

DSHS - South Texas Laboratory



BT Personnel

- } There are 2 of us under the BT Grant and 2 of us who take call.
 - } In case of an outbreak or an emergency, TB personnel would assist.
- 

Budget Issues

- } Due to current budget we are no longer testing for Salmonella, Listeria, nor E. coli 0157:H7.
 - } BAX instrument is no longer under a service agreement
 - } Media for these procedures is expensive since most of it is selective media
 - } BAX kits are extremely expensive – close to \$1000 per kit
- 

New Technology / assays

- } We currently do Tbilisi phage testing so we are able to speciate *Brucella*.
 - } We currently perform PCR/TRF testing for ricin so we are able to participate in the LRN environmental PTs – added in 2012
 - } We added AH7 subtype to our Flu subtypes.
- 

Renovations / facility issues

} Renovations:

- Ø Building Entrance secured – had coded entrance installed in building 505 (Laboratory) (2012)

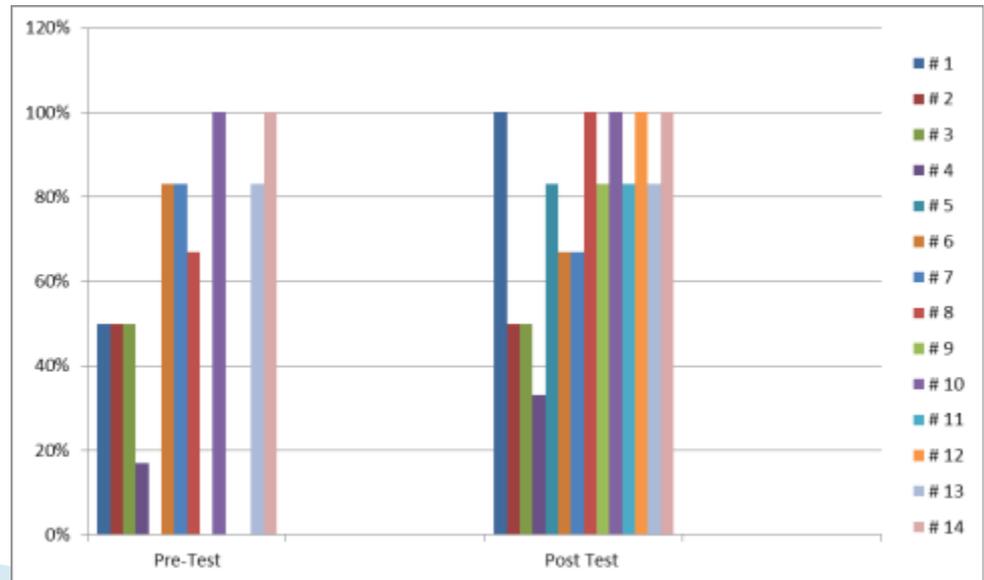
} Facility Issues:

- Ø Draining issues (2013)
- Ø Heating / cooling problems (Continuous)

Upcoming projects

- } Working on setting up a dry sentinel workshop to take to areas that cannot come to our wet workshops.
 - } Working on contacting other emergency responders in areas that are not within our county.
 - } Suggestions?
- 

Sentinel Wet Workshops



Interesting Case Studies

- } Had a case where a patient was seen in 2 different ERs, not admitted, but blood cultures collected in 2nd ER. After 6 days, received a call from 2nd ER's micro lab, will sent isolate for r/o of *Brucella spp.*
- } Prelim report given on day isolate was received.
- } *B melitensis* was confirmed and submitter, epidemiologist, and CDC notified.
- } At this time, we were informed by epi that this person had been admitted at another hospital and transferred.

Interesting Case Studies

- } Hospital where person was **initially admitted** was contacted but said they had not isolated any suspicious organisms from blood cultures – isolated *Micrococcus spp.*
- } Hospital where patient was **transferred** was contacted and microbiologists in that facility said they would be on the look out.
- } A small gram negative organism was isolated from blood cultures collected on admission, isolate was sent to us for r/o of *Brucella spp.*

Interesting Case Studies

- } *B melitensis* was confirmed.
- } Submitter and regional epidemiologist notified. CDC was also contacted.
- } Since patient had been transferred to this facility before they had any information, some work had been done on the bench so after CDC was notified, personnel got treatment for exposure.

Interesting Case Studies

} Timeline: (2012)

- 4/4 Went to ER
- 4/12 Went to a different ER – blood cultures drawn
- 4/13 Went to another hospital and was admitted. Transferred to another hospital on 4/17/12
- 4/17 Blood cultures collected on admission
- 4/18 Received call from 2nd ER Micro lab where blood cultures had been drawn
- 4/19 Sample received at LRN and prelim out
- 4/24 Isolate confirmed
- 4/27 Hospital where patient was initially admitted, contacted
- 4/27 Received call from hospital where patient was transferred, suspected isolate (staff had been placed on alert) – after work had already started
- 5/2 Sample received at LRN, testing completed 5/7/12

?
?
?
?
?
?

