TEXAS Health and Human Services | Texas Department of State Health Services

RABIES PREVENTION IN TEXAS

Texas Department of State Health Services
Zoonosis Control

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Texas Health and Human Services
Texas Department of State Health Services

RABIES PREVENTION IN TEXAS

For assistance on problems or questions regarding rabies prevention, call your local health department, a Zoonosis Control regional office (contact information listed on pages 26-29 of this document) of the Texas Department of State Health Services (DSHS), the DSHS Zoonosis Control Branch (512-776-7676 or 512-776-7111), or the DSHS Infectious Disease Control Unit (512-776-7455) during working hours. For emergency consultations on nights, weekends, and holidays, contact the DSHS Public Health Region (PHR) for your area:

PHR	PHR EMERGENCY HOTLINE
1	806-744-3577
2/3	817-822-6786
4/5N	866-310-9698
6/5S	800-270-3128 or 713-767-3000
7	254-778-6744
8	210-949-2121
9/10	888-847-6892
11	956-421-5559

INTRODUCTION

Although rabies rarely affects humans in the United States, every year many people receive rabies postexposure prophylaxis (PEP). Appropriate management of those who may have been exposed to rabies virus depends on an assessment of the risk of infection (type of exposure, type of animal, availability and rabies vaccination status of the animal involved in the exposure, etc.) and the efficacy and risk of prophylactic treatment. All available methods of systemic prophylactic treatment can be complicated by instances of adverse reactions. These are rarely severe. Decisions on management must be made promptly; the longer treatment is postponed, the less likely it is to be effective. The urgency for treatment must be tempered by recognition that, despite rabies being common in wildlife, human rabies is an extremely rare event in Texas and that hasty decisions have led to the inappropriate vaccination of people who were not at risk for infection.

Data on the efficacy of active and passive immunization after rabies exposure have come from both human and animal studies. Evidence from laboratory and field experience in many areas of the world indicates that PEP (combining wound cleansing, rabies immune globulin, and vaccine) is uniformly effective when appropriately used. Rabies has not occurred in persons who have received prompt PEP following the guidelines found in this manual.

Since the mid-1900s, the number of human rabies cases has declined significantly in the United States, probably due to several factors. Improved domestic animal control (effective leash laws, domestic animal rabies vaccination programs, and stray animal collection) has been a major factor. Before the implementation of improved animal control measures, rabid domestic animals were the most common source of human rabies in the United States. They remain the leading source of human rabies worldwide.

The control of two recent major rabies epizootics in Texas has also contributed to the low incidence of rabies in domestic animals. Consistent, aggressive and strategic use of oral rabies vaccination programs for coyotes and gray foxes, beginning in Texas during 1995, has greatly decreased the risk of rabies infection via these wildlife species in both domestic animals and humans.

Rabies continues to be enzootic in skunks in Texas. The number and percentage of skunks that are positive for rabies varies cyclically. Field studies have been conducted on oral rabies vaccination efforts for skunks.

Rabies is also enzootic in bats in Texas. In the United States, most recent human rabies cases have been identified as being due to a bat variant of rabies virus. Often, the victim does not remember or disclose an animal bite of any kind. This has resulted in a more liberal interpretation of rabies exposure by this mammal:

"…in situations in which a bat is physically present and the person(s) cannot reasonably exclude the possibility of a bite exposure, post exposure prophylaxis should be given unless prompt capture and testing of the bat has excluded rabies virus infection." (MMWR (Morbidity and Mortality Weekly Report) 1996; 45:209)

RABIES BIOLOGICALS

There are two types of rabies immunization products for use in humans: 1) vaccines that induce an active immune response, which requires about 7-10 days to develop but may persist for as long as a year or more; and 2) immune globulins that provide rapid passive immune protection for a short period of time (half-life of approximately 21 days). Both types of products must be used concurrently for PEP in those persons who have never received prior vaccination against rabies.

Vaccines for Use in Texas

This section contains some pertinent information on some of the rabies biologicals that may be available in Texas. The package insert should be consulted before the use of any of these products.

HDCV

Human diploid-cell vaccine (HDCV): HDCV is prepared using a rabies virus grown in human diploid cell culture, which is then inactivated. Vaccine is supplied as 1 ml, single-dose vials of freeze-dried vaccine with accompanying diluent for intramuscular (IM) injection for pre- and postexposure administration. It must be used immediately after reconstitution.

PCECV

Purified chick embryo cell vaccine (PCECV): PCECV contains a freeze-dried inactivated rabies virus grown on cultures of chicken fibroblasts. This vaccine is licensed in the United States for IM use in both pre- and postexposure immunization. The schedules and dosage for PCECV vaccine are the same as for HDCV.

HRIG

Human rabies immune globulin (HRIG): HRIG is concentrated rabies antibodies collected from the plasma of immunized human donors. Two different concentrations of HRIG are available in products approved for use in the United States: 150 IU/ml and 300 IU/ml. Calculate the dosage carefully based on the patient's current body weight and the concentration of the specific product used.

RATIONALE OF TREATMENT

The physician must evaluate each possible rabies exposure. Local or state public health officials should be consulted if questions arise about the need for prophylaxis. Additionally, a guide entitled *Human Rabies Postexposure Prophylaxis (PEP) in Texas – Guide* **(Table 1)** can be found in the **RABIES POSTEXPOSURE PROPHYLAXIS (PEP) FOR HUMANS** section of this manual.

MANAGEMENT OF BITING ANIMALS

PER STATE LAW, ALL ANIMAL BITES TO A HUMAN MUST BE REPORTED TO THE LOCAL RABIES CONTROL AUTHORITY (LRCA), WHICH MAY BE ANIMAL CONTROL, THE SHERIFF, OR ANOTHER LOCAL AUTHORITY.

A healthy dog, cat, or domestic ferret that has bitten a person or otherwise potentially exposed a person to rabies, must be quarantined in a DSHS-licensed facility or a veterinary clinic (under specific conditions defined in law, home confinement may be allowed by the LRCA) and observed for 10 days (240 hours) from the time of the exposure (the alternative to quarantine or home confinement is the euthanasia and testing of the animal for rabies). Any illness in the animal should be reported immediately to the LRCA. If signs suggestive of rabies develop, the animal should be euthanized in a manner that does not damage the brain, its head removed by a qualified person wearing personal protective equipment, and a suitable specimen shipped at 32 to 45 degrees Fahrenheit to a Texas DSHS-designated laboratory. An unowned dog, cat, or domestic ferret that potentially exposes a person to rabies may be euthanized and its head submitted for testing.

Any free-roaming high-risk animal* that potentially exposes a person to rabies must be euthanized at once (without damage to the brain) and head (or entire body in the case of bats and small rodents) submitted for testing. A low-risk animal does not need to be quarantined or tested unless the LRCA has cause to believe it may be rabid and has the animal tested. (Refer to Table 1. for a list of high- and low-risk animals.) If the brain is negative by fluorescent-antibody examination for rabies, the saliva can be assumed to contain no virus and the exposed person need not be treated. Exotic animals, such as lions, tigers, or monkeys, that have been kept in captivity for extended periods of time are unlikely to be infected with rabies; they can be confined and observed for thirty days rather than euthanized and tested for rabies. Livestock can also be confined and observed for 30 days in lieu of testing.

