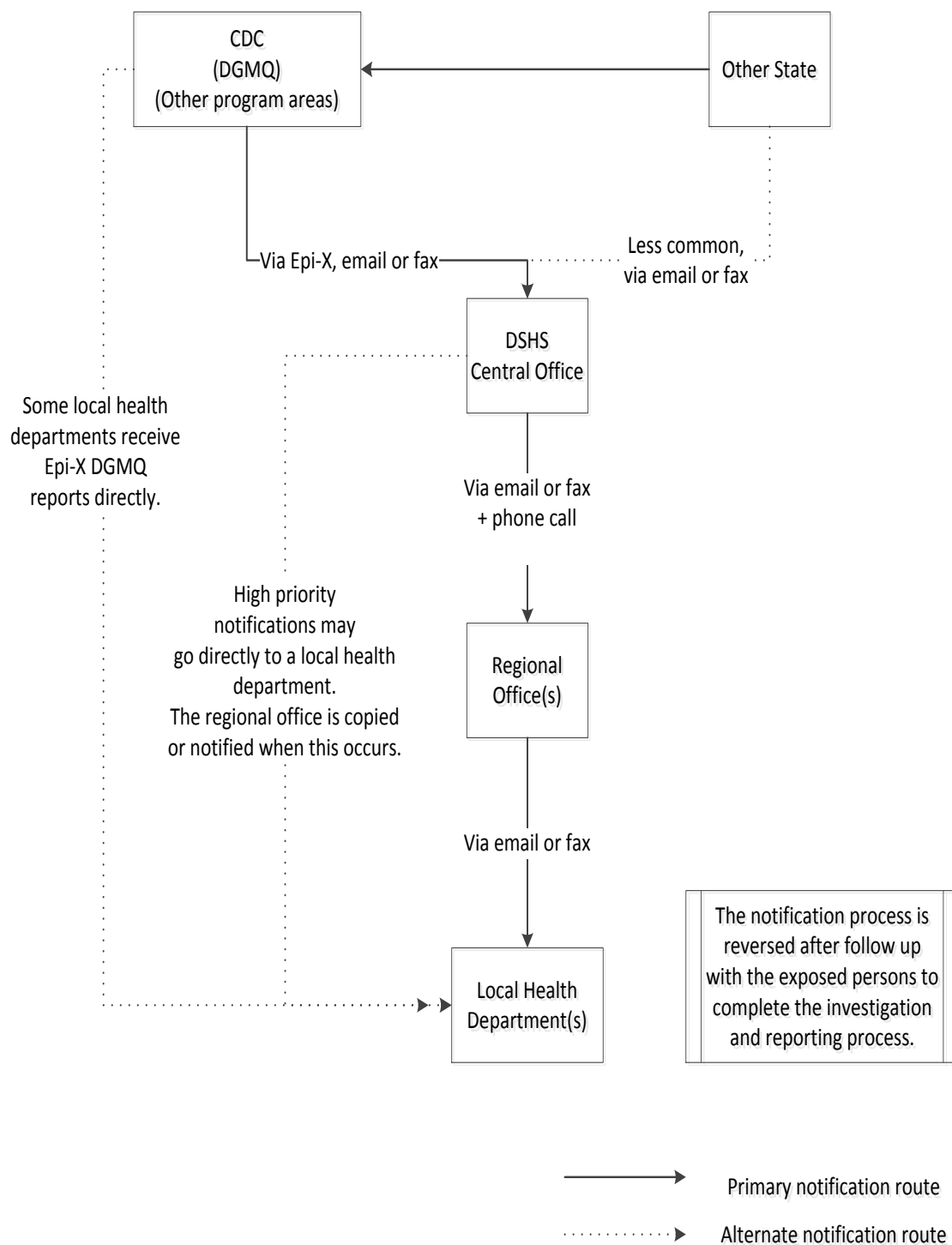
- If applicable, monitor for development of symptoms.
 - For some diseases, monitoring may be passive (e.g., tell the person to call her health care provider and/or the health department if she develops symptoms).
 - For some diseases, monitoring may be active (e.g., daily calling to assess symptoms or home visits).
 - Notify DSHS immediately of out-of-jurisdiction contacts who need to be monitored for symptoms.
- Notify DSHS of the outcome of the contacts before the deadline or within 1 work day of completion, whichever is shorter.
 - Notifications of out-of-jurisdiction persons or of persons developing symptoms should be done as soon as possible.
 - If an interview form was completed, return the form to DSHS before the deadline or within 1 work day of completion, whichever is shorter.

UPDATES

April 2017

- Updated the Background and Regional and Local Health Department expectations sections

Appendix B: Out of State Exposure Notifications



Appendix C: DSHS Laboratory Resources

rev Apr 2017

- Basic Health Department Recommendations
- Getting a Lab Submitter ID and Submission Forms
- How To Order Specimen Collection Supplies
- Basic Steps To Ship Specimens
- Preferred Specimen Summary Table

BASIC HEALTH DEPARTMENT RECOMMENDATIONS

Health departments should be prepared to collect or to assist with the collection of specimens to support public health investigations and outbreak response. While large hospitals and clinic systems may have supplies on hand and experience with shipping specimens, many small clinics and private provider offices do not. It can also take 24 to 72 hours to coordinate and ship specimen collection materials to a health department. Given the short time period for collecting certain priority specimens (e.g., measles, suspected variant/novel flu, etc.), it is essential for health departments to maintain at least a handful of supplies that can be used while additional supplies are being ordered. If your local or regional health department is in need of specimen collection supplies, DSHS EAIDB can coordinate for specimen collection kits to be sent to your location.

Health Department Checklist

- Have a DSHS Laboratory submitter ID.
 - See 'Getting a Lab Submitter ID and Submission Forms' section.
- Have an electronic copy of each of the DSHS Laboratory submission forms with the health department's submitter ID pre-filled (especially the G-2A, G-2B and G-2V).
 - Make sure you have the most up-to-date DSHS Laboratory Submission Form
 - See 'Getting a Lab Submitter ID and Submission Forms' section.
- Have at least 2 specimen shipping boxes on hand.
- Maintain a stock of viral transport media (VTM) and swabs for use in viral respiratory or VPD outbreaks.
 - Small health departments with a history of using little to no VTM should keep at least 2 unexpired VTM tubes on hand.
 - Larger health departments or health departments with a history of using the VTM should consider keeping more unexpired VTM tubes on hand.
 - Health departments with sub-offices should consider keeping at least 2 unexpired VTM tubes on hand at each sub-office unless the sub-office is located within 1 to 2 hours of another location with access to VTM.
- Maintain a stock of stool collection kits and transfer media (e.g., Cary-Blair transport media) for use in enteric pathogen outbreaks.
- Know how to ship specimens overnight using FedEx, Lone Star Overnight, or an approved courier.
- Know how to request specimen collection kits.
 - See 'How to Order Specimen Collection Supplies' section.
- For health departments with a Laboratory Response Network (LRN) laboratory (other than the DSHS Lab in Austin) in their area:
 - Keep copies of the LRN-specific laboratory submission forms on hand in addition to the DSHS lab submission forms.
 - Know if your LRN can assist with shipping specimens that need to go to the DSHS laboratory in Austin or to the CDC.
 - Check with your LRN or EAIDB to see if certain specimens can be sent to the LRN or should be sent directly to the DSHS Laboratory in Austin.

GETTING A LAB SUBMITTER ID AND SUBMISSION FORMS

The procedure for getting a DSHS lab submitter ID is the same for healthcare providers/facilities and for health departments. Any entity that may need to submit a specimen to the DSHS Laboratory will need to have a submitter ID.

How to get a DSHS submitter ID

- Complete the Submitter Identification (ID) Number Request Form found at www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589956433.
- Fax the completed form to Lab Reporting at 512-776-7533 or email it to LabInfo@dshs.state.tx.us.
- If you are not sure if your agency has a submitter ID number, call DSHS Lab Reporting at 512-776-7578 to find out.

How to get electronic copies of your DSHS submission forms

- Contact Lab Reporting to request electronic copies of the forms by calling 512-776-7578 or emailing LabInfo@dshs.state.tx.us.
- A list of forms used by the DSHS lab is available at www.dshs.state.tx.us/lab/MRS_forms.shtm.
- Please note that new forms are usually distributed each September. Each fall, you should check that you have the most current form.

Most frequently used DSHS submission forms

- G-2A: Used for submitting serology specimens
- G-2B: Used for submitting bacteriology and parasitology specimens (also includes many molecular tests for bacterial and viral diseases)
- G-2V: Used for submitting virology specimens
- G-23: Used for submitting food samples
- G-27A: Used for submitting emergency preparedness specimens, including *Clostridium botulinum* and Ebola

HOW TO ORDER SPECIMEN COLLECTION SUPPLIES

The following specimen collection kits are available to be ordered:

- Influenza/Influenza-like illness
- Pertussis (PCR)
- Fecal specimens for bacterial culture
- Fecal specimens for intestinal parasites
- Mumps/Measles/Rubella

Influenza/Influenza-like illness

- These supplies should be used for collecting specimens from someone suspected of having influenza. These supplies may also be used for collecting specimens from someone suspected of infection with parainfluenza virus, rhinovirus/enterovirus, respiratory syncytial virus, adenovirus, or human metapneumovirus.
- The provided supplies include:
 - DSHS or commercially prepared viral transport media (VTM)
 - Nasopharyngeal (NP) swab
 - Plastic tube with screw cap (secondary container)
- The following supplies are optional and can be included if requested:
 - Specimen shipping boxes (cold boxes)
 - Cold packs
 - DSHS Influenza Laboratory Surveillance Protocol
- Influenza collection supplies should be ordered by contacting the EAIDB Flu Team by email at flutexas@dshs.state.tx.us. An order form will be provided upon request.
- Note: Regional Influenza Surveillance Coordinators can assist with ordering supplies.

