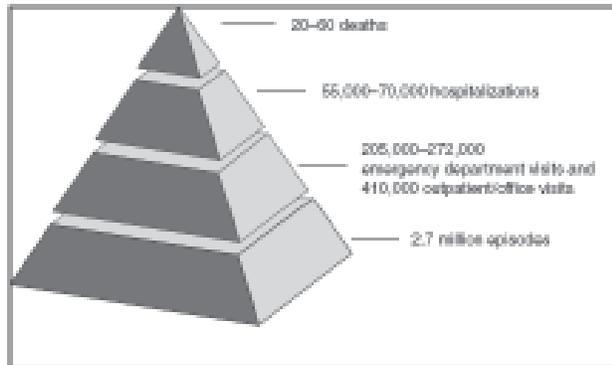


ACIP Recommendations for New Rotavirus Vaccine

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Rotavirus is the most common cause of severe gastroenteritis in infants and young children worldwide. While rotavirus gastroenteritis results in relatively few childhood deaths in the United States, nearly every child in the United States is infected with rotavirus by age 5 years. Severe dehydrating gastroenteritis occurs primarily among children aged 3-35 months. The Advisory Committee on Immunization Practices (ACIP) published Prevention of Rotavirus Gastroenteritis Among Infants and Children in the Morbidity and Mortality Weekly Report (MMWR) on August 11, 2006. The document can be found on the CDC Web site at:
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5512a1.htm>.

FIGURE 1. Estimated number of annual deaths, hospitalizations, emergency department visits, and episodes of rotavirus gastroenteritis among children aged <5 years — United States



(Continued on Page 2)

The South Carolina Health Alert Network

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What is HAN?

The South Carolina Department of Health and Environmental Control (SC DHEC) and the Division of Emergency Management have partnered to provide a robust, interactive, web-based tool that provides alerting and notification capability. This tool is known as REACH SC and is used jointly as a notification system for urgent public health threats and events that require a statewide emergency response.

The Health Alert Network (HAN) is a component of REACH SC that SC DHEC uses for emergency communication with key public health response personnel and medical professionals throughout the state. REACH SC provides 24 hour access and is used by SC DHEC to provide three levels of notification capabilities: health alerts, health advisories, and health updates. These notifications can be sent to public health and medical professionals by fax, phone, and email. This new form of redundant communication allows for rapid notification and response in the event of a potential or actual public health emergency.

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(ROTAVIRUS cont'd from Page 1)

In February 2006 the Food and Drug Administration (FDA) licensed a new rotavirus vaccine (RotaTeq[®], produced by Merck and Company, Whitehouse Station, New Jersey) for use among U.S. infants. RotaTeq[®] is a live, oral vaccine that contains five reassortant rotaviruses developed from human and bovine parent rotavirus strains. This pentavalent rotavirus vaccine (PRV) contains no preservatives or thimerosal.

The ACIP recommends routine vaccination of U.S. infants with three doses of PRV administered orally at ages 2, 4, and 6 months. The first dose should be administered between ages 6 and 12 weeks. Subsequent doses should be administered at four to ten-week intervals, and all three doses of vaccine should be administered by age 32 weeks. Vaccination should not be initiated for infants aged >12 weeks because of insufficient data on safety of the first dose of rotavirus vaccine in older infants. Vaccine should not be administered after age 32 weeks because of insufficient data on the safety and efficacy of rotavirus vaccine in infants after this age.

Rotavirus vaccine may be administered along with other routinely administered childhood vaccines. Precautions to vaccination include acute gastroenteritis, moderate-to-severe illness, preexisting chronic gastrointestinal disease, history of intussusception, and altered immunocompetence.

Enrolled VAFAC (Vaccine Assurance For All Children) providers may order rotavirus vaccine for VAFAC eligible infants through the DHEC Immunization Division. For VAFAC enrollment information or for more information regarding rotavirus vaccination, contact the DHEC Immunization Division at 1-800-277-4687.

(HEALTHALERT NETWORK cont'd from Page 1)**Why is it important?**

In times of an emerging public health threat, having the latest information in the hands of our front-line clinicians regarding clinical presentation, case definition, activities required and impact to South Carolina are critical to a timely response. The HAN is an important notification tool to ensure information-sharing among public health departments, healthcare organizations, and other first responder communities.

