



South Carolina Department of Health
and Environmental Control

Division of Acute Disease
Epidemiology (DADE)

CHESS Club

for providers

November/December 2011

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Happy New Year to all of you from your DHEC partners in healthcare!

A special thank you for all you do to populate
CHESS with Reportable Conditions.

Wishing you the best in 2012,
Ann W Bell, DHEC CHESS Trainer.

What am I Forgetting?

Patient Name – yes, this does happen from time to time. Remember to enter as much patient contact information on the first page as you have access to. This makes it easier for DHEC staff to follow up with the patient. It prevents many phone calls to your office.

Treatment – I know you don't always have access to the patient treatment information, but if you can locate this, especially for sexually transmitted diseases, it is a real help in following up with contacts.

Password- I know you are pretty good at this but there are still some users who forget to log in and out once every 30 days. If you enter a report within the 30 days, you don't have to login separately. Remember to change your password every 90 days. Do you have another account that you change every 90 days? If so, then put CHESS on the same rotation. Maybe you can use the same password for both accounts. And, it is useful to write your password down.

Lab or Morbidity Data Entry – Lab Report under Data Entry is only used for cultures! You can't enter treatment, except in the text boxes throughout the program but it does allow you to enter the patient susceptibility results > just click Susceptibility YES. Morbidity Report is used for STD's, Hepatitis, and non-culture results. This program allows you to enter the Treatment given to the patient. Even if you don't know the treatment, please enter all results under Morbidity, except for Cultures.

Do NOT enter Lead or TB in CHESS!

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Shigellosis – by David Young, DHEC Foodborne Epidemiologist

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While Shigellosis only accounted for about 3% of the reported outbreaks in South Carolina from 2007-2010, it is a highly contagious disease that can be difficult to eradicate from an institution. A single outbreak in 2011 affected more than 100 students and staff at an elementary school in South Carolina. In 2008 there were more than 500 cases of Shigellosis reported.

What is Shigellosis?



Shigellosis is an infectious disease caused by a group of bacteria called *Shigella*. Humans are the natural host for *Shigella*. Most who are infected with *Shigella* develop

diarrhea, fever, and stomach cramps starting a day or two after they are exposed to the bacteria. The diarrhea is often bloody. Shigellosis usually resolves in 5 to 7 days. Persons with shigellosis in the United States rarely require hospitalization. A severe infection with high fever may be associated with seizures in children less than 2 years old. Some persons who are infected may have no symptoms at all, but may still pass the *Shigella* bacteria to others.

The *Shigella* germ is actually a family of bacteria that can cause diarrhea in humans. They are microscopic living creatures that pass from person to person. *Shigella* were discovered over 100 years ago by a Japanese scientist named Shiga, for whom they are named. There are several different kinds of *Shigella* bacteria: *Shigella sonnei*, also known as “Group D” *Shigella*, accounts for over two-thirds of shigellosis in the United States. *Shigella flexneri*, or “group B” *Shigella*, accounts for almost all the rest. Other types of *Shigella* are rare in this country, though they continue to be important causes of disease in the developing world. One type found in the developing world, *Shigella dysenteriae* type 1, can cause deadly epidemics.

How common is Shigellosis?

Every year, about 14,000 cases of shigellosis are reported in the United States. Because many milder cases are not diagnosed or reported, the actual number of infections may be around 300,000. Shigellosis is particularly common and causes recurrent problems in settings where hygiene is poor and can sometimes sweep through entire communities. It is more common in summer than winter. Children, especially toddlers aged 2 to 4, are the most likely to get shigellosis. Many cases are related to the spread of illness in child-care settings, and many are the result of the spread of the illness in families with small children. Men who have sex with men, represent another group with an elevated risk of contracting Shigellosis.

What can a person do to prevent this illness?

- Wash hands with soap carefully and frequently, especially after going to the bathroom, after changing diapers, and before preparing foods or beverages.
- Dispose of soiled diapers properly.
- Disinfect diaper changing areas after using them.
- Keep children with diarrhea out of child care settings.
- Supervise handwashing of toddlers and small children after they use the toilet.
- Do not prepare food for others while ill with diarrhea.
- Avoid swallowing water from ponds, lakes, or untreated pools.



Currently, there is no vaccine to prevent shigellosis. However, the spread of *Shigella* from an infected person to other persons can be stopped by frequent and careful handwashing with soap.

Shigellosis...Continued

Frequent and careful handwashing is important among all age groups. Handwashing among children should be frequent and supervised by an adult in daycare centers and homes with children who have not been fully toilet trained.