Pertussis (PCR)

- These supplies should be used for collecting specimens from someone suspected of having pertussis.
- The provided supplies include:
 - Nasopharyngeal (NP) swab (may be a urethral swab which can be used as an NP swab)
 - Specimen tube
 - Medium plastic bag
 - G-2B laboratory submission form
 - Collection information sheet
- The following supplies are optional and can be included if requested:
 - Specimen shipping boxes (cold boxes)
 - Cold packs
- Collection supplies should be ordered by contacting the EAIDB VPD Team at 512-776-7676.

Notes:

- No media is used for specimens submitted for pertussis PCR at DSHS.
- Pertussis testing is not provided free of charge. Contact EAIDB for approval for DSHS payment.

Fecal specimens for bacterial culture

- These supplies should be used for collecting specimens from someone suspected of having a bacterial diarrheal illness.
- The provided supplies include:
 - Instruction sheet
 - Feces transport medium: Cary-Blair culturette kit
 - One tall plastic liner tube (with lid) for every 3 swabs ordered
- Collection supplies should be ordered by calling 512-776-7661.

Fecal specimens for intestinal parasites

- These supplies should be used for collecting specimens from someone suspected of having an intestinal parasite.
- The provided supplies include:
 - Tall mailer (can with lid, liner with lid)
 - O&P media with instructions
 - Mailing label (for Refugee program submissions)
- Collection supplies should be ordered by calling 512-776-7661.

Mumps/Measles/Rubella

- These supplies should be used for collecting viral specimens from someone suspected of having mumps, measles or rubella.
- The provided supplies include:
 - DSHS or commercially prepared viral transport media (VTM)
 - Throat or nasopharyngeal (NP) swab
 - Mumps (buccal) testing uses a throat swab
 - A throat swab is preferred over an NP swab for rubella and measles but an NP swab is acceptable
 - Plastic tube with screw cap (secondary container)
 - Instruction sheet
- The following supplies are optional and can be included if requested:
 - Specimen shipping boxes (cold boxes)
 - Cold packs
- Collection supplies should be ordered by contacting the EAIDB VPD Team at 512-776-7676.
- Serology kits can be sent from DSHS, but only under specific circumstances.

BASIC STEPS TO SHIP SPECIMENS

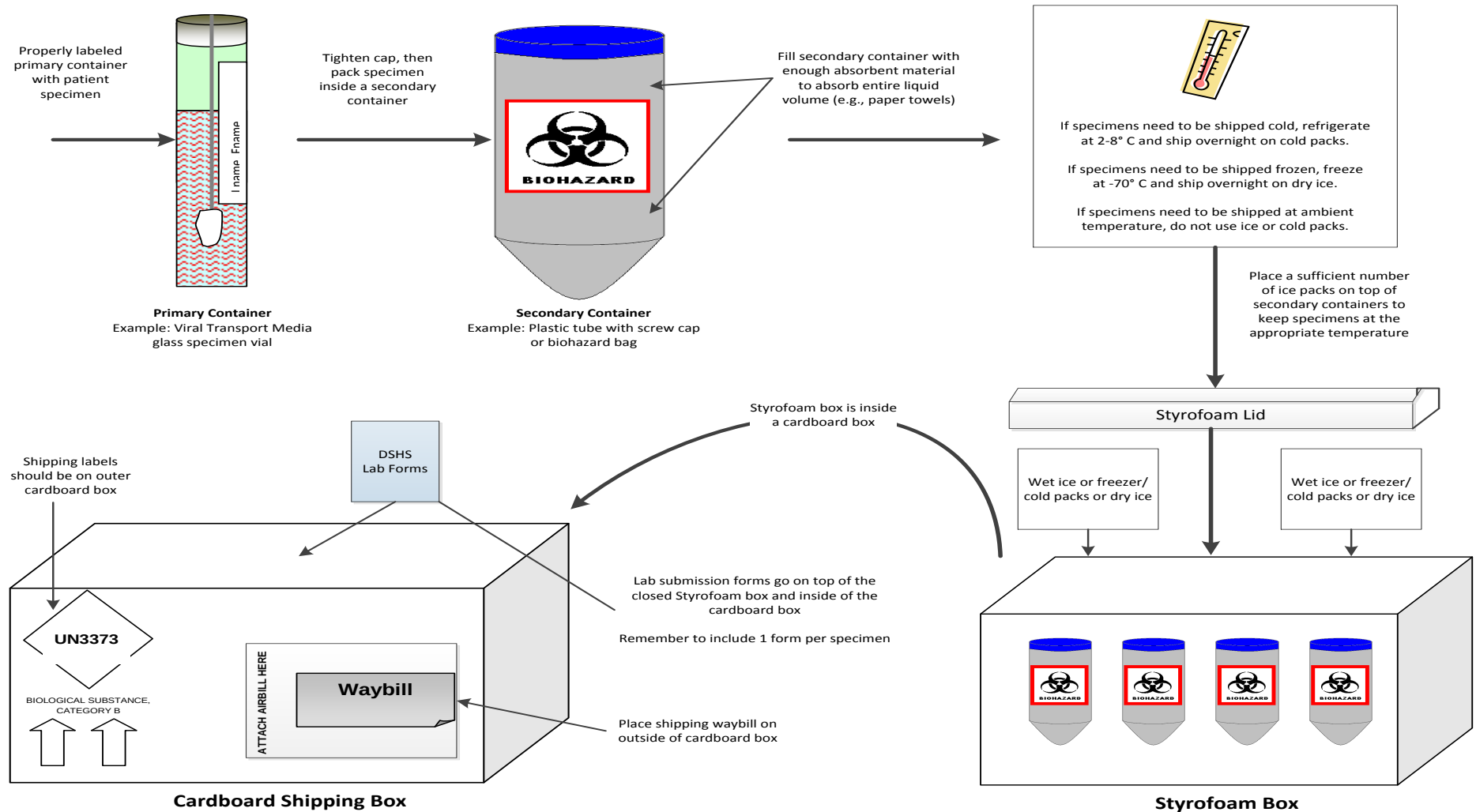
Make sure to review the disease-specific specimen submission guidance in each disease section. The disease-specific guidance covers which form to use, temperature requirements for storage and shipping, timeframes for submission and specimen types that are acceptable for submission. The following steps are basic and apply to most specimens submitted to the DSHS laboratory. More detailed information is available at http://www.dshs.state.tx.us/lab/mrs_shipping.shtm.

Basic Steps to Ship Specimens

- Verify that the correct transport media was used for the specimen/pathogen you want tested.
 - Verify the transport media is not expired.
 - Check the disease-specific guidance for approved transport media.
- Verify that all specimens are labeled correctly.
 - Most specimens require at least two identifiers on the specimen tube/container such as patient name and date of birth.
 - Multiple specimen types from the same person may also require the tube to be labeled with the specimen type or time of collection.
- Verify that one specimen submission form is completed for each specimen submitted.
 - If 5 specimens are collected from the same person then complete 5 forms.
 - Make sure that the forms are completely filled out. Specimens could be rejected if key information is missing such as date of collection.
 - Make sure that the information on the form exactly matches the information on the specimen.
- Verify whether the specimens need to be shipped at room temperature, cold or frozen.
 - Check the disease-specific guidance for approved transport temperatures.
 - If a specimen needs to be cold upon arrival at the DSHS Laboratory, make sure that a sufficient amount of wet ice or cold packs is included especially during the summer.
 - If a specimen needs to be frozen upon arrival at the DSHS Laboratory, make sure dry ice is used. Use as much as will fit but no more than 5 pounds. Blocks are better than pellets. Check with the shipping company to verify dry ice limits.
- Specimens should be triple contained.
 - The primary container is typically the tube or bottle in which the specimen is placed (e.g., the VTM tube for influenza specimens). It must be leak proof. It must also be labeled with patient identifiers (name and date of birth).
 - The secondary container may be a larger plastic tube with a screw cap or even a zipper storage bag. The secondary container should be filled with absorbent material (e.g., paper towels or absorbent pads) to fully absorb the contents of the primary container if it leaks. The secondary container should have a biohazard sticker on it and must be leak proof.
 - The tertiary container is the shipping box which must be clearly labeled for shipping biological substances.

