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## HSDE SURVEILLANCE CASE DEFINITIONS FOR SELECT REPORTABLE DISEASES IN FLORIDA April 1998

### **Amebiasis**

reporting code 00690

case report form N/A

#### **Clinical description**

Infection of the large intestine by *Entamoeba histolytica* may result in an illness of variable severity ranging from mild, chronic diarrhea to fulminant dysentery. Infection also may be asymptomatic. Extraintestinal infection also can occur (e.g., hepatic abscess).

#### **Laboratory criteria for diagnosis**

Intestinal amebiasis

- Demonstration of cysts or trophozoites of *E. histolytica* in stool or
- Demonstration of trophozoites in tissue biopsy or ulcer scrapings by culture or histopathology

Extraintestinal amebiasis

- Demonstration of *E. histolytica* trophozoites in extraintestinal tissue

#### **Case classification**

Confirmed, intestinal amebiasis: a clinically compatible illness that is laboratory confirmed.

Confirmed, extraintestinal amebiasis: a parasitologically confirmed infection of extraintestinal tissue, or among symptomatic persons (with clinical or radiographic findings consistent with extraintestinal infection), demonstration of specific antibody against *E. histolytica* as measured by indirect hemagglutination or other reliable immunodiagnostic test (e.g., enzyme-linked immunosorbent assay)

#### **Comment**

Asymptomatic intestinal carriage of *E. histolytica* should not be reported. Among asymptomatic persons, a positive serologic test does not necessarily indicate extraintestinal amebiasis.

### **Animal Bite**

reporting code 07101

case report form N/A

(Although this is a reportable condition in Florida, it is to be tracked at the county level. The state health office does not track this information.)

#### Clinical description

Variable

#### Laboratory confirmation

N/A

#### Case classification

Confirmed: bite or penetrating scratch of a human by a confirmed rabid animal

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## **Anthrax**

reporting code 02200

case report form N/A

### **Clinical Description**

An illness with acute onset characterized by several distinct clinical forms, including the following:

- Cutaneous: a skin lesion evolving during a period of 2–6 days from a papule, through a vesicular stage, to a depressed black eschar
- Inhalation: a brief prodrome resembling a viral respiratory illness, followed by development of hypoxia and dyspnea, with radiographic evidence of mediastinal widening
- Intestinal: severe abdominal distress followed by fever and signs of septicemia
- Oropharyngeal: mucosal lesion in the oral cavity or oropharynx, cervical adenopathy and edema, and fever

### **Laboratory criteria for diagnosis**

- Isolation of *Bacillus anthracis* from a clinical specimen, or
- Anthrax electrophoretic immunotransblot (EITB) reaction to the protective antigen and/or lethal factor bands in one or more serum samples obtained after onset of symptoms, or
- Demonstration of *B. anthracis* in a clinical specimen by immunofluorescence

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

## **Botulism, Foodborne**

reporting code 00510

case report form N/A

### **Clinical description**

Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

### **Laboratory criteria for diagnosis**

- Detection of botulinum toxin in serum, stool, or patient's food or
- Isolation of *Clostridium botulinum* from stool

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory confirmed botulism

Probable: a clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours)

### **Comment**

Note that this is one of the few diseases in which an "epi-linked" case without laboratory confirmation is considered confirmed

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## **Botulism, Infant**

reporting code 00511

case report form N/A

### **Clinical description**

An illness of infants, characterized by constipation, poor feeding, and “failure to thrive” that may be followed by progressive weakness, impaired respiration, and death

### **Laboratory criteria for diagnosis**

- Detection of botulinum toxin in stool or serum or
- Isolation of *Clostridium botulinum* from stool

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed, occurring in a child aged <1 year

## **Botulism, Wound**

reporting code 00513

case report form N/A

### **Clinical description**

An illness resulting from toxin produced by *Clostridium botulinum* that has infected a wound. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

### **Laboratory criteria for diagnosis**

- Detection of botulinum toxin in serum or
- Isolation of *C. botulinum* from wound

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms

## **Botulism, Other**

reporting code 00512

case report form N/A

### **Clinical description**

See Botulism, Foodborne.

### **Laboratory criteria for diagnosis**

- Detection of botulinum toxin in clinical specimen or
- Isolation of *Clostridium botulinum* from clinical specimen

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed in a patient aged  $\geq 1$  year who has no history of ingestion of suspect food and has no wounds

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## Brucellosis

reporting code 02300

case report form CDC 52.25  
Brucellosis Case Surveillance Report

### Clinical description

An illness characterized by acute or insidious onset of fever, night sweats, undue fatigue, anorexia, weight loss, headache, and arthralgia

### Laboratory criteria for diagnosis

- Isolation of *Brucella* sp. from a clinical specimen, or
- Fourfold or greater rise in *Brucella* agglutination titer between acute- and convalescent-phase serum specimens obtained  $\geq 2$  weeks apart and studied at the same laboratory, or
- Demonstration by immunofluorescence of *Brucella* sp. in a clinical specimen

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case or that has supportive serology (i.e., *Brucella* agglutination titer of  $\geq 160$  in one or more serum specimens obtained after onset of symptoms)

## Campylobacteriosis

reporting code 03840

case report form N/A

### Clinical description

An infection that may result in diarrheal illness of variable severity

### Laboratory criteria for diagnosis

- Isolation of *Campylobacter* from any clinical specimen

### Case classification

Confirmed: a case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case

## Cholera, Vibrio

reporting code 00190

case report form CDC 52.79  
Vibrio Illness Investigation

### Clinical description

An illness characterized by diarrhea and/or vomiting; severity is variable.

### Laboratory criteria for diagnosis

- Isolation of toxigenic (i.e., cholera toxin-producing) *Vibrio cholerae* O1 or O139 from stool or vomitus, or
- Serologic evidence of recent infection

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

### Comment

Illnesses caused by strains of *V. cholerae* other than toxigenic *V. cholerae* O1 or O139 should not be reported as cases of cholera. The etiologic agent of a case of cholera should be reported as either *V. cholerae* O1 or *V. cholerae* O139. Only confirmed cases should be reported to NNDSS by state health departments.

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## Ciguatera

reporting code 98809

case report form CDC 52.13  
Investigation of a Foodborne Outbreak

### Clinical description

Abdominal cramps, nausea, vomiting, diarrhea, numbness and paresthesia of lips and tongue, paresthesias of the extremities, metallic taste, arthralgia, myalgia, blurred vision and paradoxical temperature sensation.

Associated with consumption of bottom-dwelling fish such as barracuda and snapper.

### Case classification

Confirmed: Clinically compatible illness in a patient with a history of fish consumption in the 24 hours before onset of symptoms

### Laboratory criteria for diagnosis

Detection of ciguatoxin in implicated fish helpful, but not necessary for case confirmation

### Comment

Even single sporadic cases should be reported on the CDC Investigation of a Foodborne Outbreak form

## Cryptosporidiosis

reporting code 13680

case report form N/A

### Clinical description

An illness caused by the protozoan *Cryptosporidium parvum* and characterized by diarrhea, abdominal cramps, loss of appetite, low-grade fever, nausea, and vomiting.

Infected persons may be asymptomatic. The disease can be prolonged and life-threatening in severely immunocompromised persons.

### Laboratory criteria for diagnosis

- Demonstration of *Cryptosporidium* oocysts in stool, or
- Demonstration of *Cryptosporidium* in intestinal fluid or small-bowel biopsy specimens, or
- Demonstration of *Cryptosporidium* antigen in stool by a specific immunodiagnostic test (e.g., enzyme-linked immunosorbent assay)

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case

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## Cyclosporiasis

reporting code 720

case report form (3/97)  
Cyclosporiasis Case Report Form

### Clinical description

An illness of variable severity caused by the protozoan *Cyclospora cayetanensis* and commonly characterized by watery diarrhea, loss of appetite, weight loss, abdominal bloating and cramping, increased flatus, nausea, fatigue, and low-grade fever. Vomiting also may be noted. Relapses and asymptomatic infections can occur.

### Laboratory criteria for diagnosis

- Demonstration of *Cyclospora* oocysts (by morphologic criteria or by demonstration of sporulation) or *Cyclospora* DNA (by polymerase chain reaction) in stool, duodenal/jejunal aspirates or small-bowel biopsy specimens

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case

### Comment

Direct person-to-person transmission is unlikely because *Cyclospora* oocysts are not infectious at the time of excretion.

## Dengue Fever

reporting code 06100

case report form CDC 56.31A  
Dengue Case Investigation

### Clinical description

An acute febrile illness characterized by frontal headache, retroocular pain, muscle and joint pain, and rash. The principal vector is the *Aedes aegypti* mosquito and transmission usually occurs in tropical or subtropical areas. Severe manifestations (e.g., dengue hemorrhagic fever and dengue shock syndrome) are rare but may be fatal.

