

Epidemiology Newsletter

Health Service Region 8 (HSR 8)

This newsletter aims to provide valuable information to our stakeholders that aid in notifiable conditions reporting for prevention and control of disease outbreaks. It is a collaboration of DSHS HSR 8, San Antonio Metropolitan Health District, Comal County Health Department, Medina County Health Unit, and Victoria City-County Health Department.



Fall 2014

In this Issue

Ebola	1
Enterovirus D68	2
Arboviral Surveillance	3
Influenza Surveillance	3
Pertussis	4
Enteric Illnesses	5
Notifiable Conditions Report	6-8

DSHS HSR 8

7430 Louis Pasteur Drive
San Antonio, TX 78229-4509
Phone: 210-949-2000

Public Health Emergencies or

Immediately Reportable

Diseases: 210-949-2121

San Antonio Metropolitan Health District

332 W Commerce Street
San Antonio, TX 78205
Phone: 210-207-8731

Comal County Health Department

178 E Mill Street, Suite 210
New Braunfels, Texas 78130
Phone: 830-221-1150

Medina County Health Unit

3103 Avenue G
Hondo, Texas 78861
Phone: 830-741-6191

Victoria City-County Health Department

2805 N. Navarro
Victoria, Texas 77901
Phone: 361-578-6281

Ebola Response in HSR 8

Public health officials in HSR 8 continue to respond to Ebola threats to prevent further transmission in our region. Texas had three confirmed Ebola cases. Public health officials monitored about 340 people who had contact with the confirmed cases. The last person was cleared from monitoring November 7. No additional cases were diagnosed. The following summarizes the epidemiology response to Ebola in our region:

1. Texas Department of State Health Services (DSHS), HSR 8 and San Antonio Metropolitan Health District (SAMHD) developed an Ebola Virus Disease (EVD) testing algorithm based on Centers for Disease Control and Prevention guidelines, which was distributed to local health departments, infection preventionists, and medical societies.
2. DSHS, HSR 8 and SAMHD developed and distributed an informational letter specifically aimed at physicians and clinics with guidance on what Ebola is, identifying at-risk patients, and what to do should they identify a potential EVD patient (including contact information, isolation procedures, and personal protective equipment (PPE)).
3. DSHS, HSR 8 and SAMHD developed guidance for school nurses and principals should a child present with symptoms of EVD and have recent travel history to Guinea, Liberia, or Sierra Leone. This letter was distributed to the superintendents of each school district in our region.
4. Provided input on EMS/First Responder guidance regarding Ebola to the South Texas Regional Advisory Council (STRAC).
5. Fielded calls from health care workers, school nurses, and the public and provided accurate information regarding Ebola.
6. Currently following travelers (via symptom monitoring and twice daily temperature checks) arriving from Guinea, Liberia, Sierra Leone, or Mali into HSR 8 for full incubation period (21 days).
7. SAMHD Epidemiology has been meeting with college campus emergency leadership to discuss Ebola / Infectious disease campus protocols.
8. SAMHD Epidemiology has conducted Ebola presentations for college campus student body in effort to educate on the disease and local preparedness efforts.
9. DSHS, HSR 8 has conducted Ebola presentations to the community, including a local high school.
10. DSHS, HSR 8 participated in an Ebola tabletop exercise at Laughlin Air Force Base.
11. DSHS, HSR 8 helped South Texas Regional Medical Center prepare for an Ebola exercise by providing education on proper PPE.

With ongoing travel from countries with current Ebola transmission, HSR 8 continues to monitor returning travelers. Healthcare providers should frequently monitor the evolving situation and stay up to date on state and CDC guidance. Please review response guide checklists so that your facility is prepared to deal with any Ebola situation, available at: <http://www.cdc.gov/vhf/ebola/hcp/index.html>.

Please contact your local or state health department with any questions regarding Ebola.

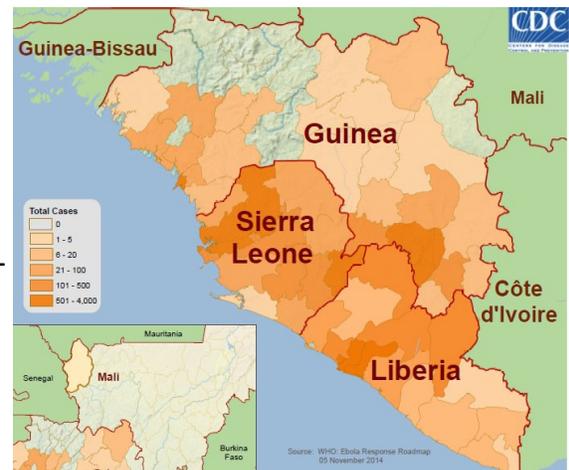
- **San Antonio Metropolitan Health District (210) 207-8876**
- **DSHS, HSR 8 at (210) 949-2000 or (210) 949-2121**

