County of Los Angeles
Department of Health Services
Public Health

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

Volume 5 • Number 2 February 2005

The Pneumococcal Vaccines

It has been five years since a pneumococcal vaccine was first licensed in the U.S. for children under two years of age. This vaccine, the pneumococcal conjugate vaccine (PCV-7), contains antigens against the seven serotypes of *Streptococcus pneumoniae (S. pneumoniae)* that account for more than 80% of invasive pneumococcal disease in U.S. children under four years of age. The vaccine is indicated for all children under two years of age and for all unimmunized children two to five who are at moderate to high risk for invasive pneumococcal disease. Unimmunized healthy children, two to five years of age, can also be given one dose of the vaccine.

The vaccine is now readily available, despite two lengthy periods of very limited vaccine supply due to production and distribution problems experienced by the vaccine's manufacturer. All providers should now be using the standard vaccination schedule that was re-issued in the September 16, 2004 Morbidity and Mortality Weekly Report (MMWR) [53(36);851-852]*. The out-dated interim vaccination schedules developed during the vaccine shortage should be removed from all clinical areas to avoid confusion.

This vaccine has already had a significant and positive impact on the health of children, even with its decreased availability during periods of vaccine shortage. Kaplan et al demonstrated a significant decrease in invasive pneumococcal disease among children at eight children's hospitals in the U.S. for the period 2001 through 2002.[1]

There is some indication that the decline in children's cases may also be contributing to a decline in adult cases as a result of the vaccine's effectiveness in eradicating asymptomatic carriage of the *S. pneumoniae* organism in children, thereby decreasing opportunities for adults to become infected. In Los Angeles County, a significant drop in the rate of invasive pneumococcal disease in the 65 and older age group has been noted by the County's Invasive Pneumococcal Disease Surveillance Program.

Continued use of PCV-7 in accordance with the standard ACIP recommendations has the potential to reduce childhood invasive pneumococcal disease to very low levels, thereby decreasing the incidence of this serious health threat to children.

Pneumococcal polysaccharide vaccine (PPV), unlike PCV-7, has been available for decades. This vaccine does not provide protective immunity to children under two but it does help protect children two and older, and adolescents and adults of any age,

Continued on page 2

Reporting Forms and Procedures

Reporting forms and procedures for Immunization and Tuberculosis Control are included in this issue. The remainder of the department's reporting forms can be found in last month's issue (Vol. 5, No. 1).

Timely and accurate reporting is a critical component of disease surveillance, prevention and control. Delay or failure to report a communicable disease (confirmed and suspected cases) may contribute to secondary transmission of disease and is a misdemeanor (Health and Safety Code 12095).

THE PUBLIC'S HEALTH

County of Los Angeles
Department of Health Services
Public Health

313 North Figueroa Street, Room 212
Los Angeles, California 90012

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The Pneumococcal Vaccines (from page 1)

from invasive pneumococcal disease. Persons aged two years and older with chronic health conditions that put them at risk for invasive pneumococcal disease and seniors 65 and older are recommended to receive the vaccine. Although PPV does not show the 90% plus efficacy against invasive pneumococcal disease that is shown by PCV-7, it does prevent invasive disease in 60% to 70% of vaccinees. This vaccine, therefore, has the potential to significantly decrease the 40,000 – 60,000 pneumococcal disease deaths which occur in the U.S. each year.

Unfortunately, PPV is a very underutilized vaccine. In Los Angeles County, the number of seniors aged 65 and older who reported ever having received PPV during a 2002 survey was 55.4%.[2] Particularly during a time of influenza vaccine supply instability, such as what occurred this year, it is very important that eligible individuals receive PPV; pneumococcal pneumonia is a major complication of influenza that can lead to death.

