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Infectious Diseases Quarterly

Surveillance of invasive *Haemophilus influenzae* disease: Serotype and Vaccination History Needed, Please!

by Lisa M. Lane, M.S., General Infectious Disease Surveillance

Haemophilus influenzae is a bacterium that can lead to invasive diseases including meningitis, epiglottitis, arthritis and cellulitis. Invasive *Haemophilus influenzae* type b (Hib) disease is vaccine preventable, and prior to the introduction of an effective vaccine, was the leading cause of bacterial meningitis among children less than 5 years of age in the United States.[1] The first Hib conjugate vaccine was introduced to infants in 1987 and added to the U.S. Recommended Childhood Immunization Schedule in 1991. Since this recommendation, the incidence of invasive Hib disease has greatly declined. [1]

A recent media dispatch highlighted an outbreak of invasive Hib disease among children less than 5 years of age in the State of Minnesota. Public health officials determined the outbreak was not the result of direct or secondary transmission of the disease among the five cases. Nonetheless, a joint investigation between the Minnesota Department of Public Health and the Centers for Disease Control and Prevention's (CDC) Division of Immunization and Respiratory Diseases did reveal an outbreak.

State and federal public health officials involved in the investigation were concerned that the interim recommendations issued by CDC in December 2007 to temporarily defer the booster dose of Hib-containing vaccine routinely administered to children 12 to 15 months of age, may have led to the children not being fully immunized—hence, at increased risk for invasive Hib disease. The current interim recommendation was a decision of CDC, in consultation with the Advisory Committee on Immunization Practices, the American Academy of Family Physicians and the American Academy of Pediatrics, due to a reduction in production by one of the Hib-containing vaccine manufacturers. The recommendation to health care providers was made to ensure vaccine availability so children could complete their primary vaccination series (either two or three doses), beginning at 2 months of age, until the vaccine supply improves. It should be mentioned that the temporary deferral does not apply to children at high risk of Hib disease (e.g., children with a chronic disease or immune system suppression).

Inside this issue:

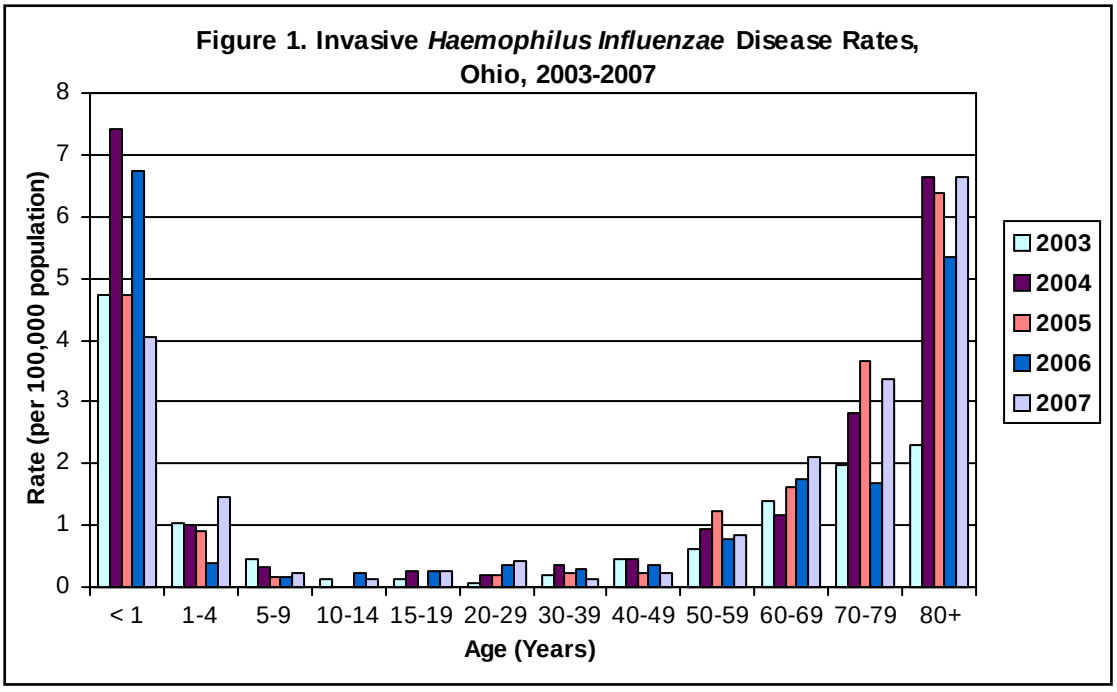
Methicillin-resistant *Staphylococcus aureus*, Zoonotic Transmission and Companion Animals	4
Hospital Performance Measures Reporting – Infection Control	6
Ticks and Tick-borne Disease in Ohio 2009	8
Summary of STDs	10
Summary of HIV/AIDS Cases	10
Summary of TB Cases	10
Quarterly Statistics	11
Announcements	12
Contact Information	14