* Refer to Texas Administrative Code, Sections 169.27(e) and (h) or consult with the LRCA for your area pertaining to exemptions to mandatory euthanasia for certain high-risk animals that meet captivity parameters as specified in state law: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=169&sch=A&rl=Y

COLLECTION AND SUBMISSION OF ANIMAL SPECIMENS FOR RABIES TESTING AT THE DSHS LABORATORY IN AUSTIN

When packing specimens for rabies diagnosis, some basic information, as mandated in Texas Administrative Code (TAC), Section 169.33, is provided below (explanatory notes to convey critical updates have been inserted that aren't part of the actual TAC). For details on packing, labeling, shipping, and Code of Federal Regulations requirements, plus laboratory hours and standard procedures, please refer to the website of the DSHS Laboratory Services Section at http://www.dshs.state.tx.us/lab/rab_prep-ship.shtm

- Damage to the brain by shooting or other trauma shall be avoided.

- The head of the suspect animal shall be separated from the body by a **qualified person wearing personal protective equipment** as soon as possible after the death of the animal. Only the head shall be submitted with the exception that whole bats and small rodents may be submitted. If only the brain is submitted rather than the entire

head, **the minimum tissue requirements for rabies testing are a complete transverse cross section of the brain stem and tissue from one of the following: cerebellum and/or hippocampus. Submissions that do not meet these tissue requirements will be considered unsatisfactory due to a lack of sufficient material.** (Note: live specimens will not be accepted, which has been an issue with bats in the past. The rabies laboratory has no means in place to euthanize animals. Therefore, with whole-animal specimens (bat or small rodent), submitters need to confirm that the animal is deceased before submitting it. Placing bats in the refrigerator is not a viable option for euthanasia because they go into a state of torpor to save energy when it's cold and don't necessarily die). Note: due to biohazard safety guidelines, the laboratory is unable to return carcasses to submitters.

● The specimen shall be immediately chilled to between 32 degrees Fahrenheit and 45 degrees Fahrenheit either in a refrigerator or by packing for shipping with sufficient amounts of refrigerants in the container; the specimen should not be frozen. When shipping, sufficient refrigerant shall be added to ensure the specimen will remain chilled to this temperature range for a minimum of 48 hours. Do not use dry ice. Gel packs or similar refrigerants are recommended. Ice is not recommended.

● If specimens are shipped, containment in compliance with requirements in the Code of Federal Regulations (CFR), Title 49, shall be used for packing. Packing methods shall prevent leakage and provide for proper identification (such as an identification number) of the specimen.

● A completed DSHS Form G-9, Rabies Submission Form, which is available at the department's Laboratory Services Section, Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756 (or at https://www.dshs.texas.gov/laboratory-services/laboratory-testing-services-manual-introduction/forms-laboratory-fee-schedule), is required for each specimen submitted to the department's Laboratory Services Section. Each form must contain the same identification information provided with the specimen. Submission form(s) shall be contained in a waterproof bag.

● Labeling on the outside of the shipping container shall be legible and include:

1. name, address, and telephone number of the laboratory;

2. name, return address, and telephone number of the shipper;

3. language in compliance with requirements in the CFR, Title 49, pertaining to the shipment of infectious substances for diagnostic purposes; and

4. the following information: "RABIES IDENTIFICATION TEAM, LABORATORY SERVICES SECTION - REFRIGERATE ON ARRIVAL."

● The following procedures are required for shipment:

1. shipment shall be by a reliable carrier; the **Austin laboratory no longer receives rabies specimens via bus services** and the department does not recommend the United States Postal Service. Transporting specimens via ride-share is not permitted. If an overnight carrier is used, ship the specimen such that it will arrive by Friday or delay shipment until Monday. If shipping on Thursday, please ensure guaranteed delivery on Friday. Do not ship via overnight carrier on Friday or the day before a holiday. These services do not deliver to the department on the weekend or on holidays (note: this section has been paraphrased from the TAC to convey a critical change in bus service, plus not allowing ride-share delivery of specimens);

2. a shipping receipt will be obtained and retained by the shipper;

3. at the time of the shipment, the shipper shall notify laboratory personnel of the shipment via telephone or laboratory-approved electronic format; and

4. the shipper shall provide the return postage (in the form of stamps, not money) if the return of the shipping container is desired.

LIST OF DSHS-DESIGNATED LABORATORIES

Contact information is provided to allow submitters to check with a specific laboratory for information on submission and testing procedures, plus any possible charges for testing, prior to submitting the specimen.

Austin - Laboratory Services Section, Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756. Telephone the **rabies hotline**: **1-800-252-8163** for shipment notification. For all other inquiries call the rabies laboratory at: (512) 776-7595.
Email: rabies.team@dshs.texas.gov
Website: http://www.dshs.state.tx.us/lab/rab_prep-ship.shtm
Hours: 8am to 5pm Monday-Friday; no specimens received on federal holidays
The Austin laboratory no longer receives rabies specimens via bus services as of May 15, 2022, plus transporting specimens via ride-share is not permitted.

Houston Health Department Bureau of Laboratory Services, 2250 Holcombe Blvd, Houston, Texas 77030.
Telephone: 832-393-3917 or 832-393-3915
Email: Jennifer.perez@houstontx.gov
Kirsten.tackett@houstontx.gov
Website: https://www.houstonhealth.org/services/laboratory-services/rabies-laboratory-services
Hours: 8am-5pm, Monday-Friday; closed on City of Houston observed holidays

San Antonio Metro Health Laboratory, 2303 SE Military Dr, Bldg. 533
Rm 1110, San Antonio, TX 78223
Telephone: (210) 207-8820, (210) 207-8787, 210-207-8747, or 210-207-8973
Email: ralph.pruett@sanantonio.gov, mark.wade@sanantonio.gov, mireya.huizar@sanantonio.gov, or claudia.garcia@sanantonio.gov
Website: http://www.sanantonio.gov/Health/HealthServices/LabServices
Hours: 7:45am- 4:30pm Monday-Friday

City of El Paso Department of Public Health Laboratory
9566 Railroad Drive
El Paso, TX 79924
Telephone: (915) 212-0438/Fax: (915) 212-0439
Email: BanuelosBM@elpasotexas.gov or lopezj1@elpasotexas.gov
Website: http://www.elpasotexas.gov/public-health
Hours: 8am-5pm, Monday-Friday; closed on City of El Paso observed holidays

MANAGEMENT OF DOMESTIC ANIMALS EXPOSED TO RABID ANIMALS

ANY DOMESTIC ANIMAL THAT IS BITTEN BY, DIRECTLY EXPOSED BY PHYSICAL CONTACT WITH, OR DIRECTLY EXPOSED TO FRESH TISSUES OF A RABID ANIMAL IS REGARDED AS HAVING BEEN EXPOSED TO RABIES.

(The following paragraphs paraphrase portions of the Texas Administrative Code, Sections 169.21 – 169.34, Rabies Control and Eradication).

An animal should not be considered currently vaccinated if documentation of vaccination within the appropriate timeframe is not available or if the initial immunization was given less than 30 days previously.

Domestic animals that are not currently vaccinated and considered to have been exposed to rabies must be euthanized **or** vaccinated against rabies immediately, placed in confinement for 90 days, and given booster vaccinations during the third and eighth weeks of isolation. For young animals, additional vaccinations may be necessary to ensure that the animal receives at least two doses at or after the minimum age prescribed by the United States Department of Agriculture (USDA) for the vaccine administered.

Currently vaccinated domestic animals considered to have been exposed to rabies must be euthanized **or** vaccinated immediately and placed in confinement for 45 days.

