

## Rabies Vaccine and Rabies Immune Globulin Procurement Change

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After September 1, 2009, private providers will be responsible for procuring rabies biologics directly from the manufacturers, distributors or pharmacies. The South Carolina Department of Health and Environmental Control will no longer provide rabies vaccine or human rabies immune globulin for postexposure prophylaxis (PEP). DHEC will continue to provide medical consultations to practitioners in determining if rabies prophylaxis is indicated for exposed individuals. As a reminder, the South Carolina Code of Laws Section 47-5-90 requires physicians to report animal bites. Animal bites should be reported to the DHEC county health department in the county where the exposure occurred. within 24 hours of evaluation. Immediate notification of the health department allows DHEC to initiate the animal

investigation. Since not all animal exposures require PEP, unnecessary PEP can often be avoided if the animal can be located for quarantine or testing. Through medical consultations, DHEC will assist providers in determining when PEP is indicated. This rabies overview summarizes the issues to be taken under consideration in managing animal exposures.

Rabies is an acute, progressive encephalomyelitis. The case to fatality rate is the highest of any infectious disease. The virus enters peripheral nerves, travels to the central nervous system, and replicates in the brain. The virus then travels distally to innervated organs, including the salivary glands where the virus is excreted

*(Continued on page 2)*

## Changes in the 2009-2010 School and Childcare Exclusion Lists

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The School and Childcare Exclusion lists were posted in July 2009 for the 2009-2010 school year. Both lists were extensively revised based upon updated guidance from the American Academy of Pediatrics (AAP), found in the *2009 Red Book* and the AAP publication *Managing Infectious Diseases in Child Care and Schools*, both published in the spring of 2009. Both of these books provide valuable guidance to providers, schools, and childcare operators on disease control. *Managing Infectious Diseases...* also contains reproducible handout pages for parents.

The lists, which specify conditions requiring exclusion from school or licensed/registered out-of-home childcare, are found on the DHEC website: [www.scdhec.gov/health/disease/exclusion.htm](http://www.scdhec.gov/health/disease/exclusion.htm), or type "exclusion list" into the search box on the DHEC home page ([www.scdhec.gov](http://www.scdhec.gov)).

*(Continued on page 4)*

### INSIDE THIS ISSUE

Changes in Rabies PEP Procurement	Page 1
School and Childcare Exclusion	Page 1
Summertime Disease Spotlight: Salmonella	Page 4
Summer Food Safety (Patient Information)	Page 4
HIDA: Hospital Infection Disclosure Act Update	Page 6
Flu Season Update on "Seasonal Flu"	Page 9
Year-to-Date Reportable Diseases	Page 11

## Changes in Rabies Biologicals Procurement

(Continued from page 1)

in saliva. The rabies virus is most commonly transmitted by the bite of a rabid animal. Non-bite exposures can rarely cause rabies. Examples include a scratch from a rabid animal, if saliva could have been introduced into the wound, or contamination of a mucous membrane with the by saliva of from a rabid animal. Contacts with blood, urine, feces, etc. are not considered exposure. The incubation period for rabies is usually four to six weeks but the range is from as little as seven days to over six years. The time from exposure to onset of illness depends on the severity, and thus the inoculum of virus into the wound, and the proximity of viral entry to the central nervous system. Appropriate wound care combined with rabies PEP is almost universally effective in preventing infection.

Human rabies is uncommon in the United States. There are normally fewer than a half dozen cases per year, yet there are between 20,000 – 40,000 human exposures per year and approximately 7,000 – 10,000 animal rabies cases are diagnosed each year. Since dog rabies transmission has been eliminated in the United States the typical rabies hosts are raccoons, skunks, foxes and bats. In South Carolina there have been no cases of **human rabies in over 50 years. Approximately 12,000 animal bites are reported each year in the state. About 200 animals test positive for rabies each year in our state; about 90% being are wild animals and 10 % domestic animals.**

Administration of rabies PEP is a medical urgency, not a medical emergency. The Advisory Committee on Immunization Practices<sup>1</sup> advises clinicians to seek assistance from public health officials for evaluating exposures or determining the need for PEP. Public health officials have expertise in managing potential rabies exposures and public health consultation is known to reduce unnecessary rabies PEP. DHEC medical consultants will assist in determining if PEP is indicated using the following criteria:

- Whether the exposing animal is available for observation or rabies testing
- The type of exposure and the severity and location of the wound. For example, head and neck exposures are more urgent for evaluating the need for PEP
- The epidemiology of animal rabies in the area and the animal species involved

- The circumstances of the exposure incident and whether provocation was involved.
- Whether a non-bite exposure has occurred.
- A risk assessment weighing potential adverse consequences associated with PEP versus the actual risk for the person acquiring rabies.

