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New Childhood and Adolescent Immunization Schedule July-December 2004 and New Influenza Vaccination Recommendations

CDC's Advisory Committee on Immunization Practices (ACIP) issued the Recommended Childhood and Adolescent Immunization Schedule — United States for 2004 in two parts this year (January-June and July-December) as ACIP anticipated making new recommendations for influenza immunization in the spring.

The childhood and adolescent immunization schedule for July-December 2004 differs from the previous schedule as follows:

It is now a recommendation that children aged 6-23 months, as well as household and out-of-home caregivers for such children, receive annual influenza vaccine.

1. It is now a recommendation that children aged 6-23 months, as well as household and out-of-home caregivers for such children, receive annual influenza vaccine. The influenza footnote in the schedule has been updated to reflect this change.
2. The influenza vaccine footnote now has the recommendation that health-care workers and other persons (including household members) in close contact with persons in groups at high risk be vaccinated annually.

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Whooping Cough Cases Expected to Increase in the County This Summer

Health care providers in Los Angeles County are being asked to heighten clinical suspicion for pertussis and to order appropriate laboratory tests especially during the summer and fall when the county normally experiences an increase in the number of reported pertussis cases, especially in infants under one year of age.

Los Angeles County and other areas in the United States have experienced a gradual cyclic increase in the number of reported pertussis cases in recent years. Pertussis incidence normally peaks every 3 to 5 years. The County's last peak was in 2002 when 171 pertussis cases were reported. In 1999, the number of reported cases reached 236, a 30-year high. There were 129 cases of pertussis reported in 2003 in the county, which was above the annual average of 101 cases reported between 1990 and 2000. Nearly two-thirds of the reported cases occurred in infants under one year of age. However, epidemiological analysis of data collected over the past ten years showed the 5-14 year age group (especially the 9-14 year olds) to be emerging as an age group disproportionately affected by pertussis morbidity. Vaccine protection is known to decrease over time, with little or no protection 5-10 years following receipt of the last vaccine dose, which is usually given at 4-6 years of age. Adolescents and adults are the primary reservoir for continued transmission of the disease.

Physicians should heighten clinical suspicion for pertussis and order appropriate laboratory tests

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Childhood and Adolescent Immunization Schedule (from page 1)

3. The range of recommendations bar for influenza vaccine for children aged 6-23 months has been moved above the dotted red line, indicating that these children should be vaccinated annually.

In preparation for the implementation of the above recommendations, the Vaccines for Children (VFC) program expanded the criteria for influenza vaccine coverage to include all VFC-eligible children aged 6-23 months and VFC-eligible children aged 2-18 years who are household contacts of children aged 0-23 months. The VFC program also covers the influenza vaccine for VFC-eligible children aged 6 months through 18 years who are at increased risk for influenza complications and VFC-eligible children aged 6 months through 18 years who are household members of persons who are at increased risk for influenza complications.

Among previously unvaccinated children aged less than 9 years, two doses of vaccine administered one or more months apart are recommended for satisfactory antibody response. If possible, the second dose should be administered before December. Health-care providers should consider beginning influenza vaccinations of infants and other children under 9 years of age receiving influenza vaccine for the first time in September or as soon as vaccine is available. Health-care providers are encouraged to consider how they will notify parents of children that are recommended to receive influenza vaccine but are not scheduled for an office/clinic visit during the fall of the need for their child to receive influenza vaccine. Health-care providers may want to consider using their reminder/recall system to have children come to the office/clinic for an immunization-only visit.

Other New Influenza Vaccine Recommendations and Updates

On April 30, 2004, CDC issued its annual MMWR on the Prevention and Control of Influenza, Recommendations of the Advisory Committee on Immunization Practices (ACIP). The primary changes and updates include the following points:

1. The 2004-2005 trivalent vaccine virus strains are A/Fujian/411/2002 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Shanghai/361/2002-like antigens. For the A/Fujian/411/2002 (H3N2)-like antigen, manufacturers may use the antigenically equivalent A/Wyoming/3/2003 [H3N2] virus, and for the B/Shanghai/361/2002-like antigen, manufacturers may use the antigenically equivalent B/Jilin/20/2003 virus or B/Jiangsu/10/2003 virus.
2. ACIP recommends that healthy children aged 6-23 months, and close contacts of children 0-23 months, be vaccinated against influenza.
3. Inactivated vaccine is preferred over live, attenuated influenza vaccine (LAIV) for vaccinating household members, health-care workers, and others who have close contact with severely immunosuppressed persons (e.g., patients with hematopoietic stem cell transplants) during periods when such persons require care in a protected environment. If a health-care workers receiving LAIV should avoid

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Childhood and Adolescent Immunization Schedule (from page 2)

refrain from contact with severely immunosuppressed patients for 7 days after vaccine receipt. No preference exists for inactivated vaccine use by health-care workers or other persons who have close contact with persons with lesser degrees of immunosuppression.

4. Severely immunosuppressed persons should not administer LAIV. However, other persons at high risk for influenza complications may administer LAIV.
5. CDC and other agencies will asses the vaccine supply throughout the manufacturing period and will make recommendations in the summer preceding the 2004-2005 influenza season regarding the need for tiered timing of vaccination of different risk groups.