Providers are encouraged to screen their patients two years of age and older for the appropriateness of PPV vaccination. In most instances, the vaccine is only given once. All persons 65 years of age and older should receive one dose of PPV. Persons aged 65 and older who have previously received a dose of this vaccine before they turned 65 should receive a second dose if it has been five or more years since their first dose. For persons under 65 years of age, revaccination is only indicated for persons who were vaccinated because they had an immunocompromising health condition. These persons can be revaccinated as early as five years after their first dose of the vaccine (if a child was under ten years of age when first vaccinated, revaccinate three years after the first dose). Please refer to the adult immunization schedule www.lapublichealth.org/ip/izschedules/adult/2004-05.pdf for recommendations on the use of PPV.

*www.cdc.gov/mmwr/preview/mmwrhtml/mm5336a8.htm

References:

1. Kaplan S, Mason E, Wald, E, et al. Decrease of invasive pneumococcal infections in children among 8 children's hospitals in the United States after the introduction of the 7-valent pneumococcol conjugate vaccine. Pediatrics. 2004;113 (no.3):443-449

2. Los Angeles County Health Survey, 2002-2003

Upcoming HIV Epidemiology Program Studies

HIV Epidemiology Program's Seroepidemiology Unit will be implementing data collection for two new epidemiologic studies in March 2005.

Brothers y Hermanos is a four-year, multi-site study of Black and Latino men who have sex with men (MSM), funded by the Centers for Disease Control and Prevention (CDC). The overall goal of **Brothers y Hermanos** is to identify the cultural, social, environmental and psychological factors within populations of Black and Latino MSM that promote or reduce HIV risk. Latino MSM will be recruited in Los Angeles County and New York City and Black MSM will be recruited in Philadelphia and New York City. The four-year study period covers both a qualitative data collection phase (completed in 2003-4) and the upcoming epidemiologic data phase, which will involve standardized, audio computer-assisted self interviews (ACASI) by MSM who will also undergo rapid HIV testing. Five hundred MSM will be recruited in each of the four study sites using respondent-driven sampling (RDS), a methodology similar to "snowball" sampling that allows study participants to refer members of their social network for enrollment into the study to produce a representative (random) sample of Latino MSM in Los Angeles County. Ultimately, findings from both the qualitative and epidemiologic study phases will inform the development of effective HIV prevention interventions tailored to Black and Latino MSM populations.

National HIV Behavioral Surveillance among Injecting Drug Users (NHBS-IDU) represents the second year of CDC's ongoing national effort to estimate HIV risk behaviors and exposure to HIV prevention programs among three groups at increased risk of HIV infection: MSM, injecting drug users (IDUs), and high-risk heterosexuals. Having completed a formative research phase to better understand and document the characteristics of the diverse IDU subpopulations in county in January of 2005, the Seroepidemiology Unit will begin recruitment of 500 male, female, and transgender IDUs for the behavioral survey in March, 2005. Across all 25 NHBS-IDU sites, study participants will be recruited using respondent-driven sampling, a methodology actually developed and refined for this particular "hidden" population. Eligible participants will be those who are county residents, 18 years or older and who have injected illicit substances in the previous 12 months. Persons enrolled in NHBS-IDU will undergo an interviewer-administered questionnaire that collects information on socio-demographics, injection drug use, needle-sharing practices, sexual behaviors, and knowledge and use of local HIV prevention programs targeting IDUs. Results of NHBS-IDU will be available at the end of 2005.

The final formative research report is available under the "reports" icon at http://lapublichealth.org/hiv/index.htm.

New Assistant Medical Director for TB Control

Kinji Hawthorne, M.D., M.P.H., has joined the county's Tuberculosis Control Program as Assistant Medical Director. Dr. Hawthorne will focus on clinical and research issues.

He received his medical degree from Emory University and completed his internal medicine training at St. Mary Hospital, LA and his Infectious Disease training at University of Washington, Seattle. He earned his MPH in epidemiology from the University of Washington School of Public Health and Community Medicine.

Dr. Hawthorne can be reached at khawthorne@ladhs.org or 213/744-6160.