Upon determining that rabies PEP is indicated, the treating physician should order the products directly from a manufacturer, distributor, or pharmacy. **DHEC will provide guidance to private providers in ordering rabies PEP biologics if needed.** Treating physicians should follow a similar process of billing third party insurers for this service as with claims submissions for other medical treatments/services. There are patient assistance programs for eligible individuals lacking health insurance. For SC Medicaid fee-for-service recipients, rabies PEP biologics are covered as an allowed physician-injectable product through Medicaid Pharmacy Services if the products are obtained from a Medicaid-enrolled pharmacy provider, or as a medical benefit. For Medicaid Managed Care Organizations rabies biologics will be covered as a medical benefit. For plans administered through Blue Cross Blue Shield, rabies PEP biologics are covered as a therapeutic intervention for an identified diagnosis, not as an immunization.

For details about rabies PEP, contact your local county health department or the DHEC Division of Acute Disease Epidemiology at 803-898-0861.

Educational resources are available for practitioners on the DHEC Web site at <http://www.scdhec.gov/> Type rabies into the search box, or read the provider guide here: [http://www.scdhec.gov/health/envhlth/general\\_sanitation/docs/Rabies-PEP-Provider-Guidance.pdf](http://www.scdhec.gov/health/envhlth/general_sanitation/docs/Rabies-PEP-Provider-Guidance.pdf)

The provider information found on the DHEC Web site provides information about reporting animal exposures, medical consultation with DHEC to guide PEP decisions, the **rabies PEP schedule, manufacturers and distributors of rabies biologics, patient assistance resources for indigents, and the Rabies Vaccine Information Sheet for Patients.**

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<sup>1</sup>Centers for Disease Control and Prevention. Human Rabies Prevention – United States, 2008. Recommendations of the Advisory Committee on Immunization Practices. MMWR 2008;57(No. RR-3)

## Summertime Salmonella

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Annually, local physicians, laboratories and other partners report approximately 1200 cases of salmonellosis to SC DHEC. CDC estimates that approximately 40,000 cases of salmonellosis are reported annually in the United States. Because many milder cases are not diagnosed or reported, the actual number of infections may be 30 or more times greater. Salmonella live in the intestinal tracts of humans and other animals, including birds and reptiles. Salmonella are usually transmitted to humans by eating foods contaminated with animal feces. Contaminated foods are often of animal origin, such as poultry, beef, milk, or eggs. However, other foods may also become contaminated. The unwashed hands of an infected food handler may also contaminate food.

DHEC staff monitor trends of Salmonella reports for potential outbreaks of illness. When providers report a case of Salmonella to DHEC a number of processes are set into action:

- Surveillance data is evaluated for an increase in reports in given population or geographic area
- An epidemiological interview may be conducted to

help identify potential sources of illness.

- DHEC Bureau of Laboratories serotypes all Salmonella isolates submitted to DHEC.
- DNA fingerprinting (Pulsed Field Gel Electrophoresis) is completed for the majority of isolates submitted to DHEC.

Local providers and laboratories are the link between individual presenting patients and public health responses. Without reports of illness from local partners, DHEC would not be able to identify and investigate outbreaks of public health significance. South Carolina local disease reporters have provided key information in numerous outbreak investigations and in turn, critical product recalls.

REPORTING: Salmonellosis is reportable within 7 days in South Carolina.

Please see the 2008 List of Reportable Conditions for more information: [http://www.scdhec.gov/health/disease/docs/reportable\\_conditions.pdf](http://www.scdhec.gov/health/disease/docs/reportable_conditions.pdf)

### Summer Food Safety: Safe Grilling Practices

Grilling and picnicking often go hand-in-hand. And just as with cooking indoors, there are important guidelines that should be followed to ensure that your **grilled food** reaches the table **safely**.

**Marinate safely.** Marinate foods in the refrigerator - *never* on the kitchen counter or outdoors. In addition, if you plan to use some of the marinade as a sauce on the cooked food, *reserve a portion separately* before adding the raw meat, poultry, or seafood. **Don't reuse marinade.**

**Cook immediately after "partial cooking."** If you partially cook food to reduce grilling time, do so *immediately before* the food goes on the hot grill.

**Cook food thoroughly.** When it's time to cook the food, have your food thermometer ready. Always use it to be sure your food is cooked thoroughly.

**Keep "ready" food hot.** Grilled food can be kept hot until served by moving it to the side of the grill rack, just away from the coals. This keeps it hot but prevents overcooking.

