To: Health Care Providers

From: LaSalle County Health Department

Date: 26 August 2019

Re: Semi-Annual Communicable Disease Report

Enclosed you will find the 2019 LaSalle County Health Department’s Semi-Annual Communicable Disease Report. Included you will find updated contacts, information on recent outbreaks and information on several current topics for your convenience. Please feel free to contact us with any questions you may have.

Sincerely,

Chris Pozzi, LEHP
Director of Environmental Health

Debra Hart, RN
Director of Nursing
LaSalle County Health Department

Communicable Disease Contact Information

Environmental Health Division

Communicable Disease/Epidemiological Surveillance (includes reportable disease and non-reportable diseases such as influenza, lice, and scabies):

<table>
<thead>
<tr>
<th>Primary Contact:</th>
<th>Backup Contact:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Erika Walzer, BS</td>
<td>Matthew Devine, MA</td>
<td></td>
</tr>
<tr>
<td>Email <a href="mailto:walzer@lasallecounty.org">walzer@lasallecounty.org</a></td>
<td>Email <a href="mailto:mdevine@lasallecounty.org">mdevine@lasallecounty.org</a></td>
<td></td>
</tr>
<tr>
<td>Phone (815)617-4206</td>
<td>Phone (815)617-4316</td>
<td></td>
</tr>
<tr>
<td>Fax (815)433-1636</td>
<td>Fax (815)433-1636</td>
<td></td>
</tr>
</tbody>
</table>

Personal Health Division

Other Communicable Diseases such as STDs, TB, and HIV:

<table>
<thead>
<tr>
<th>Primary Contact:</th>
<th>Backup Contact:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Debra Hart, RN</td>
<td>Tina Craig, RN</td>
<td></td>
</tr>
<tr>
<td>Email <a href="mailto:dhart@lasallecounty.org">dhart@lasallecounty.org</a></td>
<td>Email t <a href="mailto:craig@lasallecounty.org">craig@lasallecounty.org</a></td>
<td></td>
</tr>
<tr>
<td>Phone (815)617-4328</td>
<td>Phone (815)617-4323</td>
<td></td>
</tr>
<tr>
<td>Fax (815)433-9522</td>
<td>Fax (815)433-2876</td>
<td></td>
</tr>
</tbody>
</table>

Immunizations and Travel Recommendations:

<table>
<thead>
<tr>
<th>Primary Contact:</th>
<th>Backup Contact:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Keating, RN</td>
<td>Tina Craig, RN</td>
<td></td>
</tr>
<tr>
<td>Email <a href="mailto:jkeating@lasallecounty.org">jkeating@lasallecounty.org</a></td>
<td>Email t <a href="mailto:craig@lasallecounty.org">craig@lasallecounty.org</a></td>
<td></td>
</tr>
<tr>
<td>Phone (815)617-4334</td>
<td>Phone (815)617-4323</td>
<td></td>
</tr>
<tr>
<td>Fax (815)433-2876</td>
<td>Fax (815)433-2876</td>
<td></td>
</tr>
</tbody>
</table>

REPORTING:

WHO, WHAT, WHERE

Who is required to report?

Health care providers, hospitals, and laboratories (a full list is on the link below)

What is required to be reported? Refer to:


and the IDPH STOP and Report Infectious Disease poster attached at the end of this report.

Where are reports sent?

All reporting begins with the Local Health Department. If your patient lives in a different county or state, initial reporting is still to the Local Health Department. Reporting can be done by phone, fax, and INEDSS.
Illinois Department of Public Health

STOP and Report Infectious Disease

Illinois Reportable Diseases

Mandated reporters, such as health care providers, hospitals and laboratories, must report suspected or confirmed cases of these diseases to the local health department. Diseases in **bold** are reportable within 24 hours. Diseases marked "immediate" (or in red) are reportable as soon as possible within three hours.

- Anaplasmosis
- Any suspected bioterrorist threat (immediate)
- Any unusual case or cluster of cases that may indicate a public health hazard (immediate)
- Anthrax (immediate)
- Arboviruses (including WNV)
- Babesiosis
- **Botulism, foodborne (immediate)**
- Botulism, infant, wound, other
- Brucellosis*
- Campylobacteriosis
- Candida auris**
- Carbapenem-resistant Enterobacteriaceae (CRE)**
- Chancroid
- Chlamydia
- **Cholera**
- Cryptosporidiosis
- Cyclosporiasis
- **Diphtheria (immediate)**
- **Ehrlichiosis**
- *Escherichia coli* infections (E. coli O157:H7, and other Shiga Toxin Producing E. coli)
- Foodborne or waterborne outbreaks
- Gonorrhea

**Haemophilus influenzae**, invasive
- Hantavirus pulmonary syndrome
- Hemolytic uremic syndrome, post diarreal
- Hepatitis A
- Hepatitis B, C, D
- Histoplasmosis
- HIV infection
- Influenza, deaths in <18 yr olds
- Influenza A, novel (immediate)
- Influenza, ICU admissions
- Legionellosis
- Leptospirosis
- Listeriosis
- Lyme disease
- Malaria
- Measles
- Mumps
- **Neisseria meningitidis**, invasive
- Outbreaks of public health significance
- Pertussis (whooping cough)
- Plague (immediate)
- Poliomyelitis (immediate)
- Psittacosis
- Q fever (Cowdria burnetii)*
- Rabies, human and potential human exposure and animal

- Reye's syndrome
- Rubella
- Salmonellosis, other than typhoid
- Severe Acute Respiratory Syndrome (SARS) (immediate)
- Shigellosis
- Smallpox (immediate)
- Smallpox vaccination, complications of
- Spotted fever rickettsioses
- **S. aureus infections with intermediate or high level resistance to vancomycin**
- Streptococcal infections, Group A, invasive including STSS and necrotizing fasciitis
- **S. pneumoniae**, invasive in those <5 yrs
- Syphilis
- Tetanus
- Toxic shock syndrome due to **S. aureus**
- Trichinosis
- Tuberculosis
- **Tularemia**
- Typhoid fever
- Typhus
- Varicella (chickenpox)
- Vibriosis (non cholera)

*If bioterrorism suspected then report immediately (within three hours)

**Reportable to the Extensively Drug-Resistant Organism (XDRO) Registry by providers

Laboratories must report positive test results of these diseases to their local health department within the time frame indicated.

**All reports are confidential and should include—**

- the disease or condition being reported
- patient's name, date of birth, age, sex, race/ethnicity, address, and telephone number
- physician's name, address, and telephone number
- method of diagnosis, if available

**TO REPORT A CASE**

contact your local health department:

