June 2000

Florida Department of Health
Bureau of Epidemiology
Surveillance Case Definitions for
Select Reportable Diseases in Florida

Department of Health
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Case Definitions for Select Diseases and Conditions Under Public Health Surveillance

INTRODUCTION

The importance of surveillance data collected from reportable disease information cannot be overstated. Without such data, trends cannot be accurately monitored, unusual occurrences of diseases might not be detected, and the effectiveness of intervention activities cannot be easily evaluated. Uniform reporting criteria, in addition to the simplicity and timeliness of surveillance data, are fundamental to increasing the specificity of reporting and improving the comparability of information about diseases occurring in different regions of the state. This document provides updated uniform criteria for the local county public health departments to use when reporting Florida's notifiable infectious diseases. Newly generated case definitions that have not been previously published are designated as "adopted" with the date of adoption noted.

The case definitions included in this document differ in their use of clinical, laboratory, and epidemiologic criteria to define cases. For example, some clinical syndromes do not have confirmatory laboratory tests; however, laboratory evidence may be one component of a clinical definition (e.g., toxic-shock syndrome). Some diseases require laboratory confirmation for diagnosis regardless of clinical symptoms, whereas others are diagnosed based on epidemiologic data alone. **To assist in laboratory diagnosis and epidemiologic investigation, there are certain diseases for which an isolate of the organism should be sent to the State Central Laboratory, including: anthrax, brucellosis, cholera, diphtheria, pathogenic *E. coli* enteric disease, *H. influenzae* invasive disease, listeriosis, meningitis caused by *N. meningitidis*, plague, and typhoid fever. In addition, permanent slides from both malaria and cyclospora cases and acute and convalescent sera for arboviral encephalitis, dengue, ehrlichiosis, and RMSF should be sent to the state lab.**

Substantial amounts of information, including laboratory tests, must be collected for many diseases before a final case classification is possible. **Since final case review and classification is performed at the state level using laboratory as well clinical data, it is requested that copies of the laboratory reports be submitted with case report forms for certain diseases.** These are: brucellosis, dengue fever, ehrlichiosis, arboviral encephalitis, pathogenic *E. coli* enteric disease, hemorrhagic fever, hepatitis (A, B, Non A-Non B, C, and others), legionellosis, leptospirosis, listeriosis, lyme disease, psittacosis, Rocky Mountain Spotted Fever, invasive *Streptococcus pneumoniae* disease, glycopeptide intermediate (MIC=8ug/ml) *Staphylococcus aureus*, and glycopeptide resistant (MIC≥32ug/ml *Staphylococcus aureus*. In addition, permanent slides from cases and suspected cases of cyclosporiasis and malaria should be sent to the State Laboratory, Jacksonville Branch, for analysis.

HOW TO USE INFORMATION IN THIS REPORT

These case definitions are to be used for identifying and classifying cases for reporting to the Department of Health, Bureau of Epidemiology. Terms that are used in case classifications are defined in the section *Definition of Terms Used in Case Classification* below.

Definition of Terms Used in Case Classification

CLINICALLY COMPATIBLE CASE: a clinical syndrome generally compatible with the disease, as described in the clinical description.

CONFIRMED CASE: a case that is classified as confirmed for reporting purposes.

EPIDEMIOLOGICALLY LINKED CASE: a case in which - a) the patient has had contact with one or more persons who either have/had the disease or have been exposed to a point source of infection (i.e., a single source of infection, such as an event leading to a foodborne-disease outbreak, to which all confirmed case-patients were exposed) and b) transmission of the agent by the usual modes of transmission is plausible. A case may be considered epidemiologically linked to a laboratory-confirmed case if at least one case in the chain of transmission is laboratory confirmed.

LABORATORY-CONFIRMED CASE: a case that is confirmed by one or more of the laboratory methods listed in the case definition under Laboratory Criteria for Diagnosis.

PROBABLE CASE: a case that is classified as probable for reporting purposes.

SUPPORTIVE or PRESUMPTIVE LABORATORY RESULTS: specified laboratory results that are consistent with the diagnosis yet do not meet the criteria for laboratory confirmation.

SUSPECTED CASE: a case that is classified as suspected for reporting purposes.

Bureau of Epidemiology
SURVEILLANCE CASE DEFINITIONS
FOR
SELECT REPORTABLE DISEASES IN FLORIDA
June 2000

Animal Bite

(to humans by a potentially rabid animal resulting in a county health department or state health office recommendation for post-exposure prophylaxis, or by a nonhuman primate)

reporting code 07101 case report form: DOH 4042

Clinical description

Tissue trauma due to an animal bite

Laboratory criteria for diagnosis

N/A

Case classification

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

Comment

The following is requested by HSDE: 1) patient information – age, sex, race, occupation, location of wound on body site, and whether PEP given; 2) animal information – species, vaccinated/non-vaccinated, ownership (stray, wild, owned), and lab rabies results. Animal Bite Report forms are available from the Bureau of Epidemiology.