**Don't reuse platters or utensils.** Using the same platter or utensils that previously held raw meat, poultry, or seafood allows bacteria from the raw food's juices to spread to the cooked food. Instead, have a clean platter and utensils ready at grill-side to serve your food.

Source: <http://www.cfsan.fda.gov/~dms/fssummer.html#s3>

## Changes in the School and Childcare Exclusion Lists

(Continued from page 1)

The AAP-recommended exclusion criteria for several conditions have changed. These changes, which do not preclude the ability of schools, childcare facilities, or healthcare providers to use exclusion as a disease control strategy, are listed below. In all of the criteria, as assumption is made that the affected child has only the condition specified, and not any other signs of severe illness (fever, extreme lethargy, rapidly spreading rash, etc – see list posted on DHEC's website), which require exclusion until the child can be shown to not be a health risk to others.

The list of "general symptoms" for which children should be excluded until resolved or until the child is determined not to be a health risk for others, have been expanded to include:

- rapidly spreading rash,
- draining sores that cannot be covered,
- severe vomiting and diarrhea or vomiting blood, and
- when a student poses a risk of spreading a harmful disease to others in the school setting.

For all excludable conditions, it is recognized that physical education and sports governing bodies may impose stricter exclusion criteria. Local education agencies may also impose exclusion criteria more stringent than those mandated by DHEC.

DHEC may change currently posted exclusion criteria in the event of an outbreak of illness, especially if the school setting is felt to be associated with transmission, or if a particular student is felt to be contributing to the spread of illness in the school.

### Conditions with Changed or Additional Exclusion Criteria

#### Conjunctivitis

- "Pinkeye", whether presumed viral or bacterial, is no longer an excludable condition for students in 6<sup>th</sup> grade or higher who are not considered medically fragile, unless there is a recommendation for exclusion for the child's healthcare
- Elementary aged students and children in childcare are still excluded immediately for symptoms consistent with bacterial conjunctivitis.

#### Diarrhea

- Exclusion criteria for diarrheal episodes now include consideration of the caregiver or teacher's

ability to maintain sanitary conditions in the classroom setting.

- Criteria for medically fragile students and children in childcare also address issues associated with caring for diapered children with diarrhea.
- Students with diarrhea, unless caused by *Campylobacter*, *E. coli*, *Giardia*, *Salmonella*, or *Shigella* may return to school or childcare 24 hours after resolution of symptoms.
- A medical note documenting diagnosis, and initiation of antimicrobial therapy if done, if required for children diagnosed with *Campylobacter*, *Giardia*, *Salmonella typhi* or *Shigella*
- Negative stool cultures are still required for children diagnosed with *E. coli* O157:H7 or other Shiga toxin-producing *E. coli* (STEC) infections.

#### Fever and Influenza-like illness (ILI)

- Students with fever and other signs of possible severe illness (behavior change, irritability, headache, etc.) are still excluded from school with a fever of 101.0° F (oral).
- Given the prevalence of H1N1 and the expected amplification of transmission in schools and childcare, students with temperatures of 100° F and sore throat and/or cough are excluded until a student is fever free for 24 hours without the use of anti-pyretics.

#### HIB

No exclusion is required for students or staff *exposed to Haemophilus influenzae type B*.

#### Head Lice

- In line with current recommendations, school children of any age are now excluded at the end of the school day for head lice.
- Medically fragile children and children in licensed/regulated out of home childcare may be excluded sooner if close head-to-head contact cannot be avoided in the classroom/center setting.'
- Sports or physical education governing bodies may impose additional restrictions on participation.

#### Meningitis (any type)

Exclude for meningitis as soon as suspected.

(Continued on page 5)

## Changes in the School and Childcare Exclusion Lists

(Continued from page 4)

### Mononucleosis

Exclude for mononucleosis until cleared by student's healthcare provider as being well enough to participate safely in routine program/educational activities.

### Staph and Strep Skin and Soft tissue Infections (SSTIs)

*This section was extensively reworked based upon revised AAP guidance.*

- No exclusion is required for non-draining lesion or for carrier status.
- Impetigo exclusion criteria vary based upon whether the lesions are dry or wet/weepy.
- Students with draining lesions caused, or suspected to have been caused, by Staph or Strep are excluded if those lesions cannot be covered and/or the drainage cannot be contained in dressings.
- Students may be readmitted when the exclusion criteria are resolved, i.e., drainage is contained within dressing and/or covered adequately so that contact of others with drainage does not occur.

### Stye (Hordoeolum)

A child in childcare may be excluded for an actively draining sty, as it is impractical to cover a young child/s eye for an extended period.