During regular business hours, call _______ - _______ - _______

For emergencies after business hours, call _______ - _______ - _______

If no local health department is available, contact the

Illinois Department of Public Health

217-785-7165  •  TTY (hearing impaired use only) 800-547-0466
<table>
<thead>
<tr>
<th>Reportable Diseases Stats</th>
<th>Jan 19</th>
<th>Feb 19</th>
<th>Mar 19</th>
<th>Apr 19</th>
<th>May 19</th>
<th>Jun 19</th>
<th>Jul 19</th>
<th>Total YTD</th>
<th>Total 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arboviral</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Bacterial Meningitis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Brucellosis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Campylobacter</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Carbapenem-Resistant Enterobacteriaceae</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Haemophilus Influenza</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>E. coli 0157:H7**</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Histoplasmosis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Influenza A or B</td>
<td>3</td>
<td>1</td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>Deaths age &lt;18 years old</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Legionnaires Disease</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Listeriosis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mumps (Physician Verified)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pertussis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rabies Potential Exposure</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Rabies PEP Required</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Rubella</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Salmonella</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Shigella</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Staph Infection &lt; 61 days old</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Strep - Invasive Group A</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Strep Pneumonia Invasive &gt;5 years old</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Yersiniosis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Investigations:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-immunizable</td>
<td>8</td>
<td>6</td>
<td>11</td>
<td>8</td>
<td>10</td>
<td>7</td>
<td>29</td>
<td>79</td>
<td>137</td>
</tr>
<tr>
<td>Immunizable</td>
<td>5</td>
<td>2</td>
<td>12</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>35</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13</td>
<td>8</td>
<td>23</td>
<td>17</td>
<td>13</td>
<td>7</td>
<td>33</td>
<td>114</td>
<td>181</td>
</tr>
<tr>
<td>Tuberculosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client's Tested</td>
<td>37</td>
<td>22</td>
<td>23</td>
<td>22</td>
<td>23</td>
<td>39</td>
<td>65</td>
<td>231</td>
<td>529</td>
</tr>
<tr>
<td>Newly Found Reactors</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>Clients placed on Preventative Treatment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Confirmed or Suspect TB Cases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Active TB Cases</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td><strong>STDs:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>27</td>
<td>26</td>
<td>31</td>
<td>30</td>
<td>26</td>
<td>26</td>
<td>24</td>
<td>190</td>
<td>343</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>4</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>34</td>
<td>69</td>
</tr>
<tr>
<td>Syphilis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td><strong>HIV:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newly Identified LaSalle County Cases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Foreign Travel Recommendations</strong></td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>4</td>
<td>7</td>
<td>33</td>
<td>55</td>
</tr>
<tr>
<td><strong>Immunization Clinics:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Clients Seen</td>
<td>43</td>
<td>32</td>
<td>59</td>
<td>81</td>
<td>49</td>
<td>51</td>
<td>67</td>
<td>382</td>
<td>552</td>
</tr>
<tr>
<td><strong>Total Immunizations Given</strong></td>
<td>79</td>
<td>46</td>
<td>96</td>
<td>126</td>
<td>80</td>
<td>90</td>
<td>110</td>
<td>627</td>
<td>1032</td>
</tr>
</tbody>
</table>
LaSalle County Health Department Website

https://lasallecounty.org/health-department-communicable-diseases/

There are very useful forms, guidelines, and information on our website. We have recently updated our website. There is a section specifically for Communicable Disease now to make information easier to find. All of the forms for health care providers have been consolidated to one convenient location. If you don’t see something that you need, let us know!

Current Health Information Available includes:

Animal/Insects Spread Diseases
   Bed Bugs
   Ebola Virus
   Flood Disaster
   Hand, Foot, and Mouth Disease
   Lyme Disease
   Mold and Your Health
   Prepare Yourself for an Emergency
   Required Immunizations (Child/Adult)
   Scabies
   Seoul Virus
   Viral Hepatitis
   West Nile
   WIC
   Zika Virus

Current Health Care Information and Forms Available:

   2018 Semi-Annual Communicable Disease Report
   Acute Gastroenteritis Outbreak Guidance
   Bed Bug Guidance for Medical Facilities
   Influenza Guidance
   Measles and Mumps Guidance
   National Clinician’s Post-Exposure Prophylaxis Hotline
   Rabies Exposure Guidance
   Scabies Outbreak Guidance

   STD Codes
   STD Screenings for Pregnant Women
   Tickborne Diseases Guidance
   Varicella Reporting Form

AND MUCH MORE...
Changes to Reportable Diseases

As of January 1, 2019, a number of changes were made to the Administrative Communicable Diseases Code as well as the list of reportable diseases. A memo was sent out by IDPH in February detailing some of these changes and has been attached to this packet. The new “STOP and Report Infectious Disease” poster is also attached. If there are any questions as to what is and is not reportable, please call the LaSalle County Health Department (LCHD) for guidance.

Acute Flaccid Myelitis

Acute flaccid myelitis (AFM) is a serious condition of the spinal cord and should be reported to the Health Department as soon as it is suspected. Symptoms include rapid onset of arm or leg weakness and decreased reflexes. Difficulty moving the eyes, speaking, or swallowing may also occur. Occasionally numbness or pain may be present. Complications can include trouble breathing.

To tell the difference between AFM and other diseases a careful examination of the nervous system is in order, looking at the location of the weakness, muscle tone, and reflexes, to help differentiate such patients from patients with other forms of acute flaccid paralysis (AFP). Magnetic resonance imaging (MRI) can be very helpful in diagnosing cases of AFM. Testing nerve response can also be helpful in supporting a diagnosis of AFM; it is important that the tests are performed at the appropriate time (e.g., 7-10 days after onset of weakness) to be helpful. Finally, by testing the cerebrospinal fluid, clinicians can look for findings suggestive of AFM. All of these findings put together help a clinician make a diagnosis of AFM.

The Centers for Disease Control and Prevention (CDC) is working with state and local health departments to investigate pediatric patients hospitalized with acute neurologic illness of undetermined etiology characterized by focal limb weakness and inflammation of the spinal cord gray matter on MRI.

Candida auris

*Candida auris* is a rare but emerging multidrug-resistant yeast that has been found in healthcare settings in multiple countries, including the United States. *C. auris* can cause invasive infections, be passed from patient to patient, and persist in the environment. Its severity, communicability, and drug resistance makes correctly identifying *C. auris* crucial to treating patients and preventing infections. An IDPH memo has been attached to this packet about *Candida* species similar to *C. auris*. Though *C. auris* is reportable within 7 days, please contact the LaSalle County Health Department for guidance as soon as it is suspected.

Measles

Measles is a HIGHLY contagious viral infection characterized by a maculopapular rash that starts on the head and spreads from there. Other common symptoms include cough, coryza, conjunctivitis, high fevers, and Koplik spots. Measles is so contagious that sometimes everyone at an entire institution is considered exposed. Because it is one of the most contagious infectious diseases, it is extremely important to report even suspected cases of measles to the Health Department as soon as possible so that the proper steps can be initiated to confirm the diagnosis and prevent an outbreak. A testing decision algorithm aid is attached to this packet to help providers decide if testing for measles is necessary.
The United States is experiencing the worst outbreak of measles since it was declared eliminated in 2000. Since January 1, 2019, there have been over 1,000 cases of measles in the US across 28 states. Roughly 90% of these cases were unvaccinated. About 6% of these cases were internationally imported, meaning that the other 94% were acquired here. There have been 9 confirmed cases in Illinois as of May 29th.

Mumps

Mumps is a contagious viral infection of the parotid gland, which spreads easily via saliva. Swelling of one or both parotid glands, which presents as puffed out cheeks, is the primary symptom of mumps. Mumps is reportable as soon as possible within 24 hours, even if it is only suspected. It is important to remember that several other diseases can mimic the symptoms of mumps and even produce a false positive on Mumps IgM serum testing. For this reason, we suggest testing for at least influenza, mono, and strep throat. Attached to this packet is a testing decision algorithm as well as a scientific article detailing mumps-like illness and proper testing for a mumps diagnosis.

Arboviruses

Arboviruses (Arthropod Borne Viruses) are spread to humans from a bite by an infected insect such as ticks and mosquitoes. During the warmer months, when ticks and mosquitoes are more active, is when we see an increase in arboviral disease reports. These diseases can and do happen in our area. It is important to remember to test for them. Ask patients about outdoor activities and don’t rule out arboviral diseases even if patients, especially children, have no evidence or recollection of a bite. The CDC has recently put out a Tickborne Diseases Manual that can be helpful in ordering proper testing and aiding in diagnosis. The manual can be found at: [http://www.cdc.gov/ticks/tickborneindex.html](http://www.cdc.gov/ticks/tickborneindex.html)

In an attempt to gather information about ticks of public health concern in Illinois, the Illinois Department of Public Health and the University of Illinois have teamed up to develop the I-TICK (Illinois Tick Inventory Collaboration Network) program. The LaSalle County Health Department has been designated as an I-Tick hub where anyone can pick up tick collection kits. Collecting ticks takes place on any 5 days that the collector chooses between April 1 and December 31. Once the ticks are collected, the kits are to be returned to the LCHD and will then be sent to the University of Illinois for analysis. For more information on the I-TICK program, please contact the LaSalle County Health Department.

Influenza

Influenza (flu) is a contagious respiratory illness caused by influenza viruses. There are two main types of flu virus: Types A and B. The influenza A and B viruses that routinely spread in people are responsible for seasonal flu epidemics each year. Influenza is only reportable in Illinois under the following circumstances:

- Novel influenza (e.g.: H3N2v, H7N9)
- Influenza-associated intensive care unit hospitalizations
- Pediatric Influenza-associated deaths

Flu “season” is September through May each year. IDPH puts out new guidance for each flu season and can be found on the LaSalle County Health Department website when it becomes available. In the 2018-2019 Influenza season, LaSalle County reported 19 ICU admissions, 0 pediatric deaths, and 5
outbreaks at long term care facilities. Of the 5 outbreaks, 45 people were ill, 3 of which were hospitalized. No deaths were reported during any of the 5 outbreaks.

