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

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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 at: https://www.sfcdcp.org/health-alerts-emergencies/health-alerts/register-for-health-alerts/

Table 1: Number of Selected Reported Communicable Disease Cases

	2017		2016	
	Q3	Q1-Q3	Q3	Q1-Q3
Botulism	1	2	0	0
Invasive Meningococcal Disease	0	0	1	2
Meningitis— Bacterial[#]	2	8	0	5
Meningitis— Viral	4	8	2	7
Rabies, animal[**^]	1	3	0	1
Rabies PEP recommendation	7	15	13	25
Zika	1	10	18	25

Table 2: Number of Selected Reported Gastrointestinal Disease Cases

	2017		2016	
	Q3	Q1-Q3	Q3	Q1-Q3
Campylobacteriosis	96	325	125	368
Giardiasis	66	195	59	161
Salmonellosis[*]	57	115	39	112
Shiga toxin-producing E. coli[+]	27	49	17	29
Shigellosis[*]	48	126	57	124
Vibriosis (Non-cholera)	6	12	2	4

Table 3: Number of Selected Reported Vaccine Preventable Disease Cases

	2017		2016	
	Q3	Q1-Q3	Q3	Q1-Q3
Hepatitis A	9	15	0	1
Hepatitis B, Acute	0	1	0	1
Influenza Death (0 - 64 yrs)	1	2	0	0
Measles	0	0	0	0
Pertussis[*]	9	25	5	12
Pertussis[*] (< 6 mos of age)	0	0	0	2

Table 4: Number of Selected Reported Outbreaks

	2017		2016	
	Q3	Q1-Q3	Q3	Q1-Q3
Gastrointestinal	1	13	0	11
Respiratory	2	16	1	10
Confirmed Influenza	1	14	0	6

\# Excludes Meningococcal Meningitis

^ Only detected in bats; no other animals

\+ Includes Shiga toxin in feces & *E. coli* O157

** Includes confirmed cases only

* Includes confirmed, probable, & suspect cases

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Preventing Sepsis in Asplenic Adults: Focus on Immunization

"Asplenia" describes lost splenic function due to congenital absence, surgical removal, or functional deficiency due to conditions such as sickle cell disease. The spleen contains immunoglobulin-producing lymphocytes and mononuclear phagocytes. Asplenia particularly increases the risk of sepsis due to encapsulated bacteria.

Preventing sepsis in asplenic adults involves vaccination, education, early empirical antimicrobial therapy for febrile episodes, and prophylactic antimicrobial therapy in selected patients.

Vaccinations against the pneumococcus, meningococcus, and *Haemophilus influenzae* type b should be administered either ≥ 2 weeks prior to elective splenectomy when feasible, or ≥ 2 weeks after splenectomy. Other routine vaccinations should be kept up to date, and influenza vaccine should be given annually.

Pneumococcal vaccines. If not previously received, both PCV13 (Prevnar13) and PPSV23 (Pneumovax23) are indicated, but should not be given simultaneously due to interference with immunogenicity. Generally, PCV13 should be given first followed ≥ 8 weeks later by PPSV23. Revaccinate with PPSV23 after 5 years and again at age ≥ 65.

Meningococcal vaccines. If not previously received, MenACWY and MenB vaccines are both indicated and may be given simultaneously at different anatomic sites. Give MenACWY (Menactra or Menveo) as a 2-dose primary series ≥ 8 weeks apart, plus a booster every 5 years thereafter. Menactra (but not Menveo) should be given ≥ 4 weeks after PCV13 due to potential interference. Give MenB vaccine as a 2-dose primary series ≥ 1 month apart (Bexsero) or a 3-dose primary series at 0, 1-2 months, and 6 months (Trumenba). Use the same product for all doses in a series. The need for MenB booster doses is not currently defined.

Hib. Adults who did not previously complete a *Haemophilus influenzae* type b (Hib) vaccine series should receive a dose of Hib conjugate vaccine. No boosters are required.

Inform asplenic adults that any illness with fever could indicate onset of life-threatening infection. Those in whom fever develops should promptly initiate empirical antimicrobial therapy with amoxicillin-clavulanate, cefuroxime axetil, or levofloxacin and seek medical attention. In adults, daily antimicrobial prophylaxis is not generally recommended but may be considered during the initial 1-2 years after splenectomy. Asplenic patients should also avoid dog bites, scratches, and contact with dog saliva to prevent infection with *Capnocytophaga canimorsus*, another encapsulated organism.

CDC: Recommended Immunization Schedule for Adults by Medical Conditions and Other Indications, 2018 https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html

Infectious Disease Society of America: 2013 IDSA Clinical Practice Guideline for Vaccination of the Immunocompromised Host https://academic.oup.com/cid/article/58/3/e44/336537

Rubin, L.G., & Schaffner, W. (2014). Care of the Asplenic Patient. *NEJM*, 371:349-56.

Notes: Data includes San Francisco cases and outbreaks through September 30, 2017, by date of report. Unless otherwise noted, confirmed and probable cases and confirmed and suspect outbreaks are included. For outbreak definitions, please see the most recent Annual Report of Communicable Diseases in San Francisco, available at: https://www.sfcdcp.org/about/publications-data-and-reports/. Numbers may change due to updates to case status based on subsequent information received and/or delays in reporting.