



Epidemiology & Surveillance Quarterly Newsletter



Inside this issue:

- | | | |
|--|--------------|--|
| Descriptive Epidemiology of Cryptosporidiosis in Region 7 | 2 - 5 | Flu Season is Here
It is that time of year again. Seasonal influenza surveillance started at the beginning of October and will continue through May. |
| Incidence of cryptosporidiosis dramatically increases in Williamson County | 6-9 | The October 2007 edition of the Epidemiology & Surveillance Quarterly newsletter contains an extensive overview of influenza surveillance in Region 7, Texas and the United States. The October edition can be accessed at |
| Cryptosporidiosis in a daycare | 10-11 | http://www.dshs.state.tx.us/region7/documents/EPI/Epi-ReportQ3.pdf . |
| Notifiable Conditions in Region 7 | 12 | The current state wide flu report can be found at |
| Public Health Information Network | 13 | http://www.dshs.state.tx.us/idcu/disease/influenza/surveillance/2009/ |
| Region 7 Outbreaks, Clusters and Other Large Investigations; July to September 2008 | 13 | |



Overview of Cryptosporidiosis

Cryptosporidiosis is an intestinal parasite of a variety of vertebrates including fish, reptiles, birds, small mammals (e.g., mice, cats and dogs) large mammals (esp. sheep and cattle) as well as humans. The two most important species is *Cryptosporidium parvum* (animals and human) and *C. hominis* (primarily human). Though asymptomatic cases do occur, the major symptom in humans is diarrhea. In immunologically healthy people the parasite is usually cleared within 30 days. The disease is particularly significant for individuals who are immunodeficient especially those with HIV infection as the parasite is not readily cleared causing a prolonged disease taking a fulminant clinical course and contributing to death. ¹

The infectious stage of the parasite is the oocyst excreted by infected animals and people. The dose needed to infect 50% of healthy adults (i.e., ID50) for *C. hominis* and *parvum* dose is small, estimated between 10-83 ² and 132³ oocysts respectively. Mode of transmission is fecal-oral. Oocysts are resistant to common disinfection methods, especially chlorination used in drinking and recreational water. The low infectious dose combined with resistance to chlorine has led to water-borne outbreaks from lightly contaminated source, both drinking and recreational water. In addition, outbreaks have occurred among people who handle animals and in day care centers.

The next three sections describe the experience of Cryptosporidiosis in Health Services Region 7 during 2008. The first section discusses the descriptive epidemiology of the disease in HSR 7 during 2008. The second section deals with reported cases in Williamson County that was thought to be propagated primarily via recreational water. The final section describes an outbreak in a day care facility and demonstrates how child care settings can be an important source of community outbreaks. **The statistics presented in this newsletter may differ slightly depending on several factors including denominator data used, date data was pulled for analysis and time frame looked at.** Please keep this in mind when reviewing this newsletter.

¹ Control of Communicable Diseases Manual, 18th Edition, pages 138-139

² Chappell et al., *Cryptosporidium hominis*: experimental challenge of healthy adults. *Am J Trop Med Hyg*, 75(5), 851-857.

³ DuPont, et al., (1995). The infectivity of *Cryptosporidium parvum* in healthy volunteers. *N Engl J Med*, 332(13), 855-859

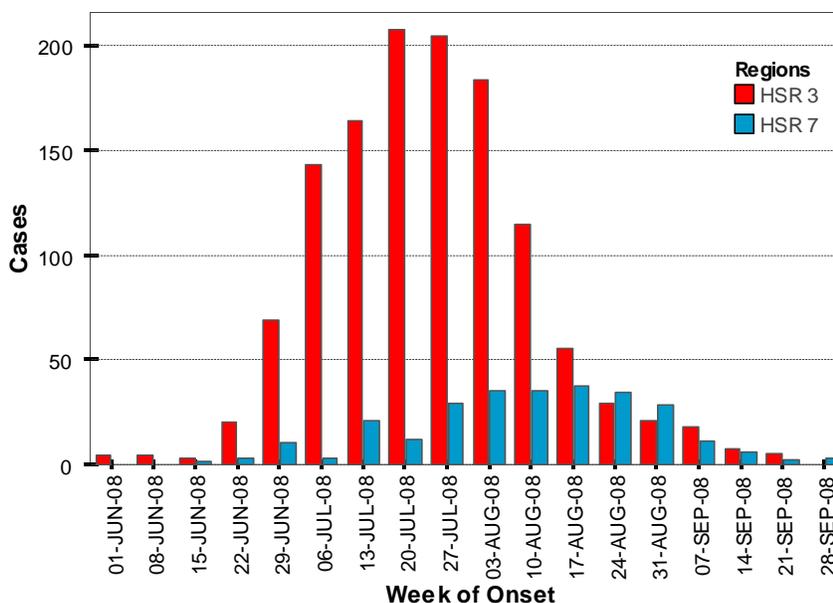
Descriptive Epidemiology of Cryptosporidiosis in Region 7

Texas has had an exceptional number of Cryptosporidiosis cases reported in 2008. An outbreak of Cryptosporidiosis in Health Service Region 3 (North Texas) contributed to the large number of cases seen within Texas this year. Preliminary Texas data show Health Service Region 3 accounting for 73% of reported cases, Health Service Region 7 for 15% and all other parts of Texas for 12%. Figure 1 shows the number of cases by week of onset comparing Regions 3 and 7. The number of cases being reported for Region 3 peaked the weeks of July 20th and 27th, whereas the peak for Region 7 was two to three weeks later.