Surveillance of invasive *Haemophilus influenzae* disease: Serotype and Vaccination History Needed, Please!—continued

Closer examination of the vaccination histories of the five Minnesota children uncovered three children were unvaccinated (i.e., met age requirements to have received all recommended doses, but received none) due to parental exemptions to vaccine; one child was too young to have received all doses in the primary series; and one child was fully vaccinated but was discovered to have a medical condition resulting in immune system suppression. The invasive Hib death occurred in one of the three unvaccinated children.

In Ohio, all invasive *Haemophilus influenzae* (*H. influenzae*) disease is reportable pursuant to Ohio Administrative Code 3701-3, regardless of serotype or age. Invasive disease refers to the bacterium being isolated from a normally sterile site such as blood, cerebral spinal fluid, joint fluid or pleural fluid. Reports of (only) invasive disease are to be made to the local public health jurisdiction where the patient resides by the close of the next business day after the case, suspected case and/or positive laboratory result is known.

The incidence of invasive *H. influenzae* disease in Ohio has averaged around 100 cases per year since 2003 [range 78 (2003) to 108 (2007)]. [2] The good news is that Ohio usually sees 15 or fewer cases of invasive *H. influenzae* reported among children less than 5 years of age each year. The bad news is the burden of disease is greater among this age group than any other except the elderly. As Figure 1 demonstrates, only those in age groups 60 years and older have a greater burden of disease.



To make matters more challenging, very few invasive *H. influenzae* cases in Ohio report a serotype. Since 2003, Ohio has seen fewer than five confirmed cases of invasive Hib disease reported among children less than 5 years of age. It is unknown how many of those cases reported without a serotype may be attributable to type b disease. In addition, the percentage of cases among children less than 5 years of age reporting a vaccination history ranged from 26 to 57 percent from 2003-2007. The lack of a reported vaccination history does not indicate 43 to 74 percent of reported cases were not vaccinated; it means the information was not reported, not requested or unavailable.

This brief overview of Ohio's surveillance data should reveal two things. First, we do not know the true burden of invasive Hib disease among Ohio's children. For this reason, it is important to determine the serotype, even if it is

Surveillance of invasive *Haemophilus influenzae* disease: Serotype and Vaccination History Needed, Please!—continued

later discovered to be non-type b or otherwise not typeable. The identification and reporting of serotypes is important for the detection of disease clusters and monitoring the changing epidemiology of invasive *H. influenzae* disease at the local, state and national levels. Second, reporting vaccination history is equally important, as without this key information, we do not know if reported cases of invasive Hib disease were vaccinated or not. This information helps CDC's Division of Immunization and Respiratory Diseases monitor vaccine efficacy and policy recommendations.

The Ohio Department of Health (ODH) asks for assistance from our local public and private sector health partners and colleagues to improve the reporting of invasive *H. influenzae* disease. This can be accomplished in two key ways: 1) Save bacterial isolates for serotyping and report the results. This is especially important on invasive *H. influenzae* cases reported among children less than 5 years of age; and 2) Ascertain and report the number of doses of Hib-containing vaccine for all cases among children less than 5 years of age. This is important information regardless of the serotype identified. All local public health departments in Ohio and certain hospitals can enter serotype results and vaccination history of the case directly into the Ohio Disease Reporting System (ODRS). ODRS is a disease surveillance system that is compliant with CDC's Public Health Information Network and serves as Ohio's version of CDC's Nationally Notifiable Disease Surveillance System.

Finally, Ohio health care providers (e.g., physicians, nurses and hospitals) are reminded to work directly with their local public health department to submit bacterial isolates to ODH Laboratory for serotyping. With a statewide average of 15 or fewer cases of invasive *H. influenzae* reported per year among this key age group, the burden of reporting should be minimal. Local health departments are reminded to first contact the ODH Immunization Program at (614) 466-4643 if they have a *H. influenzae* isolate from a normally sterile site to submit for serotyping.

With your help, we can get a clearer picture of the burden this serious disease has on the children of Ohio so disease prevention efforts can target appropriate public health interventions.