For up to date guidance on Ebola, please visit:

<http://www.cdc.gov/vhf/ebola/index.html>

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

2014 Ebola Outbreak in West Africa— Outbreak Distribution Map



Source: CDC, November 7, 2014

Enterovirus D68

Background:

The United States is currently experiencing a nationwide outbreak of EV-D68. Non-polio enteroviruses are very common and cause about 10-15 million infections in the United States each year according to CDC. As of November 20, 2014, a total of 1,121 people in 47 states and the District of Columbia have been lab confirmed to have EV-D68 illness. As of November 19, Texas has confirmed 26 cases in Anderson, Bexar (3), Dallas (10), Denton, Grayson, Harris, Johnson, Lubbock (5), Midland and Tarrant counties. Anyone can get infected with an Enterovirus and many have been hospitalized from infections caused by different types of enteroviruses.

In the U.S. EV-D68 commonly cause more infections in summer and fall seasons and usually begin to decline in late fall. Reports from most states over the last couple months have indicated reduced EV-D68-like illness activity. Other seasonal respiratory viruses, such as influenza and respiratory syncytial virus are circulating. The other enteroviruses circulating include Coxsackievirus B and Rhinoviruses A, B, C.

Texas Specimens Tested for EV-D68 at CDC, October 21, 2014

Virus detected	No. (%) of results
EV-D68	15 (28%)
Other enterovirus	24 (44%)
No enterovirus detected	15 (28%)
Total	54

Recommendations for healthcare personnel:

1. In healthcare settings, standard, contact, and droplet infection control precautions are recommended for patients with suspected EV-D68 infection.
2. For hospitalized patients with severe respiratory illness, diagnostic testing for influenza and other respiratory viruses should be considered using available hospital-based testing. **However, testing to distinguish EV-D68 from other enteroviruses does not impact patient management**, since treatment consists of supportive care.
3. Environmental disinfection of surfaces in healthcare settings should be performed using a hospital-grade disinfectant with an EPA label claim for any non-enveloped viruses (e.g., norovirus, rhinovirus).
4. Ensure that patients with a history of asthma have an asthma action plan and encourage these patients to seek care early if they experience an exacerbation.
5. Remind patients and parents that the best way to prevent the spread of many infectious diseases is by frequent and thorough hand washing, respiratory etiquette, and surface disinfection (see specific recommendations for patients, below).

Specimen Submission Guidelines:

Enterovirus D68 is **not a reportable condition** in the state of Texas. Specimen submission is optional and providers should work with their local health departments to ensure that specimens are only submitted from patients who meet the established criteria. If testing is desired, please contact your respective health department for specimen submission guidance

- **For those in Bexar County: San Antonio Metropolitan Health District (210) 207-8876**
- **For all others: DSHS, Health Service Region 8 at (210) 949-2000 or (210) 949-2121**

The current DSHS criteria for specimen submission for EV-D68 testing are limited to:

1. Pediatric patients (<21 years of age) admitted to an intensive care unit with severe respiratory illness with symptom onset no earlier than August 1, 2014, who have tested positive for enterovirus or enterovirus/rhinovirus (e.g., by multiplex PCR assays), OR
2. Suspected EV-D68 patients with atypical illness manifestations (acute onset of focal limb weakness and an MRI showing a spinal cord lesion largely restricted to gray matter).

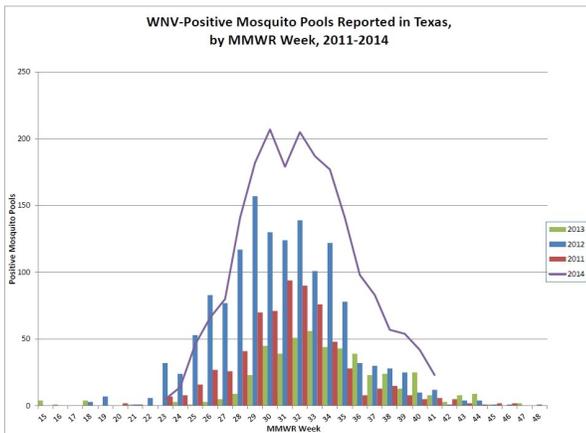
**Please report clusters or outbreaks of respiratory illness or atypical manifestations suspected to be related to EV-D68 to your local health department.

