

June 2003

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



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(24 hours/7 days)**



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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 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.

The surveillance 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. 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, and in some cases must, be sent to the State Central Laboratory in Jacksonville, including: anthrax, brucellosis, cholera, diphtheria, pathogenic *E. coli* enteric disease, *Haemophilus influenzae* invasive disease, listeriosis, meningitis caused by *Neisseria meningitidis*, plague, glycopeptide intermediate (MIC  $\geq 8\mu\text{g/ml}$  and  $< 32\mu\text{g/ml}$ ) *Staphylococcus aureus*, and glycopeptide resistant (MIC  $\geq 32\mu\text{g/ml}$  *Staphylococcus aureus*, and typhoid fever. In addition, permanent slides from both malaria and cyclospora cases and acute and convalescent sera for arboviral encephalitis, dengue, ehrlichiosis, and rocky mountain spotted fever 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 paper case report forms for certain diseases.** These are: brucellosis, dengue fever, ehrlichiosis, arboviral encephalitis, pathogenic *E. coli* enteric disease, hemorrhagic fever, leptospirosis, listeriosis, lyme disease, psittacosis, Rocky Mountain Spotted Fever, invasive *Streptococcus pneumoniae* disease, glycopeptide intermediate (MIC  $\geq 8\mu\text{g/ml}$  and  $< 32\mu\text{g/ml}$ ) *Staphylococcus aureus*, and glycopeptide resistant (MIC  $\geq 32\mu\text{g/ml}$  *Staphylococcus aureus*.

Some of the more prominent changes in this document include the combination of two previous meningococcal meningitis codes (03600 and 03620) to one code for meningococcal disease (03630), a positive laboratory result alone confirms cases of salmonellosis and shigellosis, the addition of several codes to cover potential bioterrorism agents as outline by the Centers for Disease Control and Prevention (CDC), an additional *E. coli* code and better differentiation between all *E. coli* codes, reporting of all *Streptococcus pneumoniae* invasive

disease in Merlin, the addition of Vaccinia Disease, and all arboviral encephalitides are found under a single case definition for Acute Arboviral Disease.

Case report forms for diseases under public health surveillance in Florida can be found at: [http://www9.myflorida.com/disease\\_ctrl/epi/topics/surv.htm](http://www9.myflorida.com/disease_ctrl/epi/topics/surv.htm).

## 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.

**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.

**Florida Department of Health  
Bureau of Epidemiology  
SURVEILLANCE CASE DEFINITIONS  
FOR SELECT REPORTABLE DISEASES  
June 2003**

**Acute Arboviral Disease**

reporting code = 06220 Eastern Equine Encephalitis (EEE)  
reporting code = 06230 St. Louis Encephalitis (SLE)  
reporting code = 06620 Venezuelan Equine Encephalitis (VEE)  
reporting code = 06210 Western Equine Encephalitis (WEE)  
reporting code = 06250 California/LaCrosse Encephalitis  
reporting code = 06630 West Nile Virus (WNV)  
reporting code = 06631 West Nile Fever  
case report form: (3/98) *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]).

**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 ( $\geq$  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).

**Comment:**

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

## Animal Bite

(Includes a bite or other significant exposure to a human by an animal that is either infected with or suspected of being infected with rabies or capable of transmitting herpes B viruses, including exposures from non-human primates.)

reporting code = 07101 Animal Bite  
= 07103 Monkey Bite  
case report form: FL DOH 4042

### Clinical description

Any bite or other significant exposure

### Laboratory criteria for diagnosis

N/A

### Case classification

Confirmed: bite or other significant exposure of a human by a confirmed or suspected rabid animal or any animal capable of transmitting herpes B viruses, including non-human primates.

