



Epi Update



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Florida Influenza Surveillance Report

Kateesha McConnell, M.P.H. and Richard S. Hopkins, M.D., M.S.P.H.

For the most up-to-date information regarding influenza surveillance and the progress of influenza season and the novel H1N1 pandemic in Florida, please visit the Bureau of Epidemiology influenza surveillance reports website at:

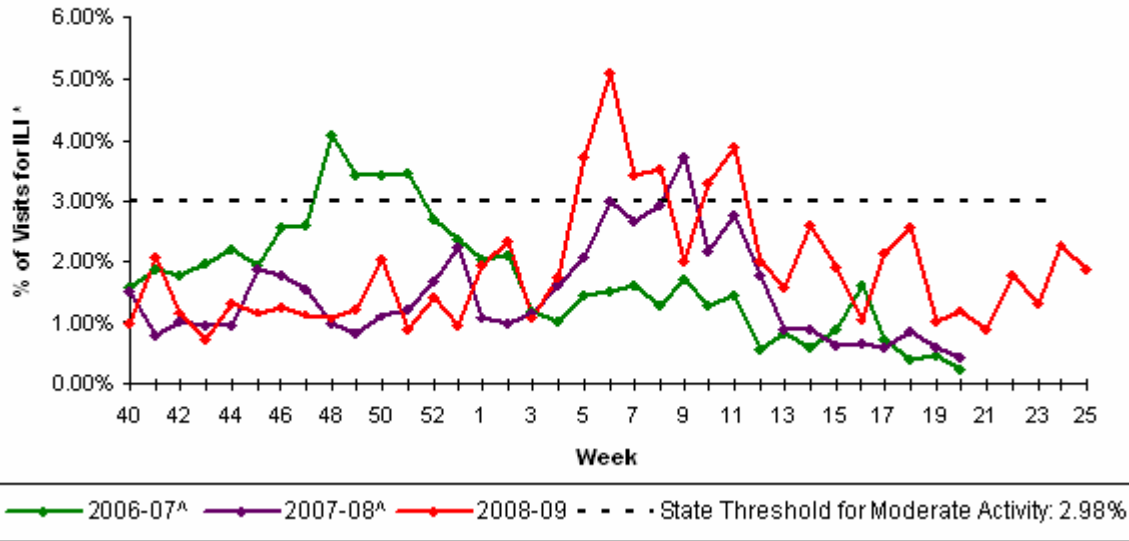
http://www.doh.state.fl.us/disease_ctrl/epi/htopics/flu/reports.htm.

Novel Influenza

At the end of April 2009, a novel swine-origin influenza A H1N1 was identified in the U.S. As a result, the Florida Department of Health instituted enhanced surveillance activities to determine the presence of the novel virus. Providers across the state were notified to report suspected illness due to infection with the novel flu virus and submit specimens for testing. Media coverage of the swine-origin influenza A H1N1 outbreak raised awareness among providers and the general public. During late April and early May, an increase in the number of reported illnesses due to influenza infection was detected in several of the surveillance systems. Although increases in reports of ILI were detected across the state in multiple surveillance systems, it appears these initial increases were due, primarily, to additional people seeking consultation from the medical community because of increased awareness.

During week 25 (06/21/09-06/27/09), the proportion of patient visits for influenza-like illness (ILI) as reported by the Florida Sentinel Physician Influenza Surveillance Network was 1.88%. This is below the state threshold for moderate activity of 2.98%. See graphic for trends over time. Note that this percentage has not fallen back to the levels seen right before the large media-driven spike of patient visits for ILI in late April and early May.

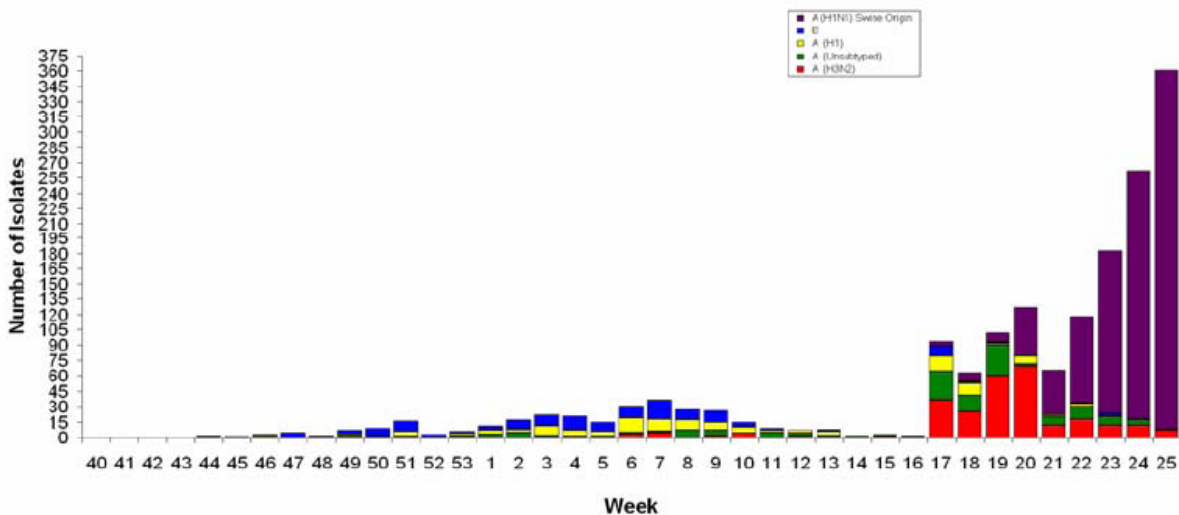
Percentage of Visits for Influenza-like Illness Reported by Sentinel Providers Statewide Summary 2008-09, 2007-08, and 2006-07