ANTIBIOTIC RESISTANCE INFORMATION CORNER

Comparison of Short-Course (5 Days) and Standard (10 Days) Treatment for Uncomplicated Cellulitis

Hepburn MJ, Dooley DP, Skidmore PJ, Ellis MW, Starnes WF, Hasewinkle WC.
Arch Intern Med. 2004 Aug 9-23;164(15):1669-74.
Available at: www.archinte.ama-assn.org/cgi/content/full/164/15/1669

Among patients with uncomplicated cellulitis, recovery for those who received a short-course 5-day treatment of levofloxacin was as effective as the standard 10-day treatment. In a randomized, double-blind, placebo-controlled trial, there were no significant differences in clinical outcome between a 5-day course (98% success in 43 of 44 patients) and a 10 day course (98% success in 42 of 43 patients). The authors of the study do not advocate short course therapy for patients who are immunocompromised or patients with complicated skin wounds including abscesses and persistent ulcers since it is unknown how effective a short course antibiotic therapy is for these populations. Efforts like these to prevent prolonged antibiotic therapy without jeopardizing the health and safety of the patient are critical in an era of antibiotic resistance.

Bad Bugs No Drugs: Infectious Diseases Society of America's Push to Gain Support From Policymakers

The lack of new antibiotics to fight drug-resistant infections has prompted considerable concern as resistance rates have continued to increase among pathogens such as methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE). Yet, only 5 of 506 drugs currently in development by major drug companies are antibacterial agents. The Infectious Diseases Society of America (IDSA) is urging policymakers to support efforts to bring back drug companies into the research and development of new antibiotics through several strategies such as providing economic incentives and streamlining drug approval procedures. Details of IDSA's recommendations and pre-written e-mails that can be sent directly to your local state senator or house of representative to support this issue can be found at: www.capwiz.com/idsociety/mail/oneclick_compose/?alertid=6143431

Resources

John Hopkins Division of Infectious Diseases – Antibiotic Guide: www.hopkins-abxguide.org

CDC – Campaign to Promote Appropriate Antibiotic Use in the Community: www.cdc.gov/drugresistance/community

California Medical Association Foundation: www.aware.md/resource/index.asp

Los Angeles County Department of Health Services, Acute Communicable Disease Control Program: www.lapublichealth.org/acd/antibio.htm

Infectious Diseases Society of America: www.idsociety.org

Reporting Cases of Vaccine-Preventable Diseases to the Health Department

Why is it important?

The Immunization Program assists with controlling the spread of vaccine-preventable diseases in the community. Timely reporting to the Health Department of suspected or confirmed cases is critically important for our control measures. Once a case is reported, it is not merely a statistic. Public health nurses investigate every reported case of measles, rubella, congenital rubella syndrome, pertussis, *Haemophilus influenzae* type b, hepatitis A, tetanus, diphtheria, and polio, as well as outbreaks of vaccine-preventable diseases; they implement control measures to prevent spread to family members and the community. The confidentiality of patient information is protected by law.

What are the reporting requirements for selected vaccine-preventable diseases?

California Code of Regulations, Title 17, Section 2500, Public Health, requires health care providers to report the following diseases or conditions of public health importance to the local health department. (Note: **This is only a partial list of all reportable diseases**. The most recent list of all reportable diseases is available in this issue and at the Department of Health Services Acute Communicable Disease Control web site www.lapublichealth.org/acd/reports/diseasepluscmr.pdf).

DISEASE	REPORTING PROCEDURE
Diphtheria	Report immediately to Acute Communicable Disease Control (ACDC) by phone (213) 240-7941. After hours, report to (213) 974-1234 for release of anti-toxin.
Haemophilus influenzae, invasive disease Hepatitis A Measles (rubeola) Pertussis (whooping cough) Poliomyelitis, paralytic	Report by mail, phone, or fax within 1 working day of identification of the case or suspected case. The Immunization Program requests an immediate phone call for measles cases (213) 351-7800; ask for Epidemiology Surveillance staff. After hours, please call (213) 974-1234.
Hepatitis B (specify acute or chronic case) Mumps Pneumococcal, invasive disease * Rubella (German measles) Rubella syndrome, congenital Tetanus	Report by mail, phone, or fax within 7 calendar days of identification of the case or suspected case. The Immunization Program requests an immediate phone call for rubella cases (213) 351-7800; ask for Epidemiology Surveillance staff. After hours, please call (213) 974-1234.
Outbreaks of any disease	Report immediately to the Communicable Disease Reporting System by phone (888) 397-3993. Report varicella outbreaks (5 or more cases) to the Immunization Program at (213) 351-7800. After hours, please call (213) 974-1234.