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

Comment

Any isolates from cases or suspected cases should be sent to the State Central Laboratory.

Detection of a suspected case is a PUBLIC HEALTH EMERGENCY.

Botulism, Foodborne

reporting code 00510 case report form CDC 52.50 (4/83)

Botulism Alert Summary

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.

Specimens (food, feces, sera) to be sent for laboratory diagnosis (toxin testing) from suspected cases of botulism must be cleared through the Bureau of Epidemiology (850) 245-4401.

Trivalent botulium antitoxin is available through the Bureau at the above telephone number, 24 hours per day.

Botulism, Infant

reporting code 00511 case report form CDC 52.50 (4/83)

Botulism Alert Summary

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

Comment

Specimens (feces, sera) to be sent for laboratory diagnosis (toxin testing) from suspected cases of botulism must be cleared through the Bureau of Epidemiology (850) 245-4401.

Botulism, Wound

reporting code 00513 case report form CDC 52.50

Botulism Alert Summary

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

Comment

Specimens to be sent for laboratory diagnosis from suspected cases of botulism must be cleared through the Bureau of Epidemiology (850) 245-4401.

Botulism, Other

reporting code 00512 case report form CDC 52.50 (4/83)

Botulism Alert Summary

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 ≥1 year who has no history of ingestion of suspect food and has no wounds

Comment

Specimens (feces, sera) to be sent for laboratory diagnosis (toxin testing) from suspected cases of botulism must be cleared through the Bureau of Epidemiology (850) 245-4401.

Brucellosis

reporting code 02300 case report form CDC 52.25 (12/81) *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 ≥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 ≥160 in one or more serum specimens obtained after onset of symptoms)

Comment

Any available isolates of the organism should be sent to the State Lab for confirmation and speciation.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Campylobacteriosis

reporting code 03840 case report form N/A

(Do not report asymptomatic infections)

Clinical description

An infection of that may result in diarrheal illness of variable severity

Laboratory criteria for diagnosis

- Isolation of *Campylobacter* from any 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

Cholera, Vibrio

reporting codes:
00190 *Vibrio cholerae* Type 01
00198 *Vibrio cholerae* Non-01

case report form CDC 52.79 (11/98) *Cholera and Other Vibrio Illness Surveillance Report*

Clinical description

An illness of variable severity that is characterized by diarrhea and/or vomiting

Laboratory criteria for diagnosis

- Isolation of toxigenic (i.e., cholera toxin-producing) *V. 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.

Any available isolates of the organism must be sent to the State Lab for confirmation and serotyping.

Ciguatera

reporting code 98809 case report forms:

1. CDC 52.13 (9/89) *Investigation of a Foodborne Illness Outbreak*
2. (5/98) *Record of Ciguatera Intoxication*

Clinical description

Abdominal cramps, nausea, vomiting, diarrhea, numbness and paresthesia of lips and tongue, pares-thesias of the extremities, metallic taste, arthralgia, myalgia, blurred vision and paradoxical temperature sensation. Associated with consumption of reef or bottom-dwelling fish such as barracuda and snapper

Case classification

Confirmed: A 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 and the *Record of Ciguatera Intoxication*. Testing for the toxin in implicated fishes is available from the FDA. Contact your regional Foodborne Illness Investigator for information.

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

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

Comment

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

Cyclosporiasis

reporting code 00720 case report form (3/97)
Cyclosporosis 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

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

Permanent slides from reported and suspect cases should be sent to the State Laboratory.

Dengue Fever

reporting code 06100 case report form CDC 56.31A (10/85)
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 ≥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 (≤100,000/mm^3), and evidence of plasma leakage documented by hemoconcentration (hematocrit increased by ≥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 (≤20 mm Hg).

Acute and convalescent sera from reported and suspect cases should be acquired and sent to the State Laboratory.

A COPY OF LABORATORY TEST RESULTS MUST ACCOMPANY THE CASE REPORT FORM.

Diphtheria

reporting code 03290 case report form CDC 4.124 (5/98)

CDC Diphtheria Worksheet

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

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 State Central Laboratory.

