County of Los Angeles
Department of Health Services
Public Health

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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VACCINE SUPPLY UPDATE

The manufacturers of several vaccines are experiencing difficulty in meeting the nationwide need for their vaccines as discussed at length in the February 2002 issue of **The Public's Health** (available at lapublichealth.org/wwwfiles/ph/ph/ph/TPH0202.pdf). As manufacturers begin to increase production, shortages will continue as much of the new inventory will fill back-orders.

Based on CDC estimates, tetanus and diphtheria toxoids (Td) vaccine is expected to remain in short supply until very late in 2002, although the sole manufacturer of the vaccine recently announced that it will now make limited quantities of Td available to office-based physicians for critical needs. Health care providers should continue to follow CDC's interim recommendations for this vaccine as outlined in the May 25, 2001 issue of MMWR [50(20);418-427] available at www.cdc.gov/mmwr/preview/mmwrhtml/mm5020a8.htm and the February 2002 issue of **The Public's Health**.

As manufacturers begin to increase production, shortages will continue as much of the new inventory will fill back-orders.

Editor's note:
Shortly after this issue was printed, the Td toxoid shortage ended. As of June 21, 2002 the CDC announced a return to the regular Td immunization schedule.

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Mosquito-borne Encephalitis Surveillance – 2002

Physicians and other health care professionals in Los Angeles County should be aware of arboviruses as a possible cause of viral meningitis and encephalitis in their patients. Saint Louis Encephalitis (SLE) has been a cause of human illness in the county with 27 cases confirmed since 1984. The last confirmed case was in an elderly resident of the San Gabriel Valley who died from the illness in 1999. Western Equine encephalitis (WEE) also has caused illness, most often among residents of the San Joaquin Valley.

Most people infected with SLE and WEE arboviruses have no symptoms Those who do become ill have a range of clinical manifestations

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West Nile Virus Heading for California

The continued spread of West Nile (WN) virus across the United States has prompted concerns regarding the likelihood of contracting this disease in Los Angeles County; it has been predicted the virus will reach California within the next three years. The first human and animal cases of WN virus encephalitis in the Western Hemisphere were reported in the New York City area in the summer of 1999. There were 83 human cases during 1999-2000 and a total of 58 human cases were reported in the United States during 2001. To date, the virus has been detected in animals in 28 states as far west as Iowa. There is no evidence that the virus has migrated west of the Rocky Mountains.

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Vaccine Supply Update (from page 1)

Shortfalls in the availability of diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine will also persist, at least into late summer of 2002. Although most Los Angeles County health care providers have not found it necessary to defer any booster doses of DTaP, the February 2002 issue of **The Public's Health** provides guidance on prioritizing doses of this vaccine based upon a provider's in-house supply.

The current production level for pneumococcal conjugate (PCV-7) vaccine has not yet met the monthly demand and providers are urged to follow the "moderate or severe" shortage recommendations, based on the quantity of vaccine available to them, as detailed in the December 21, 2001 issue of MMWR [50(50);1140-2] available at www.cdc.gov/mmwr/preview/mmwrhtml/mm5050a4.htm.

Varicella and MMR vaccines, which are also currently available in limited supply, are expected to be more readily available in sufficient amounts to meet demand by late spring or early summer of this year.

Regular updates on the status of the nationwide vaccine shortages are available on CDC's National Immunization Program web site at www.cdc.gov/nip/.

VAERS is on the Internet

The Vaccine Adverse Event Reporting System (VAERS) is now accessible on the internet. Health care providers can securely submit VAERS reports by following the "VAERS Web Submission" instructions on the left hand side of the web page at www.vaers.org. Providers may be contacted for follow-up information once the initial report is received. A copy of the VAERS reporting form and instructions for how to submit it are available by calling the toll-free number 1-800-822-7967 or by toll-free fax 1-877-721-0366.

VAERS reporting is an important part of the system for monitoring and insuring vaccine safety. All health care providers are encouraged to report any adverse event which occurs in an individual who has recently received a vaccine product.

Acquired Rifamycin Resistance in Persons with Advanced HIV Disease Being Treated for Active Tuberculosis with Intermittent Rifamycin-Based Regimens[1]

Rifamycin drugs (i.e. rifampin, rifabutin, and rifapentine) are essential for short-course therapy in persons with active tuberculosis (TB). However, adverse drug-drug interactions complicate the concurrent use of rifamycins and protease inhibitor drugs in persons with active TB who are also infected with human immunodeficiency virus (HIV-TB). The CDC has recommended use of rifabutin in place of rifampin in multidrug regimens for the treatment of active TB in individuals who are HIV-positive because rifabutin can be administered with antiretroviral treatment regimens that include protease inhibitors.[2,3] These recommendations include twice-weekly intermittent therapy. Because intermittent rifabutin-based regimens had not been evaluated in clinical trials of HIV-TB, CDC's TB Trials Consortium (TBTC) initiated TBTC Study 23, a single-arm trial of twice-weekly rifabutin-based therapy for treatment of HIV-TB.