Sample Collection:

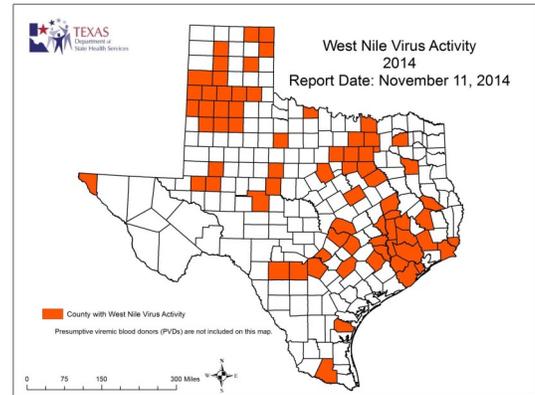
The following specimens may be submitted for EV-D68 testing:

- Nasopharyngeal (NP) or oropharyngeal (OP) swabs are preferred for EV-D68 testing, although any respiratory specimen may be submitted.
- For specimen collection, use sterile, polyester-tipped, plastic shaft swabs and viral transport medium approved for the transport of enteroviruses. Dacron or rayon-tipped swabs with a plastic shaft or any other commercially available sterile collection system intended for virus isolation also may be used. Calcium alginate swabs or swabs with wooden shafts are not acceptable for specimen collection as they may inhibit recovery of the virus.
- Specimens should ideally be frozen to -20°C or lower within 48 hours of collection.
- In general, collecting specimens from patients as close as possible to their illness onset maximizes the likelihood of virus recovery/detection.

Arboviral Surveillance



Texas Counties Reporting any West Nile Virus Activity (mosquito, avian, equine, human), January 1—November 7, 2014



Human Arbovirus Summary, Texas and HSR 8, January 1 - November 7, 2014

Virus	Fever		Neuroinvasive		Hemorrhagic Fever		Total (Human)		Deaths		PVD#	
	State	HSR 8	State	HSR 8	State	HSR 8	State	HSR 8	State	HSR 8	State	HSR 8
Chikungunya*	52	6					52	6				
Dengue*	16				1		17					
Eastern Equine Encephalitis												
Saint Louis Encephalitis	1		1				2					
West Nile	100	2	184	4			284	6	4		58	
Total Reports	169	8	185	4	1	0	355	12	4	0		

*All reported cases are imported.

#PVD - Presumptive viremic blood donors are people who had no symptoms at the time of donating blood through a blood collection agency, but whose blood tested positive when screened for the presence of West Nile virus. Unless they meet the case reporting criteria, they are not counted as a case for official reporting purposes and are not included in the "total reports" column.

HSR 8 Arboviral Cases by County: Chikungunya: Bexar (5), Comal (1); West Nile Fever: Bexar (2); West Nile Neuroinvasive Disease: Bexar (2), Comal (1), Uvalde (1)

Influenza Surveillance and Vaccine

October 1 is the official start to the flu season.

Trivalent formulations of the influenza vaccine for the 2014-2015 season include:

- A/California/7/2009 (H1N1)pdm09-like virus
- A/Texas/50/2012 (H3N2)-like virus
- B/Massachusetts/2/2012-like virus (B/Yamagata lineage)

Quadrivalent formulations of the 2014-2015 influenza vaccine include:

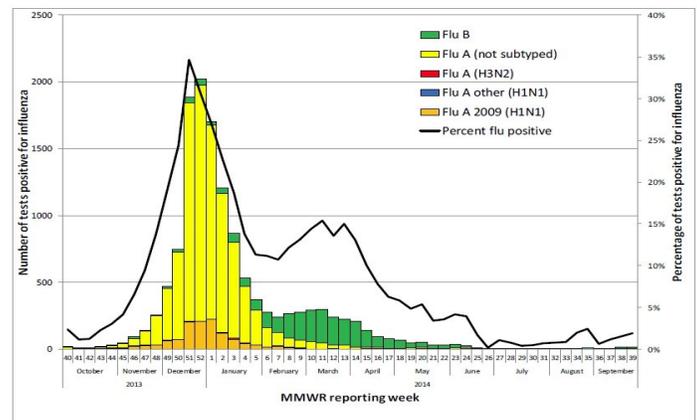
- The three virus components that are included in the trivalent formulation, and
- B/Brisbane/60/2008-like virus

Global laboratory surveillance for influenza viruses is the basis for changing one or more of the vaccine strains each year.

Who should get vaccinated?