The Sentinel Surveillance Program asks providers and labs that evaluate and/or test patients with influenza like illness to send in either data through ILINet or submit specimen to an IDPH lab for influenza subtyping. The program allows the State to identify what types of influenza is circulating in Illinois and aid in the development of the next season’s vaccine, as well as identifying rare or novel strains of Influenza that may not be identifiable via commercial molecular assays. There is no cost to participate in the program. Additional information on how to sign up is attached to this packet.

**Rabies – World Rabies Day is September 28th!**

As a reminder, patients should not be started on post-exposure prophylaxis (PEP) before consulting with the health department first. In the case of an animal bite, a bite report needs to be filled out and faxed to animal control as well as to the health department as soon as possible. The bite report form can be found on the LaSalle County Health Department website and is attached to this packet. Always remember to ask the patient the whereabouts and disposition of the animal in question. If the animal can be tested for rabies, then the patient might not have to go through unnecessary PEP treatment, saving everyone time and money. A rabies flip book was previously provided containing the necessary protocols when handling a rabies patient. If you need this flip book again, please call the Health Department. Any patient that is started on Rabies PEP is to be reported to the Health Department within 24 hours.

**Vaping – Health Alert**

Attached at the end of this report is an IDPH memo from August 19th. The memo discusses 10 Illinois cases of severe respiratory illness linked to vaping. Patients are considered a case associated with this investigation if they have significant respiratory illness without an identified etiology and have a history of any vaping in the past 3 months. Patients usually present with cough and shortness of breath, but other symptoms may also include fever, pleuritic chest pain, hemoptysis, headache, nausea, abdominal pain, and diarrhea. Please consider reporting suspect cases of severe respiratory illness with recent vape usage to the LaSalle County Health Department.

**Viral Hepatitis**

Viral Hepatitis is one of the most common communicable diseases in LaSalle County. All positive tests for any type of Hepatitis are reportable. Hepatitis A is reportable as soon as possible within 24 hours, all other types are reportable as soon as possible within 7 days. Even if you know a patient has chronic hepatitis, any positive hepatitis results are still required to be reported. The LaSalle County Health Department offers free Hepatitis C antibody testing by appointment.

If a patient tests positive for Hepatitis C (HCV) antibodies, we highly recommend following up with an HCV RNA test to confirm if the patient has a current infection. A consensus statement issued by the National Institutes of Health (NIH) recommends that infants born to HCV-positive mothers should be tested for HCV RNA on two occasions between the ages of 2 and 6 months and/or be tested for anti-HCV antibodies after 15 months of age (e.g. at 18 months). The incidence of HCV vertical transmission is approximately 2 to 5 percent in HCV RNA positive mothers, with the highest risk clearly being mothers with a high HCV viral load. The risk is also increased at least fourfold for mothers with HIV coinfection.
If a patient tests positive for Hepatitis B surface antigens (HBsAg), double check to see if they have had a recent HBV vaccine. Attached is an article that has found false positive HBsAg tests if performed within a few weeks of receiving an HBV vaccination. To help prevent perinatal transmission of HBV infection, the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommend the following:

- Universal testing of pregnant women for HBsAg
- Post-exposure prophylaxis within 12 hours of birth with HBlG and the first dose of Hep B vaccine for infants born to HBV-infected mothers
- Universal birth dose administration to all infants regardless of the mother’s HBsAg status
- Completion of a valid three dose vaccine series in all infants (some infants may have 4 doses, depending on birth weight or type of vaccine administered)
- Post-vaccination serologic testing (PVST) for HBsAg and anti-HBs at 9-12 months for Infants born to HBV-infected mothers or infants born in regions where there is high or intermediate endemic HBV.

Despite these recommendations, there are still infants who become infected with HBV. This can occur when either the mother with HBV infection is not identified at the time of delivery and the infant does not receive HBlG and the full Hep B vaccine series, or the intervention does not prevent infection.

According to CDC, without post-exposure prophylaxis with HBlG and Hep B vaccine, approximately 45% of infants born to HBV-infected mothers will become infected and up to 90% of those infected will develop chronic, life-long infection. Among infants who do develop infection, 25% will die prematurely of liver cirrhosis or cancer. CDC estimates that 1,000 newborns are infected annually.
STDs Surge Across the US: CDC says *Talk. Test. Treat.*

Three common STDs, chlamydia, gonorrhea, and syphilis, have increased sharply across the United States for the fourth year in a row. To help reverse this trend, the Center for Disease Control and Prevention (CDC) is calling on individuals and healthcare providers to take these three actions to protect themselves, their partners, and their patients from STDs: *Talk, Test, and Treat.*

More than two million cases of the three STDs combined were reported nationwide. Congenital syphilis – syphilis passed from a mother to her baby during pregnancy or delivery – has also dramatically increased.

Across the nation, this data means our work is more important than ever – and we can all get involved,” says Gail Bolan, MD, Director of CDC’s Division of STD Prevention. “CDC and other federal organizations, community leaders, health departments, community-based organizations, health care providers, and individuals can all take action at work, in our schools and communities, and at home to make a difference.”

Untreated STDs Can Have Serious Effects

Chlamydia, gonorrhea, and syphilis are curable with the right medications, yet most cases go undiagnosed and untreated – which can lead to severe health problems that include infertility, ectopic pregnancy, still births, and increased risk of HIV.

Anyone who has sex can get an STD, but some groups in the US are more affected than others. **Young people aged 15-24, gay and bisexual men, and pregnant women are most at risk.** Prior studies suggest a range of factors may be at play – from socioeconomic challenges, like poverty, to issues of stigma and discrimination.

The good news? All STDs can be prevented and treated, and most can be cured. Here’s how healthcare providers can add the *Talk. Test. Treat.* strategy into their health routine.

Healthcare Providers Can:

- Providing the best care possible means talking with patients about sexual health and safe sex practices.
- Test patients as recommended by the CDC.
- Follow CDC’s STD Treatment Guidelines to make sure patients get successful treatment and care. CDC offers a free app for Apple and Android devices, so that you can access the guidelines from wherever you are.
MEMORANDUM

TO: Local Health Departments, Hospital Infection Preventionists, Infectious Disease Physicians, Emergency Department Staff, and Long Term Care Facilities

FROM: Communicable Disease Control Section

DATE: February 11, 2019

SUBJECT: Communicable Disease Rules Changes

Amendments to the IDPH Communicable Disease Code (Rules and Regulations for Communicable Disease Control and Immunizations - 77 Illinois Administrative Code 690) were adopted on Friday, February 8, 2019. The primary change was the repeal of all or part of six diseases or conditions. Following is a summary of the changes for the diseases reportable to IDPH’s Communicable Disease Section.

**Diseases or conditions repealed and individual cases no longer reportable in I-NEDSS**

- 690.362 Creutzfeldt-Jakob Disease (CJD)
- 690.400 Enterotoxigenic *E. coli*, Enteropathogenic *E. coli* and Enteroinvasive *E. coli*
  - Cases of shiga toxin producing *E. coli* are still reportable
- 690.480 Leprosy (Hansen's Disease)
- 690.658 *Staphylococcus aureus*, Methicillin Resistant (MRSA) Infection, Clusters of Two or More Laboratory Confirmed Cases Occurring in Community Settings
- 690.660 *Staphylococcus aureus*, Methicillin Resistant (MRSA), Any Occurrence in an Infant Less Than 61 Days of Age
- 690.752 Yersiniosis

Cases of these diseases with an onset in 2018 should still be investigated and reported via I-NEDSS. Any cases reported since 1/1/2019 should be closed as not-a-case. Outbreaks of these diseases or conditions remain reportable through the Outbreak Reporting System (ORS) and should continue to be investigated.