On March 6, TBTC's Data and Safety Monitoring Board (DSMB) advised CDC to suspend enrollment in Study 23 because of the occurrence of five cases of acquired rifamycin resistance among patients enrolled in the study. Although the rate of treatment failure or relapse in the study has been low (preliminary life table rate of 4.1% among the 156 patients with some time at risk), all five patients with failure/relapse had acquired rifamycin resistance. All are responding well to treatment with alternative regimens.

In the study, common features in patients with acquired rifamycin resistance included a very low CD4 cell count (all <60/mm^3) at TB diagnosis and receipt of twice-weekly therapy (in four of five) during the intensive phase (i.e., the first 2 months of rifamycin-based short-course therapy for TB); all five received twice-weekly therapy in the continuation phase. The low relapse rate suggests that rifabutin has excellent activity in the treatment of individuals with HIV-TB. However, a relation appears to exist between the frequency of dosing and the risk for acquired resistance. In an earlier study of treatment of HIV-TB using once-weekly rifapentine plus isoniazid, acquired rifamycin resistance was common.[4] Acquired rifamycin resistance also occurred in a previous study of HIV-TB treatment with twice-weekly rifampin plus isoniazid.[5] It is not known whether the risk for acquired rifamycin resistance is greater with rifabutin than with rifampin. In all of these studies, patients with acquired rifamycin resistance had very low CD4 cell counts at the time of TB diagnosis. The consistency of these findings suggests that once- or twice-weekly therapy including isoniazid and a rifamycin increases the risk for acquired rifamycin resistance among TB patients with advanced HIV disease.

Additional data are needed to clarify these issues. Until data become available, CDC recommends that persons with HIV-TB and CD4 cell counts<100/mm should not be treated with highly intermittent (i.e., once- or twice-weekly) regimens. These patients should receive daily therapy during the intensive phase, and daily or three doses a week during the continuation phase. In this group of patients, CDC recommends directly observed therapy for both daily and three-doses-a-week regimens. The low relapse rate suggests that current recommendations concerning duration are sufficient (i.e., 6 months minimum, extended to 9 months in patients with delayed response to therapy.

The CDC does not advise additional action at this time for patients with advanced HIV disease who have completed TB therapy with intermittent regimens and are clinically stable. However, clinicians should treat suspected relapse in such patients with regimens active against rifamycin-resistant TB until results of susceptibility testing are available. For HIV-TB patients with CD4 cell counts <100/mm who are being treated with twice-weekly rifamycin-based therapy, CDC recommends more frequent therapy with the same agents (i.e., daily or three times a week).

References

1. CDC. Notice to readers: Acquired rifamycin resistance in persons with advanced HIV disease being treated for active tuberculosis with intermittent rifamycin-based regimens, *MMWR* 2002;51(10):214-215. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5110a5.htm

2. CDC. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: Principles of therapy and revised recommendations. *MMWR* 1998;47(RR-20):1-51. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/00055357.htm

3. CDC. Updated guidelines for the use of rifabutin or rifampin for the treatment and prevention of tuberculosis among HIV-infected patients taking protease inhibitors or nonnucleoside reverse transcriptase inhibitors. *MMWR* 2000;49(9):185-9. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4909a4.htm

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5. El-Sadr W, Perlman DC, Matts JP, et al. Evaluation of an intensive intermittent-induction regimen and duration of short-course treatment for human immunodeficiency virus-related pulmonary tuberculosis. *Clin Infect* Dis 1998;26:1148-58.

Mosquito-borne Encephalitis Surveillance (from page 1)

from a mild, febrile illness with sudden onset of headache, fever, dizziness, nausea and malaise to fatal encephalitis. The elderly are at greatest risk for severe manifestations of SLE. With WEE, children <1 year of age may also have severe sequelae. As usual, the full range of etiologic agents for encephalitis/meningitis must be considered in the differential diagnosis, and bacterial infection must be ruled out. Identification of SLE and WEE can be made by demonstration of specific IgM antibodies in acute-phase serum or CSF or rises in antibody titers between early and late serum specimens.

