Changes to the SC List of Reportable Conditions for 2010
Chasisity Brown Springs, MSPH, Influenza Epidemiologist
Division of Acute Disease Epidemiology

As authorized by South Carolina Statute #44-20-10 and Regulation #61-20, the S.C. Department of Health and Environmental Control (DHEC) updates the list of Reportable Conditions in January of each year. Revisions to the list of reportable conditions are based on many factors, including: (1) the need for DHEC to conduct surveillance on new conditions or to increase surveillance on certain existing conditions in order to protect the health of the public and (2) changes in reporting requirements from the U.S. Centers for Disease Control and Prevention (CDC).

The following revisions have been made to the 2009 List of Reportable Conditions:

New for 2010
♦ Influenza hospitalizations (aggregate report of totals)
♦ Influenza laboratory confirmed cases by RT-PCR, DFA, and IFA
♦ Names of organisms have been added for some conditions
♦ Rabies post-exposure prophylaxis, when recommended, has been added.

Revisions to the List of Reportable Conditions
♦ Rabies (human) has been moved to immediately reportable by phone.
♦ Influenza, positive virus culture isolates has been reworded to “Influenza, lab-confirmed cases (culture, RT-PCR, DFA, IFA)”.
♦ Influenza A, avian or other novel has been updated to read “Influenza A, avian or other novel (not H1, H3, or 2009 H1N1)”.
♦ The footnote, “report weekly only total number of positive results; individual case reporting is not

Are you using 2009 H1N1 Live Attenuated Influenza Vaccine (LAIV) in your Practice?
Riyadh D. Muhammad, MD, MPH, Medical Epidemiologist
Division of Acute Disease Epidemiology

Influenza A (H1N1) 2009 vaccines first became available in South Carolina in October 2009. Then and now, much of the H1N1 vaccine supply has been the intranasal formulation, LAIV (MedImmune). Since H1N1 vaccine supplies have been increasing slowly, it is important for medical providers to administer LAIV to as many appropriate population groups as possible (Box 1). Using LAIV in your practice would allow more of your patients to be protected from influenza. Each year, influenza causes approximately 36,000 deaths in the United States1. This year, the H1N1 pandemic has led to higher than normal flu activity, with younger age groups more severely affected than is seen in typical flu seasons2.

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Changes to the SC List of Reportable Conditions for 2010

(Continued from page 1)

necessary” has been removed. A note has been added next to influenza hospitalizations and positive rapid flu tests that reads “aggregate report of totals.”

• Footnote (7) has been clarified. It now indicates that, for designated conditions, labs are requested to submit isolates, broths, and serum to the DHEC Bureau of Laboratories for confirmatory testing or genotyping.

• A new footnote has been added: (11) to indicate that, for influenza deaths and hospitalizations, only lab-confirmed should be reported; the footnote also clarifies for which tests results are reportable. The form” SC Laboratory Confirmed Influenza Hospitalizations and Death Summary Report (for Hospital Use)” should be used to submit this information to regional public health offices. See influenza reporting article, page 3 of this edition of the Epi Notes, for further details.

• A new footnote has been added: (12) to indicate that rabies post-exposure prophylaxis should be reported when recommended by a physician.

• Under "how to report", 4. HIV and AIDS, STD/HIV Surveillance Division has been changed to Division of Surveillance and Technical Support.

Revisions to the 2010 Laboratory Reporting List

• Rabies virus (human) has been moved to immediately reportable by phone

• Influenza, positive virus culture isolates has been changed (reworded) to lab-confirmed cases (culture, RT-PCR, DFA, IFA).

• Influenza A, avian or other novel has been updated to read “influenza A, avian or other novel (not H1, H3, or 2009 H1N1)”.

• The footnote, "report weekly only total number of positive results; individual case reporting is not necessary” has been removed. A note has been added next to influenza hospitalizations and positive rapid flu tests that says (aggregate report of totals).

• A new footnote has been added: (10) to indicate that, for influenza hospitalizations and deaths, only lab-confirmed cases should be reported; it clarifies for which tests results are reportable.

• Under "how to report", 4. HIV and AIDS, STD/HIV Surveillance Division has been changed to Division of Surveillance and Technical Support.

Revisions to the Disease Reporting Card

• Section has been added to include the species and date if rabies post exposure prophylaxis (PEP) is recommended

Accessing the New Forms and Posters

The above changes may be found:

• On the DHEC Web site, linked from the Bureau of Disease Control page: http://www.scdhec.gov/health/disease/index.htm,

• On the 2010 DHEC Disease Reporting Card (color is yellow for 2010), and

• On the 2010 List of Reportable Conditions poster or the 2010 List of Reportable Conditions.

Both the Disease Reporting Cards and the posters (sizes 8 by 11 inches and 12 by 24 inches) are available from the DHEC regional public health departments or from the DHEC Division of Acute Disease Epidemiology in Columbia.
The SC 2010 List of Reportable Conditions has been updated to make influenza hospitalizations reportable, to clarify which results are valid for reporting deaths and hospitalizations, and to include laboratory confirmation by RT-PCR, DFA, and IFA. On August 28, 2009, a Health Advisory was sent out informing recipients that aggregate totals of influenza hospitalizations were to be reported to DHEC (review the Health Advisory here: http://www.scdhec.gov/health/disease/han/docs/10181-DAD-08-28-09-H1N1.pdf).

Beginning in 2010, influenza hospitalizations (aggregate report of totals) have been added to the List of Reportable Conditions. Total numbers of influenza hospitalizations by age group should be reported weekly on Monday by hospitals to the regional health department using the SC laboratory confirmed influenza hospitalization and mortality summary report worksheet (this page or see http://www.scdhec.gov/health/disease/han/docs/10181-DAD-08-28-09-H1N1.pdf). Hospitals should also use this worksheet to report total numbers of influenza deaths by age group at the same time that they report hospitalizations. However, this worksheet does not take the place of name-based reporting of influenza deaths.

On the 2010 list of reportable conditions, both influenza deaths and hospitalizations are accompanied by a footnote (11) which states, “Report lab-confirmed only. Laboratory confirmation includes culture, RT-PCR, DFA, IFA, or rapid test. For deaths, confirmation also includes autopsy results consistent with influenza.”

For the 2010 list, the verbiage “influenza, positive virus culture isolates” has been updated to include additional laboratory tests. The condition is now listed as “lab-confirmed cases (culture, RT-PCR, DFA, IFA)”.

The footnote (#) for rapid tests has been removed. There is a note next to positive rapid flu tests within the text of the list that says, “aggregate report of totals”.