In week 25, three hundred sixty-one (78%) of 461 ILI specimens tested by Bureau of Laboratories using RT-PCR were positive for influenza. This is a very high percentage – the comparable percentage during a normal winter influenza season is around 20% to 30%. This high percentage suggests that (1) clinicians are doing a good job of picking out ILI from other respiratory illnesses; and/or (2) at this time of year, other respiratory viruses are uncommon, while influenza is still active; and/or (3) some of the specimens tested are from respiratory disease outbreaks, essentially all of which are currently due to influenza.

Among the 361 specimens that tested positive, one was seasonal influenza A H1, seven were influenza A H3, none were influenza A unknown, 353 were influenza A H1N1 swine origin, and none were influenza B unknown.

FDOH State Laboratory Influenza Virus Isolates 2008-09



In summary, most ILI (almost 80%) leading to testing at the Bureau of Laboratories turns out to be influenza, and almost all the influenza tests (98%) are positive for the novel 2009 swine influenza H1N1.

As of July 1, over 1300 people have had confirmed laboratory results for the novel influenza A H1N1 virus since late April. Five of these people, including one child, have died. Daily and weekly case counts have been stable for the past three to five weeks. Almost 60% of all confirmed tests have been for people aged 5 to 24 years, and only 1.2% have been for people aged 65-years-old and older. Children under age 5 account for 13% of cases. Overall, about 12% of confirmed cases have been in hospitalized people. This percentage will probably rise as testing becomes concentrated on hospitalized cases and people who are part of outbreaks.

In week 25, one county reported widespread activity and three counties reported localized activity. Twenty-nine counties reported sporadic activity and ten counties reported no activity. Twenty-four counties did not report. The map that follows shows that the four contiguous counties from Miami-Dade to Martin are reporting widespread or localized influenza activity. ILI visit data from the ESSENCE syndromic surveillance system corroborate that ILI visits to emergency departments in southeastern Florida have been rising in recent weeks, especially in children and young adults.

Outbreaks of ILI have been reported in numerous residential and day camps for children (at least a dozen), as well as in several correctional facilities. Where influenza typing has been done, almost all these outbreaks have been confirmed as the novel 2009 influenza A H1N1 virus.

Surveillance efforts for influenza will continue over the summer and focus on the detection of outbreaks of influenza or ILI. Remember to protect yourself and your family from the flu. Practice good respiratory etiquette by covering your cough and washing your hands after coughing or blowing your nose. Help prevent the spread of flu by staying home from social gatherings, work, or school when you are sick.

Thank you to all of our surveillance partners for their continuous surveillance efforts in monitoring influenza activity in the state. We look forward to working with you during enhanced influenza surveillance activities throughout the summer and the upcoming year.

Updated Testing Guidance for 2009 Novel H1N1 Influenza A in Florida

Richard S. Hopkins, M.D., M.S.P.H., and Max Salfinger, M.D., Ph.D.

Beginning July 13, the Bureau of Laboratories will only test for the novel 2009 H1N1 virus specimens from patients:

- with life-threatening illnesses,
- from county health departments investigating suspected influenza outbreaks, and
- from the Florida network of sentinel surveillance practices.

As of today, there have been at least 1200 persons reported in Florida with lab-confirmed novel 2009 influenza A H1N1 infection. Ninety percent of positive influenza tests in the state public health laboratory in recent weeks have been positive for this new virus, rather than the seasonal influenza viruses that were circulating last winter and spring.

A specific virologic diagnosis of infection with the new virus is not currently needed for clinical or public health purposes for most people with influenza-like illness (ILI). Almost all people with influenza are infected with the new virus, which is susceptible to both oseltamivir and zanamivir (Tamiflu and Relenza). Decisions regarding infection control and personal protective equipment for patients with illness suggesting influenza do not require and should not wait for specific novel H1N1 virologic diagnosis.

RT-PCR testing to detect the novel H1N1 virus is now also available through at least one commercial laboratory (Quest), and others may soon offer the service.