Arboviral surveillance

Statewide surveillance for mosquito-borne encephalitis viruses is conducted annually from May through October. In Los Angeles County, public health surveillance efforts concentrate on monthly serologic testing of sentinel chicken flocks naive to these viruses. Additional activities include identifying and tracking the mosquitoes which transmit the virus and testing corvids (crows, jays, etc.) for WN virus. When evidence of virus is detected, mosquito abatement efforts can be targeted to the problem area. Surveillance for human disease is also conducted by investigating all reported cases of viral encephalitis and offering testing in the Public Health Laboratory (see below).This year, testing for West Nile virus has been added to the annual mosquito-borne encephalitis surveillance (see article on page 1).

Within Los Angeles County, antibodies to SLE virus were found in sentinel chicken flocks yearly from 1984 through 1998. To date, WN virus has not been identified in California, but the virus may spread to the West Coast via migrating birds during the next few years. In addition, SLE virus has been found in trapped mosquitoes occasionally. WEE virus is more commonly found in the San Joaquin Valley and Coachella Valley, but has been found both in sentinel chicken flocks and mosquitoes in the county.

PREVENTION: Reduce the risk of mosquito bites

Wild birds are the natural reservoir for SLE, WEE and WN viruses. Humans and other mammals are incidental hosts and do not act as reservoirs for the viruses. The most common mosquito vector found in California is *Culex tarsalis*. Humans acquire the disease through the bite of a mosquito that has become infected after feeding on birds carrying the virus. Person-to-person or bird-to-person transmission do not occur.

Reducing one's risk of being bitten by mosquitoes is the most important prevention measure for all mosquito-borne diseases. This includes:

- limiting outdoor activities, especially at dusk and in areas with mosquito infestation,
- wearing long sleeve shirts and pants when outside,
- using mosquito repellant, and
- assisting with mosquito suppression by eliminating standing water breeding sites.

For questions about mosquito control, please call your local Mosquito and Vector Control District.

West Nile Virus Heading for California (from page 1)

WN virus belongs to a group of viruses called flaviviruses, which includes the viruses that cause Japanese encephalitis, St. Louis encephalitis, dengue fever and yellow fever. Infection with flaviviruses is usually diagnosed by the presence of IgM in serum or CSF, but diagnosis may be difficult in people who have previous infection or immunization against one of the viruses due to cross-reaction of the flaviviral antibodies.

WN virus is transmitted by several species of mosquitoes (mainly *Culex* spp.). Most people who are bitten by an infected mosquito experience mild or no symptoms. Symptoms usually occur within 5 to 15 days after being bitten and may include fever, headache, muscle aches, swollen lymph nodes and rash. More severe illness is rare; symptoms may include encephalitis (indicating brain swelling which causes lethargy, confusion, disorientation or coma), severe muscle weakness and paralysis. Persons older than 50 years have the highest risk of disease, and case fatality is highest among the elderly.

While WN virus has not yet been identified in the county, bird migration patterns and the presence of mosquitoes able to transmit the virus will eventually allow the virus to spread to California. In addition, WN virus can spread by travel of infected individuals from endemic areas or importation of infected wild or domestic animals. The first evidence of WN virus in an area is most often a die-off of wild birds from the corvid family, crows and jays in particular. WN virus has been added to the state and county's annual mosquito-borne encephalitis surveillance (see article page 1), and testing of human serum and cerebrospinal fluid for diagnosis is available in the Los Angeles County Public Health Laboratory (see below).

TESTING FOR VIRUSES: West Nile, Western Equine and Saint Louis Encephalitis

To monitor human disease, testing of serum and cerebrospinal fluid is available upon request for human cases of viral encephalitis. Human cases are sometimes the first sign of the presence of these viruses at potential epidemic levels in the environment. The Public Health Laboratory offers assistance with diagnostic testing for arboviral infections in patients with severe febrile headache, aseptic meningitis, or encephalitis. The following specimens may be submitted:

- 5 ml spun, clotted blood for serologic determination of antibodies to SLE, WEE and WN viruses, submitted immediately following collection in a red-topped or tiger-topped tube, followed in two weeks by a convalescent specimen (testing for these viruses must be specified)
- CSF for antibody testing to SLE, WEE and WN viruses

For questions and information on submission of specimens, contact:
Los Angeles County Public Health Laboratory (213) 250-8694

SLE, WEE and WN virus infections are reportable conditions under Title 17 of the California Code of Regulations, Section 2500. Please report suspected cases of human viral meningitis/encephalitis to your local Health Department. In LAC, cases may be reported by telephone to:
Morbidity Unit (888) 397-3993 • Fax (888) 397-3778

To discuss any case with a public health physician or for further information regarding human diseases, contact:
Acute Communicable Disease Control Program (213) 240-7941

For questions regarding animal disease, contact:
Veterinary Public Health (213) 730-3723

Immunization Coalition Shares County Immunization Efforts

The Immunization Coalition of Los Angeles County ("Coalition") was established five years ago with the mission of improving the immunization coverage rates for children in the county. Since that time, significant advances have been made to prevent the spread of infectious diseases with vaccine not only to children, but to adolescents and adults at high risk of life threatening illnesses such as influenza, pneumonia, meningitis, and viral hepatitis A and B. These developments have expanded the Coalition's mission to include improving and sustaining high immunization coverage levels of all adults and children in the county.