Note: Questions regarding the follow-up of a diphtheria case should be directed to the Department of Health, Bureau of Immunization program representative at (850) 245-4342 or s/c 205-4342

Ehrlichiosis, Human

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 ≥4 weeks apart. HME diagnosis requires *E. chaffeensis* and HGE currently requires *E. equi* or HGE-agent antigen, or
- Positive polymerase chain reaction assay
- Intracytoplasmic morulae identified in blood, bone marrow, or CSF leukocytes, **and** an IFA titer ≥64

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with either a single IFA serologic titer ≥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 ehrlichosis (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. Distinct primers are used for the PCR diagnosis of HGE and HME.

Acute and convalescent sera from reported and suspect cases should be acquired on all cases and sent to the State Laboratory

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Encephalitis, Arboviral

reporting codes

06220 EEE
06230 SLE
06620 VE
06210 WEE

case report form: (3/98)
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. 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 IgM antibody by enzyme immunoassay (EIA) antibody captured in CSF or serum. Serum IgM antibodies alone should be confirmed by demonstration of IgG antibodies by another serologic assay (e.g., neutralization or hemagglutination inhibition [HAI]).

Comment

Arboviral encephalitis cannot be distinguished clinically from other central nervous system (CNS) infections.

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 (≤ twofold change) elevated antibody titer to an arbovirus (e.g., ≥320 by hemagglutination inhibition, ≥128 by complement fixation, ≥256 by immunofluorescence, and ≥160 by neutralization, or ≥400 by enzyme immunoassay IgM).

Acute and convalescent sera from reported and suspect cases should be acquired and sent to the State Laboratory.

Comment

A COPY OF LABORATORY TEST RESULTS MUST ACCOMPANY THE CASE REPORT FORM.

Encephalitis, Post Infectious

reporting codes

05200 Chickenpox
05430 Herpes
48780 Influenza
05500 Measles
07220 Mumps

case report form N/A

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

Escherichia coli O157:H7

reporting code: 41601

case report form CDC (10/93)
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 clinically compatible 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* O157 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 reports only "*E.coli*" does not indicate pathogenic *E.coli*.

If a lab result indicates a specimen is sorbitol-negative or Shiga Toxin positive only, and the case is symptomatic, report that case as *E.coli,* Other.

Isolates from all cases should be sent to the State Lab for confirmation and PFGE typing.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Escherichia coli, Other

reporting code 41602 case report form CDC (10/93) *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 known serotype not 0157:H7

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable:

- A clinically compatible 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

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

If a lab result indicates a specimen is sorbitol-negative or Shiga Toxin positive only, and the case is symptomatic, report that case as *E.coli,* Other.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

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

reporting codes 69290 Cellulitis case report form CDC 52.(2/93)

(Invasive Disease)

46430 Epiglottitis
32000 Meningitis
48220 Pneumonia
03841 Bacteremia
71100 Arthritis

National Bacterial Meningitis and Bacteremia Case Report

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

Cases of all ages should be reported.
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.
Positive antigen test results from urine or serum samples are unreliable for diagnosis of *H. influenzae* disease.
Sputum cultures are not confirmatory as sputum is not considered a sterile site.
Isolates from cases, especially those under the age of 15 years, should be sent to the State Central Laboratory for typing to determine if they are type b.

Hansen's Disease (Leprosy)

reporting code 03090 case report form CDC 52.18 (8/84)

Leprosy Surveillance Report

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

Hantavirus Infection

reporting code 07869 case report form: (6/98)

(Hantavirus Pulmonary Syndrome)

Hantavirus Pulmonary Syndrome Case Report

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 IgM or rising titers of hantavirus-specificIgG, or
- Detection of hantavirus-specific RNA 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

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.

Requests for clinical specimens to be sent to the CDC for diagnostic testing must be cleared through the Bureau of Epidemiology and assigned a tracking number; specimens must be routed through the State Central Laboratory in Jacksonville.

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., ≥1.0 mg/dL in a child aged <13 years or ≥1.5 mg/dL in a person aged ≥13 years, or ≥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/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 preceeding 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 *E. coli* O157 should be reported with BOTH disease codes (as if they were separate cases) on the Form 2016.

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, including Junin, Machupo, Marburg, and Lassa fever viruses.

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

Comment

Clinical suspicion of this condition in a person with appropriate exposure history is a PUBLIC HEALTH EMERGENCY and must be reported as soon as the diagnosis is entertained.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

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, Acute Viral

reporting code: 07010 case report form CDC 53.1 (6/93)

Viral Hepatitis Case Report

Clinical case definition

An acute illness with a) discrete onset of symptoms **and** b) jaundice **or** elevated serum aminotransferase levels. Symptoms most commonly include: fever, malaise, anorexia, nausea and abdominal discomfort, followed in a few days by jaundice.

Laboratory criteria for diagnosis

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 appropriate symptoms.