Figure 1

Texas Cryptosporidiosis 2008

Health Service Regions 3 and 7
Confirmed Cases by Week of Onset



Preliminary 2008 State Data

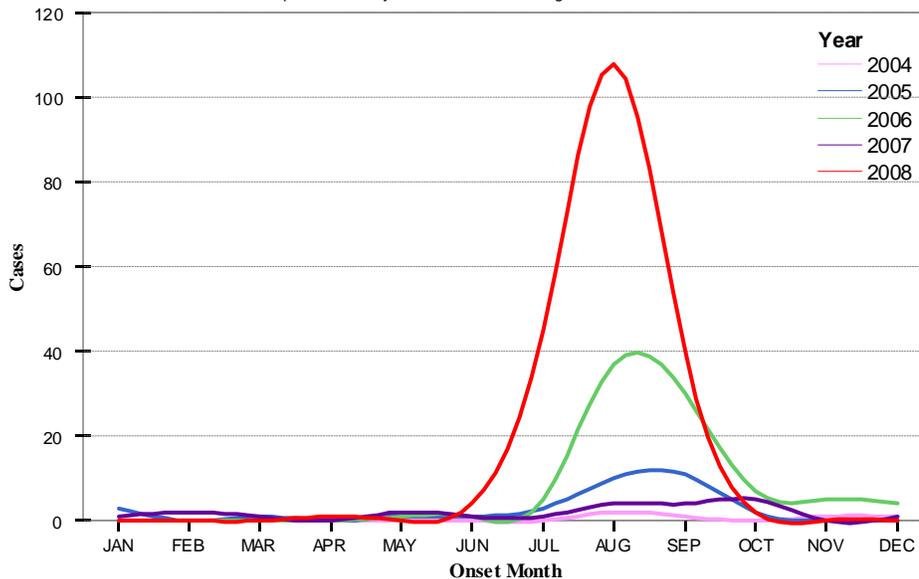
Cryptosporidiosis incidence within Region 7 follows a seasonal pattern with increases in the summer, peaking in July through August and dropping through September (Figure 2). The number of confirmed cases (212) in 2008 already exceeds the number reported from the four preceding years combined (146).

Figure 2

Cryptosporidiosis 2004 - 2008

Health Services Region 7, Confirmed Cases by Month

*Data for 2008 are not complete and only includes cases through mid-October



Statistics, tables and graphs on this page were prepared by Region 7.

Descriptive Epidemiology continued

Of the 30 counties that comprise Region 7, ten have reported cases as of mid-October, 2008. Travis and Williamson, the two most populous counties within the Region accounted for the majority of cases with more than 82 percent. Table 1 lists the number of cases per county, cumulative incidence rates of cases per 100,000 population per year, and the age adjusted rates. Williamson and Fayette counties have the highest incidence rates.

Table 1 Confirmed Cases and Rates by County

County	Cases	% of Regional Cases	Projected Population 2008	Cases / 10 ⁵ population	Cases/ 10 ⁵ population (Adjusted For Age *)
Bell	12	5.7	263,086	4.6	4.3
Brazos	7	3.3	166,821	4.2	5.5
Caldwell	1	0.5	38,700	2.6	2.6
Fayette	5	2.4	24,098	20.7	27.3
Hays	9	4.2	156,020	5.8	6.6
McLennan	2	0.9	225,379	0.9	1.1
Milam	1	0.5	26,289	3.8	4.3
Travis	97	45.8	916,083	10.6	11.2
Williamson	78	36.8	373,961	20.9	23.2
Region 7 total	212	100.0	2,722,915	7.8	8.4

* Age adjustment was done by using 5 year age group specific rates and applied to the 2000 Texas census

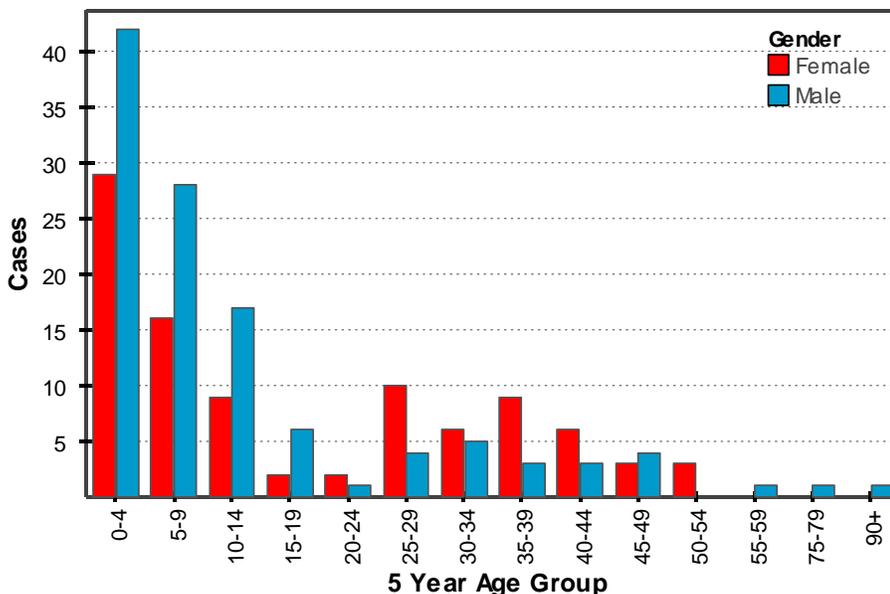
Figure 3 graphically illustrates that the majority of reported cases are among younger age groups and there is a gender difference by age. Fifty-four percent of the confirmed cases reported are nine years or younger. The mean age for males is 12.9 and females 17.1 years.

Overall, more males were reported as compared to females, 54.7 and 44.8 percentages respectively. The majority of cases age 19 and younger are male (93) versus female (56), whereas after the age of 19 the majority is reversed; female (39) versus male (23).

Figure 3

Cryptosporidiosis 2008

Region 7
Confirmed Cases in 5 Year Age Groups by Gender



Statistics, tables and graphs on this page were prepared by Region 7.

