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Florida HEALTH Seminole County

Epidemiology Program • www.seminolecohealth.com

Guidelines for Evaluating Suspected Ebola Virus Disease

The Centers for Disease Control and Prevention (CDC) is working with the World Health Organization (WHO), the ministries of health of Guinea, Liberia, Nigeria and Sierra Leone, and other international organizations in response to an outbreak of Ebola Virus Disease (EVD) in West Africa, which was first reported in late March 2014. As of August 8, 2014, according to WHO, a total of 1,779 cases and 961 deaths (case fatality 55-60%) had been reported across the four affected countries. This is the largest outbreak of EVD ever documented and the first recorded in West Africa.

EVD is characterized by sudden onset of fever and malaise, accompanied by other nonspecific signs and symptoms, such as myalgia, headache, vomiting, and diarrhea. Patients with severe forms of the disease may develop hemorrhagic symptoms and multi-organ dysfunction, including hepatic damage, renal failure, and central nervous system involvement, leading to shock and death. The fatality rate can vary from 40-90%.

In outbreak settings, Ebola virus is typically first spread to humans after contact with infected wildlife and is then spread person-to-person through direct contact with bodily fluids such as, but not limited to, blood, urine, sweat, semen, and breast milk. The incubation period is usually 8 –10 days (ranges from 2–21 days). Patients can transmit the virus while febrile and through later stages of disease, as well as postmortem, when persons touch the body during funeral preparations.

Patient Evaluation Recommendations

Healthcare providers should be alert for and evaluate suspected patients for Ebola virus infection who have both consistent symptoms and risk factors as follows:

1) Clinical criteria, which includes fever of greater than 38.6 degrees Celsius or 101.5 degrees Fahrenheit, and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage; AND

2) Epidemiologic risk factors within the past 3 weeks before the onset of symptoms, such as contact with blood or other body fluids of a patient known to have or suspected to have EVD; residence in—or travel to—an area where EVD transmission is active; or direct handling of bats, rodents, or primates from disease-endemic areas. Malaria diagnostics should also be a part of initial testing because it is a common cause of febrile illness in persons with a travel history to the affected countries.

For additional information on patient evaluation recommendations for Ebola Virus Disease see the following link: http://emergency.cdc.gov/han/han00364.asp

Any U.S. hospital with suspected patients should follow CDC's Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in U.S. Hospitals (http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html).

INSIDE THIS ISSUE:

Letter from the American Academy of Pediatrics

Florida Chapter
American Academy of Pediatrics

Dear Immunization Partners:

I want to let you know the Advisory Committee on Immunization Practices (ACIP) recommends that providers administer a dose of meningococcal conjugate vaccine (MCV4: Menactra® or Menveo®) to adolescents at age 11 or 12 years **and** a booster dose of MCV4 at age 16 years. Adolescents who receive their first dose of MCV4 at age 13 through 15 years should receive a booster dose of MCV4 at age 16 through 18 years. The minimum interval between doses of MCV4 is 8 weeks.

It is important that adolescents receive **both** the initial (at 11-12 years) and booster (at 16 years) doses of MCV4 to ensure adequate protection against meningococcal disease during late adolescence, when the disease typically peaks. ACIP recommends that adolescents receive a booster dose of MCV4 because of mounting evidence that immunity wanes approximately 3-5 years after receiving an initial dose of MCV4 at 11-12 years of age. After a booster dose of MCV4, antibody titers are higher than after the first dose and are expected to protect adolescents through the period of increased meningococcal disease risk in late adolescence.

Additional information (i.e., vaccine precautions/contraindications; administering meningococcal vaccine to high-risk groups, etc.) about meningococcal disease and vaccination is available in "Prevention and Control of Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP)" MMWR 2013;62(No.RR-2):{1-32}. Both the recommended and catch-up 2014 child/adolescent immunization schedules are available here.

The Immunization Action Coalition's (IAC) "Meningococcal Vaccination Recommendations by Age and/or Risk Factor" summarizes ACIP's recommendations for the use of meningococcal vaccine.

Click here to access a customizable parent meningococcal fact sheet, that you can insert your pediatric practice information onto and pass out to you're patients.

Florida Chapter
American Academy of Pediatrics www.fcaap.org | info@fcaap.org | 850.224

Disease Incidence Table-Seminole County

Selected Diseases/Conditions Reported to DOH-Seminole	2014 through Week 30	2013 through Week 30	2012 through Week 30	2011–2013 Average through Week 30
AIDS*	20	38	30	32.3
Animal Bite to Humans**	11	21	8	13.7
Animal Rabies	1	7	2	3.7
Campylobacteriosis	17	23	33	24.3
Chlamydia	817	1427	1443	1021
Cryptosporidiosis	3	1	4	2.3
Cyclosporiasis	2	1	1	1.0
Dengue	1	2	2	1.3
E. coli Shiga toxin-producing	6	4	7	4.3
Giardiasis	6	5	8	7.0
Gonorrhea	175	314	352	143.3
Haemophilus influenzae (invasive)	2	5	1	2.7
Hepatitis A	0	0	3	1.3
Hepatitis B (acute and chronic)	36	26	40	36.7
Hepatitis C (acute and chronic)	273	178	203	180.3
Hepatitis B in Pregnant Women	0	2	3	3.3
HIV*	35	63	47	54.6
Lead poisoning	1	1	8	3.3
Legionellosis	3	7	0	3.0
Lyme Disease	4	0	2	1.3
Meningococcal Disease	1	1	1	0.7
Pertussis	12	5	8	5.0
Salmonellosis	45	27	36	33.7
Shigellosis	5	2	42	17.7
S. pneumoniae – drug resistant	5	8	5	6.3
Syphilis	16	16	19	18.0
Tuberculosis	4	4	4	5.3
Varicella	8	12	14	12.3

* *HIV data includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually exclusive. Current AIDS/HIV data are provisional at the county level.*

** *Animal bite to humans by a potentially rabid animal resulting in a county health department or state health office recommendation for post-exposure prophylaxis (PEP), or a bite by a non-human primate.*

*Reported cases of diseases/conditions in **Bold** are >10% higher than the previous three year average for the same time period.*

All Data is Provisional

Disease Reporting

The Epidemiology Program conducts disease surveillance and investigates suspected occurrences of infectious diseases and conditions reported from physician's offices, hospitals and laboratories.

Surveillance is primarily conducted through passive reporting from the medical community as required by Chapter 381, Florida Statutes.

To report a reportable disease or outbreak during business hours please use the Report of Communicable Disease Form for diseases other than HIV/AIDS, STD, or TB, or contact the Epidemiology Department at (407) 665-3266.

To report an urgent reportable disease or outbreak after hours, please contact (407) 665-3266 and follow the instructions to reach the Epidemiologist on-call 24/7.

Reportable Diseases/Conditions in Florida - Practitioner List

Reportable Diseases/Conditions in Florida - Laboratory List

Disease Reporting Information for Health Care Providers and Laboratories

Foodborne Illnesses Reporting Links:

Report illnesses due to food online 24/7

Report unsafe or unsanitary conditions

MISSION

To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts

VISION

To be the Healthiest State in the Nation

VALUES

Innovation
Collaboration
Accountability
Responsiveness
Excellence

ADDRESS

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