Comment

Report liver enzyme results for all cases where these are available.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Hepatitis B, Acute Viral

reporting code 07030 case report form CDC 53.1 (6/93)

Viral Hepatitis Case Report

Clinical case definition

An acute illness with a) discrete onset of symptoms **and** b) jaundice **or** elevated serum aminotransferase levels. Symptoms most commonly include: anorexia, vague abdominal discomfort, nausea and vomiting. Only a small proportion of acute hepatitis B infections will be clinically recognized.

Laboratory criteria for diagnosis

1. 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

Probable: a case that is IgM anti-HBc positive, lacks jaundice or elevated liver enzymes, but has discrete onset and other appropriate symptoms. Probable cases also include patients who have a discrete onset of symptoms, have a positive HbsAg and are epidemiologically linked to a confirmed acute Hepatitis B case.

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.

Report liver enzyme results for all cases where these are available.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Hepatitis B, in Pregnant Women

reporting code 07039 case report form CDC 53.1 (6/93)

Viral Hepatitis Case Report

Clinical case definition
Acute or chronic illness, regardless of symptomatology, in which a woman tests positive for hepatitis B surface antigen (HbsAg) during pregnancy.
Laboratory criteria for diagnosis
Hepatitis B surface antigen (HBsAg) positive
Case classification
Confirmed: a case that meets the clinical case definition and is laboratory confirmed

Hepatitis C, Acute Viral

reporting code 07051 case report form CDC 53.1 (6/93)
Viral Hepatitis Case Report

Clinical case definition
An acute illness with a) discrete onset of symptoms **and** b) jaundice **or** elevated serum aminotransferase levels. Symptoms most commonly include: anorexia, vague abdominal discomfort, nausea and vomiting.-
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
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. 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.
Report liver enzymes results for all cases where these are available.
A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Hepatitis NANB, Acute Viral

reporting code 07070 case report form CDC 53.1 (6/93)
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
Comment
Report liver enzyme results for all cases where these are available.

Hepatitis Unspecified, Acute Viral

reporting code 07090 case report form CDC 53.1 (6/93)
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
Comment
Report liver enzyme results for all cases where these are available.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Hepatitis, Perinatal Hepatitis B

reporting code 07744

case report form CDC 53.1 (6/93)
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-HBsAg) 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.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

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 ≥ 10 micrograms per deciliter of whole blood measured from a venous specimen

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

Suspect: Blood lead level ≥ 10 micrograms per deciliter measured from a single capillary draw or, Blood lead level ≥ 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 ≥ 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. (see laboratory criteria above.)
4. Requirements for reporting to the State Health Office and the requirements for home health environmental inspections of elevated lead clients are decidedly different.

Legionellosis

reporting code 48280 case report form CDC 52.56 (1/91)
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 ≥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.

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Leptospirosis

reporting code 10090 case report form CDC 52.26 (2/81)
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 ≥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 ≥200 in one or more serum specimens)

Comment

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Listeriosis

reporting code 02700 case report form CDC 52.15 (2/93)

National Bacterial Meningitis and Bacteremia Case Report

Clinical description

An infection caused by *Listeria monocytogenes*, which may produce any of several clinical syndromes, including stillbirth, listeriosis of the newborn, meningitis (See Meningitis, Bacterial), bacteremia, or localized infections.

Laboratory criteria for diagnosis

- Isolation of *L. monocytogenes* from a normally sterile site (e.g., blood or CSF or, less commonly, joint, pleural, or pericardial fluid)

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Comment

Listeria meningitis will be reported as such (see meningitis, bacterial).

Isolates from all cases should be sent to the State Central Laboratory

A COPY OF LABORATORY TEST RESULTS SHOULD ACCOMPANY THE CASE REPORT FORM.

Lyme Disease

reporting code 06959 case report form CDC 52.60 (7/90)

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.

Laboratory criteria for diagnosis

- Isolation of *Borrelia burgdorferi* from a clinical specimen or
- Demonstration of diagnostic IgM or IgG antibodies to *B. burgdorferi* in serum or cerebrospinal fluid (CSF) by EIA or IFA screen followed by demonstration of IgM or IgG antibodies by Western Blot (WB) in specimens taken less than 8 weeks after appearance of EM lesions. [IgG WB should be performed on specimens taken >8 weeks after disease onset – IgM WB in the chronic stage does not aid in the diagnosis of late-stage disease]

Case classification

Confirmed: a) a case with EM that is physician and laboratory (EIA and WB) confirmed or b) a case with one late manifestation (as defined below) that is laboratory (EIA and IgG WB) confirmed

Comments

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 ≥5 cm in size. Secondary lesions also may occur. Annular erythematous lesions occurring within several hours of a tick bite represent hyper-sensitivity 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.
- *Late Manifestations*. These 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 polyarthritis. 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 (2nd° or 3rd°) 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 (≤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.