Influenza conditions now appear on the list as follows:

- Deaths (all ages) (11 = lab confirmed only)
- Hospitalizations (aggregate report of totals) (11 = lab confirmed only)
- Lab-confirmed cases (culture, RT-PCR, DFA, IFA)
- Positive rapid flu tests (aggregate report of totals)

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**SC laboratory confirmed influenza hospitalization and death summary report**

(For Hospital Use)

| Reporting hospital: |  
| County: |  
| Date of report: |  
| Reporting week: |  
| Contact name: |  
| Contact telephone: |  

<table>
<thead>
<tr>
<th>Number of persons hospitalized with laboratory confirmed influenza</th>
<th>Weekly numbers by age group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-4</td>
</tr>
<tr>
<td>Number of persons who died from laboratory confirmed influenza</td>
<td></td>
</tr>
</tbody>
</table>

Complete this form and fax to the Regional Health Department even if there were no influenza hospitalizations or deaths in the preceding week. The report should be sent by noon each Monday.
## South Carolina 2010 List of Reportable Conditions

**Attention: Health Care Facilities, Physicians, and Laboratories**

South Carolina Law §44-29-10 and Regulation §61-20 require reporting of conditions on this list to the local public health department.

South Carolina Law §44-53-1380 requires reporting by laboratories of all blood lead values in children under 6 years of age.

HIPAA: Federal HIPAA legislation allows disclosure of protected health information, without consent of the individual, to public health authorities for the purpose of preventing or controlling disease. (HIPAA 45 CFR §164.522)

### IMMEDIATELY REPORTABLE BY PHONE

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any outbreak, unusual disease, or cluster of cases (1)</td>
</tr>
<tr>
<td>Any potential biological, chemical or terrorist event (including exposures to toxins such as ricin)</td>
</tr>
<tr>
<td>Animal (mammal) bites</td>
</tr>
<tr>
<td>Anthrax (7) (Clostridium anthrax)</td>
</tr>
<tr>
<td>Botulism (Clostridium botulinum or botulinum toxin)</td>
</tr>
<tr>
<td>Foodborne outbreak - unusual cluster</td>
</tr>
<tr>
<td>Influenza A, avian or other novel (not H1N1, H3N2 or 2009 H1N1)</td>
</tr>
<tr>
<td>Measles (rubella)</td>
</tr>
<tr>
<td>Meningococcal disease (7) (9)</td>
</tr>
<tr>
<td>Plague (7) (Yersinia pestis)</td>
</tr>
<tr>
<td>Polioviruses, Paralytic and Nonparalytic</td>
</tr>
<tr>
<td>Rabies (human)</td>
</tr>
<tr>
<td>SARS - Severe Acute Respiratory Syndrome (7)</td>
</tr>
<tr>
<td>Smallpox (Varivox)</td>
</tr>
<tr>
<td>Viral Hemorrhagic Fever (Ebola, Lassa, Marburg Viruses)</td>
</tr>
</tbody>
</table>

### REPORT WITHIN 7 DAYS

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS (2)</td>
</tr>
<tr>
<td>Campylobacteriosis</td>
</tr>
<tr>
<td>Cholera (Vibrio cholerae)</td>
</tr>
<tr>
<td>Chlamydia trachomatis genital site (1)</td>
</tr>
<tr>
<td>Creutzfeldt-Jakob Disease (Age &lt; 65 years)</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
</tr>
<tr>
<td>Cyclosporiasis</td>
</tr>
<tr>
<td>Ehrlichiosis (Anaplasmosis. Ehrlichia species, Anaplasma phagocytophilum)</td>
</tr>
<tr>
<td>Giardia</td>
</tr>
<tr>
<td>Gonorrhea</td>
</tr>
<tr>
<td>Hepatitis B, chronic</td>
</tr>
<tr>
<td>Hepatitis B Surface Antigen + (HBsAg +) with each pregnancy</td>
</tr>
<tr>
<td>Hepatitis C, D, E</td>
</tr>
<tr>
<td>HIV-1 or HIV-2 infection (2)</td>
</tr>
<tr>
<td>HIV CD4 co-receptor (1)</td>
</tr>
<tr>
<td>HIV CD4 T-lymphocyte count/percentage - all results (L) (2)</td>
</tr>
<tr>
<td>HIV HLA-B5701 (L)</td>
</tr>
<tr>
<td>HIV subtype, genotype, and phenotype (L)</td>
</tr>
<tr>
<td>HIV viral load - all results (L) (2)</td>
</tr>
<tr>
<td>Influenza</td>
</tr>
<tr>
<td>• Deaths (all ages) (11)</td>
</tr>
<tr>
<td>• Hospitalizations (aggregate report of totals) (11)</td>
</tr>
<tr>
<td>• Lab-confirmed cases (culture, RT-PCR, DFA, IFA) (11)</td>
</tr>
<tr>
<td>• Positive rapid flu tests (aggregate report of totals) (11)</td>
</tr>
<tr>
<td>• Lead poisoning (elevated blood lead levels, all ages) (5)</td>
</tr>
<tr>
<td>• Lead tests, all ages (&lt;5) (L)</td>
</tr>
<tr>
<td>• Legionellosis (7)</td>
</tr>
<tr>
<td>• Leprosy (Hansen's Disease)</td>
</tr>
<tr>
<td>• Leptospirosis</td>
</tr>
<tr>
<td>• Listeriosis (7)</td>
</tr>
<tr>
<td>• Lyme disease (Borrelia burgdorferi)</td>
</tr>
<tr>
<td>• Lymphogranuloma venereum</td>
</tr>
<tr>
<td>• Malaria (Plasmodium species)</td>
</tr>
<tr>
<td>• Meningitis, acute (2)</td>
</tr>
<tr>
<td>• Meningitis, acute (2) (as confirmed by lab)</td>
</tr>
<tr>
<td>• Meningitis, acute (2) (as confirmed by lab)</td>
</tr>
<tr>
<td>• Meningitis, meningococcal (7)</td>
</tr>
<tr>
<td>• Mumps</td>
</tr>
<tr>
<td>• Pertussis</td>
</tr>
<tr>
<td>• Q fever (Coxella burneti)</td>
</tr>
<tr>
<td>• Rabies (Bacillus pestis)</td>
</tr>
<tr>
<td>• Staphylococcus aureus, vancomycin-resistant or intermediate (VRSA/VISA) (7)</td>
</tr>
<tr>
<td>• Syphilis, congenital</td>
</tr>
<tr>
<td>• Syphilis, primary or secondary (lesion or rash)</td>
</tr>
<tr>
<td>• Trichinosis</td>
</tr>
<tr>
<td>• Tuberculosis (7)</td>
</tr>
<tr>
<td>• Typhus fever (Salmonella typhi) (7)</td>
</tr>
<tr>
<td>• Typhus, epidemic (Rickettsia prowazekii)</td>
</tr>
<tr>
<td>• Viral, all types, Viral: chickens (O1 and O139) (7)</td>
</tr>
<tr>
<td>• Yellow Fever (Flavivirus)</td>
</tr>
</tbody>
</table>