It remains important for public health purposes to know the specific virologic diagnosis on people who have life-threatening illness with influenza; for example, those admitted to an ICU. For this purpose, the Bureau of Laboratories will continue to offer RT-PCR diagnostic testing to assure that no barriers are placed in the way of such diagnoses.

As of July 13, 2009, the influenza testing through the state's public health laboratories will be phased out for purposes other than sentinel surveillance, testing of patients with life-threatening illness, and outbreak investigation.

Testing recommendations

The following people should be tested for novel H1N1 infection through the Florida Bureau of Laboratories:

- People admitted to the hospital with life-threatening illness suggesting influenza infection.
- People who appear to be part of outbreaks of influenza, especially in certain group settings – please see below for further information.
- A sample of people presenting with ILI at specific practices participating in the Sentinel Practice Influenza Surveillance System.

Others should not be tested through the Florida Bureau of Laboratories.

Call your county health department (CHD) to report people hospitalized with strongly suspected or confirmed life-threatening H1N1 infection, to report possible influenza outbreaks, and to get advice on testing and management of cases and contacts. The CHD will advise on whether or not specific tests are needed on patients who appear to be part of an outbreak.

An ILI outbreak is defined as three or more people who are connected through a group setting (see below for further details), are ill with symptoms suggesting influenza, and are not part of a household cluster.

Determine if a person is part of such an outbreak by asking the person if he or she has recently had face-to-face or close social contact with other people with similar symptoms who share a similar social environment such as a school, workplace, summer camp, or church.

Examples of Settings of Concern for Outbreaks:

For children:

- Daycare
- School
- Summer day camp
- Summer residential camp (overnight)
- Summer school
- Other summer programs
- Detention facility

For adults:

- Healthcare setting, either inpatient or ambulatory (patient or staff)
- Daycare center
- Children's camp or recreation program
- School
- Jail, detention, or correctional facility (as inmate or worker)
- Nursing home (resident or worker)
- Adult congregate living facility (resident or worker)
- Group home (resident or worker)
- University and college dormitories
- Military barracks

Not every apparent case in an outbreak needs to be tested – two or three confirmed positive results are enough.

Richard Hopkins is the Acute Disease Section Administrator of the Bureau of Epidemiology, as well as the Acting State Epidemiologist for the Florida Department of Health. He can be contacted at 850.245.4412 or by email at Richard.Hopkins@doh.state.fl.us. Max Salfinger is the Chief of the Bureau of Laboratories. He can be contacted at 850-245-4517 or by email at Max.Salfinger@doh.state.fl.us.

The Association Between Diabetes Self-Management Education and Comprehensive Diabetes Clinical Care

Tammie M. Johnson, M.P.H., Dr.PH.

In 2008, 9.5% of Florida adults had a diagnosis of diabetes. Diabetes is associated with diminished health status and quality of life, along with a number of microvascular, macrovascular, and neuropathic complications, including heart disease and stroke. Disease self-management and achieving blood glucose levels as close to normal as possible are important aspects of complication mitigation.

The Florida Behavioral Risk Factor Surveillance System (BRFSS) contains questions concerning clinical services recommended by the American Diabetes Association (ADA): annual foot examinations, annual dilated retinal examinations, semi-annual A1C tests, annual influenza vaccinations, and one-time pneumococcal vaccinations. The ADA also recommends diabetes self-management education (DSME) to ensure patients with diabetes have the knowledge and skills to make the best choices possible. Trends in DSME interventions have evolved over time from models of education only to education and behavior training. In recent years, more attention has been given to interventions specifically for minority populations and the literature supports the effectiveness of DSME on psychosocial and health outcomes. A growing body of research indicates that engaging in diabetes self-management behaviors and receiving recommended clinical care are strongly associated with improved metabolic control.

Previous work in this area has focused on the association between receiving DSME and individual clinical services, not comprehensive care. DSME is associated with improved diabetes knowledge, improved self-care behavior, improved clinical outcomes, lower self-reported weight, and improved quality of life. Outcome measures improved with longer DSME administration and with follow-up support that was tailored to individual needs and preferences, and that addressed psychosocial issues.

Two main research questions guided the analyses presented here.

1. Can a measure of comprehensive diabetes clinical care be constructed using BRFSS data?
2. Is receiving DSME associated with receiving a higher level of comprehensive diabetes clinical care?

Figure 1 illustrates the key concepts driving this analysis. Ultimately, the goal is improved health outcomes. To do this, people with diabetes should maintain optimal metabolic control. Research has shown that specific self-management practices and receiving routine clinical care are associated with improved metabolic control and that receiving DSME is associated with improved adherence to individual components of self-management and clinical care regimens. This study examines the association between receiving DSME and comprehensive diabetes clinical care, which is a construct of the individual components of a diabetes clinical care regimen, using 2007 Florida BRFSS data.