### Vaccine Preventable Diseases:

- Specific times, as defined by the AAP, are given for exclusion of unimmunized or under immunized students exposed to measles, mumps, or rubella in an affected school or community, or to a varicella outbreak in a school or childcare setting.
- The lists clarify when a child may return to school or childcare if vaccinated following an excludable exposure.

### No exclusion required:

- Several conditions were added to the list for which no exclusion is required, including hand-foot-mouth disease, Lyme disease, Molluscum contagiosum, mosquito-borne illness (west Nile, Malaria, etc.), Rocky Mountain spotted fever, Tick-borne disease, and urinary tract infections.
- For any of these, an affected child who is not well enough to participate in routine program/curricular activities should be out until he/she is able to do so.

Parent Brochures on School and childcare Exclusion are available in English and Spanish at the DHEC website: <http://www.scdhec.gov/health/disease//exclusion>.

### Lista de razones para la exclusión escolar

Grados 1 al 12



Si usted cree que su niño sufre de una enfermedad que pueda transmitirse a otras personas, por favor mantenga a su niño en casa. Póngase en contacto con su doctor o su clínica.

## School Exclusion List



1st — 12th Grades

If you think that your child has an illness that can be spread to others, please keep him or her home from school. Contact your doctor or clinic.

## Hospital Infection Disclosure Act (HIDA) Update

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HIDA was signed into law in May 2006 and data collection began in July 2007. HIDA requires that all inpatient hospitals (excluding psychiatric and substance abuse) report information to the Department of Health and Environmental Control (DHEC) on certain hospital acquired infections (HAIs). The categories are: surgical site infections (SSIs); ventilator associated pneumonia (VAP); central line associated bloodstream infections (CLABSIs); and other categories. Hospitals must submit reports at least every six months on their HAI rates to DHEC. DHEC must also produce an annual hospital comparison report.

In the "other" category, methicillin resistant *staphylococcus aureus* (MRSA) bloodstream infections (BSIs) are reportable to DHEC from each clinical laboratory. These lab reports will be linked with hospital discharge data to determine if the MRSA BSI is hospital associated. A future Epi Notes article will report will present this data. In addition to the above requirements, hospitals must report on selected infection control processes.

Currently, hospitals report on the following SSI procedures and inpatient locations for CLABSIs. The date hospitals began reporting are designated for each procedure or location.

- July 2007**
  - Hysterectomies (abdominal and vaginal)
  - Coronary Artery Bypass Graft (chest only incision and chest/donor site incision)
  - CLABSIs in all Medical, Medical/Surgical and Surgical ICUs
- January 2008**
  - Hip Prosthesis (replacement)
  - Knee Prosthesis (replacement)
  - Cholecystectomy (gallbladder)
  - CLABSIs in all inpatient locations (hospitals < 150 beds)
  - CLABSIs in Pediatric ICUs
- December 2008**
  - Spinal Fusion
  - Colon (hospitals < 200 beds)
  - CLABSIs in Long Term Acute Care (LTACs)
  - CLABSIs in Rehab (Hospitals and Units)

As of February 2009, HIDA has published three six-month reports and one annual report. To see the six-month and annual reports and learn more about HAIs, please go to <http://www.scdhec.gov/health/disease/hai/>. The annual report uses the standardized infection ratio (SIR) to compare hospitals, and overwhelmingly showed that hospitals are doing an excellent job preventing infections and most are statistically not different than the national standard. There were only nineteen incidences where a hospital had a higher rate than the national standard out of almost 450 different rates reported for all hospitals combined.

For the SSIs, the percentage of hospitals that were statistically higher than the national standard ranged from 2% to 8%. Of the hospitals that performed abdominal hysterectomies, 2% were lower (better) than the national standard and for hospitals that performed coronary artery bypass grafts (CBGB) 56% were lower (better) than the national standard. Therefore, ~ 90% were not statistically different than the national standard.

For CLABSIs, the percentage of hospitals that were statistically higher than the national standard ranged from 4% - 20%. However, for some units there were only five hospitals represented (e.g., pediatric intensive care unit), resulting in a high percentage. Hospitals with a medical/surgical critical care unit and surgical critical care unit, had hospitals with lower (better) rates than the national standard. Approximately 90% of all of the reporting units have rates that are not different than the national standard. Coagulase negative staphylococci, *enterococcus sp.*, and *Candida* and other yeast, were the most commonly found pathogen in CLABSIs.