These periods of confinement for domestic animals exposed to rabies virus should not be confused with the 10-day (240 hours) observation period for a dog, cat, or domestic ferret that has potentially exposed a human to rabies as described in the **RABIES POSTEXPOSURE PROPHYLAXIS (PEP) FOR HUMANS** section. A dog, cat, or domestic ferret exposed to a rabid animal may develop rabies long after the exposure since the incubation period for rabies can be days to years; however, the average incubation typically is described as 3 to 8 weeks or 3 weeks to 3 months depending on the reference. Prolonged confinement is necessary to exclude the possibility of subsequent development of rabies in a dog, cat, or domestic ferret exposed to a rabid animal.

The above recommendations apply only to animals for which there is a USDA-licensed vaccine. For all other animals, refer to the latest edition of the publication titled *The Compendium of Animal Rabies Prevention and Control* by the National Association of State Public Health Veterinarians. No licensed vaccine is currently available for wild animals or hybrids of wild and domestic animals. The administration of a rabies vaccine in a species for which no licensed vaccine is available, is at the discretion of the veterinarian; however, an animal receiving a rabies vaccine under these conditions will not be considered vaccinated against rabies virus in potential rabies exposure situations.

RABIES POSTEXPOSURE PROPHYLAXIS (PEP) FOR HUMANS

The essential components of animal bite wound management are prompt, thorough cleansing of wounds and immunization, including administration, in most instances, of both rabies immune globulin and vaccine.

Cleansing of Wounds

Wound cleansing cannot be overemphasized. Immediate and thorough washing of all bite wounds and scratches with soap and water (plus an antiseptic, such as an iodine-based antiseptic if available and the person is not allergic) is a critical measure for preventing rabies. In experimental animals, simple local wound cleansing has been shown to markedly reduce the likelihood of rabies. Tetanus vaccination and measures to control bacterial infection should be provided as indicated.

Decision to Provide PEP

The decision to treat or not to treat must be based on all available information about the circumstances surrounding the exposure incident. The *Human Rabies Postexposure Prophylaxis (PEP) in Texas - Guide* **(Table 1)** found in this section is helpful in evaluating a possible rabies exposure and determining whether PEP is needed.

For animals that are not free-roaming, high-risk animals and are not exhibiting signs of rabies at the time of the exposure, it is typically acceptable to delay decisions about PEP for a reasonable risk-weighted period, determined through consult and risk assessment with a public health professional, to allow the designated local authority (for example, the LRCA, animal control, or sheriff) time to locate the animal for quarantine/confinement or testing.

A 10-day (240 hours) observation period from the time of the bite is necessary for a dog, cat, or domestic ferret that has bitten or otherwise potentially exposed a person to rabies; the animal is placed in quarantine (or home confinement, if applicable and approved by the LRCA) until the end of this period. In dogs, cats, and domestic ferrets, clinical signs of rabies develop within 10 days (usually less) of starting to shed virus in the saliva. Therefore, if a dog, cat, or domestic ferret is alive and clinically normal after a 10-day (240 hours) observation period following a bite, the animal could not have exposed the bite victim to the rabies virus at the time of that specific bite incident and PEP is not warranted.

Local or state health departments may be consulted to clarify the guide and to provide information concerning the prevalence of animal rabies in the geographic locale where the possible exposure occurred. Information on the number of cases of laboratory-confirmed rabies in Texas by county and species of animal is available at: https://dshs.texas.gov/IDCU/disease/rabies/cases/statistics.aspx

PEP Regimen

The PEP regimen (Table 2) should include administration of both human rabies immune globulin (HRIG) and vaccine (such as HDCV or PCECV). An exception is made for exposed persons who have been previously immunized with the recommended pre- or postexposure regimens of HDCV or PCECV (or who have been immunized with other types of rabies vaccines and have documented rabies antibody production). In these cases, HRIG should not be given, and a dose of vaccine should be given on day 0 and day 3 **(Table 2)**.

The combination of rabies immune globulin and rabies vaccine is recommended for both bite exposures and nonbite exposures, regardless of the interval between exposure and treatment. **The sooner treatment is begun after exposure, the better the chance of effectiveness.** In most cases, it is acceptable to withhold PEP for up to 72 hours while awaiting rabies test results or making efforts to locate the biting animal for testing or quarantine/observation; however, if the animal was displaying clinical signs of rabies or is a high-risk animal for rabies (particularly a bat), the exposed individual should begin treatment without awaiting test results (treatment can be discontinued if test results are negative). If there was a delay in recognizing a rabies exposure, treatment should be started even if months have lapsed since that exposure. The incubation period of rabies in humans can be days to years, but it is typically described as 3 to 8 weeks or 3 weeks to 3 months depending on the reference. The incubation period can vary due to factors such as: the age and immune status of the host; quantity of rabies virus inoculated; type and depth of the bite wound; how long the virus replicates in the host tissues; distance of the bite site from the central nervous system (CNS); and time it takes for the virus to travel from the peripheral nerves to the CNS.

Table 1. Human Rabies Postexposure Prophylaxis (PEP) in Texas – Guide

These guidelines can help determine if PEP is needed after a potential rabies exposure. **Consultation with a public health professional to assess the rabies risk is generally recommended prior to making decisions about the need for PEP.** An exposure is defined as 1) an animal bite (or scratch) that breaks the skin or 2) exposure of broken skin (bled or had serous drainage within the past 24 hours) or mucous membranes to saliva, neural tissue, or tears. Stool, blood, urine, and skunk spray do not contain rabies virus. **Note:** per state law, all animal bites to humans must be reported to the local rabies control authority (LRCA), which may be animal control, the sheriff, or another designated local authority.

Risk Category of Exposing Animal	Animal Availability	Quarantine with Observation	Laboratory Testing	Laboratory Testing Result	Human PEP Recommendation[1]
Low (Rabbits, opossums, armadillos, shrews, and rodents, such as mice, rats, squirrels, gophers, prairie dogs, nutria, and beavers[2])	Available	Not required	Testing is not required unless the LRCA or physician has cause to believe that the animal is rabid.	Positive	Administer PEP.
				Non-negative[3]	PEP may be indicated. Consult public health professional for rabies risk assessment.
				Negative	PEP not indicated.
	Not available	N/A	N/A	N/A	PEP may be indicated. Consult public health professional for rabies risk assessment.
High[4] (Bats[5], coyotes, foxes, raccoons, and skunks or type of biting animal is unknown)	Available	Not allowed for free-roaming animals[4]	Test animal (Consult with LRCA if the animal is not defined as free roaming.)	Positive or non-negative[3]	Administer PEP.
				Negative	PEP not indicated.
	Not available	N/A	N/A	N/A	Administer PEP.
Dog, Cat, Domestic Ferret[6]	Available	Quarantine or home confinement[7] until the end of a 10-day observation is allowed if animal is not exhibiting signs of rabies.	Test animal if it is exhibiting signs of rabies at the time of the exposure or if it develops signs of rabies or dies during the 10-day observation period.	Positive	Administer PEP.
				Non-negative[3]	PEP may be indicated. Consult public health professional for rabies risk assessment.
				Negative (or animal successfully completes quarantine or home confinement)	PEP not indicated.
	Not available	N/A	N/A	N/A	PEP may be indicated. Consult public health professional for rabies risk assessment.
All Other Mammals	Available	Confinement until the end of a 30-day observation period[8] is allowed if the animal is not exhibiting signs of rabies.	Test animal if it is exhibiting signs of rabies at the time of the exposure or if it develops signs of rabies or dies during the 30-day observation period.	Positive	Administer PEP.
				Non-negative[3]	PEP may be indicated. Consult public health professional for rabies risk assessment.
				Negative (or animal successfully completes confinement)	PEP not indicated.
	Not available	N/A	N/A	N/A	PEP may be indicated. Consult public health professional for rabies risk assessment.