For more information on:

- **Prevention and control of invasive Hib disease:**
  http://www.cdc.gov/ncidod/dbmd/diseaseinfo/haeminfluserob_t.htm
- **CDC's interim Hib vaccine recommendations:**
  http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5746a2.htm
- **The invasive Hib disease outbreak in Minnesota:**
  http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5803a4.htm
- **Reporting invasive *Haemophilus influenzae* disease in Ohio:**
  http://www.odh.ohio.gov/ASSETS/558F94CF31AE48D8A46969B3C1F1B432/Section7.pdf
- **The Ohio Disease Reporting System (ODRS):**
  http://www.odh.ohio.gov/odhPrograms/hsio/id_surv/odrs1.aspx

References:

[1] Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* Atkinson, W., Hamborsky, J., McIntyre, L., Wolfe, S., eds. 10th Edition. Washington DC: Public Health Foundation, 2008: 115, 119.

[2] The Ohio Department of Health. Infectious Disease Surveillance. *Annual Summary of Selected Infectious Diseases, Ohio, 2007*.

Methicillin-resistant *Staphylococcus aureus*, Zoonotic Transmission and Companion Animals

—by Annemarie Hoffman[1], Jeanette O'Quin[3], Armando E. Hoet[1,2]

[1] Veterinary Public Health Program, Department of Veterinary Preventive Medicine, College of Veterinary Medicine, [2] Division of Epidemiology, College of Public Health, The Ohio State University, Columbus, Ohio. [3] Zoonotic Disease Program, Ohio Department of Health, Reynoldsburg, Ohio

Since the 1960s, Methicillin-resistant *Staphylococcus aureus* (MRSA) has been recognized as a significant problem in human medicine. And even though MRSA was reported in a Belgian cow with mastitis in the early 70s, it has not been considered an important veterinary pathogen. However, in recent years there has been an increase in the number of reports showing that animals can be affected by MRSA and even be involved in the transmission of this pathogen to humans and other animals.

MRSA has been isolated from companion animals such as dogs, cats, rabbits and birds, as well as recreational and livestock animals such as horses, cattle, pigs and poultry. Like humans, animals can become colonized or infected when in close contact with a MRSA-contaminated environment or infected individuals, including their owners and/or veterinary personnel. Additional risk factors for companion animals may include living with a health care worker or visiting human hospitals or nursing homes.

It has been shown that MRSA strains isolated from cats and dogs are identical to the most common human MRSA strains, indicating humans may be the main source of infection or colonization for companion animals. This situation has been described as the "spillover scenario" of reverse zoonotic transmission. In contrast, studies have shown pigs and horses have unique strains of MRSA, such as ST398 (sequence type), that are different from any previously identified human types. These true zoonotic MRSA (ZO-MRSA) strains can circulate in those animal populations without producing any apparent clinical disease in the animals. However, ZO-MRSA strains can be transmitted during occupational exposure to humans who then can be clinically affected by the disease.

Based on these zoonotic transmission paths of MRSA, it is easy to determine that occupation may be an important risk factor. Just as doctors and human health care professionals are at a higher risk of exposure to MRSA in the hospital setting, staff in large and small animal veterinary hospitals can have an increased risk of MRSA infections in the animal hospital setting.

Occupational exposure at the agricultural level is also considered a risk factor because there is the potential for exposure to ZO-MRSA strains. These strains have the potential to cross the species barrier, producing infections in farmers and food animal veterinarians, who can manifest primary infections and serve as a vehicle to transmit ZO-MRSA to other humans or animals. In Europe, several reports have indicated that swine and livestock farmers and equine owners have an increased risk of acquiring ZO-MRSA. In the U.S., ZO-MRSA in swine has been reported in only one study performed in Iowa, so it is possible that the risk is not as high as in Europe. Further research is underway to determine the presence of MRSA in livestock populations, nationally and in Ohio, to determine the potential risk to public health.

Even though dogs and cats have been reported to be sources of MRSA to humans, pet ownership is not considered a risk factor.

Methicillin-resistant *Staphylococcus aureus*, Zoonotic Transmission and Companion Animals—continued

It is important to highlight that MRSA is a *human* pathogen spilling over to companion animals. However, once infected (or colonized) the dog or cat can play a role in maintaining the household cycle of MRSA transmission, or serve as a source of primary infection for some individuals. It is also important to highlight, that, unless re-exposed, most cats and dogs clear the pathogen in a few weeks.

If companion animal(s) in the household are suspected to be part of the MRSA maintenance cycle, it is recommended to deal with animals living in the patient's home as we would deal with any other human member of the household. Therefore, animals living in the household should only be screened if ALL other family members and close contacts are also screened. If screening is going to be performed and there is more than one pet in the household, it is recommended that all animals are screened because MRSA can infect some animals but not others. To screen an animal for MRSA, a veterinarian should swab the nasal and perianal areas (and any skin lesion) and submit the swabs to a veterinary diagnostic lab for routine MRSA screening.