### Laboratory criteria for diagnosis

- Isolation of dengue virus from serum and/or autopsy tissue samples, or
- Demonstration of a fourfold or greater rise or fall in reciprocal immunoglobulin G (IgG) or immunoglobulin M (IgM) antibody titers to one or more dengue virus antigens in paired serum samples, or
- Demonstration of dengue virus antigen in autopsy tissue or serum samples by immunohistochemistry or by viral nucleic acid detection

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with supportive serologic findings (a reciprocal IgG antibody titer of  $\geq 1280$  or a positive IgM antibody test on a single acute (late)- or convalescent-phase serum specimen to one or more dengue virus antigens)

### Comment

Dengue hemorrhagic fever is defined as an acute febrile illness with minor or major bleeding phenomena, thrombocytopenia ( $\leq 100,000/\text{mm}^3$ ), and evidence of plasma leakage documented by hemoconcentration (hematocrit increased by  $\geq 20\%$ ) or other objective evidence of increased capillary permeability. The definition of dengue shock syndrome follows all of the above criteria for dengue hemorrhagic fever and also includes hypotension or narrow pulse pressure ( $\leq 20$  mm Hg).

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## Diphtheria

reporting code 03290

case report form CDC 4.124  
Diphtheria Appraisal Summary

### **Clinical description**

An upper-respiratory tract illness characterized by sore throat, low-grade fever, and an adherent membrane of the tonsil(s), pharynx, and/or nose

### **Laboratory criteria for diagnosis**

- Isolation of *Corynebacterium diphtheriae* from a clinical specimen or
- Histopathologic diagnosis of diphtheria

### **Case classification**

Confirmed: a clinically compatible case that is either laboratory confirmed or epidemiologically linked to a laboratory confirmed case\_

Probable: a clinically compatible case that is not laboratory confirmed and is not epidemiologically linked to a laboratory confirmed case

### **Comment**

Cutaneous diphtheria should not be reported. Respiratory disease caused by non-toxigenic *C. diphtheriae* should be reported as diphtheria. All diphtheria isolates, regardless of association with disease, should be sent to the Diphtheria Laboratory, National Center for Infectious Diseases, CDC.

*Note: Questions regarding the follow-up of a diphtheria case should be directed to your regional Immunization Program representative or the State Health Office Immunization Program at (904) 487-2755 or s/c 277-2755.*

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## Ehrlichiosis

(Added 7-96)

reporting code 08380

case report form Rev. 7/96  
Ehrlichiosis Case Report

### Clinical description

A tickborne febrile illness most commonly characterized by acute onset, accompanied by headache, myalgia, rigors and/or malaise. Clinical laboratory findings may include intracytoplasmic microcolonies (morulae) in leukocytes of peripheral smear, cerebrospinal fluid (CSF), or bone marrow aspirate or biopsy, cytopenias (especially thrombocytopenia and leukopenia), and elevated liver enzymes (especially alanine aminotransferase or aspartate aminotransferase).

### Laboratory criteria for diagnosis

- Fourfold or greater change in antibody titer to Ehrlichia spp. antigen by immunofluorescence antibody (IFA) test in acute- and convalescent-phase specimens ideally taken  $\geq 4$  weeks apart. HME diagnosis requires E. chaffeensis and HGE currently requires E. equi or HGE-agent antigen, or
- Positive polymerase chain reaction assay. Distinct primers are used for the diagnosis of HGE and HME, or
- Intracytoplasmic morulae identified in blood, bone marrow, or CSF leukocytes, **and** an IFA antibody titer  $\geq 64$

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with either a single IFA serologic titer  $\geq 64$  or intracytoplasmic morulae identified in blood, bone marrow, or CSF leukocytes

### Comment

There are two clinically similar yet serologically distinct forms of ehrlichiosis: a) human granulocytic ehrlichiosis (HGE), caused by infection with an Ehrlichia equi-like agent and found primarily in the upper midwest and northeast, and b) human monocytic ehrlichiosis (HME) caused by Ehrlichia chaffeensis infection and found primarily in the southeastern quadrant of the United States.



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## Encephalitis, Arboviral

reporting codes 06220 EEE  
06230 SLE  
06620 VE  
06210 WEE

case report form:  
St. Louis/Eastern Equine  
Encephalitis Case Report

### Clinical description

Arboviral infection may result in a febrile illness of variable severity associated with neurologic symptoms ranging from headache to aseptic meningitis or encephalitis.

Arboviral encephalitis cannot be distinguished clinically from other central nervous system (CNS) infections. Symptoms can include headache, confusion or other alteration in sensorium, nausea, and vomiting. Signs may include fever, meningismus, cranial nerve palsies, paresis or paralysis, sensory deficits, altered reflexes, convulsions, abnormal movements, and coma of varying degree.

### Laboratory criteria for diagnosis

- Fourfold or greater change in serum antibody titer, or
- Isolation of virus from or demonstration of viral antigen or genomic sequences in tissue, blood, cerebrospinal fluid (CSF), or other body fluid, or
- Specific immunoglobulin M (IgM) antibody by enzyme immunoassay (EIA) antibody captured in CSF or serum. Serum IgM antibodies alone should be confirmed by demonstration of immunoglobulin G antibodies by another serologic assay (e.g., neutralization or hemagglutination inhibition).

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case occurring during a period when arboviral transmission is likely, and with the following supportive serology: a stable ( $\leq$  twofold change) elevated antibody titer to an arbovirus (e.g.,  $\geq 320$  by hemagglutination inhibition,  $\geq 128$  by complement fixation,  $\geq 256$  by immunofluorescence, and  $\geq 160$  by neutralization, or  $\geq 400$  by enzyme immunoassay IgM).

## Encephalitis, Post Infectious

reporting codes 05200 Chickenpox report form N/A  
05430 Herpes  
48780 Influenza  
05500 Measles  
07220 Mumps

### Clinical description

Encephalitis that occurs with or subsequent to one of the above-listed viral illnesses.

### Laboratory criteria for diagnosis

Not required

### Case classification

Confirmed: Physician diagnosis

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## ***Escherichia coli* O157:H7**

reporting code: 41601

case report form

CDC *E. coli* Case History Report **Clinical**

### **description**

An infection of variable severity characterized by diarrhea (often bloody) and abdominal cramps. Illness may be complicated by hemolytic uremic syndrome (HUS) or thrombotic thrombocytopenic purpura (TTP).

### **Laboratory criteria for diagnosis**

- Isolation of *Escherichia coli* O157:H7 from a specimen or
- Isolation of Shiga toxin-producing *E. coli* O157:NM (or **nonmotile**) from a clinical specimen

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a case with isolation of *E. coli* O157 from a clinical specimen, pending confirmation of H7 or Shiga toxin or

A clinically compatible case that is epidemiologically linked to a confirmed or probable case

### **Comment**

Patients with *E. coli* who develop hemolytic uremic syndrome should be reported with BOTH disease codes (as if they were two separate cases) on the 2016 form.

A lab result that indicates only "*E.coli*" does not indicate pathogenic *E.coli*.

If a lab result indicate a specimen is sorbitol-negative, and the case is symptomatic, report that case as *E.coli* Other.

## ***Escherichia coli*, Other**

reporting code: 41602

case report form

CDC *E. coli* Case History Report

### **Clinical description**

An infection of variable severity characterized by diarrhea (often bloody) and abdominal cramps. Illness may be complicated by hemolytic uremic syndrome (HUS) or thrombotic thrombocytopenic purpura (TTP); asymptomatic infections also may occur.

### **Laboratory criteria for diagnosis**

- Isolation of enterotoxigenic(ETEC), enteroinvasive(EIEC), enteropathogenic(EPEC), enterohemorrhagic(EHEC) or enteroaggregative(EAEC) *E. coli* from a clinical specimen with 1)known serotype and 2)serotype not O157:H7

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

Probable:

- A case with isolation of *E. coli* O157 from a clinical specimen, pending confirmation of H7 or Shiga toxin or
- A clinically compatible case that is epidemiologically linked to a confirmed or probable case

### **Comment**

Patients with *E. coli* who develop hemolytic uremic syndrome should be reported with BOTH disease codes (as if they were two separate cases) on the 2016 form.

A lab result that indicates only "*E.coli*" does not indicate pathogenic *E.coli*.

If a lab result indicate a specimen is sorbitol-negative, and the case is symptomatic, report that case as *E.coli* Other.

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## Giardiasis

reporting code 00710

case report form N/A

### Clinical description

An illness caused by the protozoan *Giardia lamblia* and characterized by diarrhea, abdominal cramps, bloating, weight loss, or malabsorption.