Among previously unvaccinated children aged less than 9 years, two doses of vaccine administered one or more months apart are recommended for satisfactory antibody response. If possible, the second dose should be administered before December.

Persons Recommended to Receive Annual Influenza Vaccine

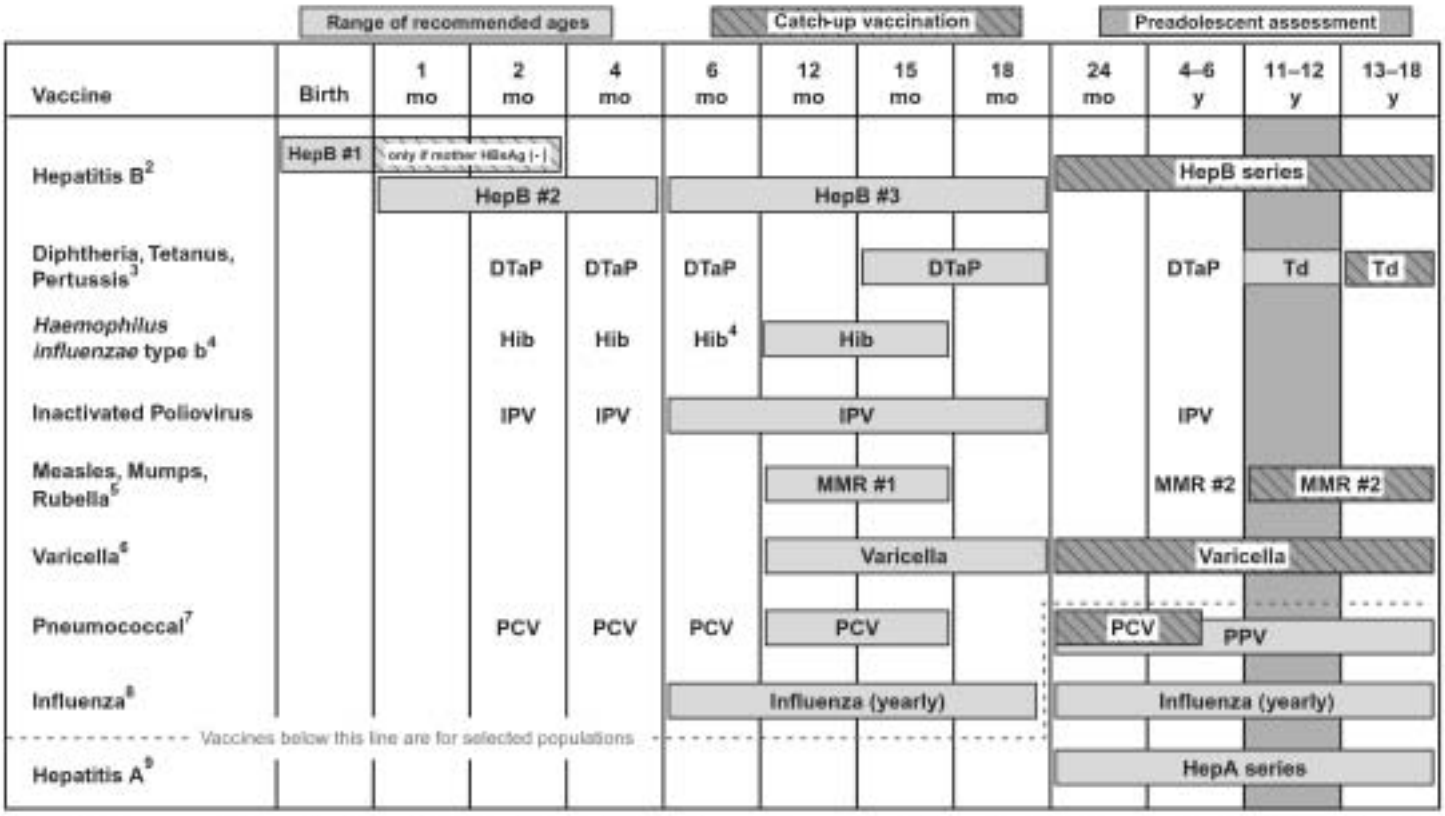
Influenza vaccination is recommended for the following persons who are at increased risk for complications from influenza:

- Persons 65 years of age and older;
- Residents of nursing homes and other chronic care facilities that house persons of any age who have chronic medical conditions;
- Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma;
- Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression [including immunosuppression caused by medications or by human immunodeficiency virus (HIV)];
- Children and adolescents (aged 6 months-18 years) who are receiving long-term aspirin therapy and, therefore, might be at risk for experiencing Reye syndrome after influenza infection;
- Women who will be pregnant during influenza season; and
- Children aged 6-23 months.

Other groups recommended to receive annual influenza vaccine:

- Persons aged 50-64 years because this group has an increased prevalence of persons with high-risk conditions.
- Persons who can transmit influenza to persons at increased risk of influenza complications, including:
  - Physicians, nurses, and other personnel in both hospital and outpatient-care settings, including medical emergency response workers (e.g., paramedics and emergency medical technicians);
  - Employees of nursing homes and chronic-care facilities who have contact with patients or residents;
  - Employees of assisted living and other residences for persons in groups at high-risk;
  - Persons who provide home care to persons in groups at high-risk; and
  - Household contacts (including children) of persons in groups at high risk.