What does it provide?

Since its inception in 2003, the South Carolina Health Alert Network has sent out over 114 public health notifications via Health Alerts, Advisories, and Updates. Examples of content from previous notifications include:

- Enhanced surveillance and the clinical indicators of possible *E. coli* O157:H7 infection
- Medical management of chlorine exposure
- Interim guidance for businesses with employees returning to the United States from areas with SARS

- Multi-state investigation of potential rabies exposure at a summer camp

The SC HAN provides not only information about activities going on across the country, but also important information for clinicians in South Carolina to use in response to both local and state-level events of public health significance.

How can you sign up?

All health alerts, advisories, and updates that originate from the CDC or SC DHEC are sent via the Health Alert Network. It is important that public health and medical professionals are notified in the event of a public health emergency and REACH SC provides the rapid means of communicating with these professionals. Once an alert notification is received, health professionals will be able to quickly respond in a timely manner. Without registering for REACH SC, however, health care professionals may miss out on receiving critical information. Registering for ReachSC is simple and there is no cost involved. To register for REACH SC, please contact Shana LeGrand Dorsey by calling 803-898-0431 or by email at legransd@dhec.sc.gov.

South Carolina Immunization Registry

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Immunization registries are confidential, computerized information systems that collect vaccination data within a geographic area. By consolidating vaccination records from multiple health-care providers, generating reminder and recall notifications, and assessing vaccination coverage, registries serve as key tools to increase and sustain high vaccination coverage. One of the national health objectives for 2010 is to increase to 95 percent the proportion of children 6 years old or younger who participate (i.e., have two or more vaccinations recorded) in fully operational, population-based immunization registries.

The new South Carolina immunization registry is part of the DHEC 'Client Automated and Reporting System (CARES). This Web-accessible registry will be available to both DHEC and private immunization providers. The new registry has recently been implemented in eight counties. All previous DHEC immunization data for the eight counties have been added to the CARES Immunization Registry. The registry will be operational statewide by May 2007.

Currently, the registry meets ten of the twelve Minimum Functional Standards for Immunization Registries defined

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(IMMUNIZATION REGISTRY cont'd from Page 2)

by the CDC. These Standards have been met by the new registry:

- It electronically stores data on all NVAC-approved core data elements
- It enables access to and retrieval of immunization information at the time of encounter
- It protects confidentiality of health information
- It ensures security of health information
- It automatically determines the routine childhood immunizations needed
- It automatically identifies individuals due/late for immunizations to enable the production of reminder/recall notifications
- It automatically produces immunization coverage reports by providers, age groups, and geographic areas
- It produces official immunization records (Day Care and School Certificates)
- It promotes accuracy and completeness of registry data

The Minimal Functional Standards for Immunization Registries can be found at http://www.cdc.gov/nip/registry/st_terr/tech/stds/min-funct-stds2001.htm. Standard #2, populating from the vital records system, and Standard #7, exchanging immunization records using HL7 standards, are in development.

Once a county public health department implements the CARES Immunization Registry, private providers in that county are encouraged to request access. A Memorandum of Agreement (between DHEC and the practice) initiates the process. Individual users within the practice must sign a User Agreement. DHEC will provide training and support. System access is via the Internet.

The first private pilot project with a Sumter County provider will begin in October 2006. Other counties where the registry is operational include: Kershaw, Lee, Union, Clarendon, Cherokee, Anderson, and Greenwood.

For more information regarding the South Carolina immunization registry, contact the DHEC Immunization Division at 1-800-277-4687.

Cryptosporidiosis: Is A Change In Test Methodology Identifying More Cases?

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DHEC Public Health Regions 6 and 7

In recent months the South Carolina Department of Health and Environmental Control (SC DHEC) has received an increased number of reports of cases of laboratory-

confirmed cryptosporidiosis among children and adults as compared to recent years. Cases associated in time and geographic location (Charleston, Berkeley, and Dorchester counties) have led to further investigations to determine causal associations. Many of these cases appear to be related to recreational water exposure, which is the primary method of spread of this illness in South Carolina, especially during the summer months; however, no single point-source exposure was identified.