### Laboratory criteria for diagnosis

- Demonstration of *G. lamblia* cysts in stool, or
- Demonstration of *G. lamblia* trophozoites in stool, duodenal fluid, or small-bowel biopsy, or
- Demonstration of *G. lamblia* antigen in stool by a specific immunodiagnostic test (e.g., enzyme-linked immunosorbent assay)

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case

### Comment

Asymptomatic infections are common, and should not be reported as cases

## Haemophilus influenzae (Invasive Disease)

reporting codes 69290 Cellulitis

case report form

46430 Epiglottitis

CDC 52.15

32000 Meningitis

National Bacterial

48220 Pneumonia

Meningitis and

03841 Bacteremia

Bacteremia Case Rept.

71100 Arthritis

### Clinical description

Invasive disease caused by *Haemophilus influenzae* may produce any of several clinical syndromes, including meningitis, bacteremia, epiglottitis, or pneumonia.

### Laboratory criteria for diagnosis

- Isolation of *H. influenzae* from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid)

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with detection of *H. influenzae* type b antigen in CSF

### Comments

1. Cases of all ages should be reported.
2. Serotype should be determined for all *Haemophilus influenzae* isolates because Hib vaccines protect against serotype b organisms only. This testing is especially important for children <15 years of age to determine possible vaccine failure or failure to vaccinate.
3. Positive antigen test results from urine or serum samples are unreliable for diagnosis of *H. influenzae* disease.

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## Hansen Disease (Leprosy)

reporting code 03090

case report form CDC 52.18  
Leprosy Surveillance

### Clinical description

A chronic bacterial disease characterized by the involvement primarily of skin as well as peripheral nerves and the mucosa of the upper airway. Clinical forms of Hansen disease represent a spectrum reflecting the cellular immune response to *Mycobacterium leprae*. The following characteristics are typical of the major forms of the disease:

- Tuberculoid: one or a few well-demarcated, hypopigmented, and anesthetic skin lesions, frequently with active, spreading edges and a clearing center; peripheral nerve swelling or thickening also may occur
- Lepromatous: a number of erythematous papules and nodules or an infiltration of the face, hands, and feet with lesions in a bilateral and symmetrical distribution that progress to thickening of the skin
- Borderline (dimorphous): skin lesions characteristic of both the tuberculoid and lepromatous forms
- Indeterminate: early lesions, usually hypopigmented macules, without developed tuberculoid or lepromatous features

### Laboratory criteria for diagnosis

- Demonstration of acid-fast bacilli in skin or dermal nerve, obtained from the full-thickness skin biopsy of a lepromatous lesion

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

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## **Hantavirus Infection (Hantavirus Pulmonary Syndrome)**

reporting code 7869

case report form: Hantavirus Pulmonary

Syndrome Case Report  
Form 10/96

### **Clinical description**

Hantavirus pulmonary syndrome (HPS), commonly referred to as hantavirus disease, is a febrile illness characterized by bilateral interstitial pulmonary infiltrates and respiratory compromise usually requiring supplemental oxygen and clinically resembling acute respiratory disease syndrome (ARDS). The typical prodrome consists of fever, chills, myalgia, headache, and gastrointestinal symptoms. Typical clinical laboratory findings include hemoconcentration, left shift in the white blood cell count, neutrophilic leukocytosis, thrombocytopenia, and circulating immunoblasts.

### **Clinical case definition**

An illness characterized by one or more of the following clinical features:

- A febrile illness (i.e., temperature >101.0 F [ $>38.3$  C]) characterized by bilateral diffuse interstitial edema that may radiographically resemble ARDS, with respiratory compromise requiring supplemental oxygen, developing within 72 hours of hospitalization, and occurring in a previously healthy person
- An unexplained respiratory illness resulting in death, with an autopsy examination demonstrating noncardiogenic pulmonary edema without an identifiable cause

### **Laboratory criteria for diagnosis**

- Detection of hantavirus-specific immunoglobulin M or rising titers of hantavirus-specific immunoglobulin G, or
- Detection of hantavirus-specific ribonucleic acid sequence by polymerase chain reaction in clinical specimens, or
- Detection of hantavirus antigen by immunohistochemistry

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

### **Comment**

Laboratory testing should be performed or confirmed at the state laboratory in Jacksonville. Because the clinical illness is nonspecific and ARDS is common, a screening case definition can be used to determine which patients to test. In general, a predisposing medical condition (e.g., chronic pulmonary disease, malignancy, trauma, burn, and surgery) is a more likely cause of ARDS than HPS, and patients who have these underlying conditions and ARDS need not be tested for hantavirus.

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## **Hemolytic Uremic Syndrome**

reporting code 42000

case report form N/A

### **Clinical description**

Hemolytic uremic syndrome (HUS) is characterized by the acute onset of microangiopathic hemolytic anemia, renal injury, and low platelet count. Thrombotic thrombocytopenic purpura (TTP) also is characterized by these features but can include central nervous system (CNS) involvement and fever and may have a more gradual onset. Most cases of HUS (but few cases of TTP) occur after an acute gastrointestinal illness (usually diarrheal).

### **Laboratory criteria for diagnosis**

The following are both present at some time during the illness:

- Anemia (acute onset) with microangiopathic changes (i.e., schistocytes, burr cells, or helmet cells) on peripheral blood smear and
- Renal injury (acute onset) evidenced by either hematuria, proteinuria, or elevated creatinine level (i.e.,  $\geq 1.0$  mg/dL in a child aged  $<13$  years or  $\geq 1.5$  mg/dL in a person aged  $\geq 13$  years, or  $\geq 50\%$  increase over baseline)

**Note:** A low platelet count can usually, but not always, be detected early in the illness, but it may then become normal or even high. If a platelet count obtained within 7 days after onset of the acute gastrointestinal illness is not  $<150,000/\text{mm}^3$ , other diagnoses should be considered.

### **Case classification**

Confirmed: an acute illness diagnosed as HUS or TTP that both meets the laboratory criteria and began within 3 weeks after onset of an episode of acute or bloody diarrhea

Probable:

- An acute illness diagnosed as HUS or TTP that meets the laboratory criteria in a patient who does not have a clear history of acute or bloody diarrhea in preceding 3 weeks or
- An acute illness diagnosed as HUS or TTP, that a) has onset within 3 weeks after onset of an acute or bloody diarrhea and b) meets the laboratory criteria except that microangiopathic changes are not confirmed

### **Comment**

Patients with HUS secondary to another reportable disease (usually *E. coli*) should be reported with BOTH disease codes (as if they were separate cases) on the 2016 form

## **Hemorrhagic Fever**

reporting code 06590

case report form N/A

### **Clinical case definition**

Acute febrile illness with hemorrhagic manifestations which may be caused by a variety of viral agents.

### **Laboratory criteria for diagnosis**

- Virus isolation or
- Detection of antigen in blood or organs or
- Detection of virus-specific IGM by ELISA or
- Detection of virus-specific neutralizing antibody rises or increasing titers by ELISA or IFA

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with history of either recent travel to an endemic area or exposure to rodents or rodent excreta

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**Hepatitis** is reportable under several distinct categories. Please review the individual case definitions that follow to determine if a particular case of hepatitis is reportable to HSDE.

## **Hepatitis A, Viral**

reporting code 07010

case report form CDC 53.1  
Viral Hepatitis Case Report

### **Clinical case definition**

An acute illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase levels

### **Laboratory criteria for diagnosis**

Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive

### **Case classification**

#### Confirmed:

A case that meets the clinical case definition and is laboratory confirmed or,

A case that meets the clinical case definition and occurs in a person who has an epidemiologic link with a person who has laboratory confirmed hepatitis A (i.e., household or sexual contact with an infected person during the 15–50 days before the onset of symptoms)

#### Probable:

A hepatitis A case that is IGM positive, lacks jaundice or elevated liver enzymes, but has discrete onset of other symptoms.

## **Hepatitis B, Viral**

reporting code 07030

case report form CDC 53.1  
Viral Hepatitis Case Report

### **Clinical case definition**

An acute illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase levels

### **Laboratory criteria for diagnosis**

IgM antibody to hepatitis B core antigen (anti-HBc) positive (if done) or hepatitis B surface antigen (HBsAg) positive 2. IgM anti-HAV negative (if done)

### **Case classification**

Confirmed: a case that meets the clinical case definition and is laboratory confirmed

### **Comment**

Persons who have chronic hepatitis or persons identified as HBsAg positive should not be reported as having acute viral hepatitis unless they have evidence of an acute illness compatible with viral hepatitis.