- This season's flu vaccine is recommended for **all people age 6 months or older**.
- The vaccine is available in shot form for all ages and in mist form for people 2 through 49 who do not have certain health problems and who are not pregnant.
- There is no priority-group order for receiving the vaccine.
- People with certain conditions – or who live with people with certain conditions – that put them at high risk of developing serious complications should they get the flu, are especially encouraged to get vaccinated, as are pregnant women.
- Because babies under 6 months of age cannot receive the vaccine, it is important that family members and others around the babies get vaccinated to protect the babies and themselves.

Laboratory Surveillance: Number and Percentage of Tests (Antigen, Culture, PCR) Positive for Influenza by Type and Subtype Reported by Texas Laboratories, 2013-2014 Season



Pertussis

Pertussis is a respiratory disease caused by the bacterium *Bordetella pertussis*. Pertussis has an incubation period of 7-10 days, with a range from 4-21 days. The illness is characterized by a cough of more than 2 weeks with paroxysms, an inspiratory whoop or posttussive vomiting. It can cause severe disease in persons of all ages but can be milder and without the typical whoop in persons who have been previously vaccinated. Individuals with mild symptoms may still transmit the disease to other susceptible people, such as the immunocompromised and infants. Infants are at the greatest risk, especially during the first few months of life without protection by vaccination. The most common complication of pertussis, and the cause of most pertussis-related deaths, is secondary bacterial pneumonia; this occurred in 4.9% of US cases from 2001 – 2003.¹ The majority, 83% (92) of pertussis deaths occurred in infants 3 months of age or less from 2004 -2008.¹

Diagnosis

Culture remains the most specific test, but can be difficult to obtain. PCR is the preferred test. Specimens from the posterior nasopharynx should be collected. DFA still has a low sensitivity and should not be relied upon as a criterion for laboratory confirmation but sometimes is used as a screening tool. Serologic assays cannot differentiate infection from vaccine response, but may be useful for adults and adolescents who present late in the course of their illness. At this time, serologic test results should not be relied upon for case confirmation.¹

Trends

Widespread use of the pertussis vaccine has caused over a 75% decrease in pertussis cases in the U.S. from the pre-vaccine high of over 200,000.¹ The lowest recorded incidence in the U.S. was in 1976 at 1,010 cases. But these values have begun to rise since the 1980s. In 2012, 48,277 pertussis cases were reported in the U.S.; many more cases go undiagnosed and unreported. In Texas, data shows that the disease has followed a similar trend and is slowly increasing since the 1990s (Figure 1). In 2013, Texas had 3,985 reported cases of pertussis, a 3.4 fold increase from 2004 with 1,184 cases.² Bexar County has also shown a 5 fold increase in pertussis cases with 115 cases in 2013 compared to 23 cases in 2011.² The rate of pertussis cases in Texas was 14.8 per 100,000 people in 2013. Three counties in Region 8 had an incidence rate higher than 10.0 per 100,000 people in 2013 as seen in Figure 2. Of the 1,874 pertussis cases reported in Texas as of 10/1/14, 21.1% are in infants; 23.4% are 1-6 years of age; 20% are 7-10 years of age; 17.2% are 11-19 years of age and 18.3% are ≥20 years of age. The infants are the most affected with a rate of 94.7 per 100,000 population.²

Figure 1: Pertussis Cases, Texas, 1920-2013

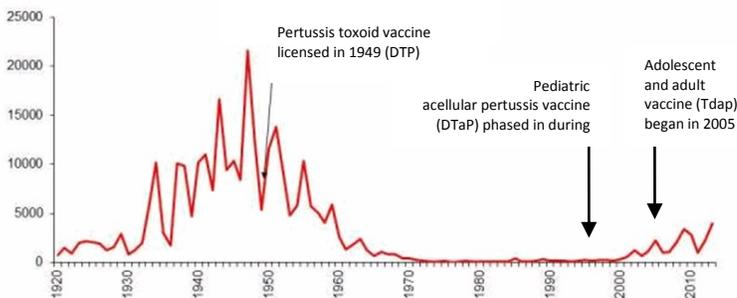
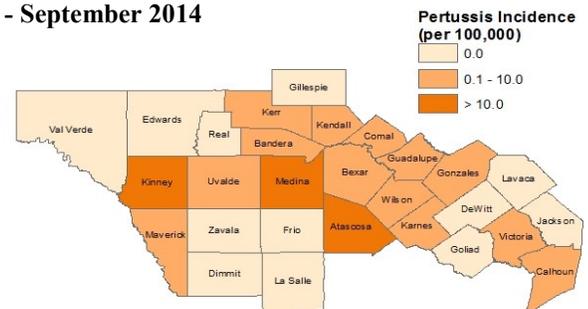