The Coalition is a volunteer-based public/private partnership with more than 200 members from over 100 public and private health care organizations. Members represent immunization providers from public and private health clinics, HMOs, county health departments, vaccine companies, community-based organizations, schools, businesses, Women, Infant, & Children, and other social service programs. The goal of the coalition is to bring together individuals and organizations to work together in various capacities to protect the community from vaccine preventable diseases.

The goals are primarily achieved through the following strategies:

- **Information Sharing** – Discussions at quarterly session meetings (January, April, July, and October) regarding information on vaccine availability and changes to the immunization schedule, health care legislation updates at the state and local levels, and presentations from invited speakers with expertise in the fields of medicine and vaccine development.

- **Provider Education** - Education and support to immunization providers through immunization assessments and feedback; the distribution of educational materials necessary for increasing and sustaining immunization rates among children and adults in the community;

The goal of the coalition is to bring together individuals and organizations to work together in various capacities to protect the Los Angeles community from vaccine preventable diseases.

- **Community Awareness** - Increasing the community's awareness and understanding of the importance of immunizations through media events and increasing the availability of educational materials and clinic referral information;

- **Resource Development** – Exploring funding opportunities to support Coalition operations and projects.

Membership in the Coalition is open to all concerned professionals and citizens who fully accept the mission of increasing immunization coverage rates of adults and children based on the Advisory Committee of Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), the American Academy of Family Physician (AAFP). Contact Wendy Berger at (213) 351-7800 for more information.

Immunization Coalition of Los Angeles County Quarterly Meeting

The mission of the coalition is to bring together individuals and organizations to work together to protect the Los Angeles community against vaccine preventable diseases through sharing information, coordinating activities, and collaborating on immunization efforts to achieve and maintain immunization coverage rates based on the Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Topic: The Politics of Vaccines - Bruce Pomer, Pomer & Associates, Sacramento
Date: Thurs, July 11, 2002
Time: 9:30 a.m. - 12:00 noon
Place: California Hospital Medical Center
1401 S. Grand Ave, LA 90015
(Parking entrance at the Grand Ave Garage - corner of Venice & Grand)
Contact: Wendy Berger (213) 351-7800
wberger@dhs.co.la.ca.us

SPRING CLEANING

As we admire the beauty of lush vegetation and enjoy the abundance of fruits that summer months bring, let us not forget that we are not the only ones who benefit during this time of year. All that greenery and available food creates the perfect environment for what else? Rodents!

So, in order to have a more enjoyable spring that is also free of pests, we recommend the following:

1. Trim and thin out dense vegetation, especially ivy and accumulated dead fronds on palm trees. Be sure to trim shrubbery and tree limbs away from any dwelling and/or roof.

2. Remove and discard any cast-off items that have been stored in your yards from the fall/winter season. Don't forget those stacks of wood piles!

3. Elevate any salvageable items at least 18" off the ground and at least a foot away from any fences and/or walls.

4. Harvest ripe fruit and pick up the ones that have fallen on the ground.

5. Be sure not to leave pet food out overnight and to clean your yard of dog droppings on a daily basis.

6. Ensure trash cans have tight fitting lids that are kept closed at all times.

7. Check around the exterior of your home to make sure there are no openings that would allow a rat/mouse to enter. Look for holes 1/2" or greater, gaps around cables/electrical wiring/pipes that penetrate the walls and beneath doors that open to the outside. Ensure that the crawl spaces, attic and foundation vents are properly screened with 1/4" mesh(16-20 gauge), and that the vent frames are tight fitting.

For more information on rodent control, call the Vector Management Program at: (626) 430-5461.

RAT BITE REFERRALS

Attention physicians and health care providers:

The Department of Health Services has noticed in recent years that the number of reported rat bite episodes has dramatically decreased. This is a request that all rat bites be reported to the Los Angeles County Vector Management Program for high priority investigations of rodent and other health code violations.

HOW TO REPORT

Report the following: name of the bite victim(s), the complete address where the bite occurred, the address and phone number of the victim or care giver, the nature of the bite episode and the location of the bite. Include helpful and pertinent information; landlord information, communication (language) accessibility, or anonymity problems and concerns.