Continued on page 4

Descriptive Epidemiology continued

Confirmed and Probable Cryptosporidiosis Cases

This summer, DSHS requested regional and local health departments to begin reporting probable as well as confirmed cases. The case definition for probable case was issued as follows:

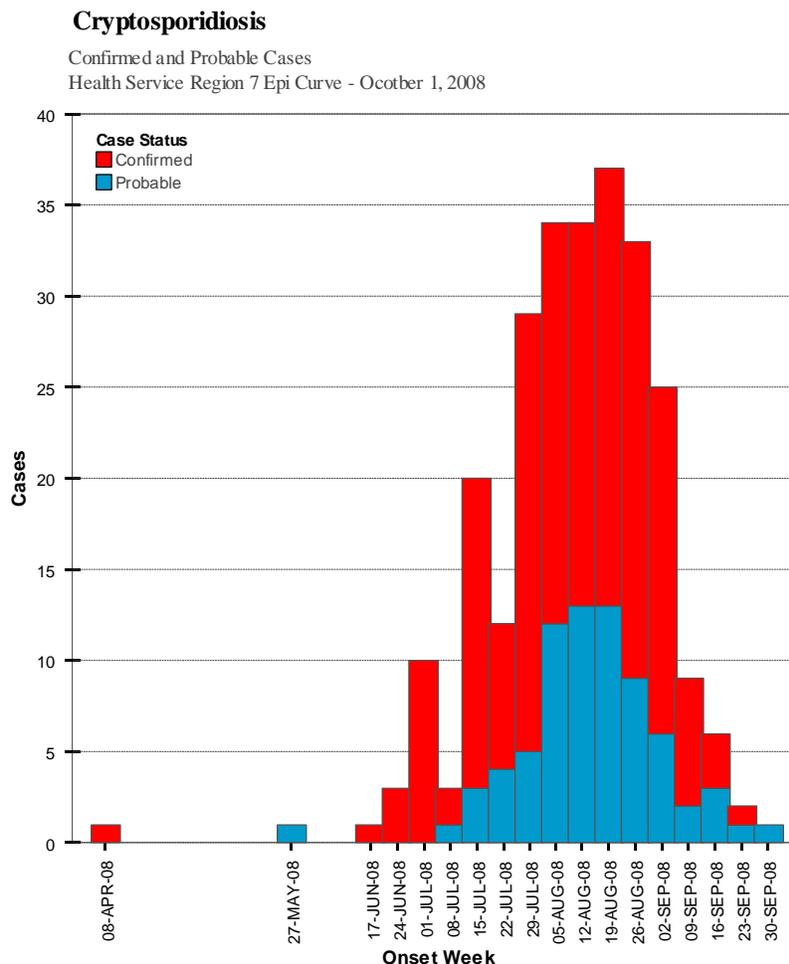
Probable: A case who is epidemiologically-linked to a laboratory-confirmed case, by at least one of the following means;

1. A person with diarrheal illness, as defined below, who has an epidemiologic link to a laboratory-confirmed case, and who had onset of symptoms within one month (before or after) of the laboratory-confirmed case.
2. A person with diarrheal illness, as defined below, who swam or had other water contact in the same water source as at least 2 other laboratory-confirmed cases, and had onset of symptoms within one month (before or after) of a laboratory-confirmed case.

Diarrheal illness: must include diarrhea of at least three days duration, with at least three loose stools in each 24-hour period, or diarrhea of at least 1 day duration with the use of anti-motility medication to control the diarrhea for at least another two days.

As of mid October, 2008 a total of 286 cases have been reported; 212 confirmed and 74 probable. Using both confirmed and probable cases the number of cases by week of onset is illustrated in Figure 4. Case counts peaked the third week of August.

Figure 4



Descriptive Epidemiology continued

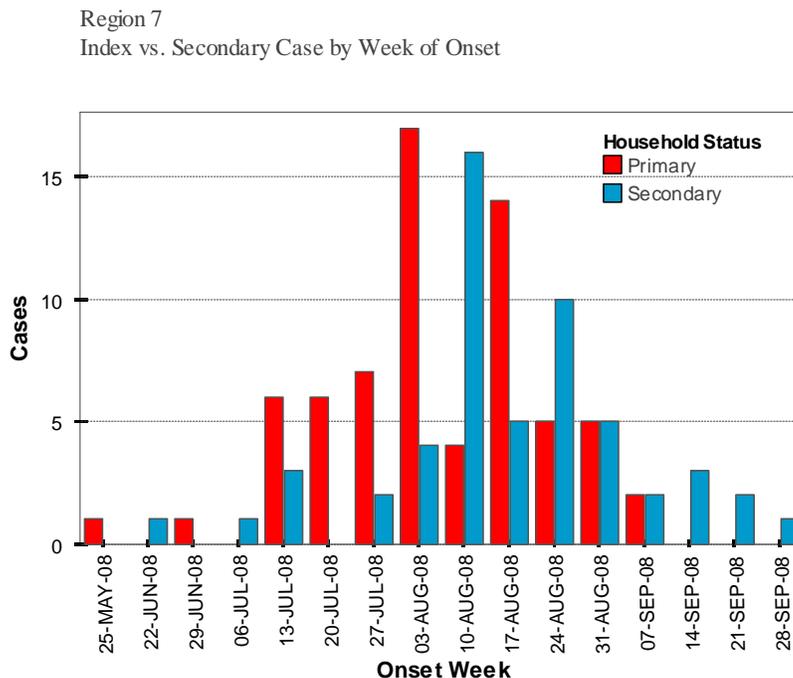
Household Analysis

Health departments are now asking and reporting on sick family members when interviewing a case of confirmed Cryptosporidiosis. As a result, the majority of probable cases 70 out of 74, are in households with at least one confirmed case. Including both confirmed and probable cases, 125 out of 286 cases are in households that have had more than one case.

The inclusion of probable cases allows for a household analysis to describe the acquisition of infection from the community and subsequent spread to household members. Households with two or more cases were selected (44) for further analysis. In each household the first case to occur and cases that occurred within two days of the first were identified as household index cases (68). Cases occurring in the household more than three days after the first case were identified as secondary cases (55). Finally two cases did not have onset dates and could not be classified as index or secondary.

An epi curve by week of onset for index cases is found in Figure 5. The week (August 3rd) with the largest number in secondary cases occurred one week after (July 27th) the largest number of index cases reported. This is consistent with the reported incubation period; 1-12 days with seven as average.