### Standardized Infection Ratio (SIR)

#### Standardized Infection Ratio (SIR) Statistical

**Method:** This indirect standardization method accounts for differences in the risk of surgical site infections among a group of procedures. An SIR is the number of observed infections divided by the number of expected infections. The expected number is based on the national average, the number of procedures performed by a hospital, and historical data for those procedures.

- An SIR of **1.0** means the observed number of

(Continued on page 7)

## HIDA Update

(Continued from page 6)

infections is equal to the number of expected infections.

- An SIR **above 1.0** means that the infection rate is higher than that found in the "standard population." For HAI reports, the standard population comes from data reported by the hundreds of U.S. hospitals that use the NHSN system. The difference above 1.0 is the percentage by which the infection rate exceeds that of the standard population.

A SIR **below 1.0** means the infection rate is lower than that of the standard population. The difference below 1.0 is the percentage by which the infection rate is lower than that experienced by the standard population.

The number of expected infections is calculated by

multiplying the number of procedures (at each hospital) by the NHSN Pooled Mean Rate. The result is divided by 100 (to remove the percent).

The SIR is found by dividing the sum of the observed number of SSIs by the sum of the expected number (\*) of SSIs across the different procedures.

***\*Please note that the "expected" number of infections does not mean that a patient would be expected to develop an infection when he enters the hospital for surgery. The goal is for the hospital is to prevent all HAIs.***

See the tables below for a complete synopsis of the hospital comparisons:

(Continued on page 8)

| Procedure                                                      | # Hospitals performing | Total # Procedures | Total # Infections | % SIR <1.0 | % SIR = 1.0 | % SIR >1.0 | Comments*       |
|----------------------------------------------------------------|------------------------|--------------------|--------------------|------------|-------------|------------|-----------------|
| <b>Coronary Artery Bypass Graft (Chest and Donor Incision)</b> | 16                     | 5669               | 98                 | 56%        | 44%         | 0%         | N/A             |
| <b>Coronary Artery Bypass Graft (Chest Incision)</b>           | 11                     | 286                | 1                  | 0%         | 100%        | 0%         | Two hospitals   |
| <b>Hysterectomy (Abdominal)</b>                                | 51                     | 8398               | 161                | 2%         | 90%         | 8%         | Two hospitals   |
| <b>Hysterectomy (Vaginal)</b>                                  | 47                     | 6542               | 47                 | 0%         | 98%         | 2%         | Two hospitals   |
| <b>Cholecystectomy (Gallbladder)</b>                           | 59                     | 7282               | 47                 | 0%         | 98%         | 2%         | Four hospitals  |
| <b>Hip Prosthesis (Replacement)</b>                            | 53                     | 5281               | 74                 | 0%         | 98%         | 2%         | Three hospitals |
| <b>Knee Prosthesis (Replacement)</b>                           | 54                     | 8287               | 71                 | 0%         | 94%         | 6%         | Six hospitals   |

### Comments\* :

- Notations like "two hospitals", "six hospitals", etc. indicate facilities where too few procedures were performed to generate statistically significant data, so their procedures, numbers of infections and SIR numbers are omitted from the table. They are, however, counted in the total number of hospitals where these infections are being monitored.

### HIDA Update

| Central Line Locations                       | # Hospitals monitoring | Total # Central Line Days | Total Infections | % SIR <1.0 | % SIR = 1.0 | % SIR >1.0 | Comments*      |
|----------------------------------------------|------------------------|---------------------------|------------------|------------|-------------|------------|----------------|
| <b>Medical/ Surgical Critical Care Units</b> | 42                     | 67621                     | 159              | 5%         | 85%         | 10%        | Two hospitals  |
| <b>Medical Critical Care</b>                 | 11                     | 20583                     | 62               | 0%         | 91%         | 9%         | N/A            |
| <b>Pediatric Critical Care Unit</b>          | 5                      | 4037                      | 19               | 0%         | 80%         | 20%        | N/A            |
| <b>Surgical Critical Care Unit</b>           | 5                      | 8102                      | 16               | 20%        | 80%         | 0%         | N/A            |
| <b>Medical Inpatient</b>                     | 6                      | 4877                      | 17               | 0%         | 83%         | 17%        | N/A            |
| <b>Medical/ Surgical Inpatient Ward</b>      | 29                     | 12989                     | 19               | 0%         | 96%         | 4%         | Four hospitals |
| <b>Surgical Inpatient</b>                    | 3                      | 1163                      | 3                | 0%         | 100%        | 0%         | N/A            |
| <b>Step-Down Unit</b>                        | 5                      | 1356                      | 1                | 0%         | 100%        | 0%         | One hospital   |

(Continued from page 7)

If you have any questions about HIDA, please contact:

Amber Taylor (Data): 803-898-0817 or [tayloral@dhec.sc.gov](mailto:tayloral@dhec.sc.gov)

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# Need the latest on H1N1 (swine) flu?

