



Communicable Disease and Epidemiology News

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Janice Boase, RN, MSN, CIC, Editor

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More on Hepatitis C Surveillance

Chronic hepatitis C virus (HCV) infection is now reportable by health care providers and institutions (*not laboratories*) in order to define the prevalence of disease locally, and to provide the data necessary to obtain and allocate resources for HCV prevention activities. Public Health will classify cases as confirmed, probable, or possible based on the following criteria.

A **confirmed case** of chronic HCV infection is defined as a case that has tested positive for HCV by an anti-HCV enzyme immunoassay (EIA) plus *supplemental confirmatory testing* by recombinant immunoblot assay (RIBA) or any case with positive qualitative or quantitative HCV RNA testing. Because EIA testing has an unacceptably high false positive rate (30-50%), when testing persons at low to moderate risk, a positive EIA without confirmatory testing is currently not considered diagnostic of HCV infection by the Centers for Disease Control and Prevention (CDC). HCV RNA may be undetectable in persons who are undergoing antiviral treatment for hepatitis C or who have spontaneously cleared the infection. In these cases, RIBA testing is the preferred confirmatory test. Persons reported to be positive for HCV by blood banks have had confirmatory testing (RIBA, and for all RIBA-positive tests, HCV RNA).

A **probable case** is defined as a positive HCV EIA test result in the absence of confirmatory testing in persons at high risk for HCV infection including persons who a) have ever used injection drugs, or b) have received blood factor concentrates prior to 1987, or c) have persistently elevated liver enzymes with no other explanation. In these settings, a positive EIA result alone is likely to represent infection, therefore it is especially important to obtain and report risk factor information for all EIA-positive cases that do not have confirmatory testing

Cases with a positive HCV EIA test, and not meeting the "confirmed" or "probable" case definitions, will be classified as **possible HCV cases**. Clinicians are encouraged to obtain confirmatory testing before establishing the diagnosis of chronic HCV infection.

Whenever possible please provide the following information when reporting a case of chronic HCV infection: routine demographic data, results and dates of diagnostic tests for HCV including results of confirmatory testing and liver function tests, and

patient risk factor information. Risk factors of relevance include: ever using injection drugs,

receiving blood products or an organ transplant prior to July, 1992, receiving factor concentrates before 1987, receiving hemodialysis, sustaining a occupational needlestick or blood splash, history of ever being a sexual partner of someone else who has been diagnosed as a hepatitis C carrier, or being an infant born to a mother who is a hepatitis C carrier.

Confirmed and probable cases of chronic hepatitis C are reportable by health care providers within one month from initial diagnosis, or one month from follow up testing of chronic HCV carriers. If you are uncertain whether a case has already been reported, please proceed with reporting.

The Center for Disease Control and Prevention's web site has a good clinical education program that offers CME credit and includes additional information on hepatitis C diagnostic testing at: <http://www.cdc.gov/ncidod/diseases/hepatitis/c/edu/> For additional questions about hepatitis C reporting, contact Shelly McKeirman, 206-296-4717.

Perinatal Hepatitis B Virus (HBV) Infection Now Legally Notifiable

Since 1989, a perinatal HBV prevention program has existed for infants born to women with chronic HBV infection to assure timely post-exposure prophylaxis (PEP), including hepatitis B vaccine, hepatitis B immune globulin (HBIG), and post-vaccination serologic testing. Because HBV infection can be prevented in up to 95% of infants with perinatal exposure and who receive appropriate and timely PEP, HBV prevention programs are a key part of the national hepatitis B eradication strategy.

The outlook for infants who become infected with hepatitis B is dismal. Over 90% will become chronically infected, and of these, up to 25% will die of liver-related disease later in life. Yet despite the availability of this effective HBV prevention program, voluntary prenatal reporting has resulted in the identification of fewer than half of the women eligible for the program. It is estimated that in Washington State in 1999, only 68 % of the total expected number of HBsAg-positive pregnant women were identified.