Figure 2: Pertussis Incidence Rates, Health Service Region 8, January - September 2014



Vaccination Coverage

Just under half (48%) of the 5,351 pertussis cases between 6 months to 6 years of age received 3 or more doses of pertussis vaccine in the U.S. in 2013; 12% received no doses.³ The pertussis vaccine coverage rate in the U.S. decreased ~ 11% between the 3rd and 4th dose of the vaccine, according to the 2013 National Immunization Survey (NIS). In the same year, the rates between the 3rd and 4th dose in Texas decreased about 13% and in Bexar County they decreased about 14%.⁴ According to the CDC, ensuring patients are up-to-date on pertussis vaccinations is the single most effective method for preventing the spread of cases.

In an effort to control and prevent cases of Pertussis, the following actions are advised:

- Treat every patient visit as an opportunity to check vaccination status and vaccinate as-needed.
 - Work to finish the **toddler vaccine series** - ensure that children continue after their first birthday to get all recommended doses.
 - Tdap is recommended as a single dose for those 11 through 18 years of age with preferred administration at **11 through 12 years** of age.
- Work to eliminate the assumption that Pertussis is a “disease of childhood”; adults who have not had a recent booster vaccine can be infected, creating a reservoir of undiagnosed cases and sources of infection for infants and adolescents.
 - Any **adult** 19 years of age and older who has not received a dose of Tdap should get one as soon as feasible. It can replace one of the 10-year Td booster doses.
 - **Pregnant women** should receive a dose of Tdap during each pregnancy, preferably at 27 through 36 weeks gestation.
- Provide **post-exposure** vaccination/boosters for all asymptomatic exposed individuals.
- Pertussis is **reportable** within one working day. For reporting, culture and PCR results should be used, when possible.

¹ Pertussis and Pertussis Vaccines, Epidemiology and Prevention of Vaccine-Preventable Diseases, NCIRD & CDC, March 2012 accessed 10/2014 <http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/15-Pert.pdf>

² Texas Department of State Health Services Pertussis website, accessed 10/2014 <http://www.dshs.state.tx.us/idcu/disease/pertussis/statistics/>

³ CDC, 2013 Provisional Pertussis Surveillance Report, January 3, 2014. accessed 10/2014 <http://www.cdc.gov/pertussis/downloads/pertussis-surveillance-report.pdf>

⁴ National Immunization Survey (NIS) - Children (19-35 months) data accessed 10/2014 <http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html>

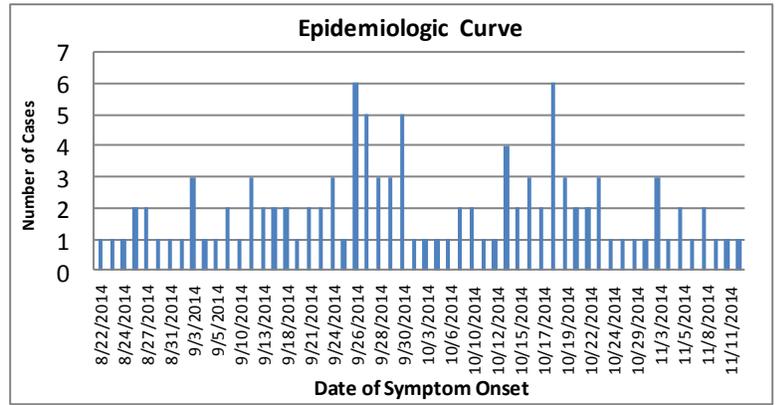
Enteric Illnesses

Victoria County Shigellosis Outbreak

As of November 21, 2014, there have been 117 cases of Shigellosis reported in Victoria County. Of those reported cases, 79 were laboratory-confirmed and 38 were epidemiologically-linked to a laboratory confirmed case. Onset of symptoms ranges from August 22, 2014 to November 14, 2014.

Shigella Facts

- Symptoms include: diarrhea (often bloody), fever, stomach cramps, nausea, sometimes vomiting
- Transmission is by fecal-oral route, through direct person-to-person contact and only requires a small number of organisms.
- Incubation period ranges from 12 to 96 hours.
- Antimicrobial treatment may shorten the duration of illness and decrease the spread of infection.
- Diagnosis is by culture of stool or rectal swab (sent for culture).