A copy of specific laboratory test results must accompany the case report form.

Malaria

reporting code 08460 case report form CDC 54.1 (10/97)
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

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 State Central Laboratory.

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

<table>
<tr><td rowspan="2">• 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</td><td>• Cryptic: an isolated case of malaria that cannot be epidemiologically linked to additional cases</td></tr>
<tr><td>• 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</td></tr>
<tr><td>• Imported: malaria acquired outside a specific area (e.g., the United States and its territories)</td><td>• Induced: malaria acquired through artificial means (e.g., blood transfusion, common syringes, or malariotherapy</td></tr>
</table>

Permanent slides from reported and suspect cases should be sent to the State Laboratory.

Measles (Rubeola)

reporting code 05590 case report form CDC 975 (9/87)
Measles Surveillance Worksheet

Clinical case definition

An illness characterized by all the following:

- a generalized rash lasting ≥3 days
- a temperature ≥101.0°F (≥38.3°C)
- cough, coryza, or conjunctivitis

Laboratory criteria for diagnosis

- Positive serologic test for measles IgM 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 the Department of Health, Bureau of Immunization program at (850) 245-4342 or s/c 277-2755.

Meningitis, Bacterial

reporting codes 32040 Grp B *Streptococcus*, 32000 *Haemophilus-influenzae*, 32070 *Listeria monocytogenes*, 32090 Other bacterial and fungal, 32020 *Streptococcus pneumoniae* — case reporting form CDC 52.15A (2/93) *National Bacterial Meningitis and Bacteremia Case Report*

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

Isolates from *H. influenzae* meningitis should be sent to the State Laboratory for determination of serotype.

Meningococcal Disease

reporting codes 03600 Meningococcal meningitis, 03620 Disseminated Meningococcemia — case report form CDC 52.15A (2/93) *National Bacterial Meningitis and Bacteremia Case Report*

Clinical description

Meningococcal disease manifests most commonly as meningitis and/or meningococcemia that may progress rapidly to purpura fulminans, shock, and death. 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.
Isolates from *N. meningitidis* meningitis should be sent to the State Central Laboratory for determination of serogroup.

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

- ≥20 micrograms per liter of urine, or
- ≥20 micrograms per liter of blood, or
- ≥5 micrograms per gram of hair

Case classification

Confirmed: Laboratory confirmed

Mumps

reporting code 07290 case report form CDC (9/97)
Mumps Surveillance Worksheet

Clinical case definition

An illness with acute onset of unilateral or bilateral tender, self-limited swelling of the parotid or other salivary gland, lasting ≥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 the Department of Health, Bureau of Immunization program at (850) 245-4342 or s/c 277-2755.

Neurotoxic Shellfish Poisoning

reporting code 98800 case report form CDC 52.13 (9/89)
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, mouth, fingers, and toes; muscular aches; dizziness, reversal of hot and cold sensations; pupil dilation; and usually accompanied by diarrhea, vomiting and ataxia. Illness is self-limited and milder than paralytic shellfish poisoning; paralysis has not been documented. Duration is from a few minutes to a few hours or a few days at most.

Laboratory criteria for diagnosis

Detection of toxin 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.

Pertussis

reporting code 03390 case report form CDC 71.14A (9/97)
Pertussis Surveiilance Worksheet

Clinical case definition

A cough illness lasting ≥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 (PCR) 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 the Department of Health, Bureau of Immunization program at (850) 245-4342 or s/c 277-2755

Pesticide-Related Illness and Injury reporting code 09894 case reporting form DACS 130320 (9/98)

Pesticide Incident Monitoring Report

Clinical case definition

Any acute adverse health effect resulting from exposure to a pesticide product (defined under the Federal Insecticide Fungicide and Rodenticide Act [FIFRA] with the exception that disinfectants are excluded*) including health effects due to an unpleasant odor, injury from explosion of the product, and allergic reaction. Symptoms typically involve one or more of the following

- Systemic signs or symptoms (including respiratory, gastrointestinal, allergic and neurological signs/symptoms)
- Dermatologic lesions
- Ocular lesions

Laboratory criteria for diagnosis

- Biological tests for the presence of, or toxic response to the pesticide and/or its metabolite (in blood, urine, etc.), which may include:
- Measurement of the pesticide and/or metabolite(s) in the biological specimen
- Measurement of a biochemical response to pesticide in a biological specimen (e.g., cholinesterase levels)
- Environmental tests for the pesticide (e.g., foliage residue, analysis of suspect liquid)
- Pesticide detection on clothing or equipment used by the case subject

Case classification

Reports are scored according to the following three criteria (a) documentation of pesticide exposure, (b) documentation of adverse health effect, and(c) evidence supporting a causal relationship. Refer to the classification matrix which follows this criteria section – the matrix provides the case classification categories and the scores needed to place the case into a specific category.