A survey of laboratorians and physician practices within the region indicate that the increase in reports of crypto may be due in part to increased testing for crypto by rapid EIA methods on stool samples. This differs from historical methods for the detection of oocysts via microscopic examination of stool specimens. It is unclear whether this investigation is documenting the natural background prevalence of cryptosporidiosis, identifying a true recent increased incidence, or both.

Clinical Information

Cryptosporidiosis is a diarrheal disease caused by microscopic parasites of the genus *Cryptosporidium*. Both the disease and the parasite are commonly known as "crypto." Once an animal or person is infected, the parasite lives in the intestine and passes in the stool. The spore phase of the parasite's life cycle, or "oocyst", allows it to survive outside the body for long periods of time and makes it **very resistant to chlorine-based disinfectants**. Crypto may survive up to a week in swimming pools under standard chlorination procedures.

The median incubation time for cryptosporidiosis is 7 days. The most common symptom of Cryptosporidiosis is watery diarrhea. Other symptoms may include dehydration, weight loss, stomach cramps or pain, fever, nausea, and vomiting. Some people with crypto will have no symptoms at all. In immunocompetent people, the diarrheal disease is self-limited, usually lasting 1-20 days. While the small intestine is the site most commonly affected, *Cryptosporidium* infections could possibly affect other areas of the digestive or the respiratory tract. Shedding of oocysts in stool may continue for up to two weeks after symptom resolution.

Risk Factors for Cryptosporidium

People who are most likely to become infected with *Cryptosporidium* include:

- Swimmers who swallow water while swimming in recreational swimming waters, lakes, rivers, ponds, and streams
- Children who attend day care centers, including diapered children
- Child care workers
- Parents of infected children
- Persons in contact with infected farm livestock, petting zoo animals, or pets.
- International travelers
- Backpackers, hikers, and campers who drink unfiltered, untreated water

(Continued on Page 4)

(CRYPTOSPORIDIOSIS cont'd from Page 3)

- Persons who drink from shallow, unprotected wells
- Persons who swallow water from contaminated sources

Diagnostic Tests and Laboratory Confirmation

- The detection of oocysts on microscopic examination of stool specimens is diagnostic. Unfortunately, routine laboratory examination of stool for ova and parasites will not detect *Cryptosporidium* species.
- The sucrose flotation method or formalin ethyl acetate method is used to concentrate oocysts in stool before staining with a modified Kinyoun acid-fast stain.
- Monoclonal antibody-based fluorescein-conjugated stain for oocysts in stool and an enzyme immunoassay (EIA) for detecting antigen in stool are available commercially.
- Because shedding can be intermittent, at least 3 stool specimens collected on separate days should be examined before considering test results negative. Oocysts are small (4-6 UM in diameter) and can be missed in a rapid scan of a slide.

Sources for Additional Information

Additional information regarding Cryptosporidiosis and disease transmission in recreational water can be found at:

- www.cdc.gov/healthyswimming/index.htm
- www.cdc.gov/ncidod/dpd/parasites/cryptosporidiosis
- American Academy of Pediatrics. *Red Book: 2006 Report of the Committee on Infectious Diseases*. 27th ed.

CHES Hospital Deployment

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Carolina's Health Electronic Surveillance System (CHES) has been used by DHEC's regional public health departments for more than two years. CHES allows health care providers to submit disease reports through a secure Web-based interface. This replaces disease report cards for many conditions. The CHES report is received by the local public health department, investigated, and then electronically forwarded to the DHEC Central Office in Columbia. A Central Office consultant reviews the investigation and makes sure the reported disease meets the case definition. The consultant then electronically submits the report to the Centers for Disease Control (CDC).

CHES is now available for external users, such as hospitals and laboratories. Winthrop University and Aiken Regional Medical Center have already activated the system and a number of other organizations will be connected to CHES within the next few weeks. Participating organizations will receive quick feedback on disease reports and know that they are reporting disease in the fastest way possible. The ultimate goal of the new system is to increase the speed and accuracy of disease reporting while reducing paperwork.

Hospitals and other reporting health care providers who are interested in using CHES to submit reportable conditions are urged to participate. For more information, please call the CHES Help Desk at (800) 917-2093 or e-mail Claire Youngblood at youngbhc@dhec.sc.gov.