Be sure to refer frequently to these sites

- SC DHEC website on Novel H1N1 Influenza: <http://www.scdhec.gov/flu/swine-flu.htm>,
- SC DHEC Flu Surveillance Page: <http://www.scdhec.gov/health/disease/acute/flu.htm>,
- The CDC's H1N1 page: <http://www.cdc.gov/h1n1flu/>,
- The DHHS flu resource page: Flu.gov: <http://www.flu.gov/>, and
- DHEC Health Alerts: <http://www.scdhec.gov/health/disease/han/index.htm>).

If you are a public health professional interested in receiving health notifications from the South Carolina Health Alert Network, please contact Shana Dorsey, HAN Coordinator at 803.898.0431 or email [DADE-OC@dhec.sc.gov](mailto:DADE-OC@dhec.sc.gov).

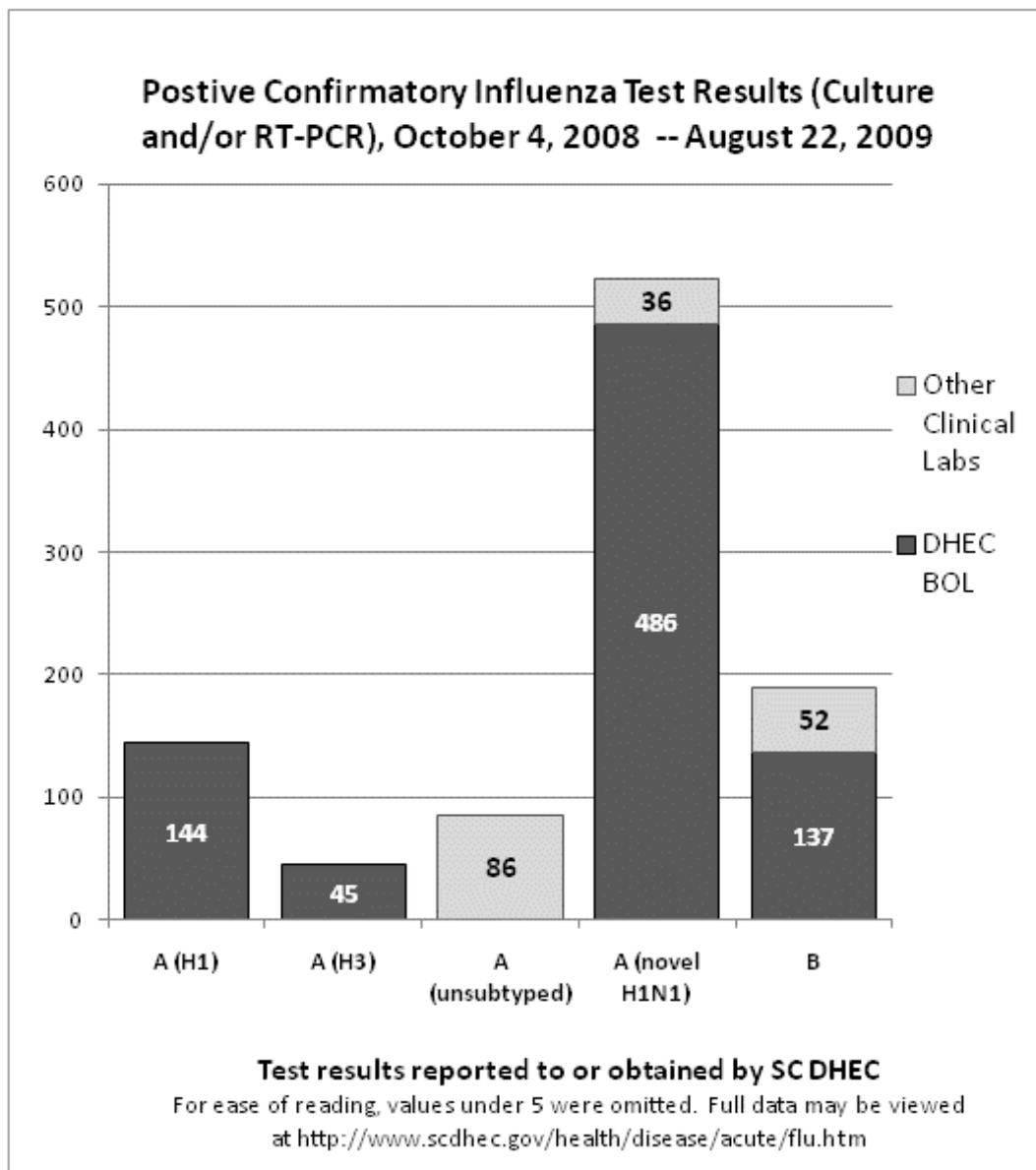
## Influenza Season Update

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South Carolina seasonal influenza surveillance consists of the viral isolates, influenza like illness, positive rapid antigen tests, influenza associated deaths, and enhanced novel influenza surveillance.