### Comment:

The following is requested by HSDE: 1) patient information – age, sex, race, occupation, location of wound or exposure 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 usually 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 or sepsis, often with radiographic evidence of mediastinal widening or pleural effusion.
- Intestinal: severe abdominal distress followed by fever and signs of septicemia

### Laboratory Criteria For Diagnosis

- Isolation of *Bacillus anthracis* from a clinical specimen,  
OR
- Other laboratory evidence of *Bacillus anthracis* infection based on at least two supportive laboratory tests that may include:
  - 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 *Bacillus 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 and requires immediate reporting to the Bureau of Epidemiology at 850-245-4401. This condition has been identified as a potential bioterrorism agent by the CDC.**

## Botulism

reporting code = 00510 (Foodborne)  
= 00511 (Infant)  
= 00513 (Wound)  
= 00512 (Other, Unspecified)  
case report form: CDC 52.50 (4/83)  
*Botulism Alert Summary*

### Clinical description

- Foodborne: An illness caused by ingestion of botulinum toxin with variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.
- Infant: An illness of infants < 12 months of age, characterized by constipation, poor feeding, and “failure to thrive” that may be followed by progressive weakness, impaired respiration, and death.
- Wound: 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.
- Other, Unspecified: An illness in a patient aged >12 months of age who has no history of ingestion of suspect food and has no wounds. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

### Laboratory criteria for diagnosis

- Detection of botulinum toxin in a clinical specimen or food for foodborne botulism
- OR
- Isolation of *Clostridium botulinum* from a clinical specimen

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed or epi-linked without laboratory confirmation

### Comment:

**Note that this is one of the few diseases in which an epi-linked case without laboratory confirmation is considered confirmed. Specimens (food or clinical) 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 botulinum antitoxin is available through the Bureau at the above telephone number, 24 hours per day. This condition has been identified as a potential bioterrorism agent by the CDC.**

## 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  $\geq 2$  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)

## Comment

**Any available isolates of the organism should be sent to the State Lab for confirmation and speciation. This condition has been identified as a potential bioterrorism agent by the CDC.**

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

## Campylobacteriosis

(Do not report asymptomatic infections)

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 clinically compatible case that is laboratory confirmed

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

## Cholera, Vibrio

reporting code = 00190 *Vibrio cholerae* Type O1

= 00198 *Vibrio cholerae* Non-O1

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. This condition has been identified as a potential bioterrorism agent by the CDC.**

## 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, paresthesias 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.

## Creutzfeldt-Jakob Disease (CJD)

reporting code = 04610

Case report form: N/A

### Clinical description

A progressive uniformly fatal dementia characterized by: Myoclonus, visual or cerebellar signs, akinetic mutism and pyramidal or extrapyramidal signs,

### Laboratory criteria for diagnosis

- Standard neuropathological techniques; and/or immunocytochemically; and/or Western blot confirmed protease-resistant PrP; and/or presence of scrapie-associated fibrils conducted on brain tissue
- 14-3-3 proteins in CSF (test not specific for CJD)
- Periodic sharp and slow wave complexes (PSWC) in EEG (Test suggestive but not specific for CJD)

### Case classification

Confirmed: A clinically compatible case diagnosed by standard neuropathological techniques; and/or immunocytochemically; and/or Western blot confirmed protease-resistant PrP; and/or presence of scrapie-associated fibrils.

Probable: Progressive dementia; and at least two out of the following four clinical features:

- Myoclonus
- Visual or cerebellar signs
- Pyramidal/extrapyramidal signs
- Akinetic mutism

AND

- A typical EEG during an illness of any duration; and/or a positive 14-3-3 CSF assay and a clinical duration to death of < 2 years
- Routine investigations should not suggest an alternative diagnosis

Suspect: Progressive dementia; and at least two out of the following four clinical features:

- Myoclonus
- Visual or cerebellar signs
- Pyramidal/extrapyramidal signs
- Akinetic mutism

AND

- No EEG or atypical EEG and duration < 2 years

**Comment:**

Cases under the age of 55 years old should be evaluated for the variant form of CJD. Brain tissue for diagnosis and CSF for the 14-3-3 protein should be sent to the National Prion disease Pathology Surveillance Center at Case Western Reserve University. Information about the center, shipping and mailing instructions can be found on their web site: <http://www.cjdsurveillance.com>.

## 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)

*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.

## 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 IgG or 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).

**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-toxicogenic *C. diphtheriae* should be reported as diphtheria. All diphtheria isolates, regardless of association with disease, should be sent to the State Central Laboratory.

