

## Texas Preventable Disease



## NEWS

contents:

TEXAS STATE DOCUMENTS  
COLLECTIONRon J. Anderson, M.D. Robert Bernstein, M.D., F.A.C.P.  
Chairman Commissioner  
Texas Board of Health

Bureau of Epidemiology, 1100 West 49th Street, Austin, Texas 78756-3180 (512-458-7207)

ANSWERS TO THE MOST FREQUENTLY ASKED QUESTIONS  
ABOUT DISEASE REPORTING:  
PART II

## DISEASE-SPECIFIC REPORTING

1. Q. What is the definition of a "meningococcal infection" for purposes of reporting?

A: Reportable meningococcal infections include meningitis, septicemia, arthritis, or other systemic diseases caused by Neisseria meningitidis. Meningococcal colonization and infections of the nasopharynx are not reported.

2. Q: Is it necessary to specify bacterial meningitis vs viral (aseptic) meningitis?

A: Yes. It is very important to differentiate not only between bacterial and aseptic meningitis, but also between the specific bacterial agents causing the meningitis. The control measures which would be implemented for one type of meningitis might not be appropriate for another.

If you receive a report of "meningitis" and the diagnosis was made by culture, make every attempt to obtain the results of the culture. If the culture result is "no growth," determine from the medical record or physician whether the case was diagnosed as aseptic meningitis or bacterial meningitis.

3. Q. Should Haemophilus influenzae infections other than meningitis be reported?

A: No, but surveillance of other manifestations of H. influenzae infection (eg, septicemia, cellulitis, epiglottitis) is maintained by the Bureau of Epidemiology. Voluntary reporting of these infections is encouraged as we begin to study the impact of the recently licensed Hib vaccine.

4. Q. Which types of "encephalitis" should be reported?

A: Encephalitis includes any diagnosed illness with an encephalitic component, including meningoencephalitis. Primary encephalitis includes primary infections of the central nervous system with either a specified (eg, herpes, arbovirus, enterovirus) or an unspecified cause.

Post-infectious encephalitis includes cases associated with an immune reaction following a preceding illness, usually a childhood disease (eg, measles, mumps, chickenpox) or a vaccine reaction. In any case, reporting agents are requested to specify either the suspected or confirmed etiologic agent of the encephalitis.



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5. Q. What is meant by "unspecified hepatitis?"
- A: Viral hepatitis should be reported as "unspecified" only if it cannot be assigned to one of the other categories: type A, type B, or non-A, non-B hepatitis. Cases of non-infectious hepatitis (alcoholic hepatitis or obstructive jaundice) are not reportable.
6. Q. Should cases of hepatitis type A be reported if there is only a clinical diagnosis?
- A: If the epidemiology and clinical diagnosis indicate hepatitis A, the case should be reported. That is, report the person's illness if it can be directly traced to a known outbreak of hepatitis A or if the case is a close contact to another known case.
7. Q. Should chronic carriers of hepatitis B or cases of chronic active hepatitis be reported to health authorities?
- A: No. Only cases of acute hepatitis B should be reported. Often laboratory tests will identify patients who are HBsAg positive, even though they are asymptomatic. These patients should not be reported, as their infections occurred at some time in the past. Likewise, patients with chronic active disease should not be reported.
8. Q. Should foodborne outbreaks be reported?
- A: Yes. Foodborne outbreaks are defined as two or more individuals having a similar illness after eating at a common event or eating a common food which is epidemiologically implicated as the source. Foodborne outbreaks should be reported on form CDC 52.13 (REV 9/83), "Investigation of a Foodborne Outbreak", even if no etiologic agent was confirmed. Completed investigation forms are reviewed by the Bureau of Epidemiology and forwarded to the Centers for Disease Control. Additional supplies of the form are available from the Bureau of Epidemiology.
9. Q. Does the Bureau of Epidemiology consider an elevated Widal test (type 0) titer diagnostic of typhoid fever?
- A: No. A case of typhoid fever is reportable only if Salmonella typhi is isolated from the blood or stool.
10. Q. Are there diagnostic criteria or case definitions for the reportable occupational diseases?
- A: No. At the present time, there are no case definitions or diagnostic criteria for cases of asbestosis, silicosis, or acute occupational pesticide poisoning. The physician's diagnosis of the patient's illness is accepted, as is a suspect diagnosis. Elevated blood lead levels in adults can be established by laboratory testing (blood lead at or above 40 µg lead/100 ml of blood).
11. Q. Should persons with a positive HTLV-III test result be reported?
- A: No. Infection with HTLV-III alone, as measured serologically in the absence of disease, is **not** reportable. Only cases of acquired immune deficiency syndrome with opportunistic infections/cancer are required to be reported.



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## NEW COMMUNICABLE DISEASE RULE

The following rule concerning the death of a person with certain communicable diseases was adopted by the Texas Board of Health on March 15, 1986, and will become effective April 20, 1986.

The new section is adopted under authority of Texas Civil Statutes, Article 4419b-1, §2.02, which provides the Texas Board of Health with the authority to adopt rules to prevent and control communicable diseases. The Department expects that the new rule will help reduce the risk of transmission of certain communicable diseases now required to be reported to the Texas Department of Health.