* Required in Los Angeles County. Use the IPD report form available at www.lapublichealth.org/acd/reports/diseasepluscmr.pdf

Where and how do I report these diseases?

Health care workers and school officials are required by law to report cases of vaccine-preventable diseases. Cases can be reported to the Communicable Disease Reporting System (CDRS) by telephone or fax. Confidential Morbidity Report (CMR) forms can be obtained by fax from any local health center registrar, from the Morbidity Central Reporting Unit (MCRU), or from the Department of Health Services web site at www.lapublichealth.org/acd/reports/diseasepluscmr.pdf. Cases among residents of Long Beach or Pasadena should be reported to those city health departments.

Report to:

Communicable Disease Reporting System
Hotline: (888) 397-3993
Fax: (888) 397-3778
(213) 482-5508

Morbidity Central Reporting Unit
Phone: (213) 240-7821

For general information only:
E-mail: cdrsreprt@ladhs.org

For cases among residents of Long Beach and Pasadena:

Long Beach City Health Dept.
Epidemiology
Phone: (562) 570-4301/4302
Fax: (562) 570-4374

Pasadena City Health Dept.
Public Health Nursing
Phone: (626) 744-6128

For additional information about vaccine-preventable disease reporting:

Immunization Program
Epidemiology Unit
Epidemiology Surveillance Staff
Phone: (213) 351-7440
Fax: (213) 351-2782

Los Angeles County Department of Health Services Public Health TB Control Program
TEL (213) 744-6271 FAX (213) 749-0926

Confidential Hospitalized TB Suspect / Discharge Care Plan / Approval Request

Patient Name:

D.O.B. ___/___/_____ MR# _____

Submitted By: _____

Phone (___) _____ Pager (___) _____

Facility _____

Fax # (___) _____

If Pulmonary: Dates of three consecutive negative smears

___/___/_____, ___/___/_____, ___/___/_____

Discharge to: [ ] Home [ ] Shelter [ ] SNF [ ] Jail/Prison [ ] Other _____

Discharge address and phone: _____

_____

Date patient to be discharged ___/___/_____ **F/U Appt. Date** ___/___/_____

Physician agreeing to assume TB care _____ Phone # (___) _____

Health Care Facility

Address _____

_____

Discharge TB medication regimen:

(Indicate total daily dose)

Rifamate® (INH+RIF)* _____ pills/day
Rifater®(INH+RIF+PZA) _____ pills/day
INH _____ mg
Rifampin _____ mg
Ethambutol* _____ mg
Pyrazinamide* _____ mg
Other _____ mg
Side Effects _____

*Current CDC/ATS and Los Angeles County TB Control recommendations for treatment of uncomplicated TB for 2 months followed by INH & RIF for 4 months.

Medical complications (*specify):*

_____

_____

# of days of medication supply _____

(Must be sufficient to supply patient until follow up provider appointment).

Does the patient have risks that indicate Directly Observed Therapy (DOT)?

[ ] Mental Impairment
[ ] Homeless
[ ] HIV
[ ] Hx of any non-compliant behavior
[ ] Substance

*Contact TB Control if uncertain about risk.