Basic food safety precautions and disinfection of drinking water prevents shigellosis from food and water. However, people with shigellosis should not prepare food or drinks for others until they have been shown to no longer be carrying the *Shigella* bacterium, or if they have had no diarrhea for at least 2 days. At swimming beaches, having enough bathrooms and handwashing stations with soap near the swimming area helps keep the water from becoming contaminated. Daycare centers should not provide water play areas.

Treatment

Most clinical infections with *Shigella sonnei* are self-limited (48 to 72 hours) and do not require antimicrobial therapy. However, antimicrobial therapy is effective in shortening the duration of diarrhea and eradicating organisms from

feces. Treatment is recommended for patients with severe disease, dysentery or underlying immunosuppressive conditions; in these patients, empiric therapy should be given while awaiting culture and susceptibility results. In mild disease, the primary indication for treatment is to prevent spread of the organism. Antimicrobial susceptibility testing of clinical isolates is indicated because resistance to antimicrobial agents is common and susceptibility data can guide appropriate therapy.

Reporting Shigellosis in South Carolina

Shigellosis is a reportable condition in South Carolina. It falls into the 'report within 7 days' category on the South Carolina 2011 List of Reportable Conditions. It should be entered electronically in CHES (Carolinas Health Electronic Surveillance System) or mailed on a DHEC 1129 card to your DHEC Regional Health Office.

Labs are also requested to submit an isolate or broth to the DHEC Bureau of Laboratories for confirmatory testing or genotyping.

References for Shigella

CDC: www.cdc.gov/nczved/divisions/dfbmd/diseases/shigellosis/

FDA: www.fda.gov/food/foodsafety/foodborneillness/foodborneillnessfoodbornepathogensnaturaltoxins/badbugbook/ucm070563.htm

Red Book: www.unboundmedicine.com/redbook/ub/view/RedBook/187302/all/Shigella_Infections

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Interview with David Young DHEC Foodborne Epidemiologist

What is your job at DHEC in the Division of Acute Disease Epidemiology?

I'm a foodborne disease epidemiologist. My goals are to prevent and/or mitigate outbreaks of foodborne disease in South Carolina. This also includes some diseases which frequently spread from person-to-person such as Shigella and Norovirus. I get involved with reported outbreaks and also analyze our lab data and case questionnaires for possible outbreaks.

Who do you work with to accomplish your responsibilities?

I work closely with my teammate, Julie Schlegel, who is another foodborne disease epidemiologist. We both work closely with the State Bureau of Labs who provide us with identification of diseases, serotypes and patterns. We work with all the regional Epi's and DSRC's and through the regions have our primary interactions with groups and facilities that are experiencing outbreaks. We interact with the CDC particularly on multi-state outbreaks and ongoing projects. Additionally, we work with the FDA and USDA.

What is your background before coming to DHEC?

I most recently worked at the DeKalb County Board of Health in Georgia as part of their arbovirus surveillance and abatement program. The previous summer I spent at the CDC in the AIDS prevention division working on safe blood collection and injection safety. Prior to that I had a long stint at IBM working in positions ranging from semiconductor development to software technical sales.

David Young

Phone:
(803) 898-3838
Email:
youngd2@dhec.sc.gov



What message would you most like to share with healthcare providers in hospitals and physician offices in SC?

I'd like healthcare providers in South Carolina to view us as partners and to engage DHEC as early as possible when there is suspicion of an outbreak. We can work with them to mitigate disease outbreaks and minimize the impact on their facility and the community.

Do you have hobbies or special interests that keep you busy during your time off?

I've been studying Spanish for several years and have used that as an excuse to travel to Latin America several times. I have a friend in Cali, Colombia with whom I speak a few times a week via Skype.

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BOL Message

Subject: Discontinued Testing at the SC DHEC Bureau of Laboratories

Dear Colleague:

As of January 1, 2012, the Bureau of Laboratories (BOL) will no longer offer the following tests: Blood Parasite Examination (thick or thin blood smear exams for malaria, babesiosis, Chagas disease, or filariasis), and the Rickettsial Serology Panel (Rocky Mountain spotted fever antibody detection and murine typhus antibody detection). These changes have been made in light of the low volume of requests and our insufficient staffing to provide a satisfactory turnaround time for these test results. Health care providers are advised to use a commercial reference laboratory to rule-out suspected cases. Any requests for these tests that are associated with public health laboratory confirmatory testing of a suspected case will be referred to the Centers for Disease Control and Prevention (CDC). Any questions regarding this letter should be directed to me. Thank you for your cooperation in this matter.