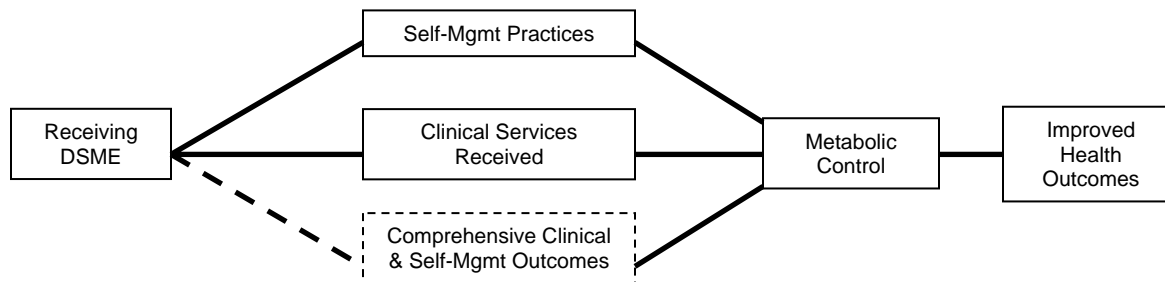


Figure 1. Conceptual framework showing the associative pathway from receiving diabetes self-management education to improved health outcomes

The BRFSS is an on-going, cross-sectional, population-based telephone survey of non-institutionalized adults 18 years of age and older in randomly selected households. The BRFSS elicits information from respondents pertaining to a variety of disease states, risk factors, preventive health practices, and emerging health issues. BRFSS uses a multi-stage, complex sample design that produces cluster-correlated data. Nearly 40,000 adults responded to the 2007 Florida BRFSS. People were defined as diabetes cases if they answered “yes” to the following question: “Have you ever been told by a doctor that you have diabetes?” Women who answered “Yes – but only told during pregnancy” and respondents indicating they had been told they have pre-diabetes were not included in this definition. In 2007, 4,947 Florida adults met this definition. The BRFSS does not discern whether a person has type 1 or type 2 diabetes. The clinical services of interest for this study were those that apply to adults with type 2 diabetes or adults who have had type 1 diabetes for five or more years. For this reason, those deemed having probable type 1 diabetes were those diagnosed before 30 years of age and using insulin only. All others are assumed to be type 2. This study included all respondents with type 2 diabetes and those who had type 1 for five or more years, which resulted in a study population of 4,888, or 98.8% of those meeting the case definition for diabetes. SAS and SUDAAN were used for this analysis. In addition to descriptive statistics, logistic and Poisson regression models were fitted to examine associations between the dependent and independent variables.

Two versions of a comprehensive diabetes clinical care (CDCC) variable were constructed using the five clinical variables previously described; a count or index version that ranges from 0-5, based on the number of clinical services a respondent received (CDCC₅) and a dichotomous version of this count/index variable (CDCC₂) indicating high CDCC (4-5 services) versus not high CDCC (0-3 services). Both CDCC variables were tested for internal validity using Cronbach’s alpha and both were ≥ 0.70 , which is generally regarded as the accepted lower bound. CDCC₅ and CDCC₂ were used as dependent variables for Poisson and logistic regression models, respectively.

Logistic and Poisson regression models were fitted using backward elimination. Table 1 shows the adjusted odds ratios (AOR) for high CDCC₂ and adjusted incidence density ratios (AIDR) for CDCC₅. Controlling for the variables listed, the odds of having high CDCC₂ is 2.5 times higher among those who received DSME compared to their counterparts. Significant associations were also observed for those with insurance (AOR 3.65), those with at least four years of college (AOR 2.70), and those in the 45-64 and 65+ age groups (2.31 and 5.29, respectively). The Poisson regression analysis showed that those who received DSME had average CDCC₅ scale scores 23% higher than those who did not receive DSME. The overall weighted mean CDCC₅ scale score was 3.1. Those who received DSME had an average CDCC₅ scale score of 3.4, compared to 2.8 among those who did not receive DSME. The average CDCC₅ scale score was also higher among those in the 45-64 year age group, those with more than a high school education, and those with health insurance. For both logistic and Poisson regression models, a pair-wise examination of explanatory variables was conducted and no significant interactions were noted.

Table 1. Final Model Logistic Regression Adjusted Odds Ratios (AOR) and Poisson Regression Adjusted Incidence Density Ratios (AIDR) by Socio-Demographic Characteristics

Characteristics (Referent)	Logistic Regression High CDCC₂ AOR (95% CI)	Poisson Regression CDCC₅ Scale AIDR (95% CI)
45-64 years of age (18-44 years of age)	2.31 (1.24, 4.32)	1.22 (1.08, 1.38)
65 years of age and older (18-44 years of age)	5.29 (2.87, 9.76)	1.45 (1.29, 1.64)
High school/<3 yrs. college (< high school)	1.55 (1.06, 2.26)	1.09 (1.02, 1.18)
4+ yrs. college (< high school)	2.70 (1.74, 4.17)	1.22 (1.13, 1.32)
Had insurance (no insurance)	3.65 (2.03, 6.56)	1.26 (1.15, 1.39)
Had DSME (no DSME)	2.48 (1.90, 3.23)	1.23 (1.16, 1.30)

The results from this study show there is a significant association between receiving DSME and having more comprehensive diabetes clinical care. Despite the benefits of receiving DSME and the relatively low cost, only 51.5% of this study population had received this educational opportunity. The results of this study show the utility of examining diabetes care in terms of comprehensiveness. Examining these data on a state level allows programs that design and implement diabetes interventions to consider and assess state-specific needs.