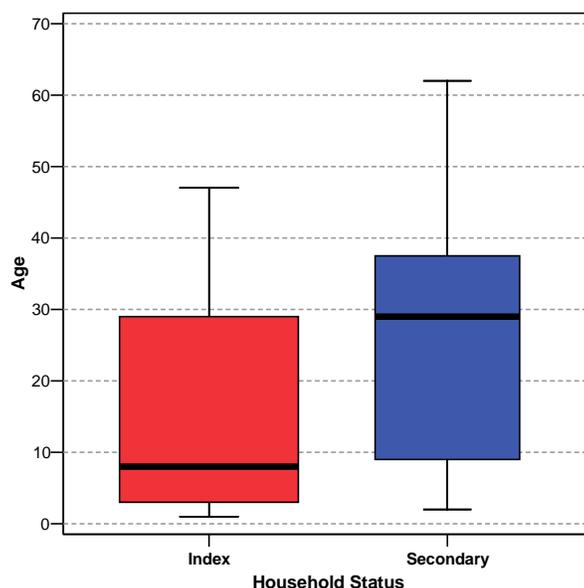
Figure 5 Cryptosporidiosis 2008



The mean ages between index and secondary cases are significantly different. For index cases the mean age is 14.9 years (95% CI 11.4 - 18.4) whereas secondary cases is 25.1 years (95% CI 9.5 -20.8). The box plot in Figure 6 shows the age ranges, median age, and distribution of ages by quartiles between the index cases and secondary cases. The age difference suggests that children acquire the disease outside of the household and household members then acquire the disease from that child.

Article submitted by Russ Jones, MPH with Health Services Region 7

Figure 6



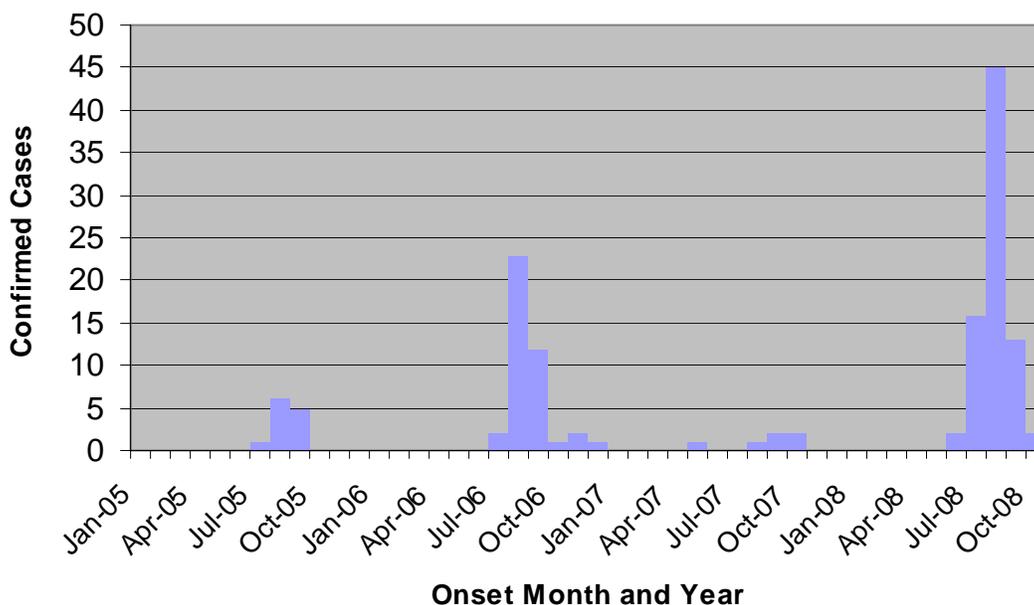
The next two articles discuss investigations of Cryptosporidiosis associated with recreational water exposure and person to person spread. These next articles include key recommendations for the prevention and control of Cryptosporidiosis.

Statistics, tables and graphs on this page were prepared by Region 7.

Incidence of Cryptosporidiosis Increases Dramatically in Williamson County

Cryptosporidiosis incidence has increased significantly in Williamson County in 2008 when compared to previous years. Incidence for laboratory confirmed cases as of 10/15/2008 was 21 cases per 100,000 population. Incidence for cryptosporidiosis in Williamson County in 2006 and 2007 was 12.4 and 1.9, respectively. Seasonal trends in incidence and the number of cases reported are clearly evident in the chart below.

**Cryptosporidiosis Reported to WCCHD by Onset Month
2006 - 2008 (as of 10/15/2008)**



Incidence was calculated for four areas within Williamson County reporting 5 or more cases in 2008 as of 10/15/2008 (see Table 1). Although 7 cases were reported for areas of Austin within Williamson County, incidence was not calculated due to a lack of population data for this area.

Table 1. Incidence for Confirmed Cryptosporidiosis (as of 10/15/2008) by Area, Williamson County, Texas

Area	Incidence (cases per 100,000 population)
Hutto	67
Round Rock	33
Cedar Park/Leander	25
Georgetown	11

Continued on page 7

Cryptosporidiosis in Williamson County cont

The earliest symptom onset date for a confirmed *crypto* case in Williamson County was 6/27/2008. The onset dates for all but three cases occurred in July or later (see Epi Curves). Following DSHS guidelines received on 8/20/2008, Williamson County & Cities Health District (WCCHD) began reporting both confirmed and probable cases. As of 10/15/2008, 62% (78/126) of cases are laboratory confirmed and 38% (48/126) are classified as probable. Comparisons with past years were made with confirmed cases only, since reporting on probable cases was not mandated in past years.