Table footnotes on next page

1. For animals that are not free-roaming, high-risk animals and are not exhibiting clinical signs of rabies at the time of the potential exposure, it is typically acceptable to delay decisions about PEP for a reasonable risk-weighted period, determined through consult with a public health professional, to allow the designated local authority, such as the LRCA, animal control, or sheriff, time to locate the animal for quarantine/confinement or testing.
2. Larger types of rodents (for example, beavers) may pose more of a rabies risk than small rodents.
3. "Non-negative" includes all specimens not suitable for testing (destroyed, decomposed, etc.).
4. Refer to Texas Administrative Code, Sections 169.27(e) and (h) or consult with the LRCA pertaining to exemptions to mandatory euthanasia and testing for certain high-risk animals that meet captivity parameters as specified in state law, in which case a 30-day observation period may be applicable in lieu of euthanasia and testing:
https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=169&rl=27
5. In incidents involving bats, PEP may be appropriate even in the absence of demonstrable bite, scratch, or mucous membrane exposure in situations in which there is reasonable probability that such exposure may have occurred (e.g., sleeping individual awakes to find a bat in the room, a person witnesses a bat in the room with a previously unattended child, mentally challenged person, or intoxicated individual, etc.).
6. The decision of whether a dog, cat, or domestic ferret should be quarantined or euthanized and tested rests with the LRCA.
7. The LRCA may allow home confinement if parameters specified in the Texas Administrative Code, Section 169.27(a) have been met:
https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=169&rl=27
8. The LRCA may authorize a 30-day observation period in lieu of testing.

Table 2. Rabies Postexposure Prophylaxis (PEP) Schedule, United States

From Centers for Disease Control and Prevention. *Use of a Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices (ACIP)*. *MMWR* 2010;59 (No. RR-2): 6. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5902a1.htm

Vaccination Status	Intervention	Regimen*
Not previously vaccinated	Wound cleansing	All PEP should begin with immediate thorough cleansing of all wounds with soap and water. If available, a virucidal agent (e.g., povidone-iodine solution) should be used to irrigate the wounds.
	Human rabies immune globulin (HRIG)	Administer 20 IU/kg body weight. If anatomically feasible, the full dose should be infiltrated around and into the wound(s), and any remaining volume should be administered at an anatomical site (intramuscular [IM]) distant from vaccine administration. Also, HRIG should not be administered in the same syringe as vaccine. Because HRIG might partially suppress active production of rabies virus antibody, no more than the recommended dose should be administered.
	Vaccine	Human diploid cell vaccine (HDCV) or purified chick embryo cell vaccine (PCECV) 1.0 mL, IM (deltoid area†), 1 each on days 0,§ 3, 7 and 14.¶
Previously vaccinated**	Wound cleansing	All PEP should begin with immediate thorough cleansing of all wounds with soap and water. If available, a virucidal agent such as povidone-iodine solution should be used to irrigate the wounds.
	HRIG	HRIG should not be administered.
	Vaccine	HDCV or PCECV 1.0 mL, IM (deltoid area†), 1 each on days 0§ and 3.

* These regimens are applicable for persons in all age groups, including children.

† The deltoid area is the only acceptable site of vaccination for adults and older children. For younger children, the outer aspect of the thigh may be used. Vaccine should never be administered in the gluteal area.

§ Day 0 is the day dose 1 of vaccine is administered.

¶ For persons with immunosuppression, rabies PEP should be administered using all 5 doses of vaccine on days 0, 3, 7, 14, and 28.

** Any person with a history of pre-exposure vaccination with HDCV, PCECV, or rabies vaccine adsorbed (RVA); prior PEP with HDCV, PCECV or RVA; or previous vaccination with any other type of rabies vaccine and a documented history of antibody response to the prior vaccination.

For immunocompetent patients not previously immunized, the recommended dose of HRIG would be given (refer to Table 2 for instructions), plus four 1.0 ml doses of HDCV or PCECV should be given intramuscularly (in the deltoid region) in adults or the anterolateral thigh in infants. Although it is recommended that the same product be used for all doses, there is no evidence of a decrease in effectiveness should a different product need to be used to complete a treatment regimen. The first dose should be given **as soon as possible after exposure;** the first day of administration is considered to be day "0." Additional doses should be given on days 3, 7, and 14 after the first dose. The spacing between doses represents the minimum interval to produce an effective antibody level as quickly as possible. The intervals should not be shortened or lengthened. If weekends or holidays preclude adhering to the schedule, lengthen an interval, but do not shorten it; it is important to obtain the first three injections within the first 14 days, but without reducing the stated interval between injections. Antibody response following the recommended vaccination regimen has been uniformly satisfactory; therefore, routine postvaccination serologic testing is not recommended by, nor available from, the DSHS.

For immunocompromised patients, in addition to HRIG (refer to Table 2 for instructions), five 1.0 ml doses of HDCV or PCECV should be given intramuscularly (in the deltoid region) in adults or the anterolateral thigh in infants on days 0, 3, 7, 14, and 28. One to two weeks after the PEP regimen is completed, a rabies titer test is recommended.

Every attempt should be made to adhere to the recommended vaccination schedules. Once vaccination is initiated, delays of a few days for individual doses are unimportant, but the effect of longer lapses of weeks or more is unknown. Most interruptions in the vaccine schedule do not require reinitiation of the entire series. For most minor deviations from the schedule, vaccination can be resumed as though the patient were on schedule. For example, if a patient misses the dose scheduled for day 7 and presents for vaccination on day 10, the day 7 dose should be administered that day and the schedule resumed, maintaining the same interval between doses. In this scenario, the remaining dose would be administered on day 17 (or days 17 and 31 for immunocompromised patients receiving a 5th dose).

The selection of sites for intramuscular injections appears to be critical for vaccine efficacy. Again, in adults and larger children, HDCV or PCECV should be given in the deltoid area. In infants and small children, the anterolateral thigh may be used. In the two laboratory- confirmed human cases of rabies following PEP with HDCV and HRIG within 24 hours, HDCV was administered in the gluteal area. Presumably, subcutaneous fat in the gluteal area may interfere with the immunogenicity of the vaccine.

The HRIG is administered only once, at the beginning of PEP, to provide passive immunity until the patient responds to the vaccine by active production of antibodies. Complete prophylaxis, including HRIG in a non-immunized person, should still be administered even if months have lapsed between the possible exposure and its recognition. If HRIG was not given when rabies vaccination was begun, it can be given up to the eighth day after the first dose of vaccine was given. From the eighth day (Day 7 of the formal treatment regimen) on, HRIG is not indicated because an antibody response to the vaccine is presumed to have occurred. For example, if the Day 0 rabies vaccine dose was given on March 10th, HRIG should not be given after March 17th.

The recommended dose of HRIG is 20 IU/kg of body weight. The dosage should be calculated carefully based on the patient's current body weight as two different formulations of HRIG are available in the US: 150 IU/ml and 300 IU/ml. The HRIG may partially suppress the active production of antibodies; therefore, no more than the recommended dose of HRIG should be given. As much as possible of the full dose of HRIG should be thoroughly infiltrated into and around the wound(s). Any remaining dosage of HRIG should be administered IM in the closest muscle mass of suitable size to accommodate the

remaining volume, with the caveat that **it should not be administered in the same syringe or in the same anatomic site as the first vaccine dose** (subsequent doses of vaccine in the series—i.e. days 3, 7, and 14—can be administered in the same anatomic location in which HRIG was administered). The HRIG should be injected into muscle, not adipose tissue. For this reason, it is recommended that HRIG not be injected into the gluteal area. If the gluteal area is used, particular care should be taken to assure IM injection. (Note: human immune globulin used to treat hepatitis cannot be substituted for HRIG.)