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Tammie Johnson is an epidemiologist in the Chronic Disease Section of the Bureau of Epidemiology, Florida Department of Health. She can be contacted at 850-245-4405 or by email at Tammie_Johnson@doh.state.fl.us.

Physical Health Among Florida Adults With Cardiovascular Disease

Bonnie Yu, M.A., M.A.S.

Heart disease is the leading cause of death in the United States and is a major cause of disability. Almost 700,000 people die of heart disease each year, which is approximately 29% of all U.S. deaths.

The purpose of this report is to compare the physical health status of people with and without cardiovascular disease using 2008 BRFSS data and to report knowledge of the signs and symptoms of heart attack and stroke using 2005 BRFSS data. Prevalence data, behavioral factors related to poor physical health, and information on cardiovascular disease management are provided to create a more comprehensive snapshot of the burden of cardiovascular disease in Florida.

The prevalence of poor physical health was 3.5 times higher among adults with cardiovascular disease (31.7%) compared to their counterparts without cardiovascular disease (9.0%). On average, adults with cardiovascular disease experienced 9.5 days in which their physical health was not good during the past 30 days compared to an average of three days among adults without cardiovascular disease. Compared to their counterparts, the prevalence of poor physical health among people with cardiovascular disease was higher among adults:

- who are 45- to 64-years-old,
- have less than a high school education,
- have annual household incomes less than \$25,000,
- who were formerly married (including divorced, widowed, and separated),
- who live in rural areas,
- who did not engage in any exercise or physical activity, and
- who did not receive emotional support.

BRFSS data from 2008 showed that, among adults with cardiovascular disease, 57% were told by doctors that they had a heart attack, 53% had coronary heart disease, 32% had a stroke, and 71% were overweight or obese.

A majority of adults with cardiovascular disease correctly identified the signs and symptoms of heart attack and stroke, as well as how to seek aid by calling 911. More adults with poor physical health than those with good physical health recognized that chest pain or discomfort, sudden trouble seeing in one or both eyes, and pain or discomfort in the arms or shoulder were symptoms of a heart attack.

A comprehensive data report with detailed data tables is available at the Florida Department of Health, Bureau of Epidemiology's website http://www.doh.state.fl.us/disease_ctrl/epi/brfss/reports.htm.

If any assistance is needed with more interpretation in detail, please contact the Bureau of Epidemiology, Chronic Disease Epidemiology Section at (850) 245-4401.

Bonnie Yu is a biological statistician in the Bureau of Epidemiology, Florida Department of Health. She can be contacted at 850.245.4444, ext 2407 or by email at Bonnie_Yu@doh.state.fl.us.

New Advances in Technology Drive Smarter, More Efficient Ways to Conduct Disease Surveillance in Florida

Christie Luce

Changes made to Rule 64D-3, *Florida Administrative Code* in November 2006 made it mandatory for laboratories and practitioners to report notifiable diseases electronically. Since then, the Florida Department of Health (FDOH) has been working with these laboratories and hospitals to support an electronic feed of their data into FDOH databases. These results go to one of two central databases and are then fed down to the surveillance applications used by different program areas. Currently, the Bureaus of HIV/AIDS, Sexually Transmitted Diseases, and Epidemiology, as well as the Childhood Lead Prevention Program are using data that is transmitted electronically. Electronic reporting also reduces the likelihood of human error caused when high volumes of laboratory results are entered manually, and increases compliance since providers and laboratories are relieved of the “choice” of whether or not to report.

Most of the largest laboratories that provide Florida results are successfully transmitting data, including LabCorp and Quest Laboratories. These two labs make up approximately 43% of the total number of results received by the department. Five smaller labs and all the state-run laboratories are also sending data. Several months of work go into setting up a new lab in the Electronic Laboratory Reporting (ELR) process. All variations of all results must be tested by the program areas that will use the data.

Once the program areas have gone through the testing process, they begin to receive live data from the sending facility. A study in 2008 looked at reporting data over a four-year period (2002-2006) and showed that the reporting time using ELR for lower priority diseases, such as *salmonella* and *shigella*, was reduced from an average of four days to only one day.