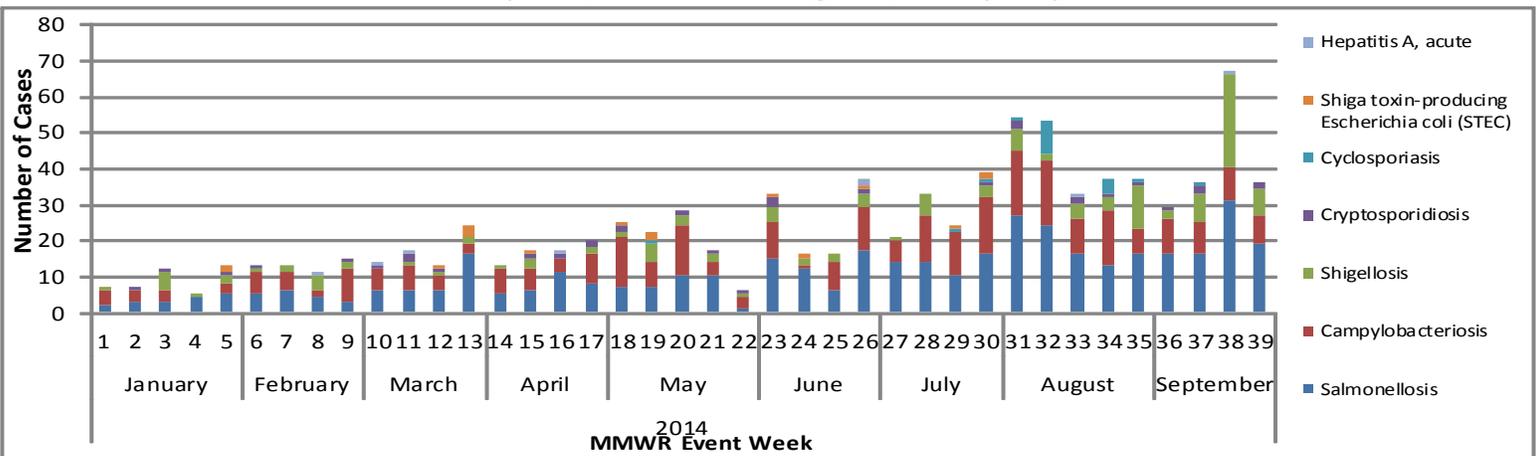
Recommendations

- Report confirmed and suspected cases of shigellosis to DSHS, HSR 8 at (210) 949-2000 or SAMHD at (210) 207-8876.
- Obtain stool for culture and sensitivities on any patient suspected of having Shigellosis. If cultures are performed, ensure sensitivities match antibiotic therapy.
- Begin empiric antibiotic treatment in patients who have severe disease, other medical risk factors, or are likely to spread disease, especially school-age children and food service workers.
- Anti-motility drugs are not recommended and may prolong illness.

Disease control measures:

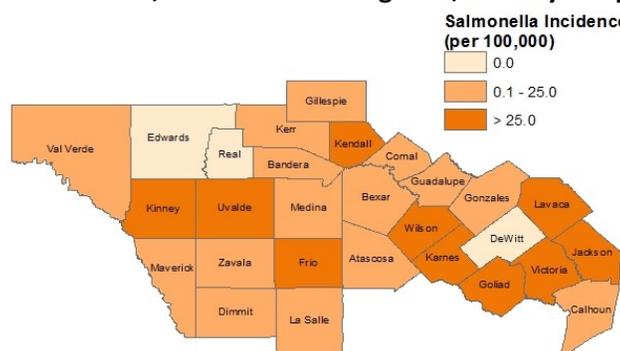
- Wash hands, for at least 20 seconds, especially after using the restroom, changing diapers, before preparing foods/drinks, and eating. Hand washing of small children should be supervised.
- Dispose of soiled diapers frequently and disinfect diaper-changing areas after each use.
- Exclude children from daycare, preschool, school or camp until they have been diarrhea free for 24 hours without the use of diarrhea suppressing medications and fever free for 24 hours without the use of fever suppressing medications.
- Food handlers should not return to work until completion of the appropriate treatment and a negative stool culture.