Sincerely,

Arthur Wozniak, Dr.P.H.
Chief, Bureau of Laboratories
South Carolina Department of
Health and Environmental Control
8231 Parklane Road - Columbia, SC 29223
Office: 803-896-0965; FAX: 803-896-0983
e-mail: wozniaka@dhec.sc.gov
Cc. HHS, CMS, Region IV CLIA Office, Atlanta, GA



Who has made the most entries in CHES?



Sarah Gay

Fort Jackson Preventive Medicine

I first trained Sarah in June 2009, and for several months we kept in contact by phone as she began her reporting career. At the time, she was the first and only reporter for Ft. Jackson. Since that time, Sarah continues to report the highest numbers in CHES of any other user in SC. Sarah is a civilian employee at a base with a constant change of Preventive Medicine staff, yet she is diligent in her efforts to educate new officers about CHES and arrange for their training.

Thank you Sarah!

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New Providers

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Fort Jackson
Preventive Medicine



Doctors Care
Ridgeview



Regional MC of
Orangeburg Lab



Regional MC of Orangeburg
Infection Prevention



East Cooper Regional MC Lab



Doctors Care
Beltline



Any Lab Test Now
Greenville



Doctors Care
Orangeburg

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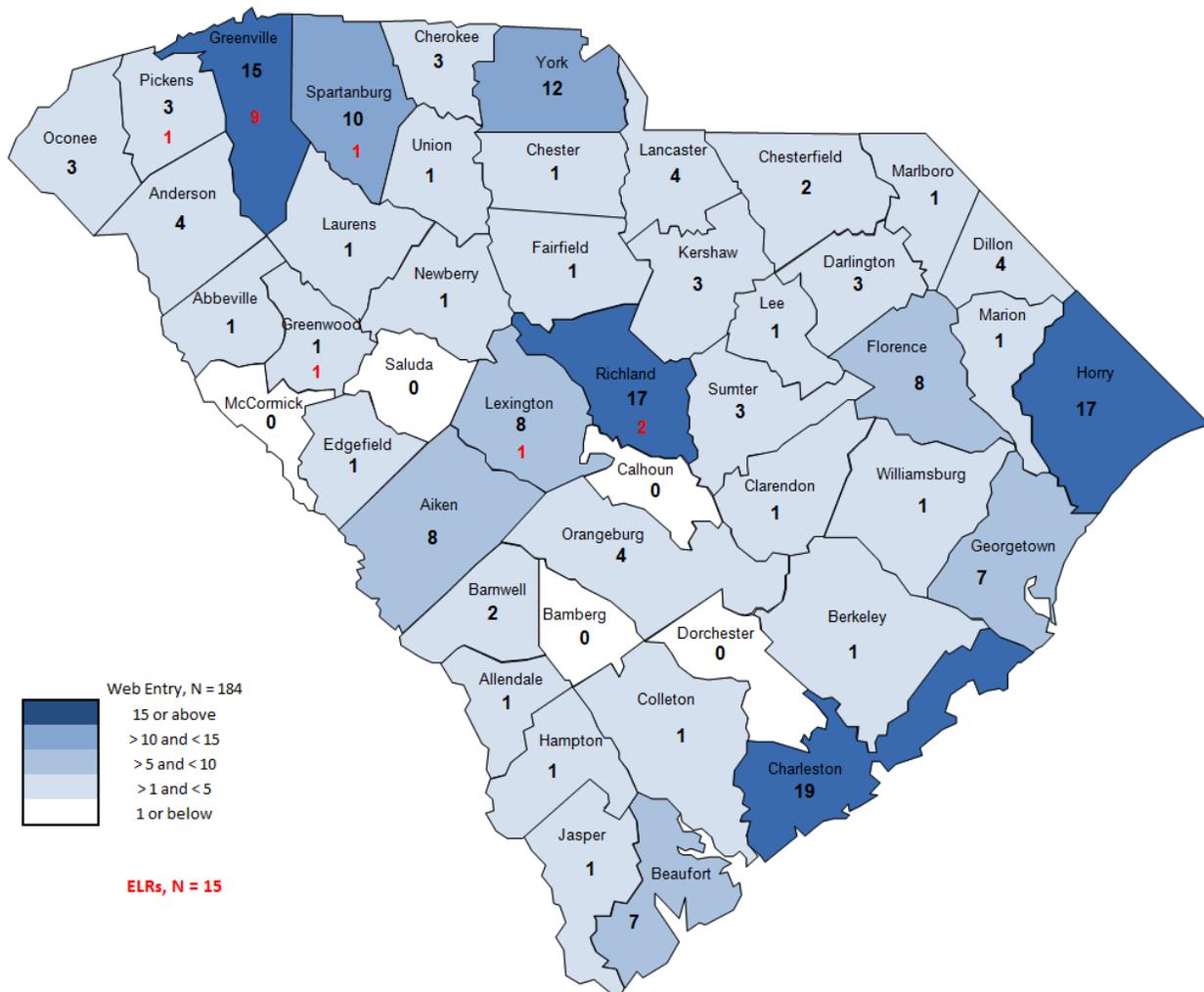
Important Information about CHESS