MRSA patients do not need to get rid of their pet(s) while they are under treatment. Companion animals should be treated as any other member of the household. Proper preventive and hygiene measures, such as keeping wounds covered and frequent handwashing, will also protect pets. Additionally, pets should not be allowed to share food with or lick infected persons.

Treatment or decolonization of pets should be performed only if other members of the household are going to be decolonized and the pets have been shown to carry the pathogen. When MRSA infection is positively identified in the pet and other human household members, collective treatment may be recommended. In this case, the family veterinarian should work with the human health care providers to coordinate treatment and follow-up.

If, after screening ***all*** members/animals in the household, only the patient and the companion animal are infected, different decolonization therapies may be implemented at the discretion of both the physician and the veterinarian. One possible course of action could be the temporary removal of the animal from the exposure (household), which could allow the pet to naturally eliminate MRSA while the patient/human members of the household undergo decolonization. Again, because every case is different, consultation with a veterinarian is recommended

Currently, the Ohio Department of Health (ODH) in collaboration with The Ohio State University (OSU) College of Veterinary Medicine is offering a free diagnostic service. For MRSA positive cases meeting the criteria, samples submitted from patients, household members and companion animals will be screened for MRSA and genetically characterized by PCR, PFGE and other molecular techniques to determine clonality (common source of origin). This temporary diagnostic program began on April 1, 2009, and will run through Nov. 30, 2009. The objective of the program is to provide additional diagnostic support to physicians treating clinical patients infected with MRSA who have direct contact with animals through pet ownership or work exposure, to determine if animals may be a possible MRSA source or reservoir.

For more detailed information about this subject:

- **Please contact the ODH Zoonotic Disease Program (ZDP) at 614-752-1029, (Option 2), or visit the ODH MRSA Web page http://www.odh.ohio.gov/alerts/mrsa1.aspx.**

For more information on the diagnostic service:

- **Please contact the ZDP or Dr. Armando Hoet, veterinary public health coordinator at The Ohio State University 614-292-0684.**

Hospital Performance Measures Reporting–Infection Control

—by Jodi A. Govern, J.D., Chief, Bureau of Diagnostic Safety & Personnel Certification, Division of Quality Assurance

The Hospital Measures Advisory Council (HMAC) was created by Substitute House Bill 197 of the 126th Ohio General Assembly. Membership of the 17-member HMAC is set forth in law, and includes the director of health, who serves as the chair; the superintendent of insurance; the executive director of the Commission on Minority Health; two members of the Ohio House of Representatives; two members of the Ohio Senate; and one representative of each of the following: health insurers, small employers, organized labor, physicians in general practice, children's hospitals, physicians specializing in public health, hospitals, health services researchers, health care consumers and large employers.

The HMAC met regularly between September 2007 and August 2008 in order to timely complete its report to the director of health. The report had to contain recommendations of all of the following: collecting information from hospitals that shows their performance in meeting measures for hospital inpatient and outpatient services; audits; disseminating information about the performance of hospitals in meeting the measures, including effective methods of displaying information on a Web site; and explaining to the public how to use the information about the performance of hospitals in meeting the measures, including explanations about the limitations of the information.

In concert with the HMAC and as required by law, the director of health convened a group of experts in data collection and analysis to develop recommendations regarding hospital performance measures for inpatient and outpatient services and to advise the director and the HMAC about the display of data on a Web site and about data audits. Each HMAC member was permitted to either appoint a data expert or serve as a data expert. This group of experts is commonly known as the Data Expert Group (DEG). The DEG permitted one of its members to organize a group of experts in pediatrics to review and recommend pediatric measures.

Finally, the HMAC was required to "convene a group of health care consumers, nurses, and experts in infection control, the members of which shall be appointed by the council according to a method selected by the council, to provide information about infection issues to the council as needed for the council to perform its duties." The HMAC decided to utilize the director of Health's Committee on Emerging Infections along with a new consumer member to serve in this role. This group is commonly known as the Infection Control Group (ICG). The HMAC charged the ICG with reviewing and making recommendations to the DEG as to which infection measures hospitals should be required to report.