On-line Viral Hepatitis Serology Course

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The Division of Viral Hepatitis at the Centers for Disease Control and Prevention (CDC) now has an on-line hepatitis serology course for physicians, nurses, and other health care providers. This course includes training on serologic interpretation for hepatitis A, B, C, D, and E. It takes approximately 30-45 minutes to go through each section of the course, take the tests, and complete the evaluation. Continuing education credits for physicians (1.3 category 1 credits) and nurses (1.6 contact hours through the American Nurses Credentialing Center's Commission on Accreditations) are available.

The course is on the CDC website at:

<http://www.cdc.gov/ncidod/diseases/hepatitis/serology/index.htm>.

Rabies Update

Mary Helen Niemeyer, MD
DHEC Region 5 Medical Director

Rabies is an almost universally fatal viral infection transmitted from the saliva and neural tissue of infected mammals. In the United States the incidence of dog rabies and associated human infection has decreased during the past 20 years, while the incidence of rabies in wildlife (especially raccoons, skunks, and bats) has increased. Bat strains of rabies virus account for over 50 percent of the human cases of rabies diagnosed annually in the United States. Extensive field experience from the United States and abroad has demonstrated that Post-Exposure Prophylaxis (PEP) combining wound treatment, passive immunization, and vaccination is uniformly effective in

(Continued on Page 5)

(RABIES UPDATE cont'd from Page 4)

preventing human rabies when appropriately implemented.

In South Carolina, mammal bites/scratches to humans are required by state law (Rabies Control Act) to be immediately reported to DHEC. DHEC staff investigated 11,544 animal exposures in 2005 and 452 victims received PEP through primary care/ER physicians. Of the 2,741 animal heads that were submitted to the State Bureau of Laboratories in 2005, 220 tested positive for rabies; the vast majority were from raccoons (129) followed by 31 foxes, 21 skunks, 21 bats, 8 cats, 7 dogs, and 3 bobcats.

DHEC has a long history of partnering with physicians in the management of animal bites/scratches. DHEC provides rabies vaccine and Human Rabies Immune Globulin (HRIG) and also consultation in the management of animal exposures. Responsibility for medical management of rabies PEP administration, including compliance with the recommended vaccination schedule, resides with the treating private physician. A new DHEC policy directs several changes that are expected to improve the interaction of consulting medical staff, improve accountability for the costly PEP products, improve documentation of activities associated with evaluation of the circumstances of potential rabies exposures, assist in educating private practitioners, and promote better adherence to the recommended course of PEP.

When a DHEC staff member delivers PEP to a treating physician's office, it will be accompanied by the **new DHEC Rabies PEP Information Packet**. This includes:

1. DHEC Rabies form 3548 "**Receipt for Delivery of Rabies PEP Products**": DHEC provides PEP and requests completion of receipt of this transaction by signatures of both the consulting DHEC nurse/physician and the treating private physician or other authorized person from the practice.
2. DHEC Rabies form 1767 "**PEP Schedule, Follow-up, and Guidelines**": This simplified documentation of the recommended rabies PEP schedule for the individual patient will have the anticipated vaccination dates filled in. After completion of the series, it is to be returned to the local health department by the treating physician.
3. **Rabies Vaccine Information Statement (VIS)**: To be given to the patient receiving the PEP
4. **RIG/vaccine package insert**
5. **Name(s) and 24-hour contact number(s) of DHEC consultants** who can answer questions regarding missed or delayed doses of rabies vaccine, possible adverse vaccine reactions, or other clinical management issues.

DHEC looks forward to continuing and improved collaboration with our valuable physician partners in achieving best practices for animal bite management in South Carolina. For questions or further information, call the local health department or the DHEC Division of Acute Disease Epidemiology at (803) 898-0861.

Mumps

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Definition: A common childhood inflammatory disease of the salivary glands with occasional serious complications.

Etiology: Mumps virus (paramyxovirus; RNA virus). Also called benign viral parotitis.

Epidemiology: Worldwide distribution with man as the only known reservoir. Prior to the vaccine, about 50% of children contracted mumps.

Transmission: Viral transmission occurs through inhalation of respiratory droplets or by direct person-to-person contact.

Infective Period: 2-3 days before symptoms until 9 days after symptoms disappear. One third of cases are subclinical.