Number of Enteric Illnesses Reported, Health Service Region 8, January—September 2014



*Event Week is defined in hierarchical order onset date, diagnosis date, report to county date, report to state date, date investigation created

Salmonellosis Incidence, Health Service Region 8, January—September 2014



Region 8 Notifiable Conditions Report, January - September*

	Atascosa		Bandera		Bexar		Calhoun		Comal		De Witt		Dimmit		Edwards		Frio		Gillespie	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
Amebiasis					13	10														1
Babesiosis					1															
Botulism, infant		1			1															
Brucellosis					4	1														
Campylobacteriosis	3	4	2	4	212	163	2	6	14	3		3			1	2	4	4	9	10
Chagas, chronic indeterminate		1			1	1														
Chagas, chronic symptomatic																				
Chlamydia	149	137	10	11	9150	**	59	56	256	237	79	49	51	51	5	2	57	78	21	40
Creutzfeldt-Jakob Disease					1															
Cryptosporidiosis				1	24	25	2	3	1		1								4	2
Cyclosporiasis					1	11				6										
Cysticercosis						1														
Dengue Fever					5															
Ehrlichiosis, chaffeensis					1	1														
Encephalitis, West Nile						2				1										
Gonorrhea	27	19	5	5	2462	**	21	9	40	29	16	17	5	19			19	29		5
Haemophilus influenzae, invasive					1															
Hemolytic uremic synd,postdiarrheal					1															
Hepatitis A, acute					7	5			1	1	1									
Hepatitis B, acute					6	5			1	1										
Hepatitis C, acute					1	3				1							1			
Hepatitis E, acute					1															
Influenza-associated pediatric mortality					2															
Legionellosis					14	10			1	2										
Leishmaniasis						1														
Listeriosis						1														
Lyme disease					1															
Malaria						1														1
Mumps					2															
Neisseria meningitidis, invasive					1	1														
Pertussis	17	5	4	1	98	57		1	12	5							2			
Poliomyelitis, Paralytic					1															
Q fever, Acute																				
Q fever, Chronic																				
Salmonellosis	10	10	6	3	166	245	4	5	22	21	6		1	2	2		4	5	6	2
Shiga toxin-producing Escherichia coli (STEC)			2		21	10		1	2											
Shigellosis	2	3		3	48	90		1	1		1	2								2
Spotted Fever Rickettsiosis						3														
Strep, other, invasive, beta-hem (non-A nonB)																				
Streptococcus pneumoniae, invasive disease (IPD)	2	1	2	1	104	71	2		4	4	2	2					1	1	1	3
Streptococcus, invasive Group A	1	2			15	28			2	8							4			1
Streptococcus, invasive Group B	1	1	2	2	65	108		1	2	5	1						2		4	2
Syphilis	11	4			812	715	1	1	10	17	1	1	1	2			7	4		2
Tuberculosis	1	2			56	68	2	2	2		1			1	1		3	9		
Tularemia									1											
Typhoid fever (Salmonella typhi)	1																			
Typhus fever-fleaborne, murine					2	14														
Vancomycin-intermediate Staph aureus					1	1														
Varicella (Chickenpox)	3	1		2	75	63			9	11	2	1	6	1			35	12	1	3
Vibrio parahaemolyticus			1		1															
Vibrio vulnificus infection					2															
Vibriosis, other or unspecified					3	2														
West Nile Fever						1														
Yersiniosis											1									

*All data is provisional and subject to change, spaces indicate no cases reported

**Data not available

Region 8 Notifiable Conditions Report, January - September*

	Goliad		Gonzales		Guadalupe		Jackson		Karnes		Kendall		Kerr		Kinney		La Salle		Lavaca	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
Amebiasis					1				1		1		1							
Babesiosis																				
Botulism, infant																				
Brucellosis																				
Campylobacteriosis	1		5	13	30	26			4	1	3	10	7	8		1	1	1	3	7
Chagas, chronic indeterminate																				
Chagas, chronic symptomatic																				
Chlamydia	10	7	81	81	319	270	31	28	36	29	77	61	84	91	7	5	16	11	20	27
Creutzfeldt-Jakob Disease																				
Cryptosporidiosis							1					1	2						1	5
Cyclosporiasis				1	1						3	1								
Cysticercosis																				
Dengue Fever																				
Ehrlichiosis, chaffeensis																				
Encephalitis, West Nile					1															
Gonorrhea	5	2	27	14	68	56	5	6	3	13	5	10	10	17	4		2	1	7	16
Haemophilus influenzae, invasive														1						
Hemolytic uremic synd,postdiarrheal																				
Hepatitis A, acute					2				1											
Hepatitis B, acute					1						1			1						
Hepatitis C, acute						1							1	1						
Hepatitis E, acute																				
Influenza-associated pediatric mortality																				
Legionellosis					1				1				1	2						
Leishmaniasis																				
Listeriosis																				1
Lyme disease										1										1
Malaria																				
Mumps																				
Neisseria meningitidis, invasive							1													
Pertussis				1	12	6	1		4	1	3	1	1	3		1				1
Poliomyelitis, Paralytic																				
Q fever, Acute													1							
Q fever, Chronic												1								
Salmonellosis	2	3	16	5	29	20	7	5	3	6	9	10	7	8		2		1	15	8
Shiga toxin-producing Escherichia coli (STEC)				1	2	1	1											1		1
Shigellosis			1	2	4	3		1		1	1		1	2						
Spotted Fever Rickettsiosis																				
Strep, other, invasive, beta-hem (non-A nonB)				1																
Streptococcus pneumoniae, invasive disease (IPD)	1		7		9	7			2	1	2		1	2						2
Streptococcus, invasive Group A	1				2	3					1		1	1				1		1
Streptococcus, invasive Group B				3	8	3			3	2	1	2	4	1				1		
Syphilis			1	1	11	14	4	1		5	2	4	2	3	1		3	1		
Tuberculosis					1				1	1			1	1				2		
Tularemia																				
Typhoid fever (Salmonella typhi)																				
Typhus fever-fleaborne, murine						1				1										
Vancomycin-intermediate Staph aureus																				
Varicella (Chickenpox)		1		1	11	14	1	1		3	1		1	3			2	1		1
Vibrio parahaemolyticus											1									
Vibrio vulnificus infection																				
Vibriosis, other or unspecified																				1
West Nile Fever																				
Yersiniosis							1	1					4	2						