### URGENTLY REPORTABLE WITHIN 24 hours by phone

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arboviral Neuroinvasive &amp; Non-Neuroinvasive Disease (acute infection, acute flaccid paralysis, or atypical Guillain-Barre Syndrome), Eastern Equine Encephalitis, LaCrosse, St Louis Encephalitis, West Nile Virus (7)</td>
</tr>
</tbody>
</table>

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1. Only labs required to report.
2. Outbreak: An excess number of cases or outbreaks over the expected occurrence of disease within a geographic area or population group.
3. Report HIV or AIDS when serom, urine, or oral fluid specimen is positive for: (a) confirmatory test (e.g., Western Blot), or (b) a HIV diagnosis test (e.g., PCR, rapid test, or viral load) or (c) clinical diagnosis of a case of HIV or AIDS. All positive rapid HIV test results must be reported to DHSS. All HIV viral load and CD4 test results must be reported by labs regardless of results.
4. Antimicrobial resistance organisms: resistant pneumococcal - MIC ≥ 2 µg/ml of penicillin G (or Quinolone dose zone ≥ 8 mm) or resistance to any single drug accepted as effective therapy. The definition of resistance may differ between laboratories by two methods used to determine susceptibility. Reports should specify the site from which the isolate was obtained and the drug susceptibility profile.
5. Invasive disease = isolated from normally sterile site: blood, bone, CSF, joint, periarticular, peritoneal, or pleural fluid; protected bronchial sampling or from lung aspirate/biopsy; necrotizing fasciitis, and cellulitis only if culture from a tissue biopsy. Always specify site of isolate.
6. Report serom, urine, or oral fluid specimen is positive for: (a) confirmatory test (e.g., Western Blot), or (b) a HIV diagnosis test (e.g., PCR, rapid test, or viral load) or (c) clinical diagnosis of a case of HIV or AIDS. All positive rapid HIV test results must be reported to DHSS. All HIV viral load and CD4 test results must be reported by labs regardless of results.
7. Antimicrobial resistance organisms: resistant pneumococcal - MIC ≥ 2 µg/ml of penicillin G (or Quinolone dose zone ≥ 8 mm) or resistance to any single drug accepted as effective therapy. The definition of resistance may differ between laboratories by two methods used to determine susceptibility. Reports should specify the site from which the isolate was obtained and the drug susceptibility profile.
8. Invasive disease = isolated from normally sterile site: blood, bone, CSF, joint, periarticular, peritoneal, or pleural fluid; protected bronchial sampling or from lung aspirate/biopsy; necrotizing fasciitis, and cellulitis only if culture from a tissue biopsy. Always specify site of isolate.
9. Failure to submit test results to the DHSS Bureau of Laboratories for confirmatory testing or genus.
10. Acute meningitis, sepsis, fever, CSF pleocytosis, sterile culture. Consult DHSS in outbreaks to submit specimens to lab for virus identification.
11. Report any new or unusual test results or test results that do not meet the criteria for reportable disease.
12. All tests and confirmatory tests. Consult DHSS in outbreaks to submit specimens to lab for virus identification.
13. Failure to submit test results to the DHSS Bureau of Laboratories for confirmatory testing or genus.
### South Carolina 2010 List of Reportable Conditions

<table>
<thead>
<tr>
<th>How To Report</th>
<th>What To Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Submit reports by one of the following methods:</strong></td>
<td><strong>Patient’s name</strong></td>
</tr>
<tr>
<td>1. <strong>Immediately Reportable Conditions</strong></td>
<td><strong>Patient’s complete address, phone, date of birth, race, sex, county, social security number</strong></td>
</tr>
<tr>
<td>☐ M-F: 8:30-5 PM: Call the regional public health office. See list below.</td>
<td><strong>Physician’s name and phone number</strong></td>
</tr>
<tr>
<td>☐ Nights, weekends, and holidays: Call the regional public health office night/weekend phone / pager number (see list below), or the statewide DHEC emergency contact number (1-888-847-0902).</td>
<td><strong>Name, institution, and phone number of person reporting</strong></td>
</tr>
<tr>
<td>2. <strong>Urgently Reportable Conditions:</strong></td>
<td><strong>Disease or condition</strong></td>
</tr>
<tr>
<td>☐ Call the regional public health office within 24 hours. See list below.</td>
<td><strong>Date of diagnosis</strong></td>
</tr>
<tr>
<td>3. <strong>Conditions Reportable Within 7 Days:</strong></td>
<td><strong>Symptoms</strong></td>
</tr>
<tr>
<td>☐ Call the regional public health office, or</td>
<td><strong>Date of onset of symptoms</strong></td>
</tr>
<tr>
<td>☐ Complete the DHEC 1129 Disease Reporting Card and mail in an envelope marked confidential to the regional public health office (see list below), or</td>
<td><strong>Date of report</strong></td>
</tr>
<tr>
<td>☐ Submit an electronic morbidity report via DHEC’s web-based reporting system. To learn more, call 1-800-917-2093.</td>
<td><strong>Lab results, specimen site, collection date</strong></td>
</tr>
<tr>
<td>4. <strong>HIV, AIDS, and STDs (excluding Hepatitis):</strong> To report these conditions: call 1-800-277-0873 or (803) 898-0758; or submit electronically via DHEC’s electronic reporting system (call 1-800-917-2093 to learn more); or submit a DHEC 1129 Disease Reporting Card or appropriate CDC Case Report Form in a confidential envelope to:</td>
<td><strong>If female, pregnancy status</strong></td>
</tr>
<tr>
<td>Division of Surveillance &amp; Technical Support, Mills/Jarrett Complex Box 101106, Columbia, SC 29211.</td>
<td><strong>Status: In daycare or a food-handler</strong></td>
</tr>
</tbody>
</table>

### Regional Public Health Offices

**Mail or call reports to the Epidemiology Office in each Public Health Region.**

#### Region 1
- **Anderson, Oconee**
  - PO Box 2962
  - 220 McGee Road
  - Anderson, SC 29625
  - Phone: (864) 260-4358
  - Fax: (860) 260-5623
  - Nights / Weekends: 1-866-298-4442

- **Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda**
  - 1736 S. Main Street
  - Greenwood, SC 29646
  - Phone: (864) 942-3600
  - Fax: (864) 942-3690
  - Nights / Weekends: 1-800-420-1915

#### Region 2
- **Greenville, Pickens**
  - PO Box 2507
  - 200 University Ridge
  - Greenville, SC 29602-2507
  - Phone: (864) 282-4139
  - Fax: (864) 262-4373
  - Nights / Weekends: 1-800-993-1186