- Specimens should be shipped according to International Air Transport Association (IATA) standards.
 - Most specimens that a health department will ship are considered Category B (infectious substance that does not meet criteria for Category A) and will need the following on the outside of the shipping box:
 - UN 3373/Category B Biological Substances label
 - Directional arrows labels
 - Submitter's address and contact person's information
 - Shipping address and contact person's information
 - Dry ice label (if applicable)
 - Isolates (pure cultures) or specimens from patients suspected of having an exotic, newly emerging or extremely rare pathogen may be classified as Category A agents. Check with the DSHS Laboratory directly for shipping Category A agents.
- Most specimens should be shipped overnight to arrive at DSHS Monday through Friday.
 - Do not ship a specimen to arrive on Saturday, Sunday or a state holiday.
 - If testing outside of normal business hours is needed, approval from EAIDB or the DSHS lab must be obtained before the specimen is shipped.
- Notify EAIDB and/or the DSHS lab when specimens for these diseases are being shipped:
 - Acute Flaccid Myelitis (AFM)
 - Botulism
 - Coronavirus, Novel (MERS)
 - Diphtheria
 - Ebola
 - Gastroenteritis outbreaks
 - Influenza, Novel/variant
 - Measles
 - Mumps
 - Polio
 - Rubella
 - Varicella
 - VISA/VRSA
 - Other rare pathogens

Example Packaging Diagram for Category B Specimens



PREFERRED SPECIMEN SUMMARY TABLE**Table Notes:**

- This table includes only the preferred specimen. Additional specimens may also be acceptable. Check the disease-specific sections for additional acceptable specimens and the appropriate media, transport temperature and timeframe for those specimens.
- The timeframe for receipt by the lab is for the preferred specimen shipped as recommended. Some specimens may be received after the recommended time period if **shipped on different media or shipped frozen. Refer to the disease-specific sections** to see if that is possible.

Condition/Pathogen	Send specimens to DSHS laboratory	Collection kit available	Preferred specimen	Media	Transport temperature	Time period for receipt	DSHS laboratory form	Note
Acute Flaccid Myelitis (AFM)	Testing done by CDC	Yes	CSF, Serum, Whole Blood, and Stool	Depends on specimen type	Depends on specimen type	Depends on specimen type	None	See AFM section for additional details
Amebiasis	Outbreaks or by request only	Yes	Raw stool	PVA & Formalin	Ambient	Not specified; within expiration date of PVA & Formalin vials	G-2B	See amebiasis section for additional details
Ascariasis	Yes	Yes – Stool	Raw stool or Adult Worm	Raw Stool - PVA & Formalin Adult Worm - Formalin or Ethanol	Ambient	Not specified; within expiration date of PVA & Formalin vials	G-2B	See ascariasis section for additional details
Botulism	Isolate required by law	No	Raw stool (>10g)	None	Cold		G-27A	See botulism section for additional details
Campylobacteriosis	Yes	No	Isolate	Agar slant	Ambient	Not specified; within expiration date of media	G-2B	See campylobacteriosis section for additional details
Cryptosporidiosis	Outbreaks or by request only	Yes	Raw stool	PVA & Formalin	Ambient	Not specified; within expiration date of PVA & Formalin vials	G-2B	See cryptosporidiosis section for additional details
Cyclosporiasis	Yes	Yes	Raw stool	PVA & Formalin	Ambient	Not specified; within expiration date of PVA & Formalin vials	G-2B	See cyclosporiasis section for additional details

Condition/Pathogen	Send specimens to DSHS laboratory	Collection kit available	Preferred specimen	Media	Transport temperature	Time period for receipt	DSHS laboratory form	Note
Diphtheria	Isolate required by law	Yes	Swab beneath membrane	Amies or Stuart's transport or Loeffler's Slant	2 – 25°C	Within 48 hours of collection	G-2B	
Ebola	DSHS/LRN Pre-approval required.	No	Blood	Two plastic EDTA purple tops with ≥ 4 ml	Cold	Send by courier for over-night or more rapid delivery	G-27A	Testing must be approved by EAIDB and CDC prior to shipping. Call 512-221-6852
<i>E. coli</i> , shiga toxin-producing	Isolate required by law	No	Isolate	Agar slant	Ambient	Not specified; within expiration date of media	G-2B	See STEC section for additional details
Fascioliasis	Yes	Yes	Raw stool	PVA & Formalin	Ambient	Not specified; within expiration date of PVA & Formalin vials	G-2B	See fascioliasis section for additional details
<i>Haemophilus influenzae</i>	Isolate required by law on patients under 5 years old	No	Isolate	Chocolate agar slant	Ambient temp	Within 48 hours of subculture	G-2B	Isolates from sterile sites only
HAV	No	N/A	N/A	N/A	N/A	N/A	N/A	Widely available commercially
HBV	No	N/A	N/A	N/A	N/A	N/A	N/A	Widely available commercially
HCV	No	N/A	N/A	N/A	N/A	N/A	N/A	Widely available commercially

Condition/Pathogen	Send specimens to DSHS laboratory	Collection kit available	Preferred specimen	Media	Transport temperature	Time period for receipt	DSHS laboratory form	Note
Hookworm (ancylostomiasis)	Yes	Yes – Stool	Raw stool or Adult Worm	Raw Stool - PVA & Formalin Adult Worm - Formalin or Ethanol	Ambient	Not specified; within expiration date of PVA & Formalin vials	G-2B	See hookworm (ancylostomiasis) section for additional details
Influenza	Specimens of interest or surveillance specimens only	Yes	NP swab	Viral Transport Media approved for influenza viruses	Cold	Within 72 hours of collection	G-2V	See Flu Surveillance Protocol for list of specimens of interest, additional specimens acceptable, and for specimens >72 hours after collection
Legionellosis	Outbreaks or by request only	No	isolate	BCYE slant	Ambient		G-2B	See Legionellosis section for other acceptable specimen types
Listeriosis	Isolate required by law	No	Isolate	Non-glucose containing agar slants	Ambient	Not specified; within expiration date of media	G-2B	See listeriosis section for additional details
Measles - PCR	Yes	Yes	Pharyngeal swab	Viral Transport Media	Cold	Within 48 hours of collection	G-2V	See measles section for additional acceptable specimens and for specimens > 48 after collection

Condition/Pathogen	Send specimens to DSHS laboratory	Collection kit available	Preferred specimen	Media	Transport temperature	Time period for receipt	DSHS laboratory form	Note
Measles - Serology	Yes	No	Spun down serum	Red or tiger top tube	Cold	Within 48 hours of collection	G-2A	
Meningitis/ Encephalitis, Amebic	Testing done by CDC	No	Multiple	Varies	Varies	Varies	Call 512-776-7560	See amebic meningitis section for details
Meningococcal (<i>Neisseria meningitidis</i>)	Isolate required by law	No	Isolate	Blood or chocolate agar	Ambient temp		G-2B	Isolates from sterile sites or purpuric lesions required to be sent; if isolate not available, EAIDB requests specimen from sterile site for PCR at CDC
Mumps - Serology	No	N/A	N/A	N/A	N/A	N/A	N/A	DSHS no longer offers mumps IgM testing. Commercially available.
Mumps - PCR	If needed	Yes	Buccal swab (use throat swab on cheek)	Viral Transport Media	Cold	Within 48 hours of collection	G-2V	Preferred method of specimen submission
Norovirus	Yes	No	Raw Stool	None	Cold	As soon as possible	G-2B	Only raw stool accepted; do not freeze; See norovirus section for details

Condition/Pathogen	Send specimens to DSHS laboratory	Collection kit available	Preferred specimen	Media	Transport temperature	Time period for receipt	DSHS laboratory form	Note
Paragonimiasis	Yes	Yes	Raw stool	PVA & Formalin	Ambient	Not specified; within expiration date of PVA & Formalin vials	G-2B	See paragonimiasis section for additional details
Pertussis - PCR	Outbreaks or by request only	Yes	NP swab	Dry tube/no media	Cold	Within 48 hours of collection	G-2B	See pertussis section for additional details
Polio	Testing done by CDC	No	Multiple	Varies	Cold	Within 48 hours of collection	G-2V	Call EAIDB VPD team at 512-776-7676
Rubella PCR	Yes	Yes	Pharyngeal swab	Viral Transport Media	Cold	Within 48 hours of collection	G-2V	Specimens will be forwarded to CDC or another state public health lab for PCR
Rubella - Serology	If needed	No	Spun down serum	Red or tiger top tube	Cold	Within 48 hours of collection	G-2A	Specimens may be submitted for serology if serology is not available from a commercial lab
Salmonellosis	Isolate required by law	No	Isolate	Agar slant	Ambient	Not specified; within expiration date of media	G-2B	See Salmonellosis section for additional details
Shigellosis	Yes	No	Isolate	Agar slant	Ambient	Not specified; within expiration date of media	G-2B	See shigellosis section for additional details