*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 = 08381 Human Granulocytic Ehrlichiosis (HGE)

reporting code = 08382 Human Monocytic Ehrlichiosis (HME)

reporting code = 08380 Human Ehrlichiosis, Other

case report form: CDC 55.1 (1/01)

*Tick-Borne Rickettsial Disease 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
- Intracytoplasmic morulae identified in blood, bone marrow, or CSF leukocytes, **and** an IFA titer  $\geq 1:64$

## Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: a clinically compatible case with either a single IFA serologic titer  $\geq 1:64$  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. 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, Post Infectious

reporting codes = 05200 Chickenpox (Varicella)  
= 05430 Herpes  
= 48780 Influenza  
= 05500 Measles  
= 07220 Mumps  
case report form: N/A

### Clinical description

Encephalitis that occurs as a result of one of the above-listed viral illnesses.

### Laboratory criteria for diagnosis

Must meet laboratory criteria for specific virus

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed.

Probable: a clinically compatible case without laboratory confirmation.

### Comment

Cases of Encephalitis, Post Infectious Measles (05500) or Mumps (07220) should additionally be reported in Merlin under the corresponding Measles (05590) or Mumps (07290) codes.

## Enterohemorrhagic *Escherichia coli* (EHEC) 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); asymptomatic infections may also occur.

### Laboratory criteria for diagnosis

- Isolation of *Escherichia coli* O157:H7 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

### Comment

Patients with *E. coli* O157 who develop hemolytic uremic syndrome (HUS) should be reported in Merlin with BOTH disease codes (as if they were two separate cases). 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*, Shiga toxin + non-O157 (41602) if serogrouped or *E. coli*, Shiga toxin +, not serogrouped (41603). **This condition has been identified as a potential bioterrorism agent by the CDC.**

**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.**

## Epsilon Toxin of *Clostridium perfringens*

reporting code = 00521

case report form: NA

### Clinical description

An enteric or enterotoxemia infection depending on the mode of transmission. Enteric infections are characterized by diarrhea accompanied by severe abdominal cramping and bloating.

### Laboratory criteria for diagnosis

- *Clostridium perfringens* isolation from clinical specimen

AND

- Detection of the epsilon toxin by ELISA from same isolation

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

### Comment

This condition has been identified as a potential bioterrorism agent by the CDC.

## *Escherichia coli* Shiga Toxin + (serogroup non-O157)

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 O157.

### 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

Patients with *E. coli*, Shiga Toxin + (serogroup non-O157) who develop hemolytic uremic syndrome (HUS) should be reported in Merlin with BOTH disease codes (as if they were two separate cases). 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 code 41603, *E. coli* serogroup non-O157.

**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* Shiga Toxin + (not serogrouped)**

reporting code = 41603  
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 Shiga toxin-producing *E. coli* that was not serogrouped 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

### **Comment**

Patients with *E. coli*, Shiga Toxin + (not serogrouped) who develop hemolytic uremic syndrome (HUS) should be reported in Merlin with BOTH disease codes (as if they were two separate cases). 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.**

## **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.



## Glanders

reporting code = 02400

case report form: N/A

### Clinical description

The types of infection include localized, pus forming cutaneous infections, pulmonary infections, bloodstream infections, and chronic suppurative infections of the skin. Generalized symptoms of glanders include fever, muscle aches, chest pain, muscle tightness, and headache. Additional symptoms have included excessive tearing of the eyes, light sensitivity, and diarrhea.

- Localized infections: If there is a cut or scratch in the skin, a localized infection with ulceration will develop within 1 to 5 days at the site where the bacteria entered the body. Swollen lymph nodes may also be apparent. Infections involving the mucous membranes in the eyes, nose, and respiratory tract will cause increased mucous production from the affected sites.
- Pulmonary infections: In pulmonary infections, pneumonia, pulmonary abscesses, and pleural effusion can occur. Chest X-rays will show localized infection in the lobes of the lungs.
- Bloodstream infections: Glanders bloodstream infections are usually fatal within 7 to 10 days.

### Laboratory criteria for diagnosis

- Isolation of *Burkholderia mallei* from blood, sputum, urine, or skin lesions. Serologic assays are not available.