To schedule a deployment or find out more information about electronic reporting of SC 2011 Reportable Diseases/Conditions, please contact Ann W. Bell at 1-800-917-2093 or bellaw@dhec.sc.gov. Also contact Ann if you or your office needs retraining.

Anytime you have problems with accessing CHESS, please call the Help Desk 1-800-917-2093. Someone is there to help you Monday – Friday 9:00am – 4:30pm, except State holidays.

CHESS Deployments

By County



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By The Numbers

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2011 Disease/Condition (as of December 7, 2011)

Disease/Condition (as of December 7, 2011)	Case Status		Total
	Confirmed	Probable	
Animal Bite - Bat (PEP Recommended)	15	0	15
Animal Bite - Cat (PEP Recommended)	4	0	4
Animal Bite - Dog (PEP Recommended)	26	0	26
Animal Bite - Fox (PEP Recommended)	3	0	3
Animal Bite - Raccoon (PEP Recommended)	13	0	13
Animal Bite - Wild (PEP Recommended)	3	0	3
Aseptic meningitis	177	1	178
Campylobacteriosis	373	14	387
Cholera	1	0	1
Creutzfeldt-Jakob Disease	0	1	1
Cryptosporidiosis	53	62	115
Dengue Fever	0	2	2
Ehrlichiosis, chaffeensis	2	1	3
Ehrlichiosis/Anaplasmosis, undetermined	0	1	1
Encephalitis, LaCrosse	0	1	1
Giardiasis	105	3	108
Group A Streptococcus, invasive	101	0	101
Group B Streptococcus, invasive	44	0	44
Haemophilus influenzae, invasive	71	0	71
Hemolytic uremic synd, postdiarrheal	3	0	3
Hepatitis	1	0	1
Hepatitis A, acute	11	0	11
Hepatitis B virus infection, Chronic	96	375	471
Hepatitis B, acute	34	0	34
Hepatitis C Virus Infection, past or present	3,258	13	3,271
Hepatitis C, acute	1	0	1
Hepatitis Delta co- or super-infection, acute	1	0	1
Hepatitis E, acute	2	0	2
Influenza, Rapid Test	45,257	0	45,257
Influenza, human isolates	492	0	492
Legionellosis	22	0	22
Listeriosis	7	0	7
Lyme disease	22	12	34
Malaria	6	0	6
Mumps	2	0	2

list continued on next page

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By The Numbers

2011 Disease/Condition (as of December 7, 2011)

Neisseria meningitidis, invasive (Mening. disease)	9	0	9
Novel Influenza A Virus Infections	7	0	7
Pertussis	71	46	117
Q fever	0	1	1
Q fever, Acute	1	0	1
Q fever, Chronic	0	1	1
Rubella	0	1	1
S. aureus, vancomycin intermediate susc (VISA)	3	0	3
Salmonellosis	1,471	10	1,481
Scombroid fish poisoning	1	0	1
Shiga toxin-producing Escherichia coli (STEC)	18	0	18
Shigellosis	55	49	104
Spotted Fever Rickettsiosis	12	22	34
Strep pneumoniae, invasive	392	0	392
Streptococcal toxic-shock syndrome	2	0	2
Tetanus	0	1	1
Toxic-shock syndrome, staphylococcal	0	3	3
Tuberculosis	95	0	95
Typhoid fever (Salmonella typhi)	1	0	1
Vancomycin-Resistant Enterococcus	1	0	1
Varicella (Chickenpox)	13	0	13
Vibrio parahaemolyticus	7	0	7
Vibrio spp., non-toxigenic, other or unspecified	2	0	2
Vibrio vulnificus infection	2	0	2
West Nile Fever	0	1	1
Yersiniosis	5	0	5