



# Epi Update



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## **Melanoma Among the White Population in Florida**

***Aruna Surendera Babu, M.P.H.***

The Florida Department of Health recognizes May as *National Melanoma Awareness Month*. Melanoma is the most serious type of cancer of the skin and accounts for less than 5% of skin cancer cases. Each year in the United States, more than 53,600 people learn they have melanoma. Overall, the lifetime risk of getting melanoma is about 1 in 50 for whites, 1 in 1,000 for blacks, 1 in 200 for Hispanics. During the entire month of May, efforts are dedicated to educate and increase awareness for all people in Florida about melanoma.

Melanoma begins in the melanocytes, which are the cells in the skin that make the pigment melanin. Risk factors associated with melanoma include having dysplastic nevi (abnormal moles), many ordinary moles, fair skin, personal and family history of melanoma or other skin cancer, weakened immune system, severe blistering sunburns, and exposure to ultraviolet (UV) radiation. Melanoma can be prevented by avoiding sun exposure between 10 a.m. and 4 p.m., wearing sunscreen, wearing protective clothing, avoiding tanning beds, and having regular skin examinations.

This article presents data on melanoma among whites in Florida because melanoma primarily occurs among whites. Data on melanoma incidence and diagnosis stage are from the Florida Cancer Data System, and mortality data are from the Florida Department of Health, Office of Vital Statistics. The Florida data are compared with that from the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute. The U.S. mortality data reported by SEER are provided by the National Center for Health Statistics.

In Florida in 2005, the incidence rate of melanoma was 19.0 per 100,000 white people and the mortality rate was 3.0 per 100,000 white people. The Florida incidence rate was lower than the SEER rate overall and for both sexes. Florida mortality rates did not differ significantly from the

U.S. mortality rates. Both incidence and mortality rates were higher among those in older age groups and males. The 2005 incidence rate was 58% higher than the rate observed in 1981 (12.0 per 100,000). The 2005 mortality rate (3.0 per 100,000) did not differ significantly from the 1981 mortality rate (2.8 per 100,000).

The American Cancer Society recommends a complete skin exam every year for adults who are 40 years of age or older or more often if a person is at high risk of developing skin cancer. Of all Florida melanoma cases, 74.8% were diagnosed at an advanced stage in 2005. The percentage of cases diagnosed at an advanced stage was higher among males (17%) than females (12%). The percentage of cancer cases diagnosed at an early stage was higher in 2005 (74.8%) compared to the percentage in 1981 (55.4%). The percentage of cancer reported without stage information decreased by 67% from 30% in 1981 to 10% in 2005.

A comprehensive fact sheet with a detailed data table on melanoma among whites in Florida is available at the Florida Department of Health, Bureau of Epidemiology's website at [http://www.doh.state.fl.us/disease\\_ctrl/epi/cancer/Melanoma\\_05.pdf](http://www.doh.state.fl.us/disease_ctrl/epi/cancer/Melanoma_05.pdf).

For additional information, please contact the Florida Department of Health, Bureau of Epidemiology at 850.245.4401 or visit our website at <http://www.floridachronicdisease.org/>.

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## **The Florida Epidemic Intelligence Service Recognizes the 2009 Program Graduates and Welcomes Three New Fellows**

***Patti Ragan, Ph.D., M.P.H., PA-C***

It has been a busy spring for the Florida Epidemic Intelligence Service Program (FL-EIS). While the program is not holding a formal graduation this year, we did want to recognize the following graduates who have completed their FL-EIS training:

**Racquel Stephenson, M.P.H.** – Seminole and Brevard Counties.

Supervisors/Mentors: Dr. Greg Danyluk, Dr. Olga Emgushov, and Barry Inman

Future plans: Racquel has become a commissioned corp. officer in the U.S. Public Health Service and accepted a regional scientist position with the Agency for Toxic Substances and Disease Registry (ATSDR), based in Edison, New Jersey.

**Pedro (Paco) Castellon, M.P.H.** – Collier and Hendry/Glades Consortium

Supervisors/Mentors: Dr. Muhammad Abbasi, Mark Crowley, and Margie Alderman.