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

### Comment

**This condition has been identified as a potential bioterrorism agent by the CDC.**

## Haemophilus influenzae (Invasive Disease)

reporting code = 69290 Cellulitis

= 48220 Pneumonia

= 46430 Epiglottitis

= 03841 Bacteremia

= 32000 Meningitis

= 71100 Arthritis

case report form: CDC 52.(2/93)

*National Bacterial Meningitis and Bacteremia  
Case Report*

**MERLIN ELECTRONIC SUBMISSION**

### 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

### Comment

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 obtained from 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 (Hantavirus Pulmonary Syndrome)

reporting code = 07869  
case report form: (6/98)  
*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  $>101.0^{\circ}\text{F}$  [ $>38.3^{\circ}\text{C}$ ]) 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-specific IgG
- 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. This condition has been identified as a potential bioterrorism agent by the CDC.**

## Hemolytic Uremic Syndrome (HUS)

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 any reportable *E. coli* infection should be reported with BOTH disease codes (as if they were separate cases) in Merlin.

## 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 A

reporting code = 07010

case report form: CDC 53.1 (8/01)

*Viral Hepatitis Case Report*

**MERLIN ELECTRONIC SUBMISSION**

### 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 clinically compatible case that is laboratory confirmed

OR

a clinically compatible case that 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 clinically compatible case that is hepatitis A 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

reporting code = 07030  
case report form: CDC 53.1 (8/01)  
*Viral Hepatitis Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### 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

AND

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 in Merlin when available.**

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

## Hepatitis B, Chronic

reporting code = 07032  
case report form: CDC 53.1 (8/01)  
*Viral Hepatitis Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### Chronic Hepatitis B Clinical description

Persons with chronic hepatitis B infection may have no evidence of liver disease or may have a spectrum of disease ranging from chronic hepatitis to cirrhosis or liver cancer. Persons with chronic infection may be asymptomatic.

### Laboratory criteria

- Hepatitis B surface antigen (HBsAg) positive, total anti-HBc positive (if done) and IgM anti-HBc negative

OR

- HBsAg positive two times at least 6 months apart

### Case Classification:

Confirmed: A case that is laboratory confirmed.

Suspect: A case that is HBsAg positive, but absent other diagnostic criteria.

## Hepatitis B Surface Antigen (HBsAg+), in Pregnant Women

reporting code = 07039  
case report form: CDC 53.1 (8/01)  
*Viral Hepatitis Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### **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**

Positive Hepatitis B surface antigen (HBsAg) result

### **Case classification**

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

## Hepatitis C, Acute

reporting code = 07051  
case report form: CDC 53.1 (8/01)  
*Viral Hepatitis Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### **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 C, Chronic

reporting code = 07054  
case report form: CDC 53.1 (8/01)  
*Viral Hepatitis Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### Clinical case definition

Persons with chronic hepatitis C may have no evidence of liver disease or may have a spectrum of disease ranging from chronic hepatitis to cirrhosis or liver cancer. Persons with chronic infection may be asymptomatic.

### Laboratory criteria

- Antibody to HCV (anti-HCV) positive (repeat reactive) by enzyme immunoassay (EIA), verified by an additional more specific assay (e.g. RIBA or PCR for HCV RNA)

OR

- Anti-HCV positive (repeat reactive) by EIA with signal to cut-off ratio  $\geq 3.8$ .

### Case Classification

Confirmed: A case that is laboratory confirmed.

Probable: A case that is anti-HCV positive (repeat reactive) by EIA and has alanine aminotransferase (ALT or SGPT) values above the upper limit of normal, but the anti-HCV EIA result has not been verified by an additional more specific assay and the signal to cut-off ratio is unknown.

Suspect: A case that is Anti-HCV positive, but absent other diagnostic criteria.

## Hepatitis NANB, Acute

reporting code = 07070  
case report form: CDC 53.1 (6/93)  
*Viral Hepatitis Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### 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 (8/01)  
*Viral Hepatitis Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### Clinical case definition

An acute illness with a) discrete onset of symptoms and b) jaundice or elevated serum aminotransferase (ALT) 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 B, Perinatal

reporting code = 07744  
case report form: CDC 53.1 (8/01)  
*Viral Hepatitis Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### 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. Post vaccination 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. The mother of a child reported under this code should be reported as HBsAg+ in a pregnant woman, code 07039.