Additional guidelines on vaccine administration are in the *ACIP General Recommendations on Immunization* (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm).

For dealing with more significant deviations to the PEP regimen, contact the Texas DSHS Zoonosis Control Branch (refer to contact information at the end of this document) or the Centers for Disease Control and Prevention (https://www.cdc.gov/vaccines/vpd/rabies/hcp/index.html).

In unusual instances, such as when the patient is immunodeficient or immunosuppressed, serologic testing (Rapid Fluorescent Focus Inhibition Test - RFFIT) is indicated one to two weeks after completing the rabies postexposure vaccination series.

These are laboratories* that provide the rabies RFFIT:

Rabies Laboratory
Kansas State University
2005 Research Park Circle
Manhattan, KS 66502
Phone: 785-532-4483
Email: rabies@vet.k-state.edu
www.vet.ksu.edu/rabies

Atlanta Health Associates
309 Pirkle Ferry Rd. Suite D300
Cumming, GA 30040
Phone: 800-717-5612
Email: info@atlantahealth.net
www.atlantahealth.net

Maryland Department of Health
ATTENTION: ACCESSIONING RABIES/RFFIT TITER TESTING
1770 Ashland Ave.
Baltimore, MD 21205
Phone: 443-681-3773
https://health.maryland.gov/laboratories/Pages/Rabies.aspx

One Health-Rabies Laboratory
University of Missouri
901 E. Campus Loop
Columbia, MO 65211
Phone: 573 882-3646
Email: muvmdlrabies@missouri.edu
https://vmdl.missouri.edu/one-health-rabies/

* Please note that the DSHS has no affiliation with these RFFIT laboratories; the contact information is being provided only as a helpful courtesy.

TREATMENT OUTSIDE THE UNITED STATES

If PEP is begun outside the United States with locally produced biologicals, it may be desirable to provide additional treatment, including restarting PEP with products licensed for use in the US, when the patient

reaches the US. For specific advice in such cases, contact the Regional Zoonosis Control office for your area (refer to the Zoonosis Control contact section at the end of this document). You may also refer to the World Health Organization (Rabies -- Zero deaths by 2030 (who.int)) or the Centers for Disease Control and Prevention (https://www.cdc.gov/vaccines/vpd/rabies/index.html).

PREEXPOSURE VACCINATION

Preexposure vaccinations are given for several reasons. First, it may provide protection to people with inapparent exposures to rabies. Second, it may protect persons whose postexposure therapy might be delayed. This is of particular importance for people at high risk of being exposed in countries where the rabies biologicals may be difficult to obtain. Also, although it does not eliminate the need for additional therapy after a rabies exposure, it simplifies postexposure therapy by eliminating the need for HRIG and decreasing the number of doses of rabies vaccine required. The guidelines for evaluating the risk categories for preexposure immunization and recommended schedules for vaccinations and titer checks are found in **Table 3**.

TABLE 3. Rabies Preexposure Prophylaxis Recommendations — United States, 2022

				Recommendations	
Risk category	**Nature of exposure**	**Typical population***	**Relevant disease biogeography†**	**Primary PrEP§ immunogenicity**	**Long-term immunogenicity¶**
1. Elevated risk for unrecognized** and recognized†† exposures including unusual or high-risk exposures	Exposure, often in high concentrations, might be recognized or unrecognized, might be unusual (e.g., aerosolized virus)	Persons working with live rabies virus in research or vaccine production facilities or performing testing for rabies in diagnostic laboratories	Laboratory	IM rabies vaccine on days 0 and 7	Check titers every 6 months; booster if titer <0.5 IU/mL§§
2. Elevated risk for unrecognized** and recognized†† exposures	Exposure typically recognized but could be unrecognized; unusual exposures unlikely	Persons who frequently 1) handle bats, 2) have contact with bats, 3) enter high-density bat environments, or 4) perform animal necropsies (e.g., biologists who frequently enter bat roosts or who collect suspected rabies samples)	All geographic regions where any rabies reservoir is present, both domestic and international	IM rabies vaccine on days 0 and 7	Check titers every 2 years; booster if titer <0.5 IU/mL§§
3. Elevated risk for recognized†† exposures, sustained risk¶¶	Exposure nearly always recognized; risk for recognized exposures higher than that for the general population and duration exceeds 3 years after the primary vaccination	Persons who interact with animals that could be rabid***; occupational or recreational activities that typically involve contact with animals include 1) veterinarians, technicians, animal control officers, and their students or trainees; 2) persons who handle wildlife reservoir species (e.g., wildlife biologists, rehabilitators, and trappers); and 3) spelunkers	All domestic and international geographic regions where any rabies reservoir is present	IM rabies vaccine on days 0 and 7	1) One-time titer check during years 1–3 after 2-dose primary series; booster if titer <0.5 IU/mL,§§ or 2) booster no sooner than day 21 and no later than year 3 after 2-dose primary series†††
		Selected travelers. PrEP considerations include whether the travelers 1) will be performing occupational or recreational activities that increase risk for exposure to potentially rabid animals (particularly dogs) and 2) might have difficulty getting prompt access to safe PEP (e.g., rural part of a country or far from closest PEP clinic)	International geographic regions with rabies virus reservoirs, particularly where rabies virus is endemic in dog populations		
4. Elevated risk for recognized†† exposures, risk not sustained¶¶	Exposure nearly always recognized; risk for exposure higher than for general population but expected to be time-limited (≤3 years from the 2-dose primary PrEP vaccination series)	Same as for risk category 3 (above), but risk duration ≤3 years (e.g., short-term volunteer providing hands-on animal care or infrequent traveler with no expected high-risk travel >3 years after PrEP administration)	Same as for risk category 3 (above)	IM rabies vaccine on days 0 and 7	None
5. Low risk for exposure	Exposure uncommon	Typical person living in the United States	Not applicable	None	None

Table footnotes on next page

Abbreviations: IM = intramuscular; IU = international units; PEP = postexposure prophylaxis; PrEP = preexposure prophylaxis.

* Nature of exposure and type of work performed are the most important variables to consider when determining a person's risk category. The examples provided are intended to be a guide, but ultimately categorizations should be done on a case-by-case basis with nature of exposure considered. Some persons might be categorized into a different risk group from those suggested by the provided examples. For example, most veterinarians are in risk category 3 because they are at risk for recognized exposures after direct contact with animals. However, a veterinary pathologist who often performs necropsies on mammals suspected to have had rabies might have risk for rabies virus exposure that is more consistent with risk category 2 than risk category 3; such persons should follow the recommendations for the risk category with which their activities best fit. Similarly, most spelunkers do not often enter high-density bat caves; those who do may follow the recommendations for risk category 2 rather than risk category 3. Persons involved in the diagnosis of rabies virus, but for whom the frequency of handling rabies virus–infected tissues is low, or the procedures performed do not involve contact with neural tissue or opening of a suspected rabid animal's calvarium could consider following the recommendations for risk category 2 rather than those for risk category 1.

† Local or state health departments should be consulted for questions about local disease biogeography.