**Other Amended Sections**

- 690.10 Definitions – changes were made to the following definitions:
  - Suspect Case; Department; Contact; Food Handler; Exclusion; REDCap; Restrict from Work; and Syndromic Surveillance
- 690.30 General Procedures for the Control of Communicable Diseases – revisions were made to the following:
  - Syndromic Data Collection – added government entities
- Control of Food Products – inserted Shiga toxin-producing *E. coli*
- Schools, Child Care Facilities, and Colleges/Universities – added language to address reporting three hour and 24 hour reportable conditions
- 690.100 Diseases and Conditions – addresses repeal of diseases/conditions listed above
- 690.110 Diseases Repealed from This Part – addresses repeal of diseases/conditions listed above
- 690.400 Escherichia coli Infections (*E. coli* O157:H7 and Other Shiga Toxin Producing *E. coli*) – language added to address noncompliance when testing food handlers, health care workers or persons in other sensitive occupations.

If you have any questions about changes to the CD Code, please contact the CD Section at 217-785-8375.
Recognizing and understanding the differences between organisms with characteristics or names that sound similar to *Candida auris* (C. auris) is important because different infection prevention and control precautions are needed for different pathogens (see attached table).

*C. auris* is a type of yeast or fungus that has rapidly emerged as a pathogen of public health importance due to the following:

1) *C. auris* can be difficult to treat due to resistance to medicines commonly used to treat *Candida* infections.
2) *C. auris* can be difficult to identify by some standard laboratory techniques.
3) *C. auris* can cause outbreaks in health care facilities as it readily contaminates patient equipment and the environment.

Candidiasis is a fungal infection caused by yeasts belonging to the genus *Candida*. There are more than 20 *Candida* species that cause human infections, most commonly, *Candida albicans*. Recognizing and understanding the difference between *C. auris* and other *Candida* species is also important as different infection prevention and control precautions are needed for *C. auris*.

*C. auris* is different from carbapenem-resistant Enterobacteriaceae (CRE), carbapenem-resistant *Pseudomonas aeruginosa* (CRPA), and *Staphylococcus aureus*, which are bacteria. While they often affect a similar population of people, the types of illnesses they cause, and some infection prevention precautions, may be different.

Please contact your [local health department](#) or IDPH at [dph.XDRORegistry@illinois.gov](mailto:dph.XDRORegistry@illinois.gov) with questions.
<table>
<thead>
<tr>
<th>Name of Pathogen/Organism</th>
<th>Type of Germ</th>
<th>S. aureus (most commonly Staphylococcus aureus)</th>
<th>Enterobacteriaceae (CRE and carbapenem-resistant Enterobacteriaceae)</th>
<th>Pseudomonas aeruginosa</th>
<th>Yeast or Fungus</th>
<th>Common sites of infections</th>
<th>Related terms, words, acronyms, and selected notes (list not exhaustive)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidia auris (C. auris)</td>
<td>Yeast or Fungus</td>
<td>S. aureus is a group of bacteria that can cause infections.</td>
<td>Enterobacteriaceae are a group of bacteria that can cause infections.</td>
<td>Pseudomonas aeruginosa is a specific type (species) of bacteria.</td>
<td>Yeast or Fungus</td>
<td>Blood, wound, lung, skin, joint, bone, heart</td>
<td>C. auris is a group (genus) of yeast that is resistant to many antifungals. It can cause bloodstream infections.</td>
<td>The medical term for a Candida auris infection is Candidiasis. These infections are commonly referred to by other names depending on what part of the body is infected (e.g., thrush, vaginal yeast infection, or diaper rash).</td>
</tr>
</tbody>
</table>
Clarification of Pathogens Commonly Confused with *Candida auris*

<table>
<thead>
<tr>
<th></th>
<th><em>Candida auris</em></th>
<th><em>Candidiasis</em></th>
<th>CRE &amp; CRPA</th>
<th>Staphylococcus aureus</th>
</tr>
</thead>
</table>
| **Who is most at risk for infection? (list not exhaustive)** | Chronically ill people, especially those who:  
  - use invasive devices such as mechanical ventilators, tracheostomies, feeding tubes, or central venous catheters;  
  - recently stayed in a hospital or long-term care facility (especially nursing homes that care for ventilated patients);  
  - have a weakened immune system due to conditions such as cancer, organ transplant, or uncontrolled HIV/AIDS;  
  - were recently treated with broad-spectrum antibiotic or antifungal drugs;  
  - have kidney failure; or  
  - have diabetes mellitus. | | | Anyone can develop a staph infection, but chronically ill people are at higher risk for types of infections that are more severe and more difficult to treat. |

**Is a patient able to spread to other people, even if they don't have symptoms of illness?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>

**Are Health Care Workers able to spread between patients?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>

**Is alcohol-based hand rub the preferred method of hand hygiene?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>

**Should Standard Precautions be implemented in a Health Care Facility?**

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Always</th>
<th>Always</th>
<th>Always</th>
</tr>
</thead>
</table>

**Should Contact Precautions be implemented in a Health Care Facility?**

|                     | Always |         |         | If methicillin resistant, vancomycin intermediate, or vancomycin resistant |

**What products should a Health Care Facility use to disinfect the patient care environment?**

- Use an [EPA List K](https://www.epa.gov) sporidical disinfecting agent.  
  *When use of products on List K is not feasible, the following products may be used for surface disinfection:*  
  - Oxivir Tb, Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant, Prime Sani-Cloth Wipe, and Super Sani-Cloth Wipe
- Use a disinfecting agent approved for health care settings. These may be sporidical or non-sporidical cleaning and disinfection products.
Measles Testing Flowchart

Unvaccinated†
OR
Vaccinated with Recent Travel* OR
Contact with Case(s)***

Maculopapular rash that started on the head, face, or unknown start location?

---

No/Low Suspicion of Measles***

Had a fever with highest reading over 101°F?

---

Taken any fever-reducing medications?

---

Had cough, coryza (cold symptoms, runny nose), OR conjunctivitis?

---

No/Low Suspicion of Measles***

Contact your local health department to report all suspect cases of measles and to discuss testing options. IDPH may also be reached at 217-782-2016 or after-hours for emergencies at 217-782-7860.

Important Notes:
† Unvaccinated refers to not being up to date on age appropriate MMR vaccines, and not vaccinated within 45 days prior to symptom onset.
* Recent travel includes any international travel and domestic travel to areas of known measles cases or outbreaks.
** Known exposure includes known interaction with confirmed measles cases or persons with measles symptoms.
***These cases will not be tested at IDPH, except if they completely meet clinical criteria. Clinicians are encouraged to speak with their LHD if they feel testing is warranted in these instances.

Adapted with permission from Indiana Department of Public Health.
Viral etiology of mumps-like illnesses in suspected mumps cases reported in Catalonia, Spain

Irene Barrabeig,1,* Josep Costa,2,3 Ariadna Rovira,1 M Angeles Marcos,4 Ricard Isanta,2 Rubén López-Adalid,2 Ana Cervilla,2 Nuria Torner,1,5,6 and Angela Domínguez5,8

Abstract

We investigated the etiology of reported sporadic suspected mumps cases with a negative RT-PCR result for the mumps virus in the Barcelona-South region in 2007–2011. Samples from mumps virus-negative patients presenting unilateral or bilateral parotitis or other salivary gland swelling were tested for Epstein-Barr virus (EBV) by real-time PCR and for respiratory viruses by two multiplex-PCR-based assays to detect parainfluenza virus (PIV) 1–4, influenza virus (InV) A, B and C, respiratory syncytial virus (RSV), enterovirus, coronavirus 229E, coronavirus OC43, and rhinovirus. 101 samples were analyzed in persons aged 8 months to 50 years. Oral samples were collected on the first day of glandular swelling in 53 patients (52.5%), and on the first two days in 74 patients (73.3%). Viruses were detected in 52 (51.5%) of samples: one virus (25 EBV, 8 PIV3, 4 adenovirus, 4 PIV2, 1 PIV1, 1 InVA, and 1 enterovirus) was detected in 44 patients (84.6%), two viruses in 7 patients, and three viruses in one patient. In 58 patients (57.5%) whose sample was collected in the first 2 days after onset of parotitis and had received two doses of MMR vaccine and in 15 patients (14.8%) whose sample was collected on the first day, it is very likely that the cause was not the mumps virus. This would mean that 72.3% (73/101) of the reported sporadic suspected mumps cases were not mumps cases. The timing of oral-sample collection is crucial to correctly interpret the negative results for mumps virus RNA, especially when suspected cases occur in vaccinated persons.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4514168/
Suspect MUMPS?