Report episodes to:

Vector Management Program
5050 Commerce Drive
Baldwin Park, CA 917506-1423
Phone (626) 430-5461

(Mondays thru Fridays, between 8:00 am to 5:00 pm)

ERRATUM: Pediatric HIV Infection Update

Correction: A recent issue of **The Public's Health** (April 2002, Vol.2, No. 4, available at: **lapublichealth.org/wwwfiles/ph/ph/ph/TPH_April_2002.pdf**) provided an update of pediatric AIDS infections in Los Angeles County. In that article, the description of the overall rate of HIV seroprevalence among childbearing women in Los Angeles (page 5) was incorrect and should instead be .07% and there should be 9, not 8, districts which contain higher rates of prevalence – these areas should be: Glendale, Hollywood-Wilshire, Central, Northeast, Southwest, East LA, San Antonio, Bellflower and Long Beach Districts. The original hard-copy versions in circulation contain the errors, but the web version is correct. For any questions regarding pediatric AIDS surveillance in Los Angeles County, please contact Dr. Toni Frederick at 213-250-8666.

Calendar

The Immunization Encounter: Critical Issues

This live satellite broadcast will address issues related to a routine immunization clinic encounter. This program will exemplify recommended standards of practice for patient intake and screening, vaccine administration, vaccine management, documentation, vaccine adverse events management and reporting, and resources for staff orientation and development. For more information, visit the Trainings and Conferences section of www.lapublichealth.org/ip/.

Date: Thursday, June 27, 2002
Time: 9:00 a.m. - 11:30 a.m.
Place: • DHS Auditorium
313 N. Figueroa, LA 90012
• Immunization Program
3530 Wilshire Blvd, LA 90010
Contact: Ina Hasley, (213) 351-7800
ihasley@dhs.co.la.ca.us

Providing Medical Care to Homeless populations and Use of Interpreter Services in STD Clinics

Sponsored by the STD Program, the program will feature Dennis Bleakley, M.D. from JWCH/Weingart Clinic and Rommony Chung, operations Director at PALS for Health. Pre-registration is not required.

Date: Friday, June 21, 2002
Time: 1:00 p.m. - 4:15 p.m.
Place: Barlow respiratory Hospital - Williams Hall
2000 Stadium Way, LA 90026
Contact: Kirby Mellinger, M.P.H., CME Coordinator at (213) 744-5912
CME: 3.0 credits

This Issue . . .

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Selected Reportable Diseases (Cases)[1] - March 2002

Disease	THIS PERIOD March 2002	SAME PERIOD LAST YEAR March 2001	YEAR TO DATE 2002	YEAR TO DATE 2001	YEAR END TOTALS 2001	YEAR END TOTALS 2000	YEAR END TOTALS 1999
AIDS[2]	155	113	431	349	1,415	1,652	1,876
Amebiasis	13	12	26	28	136	116	142
Campylobacteriosis	68	64	221	209	1,084	1,332	1,100
Chlamydial Infections	2,625	2,914	8,099	8,077	32,784	30,642	27,561
Encephalitis	3	8	12	18	44	51	7
Gonorrhea	598	642	1,889	1,947	7,800	7,212	6,053
Hepatitis Type A	69	42	156	141	517	1,025	1,258
Hepatitis Type B, Acute	2	0	23	0	56	72	282
Hepatitis Type C, Acute	9	1	16	5	11	32	696
Measles	0	0	0	0	8	5	1
Meningitis, viral/aseptic	48	41	138	100	534	491	390
Meningococcal Infections	4	10	17	28	53	53	49
Mumps	0	0	1	0	17	29	24
Non-gonococcal Urethritis (NGU)	86	134	329	378	1,423	1,575	1,742
Pertussis	26	6	45	18	100	102	237
Rubella	0	0	0	1	0	3	0
Salmonellosis	45	40	228	138	893	1,119	1,027
Shigellosis	37	30	162	87	596	878	687
Syphilis, primary & secondary	12	18	46	38	184	136	88
Syphilis, early latent (<1 yr.)	6	11	47	32	209	194	335
Tuberculosis	82	82	149	150	1,046	1,065	1,170
Typhoid fever, Acute	3	1	5	2	24	25	16

1. Case totals are provisional and are subject to change following publication.
2. Case totals are interim and may vary following periodic updates of the database.

Data provided by DHS' Public Health programs: Acute Communicable Diseases Control, Data Collection & Analysis, HIV/Epidemiology, Sexually Transmitted Diseases, and Tuberculosis Control.