§ Primary immunogenicity refers to immunogenicity that peaks 2–4 weeks after completing the recommended primary vaccination schedule. **Immunocompetent** persons are expected to mount appropriate responses, and checking titers is not routinely recommended. Persons with **primary or secondary immunodeficiency** are advised to confirm, through laboratory testing, a rabies antibody titer ≥0.5 IU/mL ≥1 week after booster vaccination (but ideally, 2–4 weeks after completing the recommended schedule) and before participating in high-risk activities. Individual laboratories set facility-specific rules about whether acceptable antibody titers should be laboratory-confirmed for all personnel, regardless of whether personnel have altered immunity.

¶ Long-term immunogenicity refers to the ability to mount an anamnestic response to rabies virus >3 years after completion of the primary rabies vaccination series.

** Unrecognized exposures are those that recipients might not know occurred; for example, a small scratch during an inconspicuous personal protective equipment breach might not be noticed by persons testing neural tissue from a rabid animal or persons conducting ecologic studies on bats in the field.

†† Recognized exposures are bites, scratches, and splashes that are usually registered by a person because the exposure is unusual (e.g., contact with a bat) or painful (e.g., bite or scratch from a raccoon).

§§ When rabies antibody titers are <0.5 IU/mL, a booster vaccination should be provided. Antibody titers to verify booster response need not be checked after these boosters are administered to persons who are immunocompetent. For persons who are immunocompromised, the indicated antibody titer should be verified ≥1 week (ideally, 2–4 weeks) after administration of every booster vaccination.

¶¶ Sustained risk is elevated risk for rabies >3 years after the completion of the primary rabies PrEP vaccination schedule.

*** Rabies virus is unlikely to persist outside a deceased animal's body for an extended time because of virus inactivation by desiccation, ultraviolet irradiation, and other factors. Risk from transmission to persons handling animal products (e.g., hunters and taxidermists) is unknown but presumed to be low (risk category 5); direct skin contact with saliva and neural tissue of mammals should be avoided regardless of profession.

††† Checking titers after recommended booster doses is not indicated unless the recipient has altered immunity.

Bolded language in the Table 3 footnotes has been modified to better align with text in the associated *MMWR* article cited below.

Table 3 and footnotes from:
Centers for Disease Control and Prevention. Use of a Modified Preexposure Prophylaxis Vaccination Schedule to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022. *MMWR*. 2022;71(18):619-627.

Again, preexposure vaccinations do not eliminate the need for prompt PEP following an exposure; it only reduces the extent of the postexposure regimen.

Vaccination Schedule

For preexposure immunization, two 1.0 ml injections of HDCV or PCECV should be given intramuscularly (IM) in the deltoid area, one each on days 0 and 7 (the first day of administration is considered to be day "0") (**Table 3 and Table 4**). Recommended booster or serology schedules based on exposure risk categories are provided in **Table 3**. The addresses and phone numbers of laboratories offering rabies serologic testing can be found in the **RABIES POSTEXPOSURE PROPHYLAXIS (PEP) FOR HUMANS** section.

If possible, immunosuppressed patients should postpone rabies preexposure prophylaxis until the immunocompromising condition is resolved. When postponement is not possible, immunosuppressed persons who are at risk for rabies should have their virus-neutralizing antibody responses checked 2 to 4 weeks after completing the 2-dose preexposure series and all booster doses.

Postexposure Therapy of Previously Immunized Persons

When an immunized person who was vaccinated according to the recommended preexposure or postexposure regimen with HDCV or PCECV, or who has previously demonstrated rabies antibody, is exposed to rabies, that person should receive two IM doses (1.0 ml each) of HDCV or PCECV, one each

on days 0 and 3 (**Table 2**). The HRIG should **not** be given in these cases. If the immune status of a previously vaccinated person who did not receive the recommended HDCV or PCECV regimen is not known, full primary PEP (HRIG plus five doses of HDCV or PCECV) may be necessary.

Table 4. Rabies preexposure vaccination schedule

Type of vaccination	Route	Regimen
Primary	IM	HDCV or PCECV, 1.0 ml (deltoid area), one each on days 0 and 7
Booster*	IM	HDCV or PCECV, 1.0 ml (deltoid area); booster may not be indicated depending on recommendation for risk category (refer to Table 3 for details)

* Administration of a booster dose of vaccine depends on exposure risk category and serologic testing results as noted in Table 3.

HDCV or PCECV can be used for PEP or booster vaccinations even if another vaccine was used for the initial preexposure vaccination.

ADVERSE REACTIONS

Serious adverse reactions associated with rabies vaccines include systemic, anaphylactic, and neuroparalytic reactions. Serious adverse reactions occur at lower rates with the rabies vaccines currently used in the USA than with those used previously.

HDCV

Local and systemic reactions may occur with the use of HDCV. In a study using five doses of HDCV, local reactions, such as pain, erythema, and swelling or itching at the injection site, were reported in about 25% of recipients. Mild systemic reactions, such as headache, nausea, abdominal pain, muscle aches, and dizziness, were reported in about 20% of recipients.

Up to 6% of persons receiving booster doses of HDCV may experience “immune complex-like” reactions (type III IgG mediated hypersensitivity reactions). The illness, characterized by onset 2-21 days post-vaccination, presents with generalized urticaria and may also include arthralgia, arthritis, angioedema, nausea, vomiting, fever, and malaise. No life-threatening cases of "immune complex-like" illness have been reported. This phenomenon rarely occurs with primary immunization with HDCV. The origin of these "immune complex-like" reactions has been attributed to sensitization to the beta-propiolactone-treated human serum albumin present in HDCV.

Those persons with a history of "immune complex-like" illness following HDCV and who must receive rabies vaccine boosters may be candidates for other rabies vaccines which do not have beta-propiolactone bound to human serum albumin. If this is not possible and HDCV must be given, the guidelines in the **Management of Adverse Reactions** section should be followed.

PCECV

As with HDCV, local reactions such as swelling, induration, and reddening have been associated with the administration of PCECV. Systemic allergic reactions are also possible and have been reported.

HRIG

Local pain and low-grade fever may follow receipt of HRIG. Although not reported specifically for HRIG, angioneurotic edema, nephrotic syndrome, and anaphylaxis have been reported after injection of other types of immune globulin (IG). These reactions occur so rarely that a causal relationship between IG and these reactions is not clear.

Management of Adverse Reactions

Once initiated, PEP should not be interrupted or discontinued because of local or mild systemic adverse reactions to rabies vaccine. Usually, such reactions can be successfully managed with anti-inflammatory and antipyretic agents.

When a person with a history of hypersensitivity must be given rabies vaccine, antihistamines may be given. Epinephrine should be readily available to counteract anaphylactic reactions, and the person should be observed for 15 minutes after vaccination.

Serious systemic anaphylactic or neuroparalytic reactions occurring during the administration of rabies vaccine pose a serious dilemma for the attending physician. A patient's risk of developing rabies must be carefully considered before deciding to discontinue vaccination. Moreover, the use of corticosteroids to treat life-threatening neuroparalytic reactions carries the risk of inhibiting the development of active immunity to rabies. It is especially important in these cases that the serum of the patient be tested for rabies antibodies after completion of the PEP course. Advice and assistance on the management of serious adverse reactions in persons receiving rabies vaccines may be sought from the DSHS Emerging and Acute Infectious Disease Unit (512-776-7455 or 512-776-7676).

All adverse events or reactions to a rabies vaccine should be reported to the Vaccine Adverse Event Reporting System (VAERS); additional information and forms can be obtained at http://vaers.hhs.gov/.