**Cryptosporidiosis Epi Curve (as of 10/15/08)
Williamson County, Texas**

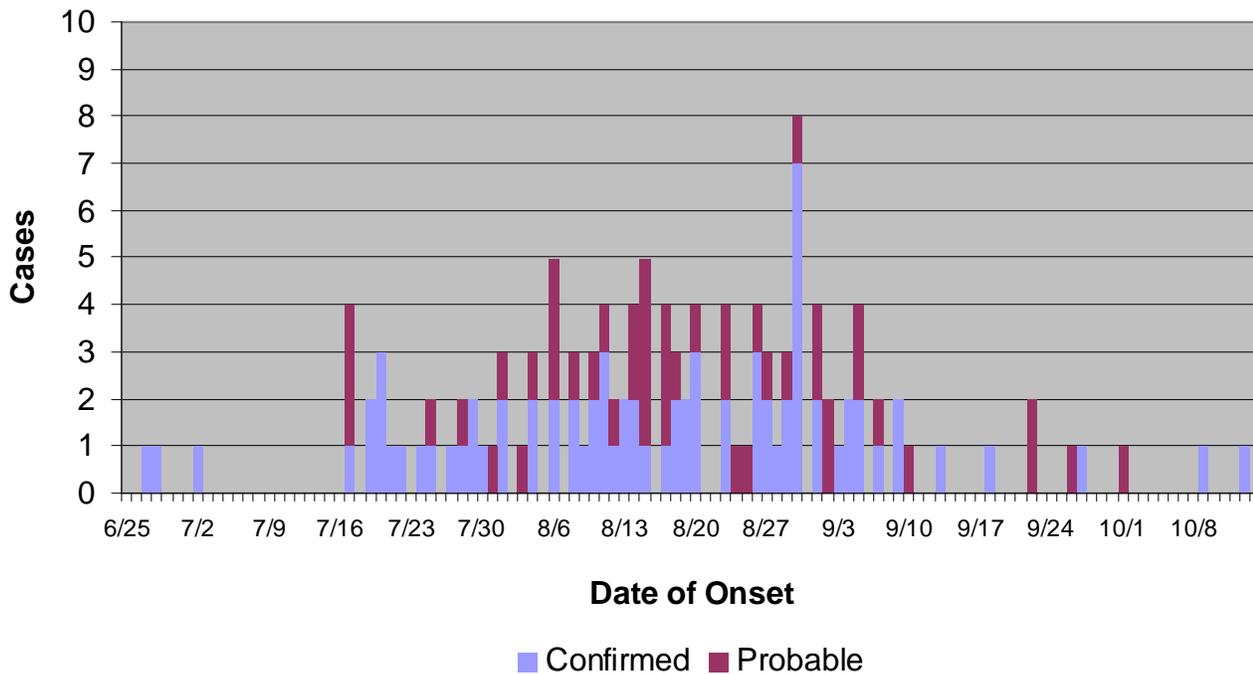


Table 2. Gender of Cryptosporidiosis (as of 10/15/2008), Williamson County, Texas

Gender	% of Confirmed and Probable Cases
Male	52% (66/126)
Female	48% (60/126)

Table 3. Age of Cryptosporidiosis (as of 10/15/2008), Williamson County, Texas

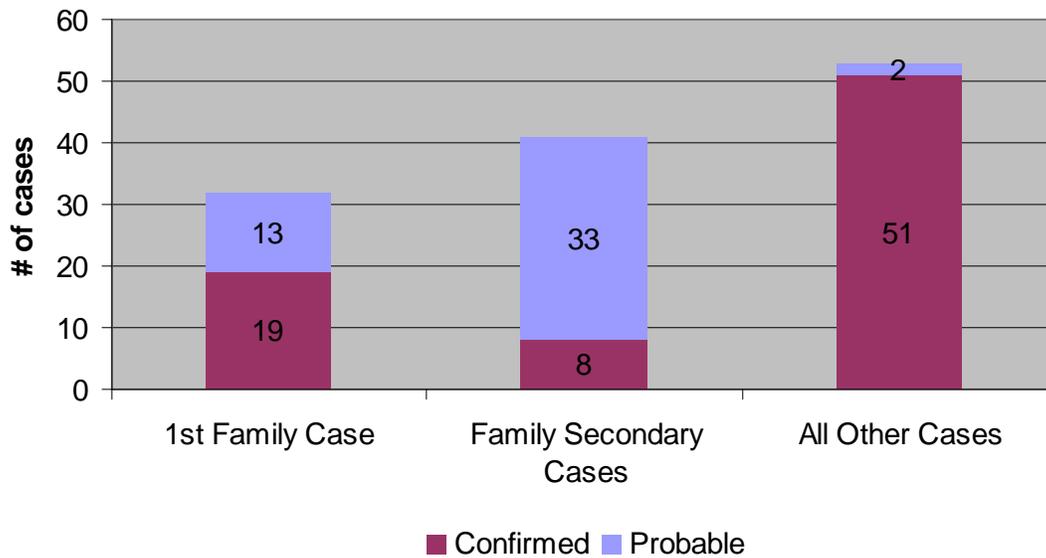
Age	% of Confirmed and Probable Cases
<1	1% (1/126)
1 – 4	22% (28/126)
5 – 14	32% (40/126)
15 – 24	7% (9/126)
25 – 39	30% (38/126)
40 – 64	8% (10/126)
>64	0% (0/126)

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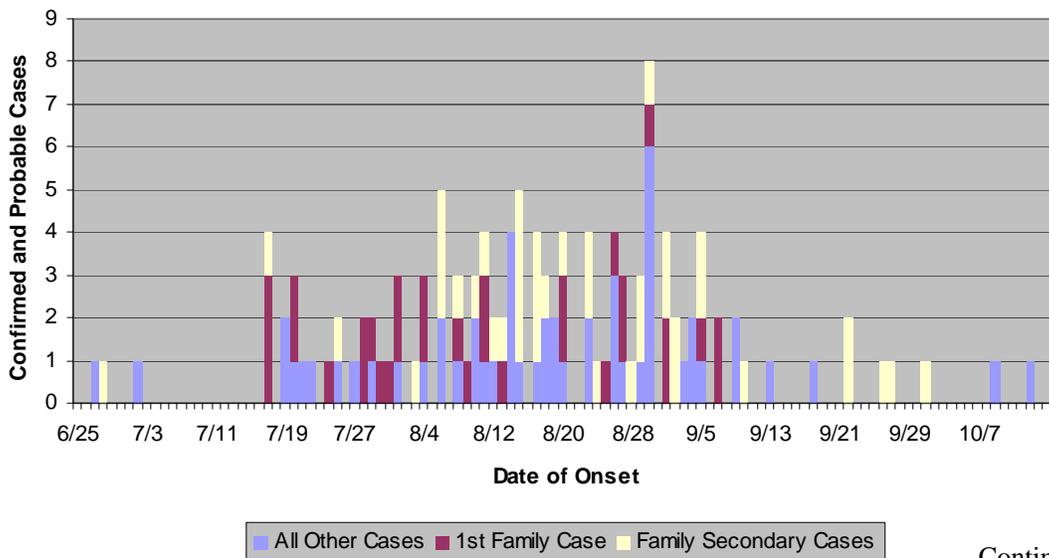
Cryptosporidiosis in Williamson County cont

Secondary transmission within households was a significant factor in spreading illness and had great impact on the reporting of probable cases. Households account for 58% (73/126) of all cases reported as of 10/15/2008. Twenty-six families or households account for 27 confirmed cases and 46 probable cases.