Contact Information/Household composition:

Number of people in household? _____
Are there children age 5 years and younger? [ ] Yes [ ] No
Are there individuals immunocompromised? [ ] Yes [ ] No

Tuberculosis Control use only:

DHS Review - Problems Noted _____

_____

Action taken before discharge _____

_____

Reviewed by _____ *Date reviewed* ___/___/_____
Approved by _____ *Date approved* ___/___/_____

Discharge Approved

[ ] Yes [ ] No

Date ___/___/_____

The Confidential Tuberculosis Suspect Case Report (H-803) form must be on file at Tuberculosis Control or submitted with this form

Los Angeles County Department of Health Services Public Health
Tuberculosis Control Program
2615 S. Grand Ave. Room 507 Los Angeles, CA 90007
Phone: 213-744-6271 Fax: 213-749-0926

Confidential Hospitalized TB Suspect/Case Discharge Care Plan / Approval Request (H- 804) Instructions

Discharge of a Suspect or Confirmed Tuberculosis Patient

As of January 1, 1994, State Health and Safety Codes mandate that patients suspected or confirmed with tuberculosis may not be discharged or transferred from a health facility (e.g. hospital) without prior approval of the Local Health Officer (i.e., TB Controller).

To facilitate a timely and appropriate discharge, the provider should submit a written discharge plan to Tuberculosis Control 1 to 2 days prior to the anticipated discharge. Tuberculosis Control will review the discharge plan for approval or denial.

Health Department Response Plan:

Weekly discharge (Non holiday 8:00 am- 5:00 pm): The written discharge plan should be submitted preferably by FAX or mail.

Tuberculosis Control staff will review the discharge plan and notify the provider **within 24 hours** of approval or inform the provider of any additional information/action required or needed for approval prior to discharge.

If a home evaluation is required to determine if the environment is suitable for discharge, health department staff will make a visit.

Holiday and Weekend Discharge: All arrangements for discharge should be made in advance when weekend discharge is anticipated. When unusual circumstances necessitate weekend or holiday discharge, the provider will phone the Los Angeles County Operator at (213) 974-1234 and ask to speak with the **Public Health Administrative Officer of the Day** (AOD). A response will usually occur within one hour. The process outlined above will be followed. If the discharge cannot be approved, the patient must be held until the next business day until appropriate arrangements can be made *(to fulfill State requirements for communicable disease reporting, the Confidential Hospitalized Tuberculosis Suspect/Case Report must be completed and submitted prior to or concurrently with the Confidential Hospitalized Tuberculosis Suspect/Case Discharge Care Plan /Approval Request)*.

(NOTE: This form is used for discharge care planning only. Call the Tuberculosis Control Program prior to faxing documents to ensure timely processing.)

Rev: 1/05

Los Angeles County
Phone: (213) 744-6271
Fax: (213) 749-0926

Confidential Morbidity Report of Tuberculosis Reactors, Suspects & Cases

Department of Health Services
Rev: 1/05

Under California law, all TB suspects and cases must be reported within ***one*** working day

Patient's Last Name	First	Middle	Date of Birth / /	Age	Sex	Patient's SS#

Patient's Address	City	State	Zip	County	Phone
					( ) -

Occupation	Country of Birth	Date Arrived in U.S. / /	Medical Record Number

(mark one) **Race:** ☐ White ☐ Black ☐ Asian *specify*_____ ☐ Pacific Islander *specify*_____ ☐ Alaska Native ☐ American Indian
(mark one) **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Previous TB Skin Test:
Date: __/__/__ _____ mm of induration
Current TB Skin Test:
Date: __/__/__ _____ mm of induration

Chest X-ray date: __/__/__
☐ Normal ☐ Cavitary ☐ Non-Cavitary
Impression: _____
_____

☐ **Check here if Reporting a Skin Test Reactor age 3 and under *only***

Complete for TB Suspect/Case Only

Active Disease
☐ **TB Suspect**
☐ **TB Case**

Site of Disease
☐ **Pulmonary TB**
☐ **Extra-pulmonary TB** **Specify Site**: _____

Cough and/or Sputum production ☐ Yes ☐ No	Date of Onset / /	Date of Diagnosis / /	Date of Death / /