PRECAUTIONS AND CONTRAINDICATIONS

Immunosuppression

Corticosteroids, other immunosuppressive agents, and immunosuppressive illnesses (such as HIV infection and cancer) can interfere with the development of active immunity and predispose the patient to developing rabies. Immunosuppressive agents should not be administered during PEP, unless essential for the treatment of other conditions. When PEP is administered to persons receiving corticosteroids or other immunosuppressive therapy, or to persons having an immunosuppressive illness, it is especially important that the person receive a 5th dose of vaccine on day 28 (if the person is not previously immunized) and that serum be tested for rabies antibody 7-14 days after the 5th dose to ensure that an adequate response has developed. Information on the laboratories that offer rabies serologic testing is found in the **RABIES POSTEXPOSURE PROPHYLAXIS (PEP) FOR HUMANS** section.

Pregnancy

Fetal abnormalities have not been associated with rabies vaccination. Due to the consequences of an inadequately treated rabies exposure, pregnancy is not considered a contraindication to PEP. If a substantial unavoidable risk of exposure to rabies exists, preexposure prophylaxis may also be indicated during pregnancy.

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DISTRIBUTION POINTS FOR HUMAN RABIES BIOLOGICALS

Note: If seeking rabies biologicals, please contact the distribution points BEFORE sending anybody directly to the office listed.

PUBLIC HEALTH REGION 1

Regional Office - Lubbock
6302 Iola Avenue
Lubbock, Texas 79424
Phone: (806) 783-6422 or (806) 744-3577
Fax: (806) 783-6466
Hours: 8:00 a.m. - 5:00 p.m. Monday-Friday
Contact: Christi Olszewski, LVT
Regional Veterinarian – Cherissa Abdul Hamid, DVM, MPH - 806-783-6482

Regional Office - Amarillo
3407 Pony Express Way
Amarillo, Texas 79118
Phone: (806) 477-1104
Fax: (806) 373-4758
Hours: 8:00 a.m. - 5:00 p.m. Monday-Friday
Contact: Tonya Finch
Regional Veterinarian – Cherissa Abdul Hamid, DVM, MPH - 806-783-6482

PUBLIC HEALTH REGION 2/3

Regional Office, Public Health Region 3
Chase Bank Building, Second Floor, Ste 200
1301 South Bowen Road
Arlington, Texas 76013
Hours: 8:00 am - 5:00 pm Monday-Friday **Consultations only. No Human Rabies Biologicals stocked or distributed from this location.**
Contact: Shannon Medrano
Email: Shannon.Medrano@dshs.texas.gov
Phone: (817) 264-4920
After Hours: (817) 822-6786 Fax: (817) 264-4925

Abilene Taylor Public Health District
850 N Sixth St
Abilene, Tx 79601
Hours: 8:00-5:00 Monday – Friday
Contact: Barbara Waldon (Primary Contact)
Email: barbara.waldon@abilenetx.gov
Phone: (325) 692-5600 (Main Line) or (325) 721-9454 (After Hours)
Fax: (325) 734-5370

Brownwood-Brown County Health Department
510 East Lee
Brownwood, Texas 76801
Hours: 7:30 a.m. - 6:00 p.m. Monday – Friday (closed 12:00 – 1:00 p.m.)
Contact: Sarah Dunham, CCMA or Jennifer Williams, LVN
Email: sdunham@brownwoodtexas.gov or jlwilliams@brownwoodtexas.gov
Phone: (325) 646-0554
Fax: (325) 643-3591

Collin County Healthcare Services
825 N. McDonald, Ste. 130 McKinney, Texas 75069
Hours: 8:00 a.m. – 11:00 a.m. and 1:00 p.m. – 4:00 p.m. Monday - Friday
Email: epifax@co.collin.tx.us
Phone: 972-548-4707 (Best Option)
After Hours: (972) 547-5350
Fax: (972) 548-4436

Contact: Daphne Lynch
Email: dlynch@co.collin.tx.us
Phone: 972-548-5596

Denton County Health Department
535 S. Loop 288
Denton, Texas 76205
Hours: 8:00 a.m. – 4:30 p.m. Monday – Friday (closed 12:00 – 1:00 p.m.)
Contact: Sonia Ninan
Email: sonia.ninan@dentoncounty.gov
Phone: (940-349-2909)
Fax: (940) 349-5078

Grayson – County Health Department
515 N. Walnut Street
Sherman, Texas 75090
Hours: 8:00 a.m. – 4:30 p.m. Monday – Friday (closed 12:00 p.m. – 1:00 p.m.)
Contact: Jeff Lillis
Phone: (903) 893-0131 X 1339
Email: lillisj@co.grayson.tx.us

Grayson – County Health Department - continued
Contact: Amanda Ortez
Phone: (903) 893-0131 X 1223
Email: orteza@co.grayson.tx.us
Contact: Ali Farmer
Phone: (Office) (903) 893-0131 X 1236 (Cell) 903-821-9887
Email: farmera@co.grayson.tx.us
Phone: (903) 893-0131
Fax: (903) 870-2023

Wichita Falls – Wichita County Public Health District

1700 Third Street
Wichita Falls, Texas 76301
Hours: 8:00 a.m. - 5:00 p.m. Monday-Friday
Contact: Alaina Vallier, RN
Email: alaina.vallier@wichitafallstx.gov
Phone: (940) 761-7827
Contact: Regina Mini
Email:regina.mini@wichitafallstx.gov
Phone: (940) 761-7844
Fax: (940) 761-7659

PUBLIC HEALTH REGION 4/5N

Regional Office
2521 West Front Street
Tyler, Texas 75702
Phone: (903) 533-5212
Fax: (903) 533-9502
Hours: 8:00 a.m. - 5:00 p.m. Monday-Friday (Consultations only. No Human Rabies Biologicals stocked or distributed.)
Contact: Amanda Hunt (903) 574-3803

PUBLIC HEALTH REGION 6/5S

Regional Office
5425 Polk Ave, Suite J
Houston, Texas 77023
Phone: (713) 767-3300
Fax: (713) 767-3193
Hours: 8:00 a.m. - 5:00 p.m. Monday-Friday
Contact: Zoonosis Control (713) 767-3300

Beaumont Public Health Department
3040 College Street
Beaumont, Texas 77701
(409) 832-4000 (Main Line)
Monday - Friday 8am-5pm
Contacts (cont. on next page):
Mary Alexander, RN
Clinical Nurse Manager
(409) 654-3625 (Office)
(409) 651-2193 (Cell)
mary.alexander@beaumonttexas.gov
Loretta Juneau
Vaccine Coordinator
(409) 654-3627 (Office)
loretta.juneau@beaumonttexas.gov

PUBLIC HEALTH REGION 7

Regional Office
1010 Old Waco Road (New address effective 02/01/2026)
Temple, TX 76502
Phone: (254) 771-6784
Fax: (254) 771-2662
Hours: 7:30 am – 4:00 pm Monday-Friday (Consultations only. No Human Rabies Biologicals distributed.)
Contact: Zoonosis Control Program

PUBLIC HEALTH REGION 8

Regional Office
7430 Louis Pasteur
San Antonio, TX 78229
(210) 949-2000
24/7 Reporting Line: 210-949-2121
Fax: (210) 692-1457
Contact: Amanda Kieffer, DVM, MPH, DACVPM
E-MAIL: Amanda.Kieffer@dshs.texas.gov

San Antonio Metro Health District
210 N Mel Waiters Way
San Antonio, TX 78207
Phone: (210) 207-2095
Hours: M-F 8:00am-3:00pm
Contact: Rabies Surveillance Nurse

Victoria County Public Health Department
2805 North Navarro
Victoria, TX 77901
Phone (361) 578-6281
Contact: Public Health Nursing