Wait! This patient might not need to be tested if they are linked to another mumps patient or outbreak. Refer to outbreak guidance from LaSalle County Health Department.

Does patient have parotitis or other salivary gland swelling?

YES
Has it been ≤3 days since symptom onset?

NO
Does the patient have:
- orchitis/oophoritis, mastitis,
- pancreatitis,
- hearing loss,
- meningitis, or
- encephalitis?

YES
Collect a buccal specimen for RT-qPCR

NO
Collect a buccal specimen for RT-qPCR and serum specimen for IgM

YES
Collect a buccal and urine specimen for RT-qPCR and serum specimen for IgM

NO
Is patient part of a group at increased risk for mumps as defined by public health authorities?

Those at risk includes people born after 1957 and those who have not been vaccinated or do not have other documented evidence of immunity.

YES
Contact your lab and let them know you're sending a patient with suspected mumps for testing.

NO
Contact the LCHD for instructions on submitting specimen to the IDPH Labs.

YES
Give third dose of MMR

NO
Make sure patient is up to date on MMR and educate on signs and symptoms.

LaSalle County Health Department
717 E Etna Rd, Ottawa, IL 61350
P: (815)433-3366
F: (815)433-1636

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
MEMORANDUM

TO: Hospital Administrators, Infection Control Professionals, Laboratories, Infectious Disease Physicians, Federally Qualified Health Centers, Illinois State Medical Society, and Local Health Departments

FROM: Communicable Disease Control Section (CDCS)
Influenza Surveillance Program

DATE: June 18, 2019

SUBJECT: 2019-2020 Influenza Sentinel Surveillance Program Participation

As the IDPH CDCS Influenza Surveillance Program prepares for the 2019-2020 influenza season, we are eliciting participation in the program from Illinois laboratories and medical providers who evaluate and/or conduct testing for patients with influenza-like illness (ILI). IDPH’s influenza surveillance program collaborates with the Centers for Disease Control and Prevention (CDC) on the national surveillance initiative, and depends on data and clinical specimens submitted from sentinel sites. Your facility practice has been identified as a provider that either cares for patients with ILI and/or conducts influenza virologic testing; therefore, we are requesting your participation in this program. If you decide to participate, there are two options explained below: the ILINet provider reporting program or the virologic sentinel program for specimen testing.

The ILINet provider program is an online tracking system where designated providers can log in and submit weekly ILI surveillance data, tracking the total number of ill patients, in addition to the number evaluated only for ILI by age group. This information must be reported every Tuesday in ILINet. Data from ILINet are used to evaluate the current influenza season, monitor influenza activity levels, identify novel strains and outbreaks, assess public health vaccination efforts in the community, and assist in vaccine formulations for the following season. Throughout the season, each participating site will receive an emailed copy of the IDPH Weekly Influenza Surveillance Report and a final summary report at the end of the season.

The virologic sentinel surveillance program is another part of the overall influenza Illinois surveillance program and involves a number of selected submission sites. This program consists of testing clinical specimens from ILI patients provided by sentinel sites at designated IDPH laboratories. A CDC FDA-cleared Influenza RT-PCR assay is used as well as culturing and subtyping. Virologic surveillance is a vital part of the influenza surveillance system as it allows the CDC, IDPH, local health departments, and the sentinel sites to:

✓ Identify types of influenza circulating in Illinois,
✓ Aid in the development of next season’s vaccine,
✓ Identify rare/novel Influenza A (e.g., H3N2v, H7) and B strains that may not be identified by commercial molecular assays, and
✓ Identify and submit specimens to CDC for antiviral susceptibility testing and identification of shifts in the virus's genetic makeup.

Participating virologic sentinel sites are asked to send at least ten specimens each week to their designated IDPH laboratory for viral testing at no cost to the sentinel site. Prior approval or notice is not needed for specimen submission if the site is a registered participating sentinel site. Sentinel sites who participate in clinical specimen testing are provided their specimen results, with an average turn-around time of three days. However, this may fluctuate depending on the volume of specimens being tested in a given week. Each site will be provided influenza collection and shipping materials at no cost to the site that contain the following items:

✓ Specimen collection kits
✓ Submission forms
✓ Cold Packs
✓ Packaging & pre-paid mailing materials

To sign up for either the ILINet provider program or the virologic sentinel surveillance program, please use the following online form: Sentinel Surveillance Sign-Up Form. Previously enrolled sites will be automatically enrolled unless the site contacts the Influenza Program to opt out. The deadline for new sites to sign up for the 2019-2020 influenza season is August 31, 2019. If you are needing to sign up after that date, please call the Communicable Disease Control Section at 217-782-2016.

If you are a medical provider location within the city of Chicago, please contact the Chicago Department of Public Health’s Influenza Coordinator, Enrique Ramirez at 312-746-5911 or Enrique.ramirez@cityofchicago.org to register.

If you have questions about either program, please contact one of the following for additional details:

✓ ILINet Program:
  ✓ IDPH Communicable Disease Control Section, Influenza Program at 217-782-2016 or dph.influenza@Illinois.gov
✓ Virologic Sentinel Surveillance Program:
  ✓ Chicago IDPH Laboratory at 312-793-4760
  ✓ Springfield IDPH Laboratory at 217-782-6562
  ✓ Carbondale IDPH Laboratory at 618-457-5131

All participating sites will receive additional, detailed specimen collection and shipping instructions from the IDPH laboratories prior to the start of the 2019-2020 influenza season. Participation in these programs can occur during the official influenza season (week 40 through week 20) or during the entire calendar year. Please indicate your preference when signing up. Thank you for your consideration of this request and future involvement in influenza surveillance. We look forward to working with you.
Illinois Influenza Sentinel Surveillance Program

What is the sentinel influenza surveillance?
IDPH coordinates an influenza surveillance program in Illinois and collaborates with the Centers for Disease Control and Prevention (CDC) on the national surveillance program. This surveillance system is dependent on data and clinical specimens submitted from sentinel sites. This program relies on provider reports and laboratory submissions for an accurate evaluation of influenza in the U.S.

What is an influenza sentinel provider and who can become one?
An ILINet provider conducts surveillance for influenza-like illness (ILI) in collaboration with the IDPH, the local health departments (LHDs), and the CDC, and then provides this data through a CDC website so it can be analyzed. Providers in any outpatient setting can participate (e.g., family practice, pediatricians, emergency room physicians, university health centers, urgent care centers, public health clinics).

What information do sentinel providers collect and how is it reported?
Sentinel providers report the total number of patient visits each week and the total number of patient visit for influenza-like illness by age group (0-4 years, 5-24 years, 25-49 years, 50-64 years, and >64 years). These data are entered into the CDC ILINet website by the facility once a week (by the end of the day every Tuesday). IDPH and CDC analyze and interpret these data and use them to evaluate the current season trends.

What is the virologic sentinel surveillance program?
The virologic sentinel surveillance program is another part of the overall influenza surveillance program in Illinois and is a laboratory surveillance system involving a number of selected submission sites. This program consists of testing clinical specimens from ILI patients provided by sentinel sites at designated IDPH laboratories. A CDC FDA-cleared Influenza RT-PCR assay is used as well as culturing and subtyping. Virologic surveillance is a vital part of the influenza surveillance system as it allows the CDC, IDPH, local health departments, and the sentinel sites to:
- Identify types of influenza circulating in Illinois.
- Aid in the development of next season’s vaccine.
- Identify rare/novel Influenza A (H3N2v; H7) and B strains that may not be identified by commercial molecular assays; and
- Identify and submit specimens to CDC for antiviral susceptibility testing and identification of shifts in the virus's genetic makeup.

How many specimens would IDPH need submitted from each site?
Sentinel sites are asked to send at least ten specimens each week to their designated IDPH laboratory for viral testing. Prior approval or notice is not needed for specimen submission if the site is a registered participating sentinel site.