- **Cherokee, Spartanburg, Union**
  - PO Box 4217
  - 151 E. Wood Street
  - Spartanburg, SC 29305-4217
  - Phone: (864) 596-2227, x-210
  - Fax: (864) 596-3443
  - Nights / Weekends: 1-800-993-1186

#### Region 3
- **Fairfield, Lexington, Newberry, Richland**
  - 2000 Hampton Street
  - Columbia, SC 29204
  - Phone: (803) 576-2749
  - Fax: (803) 576-2939
  - Nights / Weekends: 1-888-554-9915

- **Chester, Lancaster, York**
  - PO Box 817
  - 1833 Pageland Highway
  - Lancaster, SC 29720
  - Phone: (803) 286-9948
  - Fax: (803) 286-5418
  - Nights / Weekends: 1-866-867-3886

- **Chesterfield, Darlington, Dillon, Florence, Marlboro, Marion**
  - 145 E. Cheves Street
  - Florence, SC 29506
  - Phone: (803) 661-4830
  - Fax: (843) 661-4859
  - Nights / Weekends: (843) 660-8145

- **Clarendon, Kershaw, Lee, Sumter**
  - PO Box 1628
  - 105 North Magnolia Street
  - Sumter, SC 29150
  - Phone: (803) 773-3511
  - Fax: (803) 775-9941
  - Nights/Weekends: 1-877-831-4647

- ** Bamberg, Calhoun, Orangeburg**
  - PO Box 1126
  - 1550 Carolina Avenue
  - Orangeburg, SC 29116
  - Phone: (803) 533-7199
  - Fax: (803) 533-7134
  - Nights / Weekends: 1-800-614-1519

- **Aiken, Allendale, Barnwell**
  - 1680 Richland Avenue W., Suite 40
  - Aiken, SC 29801
  - Phone: (803) 642-1618
  - Fax: (803) 643-8386
  - Nights / Weekends: 1-800-614-1519

#### Region 4
- **Georgetown, Horry, Williamsburg**
  - 1931 Industrial Park Road
  - Conway, SC 29526-5482
  - Phone: (843) 915-8804
  - Fax: (843) 365-3153
  - Nights / Weekends: (843) 381-6710

#### Region 5
- **Berkeley, Charleston, Dorchester**
  - 4050 Bridge View Drive, Suite 600
  - N. Charleston, SC 29405
  - Phone: (843) 953-0060
  - Fax: (843) 953-0051
  - Nights / Weekends: (843) 219-8470

#### Region 6
- **Beaufort, Colleton, Hampton, Jasper**
  - 219 S. Lamacks Street
  - Walterboro, SC 29488
  - Phone: (843) 525-5910
  - Fax: (843) 549-6845
  - Nights / Weekends: 1-843-441-1091

#### Region 7
- **DHEC Bureau of Disease Control**
  - Division of Acute Disease Epidemiology
  - 1751 Calhoun Street
  - Box 101106
  - Columbia, SC 29211
  - Phone: (803) 898-0861
  - Fax: (803) 898-0897
  - Nights / Weekends: 1-888-847-0902

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South Carolina Department of Health and Environmental Control
Changes to the SC DHEC Disease Reporting Card for 2010

2010 SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL DISEASE REPORTING CARD

Disease reporting is required by SC Code of Laws Section 44-29-10, 44-32-1300, 44-1-110, and 44-1-140 and Regulation 61:20. See other side for list of reportable diseases. Federal HIPAA legislation allows disclosure of protected health information, without consent of the individual, to public health authorities for the purpose of preventing or controlling disease. (45 CFR §164.512)

Patient Name
Date of Birth
Patient Phone Numbers
Race
Asian
Black
White
Am Ind
Pac Isl
Hispanic or Latino
Not Hispanic or Latino
Ethnicity
Un
Male
Female
Sex
If Female, Pregnant?
Yes
No
Unknown
County
For Rabies PEP
Species:
Date PEP Recommended:
For STD Reporting
Treated:
Yes
No
Unknown
 Patient Status
In Childcare
Food Handler
Unknown
Disease (include stage, if appropriate)
Date of Diagnosis/Bite
If Lyme or RMSF, Rash?
Yes
No
Unknown
Laboratory Results
Date
Hepatitis A Results
Hepatitis B Results
Hepatitis C Results
Anti-HAV
Anti-HBs
Hepatitis C Virus (HCV)
Viral Hepatitis
Hepatitis B surface antigen (HBsAg)
Hepatitis B core antigen (HBCAg)
Hepatitis B core antibody (anti-HBc)
Date
Specimen Source (blood, stool, etc.)
ALT
AST
Diagnosis
Yes
No

Rabies PEP – If rabies post-exposure prophylaxis (PEP) was recommended following a bite, enter the species of animal and the date that PEP was recommended.

Reported by attending physician/designee and laboratory except where lab only (L) reporting is indicated.

Reported IMMEDIATELY By Phone

Any outbreak, unusual disease, or cluster of cases (L)
Any potential biological, chemical or terrorist event (including exposures to toxins such as ricin)
Animal (mammal) bites
Anthrax (7)
Botulism
Foodborne outbreak – unusual cluster
Influenza A - avian or novel (not H1N1, H3, or 2009 H1N1)
Measles (Rubella)
Meningococcal disease (4) (7) (8)
Plague (7)
Polioviruses, Paralytic and Nonparalytic
SARS, Severe Acute Respiratory Syndrome
Smallpox
Viral Hemorrhagic Fever

Cholera
Dengue
E. coli, Shigella, Campylobacter
Enterohemorrhagic E. coli
Hantavirus
Hemolytic uremic syndrome
Hemorrhagic fever
Hepatitis A, acute
Hepatitis A, chronic
Hepatitis B, surface antigen + (HBsAg) + each pregnancy
Hepatitis C
Legionnaires disease
Legionella (L)
Listeriosis
Listeria (L)
Lymphocytic Leukemia
Malaria
Meningococcal meningitis
Mumps
Mumps (L)
Norovirus
Poliovirus
Polio (L)
Rabies
Rabies (L)
Rubella
Rubella (L)
Syphilis
Syphilis (L)
Tetanus
Tuberculosis
Tuberculosis (L)
Typhoid fever
Typhoid fever (L)
Varicella
Varicella (L)

