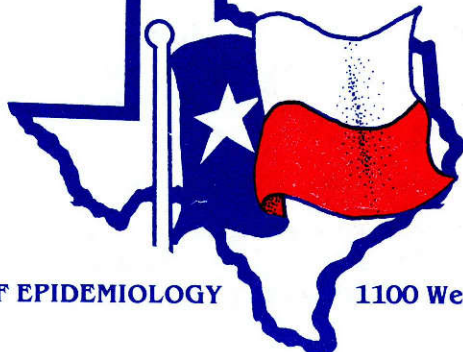


# Texas Preventable Disease NEWS



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BUREAU OF EPIDEMIOLOGY

1100 West 49th Street, Austin, Texas 78756 (512-458-7207)

## GUIDE DOGS IN HOSPITALS

Recently, the TDH Bureau of Epidemiology has had several questions on whether guide dogs can accompany their blind owners into hospitals. Under Texas law, "no person who is physically handicapped may be denied admittance to any public facility in the state because of the handicapped person's use of a white cane, dog guide, wheelchair, crutches, or other device of assistance in mobility, or because the person is handicapped."<sup>1</sup> A public facility is defined, in part, as any place to which the public is invited. In addition, "an employer who conducts business in this state may not discriminate in his or her employment practices against a handicapped person on the basis of the handicap if the person's ability to perform the task required by a job is not impaired by the handicap and the person is otherwise qualified for the job."<sup>1</sup>

Blind individuals should not be denied a job in a hospital because they require the use of a guide dog. The sight-impaired are often trained as medical transcriptionists, darkroom technicians, social workers, clinical psychologists, clergy, etc. While fulfilling job requirements, the employee may be accompanied by a harnessed or leashed guide dog to various hospital lobbies and corridors. Each hospital has the right to determine if the dog was trained at a legitimate guide dog program by reviewing the identification card given to the owner at the end of the course.

Guide dogs are described in a pamphlet, "Seeing Eye Dogs in a Hospital Setting" as educated, responsible animals which are not considered to be pets.<sup>2</sup> The dogs are "carefully chosen for their job on the basis of temperament, intelligence, responsibility, and physical fitness." These dogs are taught not to bark at or lick strangers. Likewise, a guide dog should not be petted by strangers. A blind individual with a guide dog has worked many hours to develop the capacity to control his or her dog effectively. Guide dogs are generally well groomed and have regular veterinary examinations and vaccinations.

Though there are several diseases which can be transmitted from dog to man, the circumstances required for their spread would usually not occur in a hospital setting.<sup>3</sup> Organisms which would be very unlikely to be spread in a hospital include those which require either maturation in another host (eg, Spirometra) or acquisition from a body of water (eg, Leptospira, Schistosoma). Since guide dogs are routinely groomed, they would be unlikely to spread flea- and tick-borne diseases.

Dogs can be colonized with various organisms (eg, Staphylococcus and Streptococcus), as can humans.<sup>3</sup> Although they are unlikely to transmit these organisms, guide dogs should not be allowed into operating rooms or other areas where a sterile field is required. With this exception, healthy guide dogs should be allowed to enter hospital lobbies, corridors, cafeterias, and most patient rooms.

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If a blind individual with a guide dog is hospitalized and unable to care for the dog, the dog should be left at home where it can be cared for properly, fed, and exercised.<sup>2</sup> If this is not possible, the dog could be boarded with a veterinarian temporarily. If the owner is not immunocompromised, in a burn or intensive care unit, or in isolation, the dog should be able to visit and even stay if a family member or friend can take care of the dog's needs. The hospital staff should not have to bear any of the burden of the dog's care.

Once the patient is discharged, the guide dog may accompany its owner to follow-up appointments in the hospital or doctor's office. Following the previously stated rationale, individuals with guide dogs should be allowed to visit their friends and acquaintances in the hospital.

With an understanding of the purpose and nature of guide dogs, hospitals should be less hesitant to allow their presence in hospitals. With the independence afforded by their guide dogs, blind individuals can visit and work in hospitals.

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This report was prepared by Deborah L. Martin, RN, MN, Nurse Epidemiologist, Bureau of Epidemiology, Texas Department of Health.

#### REFERENCES:

1. Texas Human Resources Code, Title 8, Chapter 121, Section 121.003.
2. The Seeing Eye, Inc. Seeing eye dogs in a hospital setting. Morristown, New Jersey 07960.
3. Hardy GJ. The seeing-eye dog: an infection risk in hospital? Can Med Assoc J 1981;124:698-700.