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



## Lead Poisoning

reporting code = 94890  
case report form:  
**MERLIN ELECTRONIC SUBMISSION**

### 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

OR

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. (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  $\geq 128$  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 (RIA) or enzyme-linked immunosorbent assay (ELISA)

## 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  $\geq 2$  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)

## Comment

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

## Listeriosis

reporting code = 02700 Bacteremia  
= 32070 Meningitis  
case report form: CDC 52.15 (2/93)  
*National Bacterial Meningitis  
and Bacteremia Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

## Clinical description

An infection caused by *Listeria monocytogenes*, which may produce any of several clinical syndromes, including stillbirth, listeriosis of the newborn, meningitis, 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

Meningitis due to *Listeria monocytogenes* should be reported with code 32070 found under Meningitis, Bacterial in this document. Do not report cases as both meningitis and bacteremia.

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

# Lyme Disease

reporting code = 06959  
case report form: CDC 52.60 (7/90)  
*Lyme Disease Case Report Form*  
**MERLIN ELECTRONIC SUBMISSION**

## 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  $\geq 5$  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. A physician must make the diagnosis of EM.
- *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 is 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 ( $\leq 30$  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*.

**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.

**Permanent slides from all diagnosed and suspected cases should be sent to the State Laboratory.**

## Measles (Rubeola)

reporting code = 05590  
case report form: CDC 975 (9/87)  
*Measles Surveillance Worksheet*  
**MERLIN ELECTRONIC SUBMISSION**

### Clinical case definition

An illness characterized by all the following:

- Generalized rash lasting  $\geq 3$  days
- Temperature  $\geq 101.0^{\circ}\text{F}$  ( $\geq 38.3^{\circ}\text{C}$ )
- 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

Suspect: any febrile illness accompanied by a clinically compatible rash

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.

## Melioidosis (*Burkholderia pseudomallei*)

reporting code = 02500

case report form: NA

### Clinical description

Illness from melioidosis can be categorized as acute or localized infection, acute pulmonary infection, acute bloodstream infection, and chronic suppurative infection. Inapparent infections are also possible. The incubation period is not clearly defined, but may range from 2 days to many years.

- *Acute, localized infection*: This form of infection is generally localized as a nodule and results from inoculation through a break in the skin. The acute form of melioidosis can produce fever and general muscle aches, and may progress rapidly to infect the bloodstream.
- *Pulmonary infection*: This form of the disease can produce a clinical picture of mild bronchitis to severe pneumonia. The onset of pulmonary melioidosis is typically accompanied by a high fever, headache, anorexia, and general muscle soreness. Chest pain is common, but a nonproductive or productive cough with normal sputum is the hallmark of this form of melioidosis.
- *Acute bloodstream infection*: This type of the disease usually results in septic shock and typically infects patients with underlying illness such as HIV, renal failure, and diabetes. The symptoms of the bloodstream infection vary depending on the site of original infection, but they generally include respiratory distress, severe headache, fever, diarrhea, development of pus-filled lesions on the skin, muscle tenderness, and disorientation. This is typically an infection of short duration, and abscesses will be found throughout the body.
- *Chronic suppurative infection*: Chronic melioidosis is an infection that involves the organs of the body. These typically include the joints, viscera, lymph nodes, skin, brain, liver, lung, bones, and spleen.

### Laboratory criteria for diagnosis

- Isolation of *Burkholderia pseudomallei* from blood, urine, sputum, or skin lesions.

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

### Comment

This condition has been identified as a potential bioterrorism agent by the CDC.

## Meningitis, Other Bacterial or Fungal

reporting codes = 32040 Group B *Streptococcus*  
= 32090 Other bacterial or fungal  
case report form: CDC 52.15A (2/93)  
*National Bacterial Meningitis and  
Bacteremia Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### 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 or fungal species from the cerebrospinal fluid (CSF)
- OR
- Positive blood culture of a bacterial or fungal species

### Case classification

Confirmed: a clinically compatible case that is either laboratory confirmed

### Comment

**See the case definitions for *Haemophilus influenzae*, Invasive Disease and *Streptococcus pneumoniae*, Invasive Disease for meningitis caused by these bacteria species.**

## Meningococcal Disease

reporting code = 03630  
case report form: CDC 52.15A (2/93)  
*National Bacterial Meningitis and Bacteremia  
Case Report*  
**MERLIN ELECTRONIC SUBMISSION**