Incidence: Mumps is primarily a childhood disease with about 95% of all cases occurring in children under 15 years of age. The incidence of mumps has shown a dramatic decrease since the introduction of the mumps vaccine in 1967. This virus is **highly contagious**. Neonates receive passive immunity from the mother and the high incidence of childhood mumps infections makes adult cases rare.

Pathogenesis: The virus usually enters the body through the upper respiratory tract and infects regional lymph nodes. Viremia results from spread of the virus from the lymph nodes to the bloodstream. The mumps virus spreads to the meninges, salivary glands (necrosis, interstitial edema, inflammation, and lymphocytic infiltration), testes, pancreas, ovaries, kidneys (virtually every case shows impaired renal function), thyroid, eyes, and mammary glands (occasionally).

The mumps virus has a tropism for glandular tissue and also is neurotropic, resulting in meningitis, encephalitis, myelitis, polyneuritis, polyradiculitis, and cranial neuritis. There also is frequent renal involvement.

Manifestations: Mumps is often asymptomatic. A clinically nondescript, febrile upper-respiratory disease is also common in infants and preschoolers.

- A. Incubation period: 14-25 days with average of 18 days
- B. Clinical presentation
 1. Approximately 30% of cases are asymptomatic.

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(MUMPS cont'd from Page 5)

2. In persons who have symptoms, the illness has variable severity.
 3. Prodrome (does not always occur): myalgia, anorexia, malaise, and a low-grade fever with only parotitis.
- C. Most common presentation:
1. Parotitis
 - a. Within the 1st day after the nonspecific prodrome, the child may complain of earache. Pain is localized near the lobe of the ear, worsened by chewing movements.
 - b. Within the 2nd day after the nonspecific prodrome, parotid gland swelling is visible and then rapidly enlarges within the next 1-3 days. During this period, pain and tenderness may be severe. Once the swelling reaches maximum, the symptoms decrease. The swelling decreases over a period of 3-7 days.
 - c. The parotid gland feels jellylike. The overlying skin is not usually warm to the touch as it is in bacterial parotitis.
 - d. Orifices of Wharton's and/or Stensen's ducts become red and swollen with pinpoint petechial hemorrhages. If obstruction of these inflamed ducts by edema or cellular debris occur, chewing or drinking may be very painful.
 - e. Parotitis can be unilateral or bilateral. If it is bilateral, one parotid gland enlarges first and then the second enlarges a few days later. Occasionally, both sides enlarge simultaneously.
 - f. Fever subsides after 1-6 days and becomes normal BEFORE the parotid swelling disappears.
 2. Most frequent of the lesser common presentations
 - a. Enlargement of parotid and submaxillary salivary glands or enlargement of only the submaxillary gland. Swelling will spread over the mandible onto the cheek and downward toward the neck. **In this case, mumps will be indistinguishable from cervical lymphadenitis.**
 - b. Enlargement of all 3 salivary glands (unilaterally or bilaterally): Parotid, submaxillary, and sublingual salivary glands. The sublingual salivary glands are the least commonly involved glands in mumps. If they enlarge, there will be swelling in the submental regions and on the floor of the mouth.
 - c. Epididymo-orchitis
 - 2nd most common manifestation of mumps in an adult males.
 - Usually follows parotitis but may occur before parotitis or may even occur without parotitis.
 - Usually unilateral.

- d. Meningoencephalitis
 - Occurs in about 10% of all cases.
 - Usually follows parotitis by 3-10 days but may occur before parotitis or may even occur without parotitis.

When to Think of Mumps:

- A. There is a history of exposure to mumps 2-3 weeks before onset of illness.
- B. There is a compatible clinical picture of parotitis or other glandular involvement.
- C. There are signs of aseptic meningoencephalitis or, in a male, epididymo-orchitis.