Cryptosporidiosis Cases (as of 10/15/2008) Williamson County, Texas



Cryptosporidiosis Epi Curve (as of 10/15/08) Williamson County, Texas



Continued on page 9

Cryptosporidiosis in Williamson County cont

During *crypto* investigations, interviewees reported many types of recreational water exposure. Recreational water venues mentioned during interviews included community or city pools, neighborhood or homeowners association pools, private pools including home pools and pools at fitness/gym facilities, water and spray parks, amusement parks, lakes, creeks, and oceans. Interviewees often reported multiple exposures, making it difficult to track down the source of infection. The most common public health intervention was to recommend hyperchlorination of a pool if a confirmed case swam in the pool during the incubation period, while symptomatic, or within two weeks of symptoms stopping. In addition, pool operators were provided with resources including sample notices, warning signs, and letters. Whenever possible, WCCHD requested a notice go out to residents or customers asking them to report possible cases to WCCHD, to make their doctor aware of the possible exposure to *crypto* should they become ill, and to emphasize the importance of not swimming if symptomatic and not swimming for two weeks after diarrhea has stopped.

Links were provided to specific resources and guidelines at the CDC and Utah Department of Health:

<http://www.cdc.gov/healthySwimming/>

<http://hlunix.hl.state.ut.us/epi/diseases/crypto/index.html>

Pool operators, the media, and the general public were referred to the WCCHD website for local *crypto* updates:

<http://www.wcchd.org/Services/DiseaseMgmt/Crypto.htm>.

Responding to a community wide outbreak of cryptosporidiosis presents many challenges. WCCHD, as well as health care providers and patients, may not receive results of confirmatory laboratory testing in time to completely prevent the spread of the *crypto*. Although hyperchlorination in response to a confirmed case does prevent spread, hyperchlorination likely would be much more effective if it was performed routinely (i.e. weekly) during periods of high cryptosporidiosis incidence. During periods of high cryptosporidiosis incidence, health care providers should consider counseling any patient with diarrheal illness not to swim until at least two weeks after their diarrhea has stopped, regardless of whether or not the patient is being treated with antibiotics or other medications.

WCCHD received several second hand reports of pools that tested “negative” for *crypto*. Although WCCHD was unable to verify what type of testing was performed, it is unlikely that sufficient volumes of water were submitted for testing. WCCHD recommended interpreting any “negative” results with caution, and stressed that these results should not impact recommendations for hyperchlorination and other control measures.

In past years, the closure or reduction in operating hours of pools, the start of the school year, and lowering temperatures have generally led to a reduction in the number of *crypto* cases reported to WCCHD starting in early September. Although this trend seems to be repeating in 2008, the size and scope of the outbreak is obviously much larger than in 2006, the last outbreak year for Williamson County. In addition, more cases are being reported to WCCHD at the “tail-end” of the outbreak. These cases are due in part to the continued use of many swimming facilities well into October. WCCHD alerted local school districts when a case was reported on a swim team. Although many neighborhood or homeowners association pools are generally closed for the season in September, it was learned that swim teams often contract with neighborhood pools to hold practice sessions. In addition, reporting of confirmed *crypto* cases swimming in indoor and private pools has persisted well into October.

The solutions to the *crypto* problem are multifaceted and will involve different areas of public health, including epidemiology and environmental health. Industry must be a key player in ensuring that the latest technology and treatment methods are in place. Training must be readily available to pool operators on procedures that specifically target *crypto*. WCCHD plans to work closely with DSHS and surrounding jurisdictions to research the feasibility of weekly hyperchlorination recommendations during summer months, advance filtration methods, and environmental/pool water testing methods. In addition, it is vital that public health agencies intensify their efforts to inform the public about recreational water illnesses.

Cryptosporidiosis in a Day Care

On September 11, 2008, Health Services Region Seven (HSR7) was notified of a cryptosporidiosis cluster among toddlers in a community within the region. Early investigation efforts connected the cluster to an area daycare facility. To prevent person to person transmission of gastrointestinal disease, the Department of State Health Services requires the exclusion of children from daycare settings when diarrheal illness is present. Exclusion is required “until diarrhea subsides without the use of diarrhea suppressing medications”.¹ This review summarizes our investigation of cryptosporidiosis related to a daycare with onsets between August 22 and September 17, 2008, the lessons learned and recommendations to prevent the spread of cryptosporidiosis.