Condition/Pathogen	Send specimens to DSHS laboratory	Collection kit available	Preferred specimen	Media	Transport temperature	Time period for receipt	DSHS laboratory form	Note
<i>Streptococcus</i> , Group A (<i>S. pyogenes</i>)	Clusters/ outbreaks (if pre-approved) or by request only	No	Isolate	Agar slant	Ambient		G-2B	Commercial testing widely available for initial ID; PFGE testing at DSHS requires pre-approval from EAIDB IRID Team at 512-776-7676
<i>Streptococcus</i> , Group B (<i>S. agalactiae</i>)	Clusters/ outbreaks (if pre-approved) or by request only	No	Isolate	Agar slant	Ambient		G-2B	Commercial testing widely available for initial ID; PFGE testing at DSHS requires pre-approval from EAIDB IRID Team at 512-776-7676
<i>Streptococcus pneumoniae</i>	Isolate required by law on patients under 5 years old	No	Isolate	Agar slant	Ambient		G-2B	Isolates from sterile sites only
Tetanus	No	N/A	N/A	N/A	N/A	N/A	N/A	Lab confirmation is not necessary
Trichuriasis	Yes	Yes – Stool	Raw stool or Adult Worm	Raw Stool - PVA & Formalin Adult Worm - Formalin or Ethanol	Ambient	Not specified; within expiration date of PVA & Formalin vials	G-2B	See trichuriasis section for additional details

Condition/Pathogen	Send specimens to DSHS laboratory	Collection kit available	Preferred specimen	Media	Transport temperature	Time period for receipt	DSHS laboratory form	Note
Varicella PCR	Yes or send directly to CDC	No	Lesion/scab scraping	NO media	Ambient temperature	Within 48 hours of collection	G-2V	DSHS will forward the specimen to MN PH lab. Providers can also submit specimens directly to CDC.
Vibriosis	Isolates required by law	No	Isolate	Agar slant	Ambient	Not specified; within expiration date of media	G-2B	See Vibriosis section for additional details
Viral Hemorrhagic Fever (non-Ebola)	Testing done by CDC	No	Multiple	Varies	Varies	Varies	Contact EAIDB	Approval from CDC is required before submitting specimen for testing. Contact EAIDB to arrange for testing.
VISA/VRSA	Yes	No	Isolate	Blood agar or BHI medium	Ambient	Within 48 hours of collection	G-2B	Call DSHS regional HAI Epidemiologist for the appropriate jurisdiction
Yersiniosis	Outbreaks or by request only	No	Isolate	Agar slant	Ambient	Not specified; within expiration date of media	G-2B	See shigellosis section for additional details

Cold = 2 – 8 °C

Ambient = room temperature

UPDATES

April 2017

- Updated the Basic Health Department Recommendations section
- In the Preferred Specimen Submission Table:
 - Added details for acute flaccid myelitis (AFM)
 - Added the word encephalitis to “meningitis, amebic”
 - Updated isolate submission requirement, effective April 2017, for salmonellosis, diphtheria and *Streptococcus pneumoniae*.

Appendix D: Summary of Updates rev Apr 2017

January 2016

Newly added conditions

- Acute Flaccid Myelitis
- Ascariasis
- Fascioliasis
- Hookworm (ancylostomiasis)
- Paragonimiasis
- Trichuriasis

Amebiasis

- Revised the Exclusion section to provide clarity.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Procedures section to address the unavailability of food and environmental swab testing for *E. histolytica* at the DSHS laboratory.

Amebic meningitis/encephalitis

- Basic Epidemiology: added organ transplantation to Transmission; changed incubation and duration periods for PAM; updated Communicability and Clinical Illness sections
- Definitions: changed Clinical Case Definition and Laboratory Confirmation for both PAM and Other Amebic to make this document consistent with the Epi Case Criteria Guide (ECCG).
- Surveillance and Case Investigation: added location of FLA form on DSHS website to Case Investigation Checklist; added some clarifications in Control Measures section, and added information on religious practices (ritual nasal rinsing and ablution) as a possible source of infection
- Reporting and Data Entry Requirements: clarified that only waterborne outbreaks of amebic meningitis/encephalitis should be reported in NORS
- Laboratory Procedures: included teleradiology information, edited CDC DPDx laboratory contact information, edited the specimen submission form requirements, and included various other changes

Botulism

- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.

Campylobacteriosis

- Revised the Exclusion section to provide clarity.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Procedures section to include additional information regarding the submission of raw stool and stool in transport medium for *Campylobacter* spp. testing and to include the General Policy of testing food samples and environmental swabs for *Campylobacter* spp.

Carbapenem-resistant *Enterobacteriaceae* (CRE)

- Added CRE as its own condition
- Updated the CRE definition per the CSTE position paper that came out April 2015.
- Deleted most of the section related to control measures for cases (aka patients) to avoid confusion as it is not necessary in most MDRO investigations to interview the patient.
- Clarified verbiage on who to contact if assistance is needed by the LHD/ HSR; contact your DSHS HAI epidemiologist.

Cryptosporidiosis

- Revised the Exclusion section to provide clarity.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Procedures section to address the unavailability of food and environmental swab testing for *Cryptosporidium* at the DSHS laboratory.

Cyclosporiasis

- Revised the Exclusion section to provide clarity.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Procedures section to include additional information regarding clinical specimen testing and testing of food and environmental swabs for *Cyclospora*.

Ebola

- Updated time period of the detection of Ebola virus in semen under Basic Epidemiology
- Edited Confirmed and removed Probable from Case Classification
- Updated High, Some, and Low risk and added No identifiable risk in Exposure Risk Levels
- Edited CDC link under Definitions

Gastroenteritis Outbreaks

- Added an Exclusion sub-section to address child-care/school and food employee exclusions.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS

Haemophilus influenzae

- Updated case definition to reflect change from HIB to all *H. flu* being reportable
- Updated investigation checklist with information on which *H. flu* cases need investigation
 - HIB cases of any age and *H. flu* cases in children <5 need full investigation
 - All other cases (*H. flu* in people 5 and older) only need info to meet case definition
- Updated control measures to include *H. flu* and HIB.
- Updated laboratory information to reflect new TAC requirement for isolates on children < 5.
- Updated flow chart to reflect changes in case definition.
- Updated language throughout chapter to refer to *H. flu*, not just HIB.

Hepatitis A

- Added special situations section and provided info about foodhandler, daycare, and common source exposures (some of these may have been moved from other parts of the chapter).

Hepatitis E

- Revised the Exclusion section to provide clarity.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.

Influenza A - novel/variant

- Definitions: changed Case Under Investigation definition and footnotes for “Novel Influenza A Viruses **with the Potential to Cause** Severe Disease in Humans”
- Laboratory Procedures: made changes to Specimen Submission section to reflect changes to submission form; removed reference to wet ice

Influenza-associated pediatric mortality

- Basic Epidemiology: minor changes to Transmission, Communicability, Clinical Illness, and Severity
- Laboratory Procedures: changes made to Submission Form instructions to reflect form updates; references to “wet ice” removed in Specimen Shipping instructions

Legionellosis

- Basic Epidemiology: added environmental video link, note about incubation period for outbreaks; clarified severity for different types of Legionellosis disease
- Surveillance and Case Investigation
 - Case Investigation Checklist: clarified investigation forms to use for cases, updated web links, added recommendations for documentation to determine onset date, slight reordering of section
 - Prevention and Control Measures:
 - Cases, contacts, and the general public: updated web links, slight reordering, updated water birth guidelines and link
 - Healthcare providers and facilities: added indications for Legionella testing, added and updated water maintenance bullet, slight reordering, minor clarifications
 - Providers and facilities that offer water birthing: updated web link and guidelines (per DSHS Midwifery Board update)
 - School/Daycare Exclusion Criteria: no changes
- Managing Special Situations
 - Travel-associated cases: clearly defined sections for single cases vs. multiple cases; added water system maintenance guidance link; updated web links; added training video link for environmental assessment; updated ASHRAE standards
 - Healthcare-associated cases: clearly defined sections for single cases vs. multiple cases; added water system maintenance guidance link; updated web links; added training video link for environmental assessment; updated ASHRAE standards; added recommendation to retain clinical isolates
 - Cases associated with a gym, spa, or other “open” facility: slight heading name change; clearly defined sections for single cases vs. multiple cases; added water system maintenance guidance link; updated web links; added training video link for environmental assessment; updated ASHRAE standards
 - Cases associated with a community: slight heading name change; updated web links; added recommendation to retain clinical and environmental isolates for comparison; added note about incubation period during outbreaks
- Reporting and Data Entry Requirements: added request for environmental assessment and testing results; minor formatting changes
- Clinical Laboratory Procedures: minor changes only
- Environmental Sampling and Testing: shortened introductory paragraph; changes to heading titles; updated web links; added sampling purpose, instructional video links, CDC sampling document link, and potential sampling sites; added several bullets to section on Choosing Sites for Sampling; to this section, moved information from previous Sampling and Additional Resources section; slight reordering of some information in section
- Additional Resources: heading name change; deleted materials and instructions for sampling (that information is now in the Environmental Sampling and Testing Section and in the CDC videos); added links to CDC’s videos on environmental sampling; updated web links; added Water System Maintenance section

Listeriosis

- Revised the Exclusion section to provide clarity.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Procedures section to include the General Policy of testing food samples and environmental swabs for *Listeria monocytogenes*.