The following is a list of infection-related measures recommended for public reporting:

- Surgical Care Improvement Project (SCIP)* Measures-Inf 1, 2, 3
- Surgical Site Infection Events (CDC-NHSN)* – CABG (chest incision only), Cesarean Section, Initial Knee Prosthesis
- Hospital-acquired *Clostridium difficile* (CDC-NHSN)*
- Hospital-acquired MRSA/MSSA (CDC-NHSN*
- Hand-washing practices in the hospital
- Infection control staffing
- Influenza vaccination for health care workers
- Pediatric Infection Measures
    - Prophylatic antibiotic received within one hour prior to surgical incision
    - Surgical site infection rates for cardiothoracic, neurosurgical and orthopedic procedures
    - Catheter-associated bloodstream infection rate for ICU patients

*For these measures, hospitals will use the specifications from the entity that created the measure. For all others, hospitals will use the specifications contained in the administrative rules.

Hospital Performance Measures Reporting—Infection Control—continued

Draft administrative rules incorporating all of the measures recommended by the HMAC were posted for comment on the ODH Web site from Jan. 23 to Feb. 23. The comments were reviewed and incorporated where appropriate. The rules were officially proposed by the director on March 27, 2009. The public hearing was held at 1:00 PM on April 28, 2009, at the Ohio Department of Health, 246 N. High Street, 7th floor. You may review these rules (OAC 3701-14-02, 3701-14-03 and 3701-14-04) at http://www.registerofohio.state.oh.us/.

It is anticipated that the first reporting of the recommended measures will occur on October 1, 2009 with that data posted on the public Web site by January 2010.

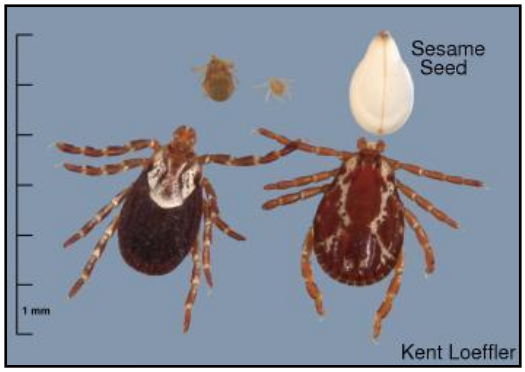
Please direct any questions about the process or the measures to:
Madelyn.dile@odh.ohio.gov or Jodi.govern@odh.ohio.gov

Ticks and Tick-borne Disease in Ohio 2009—by Mary K. Daniels, Public Health Entomologist

As winter ends, Ohioans begin to soak up the sunshine of early spring. Entomologists are always excited to see the first insects and spiders of the season, but even insect lovers may not be happy to find bloodsuckers waiting in the weeds. Ticks are hungry this time of year and blood is on the menu. People working and playing outdoors may be exposed to ticks and possibly tick-borne diseases such as Rocky Mountain spotted fever (RMSF) and Lyme disease. But, not all ticks are able to transmit every disease, so species identification is the first step in determining disease risk. The Ohio Department of Health (ODH) Zoonotic Disease Program (ZDP) offers an insect and tick identification service to all Ohioans, and business is booming now that the ticks have come out to feed. Submission and identification information may be found at the end of this article and at our Web site: http://www.odh.ohio.gov/odhPrograms/dis/zoonoses/vbdp/vbtick.aspx

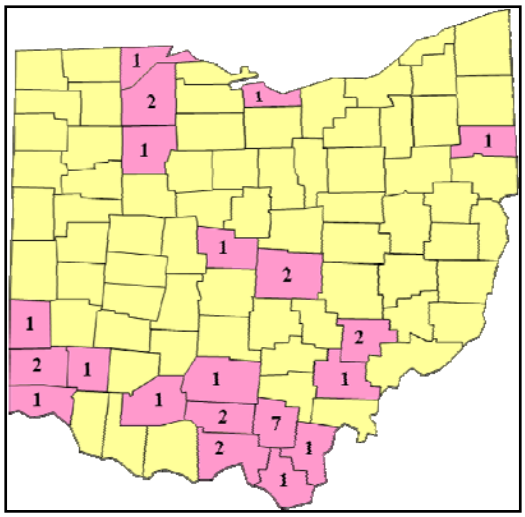
Rocky Mountain spotted fever

The American dog tick is Ohio's most common tick. In the eastern United States, it is the primary vector of RMSF, and Ohio reports approximately two dozen cases every year. The American dog tick is active from April until July and is found in weedy areas where the ticks wait at the top of a blade of grass for a meal to walk by. The tick climbs aboard as one brushes past it, and begins climbing up the body looking for a protected site to attach. The tick might make it all the way to the head before it finds a suitable attachment site. For a tick, the scalp is a cozy place to have an undisturbed meal. Contrary to popular belief, ticks do not jump out of trees, so wearing a hat in the woods will not protect against tick bites.