Future plans: Paco has accepted a position as a senior research associate in the University of Miami, Miller School of Medicine, Department of Epidemiology and Public Health.

**Taj Azarian, M.P.H.** – Duval County

Supervisors/Mentors: Dr. Sa'ad Zaheer and Ruth Voss

Future plans: Taj has accepted a position as a public health preparedness and surveillance epidemiologist at Duval County Health Department.

**Catherine Kroll, M.P.H.** – Leon County

Supervisors/Mentors: Dr. Marjorie Kirsch, Marsha Player, and Dr. Carina Blackmore

Future plans: Catherine has accepted a position as the epidemiology supervisor at the Clark County Public Health Department in Vancouver, WA.

**Sericea Smith, M.P.H.** – Polk County

Supervisors/Mentors: Dr. Daniel Haight and Cynthia Goldstein-Hart

Future plans: Sericea has been accepted to a doctoral program in epidemiology at Brunel University in West London, U.K. and anticipates starting in the fall.

Congratulations to each of our graduates!! Also, a special thank you to each of their supervisors/mentors for their integral role in the professional development of our graduates.

The Program is also pleased to welcome three new fellows in the following county health department sites for 2009—2011:

**Pamela Mann, M.P.H.** (Tulane University) – Dade County

**Amber Barnes, M.P.H.** (University of North Florida) – Duval County

**Lea Wansbrough, M.P.H.** (Emory University) – Hillsborough County

The new fellows started their assignments this spring and look forward to an exciting and productive two years to gain experience in applied epidemiology.

***Patti Ragan is the Florida EIS Program Administrator for the Bureau of Epidemiology of the Florida Department of Health. She can be contacted at 850.245.4406 or by email at Patricia\_Ragan@doh.state.fl.us***

## ***Malaria Risk in Travelers Visiting Friends and Relatives***

***Elizabeth Radke, M.P.H.***

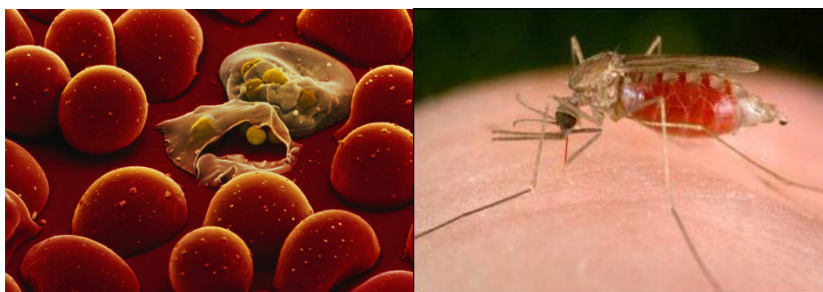


Figure 1 – *Plasmodium falciparum* attacking blood cells and *Anopheles* mosquito

Between 1999 and 2008, 756 cases of malaria were reported in Florida (mean=76). Nearly all reported malaria infections were imported and associated with travel or immigration. Although malaria is no longer considered endemic to Florida, it was a significant disease threat in the first half of the 20<sup>th</sup> century prior to development of effective insecticides and organized mosquito control. Competent vectors are still present throughout the state. A recent outbreak in Palm Beach County in 2003 illustrated the potential for outbreaks and re-introduction into Florida. For this reason, it is important to identify risk factors that are associated with infections acquired outside the country to protect the health of both travelers and non-travelers.

Data from the 65 cases of malaria reported in 2008 provide a snapshot of typical malaria patients in Florida. The majority of patients were diagnosed with infections caused by malaria species having the most potential for a severe outcome; *Plasmodium falciparum* (86%) and *P. vivax* (11%). Twenty-six cases (40%) reported recent travel to Haiti; 18 (28%) reported travel to Nigeria; and Uganda/Kenya and Ghana each were linked to four cases (6% each). The remaining cases traveled to a variety of countries in Africa, South and Central America, and Asia. Of those case reports that included reason for travel (39/65), the largest proportion (49%) indicated travel was to visit friends or relatives (VFRs).