Measles

- Edits made throughout in improve clarity.
- Deleted bullet about minimum clinical presentation for suspect measles. Information was contradictory.
- Added section on determining susceptibility of contacts.
- Updated IG information
 - Added link to immune globulin product information.
 - Added information about vaccination timing after IG administration
- Updated exclusion criteria to reflect TAC change from 14 to 21 day exclusion for unvaccinated, exposed children.
- Updated (and moved) Table 1 (Recommended follow-up of measles contacts) with more specific information on high risk and low risk contacts and their management.
- Separated control measures for school and childcare facilities to reflect the different risk status of their populations
- Updated language about testing of recently vaccinated individuals to highlight when testing should or should not be done
- Refined IgG specimen collection language in lab section for clarity

Meningococcal invasive disease

- Basic Epidemiology: Added clinical manifestations of meningococcal disease and their occurrence in Texas
- Definitions: Updated case definition to match the Epi Case Criteria Guide for 2016
- Surveillance and Case Investigation:
 - Case Investigation Checklist: Rewording of several bullets; moved information for meningococcal case in a school to the Control Measures section; changed timeframe for isolate/culture follow-up to 24 hours after start of investigation (to try to get the isolate/specimen before the lab throws it out)
 - Control Measures: Clarified that DSHS FAQ is for meningococcal meningitis; moved information on schools and institutions to this section from Checklist
 - School/Daycare Exclusion Criteria: clarified exclusion for specific types of meningococcal disease and not just meningitis
- Reporting and Data Entry Requirements: added instructions for suspect cases
- Laboratory Procedures: Added request for nonviable isolates and sterile sites specimens when isolates are not available; added request for shipment tracking number
- Invasive Meningococcal Infection: Case Status Classification flowchart: updated to reflect changes in case definition (removed requirement for clinical compatibility,

changed Gram-negative diplococci and purpura fulminans to suspect cases), added Note box, clarified lab specimens/isolates to send for each case classification

Multidrug-resistant *Acinetobacter* (MDR-A)

- Added MDR-A as its own condition
- Deleted most of the section related to control measures for cases (aka patients) to avoid confusion as it is not necessary in most MDRO investigations to interview the patient.
- Clarified verbiage on who to contact if assistance is needed by the LHD/ HSR; contact your DSHS HAI epidemiologist.

Mumps

- Updated laboratory section to reflect discontinuation of IgM at DSHS Laboratory.
- Removed information about PCR testing of urine as it is not recommended for mumps.
- Updated flow chart to match case definition.

Novel coronavirus

- Basic Epidemiology: changes to SARS incubation period and percentage of cases with diarrhea
- Definitions: updated suspect/Patient Under Investigation definition to incorporate CDC changes in fever requirement and to remove references to the Republic of Korea
- Surveillance and Case Investigation:
 - Case Investigation Checklist: slight changes to specify when to complete the PUI form and how quickly to send the completed form to DSHS
 - Prevention and Control Measures:
 - Healthcare Facilities and Healthcare Personnel: change to heading name; added detailed CDC guidance
 - Laboratory settings: extensive updates to incorporate CDC's changes
 - Air or Ground Medical Transport: NEW
 - Confirmed, Probable or Suspected (PUI) Case-Patients: added detailed recommendations including assessment of suitability of home isolation/care and reformatting of guidance per CDC's updates
 - Caregivers and Household Members: added detailed recommendations
 - Close Contacts: added detailed recommendations
 - Travelers to Arabian Peninsula and Airline Crew: added detailed CDC guidance
 - Footnotes: NEW
- Contact Tracing: added a statement to clarify that DSHS Austin may request that healthcare workers who are close contacts to a confirmed or probable case be included in contact tracing activities regardless of PPE usage
- Managing Special Situations: added footnote on fever
- Laboratory Procedures: updated DSHS lab submission form picture; attempted to clarify when serum should be collected for rRT-PCR testing at a state or local PHL (more common) vs. PCR testing at CDC (less common)

Norovirus Outbreaks

- Added an Exclusion sub-section to address child-care/school and food employee exclusions. The food employee exclusions reflect the New Texas Food Establishment Rules (TFER) which went into effect on October 11, 2015.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak

Pertussis

- Deleted redundant yet conflicting note about epi-linking from case criteria.
- Updated exclusion criteria to reflect recent TAC change. Patients with cough onset more than 21 days prior do not need to be excluded from school.
- Added section on pertussis outbreaks including outbreak definition, requesting outbreak names, and use of antibiotic prophylaxis.
- Under “special situations,” added information specific to investigating infant cases and cases with infant contacts.

Salmonellosis

- Updated the food employee Exclusion section to reflect the New Texas Food Establishment Rules (TFER) which went into effect on October 11, 2015 and now include non-typhoidal *Salmonella* with exclusion/restriction criteria.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Procedures section to include additional information regarding the submission of raw stool and stool in transport medium for *Salmonella* spp. testing and to include the General Policy of testing food samples and environmental swabs for *Salmonella* spp.

Shiga toxin-producing *Escherichia coli*

- Updated the food employee Exclusion section to reflect the New Texas Food Establishment Rules (TFER) which went into effect on October 11, 2015.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Section to include additional information regarding the submission of raw stool and stool in transport medium for STEC testing and to include the General Policy of testing food samples and environmental swabs for *E.coli* 0157:H7

Shigellosis

- Updated the food employee Exclusion section to reflect the New Texas Food Establishment Rules (TFER) which went into effect on October 11, 2015.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Section to include additional information regarding the submission of raw stool and stool in transport medium for *Shigella* spp. testing and to include the General Policy of testing food samples and environmental swabs for *Shigella* spp.

GAS

- Definitions: minor change to Laboratory Confirmation to make this section equivalent to the other invasive Streptococcus sections in this document and with Epi Case Criteria Guide (ECCG) changes
- Surveillance and Case Investigation: emphasis added on collecting enough information for GAS cases to confirm that the case meets case definition

GBS

- Definitions: minor change to Laboratory Confirmation to bring this document in line with Epi Case Criteria Guide (ECCG) changes
- Surveillance and Case Investigation: emphasis added on collecting enough information for GAS cases to confirm that the case meets case definition

Streptococcus pneumoniae

- Definitions: minor change to Clinical Case Definition to bring this document in line with Epi Case Criteria Guide (ECCG) changes
- Surveillance and Case Investigation: minor change to Case Investigation Checklist including that submitting isolates on children <5 years old is a voluntary activity

Typhoid Fever

- Updated the food employee Exclusion section to reflect the New Texas Food Establishment Rules (TFER) which went into effect on October 11, 2015.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Section to include additional information regarding the submission of raw stool and stool in transport medium for *Salmonella* Typhi testing and to include the General Policy of testing food samples and environmental swabs for *Salmonella* Typhi.

Varicella

- Updated case investigation section to highlight when investigations should be done (outbreaks, hospitalizations, deaths, missing vaccination history) and to highlight importance of provider/reporter and patient education.
- Deleted CDC information request for outbreak cases as the CDC no longer requests that information.
- Added link to CDC laboratory submission website.

***Vibrio* Infections including Cholera**

- Revised the Exclusion section to provide clarity.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Section to include additional information regarding the submission of raw stool and stool in transport medium for *Vibrio* spp. testing and to include the General Policy of testing food samples and environmental swabs for *V. cholera*, *V. parahaemolyticus* and *V. vulnificus*.

Viral Hemorrhagic Fever (Non-Ebola)

- Added list of Viral Hemorrhagic Fever agents in Laboratory Confirmation
- Removed Probable from Case Classification
- Updated time period on last exposure bullet under Suspect case classification

Yersiniosis

- Revised the Exclusion section to provide clarity.
- Added statement regarding only counting a case once per 365 days in the Reporting and Data Entry Requirements section.
- Expanded the NORS sub-section in the Reporting and Data Entry Requirements section to include the NORS outbreak definition and the types of outbreaks that should be reported in NORS.
- Expanded the Laboratory Procedures section to include additional information regarding the submission of raw stool and stool in transport medium for *Yersinia* spp. testing and to include the General Policy of testing food samples and environmental swabs for *Yersinia enterocolitica*

Appendix A

- Added a table: Guide to Food Employee Exclusions and Restrictions
- Normally Sterile Sites page – NEW
- Sterile Site and Invasive Disease Determination flowchart: minor clarifications in examples of non-sterile respiratory sites; added reference to Normally Sterile Sites definition; “joint fluid (intact joint, no skin break/abscess)” added to sterile sites at top of flowchart; removed “type b” (for H. flu) at the bottom of the flowchart
- Invasive Streptococcal Infection: Case Status Classification flowchart: clarifications added for invasive disease (from a non-sterile site) and to consult the case definitions for GAS and GBS; alpha and beta hemolysis statement emphasized

Appendix B

- Minor changes in wording

Appendix C

- In the table, for meningococcal disease, added statement about EAIDB requesting sterile site specimens from cases in which there is no isolate available to send to DSHS
- Added ascariasis, fascioliasis, hookworm (ancylostomiasis), paragonimiasis, trichuriasis, and viral hemorrhagic fever (non-ebola) to the Preferred Specimen Summary Table

Appendix E

- Updated web links
- Added TexasFlu.org, CDC’s Group B Strep website, and links to ASHRAE standards (Legionella)

April 2017**Acute Flaccid Myelitis (AFM)**

- Investigation form updated to fit CDC's case definition
- Links were updated to the most recent patient summary forms from the CDC
- Specimen collection tables were updated to reflect changes to testing procedures at the CDC

Amebic Meningitis/Encephalitis

- Definitions: changed Clinical Case Definition and Laboratory Confirmation for both PAM and Other Amebic Meningitis/Encephalitis to make this document consistent with the Epi Case Criteria Guide (ECCG).
- Surveillance and Case Investigation: separated Control Measures by *Naegleria fowleri* and *Balamuthia mandrillaris* and *Acanthamoeba* spp.
- Reporting and Data Entry Requirements: added that probable cases need to be entered into NBS and a NBS notification submitted
- Laboratory Procedures: edited CDC DPDx laboratory contact information

Ascariasis

- Basic Epidemiology: revised the Transmission, Incubation Period, and Communicability sections to provide clarity.