### Viral isolates

- Of the 283 enrolled culture providers, 74 have submitted specimens this season.
- Since October 4, 2008, of the specimens that the BOL has performed confirmatory testing on (culture and PCR), 384 have been positive for seasonal influenza and 486 have been tested positive for novel H1N1 influenza. We have received additional confirmatory results from other clinical labs for 142 positive seasonal influenza A or B specimens and 36 novel H1N1 Influenza A specimens.



## Influenza Season Update

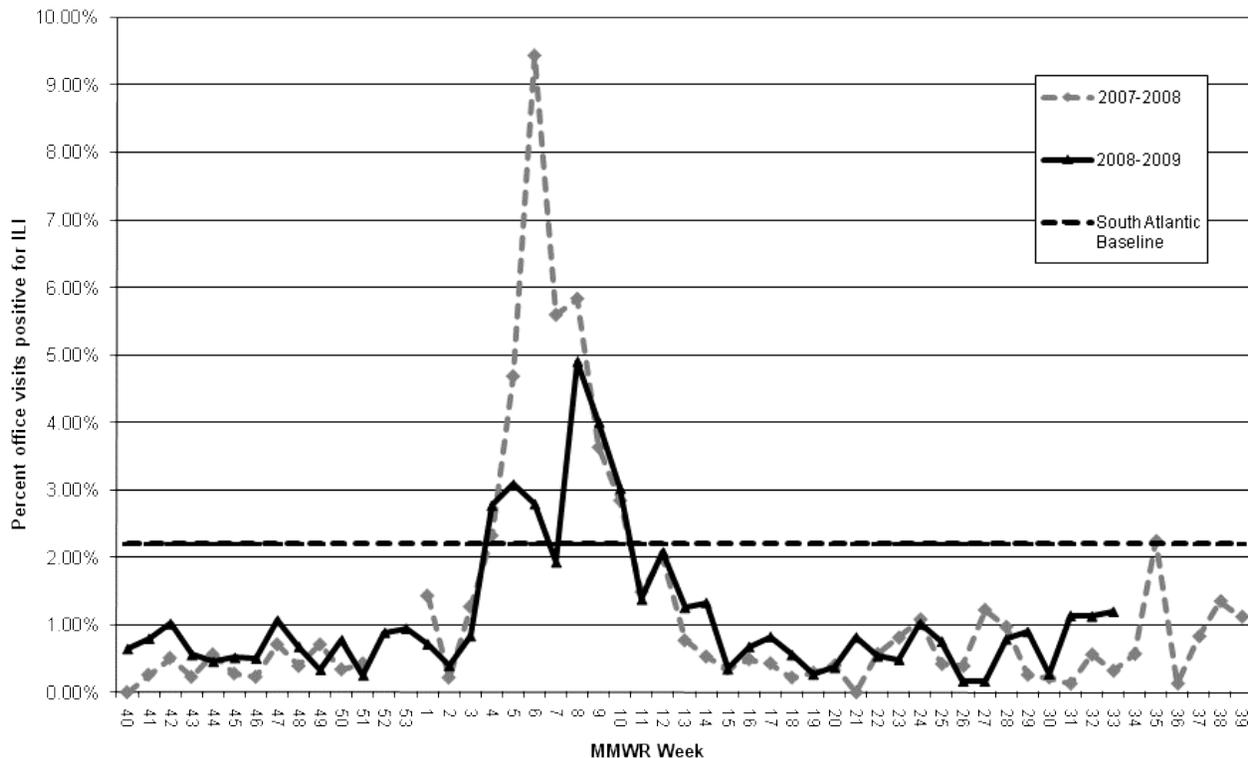
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### Influenza Like Illness Network (ILINet)

- There are currently 90 sentinel ILI providers enrolled in 36 counties throughout all regions. Fifty (55.6%) have submitted reports this season.
- South Carolina's ILI percentage was above the South Atlantic baseline (2.2%) from MMWR week 4 through MMWR week 11, with the peak during week 9.
- As of August 22, 2009, SC flu activity is below baseline in the Upstate (0.73%) and Midlands (0.27%) and at/above baseline along the coast (2.01%). The state ILI percentage is 1.20%.