Those travelers classified as VFRs are primarily immigrants from malaria-endemic developing countries. They have a several-fold increased risk of infection compared with tourists and other groups of travelers. This increased risk has been attributed to high-risk behaviors such as longer visit times and staying in villages and remote rural areas without screened windows or air conditioning. Additionally, VFRs are more likely to neglect personal protective measures against mosquitos, such as prophylactic drugs, insect repellents, and bed nets. This may be because they believe themselves to be immune to the disease after having lived in an endemic area in the past. However, any immunity they may have had is lost over time, leaving them vulnerable to serious infections when they return to their home country. Their children who were born in the U.S. have no protective immunity.

VFRs are also less likely than other travelers to seek pre-departure medical advice. The lack of medical advice may be associated with the cost of a physician visit. Rates for those with insurance in this population are low, and even for those who are insured, visits to a travel medicine specialist and chemoprophylaxis are often not covered. Primary care providers may not have the most up-to-date information about malaria distribution and drug resistance. A Canadian study of VFRs traveling to India showed that family practitioners were the primary source of information and that only 31% of travelers planned to use prophylaxis, less than 10% intended to use personal protective measures, and only 7% had been prescribed appropriate prophylaxis for their destination. Some travelers also plan to buy prophylaxis at their destination, and may receive the wrong drug, an incorrect amount of drug, or a contaminated drug.

Because of these risks, it is important to target messages to immigrant populations that plan trips to their home countries. Promotion of travel medicine services as well as educational materials can be distributed through language-appropriate pamphlets, posters, and other ethnic media and community organizations, such as churches. Primary care clinics that treat large numbers of immigrants should be encouraged to provide travel medicine training to practitioners to ensure they can provide high quality travel medicine services in a familiar and accessible setting. The Centers for Disease Control and Prevention website and the Yellow Book (Health Information for International Travelers) are valuable resources for practitioners and county health departments. The practitioner should review the traveler's itinerary to provide specific guidelines and determine what type of chemoprophylaxis, if any, is recommended based on anti-malarial resistance and malaria risk in the area of travel. Convenience and low side effects are important considerations to increase compliance. The traveler should also understand the symptoms of malaria such as fever, chills, headache, muscle aches, fatigue, nausea, jaundice, vomiting, and diarrhea, so that they can seek medical attention if they become sick. In some cases, they can be prescribed stand-by medication for use if symptoms appear.

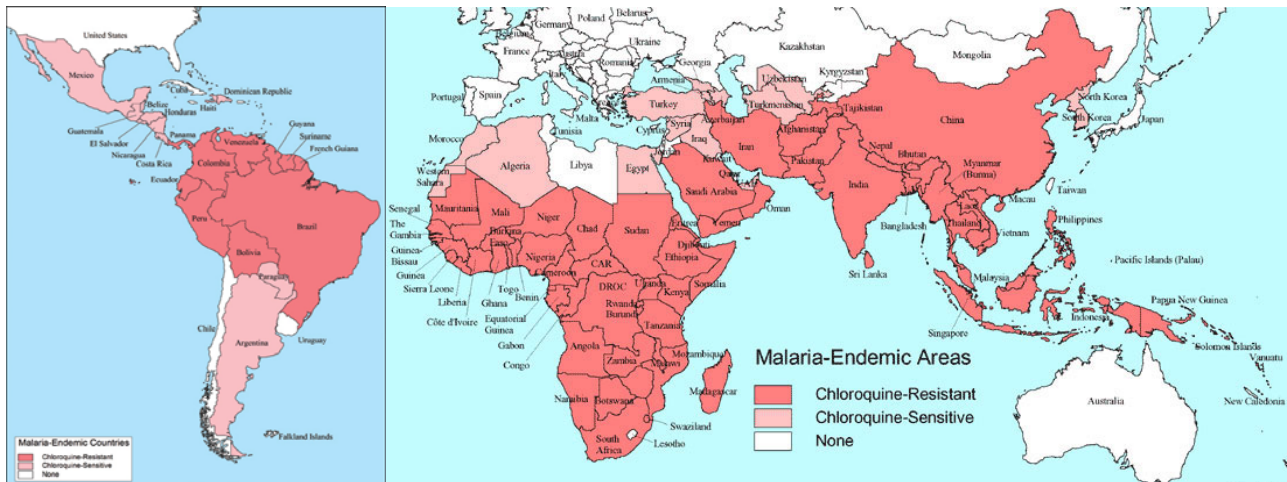


Figure 2 – Malaria Endemic Areas (from CDC)