### 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 obtained from a normally sterile site.

**Isolates of *N. meningitidis* 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

- $\geq 20$  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

## Mumps

reporting code = 07290  
case report form: CDC (9/97)  
*Mumps Surveillance Worksheet*  
**MERLIN ELECTRONIC SUBMISSION**

### 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 IgG antibody level by any standard serologic assay
- OR
- Positive serologic test for mumps 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 Surveillance Worksheet*  
**MERLIN ELECTRONIC SUBMISSION**

### 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 (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 but is not laboratory confirmed, and 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 report 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		
		1	2				4	-	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 Control Network (800-222-1222) 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 code = 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. This condition has been identified as a potential bioterrorism agent by the CDC.**

# 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

*Questions about 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  $\geq 32$  between paired acute and convalescent phase serum specimens

OR

- Presence of IgM 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. This condition has been identified as a potential bioterrorism agent by the CDC.

**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 meningoenzephalitis. 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. burnetii* in a clinical specimen by detection of antigen or nucleic acid.

### Case classification

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

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

## Comment

This condition has been identified as a potential bioterrorism agent by the CDC.

## Rabies, Animal

reporting code = 07102  
case report form:  
copy of state laboratory positive result  
**MERLIN ELECTRONIC SUBMISSION**

### 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

## Rabies, Human

reporting code = 07100  
case report form: NA

### 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 packed in dry ice.

## Ricin Toxin

reporting code = 98830  
case report form: NA

### Clinical description

- Inhalation: Within a few hours of inhaling significant amounts of ricin, the likely symptoms would be coughing, tightness in the chest, difficulty breathing, nausea, and aching muscles. Within the next few hours, the body's airways (such as lungs) would become severely inflamed (swollen and hot), excess fluid would build up in the lungs, breathing would become even more difficult, and the skin might turn blue. Excess fluid in the lungs would be diagnosed by x-ray or by listening to the chest with a stethoscope.

- Ingestion: If someone swallows a significant amount of ricin, he or she would have internal bleeding of the stomach and intestines that would lead to vomiting and bloody diarrhea. Eventually, the person's liver, spleen, and kidneys might stop working, and the person could die.
- Injection: Injection of a lethal amount of ricin at first would cause the muscles and lymph nodes near the injection site to die. Eventually, the liver, kidneys, and spleen would stop working, and the person would have massive bleeding from the stomach and intestines. The person would die from multiple organ failure.
- Death from ricin poisoning could take place within 36 to 48 hours of exposure, whether by injection, ingestion, or inhalation. If the person lives longer than 5 days without complications, he or she will probably not die.

**Showing these signs and symptoms does not necessarily mean that a person has been exposed to ricin.**

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

- N/A

#### **Case classification**

Suspect: a clinically compatible case that is suspected of inhaling ricin. A possible clue would be that a large number of people who had been close to each other suddenly developed fever, cough, and excess fluid in their lungs. These symptoms could be followed by severe breathing problems and possibly death.

#### **Comment**

**This condition has been identified as a potential bioterrorism agent by the CDC.**

## **Rocky Mountain Spotted Fever**

reporting code = 08200

case report form: CDC 55.1 (1/01)

*Tick-Borne Rickettsial Disease 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 (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  $\geq 64$  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)

#### **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*  
**MERLIN ELECTRONIC SUBMISSION**

### 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.

*Questions about rubella case definition or follow-up, 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 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 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 does not meet 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 case definition or 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 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* sp. from a clinical specimen

## Case classification

Confirmed: a case that is laboratory confirmed

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



## Saxitoxin Poisoning (Paralytic Shellfish Poisoning)

reporting code = 98840  
case report form: NA

### Clinical description

A person with circumoral paresthesia, numbness or tingling of the face, arms, and legs, motor uncoordination, respiratory distress, headache, dizziness, weakness, nausea, and vomiting, 15 minutes to 10 hours following the consumption of puffer fish caught off the Florida coast or from the consumption of molluscan shellfish (from any source). In severe cases muscle paralysis and respiratory failure occur, with death occurring in 2 to 25 hours.