At the beginning of the process, laboratories and hospitals are sent a *New ELR User Implementation Guide* that includes the standards and requirements for sending electronic data. Once a facility is successfully sending data to all program areas, each area performs quality assurance (QA) processes to ensure that the electronic data is timely and accurate. Once this has been confirmed, program areas can inform the ELR Liaison to instruct the facility to shut off the paper feed for those results. This saves resources for both the facility and the DOH, but is only done after an exhaustive QA process has been completed.

The department conducts stakeholder meetings every week to ensure that all program areas are informed about updates, problems, or concerns. A monthly call is also held on the third Thursday of each month to share important ELR information with county health departments. Each month, counties are updated on labs and hospitals in their areas that are working towards electronic reporting.

Electronic Laboratory Reporting provides timely, useful information needed for effective disease surveillance in Florida. By encouraging laboratories and hospitals to comply with the requirement to report notifiable disease results electronically, the DOH has entered into a win-win situation for everyone.

For more information on Electronic Laboratory Reporting or to be included in the monthly CHD calls, please email or call Christie Luce.

Christie Luce is the Surveillance Systems Administrator for the Bureau of Epidemiology, Florida Department of Health. She can be contacted at 850.245.4418 or by email at Christie.Luce@doh.state.fl.us.

Florida Year-to-Date Mosquito-Borne Disease Summary Through June 12, 2009

Elizabeth Radke, M.P.H., Kristina Weis, Ph.D., Danielle Stanek, D.V.M., Carina Blackmore, D.V.M., Ph.D.



During the period from January 1 through June 12, 2009, the following arboviral activity was recorded in Florida:

Eastern equine encephalitis virus (EEEV) Activity

Positive samples were obtained from seventeen equines, one captive bird, twenty-three sentinel chickens, and thirty-two live wild birds in twenty counties.

West Nile virus (WNV), St. Louis encephalitis virus (SLEV) Activity

Samples from two live wild birds from two counties tested positive for antibodies to a flavivirus; either WNV or SLEV.

Highlands J virus (HJV) Activity

Positive samples were obtained from eleven sentinel chickens in two counties.

California encephalitis group viruses (CEV) Activity

None

In addition, the following imported mosquito-borne disease was reported:

Dengue Virus (DENV)

Fourteen imported cases were reported from seven counties: Alachua (1), Brevard (3), Broward (2), Dade (2), Lee (1), Orange (3), and Sarasota (2). Countries of origin included Puerto Rico (3), Panama (2), Dominican Republic (3), Bolivia (2), Brazil (1), Honduras (1), Suriname (1), and Columbia (1).

Malaria

Thirty-six imported cases were reported from eleven counties: Alachua (1), Broward (10), Dade (7), Duval (1), Escambia (1), Lee (1), Orange (4), Palm Beach (7), Pinellas (2), Polk (1), and Seminole (1). Countries of origin included Haiti (19), Nigeria (4), Sierra Leone (2), Malawi (2), South Africa (1), Ghana (1), Zambia (1), Honduras (1), India (1), Guinea (1), Mexico (1), Thailand (1), and Pakistan (1).

Dead Bird Reports

The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. Since January 1, 216 reports representing a total of 575 dead birds (48 crows, 19 jays, 30 raptors, and 478 others) were received from 48 of Florida's 67 counties. Please note that FWC collects reports of birds that have died from a variety of causes, not only arboviruses. Report dead birds to www.myfwc.com/bird/.

See the following web site for more information:
<http://www.doh.state.fl.us/Environment/medicine/arboviral/index.html>.

Elizabeth Radke is the Arthropod-borne Disease Surveillance Coordinator with the Bureau of Environmental Public Health Medicine. She can be contacted at 850.245.4444, ext 2437 or by email at Elizabeth.Radke@doh.state.fl.us. Dr. Kristina Weis is the CDC/CSTE Applied Epidemiology Fellow with the Bureau of Environmental Public Health Medicine. She can be contacted at 850.245.4444, ext 2016 or by email at Kristina.Weis@doh.state.fl.us. Dr. Danielle Stanek is a medical epidemiologist with the Bureau of Environmental Public Health Medicine. She can be contacted at 850.245.4117 or by email at Danielle.Stanek@doh.state.fl.us. Dr. Carina Blackmore is the State Public Health Veterinarian and the Chief of the Bureau of Environmental Public Health Medicine. She can be contacted at 850.245.4732 or by email at Carina.Blackmore@doh.state.fl.us. The Bureau of Environmental Public Health Medicine is part of the Division of Environmental Health, Florida Department of Health.

Upcoming Events

Bureau of Epidemiology Monthly Grand Rounds

Date: Last Tuesday of each month
Time: 10 a.m.-11 a.m., E.T.
Location: Building 2585, Room 310A
Dial-In Number: 877.646.8762 (password: Grand Rounds)

Upcoming Topics:

- July 28 – “Pertussis” presented by Scott Pritchard, M.P.H.
- August 25 – “Florida Behavioral Risk Factor Surveillance System” presented by Youjie Huang, M.D., M.P.H., Dr.PH., Melissa Murray, M.S., and Tammie Johnson, M.P.H., Dr.PH.