ILINet providers are encouraged to continue reporting weekly throughout the summer and fall.

**Percentage of Visits for Influenza-like Illness (ILI) Reported by Sentinel Providers in South Carolina, 2007-2008 and 2008-2009 Influenza Seasons**



### Positive Rapid Antigen Tests

Since October 4, 2008, there have been a total of 24,033 positive rapid tests reported this season. This compares with 30,129 positive tests reported by this time last season.

### For More Information

Providers with questions regarding either the viral culture network or ILINet should contact Chasity Springs at [springcb@dhec.sc.gov](mailto:springcb@dhec.sc.gov).

Visit the DHEC flu surveillance website at <http://www.scdhec.gov/health/disease/acute/flu.htm>.

**Year-to-Date Summary of Reportable Conditions – January 1, 2009 to August 25, 2009**

Note: for spacing and readability, most conditions with zero reported cases were omitted from this report.

| <b>Condition</b>                                      | <b>Confirmed</b> | <b>Probable</b> | <b>Total</b> |
|-------------------------------------------------------|------------------|-----------------|--------------|
| Animal Bite—PEP Recommended                           | 219              | 0               | 219          |
| Aseptic meningitis                                    | 53               | 0               | 53           |
| Botulism, infant                                      | 0                | 0               | 0            |
| Brucellosis                                           | 1                | 0               | 1            |
| Campylobacteriosis                                    | 164              | 3               | 167          |
| Ciguatera fish poisoning                              | 0                | 0               | 0            |
| Cryptosporidiosis                                     | 39               | 2               | 41           |
| Cyclosporiasis                                        | 1                | 0               | 1            |
| Enterohemorrhagic E. coli O157:H7                     | 0                | 0               | 0            |
| Giardiasis                                            | 54               | 0               | 54           |
| Group A Streptococcus- invasive                       | 60               | 0               | 60           |
| Group B Streptococcus- invasive                       | 32               | 0               | 32           |
| Haemophilus influenzae- invasive                      | 41               | 0               | 41           |
| Hemolytic uremic syndrome - post-diarrheal            | 2                | 0               | 2            |
| Hepatitis A- acute                                    | 34               | 0               | 34           |
| Hepatitis B- acute                                    | 33               | 2               | 35           |
| Hepatitis B virus infection—Chronic                   | 85               | 396             | 381          |
| Hepatitis B virus infection—Perinatal                 | 0                | 0               | 0            |
| Hepatitis C- acute                                    | 1                | 0               | 1            |
| Hepatitis C Virus Infection- past or present          | 2,196            | 28              | 2,224        |
| Influenza- human isolates                             | 153              | 0               | 153          |
| Legionellosis                                         | 5                | 1               | 6            |
| Listeriosis                                           | 6                | 0               | 6            |
| Lyme disease                                          | 7                | 11              | 18           |
| Malaria                                               | 3                | 0               | 3            |
| Mumps                                                 | 1                | 0               | 1            |
| Neisseria meningitidis- invasive (Mening. disease)    | 10               | 1               | 11           |
| Pertussis                                             | 152              | 13              | 165          |
| Rocky Mountain spotted fever                          | 3                | 14              | 17           |
| S. aureus, vancomycin intermediate susceptible (VISA) | 0                | 0               | 0            |
| Salmonellosis                                         | 468              | 8               | 476          |
| Shiga toxin-producing Escherichia coli (STEC)         | 15               | 1               | 16           |
| Shigellosis                                           | 81               | 2               | 83           |
| Strep pneumoniae- invasive                            | 321              | 0               | 321          |
| Streptococcal disease- invasive- other                | 0                | 0               | 0            |
| Tetanus                                               | 0                | 0               | 0            |
| Toxic-shock syndrome- staphylococcal                  | 0                | 0               | 0            |
| Varicella (Chickenpox)                                | 77               | 10              | 87           |
| Vibrio parahaemolyticus                               | 7                | 1               | 8            |
| Vibrio spp.- non-toxigenic- other or unspecified      | 1                | 0               | 1            |
| Vibrio vulnificus infection                           | 1                | 0               | 1            |
| West Nile Fever                                       | 0                | 0               | 0            |
| Yersiniosis                                           | 8                | 0               | 8            |

**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](http://www.scdhec.gov/health/disease.index.htm).

**THE EPI NOTES NEWSLETTER IS AVAILABLE ONLINE AT**

[www.scdhec.gov/health/disease/index.htm](http://www.scdhec.gov/health/disease/index.htm).

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