In order to ensure all eligible infants are identified, **health care providers are now required to report all pregnant women who test positive for hepatitis B surface antigen (HBsAg) to Public Health within 3 days of receiving the lab result.**

In addition to facilitating appropriate management of the infant, Public Health mails information on HBV to the HBsAg-positive women. These educational materials describe the importance of screening and vaccination of susceptible family members, availability of HBV serologic testing and vaccination for low income and uninsured household contacts through Public Health clinics, and the importance of timely PEP and post-vaccination serologic testing for the exposed infant. Reminders are sent when infant HBV vaccine doses and post-vaccination serologic testing are due with copies to the infant's health care provider.

Unknown maternal HBV status at the time of childbirth is problematic for the mother, child, and delivery hospitals. This is due most often to a failure to communicate results of the maternal HBsAg screen to the delivery hospital, but can also indicate failure to screen for HBsAg during the prenatal period. **Documenting and communicating results of maternal HBV screening with the delivery hospital before delivery avoids the cost and inconvenience of repeat serologic testing and unnecessary administration of HBIG to newborns of mothers with unknown HBsAg status.**

When reporting chronic hepatitis B in women of childbearing age, please indicate whether the woman is pregnant. Question? Please call Linda Vrtis at 206-296-4777.

Invasive Disease Caused by Group A Streptococcus

Invasive disease caused by group A streptococcus (GAS) has now been added to the list of notifiable diseases. This disease is reportable by health care providers (not laboratories) within 3 days. *Invasive disease* is indicated by culture of GAS from blood, spinal fluid, or other normally sterile site including post-surgical or post-traumatic wounds. Other examples of invasive GAS infections include: bacteremia, meningitis, pneumonia, endocarditis, pericarditis, septic arthritis, cellulitis,

osteomyelitis, myositis, peritonitis, puerperal sepsis, neonatal omphalitis, necrotizing fasciitis, and toxic shock syndrome. Necrotizing fasciitis and other invasive GAS infections in children often occur as complications of varicella. The portal of entry is unknown in almost 50% of invasive GAS infections. In most instances, it is believed to be through the skin or mucous membranes and may follow minor or unrecognized trauma. Pharyngitis, erysipelas, and uncomplicated cellulitis caused by GAS are not reportable.

How Do You Like Your Epi-Log?

For those of you who prefer your Epi-log in a digital format, you can now sign up for an email alert whenever the latest version of the Epi-log is posted on Public Health's web site. To sign up for this service, fill out the form at: <http://www.metrokc.gov/health/scripts/epilogrequest.cfm>. If you wish to stop receiving your mailed copy of the Epi-Log, please note this in the comment field.

Notifiable Disease List Online

With an Adobe Acrobat Reader®, King County disease reporters can access the newly revised notifiable disease list. http://www.metrokc.gov/health/phnr/prot_res/cdconditions.pdf

Disease Reporting (area code 206)
 AIDS.....296-4645
 Communicable Disease...296-4774
 STDs.....731-3954
 Tuberculosis.....731-4579
 24-hr Report Line.....296-4782

Hotlines:
 CD Hotline.....296-4949
 HIV/STD Hotline.....205-STD5
<http://www.metrokc.gov/health>

Reported Cases of Selected Diseases Seattle-King County 2000

	Cases Reported In November		Cases Reported Through November	
	2000	1999	2000	1999
NR= Not reportable in 1999				
AIDS	13	32	220	215
Campylobacteriosis	25	21	303	256
Cryptosporidiosis	0	NR	5	NR
Chlamydial infections	343	376	4087	3556
Enterohemorrhagic <i>E. coli</i> (non-O157)	0	NR	1	NR
<i>E. coli</i> O157: H7	1	4	56	43
Giardiasis	23	19	217	184
Gonorrhea	128	51	1056	836
<i>Haemophilus influenzae B</i> (cases <6 years of age)	0	0	0	0
Hepatitis A	7	30	94	202
Hepatitis B	2	7	40	41
Hepatitis C/ non-A, non-B	0	0	10	8
Herpes, genital	41	40	678	595
Measles	0	0	2	1
Meningococcal Disease	4	0	16	20
Mumps	0	0	9	1
Pertussis	12	10	199	147
Rubella, congenital	0	0	1	0
Rubella	0	0	1	2
Salmonellosis	11	8	192	248
Shigellosis	8	5	144	56
Syphilis, congenital	0	0	1	0
Syphilis, late	9	4	32	44
Syphilis	5	3	67	69
Tuberculosis	11	6	114	106