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#### INTRODUCED AUTOCHTHONOUS MALARIA

A 26-year-old Dallas woman had onset of a flu-like illness consisting of sore throat, malaise, and subjective fever on June 1, 1985. Symptoms resolved spontaneously over several days. On June 8, she developed shaking chills, fever, headaches, and severe left-sided pleuritic pain. She was started on ampicillin, but fever to 104°F and chills recurred requiring her hospitalization on June 12 with a presumptive diagnosis of tubo-ovarian abscess. She was started on cefoxitin with initial improvement, but her fever returned three to four days later. Laboratory studies indicated a mild hemolytic anemia and a laboratory technologist noted large numbers of intra-erythrocytic parasites in a routine blood smear on June 17. Review of that smear, as well as those of June 12 and 14, confirmed the presence of Plasmodium vivax (subsequently confirmed by the Texas Department of Health). Treatment with chloroquine and primaquine led to a complete recovery.

The woman resides in a densely populated part of south Dallas which includes an unknown number of immigrants from Central America. She has not traveled outside of Dallas in the last several years and has neither traveled to countries endemic for malaria nor been in the military services. She had one blood transfusion on June 17, but never any before the onset of illness. In the six months before onset of her symptoms, she had her ears pierced and had a laparoscopy, both in February. She denied use of intravenous drugs, denied knowing anyone who uses intravenous drugs, and had no cutaneous signs of drug use. She is unemployed, rarely leaves her neighborhood, and sits on her porch every evening. Her apartment is air-conditioned

and screened. She knows no one who has had a malaria-like illness. She does recall numerous mosquito bites in the weeks before her present illness.

Mosquito light traps, set by the City of Dallas Environmental Health Division, in that area of town, had yielded about 1% anophelines in May and June. The nearest breeding sites for mosquitoes is in the Trinity River flood plain about a mile from her house. None of about 100 anophelines examined had malaria parasites. Most of the anophelines captured were A. quadrimaculatus.

It is likely that this patient acquired her mosquito-borne vivax malaria at her urban residence, where she was frequently exposed to mosquitoes while sitting outside in the evening. The usual incubation period for vivax malaria can range from 10 to 40 days with an average of 14 days; she had not been out of the area in that period of time.

This is the first introduced autochthonous case of malaria (malaria acquired by mosquito transmission from an imported case in an area where mosquito-borne malaria is not a regular occurrence) in the United States since 1981, when one case occurred in California. This is the first such case in Texas since 1970. The threat that endemic malaria will be reestablished in Texas is remote. Since 1950 there have been thousands of cases of imported malaria in the state, but only two episodes of introduced autochthonous malaria. In both episodes, mosquito transmission ended with just one generation of cases. Nevertheless it is essential for physicians to be vigilant for malaria and report all cases promptly to facilitate effective surveillance and control. Episodes such as this are not a significant public health threat provided that current malaria surveillance and control activities are maintained.

This case was reported by JD Smilack, MD, DV Powell, MD, St. Paul Medical Center; FW Becker, M Ramhdam, City of Dallas Environmental Health Division, Department of Health and Human Services; CE Haley, MD, MS, Dallas County Epidemiologist; PV Fournier, MPH, Texas Department of Health.

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### VIRAL ISOLATES FOR AUGUST 1985

<u>Virus</u>	<u>COUNTY OF RESIDENCE OF PATIENT(S)</u> <u>(NUMBER OF ISOLATES)</u>
Cytomegalovirus	Dallas (7), Galveston (1), Tarrant (1)
Coxsackie B2	Dallas (1)
Coxsackie B3	Galveston (1), Grayson (1)
Coxsackie B4	Galveston (1)
Echovirus 4	Bell (2)
Echovirus 7	Galveston (1)
Echovirus 11	Galveston (2), Hidalgo (1)
Echovirus 19	Bexar (1)
Echovirus 21	Bell (3)
Enterovirus	Bell (5), Bexar (1), Dallas (2), El Paso (2) Grayson (1), Hidalgo (1), Lubbock (1), McLennan (1), Potter (1), Tarrant (1)
Rotavirus	Bexar (1), Dallas (2)
Varicella/Zoster	Bell (1)
<u>Chlamydia trach.</u>	Bell (7), Dallas (9), Tarrant (1), Travis (3)

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USDA MEAT AND POULTRY  
TOLL-FREE HOTLINE

The US Department of Agriculture's Meat and Poultry Hotline has recently become toll-free. It provides help for consumers with questions ranging from how long to keep meat and poultry in the refrigerator, to how to pack a safe picnic lunch. The toll-free hotline operates from 10 AM to 4 PM, EDT. The number is: (800) 535-4555.

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