Educational materials should include information about malaria and preventive measures such as personal protection against mosquitos and chemoprophylaxis. Mosquito avoidance practices are similar to those employed in the United States: staying inside with screened doors and windows during peak biting times from dusk to dawn; wearing clothing that covers the skin; and using insecticides and repellents. In addition, avoidance practices should also include insecticide impregnated bed nets. These measures also protect against other tropical mosquito-borne diseases, such as dengue and Chikungunya, making the message even more important. The overall VFR campaign could also include information on preventing other diseases that they are at risk for, including food-borne diseases and tuberculosis.

### Preventing Mosquito Bites

- If possible, remain indoors in a screened or air-conditioned area during the peak biting period between dusk and dawn.
- If no screening or air conditioning is available, use pyrethroid-containing repellent in living and sleeping areas during evening and night-time hours and sleep under bed nets, preferably insecticide-treated.

To access information on ordering insecticide-treated bed nets:

- [www.travmed.com](http://www.travmed.com), phone 1-800-872-8633
- [www.travelhealthhelp.com](http://www.travelhealthhelp.com), phone 1-888-621-3952
- Wear long-sleeved shirts, long pants, and hats when outdoors.
- Use insect repellent when outdoors. Sprays that contain DEET (N,N-diethyl-meta-toluamide) offer good protection. Higher concentrations of DEET may have a longer repellent effect; however, concentrations over 50% provide no added protection. Timed-release DEET products may have a longer repellent effect than liquid products.
  - Follow the directions on the product label.
  - DEET should not be used on children younger than two months.
  - Protect infants by using a carrier draped with mosquito netting with an elastic edge for a tight fit.
  - Assist children less than 10-years-old with application of repellent.
  - Avoid applying repellent to young children’s hands, or around their eyes and mouths.

### Anti-malarial Drug Guidelines

- Visit a healthcare provider familiar with travel medicine four to six weeks before traveling to countries that are endemic for malaria to obtain helpful travel information, vaccinations for other diseases, and anti-malarial drug prescriptions.
- Purchase anti-malarial drugs before traveling overseas to make sure that they are effective. Drugs bought in other countries may not be protective.
- Take all drugs as prescribed before, during, and after travel for complete protection. Partial use may result in infection.

A fact sheet for VFRs is available at <http://www.doh.state.fl.us/Environment/medicine/arboviral/malaria.html>

Additional resources are available at [http://www.doh.state.fl.us/Environment/medicine/arboviral/info\\_links\\_general.htm](http://www.doh.state.fl.us/Environment/medicine/arboviral/info_links_general.htm)

Malaria Information for Travelers at CDC: [http://www.cdc.gov/malaria/travel/vfr\\_general.htm](http://www.cdc.gov/malaria/travel/vfr_general.htm)  
 CDC Yellow Book – Health Information for International Travel is available at <http://www.cdc.gov/Features/YellowBook/>

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## Florida Year-to-Date Mosquito-Borne Disease Summary Through May 13, 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 May 13, 2009, the following arboviral activity was recorded in Florida:

### **Eastern equine encephalitis virus (EEEV) Activity**

Positive samples were obtained from seven equines, nine sentinel chickens, and twelve live wild birds in eleven counties.

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

None

### **Highlands J virus (HJV) Activity**

Positive samples were obtained from seven sentinel chickens in one county.

### **California encephalitis group viruses (CEV) Activity**

None

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

### **Dengue Virus (DENV)**

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

### **Malaria**

Thirty-one imported cases were reported from eleven counties: Alachua (1), Broward (10), Dade (6), Duval (1), Escambia (1), Lee (1), Orange (2), Palm Beach (5), Pinellas (2), Polk (1), and Seminole (1). Countries of origin included Haiti (17), Nigeria (4), Sierra Leone (2), South Africa (1), Honduras (1), India (1), Malawi (1), Mexico (1), Thailand (1), Uganda/Ghana (1), and an unspecified African country (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, 177 reports representing a total of 455 dead birds (44 crows, 14 jays, 22 raptors, and 375 others) were received from 45 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/](http://www.myfwc.com/bird/).