Field Office – Maverick County
1593 Veterans Blvd.
Eagle Pass, Texas 78852
Phone: (830) 758-4253 / 210-949-2121
Contact: Immunizations Nurse

Field Office - Val Verde County
173 Wildcat Drive
Del Rio, Texas 78840
Phone: (830) 768-2800 / 210-949-2121
Contact: Immunizations Nurse

Field Office – Uvalde County
112 Joe Carper Drive
Uvalde, Texas 78801
Phone: 210-949-2121
Contact: Zoonosis Control

PUBLIC HEALTH REGION 9/10

Regional Office
1101 N Midland Dr.
Midland, Texas 79703
Phone: (432) 571-4118
Fax: (432) 689-0451
Contact: Kelly Spencer

PUBLIC HEALTH REGION 11

Regional Office
601 West Sesame Drive
Harlingen, Texas 78550
Phone: (956) 444-3212
Fax: (956) 444-3216
Hours: 8:00 a.m. - 5:00 p.m. Monday-Friday
Contact: Letty Tamayo – ext. 3212
After Hours: (956) 421-5559

ZOONOSIS CONTROL -
TEXAS DEPARTMENT OF STATE HEALTH SERVICES

PUBLIC HEALTH REGION 1

6302 Iola Avenue
Lubbock, Texas 79424
(806) 783-6422 or (806) 744-3577 main
Fax: (806) 783-6466
Cherissa Abdul Hamid, DVM, MPH – Zoonosis Control Veterinarian - 6482
Christi Olszewski, LVT – Program Specialist - 6422
E-MAIL: Cherissa.AbdulHamid@dshs.texas.gov

AMARILLO OFFICE
3407 Pony Express Way
Amarillo, Texas 79118
Phone: (806) 477-1104
Fax: (806) 373-4758
Tonya Finch – Public Health and Prevention Specialist
E-MAIL: Tonya.Finch@dshs.texas.gov
Cherissa.AbdulHamid@dshs.texas.gov

PUBLIC HEALTH REGION 2/3

1301 South Bowen Road, Suite 200
Arlington, Texas 76013
(817) 264-4920
Fax: (817) 264-4925
After hours: (817) 822-6786
Annajane (Aj) Marlar, DVM, MRCVS, DACVO – Zoonosis Control Veterinarian – 4529
Mason Bird – Zoonosis Control Specialist – 4922
Nicholas Ferguson – Zoonosis Control Specialist – 4665
Jessica Kirkland – Zoonosis Control Specialist – 4923
Shannon Medrano – Public Health and Prevention Specialist
E-MAIL: HSR2-3.ZoonoticReporting@dshs.texas.gov
E-MAIL: Annajane.Marlar@dshs.texas.gov

PUBLIC HEALTH REGION 4/5N

2521 West Front Street
Tyler, Texas 75702
(903) 533-5212
Fax: 903-533-9502
Brent Moore, DVM, MS, MPH, DACVPM - Zoonosis Control Veterinarian - 5243
Samantha Puttick – Zoonosis Control Specialist – 5260
Amanda Hunt – Public Health and Prevention Specialist
E-MAIL: Brent.Moore@dshs.texas.gov

PUBLIC HEALTH REGION 6/5S

5425 Polk Avenue, Suite J
Houston, Texas 77023-1497
(713) 767-3300
Fax: (713) 767-3193
Brendan Sullivan, DVM, MPH – Zoonosis Control Veterinarian -3302
Jael Miller – Zoonosis Control Specialist – 3303
Sharlyn Rodriguez Purcell – Zoonosis Control Specialist – 3301
Krista Ochoa, MPH – Program Specialist - 3180
Brittany Singletary – Public Health and Prevention Specialist
E-MAIL: Brendan.Sullivan@dshs.texas.gov

PUBLIC HEALTH REGION 7

1010 Old Waco Road (New address effective 02/01/2026)
Temple, TX 76502
(254) 771-6784
Fax: (254) 771-2662
David Smonko, DVM – Zoonosis Control Veterinarian - 6789
Amber Frenzel, MPH – Zoonosis Control Specialist – 6762
Jay Leivdal, MS – Zoonosis Control Specialist – 6708
Melissa D. Maass, LVT – Zoonosis Control Specialist - 6749
Makenzie Garcia – Public Health & Prevention Specialist
E-MAIL: David.Smonko@dshs.texas.gov

PUBLIC HEALTH REGION 8

7430 Louis Pasteur
San Antonio, TX 78229
(210) 949-2000
24/7 Reporting Line: 210-949-2121
Fax: (210) 692-1457
Amanda Kieffer, DVM, MPH, DACVPM – Zoonosis Control Veterinarian – 2048
Rachel Panneton, MPH – Public Health & Prevention Specialist, 2165
Jonathan Stewart, MPH - Zoonosis Control Specialist - 2046
E-MAIL: Amanda.Kieffer@dshs.texas.gov
Region8.Zoonosis@dshs.texas.gov

PUBLIC HEALTH REGION 9/10

401 E Franklin St, Suite 210
El Paso, Texas 79901-1206
(915) 834-7780
Fax: (915) 834-7800
Susan Schaff, DVM, MPH – Zoonosis Control Veterinarian – 7782
Veronica Suarez, MS – Zoonosis Control Specialist
E-MAIL: Susan.Schaff@dshs.texas.gov
R9-10.Zoo@dshs.texas.gov

MIDLAND OFFICE
1101 N Midland Drive
Midland, Texas 79703
(432) 571-4118
Fax: (432) 571-4162
Kelly Spencer - Zoonosis Control Specialist
E-MAIL: Kelly.Spencer@dshs.texas.gov
R9-10.Zoo@dshs.texas.gov

PUBLIC HEALTH REGION 11

601 West Sesame Drive
Harlingen, Texas 78550
(956) 444-3212
Fax: (956) 444-3216
After hours: 956-421-5559
Ronald Tyler, DVM, MS – Zoonosis Control Veterinarian - 3222
Vacant – Zoonosis Control Specialist - 3221
Letty Tamayo, MS – Public Health and Prevention Specialist
E-MAIL: Ronald.Tyler@dshs.texas.gov

ZOONOSIS CONTROL BRANCH - CENTRAL OFFICE

Mail Code 1956
P.O. Box 149347
Austin, Texas 78714-9347
(512) 776-7676
Fax: (512) 776-7454

Physical:
1100 West 49th Street
Austin, Texas 78756

888-963-7111

Susan Rollo, MS, DVM, PhD, DACVPM – Branch Manager/State Public Health Veterinarian – 3306
Eric Fonken, DVM, MPAff – Assistant State Public Health Veterinarian – 512-922-8419
Amira Bashadi, MPH – Epidemiologist - 3791
Kelly Broussard, MPH – Epidemiologist – 6920
Emily Cavasos – Public Health & Prevention Specialist -2790
Colleen Cook, MS – Program Specialist -3520
Kaley Dzienowski – Staff Services Officer - 6001
Maria Hernandez – Program Specialist - 2279
Patrick Hunt - Program Specialist - 6270
Leigh-Anne Lawton, MS – Entomologist – 713-767-3276
Bonny Mayes, MA – Epidemiologist – 512-221-6850
Briana O'Sullivan, MPH – Epidemiologist - 7255
Kamesha Owens, MPH – Program Specialist - 2914
Kathy Parker, MPH – Program Specialist – 512-705-2947
Pam Wilson, DrCH, MEd, LVT, MCHES - Program Specialist – 6622
Agency Cell Phone, (512) 662-3234
E-MAIL: Susan.Rollo@dshs.texas.gov