*Reminder: Women who are known to have tested HbsAg positive during pregnancy must be reported to the State Health Office, Bureau of Immunization in accordance with County Health Department Guidebook, Internal Operating Policy: Immun 7, and Technical Assistance: Immun 7. Questions regarding these procedures should be directed to the State Health Office Immunization Program at (904) 487-2755 or s/c 277-2755.*

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## Hepatitis C, Viral

(Hepatitis C - Reportable as of 1-98)

reporting code 07051

case report form CDC 53.1  
Viral Hepatitis Case Report

### Clinical case definition

An acute illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase levels

### Laboratory criteria for diagnosis

1. Serum aminotransferase levels >2.5 times the upper limit of normal, and
2. IgM anti-HAV negative, and
3. IgM anti-HBc negative (if done) or HBsAg negative, and
4. Antibody to hepatitis C virus (anti-HCV) positive, verified by a supplemental test

### Case classification

#### Confirmed:

A case that meets the clinical case definition and is laboratory confirmed

#### Probable:

A hepatitis C case with a clinically compatible illness and with positive anti-HCV laboratory results.

### Comments

1. Up to 20% of acute hepatitis C cases will be anti-HCV negative when reported and will be classified as non-A, non-B hepatitis because some (5%–10%) have not yet seroconverted and others (5%–10%) remain negative even with prolonged follow-up ( 6 ).
2. Available serologic tests for anti-HCV do not distinguish between acute and chronic or past infection. Thus, other causes of acute hepatitis should be excluded for anti-HCV positive patients who have an acute illness compatible with viral hepatitis.

## Hepatitis NANB, Viral

reporting code 07070

case report form CDC 53.1  
Viral Hepatitis Case Report

### Clinical case definition

An acute illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase levels

### Laboratory criteria for diagnosis

1. Serum aminotransferase levels >2.5 times the upper limit of normal, **and**
2. IgM anti-HAV negative, **and**
3. IgM anti-HBc negative (if done) or HBsAg negative, **and**
4. Anti-HCV negative (if done)

### Case classification

#### Confirmed:

A case that meets the clinical case definition and is laboratory confirmed



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**Hepatitis Unspecified, Viral**

reporting code 07090

case report form CDC 53.1  
Viral Hepatitis Case Report

## **Clinical case definition**

An acute illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase levels

## **Laboratory criteria for diagnosis**

1. No lab results available for A, B or C or
2. A, B or C is negative and the others are unknown

## **Case classification**

### Confirmed:

A case that meets the clinical case definition and is laboratory confirmed.

**Hepatitis,**

reporting code 7744

case report form CDC 53.1

**Perinatal Hepatitis B**

Viral Hepatitis Case Report

## **Clinical description**

Perinatal hepatitis B in the newborn may range from asymptomatic to fulminant hepatitis.

## **Laboratory criteria for diagnosis**

- Hepatitis B surface antigen (HBsAg) positive

## **Case classification**

Confirmed: HBsAg positivity in any infant aged >1–24 months who was born to an HBsAg-positive mother

## **Comment**

Infants born to HBsAg-positive mothers should receive hepatitis B immune globulin (HBIG) and the first dose of hepatitis B vaccine within 12 hours of birth, followed by the second and third doses of vaccine at 1 and 6 months of age, respectively. Postvaccination testing for HBsAg and antibody to hepatitis B surface antigen (anti-HBs) is recommended from 3 to 9 months following completion of the vaccine series. If HBIG and the initial dose of vaccine are delayed for >1 month after birth, testing for HBsAg may determine if the infant is already infected.

*Reminder: Women who are known to have tested HbsAg positive during pregnancy must be reported to the State Health Office, Bureau of Immunization in accordance with County Health Department Guidebook, Internal Operating Policy: Immun 7, and Technical Assistance: Immun 7. Questions regarding these procedures should be directed to the State Health Office Immunization Program at (904) 487-2755 or s/c 277-2755.*

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## Histoplasmosis

reporting code 11590

case report form N/A

### Clinical case definition

Systemic mycosis of varying severity, with the primary lesion usually in the lungs.

### Laboratory criteria for diagnosis

- Culture or identification of the fungus in smears of ulcer exudates, bone marrow, sputum or blood

### Case classification

Confirmed: Clinically compatible illness that is laboratory confirmed

Probable: Clinically compatible illness with a single high titer or paired rising titers

### Comment

While infection with *Histoplasma capsulatum* is common, acute illness is not. Disseminated histoplasmosis is considered an important marker for AIDS, so please notify your AIDS surveillance staff of all cases

## Kawasaki Disease

reporting code 44610

case report form CDC 55.54

Kawasaki Syndrome Case Reporting

### Clinical case definition

Self-limited febrile, exanthematous multi-system illness

### Laboratory criteria for diagnosis

N/A

### Case classification

Confirmed: Fever of at least five days' duration and at least four of the following five symptoms **in a case where there is no other more reasonable explanation for the observed clinical findings\***:

1. bilateral conjunctival infection
2. oral changes
3. peripheral extremity changes
4. **truncal rash that varies from erythematous maculopapular lesions to scarlatiniform**
5. cervical lymphadenopathy

***\*Note: To exclude other diagnoses, check ASO titers or throat cultures. Additional lab data e.g. highest platelet county during illness, aseptic pyuria, aseptic meningitis, aspirin levels at the beginning of illness and later, correlating this with the dose of aspirin given.***

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## Lead Poisoning

reporting code 94890

case report form N/A

### Clinical case definition

Often asymptomatic but may result in impaired neurobehavioral development, low IQ, slow nerve conduction, peripheral neuropathies, and encephalopathy.

### Laboratory criteria for diagnosis

Confirmed: Blood lead level  $\geq 10$  micrograms per deciliter of whole blood measured from a venous specimen

Probable: Blood lead level  $\geq 10$  micrograms per deciliter measured from **TWO** capillary draws taken **within 12 weeks** of one another

Suspect: Blood lead level  $\geq 10$  micrograms per deciliter measured from a single capillary draw or, Blood lead level  $\geq 10$  micrograms per deciliter of blood with no test type indication.

### Case classification

No symptoms necessary; case classifications provided in the “laboratory criteria for diagnosis”

### Comment

1. Only report lead poisoning to HSDE once per lifetime.
2. Capillary tests  $\geq 10$  micrograms per deciliter with a venous follow-up tests should not be counted as “suspected” cases. If a case is initially reported as “suspect” and then a confirmatory venous test result is received, the “suspect” case needs to be updated to a “confirmed” status.
3. The reportable level of lead poisoning in Florida is the same for children as for adults.
4. Requirements for reporting to the State Health Office and the requirements for home health environmental inspections of elevated lead clients, are decidedly different.

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## Legionellosis

reporting code 48280

case report form CDC 52.56  
Legionellosis Case Report

### Clinical description

Legionellosis is associated with two clinically and epidemiologically distinct illnesses: Legionnaires disease, which is characterized by fever, myalgia, cough, pneumonia, and Pontiac fever, a milder illness without pneumonia.

### Laboratory criteria for diagnosis

- Isolation of Legionella from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluids, or
- Demonstration of a fourfold or greater rise in the reciprocal immunofluorescence antibody (IFA) titer to  $\geq 128$  against Legionella pneumophila serogroup 1 between paired acute- and convalescent-phase serum specimens, or
- Detection of L. pneumophila serogroup 1 in respiratory secretions, lung tissue, or pleural fluid by direct fluorescent antibody testing, or
- Demonstration of L. pneumophila serogroup 1 antigens in urine by radioimmunoassay or enzyme-linked immunosorbent assay

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

### Comment

The previously used category of "probable case," which was based on a single IFA titer, lacks specificity for surveillance and is no longer used.

## Leptospirosis

reporting code 10090

case report form CDC 52.26  
Leptospirosis Case Investigation Report

### Clinical description

An illness characterized by fever, headache, chills, myalgia, conjunctival suffusion, and less frequently by meningitis, rash, jaundice, or renal insufficiency. Symptoms may be biphasic.

### Laboratory criteria for diagnosis

- Isolation of Leptospira from a clinical specimen, or
- Fourfold or greater increase in Leptospira agglutination titer between acute- and convalescent-phase serum specimens obtained  $\geq 2$  weeks apart and studied at the same laboratory, or
- Demonstration of Leptospira in a clinical specimen by immunofluorescence

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with supportive serologic findings (i.e., a Leptospira agglutination titer of  $\geq 200$  in one or more serum specimens)

**Lyme Disease**reporting code 06959case report form CDC 52.60  
Lyme Disease Case Report Form**Clinical description**

A systemic, tickborne disease with protean manifestations, including dermatologic, rheumatologic, neurologic, and cardiac abnormalities. The best clinical marker for the disease is the initial skin lesion (i.e., erythema migrans [EM]) that occurs in 60%–80% of patients.

This surveillance case definition was developed for national reporting of Lyme disease; it is not intended to be used in clinical diagnosis.

