Communicable Disease (CD) Quarterly Report

San Francisco Department of Public Health

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Disease Reporting: 415-554-2830 (phone); 415-554-2848 (fax); http://www.sfcdcp.org

Tomás Aragón, MD, DrPH, Health Officer

Cora Hoover, MD, MPH, Director, Communicable Disease Control and Prevention

The **Communicable Disease Control Unit** receives and responds to reports of communicable diseases. For urgent reports during business hours, please call (415) 554-2830. For urgent or emergent reports after hours, please call (415) 554-2830 and follow instructions to page the on-call physician. For non-urgent reports, please fax a Confidential Morbidity Report (CMR) to (415) 554-2848.

Please see our website for more information: http://www.sfcdcp.org

Sign up to receive Health Alerts and Advisories at: http://www.sfcdcp.org/registerforalert.html

Table 1: Number of Select Reported Communicable Disease Cases

	2016		2015	
	Q2	Q1+Q2	Q2	Q1+Q2
Botulism	0	0	0	0
Invasive Meningococcal Disease	0	1	2	3
Meningitis— Bacterial#	5	5	0	0
Meningitis— Viral	3	5	3	4
Rabies, animal**^	0	1	2	2
Rabies PEP recommendation	5	12	9	16
Zika	4	7	0	0

Table 2: Number of Select Reported Gastrointestinal Disease Cases

	2016		2015	
	Q2	Q1+Q2	Q2	Q1+Q2
Amebiasis	11	19	16	30
Campylobacteriosis	128	243	128	252
Giardiasis	46	102	40	96
Salmonellosis*	43	73	44	75
Shiga toxin-producing E. coli+	7	12	5	8
Shigellosis*	30	67	56	193
Vibriosis (Non-cholera)	1	2	1	2

Table 3: Number of Select Reported Vaccine Preventable Disease Cases

	2016		2015	
	Q2	Q1+Q2	Q2	Q1+Q2
Hepatitis A	1	1	2	4
Hepatitis B, Acute	0	1	1	2
Influenza Death (0 - 64 yrs)	0	0	0	2
Measles	0	0	0	0
Pertussis*	5	7	25	44
Pertussis* (< 6 mos of age)	2	2	1	1

Table 4: Number of Select Reported Outbreaks

	2016		2015	
	Q2	Q1+Q2	Q2	Q1+Q2
Gastrointestinal	5	11	9	10
Respiratory	2	9	0	13
Confirmed Influenza	1	6	0	13

Excludes Meningococcal Meningitis

** Includes confirmed cases only

^ Only detected in bats; no other animals

* Includes confirmed, probable, & suspect cases

+ Includes Shiga toxin in Feces & E. coli O157

Authors: Cora Hoover, Yanyuan Liu, Wendy Lu, Melissa Ongpin, and David Stier

Feature Article: Seasonal Influenza

Disease: Seasonal influenza is an acute, contagious respiratory illness characterized by high fever, cough, headache, muscle and joint pain, severe malaise, sore throat, and runny nose. Common complications of influenza include viral pneumonia, secondary bacterial pneumonia or sinusitis, and exacerbations of underlying pulmonary or cardiac conditions. Rare but serious complications include encephalitis, myositis, myocarditis, pericarditis, and sepsis. The risk of complications is highest among children age <2 years, adults age ≥65 years, pregnant women, and people of any age with weakened immune systems or chronic heart, lung, kidney, liver or metabolic diseases. "Flu season" in the US is characterized by widely circulating influenza virus, typically December through March, but may begin earlier or end later in the year.

Vaccines: Intranasal influenza vaccine (FluMist) is not recommended for the 2016-17 flu season due to recent poor efficacy. Instead, inactivated influenza vaccine (IIV) is recommended for all persons age ≥ 6 months who lack contraindications. Trivalent IIV (IIV3) is being phased out in favor of quadrivalent IIV (IIV4) which contains 2 influenza B type antigens in addition to the A(H1N1) and A(H3N2) influenza A subtypes. For those age ≥65 years, high-dose IIV3 prevents influenza more effectively than regular-dose IIV3; however efficacy data vs. regular-dose IIV4 are not yet available. Experience is limited with a new IIV3 vaccine (Fluad) containing an adjuvant to stimulate immune response in those age ≥65 years. Quadrivalent egg-free vaccine (FluBlok) and intradermal vaccine are available. Thimerosal-free formulations should be used with pregnant females and children ≤35 months of age. Children age ≤ 8 years with 0 or 1 previous lifetime dose of flu vaccine should receive 2 doses of vaccine this year. Persons who have allergy to egg resulting in reactions other than just hives should receive flu vaccine under the care of a physician experienced in the recognition and management of severe allergic reactions.

Antivirals: Treatment with a neuraminidase inhibitor, such as oseltamivir, should be started as soon as possible and ideally within 48 hours of symptom onset, for any patient with confirmed or suspected influenza who is hospitalized, has severe, complicated or progressive illness, or is at higher risk of influenza complications. Oseltamivir and zanamivir also provide effective post-exposure chemoprophylaxis when started within 48 hours of close contact with a person ill with influenza. During institutional outbreaks of influenza, chemoprophylaxis should be initiated immediately and continued for at least 2 weeks or until 10 days after the illness onset in the last patient.

Resources

ACIP influenza vaccine recommendations: http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

CDC influenza vaccines summary: http://www.cdc.gov/flu/protect/vaccine/vaccines.htm

CDC influenza antiviral guidance: http://www.cdc.gov/flu/professionals/antivirals/antiviral-use-influenza.htm

SFDPH influenza guidance: http://sfcdcp.org/fluproviders

SFDPH long term care facilities guidance: http://sfcdcp.org/longtermcare

Notes: Data includes San Francisco cases and outbreaks to June 30, 2016, by date of report. Unless otherwise noted, confirmed and probable cases and confirmed and suspect outbreaks are included. Numbers may change due to updates to case status based on subsequent information received and/or delays in reporting.