The American dog tick, *Dermacentor variabilis,* will bite and feed on any available mammal, including humans.

Rocky Mountain Spotted Fever 2008
Total: 32 cases



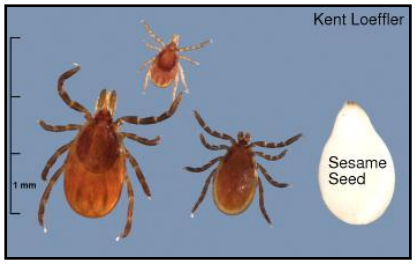
RMSF is caused by the bacterium *Rickettsia rickettsii*. The bacteria are transmitted through tick saliva while feeding, and it usually takes several hours of attachment and feeding for the bacteria to be transferred to the host. Only 1 percent to 3 percent of the tick population carries *R. rickettsii* (even in areas where the majority of human cases are reported), so risk of exposure to an infected tick is low. In 2008, Ohio reported 32 cases of RMSF.

Ticks and Tick-borne Disease in Ohio 2009—continued

Lyme disease

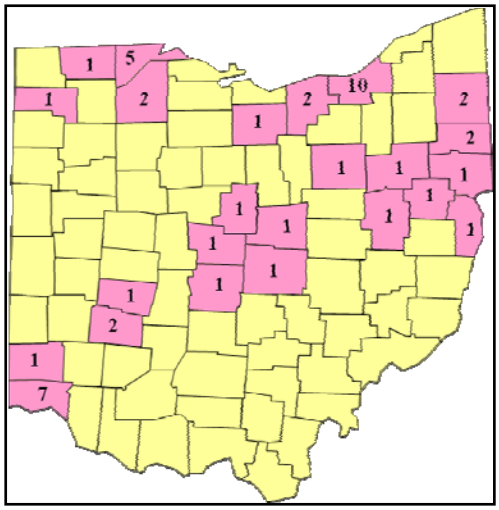
In the eastern United States, Lyme disease is transmitted by *Ixodes scapularis* ticks, also known as "deer ticks." The young ticks are active in late spring and summer and are found in areas of deciduous forest, especially those with a leaf litter habitat on the ground. Deer ticks are not common in Ohio; only 35 have been submitted for identification since 1987. Data from the past 10 years show that almost half of Ohio Lyme disease case-patients had no travel history. This means people are acquiring Lyme disease in Ohio, despite the fact that the tick responsible for the disease is rarely found here.

Adult female *Ixodes scapularis*



Deer tick: *Ixodes scapularis*

Lyme Disease 2008
Total: 48 cases



Lyme is a bacterial disease caused by *Borrelia burgdorferi*, a spirochete-type bacterium. In the early stages, it is commonly treated with a three-week regimen of antibiotics. Lyme disease is the most commonly reported vector-borne disease in the United States with more than 20,000 cases reported each year, mostly from New England states. In 2008, Ohio reported 48 cases of Lyme disease.

Prevention

Avoiding tick bites is the best way to prevent a tick-borne disease. Bites can be avoided by tucking pants into socks and using a repellant to keep ticks from gaining access to the skin. If a tick is found attached, do not be alarmed. However, take care to remove the tick as soon as possible.

Proper tick removal helps to reduce disease transmission and keeps the tick in good condition for identification. When a tick attaches, it glues itself to the skin, so be patient when removing. Grasp the tick with tweezers close to the skin and pull straight up, gently, until it is removed. Save the tick in a jar or sealable plastic bag, and send it in for identification.

Tick identification is available through the ZDP. Please complete the submission form on our Web site:
http://www.odh.ohio.gov/odhPrograms/dis/zoonoses/vbdp/vbtick.aspx
and mail to ODH (address at right).
An entomologist will mail a follow-up report to the address provided.

Tick Identification
Ohio Department of Health
Zoonotic Disease Program
8955 E. Main St.
Reynoldsburg, OH 43068

Quarterly Summary of Sexually Transmitted Diseases, Ohio
Fourth Quarter, 2008*
January 1, 2008 - December 31, 2008

SEXUALLY TRANSMITTED DISEASES	QUARTER	YEAR
CHLAMYDIA	11,764	46,675
GONORRHEA	4,098	16,480
SYPHILIS	186	756
TOTAL	**16,048**	**63,911**

* 2008 data include only confirmed cases, except for gonorrhea, which includes confirmed and suspected cases reported to the CDC. This report includes both quarter-specific and year-through-quarter cumulative frequencies for each disease. Quarter is determined by date of diagnosis. Some reportable conditions may be under investigation. Therefore, all data in this report are provisional, but current as of April 14, 2009.