Urgently Reportable Within 24 Hours By Phone

AIDS (L)
Anthrax
Botulism
tBorna disease
Cholera
Cholera hemorrhagic gastroenteritis (L)
Clostridium difficile (CDI) (L)
Clostridium tetani (tetanus) (L)
Coccidiosis
Cyclosporiasis
Cryptosporidiosis
Cytomegalovirus disease
Cytomegalovirus (CMV) (L)
Encephalitis
Epilepsy
Escherichia coli (E. coli) (L)
Foodborne Illness
Gastroenteritis
Hantavirus
Hepatitis A, acute
Hepatitis A, chronic
Hepatitis B, surface antigen (HBsAg) + each pregnancy
Hepatitis C
Hepatitis D, D/E
Legionnaire's disease
Legionnaire's (L)
Lyme disease
Lyme (L)
Meningococcal disease
Mumps
Mumps (L)
Norovirus
Poliovirus
Polio (L)
Rabies
Rabies (L)
Rubella
Rubella (L)
Syphilis
Syphilis (L)
Tetanus
Tuberculosis
Tuberculosis (L)
Typhoid fever
Typhoid fever (L)
Varicella
Varicella (L)

Report Within 7 Days

AIDS (L)
Anthrax
Botulism
Clostridium difficile (CDI) (L)
Cryptosporidiosis
E. coli, Shigella, Campylobacter
Cyclosporiasis
Cytomegalovirus disease
Cytomegalovirus (CMV) (L)
Encephalitis
Epilepsy
Escherichia coli (E. coli) (L)
Foodborne Illness
Gastroenteritis
Hantavirus
Hepatitis A, acute
Hepatitis A, chronic
Hepatitis B, surface antigen (HBsAg) + each pregnancy
Hepatitis C
Hepatitis D, D/E
Legionnaire’s disease
Legionnaire’s (L)
Lyme disease
Lyme (L)
Meningococcal disease
Mumps
Mumps (L)
Norovirus
Poliovirus
Polio (L)
Rabies
Rabies (L)
Rubella
Rubella (L)
Syphilis
Syphilis (L)
Tetanus
Tuberculosis
Tuberculosis (L)
Typhoid fever
Typhoid fever (L)
Varicella
Varicella (L)

New Reportable Condition: Rabies post-exposure prophylaxis (PEP) recommended (12). Footnote 12 reads: Rabies post exposure prophylaxis should be reported when a physician recommends it.
**Question**: What is known about effectiveness of vaccines against the current pandemic H1N1 influenza strain, and more generally, what is the effectiveness of influenza vaccines and what kind of protection can society really expect from them?

**Answer**: Issues relating to vaccine effectiveness are more commonly discussed in specialized epidemiology journals and the like. Nonetheless, because of the attention focused on pandemic H1N1 influenza since it emerged last April, there has been unusual, though quite natural, interest this year relating to the "effectiveness" of influenza vaccines. In reply to your question, we therefore present here:

i) a short introduction to vaccine effectiveness calculations;
ii) examples of factors that can affect influenza vaccine effectiveness; and
iii) brief perspectives regarding the benefits of influenza vaccination for individual vaccinees as well as for society.

1. **Calculating Vaccine Effectiveness**. Both the scientific literature and the lay press speak about vaccine effectiveness (VE) by means of numbers, usually expressed as a percent. Thus, a basic question about effectiveness might ask: "What does it actually mean when we say a vaccine is 75% (or 85% or even 95%) effective?" Someone considering this question for the first time might propose as a first reply something like, "That means the vaccine works 75% of the time." A somewhat more sophisticated answer might be something along these lines: "The vaccine can reduce the risk of getting influenza by 75%," and this wording could certainly serve as a useful explanation for patients. Both of these intuitive answers are on the right track in an informal way, but we will present here the more formal way in which VE is typically quantified in epidemiological studies.

Many standard references\(^1,2\) express VE through the following formula:

\[
VE = 1 - \frac{ARV}{ARU}
\]

Where:

- \(ARU\) = attack rate in the unvaccinated
- \(ARV\) = attack rate in the vaccinated

Actually (see the worked example below) this calculation of VE will yield a decimal fraction such as, "0.85" which would be fine, except that since VE is more commonly expressed as a percent it is customary to indicate that the result shown above is to be multiplied by 100 so that VE will be expressed as a percent -- in this case 85% -- rather than as a decimal. Thus, to convert the decimal to a percent, we add to the formula shown above a final multiplication by 100 so that we have:

\[
VE = 1 - \frac{ARV}{ARU} \times 100
\]

Either way, this formula is helpful conceptually because it shows that a formal calculation of VE requires information about the occurrence of disease not only among vaccinated persons, but also among the unvaccinated!

The way the formula works in practice can best be explained by working through an illustrative example, which summarizes influenza season events for a hypothetical cohort of 2000 persons, where:

| V+ indicates vaccinated persons | D+ indicates disease (influenza) occurred |
| V- indicates unvaccinated persons | D- indicates disease (influenza) did not occur |

For example, starting with:

| V+ | D+ | D- |
| 50 | | 1000 |

This shows that 50 of the 1000 vaccinated persons in the cohort developed influenza during the flu season. The "attack rate" among these vaccinated (ARV) individuals is calculated as follows:

\[
ARV = \frac{50}{1000} = 0.05
\]

We then consider what happened to the other 1000 persons in the cohort who did not receive influenza vaccine.

| V- | |
| 200 | 1000 |

This shows that 200 of the 1000 unvaccinated persons in the cohort developed influenza during the flu season. The "attack rate" among the unvaccinated (ARV) can then also be calculated:

(Continued on page 8)
Ask Epi: Perspectives on Efficacy of Influenza Vaccines

(Continued from page 7)

\[
ARV = \frac{200}{1000} = 0.20
\]

Then, for conceptual clarity, and to use the typical layout commonly used in many epidemiologic studies, we can summarize the experience of both the vaccinated and the unvaccinated in a 2x2 table:

<table>
<thead>
<tr>
<th></th>
<th>D+</th>
<th>D-</th>
</tr>
</thead>
<tbody>
<tr>
<td>V+</td>
<td>50</td>
<td>1000</td>
</tr>
<tr>
<td>V-</td>
<td>200</td>
<td>1000</td>
</tr>
</tbody>
</table>

ARV = 0.05
ARU = 0.20

Then, applying the VE formula:

\[
VE = 1 - \frac{ARV}{ARU} \times 100 = (1 - \frac{0.05}{0.20}) \times 100 = (1 - 0.25) \times 100 = 0.75 \times 100 = 75\%
\]

Note: In this example, the calculation did not require use of the numbers in two cells of the right hand column of the 2x2 table. These numbers would easily have been available by subtraction (e.g., 1000-50 = 950), but are not shown here because they are not used in the VE calculation.

This result can be interpreted several ways. First, we can see that the vaccinated, though they were not totally protected from influenza during the flu season, did have a much lower risk of developing influenza than the unvaccinated. In prose, the numerical line of reasoning might run as follows: “If the group of 1000 vaccinees had NOT received vaccine, their attack rate would also have been 0.20 (since their risk would then have been identical to that of the unvaccinated), and, accordingly the group would thus have had 200 cases. But, through the benefits of vaccine, the group only experienced 50 cases; and this reduction, from 200 to 50 cases, indeed corresponds to a reduction of 75%.