A. Documentation of Pesticide Exposure:

1. Laboratory, clinical, or environmental evidence corroborate exposure
   - analytical results from foliage residue, clothing residue, air, soil, water, or biologic samples
   - observation of residue and/or contamination (including damage to plant material from herbicides) by a trained professional**
   - biologic evidence of exposure (e.g., response to administration of an antidote such as 2-PAM, Vitamin K, or repeated doses of atropine
   - documentation of a characteristic eye injury or dermatological effects at the site of direct exposure by a licensed health care provider
   - clinical description of two or more post-exposure health effects characteristic for the pesticide by a licensed health care provider
2. Evidence of exposure based solely upon written or verbal report
   - report by case
   - report by witness
   - written records of application
   - observation of residue and/or contamination (including damage to plant material from herbicides) by other than a trained professional

- other evidence suggesting that exposure occurred

3. Strong evidence that no pesticide exposure occurred
4. Insufficient data

B. Documentation of Adverse Health Effect

1. Two or more new post-exposure abnormal signs and/or test/laboratory findings reported by a licensed health care provider
2. Two or more new post-exposure abnormal signs reported (when new post-exposure signs and test/laboratory findings are insufficient to satisfy a B1 score, they can be used in lieu of symptoms towards satisfying a B2 score)
3. One post-exposure abnormal sign or symptom or insufficient data

C. Evidence Supporting a Causal Relationship Between Pesticide Exposure and Health Effects

1. Where the signs and symptoms documented under the criteria B. Health Effects are:
   - characteristic for the pesticide and the temporal relationship between exposure and health effects is plausible
   - consistent with an exposure-health effect relationship based upon the known toxicology (i.e., exposure dose, symptoms, and temporal relationship) of the putative agent from commonly available toxicology texts, government publications, information supplied by the manufacturer, or two or more case series or positive epidemiologic studies published in the peer-review literature
2. Evidence of exposure–health effect relationship is not present because
   - the exposure dose was insufficient to produce the observed health effects or
   - a temporal relationship does not exist (i.e., health effects preceded the exposure or occurred too long after exposure) or
   - the constellation of health effects are not consistent based upon the known toxicology of the putative agent from information in commonly toxicology texts, government publications, information supplied by the manufacturer, or the peer-reviewed literature
3. Definite evidence of non-pesticide causal agent
4. Insufficient toxicological information is available to determine causal relationship between exposure and health effects including
   - circumstances where minimal human health effects data are available or
   - where there are less than two published case series or positive epidemiologic studies linking health effects to exposure to the particular pesticide product/ingredient or class of pesticides

CASE CLASSIFICATION MATRIX

CLASSIFICATION CATEGORIES											
CLASSIFICATION CRITERIA	Confirmed Case	Probable Case		Possible Case	Suspicious Case	Unlikely Case	Insufficient Information		Not a Case		
									Asymptomatic	Unrelated	
A. Exposure	1	1	2	2	1 or 2	1 or 2	4	-	-	3	-
B. Health Effects	1	2	1	2	1 or 2	1 or 2	-	4	3	-	-
C. Causal Relationship	1	1	1	1	4	2		-	-	-	3

Comment

The Florida Poison Information Network (800-282-3171) can provide emergency information to physicians and the public. For information regarding Florida pesticide laws and regulations, contact the Florida Department of Agriculture and Consumer Services, Bureau of Compliance Monitoring at 850-488-3314. For information regarding this case definition, contact the Florida Department of Health, Bureau of Environmental Epidemiology, Pesticide Poisoning Surveillance Program at (850) 245-4117.

* **PESTICIDES:** are defined under FIFRA as any substance or mixture of substances intended to prevent, destroy, repel or mitigate insects, rodents, nematodes, fungi, weeds, microorganisms, or any other form of life declared to be a pest by the Administrator of the USEPA and any substance or mixture of substance intended for use as a plant regulator, defoliant, or desiccant. Pesticides include herbicides, insecticides, rodenticides, fungicides, disinfectants, wood treatment products, growth regulators, insect repellents, etc.

** **TRAINED PROFESSIONAL**: may be a plant pathologist, agricultural inspector, agricultural extension agent, industrial hygienist or any other licensed or academically trained specialist with expertise in plant pathology and/or environmental effects of pesticides. A licensed pesticide applicator may also be considered a trained professional.