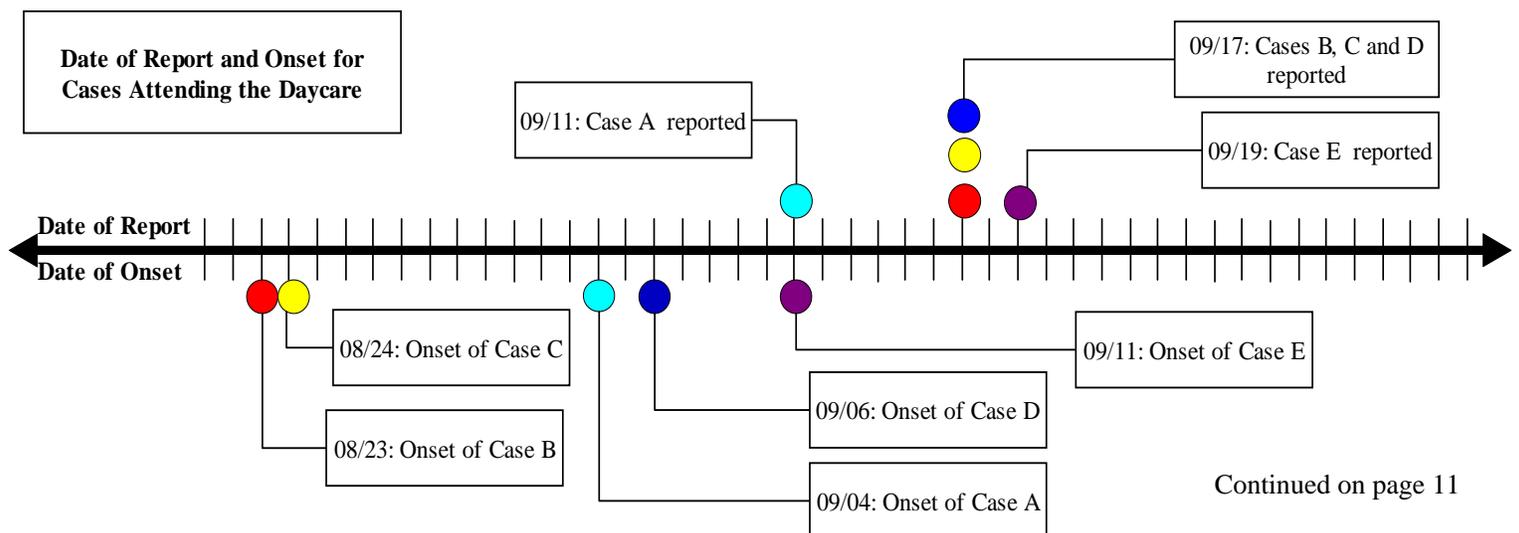
Epidemiologic Investigation

On September 11, HSR7 received notification of a cryptosporidiosis case. Four additional reports were received over the next eight days. The reports identified cases among children under two who attended the same daycare facility. Phone interviews with the nurse from the reporting clinic and the owner of the daycare facility were conducted. Five out of 10 children who attended the daycare facility demonstrated symptoms consistent with cryptosporidiosis. All five children were under the age of two and still wore diapers or training pants. Lab tests confirmed four of the five sick children attending the daycare were positive for cryptosporidium oocysts in their stool. The daycare owner stated that children were excluded from the daycare once it was clear they had a diarrheal illness. The first reported case was excluded on September 04, two days before other cases of illness became apparent. This child had a recent history of travel to South Texas and into Mexico so was suspected as the index case.

Interviews with parents of children attending the daycare proved to be a valuable resource. Recall among parents enabled us to identify other probable cases among family members and construct of a timeline for the onset of illness. Information collected from interviews also led us to another laboratory confirmed case of cryptosporidiosis and five probable cases among family members of the sick children. The additional confirmed case was observed in the older sibling of the first reported case. Onset was September 14, ten days after the onset of diarrhea illness in the younger sibling. The probable cases were among adults of sick children who attended the daycare. Symptomatic adults self medicated and did not see a physician so were not tested for cryptosporidiosis.

Overall we found 23 people who were potentially exposed to cryptosporidiosis, 11 were symptomatic. Of these 11, five cases were laboratory confirmed and six were probable through close contact and symptoms. The median age among daycare attendees who became ill was 22 months. The attack rate for this cluster among the exposed is approximately 48%. The earliest symptoms were identified during investigations among a set of siblings under two years old. The first symptomatic case had onset of symptoms on August 22. The second case was a sibling to the first symptomatic case and presented symptoms on August 23rd.

Both cases were away from the daycare when symptoms first began and were medicated by the parents. The siblings were reported to have an on again off again diarrheal illness, but were not excluded from daycare until after seeing a physician on September 9. The children had a history of travel to the coast, but poor recall from the parents hindered our ability to identify a likely source for their illness. After all interviews with parents were complete, these siblings were determined to be considered co-index cases.



Continued on page 11

Cryptosporidiosis in a day care cont

Several lessons were learned from this investigation:

- Contacting cases (or parents of cases) for interviews may take several attempts. It took an average of five calls per contact before we were able to complete interviews.
- Conducting interviews required working hours other than 8am-5pm. All but two of the people we needed to speak with were unavailable between 8 am and 5 pm. We had to conduct most of our interviews after 5pm.
- In this investigation, mothers were largely the best of information source about children. Although one father had an exceptional knowledge about his child, mothers tended to keep more complete information readily available. More often mothers knew complete details regarding their child's doctor, clinic phone number, ECT...
- Early information may be incomplete and may not provide enough detail to determine the beginning of an outbreak. For this investigation, the first case reported from a local clinic was a child new to the daycare with a history of recent traveled to South Texas and into Mexico from August 19 thru the 23rd. The child started at the daycare facility on August 25th and the child's onset of illness was September 4th. Based on initial case reports and the compatible exposure history (recreational water), the original hypothesis favored the likelihood this child was the index case at the daycare. When more cases were identified and a complete timeline constructed, it became clear the original hypothesis was not accurate. The first cases actually had an onset of August 22nd and 23rd. These cases were identified in children attending the daycare that did not see a physician until September 9th. Based on complete information it is likely these children were the index cases at the daycare.
- Although children with diarrheal illness were eventually excluded from the daycare, the index cases were not excluded following the DSHS recommendations. They should have been excluded until their diarrhea resolved without diarrhea suppressing medications. Since cryptosporidiosis is readily spread from person to person, this created a favorable environment for other children to get sick.
- Education is important in reducing possible outbreaks of diarrheal illness at day care facilities. Above all, good hygiene is important to reducing the spread of illness.
- Parents need to understand the importance of when to keep their children home to prevent the spread of illness.
- Daycare facility managers must be watchful and know when to exclude children from daycare.
- Decontaminate surfaces at changing stations with hydrogen peroxide (use 3%) and let soak for 20 minutes (do not mix hydrogen peroxide & bleach solutions).²
- Disinfect toys, high chairs and bathroom areas more frequently than usual during and after symptoms of gastrointestinal illnesses.