Differential Diagnosis for Pediatric Parotid Disease:

- A. Mumps may be confused with various conditions affecting the parotid glands or neighboring lymph nodes:
 1. Anterior cervical or preauricular lymphadenitis with surrounding edema:
 - a. A swollen parotid gland from mumps can be identified by its characteristic location, consistency and outline. The parotid glands will have a brawny consistency, a well-defined posterior border, and an ill-defined anterior and inferior borders.
 - b. Enlarged preauricular or posterior auricular lymph nodes have a well-defined, discrete borders, are firm and do not have the characteristic anatomic location of the parotid gland to the ear.
 - c. An important point to remember is that in parotitis the small hollow just under the ear disappears but does not disappear if there is lymphadenitis.
 - B. Other Causes of Parotitis or Enlarged Parotid Gland
 1. Bacterial parotitis
 - a. The skin over the parotid gland is usually red and hot.
 - b. The parotid gland is exquisitely tender.
 - c. There is often pus from Stensen's duct if the parotid gland is massaged.
 - d. This is usually caused by *S. aureus*, but may also be caused by other bacteria.
 2. Recurrent parotitis - Frequent recurrent swelling of the parotid gland (cause unknown).
 3. Obstructive parotitis - Due to a calculus that obstructs Stensen's duct. This is usually recurrent.
 4. Parotitis due to other viral infections
 5. Coxsackie virus
 6. Parainfluenza 3
 7. Hemangiomas
 8. Lymphangiomas
 9. Benign and malignant and mixed tumors
 10. Sjogren's syndrome
 11. Sarcoidosis
 12. HIV

Year-to-Date Summary of Selected Reportable Conditions - January 1, 2006 - August 14, 2006 *

Condition	Confirmed	Probable	Total
Anthrax	0	*	0
Arboviral Neuroinvasive Disease	0	0	0
Botulism	0	0	0
Brucellosis	2	0	2
Campylobacter enteriditis	153	0	153
Cholera	0	*	0
Creutzfeldt-Jakob disease (age <55 years)	0	0	0
Cryptosporidiosis	91	*	91
Cyclosporiasis	4	*	4
Dengue	0	1	1
Diphtheria	0	0	0
Ehrlichiosis	1	4	5
Enterohemorrhagic E. Coli (includes O157:H7)	7	0	7
Giardiasis	75	1	76
Glanders	0	0	0
Haemophilus influenzae, non-type b invasive disease	26	0	26
<i>Haemophilus influenzae</i> type b, invasive disease	2	0	2
Hantavirus	0	*	0
Hemolytic uremic syndrome	1	0	1
Hepatitis A, acute	19	*	19
Hepatitis B, acute	65	*	65
Hepatitis B, chronic	475	*	475
Hepatitis C, acute	0	*	0
Hepatitis C, chronic or past	2,161	1,299	3,460
Hepatitis D	1	*	1
Hepatitis E	1	*	1
Influenza, positive virus culture isolates	30	*	30
Kawasaki disease	2	*	2
Legionellosis	3	*	3
Leprosy	0	*	0
Leptospirosis	0	0	0
Listeriosis	6	*	6
Lyme disease	11	*	11
Malaria	9	*	9
Measles (rubeola)	0	0	0
Meningitis, aseptic	78	*	78
Meningococcal disease	17	0	17
Mumps	4	0	4
Pertussis	126	15	141
Plague	0	0	0
Poliomyelitis	0	0	0
Psittacosis	0	0	0
Q fever	0	0	0
Rabies (human)	0	*	0
Rocky Mountain Spotted Fever	2	30	32
Rubella (includes congenital)	0	0	0
Salmonellosis	667	2	669
SARS	0	0	0
Shigellosis	74	0	74
Smallpox	0	0	0
Staphylococcus aureus, vancomycin-resistant (VRSA/VISA)	0	*	0
Streptococcus group A, invasive disease	57	*	57
Streptococcus group B, age < 90 days	30	*	30
Streptococcus pneumoniae, invasive	173	*	173
Tetanus	1	*	1
Toxic Shock (Staphylococcal or Streptococcal)	0	0	0
Toxins	1	0	1
Trichinosis	0	*	0
Tularemia	0	0	0
Typhoid Fever	0	0	0
Typhus (scrub) fever	0	0	0
Varicella	474	361	835
Vibrio infections (non-cholera)	6	*	6
Viral Hemorrhagic Fever	0	0	0
Yellow Fever	0	0	0
Yersiniosis	3	0	3

* Probable case 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

THE EPI NOTES NEWSLETTER IS NOW AVAILABLE ON LINE AT
www.scdhec.gov/health/disease/index.htm

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