Campylobacteriosis

- Updated statement regarding how often to count a case, only counting a case once per 30 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Carbapenem- resistant *Enterobacteriaceae* (CRE)

- Added information and clarification about jurisdiction and who should investigate cases and included information about consulting with a DSHS regional HAI Epidemiologist for more help with an investigation.
- Added more specific information about control measures and isolation.
- Clarified instructions on how to handle an outbreak.

Congenital Rubella Syndrome (CRS)

- Edits made throughout the document to improve clarity

Cryptosporidiosis

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.

Cyclosporiasis

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.

Diphtheria

- Updates made to document to clarify case classification
- Updates made to process for obtaining diphtheria antitoxin

Ebola Virus Disease

- Edited Laboratory Confirmation.
- Updated and edited Local and Regional Reporting and Follow-up Responsibilities.
- Removed footnotes related to Ebola outbreak 2014 which no longer apply.

Gastroenteritis Outbreaks

- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Haemophilus influenzae

- The phase “clinically compatible” has been removed from the case definition to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
- Edits made throughout the document to improve clarity

Hepatitis A

- The clinical case definition has been updated to require both the discrete onset of symptoms and either jaundice or elevated liver enzymes to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
- Parenthetical note added about epi linkage, discussing sexual and household contacts

Hepatitis B, acute and perinatal

- **Hepatitis B, acute**
 - The laboratory criteria for diagnosis has been updated to require a hepatitis B surface antigen (HBsAg) positive test results and, if done, an IgM antibody to hepatitis B core antigen (anti-HBc IgM) positive laboratory result
 - The clinical case definition has been updated to require both the discrete onset of symptoms and either jaundice or elevated liver enzymes to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
- **Hepatitis B, perinatal**
 - The laboratory criteria for diagnosis has been updated to include hepatitis B e antigen (HBeAg) and hepatitis B virus DNA (HBV DNA) to the laboratory confirmed definition
 - A probable case definition has been added to perinatal hepatitis B to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
 - Notes were added to laboratory criteria for diagnosis as well as case definition

Hepatitis C

- Updated laboratory criteria.
- Updated case definition to reflect new case criteria including the addition of “probable” case classification.
- Updated Basic Epidemiology information to reflect latest information from CDC including probability of symptom manifestation and probability of progression to Chronic Hepatitis C infection.
- Added information for Acute HCV infected pregnant women to the “Managing Special Situations” section.

Hookworm (ancylostomiasis)

- Basic Epidemiology: revised the Transmission, Incubation Period, and Communicability sections to provide clarity.

Influenza A-Novel/Variant

- Definitions: modified the Case Under Investigation definition and footnote number 1 for the “Novel Influenza A Viruses **Associated with Severe Disease in Humans**” subsection
- Laboratory Procedures: changes made to Submission Form instructions to reflect updates to the DSHS Laboratory G-2V Specimen Submission Form and the DSHS Laboratory submission procedure

Influenza-Associated Pediatric Mortality

- Laboratory Procedures: changes made to Submission Form instructions to reflect updates to the DSHS Laboratory G-2V Specimen Submission Form and the DSHS Laboratory submission procedure

Legionellosis

- Basic Epidemiology: added additional species of *Legionella* to Infectious Agents. Added additional symptoms to Legionnaires’ disease under clinical Illness.
- Surveillance and Case Investigation
 - Case Investigation Checklist: corrected urine antigen to urinary antigen, changed multiple attempts to at least three attempts, added information about what to do in the event of a death.
 - Prevention and Control Measures: changed physician to medical provider, added information about the CDC Toolkit, minor grammatical changes.
 - School/Daycare Exclusion Criteria: no changes
- Managing Special Situations
 - Travel-associated cases: added additional information about the environmental assessment; added CDC toolkit link; updated web links; clarified that environmental sampling should be informed by environmental assessment and needs to be approved by health department
 - Healthcare-associated cases: added information about what to do if it involves outpatients; added additional information about the environmental assessment; added CDC toolkit link; updated web links; added clarification about the retrospective and prospective surveillance dates; added clarification about clinical *Legionella* isolates; clarified that environmental sampling should

- be informed by environmental assessment and needs to be approved by health department
- Cases associated with a gym, spa, or other “open” facility: added additional information about the environmental assessment; added CDC toolkit link; updated web links; clarified that environmental sampling should be informed by environmental assessment and needs to be approved by health department
- Cases associated with a community: no changes
- Reporting and Data Entry Requirements: no changes
- Clinical Laboratory Procedures: updated section number on Laboratory Submission Form; added information about name and approved secondary identifier
- Environmental Sampling and Testing: added that the sampling plan should be approved by the health department
- Additional Resources: added links to CDC’s toolkit Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards and EPA’s - Technologies for Legionella Control in Premise Plumbing Systems: Systematic Review; updated web links

Listeriosis

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.

Measles

- Edits made throughout the document to improve clarity

Meningococcal Infection, Invasive

- Edits made throughout the document to improve clarity

Multidrug-resistant *Acinetobacter* (MDR-A)

- Added information and clarification about jurisdiction and who should investigate cases and included information about consulting with a DSHS regional HAI Epidemiologist for more help with an investigation.
- Added more specific information about control measures and isolation.
- Clarified instructions on how to handle an outbreak.

Mumps

- Updated reporting time frame from “within 1 week” to “within 1 work day”
- Added clarifying language to the case classification

Novel Coronavirus

- Definitions: updated the footnotes.
- Contact Tracing: updated the close contact definition for MERS
- Laboratory Procedures: updated DSHS lab submission G-2V form picture; updated what type of information needs to match between the DSHS lab G-2V submission form and the specimen tube

Pertussis

- Updates made throughout document to improve clarity

Polio (paralytic and non-paralytic infection)

- Updated definitions section to differentiate between paralytic and non-paralytic polio cases
- Updated reporting requirements for paralytic and non-paralytic polio

Rubella

- Edits made throughout the document to improve clarity

Salmonellosis (non-typhoidal)

- Updated case definition to match the Epi Case Criteria Guide for 2017
 - CIDT methods now included in Probable case definition
- Added statement in Laboratory Procedures section regarding new *Salmonella* isolate submission requirement.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Shiga toxin-producing *E. coli*

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Shigellosis

- Updated case definition to match the Epi Case Criteria Guide for 2017
 - CIDT methods now included in Probable case definition
- Updated statement regarding how often to count a case, only counting a case once per 90 days in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section

GAS

- Definitions: minor change to the confirmed Case Classification, added an additional note about case counting to match the change made in the Epi Case Criteria Guide (ECCG)

GBS

- Definitions: minor change to the confirmed Case Classification, added additional notes about case counting to match the change made in the Epi Case Criteria Guide (ECCG)

Streptococcus pneumoniae

- The case classification for confirmed cases has been updated to remove the requirement for being clinically compatible to reflect the current change in case definition from the Council of State and Territorial Epidemiologists
- A case classification for probable cases has been added to reflect the current addition in case definition from the Council of State and Territorial Epidemiologists
- A note regarding the timeframe for counting new cases has been added

Trichuriasis

- Basic Epidemiology: revised the Transmission, Incubation Period, and Communicability sections to provide clarity.

Typhoid Fever

- Updated statement regarding how often to count a case, only counting a case once per 365 days in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Varicella

- Edits made to clarify investigation aspects of confirmed and probable cases
- Updates made to provide instruction in handling varicella cases who have crossed the border into the United States within the last two weeks
- Number of days added for providing varicella vaccine as post-exposure prophylaxis

***Vibrio* infections including cholera**

- Updated case definition to match the Epi Case Criteria Guide for 2017
 - CIDT methods now included in Probable case definition
- Updated statement regarding how often to count a case, only counting a case once per 30 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Viral Hemorrhagic Fever (Non-Ebola)

- Updated case classification information to align with Epi Case Criteria Guide
- Added reference to Ebola guidelines for suspect case investigation.

VISA/VRSA

- Minor grammatical corrections.
- Clarified instructions for who conducts an investigation.

Yersiniosis

- Updated statement regarding how often to count a case, only counting a case once per 365 days, in the Definitions and Reporting and Data Entry Requirements section.
- Updated table regarding the submission of raw stool or stool in transport medium in the Laboratory Procedures section.

Appendix B

- Updated the Background and Regional and Local Health Department expectations sections

Appendix C

- Updated the Basic Health Department Recommendations section
- In the Preferred Specimen Submission Table:
 - Added details for acute flaccid myelitis (AFM)
 - Added the word encephalitis to “meningitis, amebic”
 - Updated isolate submission requirement, effective April 2017, for salmonellosis, diphtheria and *Streptococcus pneumoniae*.