CDC recommendations for cryptosporidiosis

CDC recommends preparing communities "before a significant increase of cases occurs or an outbreak is detected".² Planning includes: 1) Identify and develop relationships to communicate with partners, set disease action thresholds, education about cryptosporidiosis through health communication materials and collaboration with partners. Partners must include aquatics operators and managers, childcare programs and good hygiene practices. 2) Action:² once disease increases to the area threshold take action. Action also includes aquatics operators and managers. 3) After an outbreak is controlled conduct a post response evaluation. CDC resources can be found along with others important documents such as information for child care operators, the *Healthy Swimming* resources on the CDC website at www.cdc.gov/crypto or at healthyswimming@cdc.gov or by phoning 770-448-7775.

References

1. Texas Administrative Code, Title 25, *Health Services*, Part 1 *Department of State Health Services*, Chapter 97, *Communicable Diseases*, Subchapter A, *Communicable Diseases Control of Communicable Diseases*, Rule 97.7, *Diseases Requiring Exclusion from Child-care Facilities and Schools*.
2. *Cryptosporidiosis Outbreak Response & Evaluation*, initially developed with the Kansas Department of Health and Environment and the Lawrence-Douglas County Health Department, Kansas. http://www.cdc.gov/crypto/pdfs/core_guidelines.pdf

Select Notifiable Conditions Reported in 2006 , 2007 and January to September 2008

Notifiable Condition	2006 Count	2007 Count*	2008 YTD Count*
Amebiasis	30	61	51
Aseptic meningitis	270	278	217
Bacterial meningitis, other	18	24	20
Brucellosis	2	5	2
Campylobacteriosis	146	275	163
Cruetzfeldt-Jakob Disease	2	0	0
Cryptosporidiosis #	109	37	242
Cyclosporiasis	1	0	0
Cysticercosis-	~	0	2
Enterohemorrhagic <i>E.coli</i> O157:H7	9	0	0
Enterohemorrhagic <i>E.coli</i> , shiga + (not serogrouped or non-O15:H7 serogroup)	10	11	9
Group A Streptococcus, invasive	57	44	43
Group B Streptococcus, invasive	76	52	62
<i>Haemophilus influenzae</i> , invasive	1	0	0
Hepatitis, unspecified	75	10	23
Hepatitis A, acute	23	28	19
Hepatitis B virus infection, Chronic^	241	227	283
Hepatitis B, acute	55	68	34
Hepatitis C Virus Infection, chronic or resolved^	2025	1271	1540
Hepatitis C, acute	3	13	5
Hepatitis E, acute	0	2	1
Legionellosis	8	6	6
Leishmaniasis-	~	2	0
Listeriosis	1	3	5
Lyme disease	5	11	7
Malaria	9	20	6
Mumps	15	2	1
<i>Neisseria meningitidis</i> , invasive (Meningococcal disease)	7	9	7
Pertussis	337	272	120
Plague	1	0	0
Q fever	3	8	3
Rocky Mountain spotted fever	2	2	3
Salmonellosis	366	390	468
Shigellosis	388	252	170
<i>Streptococcus pneumoniae</i> , invasive	129	224	182
Streptococcus, other, invasive, beta-hem (non-A nonB)^	15	12	5
Typhoid fever (<i>Salmonella typhi</i>)	0	2	3
Typhus fever	0	2	13
Vancomycin-Resistant Enterococcus	5	5	1
Varicella (Chickenpox)	1728	1230	802
Vibriosis	12	3	5
Yersiniosis	3	5	3
Grand Total	6190	4866	4526

Includes confirmed and probable notifiable conditions reported to the Texas Department of State Health Services Region 7 that are tracked in the NEDSS database. Year to Date (YTD) for 2008 includes cases reported and entered from January 2008 through September 2008.

* Data is provisional and may change as investigations are completed or updated.

^ Disease is not reportable. Note: Newly reported chronic Hepatitis C was taken off of the notifiable conditions list as of June 5, 2007.

~ Disease was added to the notifiable conditions list in 2007.

Prior to July 2008, probable cases were not routinely entered into the NEDSS database

Public Health Information Network (PHIN)

Between July and September, 1 PHIN message was sent out to physicians, nurses and area hospitals in Region 7 counties. These messages contained information from the Centers for Disease Control and Prevention and/or the Texas Department of State Health Services regarding ongoing health investigations with the potential to impact Texans. The PHIN provides a secure format for sharing critical health information that may contain sensitive health information. PHIN messages are sent by email, phone or fax depending on the importance or time sensitive nature of the message.

Didn't get the alerts?

Healthcare providers, school officials, emergency medical services and emergency management coordinators are eligible for PHIN access. Go to <https://texphin.dshs.state.tx.us/> to sign up to use the PHIN. In addition to getting critical health information from the Department of State Health Services, PHIN users can also access the New England Journal of Medicine through the PHIN web portal. If you have any questions about the PHIN, call 254-778-6744 and ask to speak with Carol Davis, Jacquie Hagerty or Russ Jones.

Region 7 Outbreaks, Clusters and Other Large Investigations; July — September 2008

In July, HSR 7 Epidemiology responded to a report of meningococemia in a 71 year old. The case tested positive on 07/14/08 but was not reported until 07/22/08. We received the report when the ICP from the original hospital called to verify that the hospital the case was transferred to had reported the case to us. The second hospital did not report the case until after HSR 7 called asking for information. Thanks to the ICP that did call us, we were able to notify a nursing home about their risk and arrange for family members to receive prophylaxis.

This summer, Austin/Travis County Health and Human Services Department (ATCHHSD) investigated a cluster of Typhus cases. Over 13 potential murine typhus (human) cases were investigated. In August, an EpiAid team was requested from the CDC. The EpiAid team worked with Austin/Travis County and DSHS Region 7 to trap animals in areas where human cases were reported. In addition to collecting samples from trapped animals, the team also collected samples from the pets of some of the cases. The team obtained samples from 59 animals (17 cats, 10 dogs, 9 raccoons, 4 rats and 18 opossums). The CDC confirmed the presence of murine typhus in opossums. This investigation is still being finalized and the numbers reported here should be considered preliminary only and are subject to change. Please refer to the ATCHHSD website for information about the investigation at http://www.ci.austin.tx.us/health/news_typhus_update.htm.

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