Does the laboratory sentinel site pay for shipping or testing materials?
No. IDPH laboratory provides the testing and shipping materials, including prepaid shipping labels, to each site that participates. This program is no cost to the sentinel site volunteering to participate.

How does a provider or laboratory sign up to participate?
If you are interested in signing up or if you have additional questions, please call one of the numbers below. You may also sign up online: Sentinel Surveillance Sign-Up Form. The deadline to sign up as a sentinel site for the 2019-2020 influenza season is August 31, 2019. Previously enrolled sites will be automatically enrolled unless the site contacts the Influenza Program to opt out.
- IDPH Communicable Disease Control Section, Influenza Program Phone: 217-782-2016
- Chicago IDPH Laboratory: 312-793-4760
- Springfield IDPH Laboratory: 217-782-6562
- Carbondale IDPH Laboratory: 618-457-5131

If you are a medical provider in the city of Chicago interested in participating, please call the Chicago Department of Public Health's Influenza Coordinator at 312-746-5911.
Positive hepatitis B surface antigen tests due to recent vaccination: a persistent problem

Carolyn D Rygaard, Cory S Morris, Denny Drees, Tami Bebber, Scott R Davis, Jeff Kulhavy, and Matthew D Krasowski

Background

Hepatitis B virus (HBV) is a common cause of viral hepatitis with significant health complications including cirrhosis and hepatocellular carcinoma. Assays for hepatitis B surface antigen (HBsAg) are the most frequently used tests to detect HBV infection. Vaccination for HBV can produce transiently detectable levels of HBsAg in patients. However, the time course and duration of this effect is unclear. The objective of this retrospective study was to clarify the frequency and duration of transient HBsAg positivity following vaccination against HBV.

Methods

The electronic medical record at an academic tertiary care medical center was searched to identify all orders for HBsAg within a 17 month time period. Detailed chart review was performed to identify all patients who were administered HBV vaccine within 180 days prior to HBsAg testing and also to ascertain likely cause of weakly positive (grayzone) results.

Results

During the 17 month study period, 11,719 HBsAg tests were ordered on 9,930 patients. There were 34 tests performed on 34 patients who received HBV vaccine 14 days or less prior to HBsAg testing. Of these 34 patients, 11 had grayzone results for HBsAg that could be attributed to recent vaccination. Ten of the 11 patients were renal dialysis patients who were receiving HBsAg testing as part of routine and ongoing monitoring. Beyond 14 days, there were no reactive or grayzone HBsAg tests that could be attributed to recent HBV vaccination. HBsAg results reached a peak COI two to three days following vaccination before decaying. Further analysis of all the grayzone results within the 17 month study period (43 results out of 11,719 tests) revealed that only 4 of 43 were the result of true HBV infection as verified by confirmatory testing.

Conclusions

Our study confirms that transient HBsAg positivity can occur in patients following HBV vaccination. The results suggest this positivity is unlikely to persist beyond 14 days post-vaccination. Our study also demonstrates that weakly positive HBsAg results often do not reflect actual HBV infection, underscoring the importance of confirmatory testing. This study also emphasizes that vaccination-induced HBsAg positives occur most commonly in hemodialysis patients.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3515481/

Overview: Serial (e.g., annual) TB screening is no longer recommended for health care personnel. Baseline testing should still be performed upon hire or for any current employees that have not had baseline testing completed as per the 2005 CDC guidelines. Treatment is now encouraged for all healthcare personnel diagnosed with untreated latent TB infection unless medically contraindicated. The recommendation for annual TB education remains unchanged; however emphasis should be placed on including information about TB risk exposures. Attached is a baseline risk assessment form from the CDC that may be used.

Reference:

Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019

The 2005 CDC guidelines for preventing *Mycobacterium tuberculosis* transmission in health care settings include recommendations for baseline tuberculosis (TB) screening of all U.S. health care personnel and annual testing for health care personnel working in medium-risk settings or settings with potential for ongoing transmission (1). Using evidence from a systematic review conducted by a National Tuberculosis Controllers Association (NTCA)-CDC work group, and following methods adapted from the Guide to Community Preventive Services (2,3), the 2005 CDC recommendations for testing U.S. health care personnel have been updated and now include 1) TB screening with an individual risk assessment and symptom evaluation at baseline (preplacement); 2) TB testing with an interferon-gamma release assay (IGRA) or a tuberculin skin test (TST) for persons without documented prior TB disease or latent TB infection (LTBI); 3) no routine serial TB testing at any interval after baseline in the absence of a known exposure or ongoing transmission; 4) encouragement of treatment for all health care personnel with untreated LTBI, unless treatment is contraindicated; 5) annual symptom screening for health care personnel with untreated LTBI; and 6) annual TB education of all health care personnel.

Background

Historically, U.S. health care personnel were at increased risk for LTBI and TB disease from occupational exposures; however, recent data suggest that this might no longer be the case. TB rates in the United States have declined substantially; the annual national TB rate in 2017 (2.8 per 100,000 population) represents a 73% decrease from the rate in 1991 (10.4) and a 42% decrease from the rate in 2005 (4.8) (4,5). Surveillance data reported to CDC during 1995–2007 revealed that TB incidence rates among health care personnel were similar to those in the general population (6), raising questions about the cost-effectiveness of routine serial occupational testing (7). In addition, a recent retrospective cohort study of approximately 40,000 health care personnel at a tertiary U.S. medical center in a low-TB-incidence state found an extremely low rate of TST conversion (0.3%) during 1998–2014, with a limited proportion attributable to occupational exposure (8). Moreover, IGRA and TSTs have well-documented limitations for serial testing of health care personnel at low risk for LTBI and TB disease (9,10).

Methods

In 2015, an NTCA-CDC work group comprising experts in TB, infection control, and occupational health was formed to discuss potential updates to recommendations for health care personnel TB screening and testing. The work group included representation from CDC, state and local public health departments, academia, and occupational health associations. During 2015–2016, the work group met periodically to discuss where updates were needed to the 2005 CDC recommendations and to establish a plan for the review of evidence. In January 2017, the work group commenced a systematic literature review of the screening and testing of health care personnel for TB and discussed the findings during a web conference in September 2017. Updated recommendations were developed by the work group during a web conference in December 2017.

Systematic review methods and findings. A systematic review of evidence published after release of the 2005 guidelines was conducted using methodology developed for the Guide to Community Preventive Services (2,3). The search included articles indexed in MEDLINE, EMBASE, and Scopus. The medical subject headings used for the search were “latent tuberculosis” and “tuberculosis”; search terms included “healthcare worker,” “healthcare personnel,” “health worker,” “occupational exposure,” and “occupational diseases.” English language articles were included that 1) were published during January 2006–November 2017; 2) described TB screening and testing in low-incidence (11), high-income countries (12); 3) employed study designs that were randomized controlled trials, prospective cohort, retrospective cohort, or cross-sectional studies; and 4) reported LTBI prevalence, test conversion or reversion, or TB transmission rates. Each study was independently abstracted and assessed for suitability of study design by two reviewers using a data abstraction form adapted from the Guide to Community Preventive Services (9).

This search identified 1,147 citations, of which 39 studies focused on TB screening and testing among health care personnel; three studies (one that was an economic evaluation, one that focused only on test performance, and one of limited...
execution quality) were excluded, leaving 36 studies in the analysis (Supplementary Box, https://stacks.cdc.gov/view/cdc/77668). Sixteen (44%) of these had been conducted in the United States, with the remaining studies from Australia (one), Europe (17), Israel (one), and New Zealand (one). Thirty-four (94%) studies had been conducted in a hospital setting; most used either a retrospective cohort or cross-sectional design (14). Substantial unexplained heterogeneity existed for all outcomes examined, even when stratified by location or study design. An examination of the patterns of results did not indicate publication bias.