Source: Ohio Department of Health STD Surveillance

Reported HIV/AIDS diagnoses in Ohio in 2007[a]

	HIV	AIDS	HIV/AIDS
Diagnosed[b]	866	162	1028
PLWHA*	8,125	7,288	15,413

[a]Data reported through December 31, 2008.

[b]HIV/AIDS diagnoses include persons with a diagnosis of an HIV infection (not AIDS), a diagnosis of an HIV infection and later AIDS, and concurrent diagnosis of HIV infection and AIDS.

[*]Persons Living with HIV/AIDS

Source: Ohio Department of Health, HIV/AIDS Surveillance Program

Quarterly Summary of Tuberculosis Cases, Ohio
First Quarter, 2009*
January 1, 2009 - March 31, 2009

	QUARTER	YEAR
TUBERCULOSIS (TB)	33	33

* 2009 data include confirmed cases reported to the CDC. This report includes both quarter-specific and year-through-quarter cumulative frequencies for tuberculosis. Quarter is determined by count date, which is the date the ODH TB Surveillance Program determines the tuberculosis suspect meets the CDC Surveillance Case Definition for TB. All data in this report are provisional, but current as of April 14, 2009.

Source: Ohio Department of Health TB Surveillance

Quarterly Summary of Selected Reportable Infectious Diseases

First Quarter, 2009*

January 4, 2009 – March 28, 2009

Reportable Condition	Quarter	Year
Amebiasis	9	9
Botulism, Infant	1	1
Campylobacteriosis	173	173
Coccidioidomycosis	6	6
Cryptosporidiosis	59	59
Cytomegalovirus (CMV), Congenital	9	9
Ehrlichia chaffeensis	1	1
Enterohemorrhagic *Escherichia coli* O157:H7	10	10
Enterohemorrhagic *Escherichia coli*, Not O157:H7	4	4
Enterohemorrhagic *Escherichia coli*, Unknown Serotype	4	4
Giardiasis	173	173
Haemophilus influenzae, Invasive Disease	30	30
Hemolytic Uremic Syndrome (HUS)	1	1
Hepatitis A	14	14
Hepatitis B, Acute	91	91
Hepatitis B, Chronic	360	360
Hepatitis C, Acute	32	32
Hepatitis C, Past or Present Infection	3,565	3,565
Influenza-Associated Hospitalization	452	452
Influenza-Associated Pediatric Mortality	3	3
Legionellosis	41	41
Listeriosis	3	3
Lyme Disease	1	1
Meningitis, Aseptic	149	149
Meningitis, Other Bacterial	19	19
Meningococcal Disease	16	16
Mumps	1	1
Pertussis	242	242
Rocky Mountain Spotted Fever (RMSF)	1	1
Salmonellosis	266	266
Shigellosis	407	407
Staphylococcus aureus, Intermediate Resistance to Vancomycin (VISA)	2	2
Streptococcal Disease, Group A, Invasive	92	92
Streptococcal Disease, Group B, in Newborn	19	19
Streptococcal Toxic Shock Syndrome (STSS)	5	5
Streptococcus pneumoniae, Invasive, Drug Resistant/Intermediate (all ages)	121	121
Streptococcus pneumoniae, Invasive, Drug Susceptible/Unknown (all ages)	343	343
Typhoid Fever	4	4
Varicella	754	754
Vibriosis (Not Cholera)	2	2
Yersiniosis	7	7
Total	**7,492**	**7,492**

* 2009 data include confirmed, probable and suspected cases reported to the CDC. This report includes both quarter-specific and year-through-quarter cumulative frequencies for each disease. Quarter is determined by the MMWR week the case was sent to the CDC for all cases except for influenza-associated hospitalization, which are by date of report to the Ohio Department of Health, and influenza-associated pediatric mortality, which are by date of death. This report includes only Class A and B reportable diseases. Data were reported to the Ohio Department of Health via the Ohio Disease Reporting System. Some reportable conditions may be under investigation. Therefore, all data in this report are provisional, but current as of April 3, 2009.

Source: Ohio Department of Health Infectious Disease Surveillance.

IDQ Announcements–Spring 2009

April 25 is **World Meningitis Day**. Meningitis and septicemia kill and maim children, young people and adults the world over. These diseases impact all persons, without regard to race/ethnicity, socioeconomic status, religion or geography. Some strains of pneumococcal and meningococcal meningitis can be prevented through vaccination. The Confederation of Meningitis Organizations urged health care professionals, meningitis advocates, and others to symbolically join hands on April 25 to make World Meningitis Day a day of action to raise awareness about meningitis and septicemia. To learn more about World Meningitis Day, go to: http://www.comoonline.org/wmd.html.