For information concerning regulation and use of pesticides, contact the US EPA's Office of Pesticide Programs, at 703-305-5336. For information concerning Florida pesticide laws and regulations, contact the Florida Department of Agriculture and Consumer Services, Office of Pesticides at 850-487-0532.

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

Comment

Isolates from any case or suspect case should be sent to the State Central Laboratory for confirmation.

Poliomyelitis, Paralytic

reporting code 04590 case report form CDC (9/97) *Suspected Polio Case Worksheet*

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 the Department of Health, Bureau of Immunization program at (850) 245-4342 s/c 277-2755

Psittacosis

reporting code 07390 case report form CDC 52.2 (3/81) *Psittacosis Case Surveillance Report*

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 ≥32 between paired acute and convalescent phase serum specimens, or
- Presence of IgM antibody against *C. psittaci* by MIF to a reciprocal titer of ≥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 ≥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.

A copy of laboratory test results should accompany the case report form.

Q Fever

reporting code 08300 case report form N/A

Clinical description

Acute Infection: A febrile illness usually accompanied by rigors, myalgia, malaise, and retrobulbar headache. Severe disease can include acute hepatitis, pneumonia, and meningoencephalitis. Clinical laboratory findings may include elevated liver enzyme levels and abnormal chest film findings. Asymptomatic infections may also occur.

Chronic Infection: Potentially fatal endocarditis may evolve months to years after acute infection, particularly in persons with underlying valvular disease. A chronic fatigue-like syndrome has been reported in some Q fever patients.

Laboratory criteria for diagnosis

- Fourfold or greater change in antibody titer to *C. burnetii* phase II or phase I antigen in paired serum specimens ideally taken 3-6 weeks apart, or,
- Isolation of *C. burnetii* from a clinical specimen by culture, or
- Demonstration of *C. burnetti* in a clinical specimen by detection of antigen or nucleic acid.

Case classification

Probable: a clinically compatible or epidemiologically linked case with a single supportive IgG or IgM titer. Cutoff titers are determined by individual laboratories. CDC tests for IgG antibodies with an indirect immunofluorescence assay (IFA), and uses a titer 1:128 as the cutoff for significant antibody.

Confirmed: a clinically compatible or epidemiologically linked case that is laboratory confirmed.

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), or
- 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), and OUTBREAK.

Rabies, Human

reporting code 07100 case report form TBA

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 ≥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.

Rocky Mountain Spotted Fever

reporting code 08200 case report form CDC 55.1 (4/81)
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 ≥3 weeks apart, or
- Positive polymerase chain reaction (PCR) 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 ≥64 or a single CF titer of ≥16 or other supportive serology (fourfold rise in titer or a single titer ≥320 by Proteus OX-19 or OX-2, or a single titer ≥128 by an LA, IHA, or MA test)

Comment
Acute and convalescent sera should be acquired on all cases and sent to the State Laboratory.
A copy of laboratory test results should accompany the case report form.

Rubella

reporting code 05690 case report form CDC (9/97)
Rubella surveillance Worksheet

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 IgG antibody level by any standard serologic assay, or
- Positive serologic test for rubella 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 the Department of Health, Bureau of Immunization program at (850) 245-4342 or s/c 277-2755

Rubella, Congenital Syndrome

reporting code 77100 case report form CDC 71.17 (3/97)
Congenital RubellaSyndrome 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 IgM 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 the Department of Health, Bureau of Immunization program at (850) 245-4342 s/c 277-2755.

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 a extraintestinal infection and localize in any tissue in the body producing absesses and causing such diseases as septic arthritis, endocarditis, meningitis, pericarditis, pneumonia, bacteremia, pyoderma or pyelonephritis.

Laboratory criteria for diagnosis

- Isolation of *Salmonella* sp. 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* sp. 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

Smallpox

reporting code 05090 case report form N/A

Clinical description
A systemic viral disease with exanthem, characterized by sudden onset of fever, malaise, headache, severe backache, prostration, and occasionally abdominal pain. Rash appears 2-4 days after onset of initial symptoms at which time fever may fall.

Laboratory criteria for diagnosis

- Isolation of *Variola* virus on chick embryos or in cell culture from lesion scrapings, vesicular or pustular fluids or crusts, and by a rise in titer in serologic tests

Case classification

Confirmed: a clinically compatible illness that is laboratory confirmed

Comment

Detection of a suspected case is a PUBLIC HEALTH EMERGENCY.

Staphylococcus aureus, Glycopeptide Intermediate (GISA/VISA)

reporting code 38100 case report form NA

Clinical description

Staphylococcal infections are often acute and pyogenic and may spread to surrounding tissue. Some infections involve the skin (furuncles, boils, cellulitis, impetigo, scalded skin syndrome, and post-operative wound infections of various sites). Other infections produced include bacteremia, pneumonia, osteomyelitis, acute endocarditis, myocarditis, cervicitis, meningitis, and abcesses of the muscle, urogenital tract, central nervous system, and various inta-abdominal organs.