Five U.S. studies reported prior bacillus Calmette-Guérin vaccination by health care personnel (median percentage = 7%; range = 2.3%–93%). Eight of the 16 U.S. studies reported two-step TST testing at baseline. The remaining studies reported IGRA (six) or a combination of IGRA and TST (two) at baseline. Findings from the metaanalyses indicated that 5% and 3% of U.S. health care personnel tested positive at baseline by IGRA and TST, respectively, and that 4% and 0.7% converted from a negative to a positive during serial testing by IGRA and TST, respectively. Among U.S. health care personnel who had a baseline positive test and were retested by the same method during serial testing, the second test was negative in 48% of cases by IGRA and 62% by TST. No U.S. studies were found that evaluated the clinical implications of these discordant results. Among 63,975 U.S. health care personnel from eight studies reporting disease occurrence, none experienced TB disease. Based on expert opinion from the NTCA-CDC work group and findings from the systematic review indicating that a limited proportion of health care personnel test positive at baseline and convert during serial testing, recommendations were drafted for presentation to the Advisory Council on the Elimination of Tuberculosis (ACET) and the Healthcare Infection Control Practices Advisory Committee (HICPAC).

**Expert consultation results.** The draft NTCA-CDC recommendations were presented publicly at the April 2018 ACET meeting (13) and the May 2018 HICPAC meeting (14). Members of ACET and HICPAC were asked to provide feedback to CDC regarding the recommendations and their accuracy, practicability, clarity, and usefulness. Commenters during the ACET meeting noted that the recommendation encouraging treatment of health care personnel with LTBI could potentially generate cost savings and play an important role in the elimination of active TB disease in the United States. Commenters during the HICPAC meeting were supportive of the need to reduce TB testing for health care personnel; questions were raised about the evidence for, and feasibility of, implementing some of the proposed changes. Commenters during both meetings also encouraged the work group’s plan for a supplemental document to aid health care facilities in implementing the updated recommendations. In addition, the recommendations were presented by NTCA at the National Tuberculosis Conference in May 2018 (15) for comment and feedback. Conference attendees supported the need for updated guidelines and the content of the recommendations that were presented.

In July 2018, the NTCA-CDC work group held another web conference to address feedback received from the ACET, HICPAC, and National Tuberculosis Conference meetings and finalized the updated recommendations. The work group requested that NTCA convene a new work group to develop the supplemental implementation guidance document supported by ACET and HICPAC. The supplemental document is expected to be completed by NTCA in 2019.

**Updated Recommendations.** Recommendations from the 2005 CDC guidelines that are outside the scope of health care personnel screening, testing, treatment, and education remain unchanged (Table); this includes continuing facility risk assessments for guiding infection control policies and procedures. Here, TB screening is defined as a process that includes a TB risk assessment, symptom evaluation, TB testing for *M. tuberculosis* infection (by either IGRA or TST) for health care personnel without documented evidence of prior LTBI or TB disease, and additional workup for TB disease for health care personnel with positive test results or symptoms compatible with TB disease. This update does not include recommendations for using an IGRA versus a TST for diagnosing LTBI, which have been published elsewhere (16).

**Baseline (preplacement) screening and testing.** All U.S. health care personnel should have baseline TB screening, including an individual risk assessment (Box), which is necessary for interpreting any test result. The 2005 guidelines state that baseline test results provide a basis for comparison in the event of a potential or known exposure to *M. tuberculosis*, facilitate detection and treatment of LTBI or TB disease in health care personnel before placement, and reduce the risk to patients and other health care personnel (1). The risk assessment and symptom evaluation help guide decisions when interpreting test results. For example, health care personnel with a positive test who are asymptomatic, unlikely to be infected with *M. tuberculosis*, and at low risk for progression on the basis of their risk assessment should have a second test (either an IGRA or a TST) as recommended in the 2017 TB diagnostic guidelines of the American Thoracic Society, Infectious Diseases Society of America, and CDC (16). In this example, the health care personnel should be considered infected with *M. tuberculosis* only if both the first and second tests are positive.
TABLE. Comparison of 2005* and 2019† recommendations for tuberculosis (TB) screening and testing of U.S. health care personnel (HCP)

<table>
<thead>
<tr>
<th>Category</th>
<th>2005 Recommendation</th>
<th>2019 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (preplacement)</td>
<td>TB screening of all HCP, including a symptom evaluation and test (IGRA or TST) for those without documented prior TB disease or LTBI.</td>
<td>TB screening of all HCP, including a symptom evaluation and test (IGRA or TST) for those without documented prior TB disease or LTBI (unchanged); individual TB risk assessment (new).</td>
</tr>
<tr>
<td>screening and testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postexposure screening and testing</td>
<td>Symptom evaluation for all HCP when an exposure is recognized. For HCP with a baseline negative TB test and no prior TB disease or LTBI, perform a test (IGRA or TST) when the exposure is identified. If that test is negative, do another test 8–10 weeks after the last exposure.</td>
<td>Symptom evaluation for all HCP when an exposure is recognized. For HCP with a baseline negative TB test and no prior TB disease or LTBI, perform a test (IGRA or TST) when the exposure is identified. If that test is negative, do another test 8–10 weeks after the last exposure (unchanged).</td>
</tr>
<tr>
<td>Serial screening and testing for HCP without LTBI</td>
<td>According to health care facility and setting risk assessment. Not recommended for HCP working in low-risk health care settings. Recommended for HCP working in medium-risk health care settings and settings with potential ongoing transmission.</td>
<td>Not routinely recommended (new); can consider for selected HCP groups (unchanged); recommend annual TB education for all HCP (unchanged), including information about TB exposure risks for all HCP (new emphasis).</td>
</tr>
<tr>
<td>Evaluation and treatment of positive test results</td>
<td>Referral to determine whether LTBI treatment is indicated.</td>
<td>Treatment is encouraged for all HCP with untreated LTBI, unless medically contraindicated (new).</td>
</tr>
</tbody>
</table>

Abbreviations: IGRA = interferon-gamma release assay; LTBI = latent tuberculosis infection; TST = tuberculin skin test.
† All other aspects of the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005 remain in effect, including facility risk assessments to help guide infection control policies and procedures.

**Postexposure screening and testing.** After known exposure to a person with potentially infectious TB disease without use of adequate personal protection, health care personnel should have a timely symptom evaluation and additional testing, if indicated. Those without documented evidence of prior LTBI or TB disease should have an IGRA or a TST performed. Health care personnel with documented prior LTBI or TB disease do not need another test for infection after exposure. These persons should have further evaluation if a concern for TB disease exists. Those with an initial negative test should be retested 8–10 weeks after the last exposure, preferably by using the same test type as was used for the prior negative test.

**Serial screening and testing for health care personnel without LTBI.** In the absence of known exposure or evidence of ongoing TB transmission, U.S. health care personnel (as identified in the 2005 guidelines) without LTBI should not undergo routine serial TB screening or testing at any interval after baseline (e.g., annually). Health care facilities might consider using serial TB screening of certain groups who might be at increased occupational risk for TB exposure (e.g., pulmonologists or respiratory therapists) or in certain settings if transmission has occurred in the past (e.g., emergency departments). Such determinations should be individualized on the basis of factors that might include the number of patients with infectious pulmonary TB who are examined in these areas, whether delays in initiating airborne isolation occurred, or whether prior annual testing has revealed ongoing transmission. Consultation with the local or state health department is encouraged to assist in making these decisions.

Health care personnel might have risks for TB exposure that are not related to their work in the United States, or they might

**BOX. Indicators of risk** for tuberculosis (TB) at baseline health care personnel assessment

Health care personnel should be considered to be at increased risk for TB if they answer “yes” to any of the following statements.

1. Temporary or permanent residence (for ≥1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe) or

2. Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-α antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication or

3. Close contact with someone who has had infectious TB disease since the last TB test

Abbreviation: TNF = tumor necrosis factor.
Summary

What is already known about this topic?
Since 1991, U.S. tuberculosis (TB) rates have declined, including among health care personnel (HCP). Serial TB testing has limitations in populations at low risk.

What is added by this report?
A systematic review found a low percentage of HCP have a positive TB test at baseline and upon serial testing. Updated recommendations for screening and testing HCP include an individual baseline (preplacement) risk assessment; symptom evaluation and testing of persons without prior TB or latent TB infection (LTBI), no routine serial testing in the absence of exposure or ongoing transmission, treatment for HCP diagnosed with LTBI, annual symptom screening for persons with untreated LTBI, and annual TB education of all HCP.