### Laboratory criteria for diagnosis

- Toxin detection in urine or epidemiology linked food specimen

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Suspect: a clinically compatible case that is not laboratory confirmed and has a demonstrated epidemiologic link

## 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 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. **This condition has been identified as a potential bioterrorism agent by the CDC.**

## ***Staphylococcus aureus*, Glycopeptide Non-Susceptible**

reporting code = 38100 (Intermediate)  
= 38101 (Resistant)  
case report form: NA

### **Clinical description**

Staphylococcal infections can be asymptomatic but 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 abscesses of the muscle, urogenital tract, central nervous system, and various intra-abdominal organs.

### **Laboratory criteria for diagnosis**

Intermediate Resistance (GISA/VISA):

- Isolation of *Staphylococcus aureus* from a clinical specimen with an MIC =  $\geq 8$   $\mu\text{g/ml}$  and  $< 32$   $\mu\text{g/ml}$  to Vancomycin

Resistance (GRSA/VRSA):

- Isolation of *Staphylococcus aureus* from a clinical specimen with an MIC  $\geq 32$   $\mu\text{g/ml}$  to Vancomycin

### **Case classification**

Confirmed: a clinically compatible case that is laboratory confirmed

### **Comment**

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

## ***Staphylococcus* Enterotoxin B (SEB)**

reporting code = 38200  
case report form: NA

### **Clinical description**

Staphylococcal enterotoxin B (SEB) is an exotoxin produced by *Staphylococcus aureus*. Clinical signs include nonspecific flu-like symptoms.

- General Symptoms: fever, chills, headache, myalgia, conjunctival injection, varying degrees of prostration and potentially septic shock or death.
- Aerosolized Exposure: nonproductive cough for up to 4 weeks, retrosternal chest pain and shortness of breath.
- Ingestion Exposure: nausea or vomiting and diarrhea.

### **Laboratory criteria for diagnosis**

- N/A

### **Case classification**

Confirmed: a clinically compatible case that is diagnosed by clinical signs and epidemiology.

Staphylococcal enterotoxin B may be found in blood, urine, respiratory secretions or nasal swabs for a short period of time. The toxin is detected by ELISA and chemiluminescence tests. Specimens that are suspected of containing the toxin should be sent immediately to the state laboratory.

### **Comment**

**This condition has been identified as a potential bioterrorism agent by the CDC.**

## 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 (Primary Bacteremia,  
Drug Resistant)  
= 32020 (Meningitis)  
= 04830 (Susceptible)  
case report form: DOH (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)

### 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 information 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 ( $\mu\text{g/mL}$ ) 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.

## 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 case definition 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 with symptoms including fever, sore throat, malaise, headache, myalgias, sweats, anorexia, abdominal pain, chest pain, or cough. 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 *Toxoplasma gondii* in tissues or body fluids, or four-fold change in specific IgG antibody titers in sequential sera.

### Case classification

Confirmed: a clinically compatible case that is laboratory confirmed

Probable: an asymptomatic case that is laboratory confirmed

### Comment

IgM antibody detection will confirm acute disease in a patient with a four-fold rise in IgG

## 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 lymphadenopathy;
- 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 immunofluorescence

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. This condition has been identified as a potential bioterrorism agent by the CDC.**

## 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. typhi* should be sent to the State Central Laboratory for antimicrobial susceptibility testing.**

## Typhus Fever (*Rickettsia prowazekii*)

reporting code = 08190  
case report form: N/A

## Clinical description

Several distinct *Rickettsiae* species cause typhus fevers in humans. Each agent produces disease with a distinct epidemiology, but all cause illness, usually with fever, headache, or rash, or a combination of these.