Bacteriology ☐ **Not Done**

Date Collected	Specimen Type	Smear AFB	Culture MTB

Treatment ☐ **Not Started**

Drug	Dose	Start Date
INH		
Rifampin		
EMB		
PZA		
Rifamate®		
Rifater®		

Lab Name:_____ **Phone:** (____)_____

Remarks:

Reporting Health Care Provider	Telephone Number ( )	Fax Number ( )
Reporting Health Care Facility Address	**Submitted By**	**Date Submitted**

For TB Control Use
☐ New or Open
DP#:_____
☐ Close date _____
☐ Conf. date _____
☐ TB or ☐ PMD
☐ Faxed date _____
☐ Faxed date _____
cc: _____

County of Los Angeles ● Department of Health Services ● Public Health

Tuberculosis Control Program

2615 S. Grand Ave., Room 507 Los Angeles, CA 90007

WHY DO YOU REPORT ?

Because it is required! Reporting of all patients with ***confirmed*** or ***suspect*** Tuberculosis is mandated by State Health and Safety Codes (HSC) Section 121362 and Title 17, Chapter 4, Section 2500 and must be done within ***one working day of diagnosis.*** HSC Section 121361 also mandates that prior to discharge, all tuberculosis suspects and cases in hospitals and prisons have an individualized, written discharge plan approved by the Local Health Officer (i.e., TB Controller).

WHO MUST REPORT ?

1. All health care providers (including administrators of health care facilities and clinics) in attendance of a patient suspected to have or confirmed with active tuberculosis must report within ***one working day*** from the time of identification.
2. The director of any clinical lab or designee must report laboratory evidence suggestive of tuberculosis to the Health Department on the same day that the physician who submitted the specimen is notified (California Code of Regulations Section 2505).

WHEN DO YOU REPORT ?

1. When the following conditions are present:
   - signs and symptoms of tuberculosis are present, and /or
   - the patient has an abnormal chest x-ray consistent with tuberculosis, or
   - the patient is placed on two or more anti-TB drugs
2. When bacteriology smears or cultures are positive for acid fast bacilli (AFB).
3. When the patient has a positive culture for ***M. tuberculosis*** **complex** ***(i.e., M. tuberculosis, M. bovis, M. canettii, M. africanum, M. microti)***
4. When a pathology report is consistent with tuberculosis.
5. When a patient **age 3 years** or younger has a positive Tuberculin skin test and normal chest x-ray.

DELAY OR FAILURE TO REPORT:

Delay or failure to report communicable diseases has contributed to serious consequences in the past. Under the ***California Code of Regulations,*** Title 16 (section 1364.10), failure to report a communicable disease is a violation of State regulations subject to a citation(s) and monetary fine(s).

The Medical Board of California determined failure to report in a timely manner a citable offense under ***California Business and Professions Code*** (Section 2234), "Unprofessional Conduct."

HOW DO YOU REPORT ?

The Confidential Morbidity Report (CMR) form on the other side is to be completed in its entirety and submitted to Tuberculosis Control:

1. ***BY FAX:*** ***(213) 749-0926***

   or

2. ***BY PHONE:*** ***(213) 744-6271*** After hours, leave your name, phone or pager #, patient name, DOB and medical record number on voice mail.

Rev: 1/05

County of Los Angeles Department of Health Services Public Health TB Control Program
TEL (213) 744-6271 FAX (213) 749-0926

Confidential Hospitalized TB Suspect/Case Report (H-803)

****Patient:** _____
Last First MI

Address: _____

Phone (___) _____

Birthdate: ___/___/___ **Sex:** ☐ Male ☐ Female

Social Security Number: _____

****If PT. Under 18,** (Parent Name/DOB):

Employer/School: _____

Occupation: _____

Race: ☐ White ☐ Black ☐ Am. Indian ☐ Alaska Native
☐ Asian (specify)_____ ☐ Pacific Islander *(specify)*_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Country of Origin: _____ Date of US Entry ___/___/___

Contact Person (name/ph#) _____

Date of Diagnosis ___/___/___ Pulmonary TB ☐

Skin Test Date ___/___/___ Chest X-ray Date ___/___/___

Result _____ MM

☐ Not done ☐ Unknown

If Pulmonary, check symptoms.