See the following web site for more information:

<http://www.doh.state.fl.us/Environment/medicine/arboviral/index.html>.

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# Florida Influenza Surveillance Report

*Kateesha McConnell, M.P.H.*

Influenza surveillance in Florida consists of seven surveillance components: 1) Florida Sentinel Provider Influenza Surveillance Network (FSPISN); 2) Florida Pneumonia and Influenza Mortality Surveillance System; 3) Bureau of Laboratories viral surveillance; 4) County influenza activity levels; 5) Notifiable Disease Reports 6) Influenza or influenza-like illness (ILI) outbreaks and 7) Syndromic surveillance.

For the most up-to-date information regarding influenza surveillance and the progress of influenza season 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](http://www.doh.state.fl.us/disease_ctrl/epi/htopics/flu/reports.htm).

At the end of April, swine origin influenza A H1N1 was identified in the U.S. As a result of the identification of this novel influenza virus, the state of Florida instituted enhanced surveillance activities in order to determine the presence of the novel virus within the state. 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 influenza A H1N1 (swine) influenza outbreak raised awareness among providers and the general public. During 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 increases were due in large part to additional people seeking consultation from the medical community because of increased awareness of the current swine flu situation. As of May 27, 2009, there have been 165 cases and no deaths of novel H1N1 reported in the state. Nationwide there have been a total of 7,927 cases and 11 deaths. Continuous updates on novel H1N1 are available for Florida at: [http://www.doh.state.fl.us/disease\\_ctrl/epi/swineflu/index.html](http://www.doh.state.fl.us/disease_ctrl/epi/swineflu/index.html) and national updates can be found at: <http://www.cdc.gov/h1n1flu/update.htm>.

Initially, sentinel provider data, laboratory viral surveillance, and syndromic surveillance confirmed activity due to novel H1N1 during week 17 (04/26/09-05/02/09). During weeks fourteen through nineteen of 2009 (04/05/09-05/16/09), statewide influenza activity was reported as local (week 14), sporadic (week 15, 16), regional (week 17, 18) and local (week 19) using the national CDC influenza activity criteria. The average proportion of patient visits for ILI as reported by the FSPISN during weeks fourteen through nineteen was 1.88% which is below the state threshold for moderate activity of 2.98%. So far this flu season, there have been eight reported ILI outbreaks investigated in Florida. Three deaths of children are being evaluated as seasonal influenza-associated deaths not related to novel influenza A H1N1 strain.

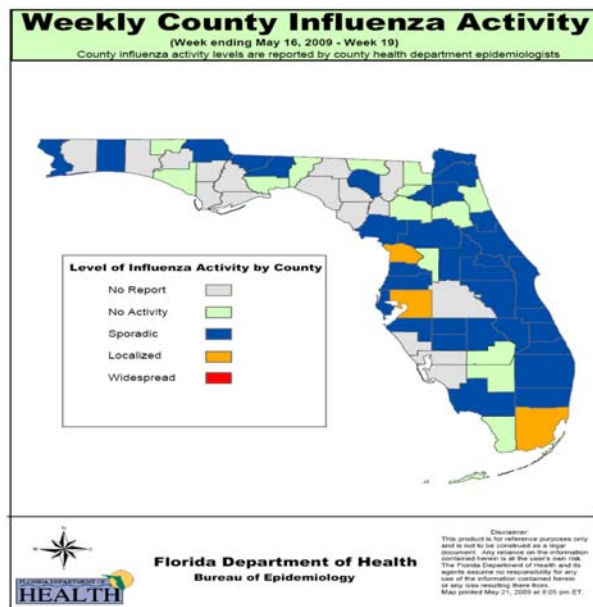
Nationally, most of the viruses characterized this season have been related to the strains found in the 2008-09 vaccine. In Florida, laboratory testing has shown a shift in the proportion of positive influenza A and B isolates or specimens. Earlier this season Florida saw a larger proportion of influenza B, whereas now the total proportion of the isolates is more evenly split between influenza A and B. This pattern is somewhat different than our usual pattern in Florida. Traditionally, influenza A activity is seen earlier in the influenza season and influenza B activity is increased later in the influenza season with the peak influenza B activity seen in the February-March timeframe. Influenza A is typically associated with more severe illness and the ability to cause more outbreaks than influenza B.