Appendix D

- Added updates made in 2017

Appendix E

- Updated Resources and links

Appendix E: Additional Resources rev Apr 2017

- Disease Investigation Tools
- Helpful DSHS Websites
- Helpful CDC Websites
- Additional Links and Resources
- Acronyms and Abbreviations

DISEASE INVESTIGATION TOOLS

- The Emerging and Acute Infectious Disease Guidelines:
<http://www.dshs.texas.gov/IDCU/investigation/Investigation-Guidance.xls>
- DSHS Reporting Forms: www.dshs.texas.gov/idcu/investigation/forms/
- VPD Investigation Forms:
www.dshs.texas.gov/idcu/health/vaccine_preventable_diseases/forms/
- Other Investigation Forms and tools: www.dshs.texas.gov/idcu/investigation/
- Notifiable Conditions List:
<http://www.dshs.texas.gov/idcu/investigation/conditions/>
- The Epi Case Criteria Guide:
<http://www.dshs.texas.gov/IDCU/investigation/Guidance-Manuals.xls>
- NBS (NEDSS) Data Entry Guidelines:
<http://txnedss.dshs.state.tx.us:8009/PHINDox/UserResources/>
- Hep A toolkit:
http://www.dshs.texas.gov/idcu/disease/hepatitis/hepatitis_a/links/
- Measles toolkit:
<http://www.dshs.texas.gov/idcu/disease/measles/links/>
- Pertussis toolkit:
<http://www.dshs.texas.gov/idcu/disease/pertussis/links/>
- Laboratory Submission Guide: www.dshs.texas.gov/lab/MRS_labtests_toc.shtm
- Council to Improve Foodborne Outbreak Response (CIFOR) Guidelines:
<http://www.cifor.us/documents/CIFOR%20Industry%20Guidelines/CIFOR-Industry-Guideline.pdf>
- CDC Legionellosis Hypothesis-Generating Form: www.cdc.gov/legionella/health-depts/inv-tools-single/index.html
- CDC *Legionella* Environmental Assessment Form:
<http://www.cdc.gov/legionella/health-depts/inv-tools-cluster/environmental-inv-tools.html>
- Texas Influenza Surveillance Handbook:
www.dshs.texas.gov/idcu/disease/influenza/Texas-Influenza-Surveillance-Handbook/
- Vaccine Information Sheets:
<http://www.dshs.texas.gov/immunize/literature/litlist.shtm>

- A Primer for Lone Ranger Epidemiologists in Texas Counties
<http://www.dshs.texas.gov/IDCU/investigation/Guidance-Manuals.xls>
- Communicable Disease Chart and Notes for Schools and Child-Care Centers (i.e., School Exclusion chart)
 - Copies can be ordered at
<https://secure.immunizetexasorderform.com/default.asp>
- Texas Food Establishment Rules (TFER)
<https://www.dshs.texas.gov/foodestablishments/laws-rules.aspx>

HELPFUL WEBSITES

DSHS Websites

- Main Agency Website: www.dshs.texas.gov/
- Emerging and Acute Infectious Disease Branch:
www.dshs.texas.gov/idcu/health/ideas/
- State level data by condition can be found on the EAIDB website
<http://www.dshs.texas.gov/idcu/data/>
- Foodborne Illness Main Page:
http://www.dshs.texas.gov/idcu/health/foodborne_illness/
- Food Establishments Group, Rules and Regulations:
<https://www.dshs.texas.gov/foodestablishments/laws-rules.aspx>
- Perinatal Hepatitis B Prevention Program:
www.dshs.texas.gov/idcu/disease/hepatitis/hepatitis_b/perinatal/
- Immunization Unit: <https://www.dshs.texas.gov/immunize/>
- Infectious Disease Control Unit: <http://www.dshs.texas.gov/idcu/>
- Laboratory Services Section Main Page:
<http://www.dshs.texas.gov/lab/>
- Recommended Immunization Schedules:
<http://www.dshs.texas.gov/immunize/schedule/default.shtm>
- School & Child-Care Facility Immunization Requirements:
<http://www.dshs.texas.gov/immunize/school/default.shtm>
- Texas Administrative Code (TAC), Title 25 Health Services, §§97.1-97.14:
[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=97](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=97)

- TexasFlu.org: www.texasflu.org
- Vaccine Adverse Event Reporting System (VAERS):
www.dshs.texas.gov/immunize/safety/vaersweb.shtm
- Vaccine Preventable Diseases Main Page:
www.dshs.texas.gov/idcu/health/vaccine_preventable_diseases/
- Antibiotic-Resistance / MDRO Main Page:
http://www.dshs.texas.gov/idcu/health/antibiotic_resistance/

CDC Websites

- CDC Vaccine Preventable Diseases:
<https://www.cdc.gov/vaccines/vpd/>
- Manual for the Surveillance of Vaccine Preventable Diseases:
www.cdc.gov/vaccines/pubs/surv-manual/index.html
- Morbidity and Mortality Weekly Report (MMWR): www.cdc.gov/mmwr/
- Epidemiology and Prevention of Vaccine Preventable Disease (Pink Book):
www.cdc.gov/vaccines/pubs/pinkbook/index.html
- Epidemiology & Prevention of Vaccine-Preventable Diseases 2012 (EpiVac) Web-On-Demand Modules: <https://www.cdc.gov/vaccines/ed/webinar-epv/index.html>
- Recommendations of the Advisory Committee on Immunization Practices (ACIP) Influenza Prevention and Control Recommendations:
www.cdc.gov/flu/professionals/acip/index.htm
- Foodborne Outbreaks:
<http://www.cdc.gov/foodsafety/outbreaks/>
- Food Safety:
<http://www.cdc.gov/foodsafety/>
- National Outbreak Reporting System (NORS)
<http://www.cdc.gov/nors/>
- Centers for Disease Control and Prevention *Streptococcus pneumoniae* information:
<http://www.cdc.gov/pneumococcal/about/index.html>
- Centers for Disease Control and Prevention group A *Streptococcus* information:
<http://www.cdc.gov/groupastrep/index.html>
- Centers for Disease Control and Prevention group B *Streptococcus* information:
<http://www.cdc.gov/groupbstrep/index.html>

- Centers for Disease Control and Prevention Antibiotic/ Antimicrobial Resistance: <http://www.cdc.gov/drugresistance/about.html>
- Centers for Disease Control and Prevention Drug resistance Threat Report 2013: <http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf>
- Centers for Disease Control and Prevention – CRE Toolkit updated 2015: <https://www.cdc.gov/hai/organisms/cre/cre-toolkit/>
- Centers for Disease Control and Prevention - Surveillance Reporting for Enrolled Facilities <https://www.cdc.gov/nhsn/enrolled-facilities/index.html>
- Centers for Disease Control and Prevention MDRO and CDI module 2017 https://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf
- Centers for Disease Control and Prevention - Healthcare Infection Control Practices Advisory Committee (HICPAC) 2007 Guideline for Isolation Precautions https://www.cdc.gov/hicpac/2007IP/2007ip_appendA.html
- Centers for Disease Control and Prevention Ebola (Ebola Virus Disease) information: <http://www.cdc.gov/vhf/ebola/>
- Centers for Disease Control and Prevention Viral Hemorrhagic Fevers (VHFs) information: <http://www.cdc.gov/vhf/virus-families/index.html>
- Centers for Disease Control and Prevention Neglected Tropical Disease information: <http://www.cdc.gov/globalhealth/ntd/>
- Council of State and Territorial Epidemiologists Revised Guidelines for Determining Residency for Disease Notification Purposes <http://wwwn.cdc.gov/nndss/document/11-SI-04.pdf>

Additional Links and Resources

- Control of Communicable Diseases Manual (20th Edition). Heymann, D.L. (Ed). American Public Health Association: Washington; 2015. www.unboundmedicine.com/ccdm/ub (A subscription is required for full online access. If you are in need of a printed book copy, please contact DSHS IDCU.)
- Red Book:
2015 Report of the Committee on Infectious Diseases (30th Edition). Kimberlin DW, Long SS, Brady MT, Jackson MA (Eds). American Academy of Pediatrics: Elk Grove Village, IL; 2015. aapredbook.aappublications.org/ (A subscription is required for full online access. DSHS employees can access this through the DSHS Library.)
- FDA Bad Bug Book; Handbook of Foodborne Pathogenic Microorganisms and Natural Toxins: <http://www.fda.gov/downloads/food/foodborneillnesscontaminants/ucm297627.pdf>