Alternatively, this same reduction in cases due to vaccination could be displayed graphically (see figure opposite).

The numerical reasoning and the graphical display are of course equivalent, and just offer complementary explanations of the concept of vaccine effectiveness. Either way, the main point is that vaccine effectiveness is studied and calculated not based solely on what happens to vaccinated persons, but also based on what happens to unvaccinated persons in the same population. In effect then, the concept of VE provides a way to compare the difference between what happens to the two groups. Though VE studies actually come in several flavors, even the more “sophisticated” vaccine effectiveness study designs can be understood as variants of the basic approach outlined above.

Note: In observational studies, vaccine effectiveness is typically assessed through either prospective or retrospective cohort studies using very much the type of reasoning and calculation shown above, or through case-control studies, though other variant study designs such as the “screening method” or “case-cohort” methods are also used. In experimental settings, VE (in that context referred to as “vaccine effectiveness”) is assessed through randomized-control trials (RCTs).

2. Effectiveness of Influenza Vaccines.

The current USPHS Advisory Committee on Immunization Practice (ACIP) statement on seasonal influenza vaccines contains four pages of summary information about influenza VE trials conducted in recent decades in which VE has been found to range from 20% to 91% (mean of values listed: 60%). At first glance, such a broad range of VE estimates is disconcerting. However, on closer reading, it turns out that much of this variability (see Table 1) depends on a series of factors which, when considered individually or in combination, can quite understandably affect VE.

Thus VE would naturally be expected to be high when vaccinees were healthy young adults, when the year’s vaccine virus strains closely matched circulating virus, and where the outcome measured was laboratory confirmed influenza. On the other hand, we would reasonably expect VE to be lower when given to a group of elderly...
persons with underlying chronic and or immunologic conditions, in a year when there was a poor fit between vaccine virus and circulating strains, and where the outcome measured was occurrence of influenza-like illness (ILI) which of course may be due to viruses other than influenza.

Nonetheless, overall vaccine effectiveness in a given year will be some type of mix or average of higher and lower VEs, and it is easy to see that overall vaccine effectiveness in a population might be of the order of 70% rather than 90%+ as may be expected with certain other vaccines (e.g., measles vaccine.)

3. Potential impact of influenza vaccines. Influenza can affect a large proportion of the population in any given year, up to 10-20% or more. Therefore, even an influenza vaccine of somewhat modest VE, when applied to such a large number of potential cases, may prevent many more US deaths each year than could a vaccine against another disease such as measles, even though measles VE is in fact higher than influenza VE. Table 2 (page 10) illustrates this line of reasoning with some sample numbers and calculations and comparing the impacts of influenza and measles vaccination on mortality.

4. Summary. While it is true that the effectiveness of influenza vaccine for certain individuals (e.g., the very elderly and/or persons with certain underlying conditions / see Table 1) should not be overestimated, conversely, the potential beneficial impact of influenza vaccines for society as a whole should not be underestimated. Further, when considering these issues, the "indirect benefits" of influenza vaccine should also be considered. That is, vaccinated persons not only benefit from a reduction of their own risk of developing influenza, but as a group they will also be less likely to infect their close contacts in various settings such as work, school, and home. Reducing transmission in these settings offers beneficial impact respectively: (i) for continuity of business operations; (ii) for prevention of large-scale school absenteeism and consequent risk of school closures; and (iii) for protection of vulnerable infants.

Epidemiologic studies to evaluate formally the effectiveness of this year’s H1N1 vaccine are just now in progress and results may not be available for several weeks or months. Nonetheless, there is every reason to expect that VE for this year’s H1N1 vaccine will be similar to what has been observed for many years for routine seasonal influenza vaccines. Thus, whether viewed from the individual or from the broader societal perspective, the value of influenza vaccination remains high and needs to be strongly recommended to our patients and to the public.
### Ask Epi: Perspectives on Efficacy of Influenza Vaccines

#### Table 2: Schematic Perspective on the Value of Influenza Vaccination*

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Measles Vaccine</th>
<th>Influenza Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine effectiveness</td>
<td>1 dose: ~90%</td>
<td>~ 70% (~50-90% depending on many factors such as those shown in Table 1)</td>
</tr>
<tr>
<td></td>
<td>2 doses: ~95%</td>
<td></td>
</tr>
<tr>
<td>US Cases per year if no vaccine</td>
<td>~4,000,000 (1 birth cohort)</td>
<td>~30,000,000 (e.g., if 10% of USA population would get influenza)</td>
</tr>
<tr>
<td>Case fatality rate</td>
<td>~1/1000</td>
<td>~1/1000</td>
</tr>
<tr>
<td>Fatalities per year if no vaccine</td>
<td>~4,000</td>
<td>~40,000</td>
</tr>
<tr>
<td>Annual fatalities potentially averted with very high vaccine coverage: assuming only &quot;direct” protection</td>
<td>~3,800</td>
<td>~28,000</td>
</tr>
<tr>
<td>Annual fatalities potentially averted with high vaccine coverage: taking into account also &quot;indirect” population benefits of vaccination (&quot;herd -immunity”)</td>
<td>~4,000</td>
<td>~32,000</td>
</tr>
<tr>
<td>Purpose of vaccine from individual perspective</td>
<td>Provides high level of protection against measles</td>
<td>Provides good level of protection against influenza</td>
</tr>
<tr>
<td>Purpose of vaccination from a societal perspective</td>
<td>Key tool which (except for importations) has allowed for elimination of measles from the USA</td>
<td>Mitigation of impact of influenza: e.g., decrease in morbidity, mortality, school and work days lost, and impact on the health-care system.</td>
</tr>
</tbody>
</table>

* Numbers shown are illustrative, and especially for influenza illustrate expected orders of magnitude. For influenza, expected numbers of cases and deaths would depend on infectiousness and virulence of circulating strains, vaccine coverage, vaccine effectiveness and other factors.

(Continued from page 9)

#### References:

Beginning December 10, 2009, DHEC expanded the recommended groups for H1N1 LAIV to all healthy, non-pregnant persons ages 2 through 49 years, whether or not they are in one of the H1N1 vaccine target groups (Box 2). This will not apply to the inactivated injectable H1N1 vaccines. Please order (if you are providing the H1N1 vaccine in your practice) or recommend (if you are not providing the H1N1 vaccine in your practice) the H1N1 LAIV to the appropriate patients in your practice. If you are interested in becoming an H1N1 vaccine provider, please contact the DHEC Immunization Division at 800-277-4687 or immunize@dhec.sc.gov.