National Infant Immunization Week (NIIW) is an annual observance to highlight the importance of protecting infants from vaccine-preventable diseases. It is a call to action for parents, caregivers and health care providers to ensure infants are fully immunized against 14 vaccine-preventable diseases. This year NIIW was held April 25–May 2, and coincided with Vaccination Week in the Americas and European Immunization Week.

Friday, June 27 is **National HIV Testing Day** (NHTD). NHTD is an annual event meant to raise awareness of the importance of knowing one's HIV status and encourage at-risk individuals to receive an HIV test. The Centers for Disease Control and Prevention estimates more than 1 million Americans are living with HIV, and one-quarter of those people are unaware of their infection. HIV testing enables people with HIV to take steps to protect their own health and that of their partners, and helps people who test negative get the information they need to stay uninfected. Across the United States, thousands of HIV counseling and testing sites, state and local health departments and community-based HIV/AIDS service providers will participate in NHTD events by holding health fairs, providing community and media outreach and hosting special testing-related events. For more information go to http://www.HIVtest.org, which allows users to locate HIV testing sites in their area. To learn more about HIV and NHTD events in Ohio, call or e-mail Ohio AIDS/HIV/STD Hotline to access free, anonymous and confidential answers to questions and concerns at 1-800-332-2437. For TTY for the deaf and hearing impaired call or 1-800-332-3889. For answers through e-mail: ohioaidshotline@catf.net.

The week preceding Memorial Day has been designated as **National Recreational Water Illness Prevention Week**. The fifth-annual observance will take place May 18–24, 2009. The goal is to highlight the importance of healthy swimming, healthy swimming behaviors and recreational water illness prevention. More information is available at the Centers for Disease Control and Prevention healthy swimming Web site: (http://www.cdc.gov/healthyswimming/rwi_prevention_week.htm) which emphasizes operation and prevention tips for pool operators and patrons to ensure a healthy swimming experience.

Local health departments are encouraged to promote National Recreational Water Illness Prevention Week. Suggestions for promotion are available at: http://www.cdc.gov/healthyswimming/tools.htm.

Additional resources on Recreational Water Illness are available for special groups.

For swimmers: (http://www.cdc.gov/healthyswimming/pdf/pool_user_tips.pdf);

For spa users: (http://www.cdc.gov/healthyswimming/pdf/spa_user_tips.pdf);

For everyone: (http://www.cdc.gov/healthyswimming/6_steps.htm);

And for home pool users: (http://www.cdc.gov/healthyswimming/rwi_prevention_week_test_strip_table.htm).

IDQ Announcements–Spring 2009

The global observance of **World Hepatitis Day** is May 19, 2009. One in 12 people worldwide are living with either chronic hepatitis B or chronic hepatitis C, yet most are unaware of their infection(s). Also, general awareness of chronic viral hepatitis is low, even though the prevalence is higher than that of HIV. The aim of this international day focusing on chronic viral hepatitis is to raise awareness of these diseases within the general population, people at risk, health care providers and governments. For more information on the global campaign, please visit http://www.worldhepatitisday.org. For information on planning efforts in the United States, please visit http://www.NVHR.org.

Teenagers need immunizations, too. Governor Strickland has declared June to be **Teen Immunization Month.** Local health districts across Ohio have initiated a number of activities to promote the need for teen immunizations in June. The Centers for Disease Control and Prevention (CDC) recommends immunizations for 11–18-year-olds against tetanus, diphtheria, pertussis (whooping cough), measles, mumps, rubella, meningococcal disease, influenza, hepatitis B, chickenpox and human papillomavirus. Consider what steps you can take to ensure teens that you know are fully immunized. Send someone you know a Health-e-card to educate about the need for teen immunizations. Go to http://www2a.cdc.gov/ecards/index.asp to access Health-e-cards designed by the CDC. Contact the Ohio Department of Health Immunization Program at (641) 466-0261 for more information about teen immunizations.

The **2009 Ohio Public Health Epidemiology Symposium** will take place on Wednesday, June 17th at Columbus State Community College. Registrations are now being accepted on OhioTRAIN at https://oh.train.org. Any questions may be directed to Angela Scott-Owens at the Ohio Department of Health at 614-466-1388 or via e-mail at angela.scottowens@odh.ohio.gov.

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