Laboratory criteria for diagnosis

- Isolation of *Staphylococcus aureus* from a clinical specimen with an MIC = ≥8 ug/ml

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Comment

Isolates must be sent to the State Central Laboratory for confirmation.

Staphylococcus aureus, Glycopeptide Resistant (GRSA/VRSA)

reporting code 38101 case report form NA

Clinical description

Staphylococcal infections are often acute and pyogenic and may spread to surrounding tissue. Some infections involve the skin (furuncles, boils, cellulitis, impetigo, scalded skin syndrome, and post-operative wound infections of various sites). Other infections produced include bacteremia, pneumonia, osteomyelitis, acute endocarditis, myocarditis, cervicitis, meningitis, and abcesses of the muscle, urogenital tract, central nervous system, and various inta-abdominal organs.

Laboratory criteria for diagnosis

- Isolation of *Staphylococcus aureus* from a clinical specimen with an MIC ≥ 32 ug/ml

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Comment

Isolates must be sent to the State Central Laboratory for confirmation.

Streptococcal Disease, Invasive, Group A

reporting code 03400 case report form Rev. 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

Streptococcus pneumoniae, Invasive Disease

reporting code 04823

case report form (6/99)
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

Case classification
Confirmed: a clinically compatible case that is laboratory confirmed

Comment
Report both resistant* and non-resistant isolates.
A copy of laboratory test results with susceptibility infomation must accompany the case report form.

*Resistance defined by National Committee for Clinical Laboratory Standards (NCCLS)-approved methods and NCCLS-approved interpretive minimum inhibitory concentration (MIC) standards (µg/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.

Tetanus

reporting code 03700

case report form CDC (9/97)
Tetanus Surveillance Worksheet

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 the Department of Health, Bureau of Immunization program at (904) 487-2755 or s/c 277-2755

Toxoplasmosis

reporting code 13090

case report form NA

Clinical description
A systemic protozoan disease that is frequently asymptomatic, or may be 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: a clinically compatible case that is laboratory confirmed
Probable: an asymptomatic case that is laboratory confirmed

Trichinosis

reporting code 12400

case report form CDC 54.7A (2/90)
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.

Tularemia

reporting code 02190 case report form N/A

Clinical description

An illness characterized by several distinct forms, including: ULCEROGLANDULAR – cutaneous ulcer with regional lymphadenopathy; GLANDULAR - regional lymphadenopathy with no ulcer; OCULOGLANDULAR – conjunctivitis with preauricular lymphadenopathy; oropharyngeal – stomatitis or pharyngitis or tonsillitis and cervical lymphadeenopathy; intestinal – intestinal pain, vomiting, and diarrhea; PNEUMONIC – primary pleuropulmonary disease; TYPHOIDAL – febrile illness without early localizing signs and symptoms

Laboratory criteria for diagnosis

Confirmatory:

- Isolation of *Francisella tularensis* from a clinical specimen
- Demonstration of *Francisella tularensis* by immunofluoresence, or
- Fourfold or greater change in serum antibody titer to *Francisella tularensis* antigen

Presumptive:

- Elevated serum antibody titer(s) to *F. tularensis* antigen (without documented fourfold or greater change) in a patient with no history of tularemia vaccination or
- Detection of *F. tularensis* in a clinical specimen by fluorescent assay

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with laboratory results indicative of presumptive infection

Comment

Clinical diagnosis is supported by evidence or history of a tick or deerfly bite, exposure to tissues of a mammalian host of *Francisella tularensis*, or exposure to potentially contaminated water.

Typhoid Fever

reporting code 00200 case report form CDC 52.5 (8/83)
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.

Any available isolates of *S. typhii* should be sent to the State Central Laboratory for antimicrobial susceptibility testing.

Vibrio, Infections

reporting codes 00193 *Vibrio*, other case report form *CDC 52.79 (11/98)*

Clinical description

Acute bacterial enteric disease with sudden onset of watery diarrhea

Any acute bacterial wound, enteric or systemic disease resulting from a *Vibrio* infection

Laboratory criteria for diagnosis

Isolation of a *Vibrio* species from a clinical site.

Case classification

Confirmed: Clinically compatible illness that is culture confirmed

Probable: Clinically compatible illness that is epi-linked to a confirmed case.

Note: Also 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., ≥32 by complement fixation, ≥256 by immunofluorescence assay, ≥320 by hemagglutination inhibition, ≥160 by neutralization, or a positive serologic result by IgM-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.)