*All data is provisional and subject to change, spaces indicate no cases reported

Region 8 Notifiable Conditions Report, January - September*

	Maverick		Medina		Real		Uvalde		Val Verde		Victoria		Wilson		Zavala		Region 8	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
Amebiasis									1				1				16	14
Babesiosis																	1	0
Botulism, infant																	1	1
Bruceellosis																	4	1
Campylobacteriosis	3	15	5	3	2		5	3	9	2	31	12	1	7			357	308
Chagas, chronic indeterminate											1						2	2
Chagas, chronic symptomatic											1						0	1
Chlamydia	191	209	98	65	10	10	139	103	149	159	386	392	78	60	50	32	11619	2301
Creutzfeldt-Jakob Disease																	1	0
Cryptosporidiosis				1								2	1				37	40
Cyclosporiasis							1				1						7	19
Cysticercosis																	0	1
Dengue Fever																	5	0
Ehrlichiosis, chaffeensis																	1	1
Encephalitis, West Nile								1									1	4
Gonorrhea	34	28	21	13	2	3	12	26	22	23	105	108	15	12	4	3	2946	483
Haemophilus influenzae, invasive																	1	1
Hemolytic uremic synd, postdiarrheal													1				2	0
Hepatitis A, acute				1													11	8
Hepatitis B, acute									1				1				11	7
Hepatitis C, acute																	3	6
Hepatitis E, acute											1						1	1
Influenza-associated pediatric mortality																	2	0
Legionellosis													2				18	16
Leishmaniasis																	0	1
Listeriosis																	1	1
Lyme disease																	1	2
Malaria																	0	2
Mumps																	2	0
Neisseria meningitidis, invasive																	2	1
Pertussis	1	1	3	12			3	1			1	1		2			163	99
Poliomyelitis, Paralytic																	1	0
Q fever, Acute																	1	0
Q fever, Chronic																	0	1
Salmonellosis	9	8	9	8	1		8	13	15	10	22	39	14	14	3	2	396	455
Shiga toxin-producing Escherichia coli (STEC)	1											1	2	1			31	17
Shigellosis			1	1			1	1	2	1	1	64		2			66	177
Spotted Fever Rickettsiosis			1														1	3
Strep, other, invasive, beta-hem (non-A nonB)									1								1	1
Streptococcus pneumoniae, invasive disease (IPD)			2	1					2	2	1	2	4				149	100
Streptococcus, invasive Group A													1				26	47
Streptococcus, invasive Group B	3	3		1				1	3		1		2	3			102	139
Syphilis	4	11	7	7			3	2	6	6	18	14	7	5			912	820
Tuberculosis	3	7					1		5	3	1		2		2		83	96
Tularemia																	1	0
Typhoid fever (Salmonella typhi)																	1	0
Typhus fever-fleaborne, murine											1						3	16
Vancomycin-intermediate Staph aureus (VISA)																	1	1
Varicella (Chickenpox)	7	8					2	2	5	6	3	2	1	2	6	2	172	140
Vibrio parahaemolyticus																	3	0
Vibrio vulnificus infection																	2	0
Vibriosis, other or unspecified																	4	2
West Nile Fever																	0	1
Yersiniosis											2	2					7	6

*All data is provisional and subject to change, spaces indicate no cases reported