☐ Cough ☐ Night sweats

☐ Sputum production ☐ Hemoptysis

☐ Weight loss _____(No. of lbs.)

Recorded By: _____
Phone (___) _____ Fax (___) _____

Hospital/Clinic where diagnosed _____

Medical Record # _____

Pt. currently hospitalized? ☐ Yes ☐ No Adm. Date ___/___/___

Treating Physician: _____

Address: _____

Phone (___) _____

Referred for F/U _____

Address: _____

Phone (___) _____

Will MD be continuing TB care? ☐ Yes ☐ No

Extra Pulmonary ☐ (Site) _____

Cavitary ☐ Non-Cavitary ☐

Impression: _____

Past history of TB Treatment? ☐ No ☐ Yes

If yes, where, when treated? _____

If asymptomatic, reason for evaluation _____

Other medical conditions relevant to diagnosis:

_____

_____

HIV Status: DATE ___/___/___

☐ POSITIVE ☐ NEGATIVE ☐ UNKNOWN

☐ NOT DONE ☐ REFUSED ☐ PENDING

BACTERIOLOGY

Pathology Report: _____

Lab Name and Account #: _____

Patient weight _____

Psychosocial History: _____

Allergies: _____

Specimen Number	Specimen Collection Date	Specimen Type	Smear AFB	Culture M.TB +/-

MEDICATIONS	DOSE	START DATE
Isoniazid		
Rifampin		
Ethambutol		
Pyrazinamide		
Rifamate®		
Rifater®		

Additional Comments: _____

Date Reported ___/___/___

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES TUBERCULOSIS CONTROL PROGRAM

Confidential Hospitalized TB Suspect/Case Report (H-803) Instructions

Reporting of all patients with confirmed or suspected Tuberculosis is mandated by the State Health and Safety Codes (HSC) Division 105, Part 5 and Administrative Codes, Title 17, Chapter 4, Section 2500 and must be done within 1 day of diagnosis.

Why do you report ?

Because it is required. The Health Department performs many vital functions to ensure public health and safety. These functions include contact investigation, home visits, patient education, patient compliance assessment and directly observed therapy (DOT). Tuberculosis Control staff also will assist in facilitating appropriate discharge planning. HSC section 121361 also mandates that, prior to discharge, all tuberculosis suspects and cases in hospitals and prisons have an individualized, written, discharge plan approved by the Local Health Officer (i.e., TB Controller).

Who must report ?

1. All health care providers (including administrators of healthcare facilities and clinics) in attendance of a patient suspected to have, or confirmed with, active tuberculosis, must report within 1 working day from the time of identification (California Code: Title 17, Chap. 4, Sec. 2500).

2. The director of any clinical lab or designee must report laboratory evidence suggestive of tuberculosis to the Health Department on the same day that the physician who submitted the specimen is notified (California Code: Title 17, Chap. 4, Sec. 2505).

When do you report ?

1. When the following conditions are present:
   - signs and symptoms of tuberculosis are present, and/or
   - the patient has an abnormal CXR consistent with tuberculosis, or
   - the patient is placed on two or more anti-TB drugs
2. When bacteriology smears or cultures are positive for acid fast bacilli (AFB)
3. When the patient has a positive culture for *M. tuberculosis* complex *(i.e., M. tuberculosis, M. bovis, M. canettii, M. africanum, M. microti)*
4. When a pathology report is consistent with tuberculosis

How do you report ?

The Confidential Hospitalized TB Suspect/Case Report (H-803) (on the back of this form) is to be completed in its entirety and submitted to Tuberculosis Control. The Confidential Morbidity Report (CMR) should not be used for hospitalized patients.

1. BY FAX: (213) 749-0926

2. BY PHONE: (213) 744-6271: After hours, leave your name, phone or pager #, patient's name, DOB and medical record number on voicemail.