What are the implications for public health practice?
Increasing LTBI treatment among HCP might further decrease TB transmission in healthcare settings.

have risks for TB progression after baseline testing that necessitate special consideration. If these risks are unrecognized, these health care personnel might experience TB disease and transmit TB to patients, coworkers, or other contacts. Therefore, health care facilities should educate all health care personnel annually about TB, including risk factors, signs, and symptoms; facilities also should encourage health care personnel to discuss any potential occupational or nonoccupational TB exposure with their primary care provider and occupational health clinician. The decision to perform TB testing after baseline should be based on the person’s risk for TB exposure at work or elsewhere since that person’s last test.

Evaluation and treatment of health care personnel with positive test results. Health care personnel with a newly positive test result (with confirmation for those persons at low risk as described previously) should undergo a symptom evaluation and chest radiograph to assess for TB disease. Additional workup might be indicated on the basis of those results. Health care personnel with a prior positive TB test and documented normal chest radiograph do not require a repeat radiograph unless they are symptomatic or starting LTBI treatment (16). The local public health department should be notified immediately if TB disease is suspected.

Health care personnel with LTBI and no prior treatment should be offered, and strongly encouraged to complete, treatment with a recommended regimen, including short-course treatments, unless a contraindication exists (17,18). Health care personnel who do not complete LTBI treatment should be monitored with annual symptom evaluation to detect early evidence of TB disease and to reevaluate the risks and benefits of LTBI treatment. These health care personnel also should be educated about the signs and symptoms of TB disease that should prompt an immediate evaluation between screenings.

Health care facilities should aim to identify LTBI among health care personnel and encourage LTBI treatment. Health care facilities are urged to collaborate with public health agencies to assist in achieving this goal. Public health agencies can serve as a source for technical assistance, medical consultation regarding diagnosis and treatment of LTBI, and clarification of state or local regulations, surveillance requirements, and guidelines. Sharing information and experiences with public health agencies is necessary for understanding the impact of these recommendations on the overall incidence of TB and LTBI in the United States and the need to revise future recommendations for health care personnel.

Corresponding author: Gibril J. Njie, gnjie@cdc.gov, 404-639-3219.

1Connecticut Department of Public Health; 2National Tuberculosis Controllers Association, Smyrna, Georgia; 3Division of Tuberculosis Elimination, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC; 4Logistics Health Incorporated, La Crosse, Wisconsin; 5American College of Occupational and Environmental Medicine, Elk Grove Village, Illinois; 6Respiratory Health Division, National Institute for Occupational Safety and Health, CDC; 7Association of Occupational Health Professionals in Healthcare, Warrendale, Pennsylvania; 8Division of Healthcare Quality Promotion, National Center for Emerging and Zoonotic Infectious Diseases, CDC; 9Oregon Health & Science University, Portland; 10Beaumont Hospital, Royal Oak, Michigan; 11Denver Health and Hospital Authority, Denver Public Health, Denver, Colorado; 12Maryland Department of Health; 13Veterans Administration Palo Alto Healthcare System, Palo Alto, California.

All authors have completed and submitted the ICMJE form for disclosure of potential conflicts of interest. Wendy Thanassi reports a grant from Qiagen Inc. outside the submitted work. Lorna Will reports personal fees from the National Tuberculosis Controllers Association during the conduct of the study. Mary Ann Gruden reports personal fees from the Allegheny Health Network, Association of Occupational Health Professionals in Healthcare, and National Institute for Occupational Safety and Health Board of Scientific Counselors outside the submitted work. No other potential conflicts of interest were disclosed.

References


**Health Care Personnel (HCP)**

**Baseline Individual TB Risk Assessment**

**HCP should be considered at increased risk for TB if any of the following statements are marked “Yes”:**

<table>
<thead>
<tr>
<th>Temporary or permanent residence of ≥1 month in a country with a high TB rate</th>
<th>YES ☐</th>
<th>NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe</td>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
</tbody>
</table>

**OR**

| Current or planned immunosuppression, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication | YES ☐ | NO ☐ |

**OR**

| Close contact with someone who has had infectious TB disease since the last TB test | YES ☐ | NO ☐ |

Abbreviations: HCP, health care personnel; TB, tuberculosis; TNF, tumor necrosis factor.


Adapted from: Risk assessment form developed by the California Department of Health, Tuberculosis Control Branch.


[https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?ss=uid=mm6819a3_w](https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?ss=uid=mm6819a3_w)
Summary and Action Items
1. All patients with serious respiratory illness of unknown etiology should be asked about recent vaping practices.
2. Patients with unexplained serious respiratory illness and recent vaping should be reported to the local health department.
3. In patients with unexplained serious respiratory illness and vaping exposures, IDPH recommends ruling out common infectious and non-infectious etiologies.
4. If possible, take a detailed history of the frequency of vaping and the products used, and document these in the medical notes.
5. If the patient has products they have vaped, ask them not to use them again and save them in case product testing is requested.
6. IDPH is asking for any clinical samples from broncho-alveolar lavage (BAL) and/or tissue biopsies be saved, and if possible, sent to the IDPH laboratory.

Background
Many states are reporting cases of severe respiratory illness among individuals who have a recent history of vaping (use of e-cigarette and similar devices to inhale aerosolized liquid).

As of August 19, 2019, 10 Illinois residents are considered cases and others are under investigation. Most cases are in Chicago and the collar counties. The age range of the patients is from 15 to 27 years, and 77% are male.

At this time, patients are considered cases associated with this investigation if they have significant respiratory illness without an identified etiology and have a history of any vaping in the past 3 months.

Potential Exposures and Transmission
Patients have all reported vaping in the weeks to months prior to illness. Products used by cases may contain THC, CBD, nicotine, flavors and other chemicals. At this time, no particular product nor device has been determined to be the cause.

Symptoms
Patients present with cough and shortness of breath. Other presenting symptoms may include fever, pleuritic chest pain, hemoptysis, headache, nausea, abdominal pain and diarrhea. Symptoms worsen over a period of days or weeks before hospital admission. On hospital admission, most patients are febrile, tachycardic and may be hypoxic. The majority of patients have required hospitalization. Several patients had progressive respiratory compromise requiring intubation. No infectious etiology has been identified.

Diagnosis
Among reported cases, chest radiographs show bilateral opacities, typically in the lower lobes and CT imaging of the chest shows diffuse ground glass opacities, often with subpleural
sparing. Evaluation for infectious etiologies have been negative. Most patients have raised inflammatory markers, including a neutrophilia and high CRP.

Management
In patients with significant respiratory illness of unknown etiology, we recommend asking patients about recent vaping practices. All patients presenting with this clinical picture and a history of vaping should be reported to your local health department.

Common infectious etiologies should be ruled out (respiratory panel, influenza, sputum/blood cultures) As clinically indicated, rheumatologic or neoplastic processes, and less common infections should be considered. Aggressive supportive care is warranted, and in severe cases, mechanical ventilation may be warranted. Consider appropriate specialty consults. Preliminary information indicates clinical improvement with administration of systemic steroids.

Prevention
At this time, it is not known what product(s), chemicals or devices may be linked to illnesses. Patient education regarding the unknown risk associated with vaping and e-cigarette use is encouraged. Educational materials to provide to patients may be located on the IDPH website (see resources).

IDPH and Local Health Department Response
Local health departments, IDPH and infection control preventionists are conducting interviews with patients to identify possible exposures. IDPH is working closely with the CDC and FDA, as well as other states, on this investigation.

Local health departments who hear about suspect cases should notify IDPH. IDPH is collating medical records, including chest radiographs and CT images, and reviewing information from local health departments to assess for any common exposures.

Information will be placed on the communicable disease web portal under A-Z, “vaping and severe respiratory illness”. Additionally, the IDPH website will remain up-to-date with confirmed case count and other information as deemed necessary.

Contact
Contact your local health departments with suspect cases as soon as possible. Local health departments can contact Dr. Isaac Ghinai (isaac.ghinai@illinois.gov) in the IDPH CD Section with any inquiries, or Dr Jen Layden (jennifer.layden@illinois.gov).

Resources
IDPH Website

Target Audience
Local Health Departments, Infectious Disease Physicians, Pulmonology Physicians, Intensive Care Physicians, Emergency Departments, Infection Preventionists, Health Care Providers, and Laboratories

Date Issued
August 19, 2019

Author: IDPH Communicable Disease Section