- FDA Recalls of Food & Dietary Supplements:
<http://www.fda.gov/food/recallsoutbreaksemergencies/recalls/default.htm>
- Hepatitis B Foundation: www.hepb.org/
- Immunization Action Coalition: www.immunize.org/
- Viral Hepatitis Serology Training Online:
www.cdc.gov/hepatitis/Resources/Professionals/Training/Serology/training.htm
- Prevention of Invasive Group A Streptococcal Disease among Household Contacts of Case Patients and among Postpartum and Postsurgical Patients: Recommendations from the Centers for Disease Control and Prevention:
<http://cid.oxfordjournals.org/content/35/8/950.long>
- American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. (ASHRAE) guidance for legionellosis:
 - ASHRAE Standard 12-2000: “Minimizing the Risk of Legionellosis Associated with Building Water Systems”:
<https://www.baltimoreaircoil.com/english/ashrae12>
 - ANSI/ASHRAE Standard 188-2015: “Legionellosis: Risk Management for Building Water Systems”: <https://www.ashrae.org/resources--publications/bookstore/ansi-ashrae-standard-188-2015-legionellosis-risk-management-for-building-water-systems>
- Texas Food Safety and Defense Task Force
<http://tx.foodprotectiontaskforce.com/home/>
- Texas Legionellosis Task Force Guidance:
www.dshs.texas.gov/idcu/disease/legionnaires/taskforce/
- Certification Board of Infection Control and Epidemiology
<http://www.cbic.org/>
- Association for Professionals in Infection Control and Epidemiology
<http://www.apic.org/>
- Association for Professions in Infection control and Epidemiology – Guide to the Elimination of Multidrug resistant *Acinetobacter baumannii* transmission in Healthcare Settings http://www.apic.org/Resource_/EliminationGuideForm/b8b0b11f-1808-4615-890b-f652d116ba56/File/APIC-AB-Guide.pdf

ACRONYMS & ABBREVIATIONS

Acronym or Abbreviation Meaning

AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunizations Practices
AFRI	Acute febrile respiratory illness
Ag	Antigen
AIDS	Acquired immune deficiency syndrome
ALF	Assisted living facility
APIC	Association for Professionals in Infection Control and Epidemiology
ARDS	Acute respiratory distress syndrome
ARI	Acute respiratory illness
ASAP	As soon as possible
ASHRAE	American Society of Heating, Refrigerating and Air-Conditioning Engineers
AVR	Antiviral resistant
BAL	Bronchoalveolar lavage
BMI	Body mass index
BSL	Biosafety Level
BT	Bioterrorism
BCYE	Buffered charcoal yeast extract (agar)
ccIVV	Cell culture-based inactivated influenza vaccine
CDC	Centers for Disease Control and Prevention
CIDRAP	Center for Infectious Disease Research and Policy (University of Minnesota)
CLIA	Clinical Laboratory Improvement Amendments
CLSI	Clinical and Laboratory Standards Institute
CMS	Centers for Medicaid and Medicare Services
CMV	Cytomegalovirus
CNS	Central nervous system
CO	(DSHS) Central office
CO ₂	Carbon dioxide
COB	Close of business
COPD	Chronic obstructive pulmonary disease
CRE	Carbapenem-resistant <i>Enterobacteriaceae</i>
CRS	Congenital rubella syndrome
CSF	Cerebrospinal fluid
CSTE	Council of State and Territorial Epidemiologists
CSV	Comma-separated values
Cx	Culture
DFA	Direct fluorescent antibody test
DGMQ	(CDC) Division of Global Migration and Quarantine
DNA	Deoxyribonucleic acid
DOB	Date of birth
DOD	Date of death
DSHS	(Texas) Department of State Health Services
DTP	Diphtheria and Tetanus Toxoids and Pertussis (vaccine)
TT	Tetanus toxoids

Acronym or Abbreviation Meaning

ED	Emergency department
EIA	Enzyme immunoassay (interchangeable with ELISA)
ELC	Epidemiology & Laboratory Capacity
ELISA	Enzyme-linked immunosorbent assay (interchangeable with EIA)
ELITE	Environmental Legionella Isolation Techniques Evaluation (program)
EMS	Emergency medical services
ER	Emergency room
ERT	(DSHS) Epidemiology Response Team
EVD	Ebola virus disease
FDA	Food and Drug Administration
FLA	Free living ameba
FTM	Flu transport medium
GAE	Granulomatous Amebic Encephalitis
GAS	Group A Streptococcus
GBS	Group B Streptococcus
GIN	(WHO) Global Influenza Surveillance Network
HAI	Healthcare-associated infection
HAV	Hepatitis A virus
HBcAg	Hepatitis B core antigen
HBsAg	Hepatitis B e antigen
HBIG	Hepatitis B immune globulin
HBsAg	Hepatitis B virus surface antigen
HBV	Hepatitis B virus
HCP	Healthcare provider/professional
HCV	Hepatitis C virus
HCW	Healthcare worker
HD	Health department
HHS	Health and Human Services
HI	Hemagglutination inhibition
Hib	<i>Haemophilus influenzae</i> type B
HICPAC	Healthcare Infection Control Practices Advisory Committee
HIV	Human immunodeficiency virus
HPAI	Highly pathogenic avian influenza
HSR	(DSHS) Health Service Region
HVAC	Heating, ventilation, and air conditioning
Hx	History
IATA	International Air Transport Association
IC	Infection control
ICD	International Classification of Diseases
ICP	Infection control practitioner
ICS	Incident command system
ICU	Intensive care unit
ID	Identification

Acronym or Abbreviation	Meaning
IDCU	(DSHS) Infectious Disease Control Unit
IG	Immune globulin
IgA	Immunoglobulin A
IgG	Immunoglobulin G
IGIV	Immune globulin intravenous
IgM	Immunoglobulin M
IHC	Immunohistochemical
IIF	Indirect Immunofluorescence
IISP	Influenza Incidence Surveillance Project
IIV	Inactivated influenza vaccine
IIV3	Trivalent inactivated influenza vaccine
IIV4	Quadrivalent inactivated influenza vaccine
ILI	Influenza-like illness
ILINet	U.S. Outpatient Influenza-like Illness Surveillance Network
IM	Intramuscular
ImmTrac	(Texas Immunization registry)
IP	Infection preventionist
IPV	Inactivated Polio Vaccine
IRID	(DSHS) Infectious Respiratory and Invasive Disease (Team)
ITM	Influenza transport medium
IVDU	Intravenous Drug Use(r)
IVIG	Intravenous immunoglobulin
KPC	<i>Klebsiella pneumonia</i> carbapenemase
LAIV	Live, attenuated influenza vaccine
LHD	Local health department
LIMS	Laboratory information management system
LRN	Laboratory Response Network
LTC	Long term care (facility)
MAARI	Medically attended acute respiratory illness
MC	Mail code
MD	Medical doctor
MDR-A	Multidrug-resistant <i>Acinetobacter</i>
MDRO	Multidrug-resistant organisms
MHT	Modified Hodge test
MMR	Measles, mumps, and rubella (vaccine)
MMWR	Morbidity and Mortality Weekly Report
MOA	Memorandum of agreement
MOU	Memorandum of understanding
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MSSA	Methicillin-sensitive <i>Staphylococcus aureus</i>
N/A	Not applicable
NAT	Nucleic acid testing
NBS	NEDSS Base System
NDM	New Delhi Metallo-beta-lactamase
NEDSS	National Electronic Disease Surveillance System

Acronym or Abbreviation Meaning

NF	Necrotizing fasciitis
NORS	National Outbreak Reporting System
NPI	National provider identifier
NREVSS	National Respiratory and Enteric Virus Surveillance System
NVSN	New Vaccine Surveillance Network
OP	Oropharyngeal
OPV	Oral Polio Vaccine
OTC	Over-the-counter
PAHO	Pan American Health Organization
PAM	Primary amebic meningoencephalitis
PCV7	Pneumococcal conjugate vaccine 7-valent
PCV13	Pneumococcal conjugate vaccine 13-valent
PFGE	Pulsed-field gel electrophoresis
PCR	Polymerase chain reaction
PEP	Post exposure prophylaxis
PHEP	Public Health Emergency Preparedness
PHLIMS	Public health laboratory information management system
PHP	Public Health Preparedness
PIO	Public Information Office
PO	<i>Per os</i> (oral administration) or post office
PPE	Personal protective equipment
PPSV23	Pneumococcal polysaccharide vaccine 23-valent
PPV	Positive predictive value
ProMed	Program for Monitoring Emerging Diseases
PUI	Patient under investigation
PVA	Polyvinyl alcohol
RHD	Regional health department
RIV	Recombinant (hemagglutinin) influenza vaccine
RNA	Ribonucleic acid
rRT-PCR	Real-time reverse transcription polymerase chain reaction
SARI	Severe acute respiratory illness
SHD	State health department
SOB	Shortness of breath
SSN	Social security number
SST	Serum separator tube
Sx	Symptoms
TAC	Texas Administrative Code
TAHC	Texas Animal Health Commission
Td	Tetanus-diphtheria (vaccine)
Tdap	Tetanus toxoid, Reduced Diphtheria toxoid, Acellular Pertussis (vaccine) (7 & older)
TIG	Tetanus immune globulin
TIV	Trivalent inactivated vaccine (used prior to 2013-14 influenza season)
TMP-SMP	Trimethoprim/sulfamethoxazole (antibiotic)
TPI	Texas provider identifier
TPW	Texas Parks and Wildlife

Acronym or Abbreviation	Meaning
TSS	Toxic shock syndrome
TT	Tetanus toxoid
USMU	(CDC) US-Mexico Unit
UTM	Universal transport medium
VariZIG	Varicella Zoster immune globulin
VHF	Viral hemorrhagic fever
VISA	Vancomycin-intermediate <i>Staphylococcus aureus</i>
VPD	Vaccine preventable disease
VRSA	Vancomycin-resistant <i>Staphylococcus aureus</i>
VTM	Viral transport medium
VZV	Varicella zoster virus
WHO	World Health Organization