**Clinical criteria for reporting (not diagnosis)**

Definition of terms used in the clinical description and case definition:

- Erythema migrans. For purposes of surveillance, EM is defined as a skin lesion that typically begins as a red macule or papule and expands over a period of days to weeks to form a large round lesion, often with partial central clearing. A single primary lesion must reach  $\geq 5$  cm in size. Secondary lesions also may occur. Annular erythematous lesions occurring within several hours of a tick bite represent hypersensitivity reactions and do not qualify as EM. For most patients, the expanding EM lesion is accompanied by other acute symptoms, particularly fatigue, fever, headache, mildly stiff neck, arthralgia, or myalgia. These symptoms are typically intermittent. The diagnosis of EM must be made by a physician. Laboratory confirmation is recommended for persons with no known exposure.
- Late manifestations. Late manifestations include any of the following when an alternate explanation is not found:
  1. Musculoskeletal system. Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints, sometimes followed by chronic arthritis in one or a few joints. Manifestations not considered as criteria for diagnosis include chronic progressive arthritis not preceded by brief attacks and chronic symmetrical polyarthritides. Additionally, arthralgia, myalgia, or fibromyalgia syndromes alone are not criteria for musculoskeletal involvement.
  2. Nervous system. Any of the following, alone or in combination: lymphocytic meningitis; cranial neuritis, particularly facial palsy (may be bilateral); radiculoneuropathy; or, rarely, encephalomyelitis. Encephalomyelitis must be confirmed by demonstration of antibody production against *B. burgdorferi* in the CSF, evidenced by a higher titer of antibody in CSF than in serum. Headache, fatigue, paresthesia, or mildly stiff neck alone are not criteria for neurologic involvement.
  3. Cardiovascular system. Acute onset of high-grade (2° or 3°) atrioventricular conduction defects that resolve in days to weeks and are sometimes associated with myocarditis. Palpitations, bradycardia, bundle branch block, or myocarditis alone are not criteria for cardiovascular involvement.
- Exposure. Exposure is defined as having been ( $\leq 30$  days before onset of EM) in wooded, brushy, or grassy areas (i.e., potential tick habitats) in a county in which Lyme disease is endemic. A history of tick bite is not required.
- Disease endemic to county. A county in which Lyme disease is endemic is one in which at least two confirmed cases have been previously acquired or in which established populations of a known tick vector are infected with *B. burgdorferi*.

**Laboratory criteria for diagnosis**

- Isolation of *Borrelia burgdorferi* from a clinical specimen or
- Demonstration of diagnostic immunoglobulin M or immunoglobulin G antibodies to *B. burgdorferi* in serum or cerebrospinal fluid (CSF). A two-test approach using a sensitive enzyme immunoassay or immunofluorescence antibody followed by Western blot is recommended.

**Case classification**

Confirmed: a case with EM or

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a case with at least one late manifestation (as defined in clinical criteria for reporting) that is laboratory confirmed.

## Malaria

reporting code 08460

case report form CDC 54.1

Malaria Case Surveillance Report

### Clinical description

Signs and symptoms are variable; however, most patients experience fever. In addition to fever, common associated symptoms include headache, back pain, chills, sweats, myalgia, nausea, vomiting, diarrhea, and cough. Untreated *Plasmodium falciparum* infection can lead to coma, renal failure, pulmonary edema, and death. The diagnosis of malaria should be considered for any person who has these symptoms and who has traveled to an area in which malaria is endemic. Asymptomatic parasitemia can occur among persons who have been long term residents of areas in which malaria is endemic.

### Laboratory criteria for diagnosis

- Demonstration of malaria parasites in blood films

### Case classification

Confirmed: an episode of microscopically confirmed malaria parasitemia in any person (symptomatic or asymptomatic) diagnosed in the United States, regardless of whether the person experienced previous episodes of malaria while outside the country

### Comment

The CDC case report form contains instructions to submit blood smears with the case report. This is an antiquated requirement - do NOT submit smears. However, for cases in which the reporting source is unable to speculate, a smear should be sent to the state laboratory.

A subsequent attack experienced by the same person but caused by a different *Plasmodium* species is counted as an additional case. A subsequent attack experienced by the same person and caused by the same species in the United States may indicate a relapsing infection or treatment failure caused by drug resistance.

Blood smears from questionable cases should be referred to the National Malaria Repository, CDC, for confirmation of the diagnosis.

Cases also are classified according to the following World Health Organization categories:

- Autochthonous:

Indigenous: malaria acquired by mosquito transmission in an area where malaria is a regular occurrence

Introduced: malaria acquired by mosquito transmission from an imported case in an area where malaria is not a regular occurrence

- Imported: malaria acquired outside a specific area (e.g., the United States and its territories)

- Induced: malaria acquired through artificial means (e.g., blood transfusion, common syringes, or malariotherapy)

- Relapsing: renewed manifestation (i.e., of clinical symptoms and/or parasitemia) of malarial infection that is separated from previous manifestations of the same infection by an interval greater than any interval resulting from the normal periodicity of the paroxysms

- Cryptic: an isolated case of malaria that cannot be epidemiologically linked to additional cases

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## Measles (Rubeola)

reporting code 05590

case report form HRS 975

Epidemiologic Case History of Rash Illness

### Clinical case definition

An illness characterized by all the following:

- a generalized rash lasting  $\geq 3$  days
- a temperature  $\geq 101.0$  F ( $\geq 38.3$  C)
- cough, coryza, or conjunctivitis

### Laboratory criteria for diagnosis

- Positive serologic test for measles immunoglobulin M antibody, or
- Significant rise in measles antibody level by any standard serologic assay, or
- Isolation of measles virus from a clinical specimen

### Case classification

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed case. A laboratory confirmed case does not need to meet the clinical case definition.

Probable: a case that meets the clinical case definition, has noncontributory or no serologic or virologic testing, and is not epidemiologically linked to a confirmed case

Suspected: any febrile illness accompanied by rash

*Note: Questions regarding the follow-up of measles should be directed to your District Immunization Program representative or the State Health Office Immunization Program at (904) 487-2755 or s/c 277-2755*

## Meningitis, Bacterial (see also Meningococcal Disease)

reporting codes 32040 Grp B Strep

case reporting form CDC 52.15

32000 H-flu

National Bacterial Meningitis

32070 List mono

and Bacteremia Case Report

32090 Other bacterial

32020 Strep pneumoniae

### Clinical description

Bacterial meningitis manifests most commonly with fever, headache, and a stiff neck; the disease may progress rapidly to shock and death. However, other manifestations may be observed.

### Laboratory criteria for diagnosis

- Isolation of a bacterial species from the cerebrospinal fluid

### Case classification

Confirmed: a clinically compatible case that is either laboratory confirmed or is accompanied by a positive blood culture

### Comment

Sputum cultures are not considered confirmatory as sputum is not a normally sterile site.

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## Meningococcal Disease

reporting codes 03600 Meningococcal case reporting form CDC 52.15  
03620 Disseminated National Bacterial Meningitis  
meningococemia and Bacteremia Case Report

### Clinical description

Meningococcal disease manifests most commonly as meningitis and/or meningococemia that may progress rapidly to purpura fulminans, shock, and death. However, other manifestations might be observed.

### Laboratory criteria for diagnosis

- Isolation of *Neisseria meningitidis* from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid)

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a case with a positive antigen test in CSF or clinical purpura fulminans in the absence of a positive blood culture

### Comment

Positive antigen test results from urine or serum samples are unreliable for diagnosing meningococcal disease. Sputum cultures are not considered confirmatory as sputum is not a normally sterile site.

## Mercury Poisoning

reporting code 94899 case report form N/A

### Clinical description

Symptoms depend upon the form of mercury (organic or inorganic) as well as the route and dose ingested. Any organ system may be affected.

### Laboratory criteria for diagnosis

- $\geq 20$  micrograms per liter of urine, or
- $\geq 20$  micrograms per liter of blood, or
- $\geq 5$  micrograms per gram of hair

### Case classification

Confirmed: Laboratory confirmed



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## Mumps

reporting code 07290

case report form N/A

### Clinical case definition

An illness with acute onset of unilateral or bilateral tender, self-limited swelling of the parotid or other salivary gland, lasting  $\geq 2$  days, and without other apparent cause

### Laboratory criteria for diagnosis

- Isolation of mumps virus from clinical specimen, or
- Significant rise between acute- and convalescent-phase titers in serum mumps immunoglobulin G antibody level by any standard serologic assay, or
- Positive serologic test for mumps immunoglobulin M (IgM) antibody

### Case classification

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed or probable case. A laboratory confirmed case does not need to meet the clinical case definition.

Probable: a case that meets the clinical case definition, has noncontributory or no serologic or virologic testing, and is not epidemiologically linked to a confirmed or probable case

### Comment

Two probable cases that are epidemiologically linked would be considered confirmed, even in the absence of laboratory confirmation. False positive IgM results by immunofluorescent antibody assays have been reported.