## Laboratory criteria for diagnosis

- Demonstration of *Rickettsiae* species 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: a clinically compatible case that is lacking laboratory confirmation

## Comment

**This condition has been identified as a potential bioterrorism agent by the CDC.**

## Vaccinia Disease

reporting code = 9990  
case report form: VAERS

## Clinical description

Vaccinia disease can present as any number of clinical manifestations ranging from self-limited responses to life-threatening events due to receiving or being inadvertently inoculated with vaccinia as a result of smallpox vaccination. Clinical complications can include any of the following:

- Eczema vaccinatum - Characterized by localized or generalized popular, vesicular, or pustular rash, which can occur anywhere on the body, with a predilection for areas of previous atopic dermatitis (e.g. face, forearms, antecubital fossa, popliteal fossa). Rash onset may occur concurrently or shortly after development of the Smallpox vaccine lesion and is often accompanied by fever, malaise, lymphadenopathy and prostration or severe systemic illness.
- Erythema multiforme major (Stevens-Johnsons Syndrome) - Characterized by systemic symptoms (fever, malaise, prostration) and involvement of 2 or more mucosal surfaces or 10% of the body surface area.
- Fetal vaccinia (Congenital vaccinia) - Characterized by skin lesions (e.g. vesicular, pustular, or ulcerative) and/or organ involvement in a newborn. The skin lesions are similar to those of Generalized Vaccinia or Progressive Vaccinia and can be confluent and extensive.

- Post-vaccinial encephalitis (Post vaccinial encephalomyelitis) - Post-Vaccinial Encephalopathy or Post-Vaccinial Encephalitis, onset of symptoms 6-15 days post-vaccination, is characterized by any change in mental status (confusion, delirium, drowsiness, restlessness, disorientation, amnesia, seizures, loss of consciousness, coma) or in sensorimotor function (altered sensation, weakness, paresis, aphasia, incontinence or urinary retention, obstinate constipation) or any combination thereof.
- Progressive vaccinia - Characterized by a painless progressive and ulcerating lesion at the vaccination site that does not heal, often with central necrosis, and with little or no inflammation.
- Generalized vaccinia - Characterized by disseminated maculopapular or vesicular rash, frequently on an erythematous base, usually occurring 6-9 days after first-time vaccination. Lesions may occur on any part of the body, most often on the trunk and abdomen, less commonly on the face and limbs. Though usually benign and self-limiting, can develop into severe systemic illness.
- Inadvertent inoculation - Characterized by extensive vesicular and pustular lesion/s at a distant different location on the vaccinee, or anywhere on a close contact, which is not generalized but may involve a large contiguous area.
- Ocular vaccinia - Characterized by inflammation of peri-ocular soft tissue or the eye itself (blepharitis, conjunctivitis, keratitis, iritis) or any combination thereof.
- Pyogenic infection - Characterized by (staphylococcal infections) vesiculo-pustular lesion at the site of vaccination, often spreading peripherally in circumferential fashion, with clearing behind the advancing border. Bacterial lymphangitis and regional lymphadenitis may occur, but most often the lesions are solely superficial infections  
OR  
(streptococcal infections) a piled up eschar, heaping at the vaccination site. Lymphangitis occurs commonly as does edematous painful regional lymphadenitis  
OR  
(enteric and anaerobic infections) purulence with or without extensive necrosis at the vaccination site. Necrotic fasciitis has also been encountered in some cases.
- Other serious adverse events - Serious to life-threatening events resulting in hospitalization, permanent disability, life-threatening illness, or death in a Smallpox vaccinee, or a close contact of a vaccinee.

### **Laboratory criteria for diagnosis**

- None unless laboratory confirmation is indicated to distinguish from other infections or other pox.

### **Case classification**

Probable: clinical features compatible with the diagnosis, other causes are excluded, and supportive information is available.

Suspect: clinical features compatible with the diagnosis but either further investigation is required

OR

additional investigation of the case did not provide supporting evidence for the diagnosis AND did not identify an alternative diagnosis.

*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.*

## Vibrio, Infections

(see also Cholera, Vibrio)

reporting codes = 00193 *Vibrio*, other  
= 00194 *V. fluvialis*  
= 00195 *V. alginolyticus*  
= 00196 *V. hollisae*  
= 00197 *V. mimicus*  
= 00198 *V. cholerae* type non-01  
= 00199 *V. vulnificus*  
= 00540 *V. parahaemolyticus*  
case report form: CDC 52.79 (11/98)  
*Cholera and Other Vibrio Illness Surveillance Report*

### 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 by the state laboratory

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

### Comment

**Any available isolates of must be sent to the State Central Laboratory for confirmation.**

*The Florida Department of Agriculture and Consumer Services (DACs) Molluscan Shellfish Program should be notified 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 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.)