The H1N1 LAIV received full FDA approval on September 15, 2009\(^3\). **It is not experimental, it has been tested, no short cuts were made to achieve FDA approval, and it is not being used under an emergency status.** The vaccine does not contain adjuvants and is made in exactly the same way and using the same facilities as the seasonal LAIV. H1N1 LAIV is as safe as the injectable vaccine and works well in children and adults\(^1\). Common side effects of the H1N1 LAIV include runny nose, headache, sore throat, cough, and wheezing.

The H1N1 LAIV contains a live virus that has been weakened. It does not cause influenza in either vaccine recipients or the close contacts of those who have received the vaccine\(^1\). In a randomized trial, the LAIV virus was found in the nose of only 1 out of 99 children who were childcare center contacts of children vaccinated with LAIV. However, that one child had only URI symptoms and did not develop fever or influenza\(^4\).

### Box 1. Contraindications and Precautions for LAIV Administration

**LAIV is approved for use in healthy people 2-49 years of age who are not pregnant.**

The effectiveness or safety of LAIV is not known for the following groups and they **should not receive LAIV:**

- Persons who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, neurological/neuromuscular, hematological or metabolic disorders (including diabetes), immunosuppression (including immunosuppression caused by medications or by HIV)
- Children 2-4 years of age with wheezing in the past 12 months
- Children or adolescents receiving aspirin or other salicylate therapy
- Pregnant women
- People who have a severe allergy to chicken eggs or who are allergic to any LAIV components
- Persons < 2 years or those ≥50 years

**The following are precautions to receiving LAIV:**

- Guillain-Barré Syndrome (GBS) within 6 weeks following a previous dose of an influenza vaccine
- Moderate or severe illness with or without fever
- Healthcare providers and others with close contact to certain severely immunosuppressed persons \(^{A,B}\) should either not receive LAIV or avoid contact with such persons for 7 days after receiving LAIV

---

**Footnotes for Box 1:**

A. Immunosuppressed patients who require care in a protective environment (typically defined as a specialized patient-care area with a positive airflow relative to the corridor, high-efficiency particulate air filtration, and frequent air changes), e.g., patients with hematopoietic stem cell transplants.

B. Transmission of the LAIV virus from a recently vaccinated person **causing influenza** in a contact has not occurred. The reason for avoiding LAIV among healthcare providers (and other close contacts) of certain severely immunocompromised persons is the theoretical risk that the LAIV virus might be transmissible to severely immunosuppressed persons, and cause influenza.
H1N1 LAIV can be used to vaccinate healthcare providers. The only precaution to vaccinating healthcare providers with LAIV is for those who care for certain severely immunosuppressed patients who are in protective environments (Box 1, footnote A). Otherwise, H1N1 LAIV can be given to any other group of healthcare providers including those who care for pregnant women, neonatal intensive care unit patients, other groups of patients with lesser degrees of immunosuppression (e.g., persons with diabetes, persons with asthma who take corticosteroids, persons who have recently received chemotherapy or radiation but who are not being cared for in a protective environment as previously defined, or persons infected with HIV), and persons in all other groups at high risk for influenza-related complications.

DHEC encourages providers to take advantage of the available supply of H1N1 LAIV. This vaccine is safe to use for many healthcare providers and their patients and is an effective way to prevent influenza, without the pain of an injection.

Box 2: Initial Target Groups for H1N1 Vaccine Administration
ACIP recommends that programs and providers provide vaccine to all persons in the following five initial target groups as soon as vaccine is available (order of target groups does not indicate priority):
- pregnant women,
- persons who live with or provide care for infants aged <6 months (e.g., parents, siblings, and child care providers),
- health-care and emergency medical services personnel,
- children and young adults aged 6 months–24 years, and
- persons aged 25–64 years who have medical conditions that put them at higher risk for influenza-related complications.

(Continued from page 11)

References:

Recommended website:
http://www.cdc.gov/h1n1flu/vaccination/vaccine_safety_qa.htm

Recommended website:
The H1N1 vaccine is not experimental, it has been tested, no short cuts were made to achieve FDA approval, and it is not being used under an emergency status

Image Source: www.shotnurse.com
What is syndromic surveillance?
Syndromic surveillance is the systematic, ongoing collection, collation, analysis, and interpretation, in real-time, of existing health data essential for the planning, implementation, and evaluation of public health practice and emergency response. The term "syndromic" applies to surveillance using health-related data that precede a diagnosis. Analysis of these data sources may signal sufficient probability of a case or an outbreak to warrant further public health response.

There are several data sources that are used for syndromic surveillance, which may be categorized into clinical and non-clinical. Clinical data sources include emergency department patient visits, laboratory testing orders, 911 calls, and ambulance dispatch. Unlike traditional surveillance, syndromic surveillance does not use actual diagnoses. For example, symptoms (patient chief complaints) are used for clinical data and presumed symptoms for some non-clinical data (e.g., "sick" or "not sick" for absentee data).

The purpose of syndromic surveillance is to detect outbreaks, whether natural or man-made, earlier. This earlier detection allows for a timelier public health response than would be possible with traditional surveillance. Syndromic surveillance also provides situational awareness during large-scale outbreaks of public health significance. Syndromic surveillance can also be used to monitor sentinel events that may fall under the radar of more traditional surveillance systems.

South Carolina Aberration Alerting Network (SCAAN)
The South Carolina Aberration Alerting Network (SCAAN) is a unified syndromic surveillance system for South Carolina that includes data streams from SC hospital emergency department chief-complaint and admissions data, Poison Control Center call data, over-the-counter (OTC) pharmaceutical sales surveillance, and the Center for Disease Control and Prevention (CDC) BioSense biosurveillance system.

For this issue of Epi Notes, there will be a focus on the SC hospital emergency department syndromic surveillance. More information on the other segments within the SCAAN system will be available in future issues of Epi-Notes.

SC Hospital Emergency Department Syndromic Surveillance
Data Acquisition
Syndromic surveillance begins with the acquisition of chief complaint data from participating emergency departments. Currently, the Medical University of South Carolina (MUSC), Greenville Hospital System, Self-Regional Healthcare, Roper, St. Francis, and Kershaw Health are sending daily feeds of their emergency department patient chief complaints to DHEC. Several other hospital facilities, such as Laurens County Health Care System, Conway Medical Center, Grand Strand Regional Medical Center, AnMed, Oconee Medical Center, and McLeod Health Systems are all close to “going live” with the SCAAN system.

These daily patient chief complaints are gathered from existing patient information systems and are electronically transferred via a simple and secure file interface to a central state server. This operation generally requires no personnel time after the process for generating and transferring the data file has been established. The daily feeds are received the following morning by DHEC and contain information from the previous day. The chief complaint data are then classified into pre-determined syndromes. Hospital-specific syndromic reports (pdf format) are sent back daily to each hospital and their infection preventionists.