3. BY MAIL: Tuberculosis Control Program
   2615 S. Grand Avenue, Room 507
   Los Angeles, CA 90007

Reporting tuberculin skin test

Definition of a Positive Tuberculin Skin Test:

≥ 5 mm of induration is considered positive for contacts, suspects and HIV+ or immuno-suppressed individuals of any age.
≥ 10 mm of induration is considered positive for all other screening subjects of any age.

A positive tuberculin skin test with a normal chest x-ray is not reportable unless the patient is age 3 years or younger. However, health department follow-up may be requested for PPD reactors who also meet one of the following criteria. The reason for referral must be noted on the Remarks section.

a. HIV infected or at risk for HIV infection
b. Contact to infectious case of tuberculosis
c. Abnormal chest film consistent with old TB or silicosis
d. Children 3 years old or under with a positive tuberculin skin test
e. Documented converters
f. Medical conditions that increase TB risk:
   Diabetes mellitus
   - Prolonged steroid therapy
   - Immunosuppressive therapy
   - End stage renal disease

   Unexplained rapid weight loss

Calendar

Epidemiology and Prevention of Vaccine-Preventable Diseases

This four-part series provides comprehensive core content about vaccine-preventable diseases and immunization practice. This course is ideal for physicians, nurses, nurse practitioners, and physician assistants. It is also appropriate for private and public healthcare providers including pediatricians, family practice specialists, medical assistants, residents, and medical and nursing students.

You must register to attend. Registration available at www.phppo.cdc.gov/phtnonline.

Dates: February 17 & 24, and March 3 & 10
Time: 9:00 a.m. - 12:30 p.m.
Locations: Immunization Program, 3530 Wilshire Blvd Ste 700, LA 90010
Health Services Admin, Auditorium, 313 N Figueroa St, LA 90012

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

County of Los Angeles
Department of Health Services
Public Health

313 North Figueroa Street, Room 212
Los Angeles, California 90012

This Issue . . .

Selected Reportable Diseases (Cases)* - Aug-Sept 2004

Disease	THIS PERIOD Aug & Sept 2004	SAME PERIOD LAST YEAR Aug & Sept 2004	YEAR to date Sept 2004	YEAR to date Sept 2003	YEAR END TOTALS 2003	YEAR END TOTALS 2002	YEAR END TOTALS 2001
AIDS*	777**	432	1,965	1,809	2,590	1,719	1,354
Amebiasis	23	22	76	93	121	102	139
Campylobacteriosis	173	214	693	824	1,093	1,067	1,141
Chlamydial Infections	6,605	6,242	28,816	27,737	36,555	35,688	32,670
Encephalitis	22	7	45	35	41	61	41
Gonorrhea	1,747	1,383	7,106	5,957	8,008	7,800	7,443
Hepatitis Type A	42	73	246	284	376	438	542
Hepatitis Type B, Acute	10	7	51	15	56	29	44
Hepatitis Type C, Acute	3	0	3	0	0	3	1
Measles	1	0	1	0	0	0	8
Meningitis, viral/aseptic	253	411	564	843	899	466	530
Meningococcal Infections	4	3	25	22	34	46	58
Mumps	0	1	2	10	10	16	17
Non-gonococcal Urethritis (NGU)	251	243	1,131	1,073	1,393	1,393	1,429
Pertussis	34	7	86	97	128	170	103
Rubella	0	0	0	0	0	0	0
Salmonellosis	208	193	858	716	996	956	1,006
Shigellosis	148	146	356	550	671	974	684
Syphilis, primary & secondary	71	69	332	342	442	364	188
Syphilis, early latent (<1 yr.)	44	55	283	278	365	353	209
Tuberculosis	145	129	550	547	949	1,021	1,046
Typhoid fever, Acute	2	5	12	15	16	33	17

* Case totals are provisional and may vary following periodic updates of the database.
** The sharp increase in AIDS cases (September 2004) is artificial and due to a batch of cases reported electronically from a major provider.