*Questions regarding the follow-up of mumps cases should be directed to your District Immunization Program representative or the State Health Office Immunization Program at (904) 487-2755 or s/c 277-2755*

## Neurotoxic Shellfish Poisoning

reporting code 98800

case report form CDC 52.13

Investigation of Foodborne Illness

### Clinical case definition

Onset is within a few minutes to a few hours after consumption of epidemiologically implicated shellfish. Symptoms include tingling and numbness of lips, tongue, and throat, muscular aches, dizziness, reversal of hot and cold sensations and diarrhea and vomiting. Duration is from a few hours to several days with complete recovery (few sequelae) and no reported fatalities.

### Laboratory criteria for diagnosis

Isolation of neurotoxin in epidemiologically implicated shellfish

### Case classification

Confirmed: Clinically compatible illness that is associated with consumption of shellfish from areas where other toxic shellfish have been found.

### Comment

Report even a single case of neurotoxic shellfish poisoning on the CDC Foodborne Outbreak form

Although the current Florida rule denotes "paralytic shellfish poisoning" as a reportable condition, the shellfish poisoning syndrome found in Florida is actually neurotoxic shellfish poisoning.

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## **Paralytic Shellfish Poisoning**

(See Neurotoxic Shellfish Poisoning)

Although the current Florida rule denotes “paralytic shellfish poisoning” as a reportable condition, the shellfish poisoning syndrome found in Florida is actually neurotoxic shellfish poisoning.

## **Pertussis**

reporting code 03390

case report form CDC 71.14A  
Pertussis Report

### **Clinical case definition**

A cough illness lasting  $\geq 2$  weeks with one of the following: paroxysms of coughing, inspiratory “whoop,” or posttussive vomiting, without other apparent cause

### **Laboratory criteria for diagnosis**

- Isolation of *Bordetella pertussis* from clinical specimen or
- Positive polymerase chain reaction for *B. pertussis*

### **Case classification**

Confirmed: a case that is laboratory confirmed or one that meets the clinical case definition and is either laboratory confirmed or epidemiologically linked to a laboratory confirmed case\_

Probable: a case that meets the clinical case definition, is not laboratory confirmed, and is not epidemiologically linked to a laboratory confirmed case

*Questions about pertussis follow-up should be directed to your District Immunization Program representative or the State Health Office Immunization Program at (904) 487-2755 or s/c 277-2755*

## **Pesticide Poisoning**

reporting code 09894

case reporting form DACS 130320  
Pesticide Incident Monitoring Report

### **Clinical case definition**

Symptoms typically include vomiting, tremors, convulsions, visual disturbances, respiratory difficulty and gastrointestinal hyperactivity

### **Laboratory criteria for diagnosis**

Identification of toxic pesticides or their metabolites in blood or urine

### **Case classification**

Confirmed: Clinically compatible illness with either laboratory confirmation of therapeutic response to specific antidote

Probable: Clinically compatible illness with history of pesticide exposure

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## Plague

reporting codes 02000 Bubonic  
02050 Pneumonic

case report form N/A

### Clinical description

Plague is transmitted to humans by fleas or by direct exposure to infected tissues or respiratory droplets; the disease is characterized by fever, chills, headache, malaise, prostration, and leukocytosis that manifests in one or more of the following principal clinical forms:

- Regional lymphadenitis (bubonic plague)
- Septicemia without an evident bubo (septicemic plague)
- Plague pneumonia, resulting from hematogenous spread in bubonic or septicemic cases (secondary pneumonic plague) or inhalation of infectious droplets (primary pneumonic plague)
- Pharyngitis and cervical lymphadenitis resulting from exposure to larger infectious droplets or ingestion of infected tissues (pharyngeal plague)

### Laboratory criteria for diagnosis

#### Presumptive

- Elevated serum antibody titer(s) to *Yersinia pestis* fraction 1 (F1) antigen (without documented fourfold or greater change) in a patient with no history of plague vaccination or
- Detection of F1 antigen in a clinical specimen by fluorescent assay Confirmatory
- Isolation of *Y. pestis* from a clinical specimen or
- Fourfold or greater change in serum antibody titer to *Y. pestis* F1 antigen

### Case classification

Confirmed: a clinically compatible case with confirmatory laboratory results

Probable: a clinically compatible case with presumptive laboratory results

Suspected: a clinically compatible case without presumptive or confirmatory laboratory results

## Poliomyelitis, Paralytic

reporting code 04590

case report form CDC 55.2  
Polio Surveillance Case Report

### Clinical case definition

Acute onset of a flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs, without other apparent cause, and without sensory or cognitive loss

### Case classification

Confirmed: a case that meets the clinical case definition and in which the patient has a neurologic deficit 60 days after onset of initial symptoms, has died, or has unknown follow-up status

Probable: a case that meets the clinical case definition

*Note: For assistance with polio case definitions or follow-up, please contact your District Immunization Program Representative or the State Health Office Immunization Program office at (904) 487-2755 s/c 277-2755*

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## Psittacosis

reporting code 7390

case report form CDC 52.2  
Psittacosis Case Surveillance

### Clinical description

An illness characterized by fever, chills, headache, photophobia, cough, and myalgia

### Laboratory criteria for diagnosis

- Isolation of *Chlamydia psittaci* from respiratory secretions, or
- Fourfold or greater increase in antibody against *C. psittaci* by complement fixation or microimmunofluorescence (MIF) to a reciprocal titer of  $\geq 32$  between paired acute- and convalescent-phase serum specimens, or
- Presence of immunoglobulin M antibody against *C. psittaci* by MIF to a reciprocal titer of  $\geq 16$

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case or that has supportive serology (e.g., *C. psittaci* titer of  $\geq 32$  in one or more serum specimens obtained after onset of symptoms)

### Comment

The serologic findings by CF also may occur as a result of infection with *Chlamydia pneumoniae* or *Chlamydia trachomatis*. The MIF might be more specific for infection with *C. psittaci*, but experience with and availability of this newer test are more limited.

## Rabies, Animal

reporting code 07102

case report form: copy of state laboratory  
positive result

### Laboratory criteria for diagnosis

- A positive direct fluorescent antibody test (preferably performed on central nervous system tissue)
- Isolation of rabies virus (in cell culture or in a laboratory animal)

### Case classification

Confirmed: a case that is laboratory confirmed

### Comment

When completing the 2016 for a case of animal rabies, the following fields are to be filled: ICDCODE, DXSTATUS, LASTNAME (note the species of the animal i.e. RACCOON, CAT), ZIPCODE (where the animal was found), EVENTDATE, EVENTTYPE (since a lab result is needed for confirmation, eventtype should be "3" for rabies cases), OUTBREAK.

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## Rabies, Human

reporting code 07100

case report form N/A

### Clinical description

Rabies is an acute encephalomyelitis that almost always progresses to coma or death within 10 days after the first symptom.

### Laboratory criteria for diagnosis

- Detection by direct fluorescent antibody of viral antigens in a clinical specimen (preferably the brain or the nerves surrounding hair follicles in the nape of the neck), or
- Isolation (in cell culture or in a laboratory animal) of rabies virus from saliva, cerebrospinal fluid (CSF), or central nervous system tissue, or
- Identification of a rabies-neutralizing antibody titer  $\geq 5$  (complete neutralization) in the serum or CSF of an unvaccinated person.

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

### Comment

Laboratory confirmation by all of the above methods is strongly recommended.

CDC requests the following specimens: CSF, serum, or saliva (not sputum), biopsy of skin from the back of the neck just above hairline. Neck biopsy and saliva specimens should be sent by dry ice.

## Reyes Syndrome

reporting code 33181

case report form CDC 55.8  
Reye Syndrome Case Investigation Report

### Clinical case definition

An illness that meets all of the following criteria:

- Acute, noninflammatory encephalopathy that is documented clinically by a) an alteration in consciousness and, if available, b) a record of the CSF containing  $\leq 8$  leukocytes/mm<sup>3</sup> or a histologic specimen demonstrating cerebral edema without perivascular or meningeal inflammation
- Hepatopathy documented by either: a) a liver biopsy or an autopsy considered to be diagnostic of Reye syndrome or b) a threefold or greater increase in the levels SGOT/SGPT or serum ammonia.
- No more reasonable explanation for the cerebral and hepatic abnormalities.

### Laboratory criteria for diagnosis

N/A

### Case classification

Confirmed: a case that meets the clinical case definition.