Florida Bureau of Laboratories has tested a total of 2436 specimens for influenza viruses since September 28, 2008. Five hundred sixty-six (23%) of the specimens have tested positive for influenza. Of the 566 specimens, 409 were influenza A and 157 were influenza B isolates. Enhanced laboratory testing activities in response to swine origin influenza A H1N1 was initiated during week 17. Increased testing led to an increase in the number of positive influenza isolates identified by the Bureau of Laboratories, the largest portion of positive influenza isolates were from seasonal influenza strains.

During week nineteen, no counties reported widespread activity and three counties reported localized activity. Thirty-three counties reported sporadic activity and fourteen counties reported no activity. Seventeen counties did not report.

Overall, influenza is on the decline however it is still present in the community. 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 upcoming year.





### **Regional Epidemiology Epi-RIOT Trainings**

We are pleased to announce that we will be offering two additional Regional Epidemiology Epi-RIOT Trainings in July. Please register through the Bureau of Epidemiology Internet site: [http://www.doh.state.fl.us/disease\\_ctrl/epi/conf/training/Regional\\_Epi\\_Training.html](http://www.doh.state.fl.us/disease_ctrl/epi/conf/training/Regional_Epi_Training.html)

Upcoming Dates:

- July 1 – Broward County, Ft. Lauderdale
- 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, April 1-30, 2009

Disease Category	Month				Cumulative (YTD)	
	2009	2008	Mean <sup>†</sup>	Median <sup>‡</sup>	2009	2008
<b>A. Vaccine Preventable Diseases</b>						
Diphtheria	0	0	0	0	0	0
Measles	0	0	0	0	1	0
Mumps	2	1	0.8	1	8	12
Pertussis	32	21	13.2	12	137	52
Poliomyelitis	0	0	0	0	0	0
Rubella	0	0	0	0	0	0
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	0	0
Varicella	163	197	N/A	N/A	611	771
<b>B. CNS Diseases &amp; Bacteremias</b>						
Creutzfeldt-Jakob Disease	0	0	0.6	1	6	5
<i>H. Influenzae</i> (invasive)	28	7	11.6	6	99	43
in those ≤5	1	7	7	7	10	31
Listeriosis	1	4	2.4	2	2	15
Meningitis (bacterial, cryptococcal, mycotic)	15	6	9.6	10	72	52
Meningococcal Disease	6	4	8.6	9	30	24
<i>Staphylococcus aureus</i> (VISA, VRSA)	0	0	0	0	2	0
Streptococcal Disease, Group A, Invasive	30	28	23	20	117	107
<i>Streptococcus pneumoniae</i> (invasive disease)						
Drug resistant	63	64	63.2	66	388	303
Drug susceptible	72	64	56.4	59	341	297
<b>C. Enteric Infections</b>						
Campylobacteriosis	67	73	71.6	73	285	321
Cholera	0	0	0	0	0	0
Cryptosporidiosis	22	29	18.4	19	87	109
Cyclospora	1	1	5.6	4	10	10
<i>Escherichia coli</i> , Shiga-toxin producing (STEC)**	17	2	6.6	3	53	15
Giardiasis	145	86	73.6	69	596	340
Hemolytic Uremic Syndrome	0	0	2	1	1	0
Salmonellosis	263	238	226.8	238	1016	1103
Shigellosis	39	79	100.4	70	146	322
Typhoid Fever	3	2	0.8	1	5	6
<b>D. Viral Hepatitis</b>						
Hepatitis A	28	11	13.6	14	86	52
Hepatitis B, Acute	22	28	37	37	116	114
Hepatitis C, Acute	4	2	3.4	2	12	16
Hepatitis +HBsAg in pregnant women	38	42	48.6	50	213	203
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, April 1-30, 2009