Data Analyses & Interpretation
Early Aberration Reporting System (EARS) methods were developed by the CDC to analyze real-time public health surveillance data without needing historical data. EARS uses a running baseline consisting of the average number of counts for a syndrome from a previous 7-day period and compares current syndrome counts with that previous average; it performs analysis via cumulative sum (CUSUM) methods. For more information on EARS analysis, go to http://www.bt.cdc.gov/surveillance/ears/

Following is a graphical output from the EARS software of the "Respiratory" syndrome category using data from one of our current healthcare providers. During this one-month period, aberrations from the running CUSUM indicated days requiring further investigation. Some examples of patient chief complaints that were included

(Continued on page 14)
in developing the “Respiratory” syndrome category are “difficulty breathing”, “chest cold”, “pneumonia”, “respiratory difficulty”, “gasping”, “pulmonary”, etc. The C1C2C3 flag (diamond-shaped) indicated a sharp increase in the number of emergency room visits due to a respiratory-like illness for that hospital on that day.

Syndromic surveillance occurs prior to diagnosis, therefore, a close working relationship between the data provider and public health for interpretation of aberrations is required. Based upon both local “domain knowledge” (i.e., the healthcare facility) and broader public health awareness of broader issues (i.e., Regional or statewide outbreaks, increased national surveillance) collaboration is paramount.

For example, if multiple aberrations (“flags”) occur on multiple days, Public Health would contact the infection preventionist of the healthcare facility providing the data. Together they would work to determine, via casual inquiries or formal investigations, if these flags indicate a real event or a false-positive signal. With additional experience and modifications, the number of false-positive flags will decrease. However, the close working relationship between the healthcare system and public health will always need to be maintained. These relationships are the key to surveillance, both traditional and syndromic.

As with any surveillance system, one must be cognizant of limitations. Questions regarding completeness of data, representativeness, flexibility, etc. are factors to be considered with any surveillance system. Hospital-based chief-complaint data analysis is another “arrow in the quiver” of ways to monitor and respond to events of public health significance. In subsequent issues, we will discuss other non-traditional sources of data.

**Getting Started**

SC DHEC will provide software free of charge, and will also provide support and assistance in implementing the transfer and analysis of syndromic data. For more information regarding syndromic surveillance in South Carolina and how you can participate, please feel free to contact Himal Dhotre (dhotrehc@dhec.sc.gov) or Dan Drociuk (drociukd@dhec.sc.gov).

**Reference**

## Year-to-Date Summary of Reportable Conditions *
**January 1, 2009 to December 11, 2009**

<table>
<thead>
<tr>
<th>Reportable Condition</th>
<th>Confirmed</th>
<th>Probable</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animal Bites – PEP recommended*</td>
<td>339</td>
<td>**</td>
<td>339</td>
</tr>
<tr>
<td>Aseptic Meningitis</td>
<td>78</td>
<td>0</td>
<td>78</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Campylobacter enteriditis</td>
<td>252</td>
<td>3</td>
<td>255</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>57</td>
<td>2</td>
<td>59</td>
</tr>
<tr>
<td>Cyclosporiasis</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Dengue fever</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ehrlichiosis, chaffeensis</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Ehrlichiosis, ewingii</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Giardiasis</td>
<td>97</td>
<td>0</td>
<td>97</td>
</tr>
<tr>
<td>Haemophilius influenza, invasive</td>
<td>71</td>
<td>0</td>
<td>71</td>
</tr>
<tr>
<td>Hemolytic uremic syndrome, post-diarrheal</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis A, acute</td>
<td>58</td>
<td>0</td>
<td>58</td>
</tr>
<tr>
<td>Hepatitis B, acute</td>
<td>50</td>
<td>3</td>
<td>53</td>
</tr>
<tr>
<td>Hepatitis B, chronic</td>
<td>118</td>
<td>472</td>
<td>590</td>
</tr>
<tr>
<td>Hepatitis C, acute</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis C, chronic or past</td>
<td>3312</td>
<td>7</td>
<td>3319</td>
</tr>
<tr>
<td>Influenza, human isolates (not novel H1N1)</td>
<td>373</td>
<td>0</td>
<td>373</td>
</tr>
<tr>
<td>Influenza, Novel Influenza A Virus Infections (H1N1)</td>
<td>1913</td>
<td>23</td>
<td>1936</td>
</tr>
<tr>
<td>Legionellosis</td>
<td>14</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Listeriosis</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Lyme disease</td>
<td>17</td>
<td>14</td>
<td>31</td>
</tr>
<tr>
<td>Malaria</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Meningococcal disease (Neisseria meningitidis)</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Mumps</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Pertussis</td>
<td>210</td>
<td>21</td>
<td>231</td>
</tr>
<tr>
<td>Psittacosis</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rocky Mountain Spotted Fever</td>
<td>3</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Salmonellosis</td>
<td>1118</td>
<td>9</td>
<td>1127</td>
</tr>
<tr>
<td>Shiga toxin-producing Escherichia coli (STEC)</td>
<td>20</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>Shigellosis</td>
<td>116</td>
<td>2</td>
<td>118</td>
</tr>
<tr>
<td>Streptococcus group A, invasive disease</td>
<td>72</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td>Streptococcus group B, age &lt;90 days</td>
<td>41</td>
<td>0</td>
<td>41</td>
</tr>
<tr>
<td>Streptococcus pneumoniae, invasive</td>
<td>438</td>
<td>0</td>
<td>438</td>
</tr>
<tr>
<td>Varicella (only outbreak associated or hospitalized cases are reportable)</td>
<td>109</td>
<td>14</td>
<td>123</td>
</tr>
<tr>
<td>Vibrio infections (non-cholera)</td>
<td>12</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>West Nile Fever</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Yersiniosis</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

*To save space, several conditions with zero reported cases in 2009 were omitted from this list.

*Animal bites with PEP recommended: Bat-62; Cat-71; Dog-105; Farm Animal-19; Fox-10; Raccoon-47; Wild-10; Other-15.

**Probable cases status is not allowed for this condition.
Epi Notes
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FOR DISEASE REPORTING
For immediately reportable conditions, call your local county health department or, for after hours, call 1-888-847-0902. Routine reports may be phoned in to your local health department or mailed on a completed DHEC DISEASE REPORTING CARD (DHEC 1129.) Local county health department numbers are listed on the Official List of Reportable Conditions. For a copy of the current Official List of Reportable Conditions, call 803-898-0861 or visit www.scdhec.gov/health/disease/index.htm.


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J. Gibson, MD, MPH, Director
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