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## Rocky Mountain Spotted Fever

reporting code 08200

case report form CDC 55.1  
Rocky Mountain Spotted  
Fever Case Report

### **Clinical description**

A tickborne febrile illness most commonly characterized by acute onset and usually accompanied by myalgia, headache, and petechial rash (on the palms and soles in two thirds of the cases)

### **Laboratory criteria for diagnosis**

- Fourfold or greater rise in antibody titer to *Rickettsia rickettsii* antigen by immunofluorescence antibody (IFA), complement fixation (CF), latex agglutination (LA), microagglutination (MA), or indirect hemagglutination antibody (IHA) test in acute- and convalescent-phase specimens ideally taken  $\geq 3$  weeks apart, or
- Positive polymerase chain reaction assay to *R. rickettsii*, or
- Demonstration of positive immunofluorescence of skin lesion (biopsy) or organ tissue (autopsy), or
- Isolation of *R. rickettsii* from clinical specimen

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with a single IFA serologic titer of  $\geq 64$  or a single CF titer of  $\geq 16$  or other supportive serology (fourfold rise in titer or a single titer  $\geq 320$  by Proteus OX-19 or OX-2, or a single titer  $\geq 128$  by an LA, IHA, or MA test)

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## Rubella

reporting code 05690

case report form HRS 975  
Epidemiologic Case History  
of Rash Illness

### **Clinical case definition**

An illness that has all the following characteristics:

- Acute onset of generalized maculopapular rash
- Temperature >99.0 F (>37.2 C), if measured
- Arthralgia/arthritis, lymphadenopathy, or conjunctivitis

### **Laboratory criteria for diagnosis**

- Isolation of rubella virus, or
- Significant rise between acute- and convalescent-phase titers in serum rubella immunoglobulin G antibody level by any standard serologic assay, or
- Positive serologic test for rubella immunoglobulin M (IgM) antibody

### **Case classification**

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a laboratory confirmed case

Probable: a case that meets the clinical case definition, has no or noncontributory serologic or virologic testing, and is not epidemiologically linked to a laboratory confirmed case

Suspect: any generalized rash illness of acute onset

### **Comments**

Serum rubella IgM test results that are false positives have been reported in persons with other viral infections (e.g., acute infection with Epstein-Barr virus [infectious mononucleosis], recent cytomegalovirus infection, and parvovirus infection) or in the presence of rheumatoid factor. Patients who have laboratory evidence of recent measles infection are excluded.

*Note: For questions regarding the follow-up of a rubella case, contact your District Immunization Program representative or the State Health Office Immunization Program at (904) 487-2755 or s/c 277-2755*

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**Rubella, Congenital Syndrome** reporting code 77100

case report form CDC 4.271  
Congenital Rubella Syndrome  
Case Report

## **Clinical description**

An illness usually manifesting in infancy resulting from rubella infection in utero and characterized by signs or symptoms from the following categories:

- Cataracts/congenital glaucoma, congenital heart disease (most commonly patent ductus arteriosus, or peripheral pulmonary artery stenosis), loss of hearing, pigmentary retinopathy
- Purpura, splenomegaly, jaundice, microcephaly, mental retardation, meningoencephalitis, radiolucent bone disease.

## **Clinical case definition**

Presence of any defects or laboratory data consistent with congenital rubella infection

## **Laboratory criteria for diagnosis**

- Isolation of rubella virus, or
- Demonstration of rubella-specific immunoglobulin M antibody, or
- Infant rubella antibody level that persists at a higher level and for a longer period than expected from passive transfer of maternal antibody (i.e., rubella titer that does not drop at the expected rate of a twofold dilution per month)

## **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a case that is not laboratory confirmed and that has any two complications listed in paragraph a) of the clinical description or one complication from paragraph a) and one from paragraph b), and lacks evidence of any other etiology

Suspect: a case with some compatible clinical findings but not meeting the criteria for a probable case

## **Comments**

1. A case that demonstrates laboratory evidence of infection, but without any clinical symptoms or signs is not reportable.
2. In probable cases, either or both of the eye-related findings (i.e., cataracts and congenital glaucoma) are interpreted as a single complication. In cases classified as infection only, if any compatible signs or symptoms (e.g., hearing loss) are identified later, the case is reclassified as confirmed.

*Questions regarding rubella follow-up should be directed to your District Immunization Program representative or the State Health Office Immunization Program at (904) 487-2755 s/c 277-2755.*



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## Salmonellosis

reporting code 00300

case report form N/A

### Clinical description

An illness of variable severity commonly manifested by diarrhea, abdominal pain, nausea, and sometimes vomiting. Also, the infectious agent may cause an extraintestinal infection and localize in any tissue in the body producing abscesses and causing such diseases as septic arthritis, endocarditis, meningitis, pericarditis, pneumonia, bacteremia, pyoderma or pyelonephritis.

### Laboratory criteria for diagnosis

- Isolation of *Salmonella* from a clinical specimen

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case

## Shigellosis

reporting code 00490

case report form N/A

### Clinical description

An illness of variable severity characterized by diarrhea, fever, nausea, cramps, and tenesmus.

### Laboratory criteria for diagnosis

- Isolation of *Shigella* from a clinical specimen

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case

## Streptococcal Disease, Invasive, Group A

reporting code 03400

case report form Rev. 7/96

(Added 7-96)

Invasive Group A streptococcus  
Surveillance Report

### Clinical description

Invasive group A streptococcal infections may manifest as any of several clinical syndromes, including pneumonia, bacteremia in association with cutaneous infection (e.g., cellulitis, erysipelas, or infection of a surgical or nonsurgical wound), deep soft tissue infection (e.g., myositis or necrotizing fasciitis), meningitis, peritonitis, osteomyelitis, septic arthritis, postpartum sepsis (i.e., puerperal fever), neonatal sepsis, and nonfocal bacteremia.

### Laboratory criteria for diagnosis

- Isolation of group A Streptococcus (*Streptococcus pyogenes*) by culture from a normally sterile site (e.g., blood or cerebrospinal fluid, or, less commonly, joint, pleural, or pericardial fluid)

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

### Comment

See also Streptococcal Toxic Shock Syndrome.

Patients with toxic shock syndrome secondary to a streptococcal disease invasive group A infection should be reported with BOTH disease codes (as if they were separate cases) on the 2016 form.

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## ***Streptococcus pneumoniae*, Drug-Resistant Invasive Disease**

(Added 7-96)

reporting code 04823

case report form Rev. 7/96

Invasive *Streptococcus pneumoniae* Surveillance Report

### **Clinical description**

*Streptococcus pneumoniae* causes many clinical syndromes, depending on the site of infection (e.g., acute otitis media, pneumonia, bacteremia, or meningitis).

### **Laboratory criteria for diagnosis**

- Isolation of *S. pneumoniae* from a normally sterile site (e.g., blood, cerebrospinal fluid, or, less commonly, joint, pleural, or pericardial fluid) and
- “Nonsusceptible” isolate (i.e., intermediate or high level resistance of the *S. pneumoniae* isolate to at least one antimicrobial agent currently approved for use in treating pneumococcal infection)

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case caused by laboratory confirmed culture of *S. pneumoniae* identified as “nonsusceptible” (i.e., an oxacillin zone size of <20 mm) when oxacillin screening is the only method of antimicrobial susceptibility testing performed

## **Tetanus**

reporting code 03700

case report form CDC 71.15  
Tetanus Surveillance Case Report

### **Clinical case definition**

Acute onset of hypertonia and/or painful muscular contractions (usually of the muscles of the jaw and neck) and generalized muscle spasms without other apparent medical cause

### **Laboratory criteria for diagnosis**

N/A

### **Case classification**

Confirmed: a clinically compatible case, as reported by a healthcare professional

*Questions regarding tetanus follow up should be directed to your District Immunization Program representative or the State Health Office Immunization Program at (904) 487-2755 or s/c 277-2755*

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## Toxic Shock Syndrome, Staphylococcal

reporting code 3812

case report form CDC 52.3

Toxic Shock Syndrome  
Case Report

Comment: *Streptococcal* Toxic Shock Syndrome is a separate reportable condition

### Clinical case definition

An illness with the following clinical manifestations:

- **Fever:** temperature  $\geq 102.0$  F ( $\geq 38.9$  C)
- **Rash:** diffuse macular erythroderma
- **Desquamation:** 1–2 weeks after onset of illness, particularly on the palms and soles
- **Hypotension:** systolic blood pressure  $\leq 90$  mm Hg for adults or less than fifth percentile by age for children aged  $<16$  years; orthostatic drop in diastolic blood pressure  $\geq 15$  mm Hg from lying to sitting, orthostatic syncope, or orthostatic dizziness

- **Multisystem involvement (three or more of the following):**

Gastrointestinal: vomiting or diarrhea at onset of illness Muscular: severe myalgia or creatine phosphokinase level at least twice the upper limit of normal Mucous membrane: vaginal, oropharyngeal, or conjunctival hyperemia Renal: blood urea nitrogen or creatinine at least twice the upper limit of normal for laboratory or urinary sediment with pyuria ( $\geq 5$  leukocytes per high power field) in the absence of urinary tract infection Hepatic: total bilirubin, alanine aminotransferase enzyme, or aspartate aminotransferase enzyme levels at least twice the upper limit of normal for laboratory Hematologic: platelets  $<100,000/\text{mm}^3$  Central nervous system: disorientation or alterations in consciousness without focal neurologic signs when fever and hypotension are absent.