Disease Category	Month				Cumulative (YTD)	
	2009	2008	Mean <sup>†</sup>	Median <sup>¶</sup>	2009	2008
<b>F. Vector Borne, Zoonoses</b>						
Dengue	4	0	0.4	1	13	14
Eastern Equine Encephalitis <sup>††</sup>	0	0	0	0	0	0
Ehrlichiosis/Anaplasmosis	0	1	0.2	1	2	1
Leptospirosis	0	0	0	0	0	0
Lyme Disease	6	3	2.4	2	20	12
Malaria	6	1	4	4	30	15
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	9	13	14.2	13	60	40
Rabies (possible exposure)	125	97	87.2	82	496	397
Rocky Mountain Spotted Fever	0	2	1.6	3	1	3
St. Louis Encephalitis <sup>††</sup>	0	0	0	0	0	0
Toxoplasmosis	0	1	1	2.5	1	2
Trichinellosis	0	0	0	0	0	0
Tularemia	0	0	0	0	0	0
Typhus Fever (epidemic and endemic)	0	0	0	0	0	0
Venezuelan Equine Encephalitis <sup>††</sup>	0	0	0	0	0	0
West Nile Virus <sup>††</sup>	0	0	0	0	0	0
Western Equine Encephalitis <sup>††</sup>	0	0	0	0	0	0
Yellow Fever	0	0	0	0	0	0
<b>G. Others</b>						
Anthrax	0	0	0	0	0	0
Botulism-Foodborne	0	0	0	0	0	0
Botulism-Infant	0	0	0	0	1	0
Brucellosis	2	0	0.8	1	3	1
Glanders	0	0	0	0	0	0
Hansen's Disease (Leprosy)	0	1	1.2	1	1	4
Hantavirus Infection	0	0	0	0	0	0
Legionella	8	9	10.2	9	48	48
Melioidosis	0	0	0	0	0	0
Vibriosis	3	6	6	7	14	19

\* 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](mailto: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](mailto: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:

- Gastrointestinal cluster investigation update, Orange County
- Varicella/school cases, Alachua County
- *Salmonella* in pistachio nuts update
- Investigating a case of *Salmonella Montevideo*, Alachua County
- Norovirus outbreak in a school update, Pinellas County
- Gastrointestinal illness at a shelter/rehabilitation facility, Broward County
- Gastrointestinal illness outbreak in an assisted living facility, Broward County
- Imported malaria, Escambia County
- Gastrointestinal illness outbreak update, Leon County
- Lead investigation, Broward County
- Norovirus outbreak at an assisted living facility, Hillsborough County
- Cluster of gastrointestinal illness is identified through ESSENCE, Duval County
- Swine influenza A (H1N1) infection in two children, southern California
- Cluster of serogroup W135 meningococcal disease update, South Florida
- Reported allergic reactions at a school after suspected consumption of jicama, Manatee County
- CDC health advisory: investigation and interim recommendations on swine flu
- Cluster of gastrointestinal illnesses, Lafayette County
- Nationwide outbreak of *Salmonella St. Paul* linked to alfalfa sprouts
- Investigation of air passengers on flight with confirmed swine influenza case, Florida
- Background material about testing for swine influenza
- Gastrointestinal illness cluster update, Bay County,
- Surveillance and epidemiology during community mitigation response to influenza epidemic
- Swine influenza questions and answers
- Guidance document: Enhanced Influenza Surveillance for Hospitals and Clinicians
- Update on school (K-12) dismissal and childcare facilities: Interim CDC Guidance
- Suspected foodborne outbreak-associated with a charity event, Broward County
- Norovirus investigation following a church supper update, Lafayette County
- Primary epidemiology contacts daily EIEIO reporting guidelines
- Swine flu response protocol for reporting laboratory results on untypeable specimens
- New surveillance case definitions from CDC for swine-origin influenza
- Influenza outbreak in a school, Hillsborough County
- Assessing the severity of an influenza pandemic from the World Health Organization
- Measles case investigation, Orange County
- Pertussis case, Palm Beach County

- Suspected foodborne outbreak, Collier 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>

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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](mailto:Leesa.Gibson@doh.state.fl.us).