Regional Epidemiology Epi-RIOT Trainings

We are pleased to announce that we will be offering one additional Regional Epidemiology Epi-RIOT Trainings.

Upcoming Dates:

- July 21 – Marion County, Ocala

Reportable Diseases in Florida

Up-to-date information about the occurrence of reportable diseases in Florida, based on the Merlin surveillance information system, is available at the following site: <http://www.floridacharts.com/merlin/freqrpt.asp>. Counts can be displayed by disease, diagnosis status, county, age group, gender, or time period.

Monthly Notifiable Disease Data

Table 1. Provisional Cases* of Selected Notifiable Diseases, Florida, May 1-31, 2009

Disease Category	Month				Cumulative (YTD)	
	2009	2008	Mean [†]	Median [‡]	2009	2008
A. Vaccine Preventable Diseases						
Diphtheria	0	0	0	0	0	0
Measles	4	0	1	5	5	0
Mumps	2	3	1.8	2	8	15
Pertussis	63	16	12.2	14	200	68
Poliomyelitis	0	0	0	0	0	0
Rubella	0	2	0.4	2		2
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0.4	1	0	0
Varicella	172	193	N/A	N/A	783	964
B. CNS Diseases & Bacteremias						
Creutzfeldt-Jakob Disease	1	2	1.8	2	7	7
<i>H. Influenzae</i> (invasive)	20	16	10.8	3	119	59
in those ≤5	2	7	3.8	3	12	38
Listeriosis	2	2	1.6	2	4	17
Meningitis (bacterial, cryptococcal, mycotic)	21	13	12	12	93	65
Meningococcal Disease	2	5	5.6	5	31	29
<i>Staphylococcus aureus</i> (VISA, VRSA)	1	0	0	0	3	0
Streptococcal Disease, Group A, Invasive	22	22	22.8	22	139	129
<i>Streptococcus pneumoniae</i> (invasive disease)						
Drug resistant	67	68	54	57	455	371
Drug susceptible	58	63	55	57	399	360
C. Enteric Infections						
Campylobacteriosis	73	80	82.8	80	358	401
Cholera	0	0	0	0	0	0
Cryptosporidiosis	24	25	19.8	23	111	134
Cyclospora	2	2	60.2	2	12	12
<i>Escherichia coli</i> , Shiga-toxin producing (STEC)**	16	4	2.2	1	67	19
Giardiasis	125	116	83	78	721	456
Hemolytic Uremic Syndrome	0	0	0.2	1	1	0
Salmonellosis	310	298	277	296	1326	1401
Shigellosis	34	58	124.8	83	176	380
Typhoid Fever	1	1	0.4	1	6	7
D. Viral Hepatitis						
Hepatitis A	15	17	14.6	13	98	69
Hepatitis B, Acute	24	32	36.6	39	140	146
Hepatitis C, Acute	10	4	2.6	3.5	22	20
Hepatitis +HBsAg in pregnant women	48	63	47.8	53	261	266
Hepatitis D, E, G	0	0	0	0	2	0

* Confirmed and probable cases based on date of report as reported in Merlin
Incidence data for 2009 is provisional, data for 2008 was finalized on April 1, 2009

† Mean of the same month in the previous five years

‡ Median for the same month in the previous five years

** Includes *E. coli* O157:H7; shiga-toxin positive, serogroup non-O157; and shiga-toxin positive, not serogrouped

†† Includes neuroinvasive and non-neuroinvasive

N/A indicates that no historical data is available to calculate mean and median

Table 1. (cont.) Provisional Cases* of Selected Notifiable Diseases, Florida, May 1-31, 2009

Disease Category	Month				Cumulative (YTD)	
	2009	2008	Mean [†]	Median [¶]	2009	2008
F. Vector Borne, Zoonoses						
Dengue	2	3	1.6	2	15	17
Eastern Equine Encephalitis ^{††}	0	0	0	0	0	0
Ehrlichiosis/Anaplasmosis	1	0	0.8	1	3	1
Leptospirosis	0	0	0	0	0	0
Lyme Disease	6	4	1	2.5	22	16
Malaria	5	5	4.2	5	35	20
Plague	0	0	0	0	0	0
Psittacosis	0	0	0	0	0	1
Q Fever (acute and chronic)	0	0	0	0	1	0
Rabies, Animal	12	8	13.6	13	72	48
Rabies (possible exposure)	118	123	104.2	102	614	520
Rocky Mountain Spotted Fever	3	1	0.8	1	4	4
St. Louis Encephalitis ^{††}	0	0	0	0	0	0
Toxoplasmosis	0	1	1	1	1	3
Trichinellosis	0	0	0.2	1	0	0
Tularemia	0	0	0	0	0	0
Typhus Fever (epidemic and endemic)	0	0	0	0	0	0
Venezuelan Equine Encephalitis ^{††}	0	0	0	0	0	0
West Nile Virus ^{††}	0	0	0	0	0	0
Western Equine Encephalitis ^{††}	0	0	0	0	0	0
Yellow Fever	0	0	0	0	0	0
G. Others						
Anthrax	0	0	0	0	0	0
Botulism-Foodborne	0	0	0	0	0	0
Botulism-Infant	0	0	0.2	1	1	0
Brucellosis	1	1	0.4	1	4	2
Glanders	0	0	0	0	0	0
Hansen's Disease (Leprosy)	0	1	0.8	1	1	5
Hantavirus Infection	0	0	0	0	0	0
Legionella	15	8	8	8	63	56
Melioidosis	0	0	0	0	0	0
Vibriosis	13	7	8.4	7	27	26