## §97.11. Death of a Person with Certain Communicable Diseases.

(a) If a physician has knowledge that a person had, at the time of death, a communicable disease listed in subsection (c) of this section, then the physician shall affix or cause to be affixed a tag on the body, preferably on a great toe.

(b) The tag shall be on card stock paper and shall be no smaller than five centimeters by ten centimeters. The tag shall include the words "COMMUNICABLE DISEASE - BLOOD/BODY FLUID PRECAUTIONS REQUIRED" in letters no smaller than 6 millimeters in height. The name of the deceased person shall be written on the tag. The tag shall remain affixed to the body until the preparation of the body for burial has been completed.

(c) Diseases that shall require tagging are acquired immune deficiency syndrome, anthrax, viral hepatitis, plague, rabies, Rocky Mountain spotted fever, syphilis, tuberculosis, tularemia, and viral hemorrhagic fever.

(d) All persons should routinely practice the following procedures when performing postmortem care on a deceased person who is known or suspected of having a communicable disease listed in subsection (c) of this section:

(1) A person should wear a gown, gloves, a mask, and eye-coverings when performing procedures involving extensive contact with blood or body fluids. Skin should be washed immediately if the skin is or may be contaminated with blood or body fluids.

(2) Needles should not be recapped, purposefully bent, broken, or removed from disposable syringes. Needles and other sharp items should be disposed of in puncture-resistant containers. Contaminated articles that may be disposed of by bagging should be double-bagged in plastic bags not less than 1.5 mil thick each. Other articles may be disposed of by incineration or disinfected by chemical disinfection or steam sterilization.

(3) Spills of blood and other body fluids should be cleaned promptly with a solution of household chlorine bleach diluted 1:10 with water.

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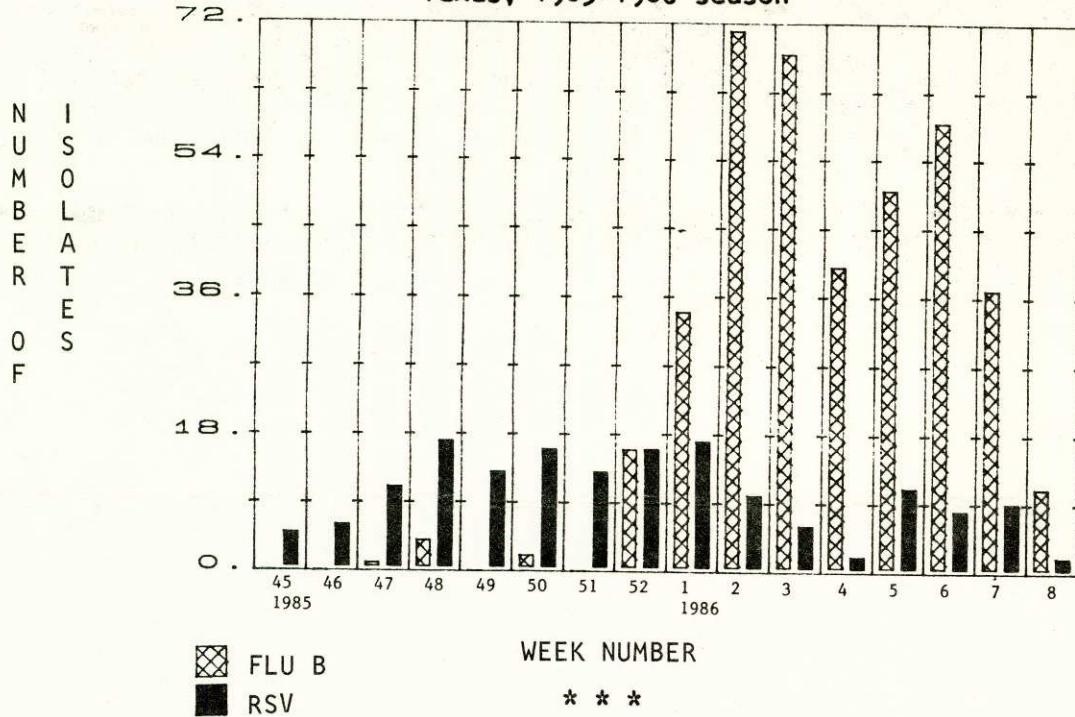
## VIRAL UPDATE

Based on the number of viral isolates reported (Figure 1), influenza B virus activity peaked during the first seven weeks of 1986. Few influenza B viruses were reported in week 8 (February 23 through March 1) suggesting the influenza epidemic has diminished.

Respiratory syncytial viruses (RSV) also cause epidemics in the late fall, winter, or spring months of each year. RSV epidemics usually last four to five months and primarily affect children less than 1 year of age. The number of reported RSV increased in week 47 and remained elevated through week 2 (November 24, 1985, through January 18, 1986). A second peak is evident from week 5 through week 7.



Figure 1.  
Number of influenza B and respiratory syncytial viruses by week,  
Texas, 1985-1986 season



APRIL FOOLISH

Erratum: The answer to question number 5 in the April 5, 1986, TPDN was prepared by an April fool, subsequently ejected from the Epidemiology Bureau. The answer to the question "Who is my local health authority?" should have read as follows:

The local health authority includes: the city or county health officer, the director of an organized health department or a local board of health, or the director of a Texas Public Health Region, or the director of a public health district, within their respective jurisdictions.

We'll try to do better next April!

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