### Laboratory criteria

Negative results on the following tests, if obtained:

- Blood, throat, or cerebrospinal fluid cultures (blood culture may be positive for *Staphylococcus aureus*)
- Rise in titer to Rocky Mountain spotted fever, leptospirosis, or measles

### Case classification

Confirmed: a case in which all six of the clinical findings described above are present, including desquamation, unless the patient dies before desquamation occurs

Probable: a case in which five of the six clinical findings described above are present

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## Toxic Shock Syndrome, Streptococcal

(Added 7-96)

Comment: *Staphylococcal* Toxic Shock Syndrome is a separate reportable condition

reporting code 3412

case report form CDC 52.3

Toxic Shock Syndrome  
Case Report

### Clinical description

Streptococcal toxic shock syndrome (STSS) is a severe illness associated with invasive or noninvasive group A streptococcal (*Streptococcus pyogenes*) infection.

STSS may occur with infection at any site but most often occurs in association with infection of a cutaneous lesion. Signs of toxicity and a rapidly progressive clinical course are characteristic, and the case fatality rate may exceed 50%.

### Clinical case definition

An illness with the following clinical manifestations occurring within the first 48 hours of hospitalization or, for a nosocomial case, within the first 48 hours of illness:

- Hypotension defined by a systolic blood pressure  $\leq 90$  mm Hg for adults or less than the fifth percentile by age for children aged  $<16$  years
  - Multi-organ involvement characterized by two or more of the following:
    1. Renal impairment: Creatinine  $\geq 2$  mg/dL ( $\geq 177$   $\mu\text{mol/L}$ ) for adults or greater than or equal to twice the upper limit of normal for age. In patients with preexisting renal disease, a greater than twofold elevation over the baseline level.
    2. Coagulopathy: Platelets  $\leq 100,000/\text{mm}^3$  ( $\leq 100 \times 10^6/\text{L}$ ) or disseminated intravascular coagulation, defined by prolonged clotting times, low fibrinogen level, and the presence of fibrin degradation products
    3. Liver involvement: Alanine aminotransferase, aspartate aminotransferase, or total bilirubin levels greater than or equal to twice the upper limit of normal for the patient's age. In patients with preexisting liver disease, a greater than two-fold increase over the baseline level
- \*Resistance defined by National Committee for Clinical Laboratory Standards (NCCLS)-approved methods and NCCLS-approved interpretive minimum inhibitory concentration (MIC) standards ( $\mu\text{g/mL}$ ) for *S. pneumoniae*. NCCLS recommends that all invasive *S. pneumoniae* isolates found to be "possibly resistant" to beta-lactams (i.e., an oxacillin zone size of  $<20$  mm) by oxacillin screening should undergo further susceptibility testing by using a quantitative MIC method acceptable for penicillin, extended-spectrum cephalosporins, and other drugs as clinically indicated ( 11,12).
4. Acute respiratory distress syndrome: defined by acute onset of diffuse pulmonary infiltrates and hypoxemia in the absence of cardiac failure or by evidence of diffuse capillary leak manifested by acute onset of generalized edema, or pleural or peritoneal effusions with hypoalbuminemia
  5. A generalized erythematous macular rash that may desquamate
  6. Soft tissue necrosis, including necrotizing fasciitis or myositis, or gangrene

### Laboratory criteria for diagnosis

- Isolation of group A *Streptococcus* by culture from an appropriate clinical specimen (nonsterile site is acceptable for a "probable" case, see "case classification" below)

### Case classification

Confirmed: a case that meets the clinical case definition and with isolation of group A *Streptococcus* from a normally sterile site (e.g., blood or cerebrospinal fluid or, less commonly, joint, pleural, or pericardial fluid)

Probable: a case that meets the clinical case definition in the absence of another identified etiology for the illness and with isolation of group A *Streptococcus* from a nonsterile site

### Comment

See also Streptococcal Disease, Invasive, Group A.

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## **Toxoplasmosis**

reporting code 13090

case report form N/A

### **Clinical description**

A systemic protozoan disease which is frequently asymptomatic or may present as an acute disease resembling infectious mononucleosis. Among immunodeficient individuals such as AIDS patients, the disease may include cerebral signs, pneumonia, generalized skeletal muscle involvement, myocarditis, a maculopapular rash and death.

### **Laboratory criteria for diagnosis**

Demonstration of the agent in tissues or body fluids, or fourfold change in specific antibody titers in sequential sera.

### **Case classification**

Confirmed: Clinically compatible illness that is laboratory confirmed

Probable: Asymptomatic case that is laboratory confirmed

## **Trichinosis**

reporting code 12400

case report form CDC 54.7

Trichinosis Surveillance Case Report

### **Clinical description**

A disease caused by ingestion of *Trichinella* larvae. The disease has variable clinical manifestations. Common signs and symptoms among symptomatic persons include eosinophilia, fever, myalgia, and periorbital edema.

### **Laboratory criteria for diagnosis**

- Demonstration of *Trichinella* larvae in tissue obtained by muscle biopsy, or
- Positive serologic test for *Trichinella*

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

### **Comment**

In an outbreak setting, at least one case must be laboratory confirmed. Associated cases should be reported as confirmed if the patient shared an epidemiologically implicated meal or ate an epidemiologically implicated meat product and has either a positive serologic test for trichinosis or a clinically compatible illness.

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## Typhoid Fever

reporting code 00200

case report form CDC 52.5  
Typhoid Fever Surveillance Report

### Clinical description

An illness caused by *Salmonella typhi* that is often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and nonproductive cough.

However, many mild and atypical infections occur.

Carriage of *S. typhi* may be prolonged.

### Laboratory criteria for diagnosis

- Isolation of *S. typhi* from blood, stool, or other clinical specimen

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case in an outbreak

### Comment

Isolation of the organism is required for confirmation. Serologic evidence alone is not sufficient for diagnosis. Asymptomatic carriage should not be reported as typhoid fever.

## Typhus

reporting codes 08000 Louse  
08100 Murine

case report form N/A

### Clinical description

A rickettsial disease often with sudden onset marked by headache, chills, prostration, fever and general pains.

A macular rash appears on the fifth or sixth day, but may be absent in mild infections. The disease is transmitted by infected lice.

### Laboratory criteria for diagnosis

Positive immunofluorescent antibody test, group specific or type-specific complement fixation test or latex agglutination test.

### Case classification

Confirmed: Clinically compatible illness that is laboratory confirmed

### Comment

Louse-borne typhus is caused by *Rickettsia prowazekii* while Murine typhus is caused by *Rickettsia typhi*. The course of Murine typhus is generally milder than that of louse-borne typhus.

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## **Vibrio, Infections (see also Cholera, Vibrio)**

reporting codes 00193 *Vibrio*, other case report form CDC 52.79

00194 *V. fluvialis* Vibrio Illness Case Report form

00195 *V. alginolyticus* Investigation

00196 *V. hollisae*

00197 *V. mimicus*

00198 *V. cholerae* type non-01

00199 *V. vulnificus*

00540 *V. parahaemolyticus*

### **Clinical description**

Acute bacterial enteric disease with sudden onset of watery diarrhea.

**Any acute bacterial wound, enteric or systemic infection from a Vibrio species.??**

### **Laboratory criteria for diagnosis**

Diagnosis is confirmed by culturing the organism from feces. A presumptive diagnosis can be made by visualization of characteristic vibrio motility inhibited by serotype-specific antiserum, or demonstration of a significant rise in titer of antitoxin and vibriocidal antibodies.

### **Case classification**

Confirmed: Clinically compatible illness that is culture confirmed

Probable: Clinically compatible illness with positive serology or epi-linked to a confirmed case.

*Note: Please notify the Florida Department of Environmental Protection of any Vibrio infections thought to be associated with shellfish consumption*

## **Yellow Fever**

reporting code 06090

case report form N/A

### **Clinical description**

A mosquito-borne viral illness characterized by acute onset and constitutional symptoms followed by a brief remission and a recurrence of fever, hepatitis, albuminuria, and symptoms and, in some instances, renal failure, shock, and generalized hemorrhages

### **Laboratory criteria for diagnosis**

- Fourfold or greater rise in yellow fever antibody titer in a patient who has no history of recent yellow fever vaccination and cross-reactions to other flaviviruses have been excluded or
- Demonstration of yellow fever virus, antigen, or genome in tissue, blood, or other body fluid

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with supportive serology (stable elevated antibody titer to yellow fever virus [e.g.,  $\geq 32$  by complement fixation,  $\geq 256$  by immunofluorescence assay,  $\geq 320$  by hemagglutination inhibition,  $\geq 160$  by neutralization, or a positive serologic result by immunoglobulin M-capture enzyme immunoassay]. Cross-reactive serologic reactions to other flaviviruses must be excluded, and the patient must not have a history of yellow fever vaccination.)