* Confirmed and probable cases based on date of report as reported in Merlin

Incidence data for 2009 is provisional, data for 2008 was finalized on April 1, 2009

† Mean of the same month in the previous five years

¶ Median for the same month in the previous five years

†† Includes neuroinvasive and non-neuroinvasive

N/A indicates that no historical data is available to calculate mean and median

Note: The 2009 case counts are provisional and are subject to change until the database closes. Cases may be deleted, added, or have their case classification changed based on new information and therefore the monthly tables should not be added to obtain a year to date number.

Please refer any questions regarding the data presented in these tables to Kate Goodin at Kate_Goodin@doh.state.fl.us or 850.245.4444 Ext. 2440.

This Month on EpiCom

Christie Luce



EpiCom is located within the Florida Department of Health's Emergency Notification System (FDENS). The Bureau of Epidemiology encourages *Epi Update* readers to register on the EpiCom system by emailing the Florida Department of Health Emergency Notification System Helpdesk at FDENS-help@doh.state.fl.us. Users are invited to contribute appropriate public health observations related to any suspicious or unusual occurrences or circumstances through the system. EpiCom is the primary method of communication between the Bureau of Epidemiology and other state medical agencies during emergency situations. The following are titles from select recent postings:

- *Vibrio vulnificus* case - raw oyster consumption, Alachua County
- Update: lab-confirmed measles case, Orange County
- Influenza A H1N1 – swine origin clusters, Hillsborough County
- Suspected gastrointestinal illness in a correctional facility, Hamilton County
- Lab-identified cluster of PFGE-linked *Salmonella* group Z (O 50) cases
- Update: influenza A outbreak in a private school, Hillsborough County
- Update to version 5 of H1N1 guidance for labs and doctors
- TB outbreak investigations, Duval and Columbia Counties
- Pertussis cases, Santa Rosa County
- Cluster of respiratory illness at a daycare facility, Hillsborough County
- Summary of Influenza Outbreaks and Clusters April to May 2009, Hillsborough County
- CDC Swine Flu Updated Key Points - May 29, 2009
- Cluster of influenza cases at a high school, Seminole County
- Investigation of two E.coli 0157:H7 cases in a correctional facility, Lafayette County
- Influenza-like illness outbreak in a school setting, Hillsborough County
- *Salmonella* outbreak in a restaurant, Broward County
- Update: school-based influenza outbreak, Hillsborough County
- Influenza A H1N1 – swine origin activity, Martin County
- Update: cluster of influenza cases at a high school, Seminole County
- Cluster of novel influenza A H1N1, Orange County
- Update: Norovirus gastrointestinal illness outbreak, Collier County
- Meningococcal disease in a high school student, Orange County
- CDC MMWR update on novel H1N1 infection, Mexico
- Rabies alert, Duval County
- Suspected Brucellosis in a traveler, Palm Beach County
- Influenza A H1N1 – swine origin reporting guidance for county health departments
- Novel influenza A H1N1 cluster, Seminole and Duval Counties
- Increase in reported cases of Varicella disease and ESSENCE rash syndrome category, Duval County
- Cluster of influenza-like illness in a North Carolina Camp involving Florida residents
- Foodborne outbreak at a local country club, Broward County
- Novel H1N1 influenza outbreak at a federal detention center, Miami-Dade County

For physicians and other healthcare providers who want more information on diagnosis and treatment of foodborne illness: *Recommendations and Reports April 16, 2004/Vol. 53/No. RR-4:*

Diagnosis and Management of Foodborne Illnesses A Primer for Physicians and Other Health Care Professionals at <http://www.cdc.gov/mmwr/PDF/rr/rr5304.pdf>

Christie Luce is the Surveillance Systems Administrator for the Bureau of Epidemiology. She can be contacted at 850.245.4418 or by email at Christie.Luce@doh.state.fl.us.

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For submission guidelines or questions regarding Epi Update, please contact Leesa Gibson at 850.245.4409 or by email at Leesa.Gibson@doh.state.fl.us.