Recommended Childhood and Adolescent Immunization Schedule[1], United States, July-December 2004



1. Indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of April 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. ▩ Indicates age groups that warrant special effort to administer those vaccines not given previously. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.org/ or by telephone, 800-822-7967.

2. Hepatitis B vaccine (HepB). All infants should receive the first dose of HepB vaccine soon after birth and before hospital discharge; the first dose also may be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent HepB vaccine can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series; 4 doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose except for combination vaccines, which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks. Infants born to HBsAg-positive mothers should receive HepB vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1–2 months. The last dose in the vaccination series should not be administered before age 24 weeks. These infants should be tested for HBsAg and anti-HBs at age 9–15 months. Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB vaccine series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the vaccination series should not be administered before age 24 weeks.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). The fourth dose of DTaP may be administered at age 12 months provided that 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary vaccination in infants at ages 2, 4, or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be given at age ≥12 months.

5. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not received the second dose previously should complete the schedule by the visit at age 11–12 years.

6. Varicella vaccine (VAR). Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses given at least 4 weeks apart.

7. Pneumococcal vaccine. The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

8. Influenza vaccine. Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, and diabetes), health care workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53:[RR][in press]) and can be administered to all others wishing to obtain immunity. In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine, because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2000;52(No. RR-13):1–8. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if 6–35 months or 0.5 mL if ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

9. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups. Consult your local public health authority and *MMWR* 1999;48(No.RR-12):1–37. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A vaccination series during any visit. The 2 doses in the series should be administered at least 6 months apart.

Additional information about vaccines, including precautions and contraindications for vaccination and vaccine shortages is available at http://www.cdc.gov/nip or from the National Immunization Information Hotline, 800-232-2522 (English) or 800-232-0233 (Spanish). Approved by the **Advisory Committee on Immunization Practices** (http://www.cdc.gov/nip/acip), the **American Academy of Pediatrics** (http://www.aap.org), and the **American Academy of Family Physicians** (http://www.aafp.org).

New Guidelines for the Selective Use of Herpes Simplex Virus Type 2 Serology Tests

Genital herpes is one of the most common sexually transmitted diseases in the U.S., affecting 22% of sexually active adults. Now, with the availability of type-specific serology tests that can distinguish between antibodies for herpes simplex virus type 1 and type 2 (HSV-1 and HSV-2), clinicians can better diagnose genital ulcer disease and screen for asymptomatic herpes infections. The California Sexually Transmitted Diseases Controllers Association and the California Department of Health Services recently reviewed the relevant literature and came up with some helpful guidelines for the targeted use of HSV-2 type-specific serologies.

Genital Herpes Background

Genital herpes, the majority of cases caused by HSV-2, causes a wide range of symptoms, from the typical painful vesicles/ulcers to those that are less typical, including: urethritis, cervicitis, skin or mucosal fissures, and non-specific itching, burning, or tingling of anogenital skin. However, 90% of people seropositive for HSV-2 are unaware of their infection. After primary infection, HSV-2 establishes latency in spinal cord ganglia. HSV-2 infected persons have recurrent viral reactivations that can be either symptomatic or asymptomatic. Regardless of symptoms, people with HSV-2 antibodies are likely to have recurrent episodes of asymptomatic shedding; therefore, sexual partners of these individuals are at risk of becoming infected. HSV-2 infections can cause significant morbidity in infected persons and in neonates, and may be a cofactor for HIV acquisition and transmission.

While there is no cure for HSV-2 at this time, antiviral therapy has been shown to decrease the frequency and the duration of recurrences and to decrease the frequency of viral shedding. Condoms have been shown to decrease the transmission of HSV-2 to uninfected partners; however, to be effective they must be used correctly and consistently, even in the absence of lesions or prodrome. Chronic suppressive therapy for symptomatic individuals with HSV-2 infections appears to decrease transmission to uninfected regular partners.

Summary of Recommendations

Type specific serologic tests for HSV-2 are a useful clinical tool to aid in the diagnosis of problematic genital ulcer disease, when used in conjunction with direct testing. The goals of screening for HSV-2 infection (i.e. testing in people without symptoms) is to identify infected persons in order to help patients recognize symptoms, as well as to educate them about how to protect themselves from acquiring HIV and how to protect their seronegative partners from becoming infected with HSV-2 and/or HIV (if co-infected with HIV). The following recommendations are based on currently available scientific data and assume that risk-reduction counseling is offered to the patient at the same time with HSV serologic screening.

Recommended Use of HSV-2 Serologies for Diagnosis and Screening

- Diagnosis of genital lesions/symptoms: type-specific serology tests **should be available** for diagnostic purposes in conjunction with virologic tests at any clinical setting where patients are seen for STDs. Serology tests may be useful in the following situations:
  - o a culture-negative recurrent lesion,
  - o a history suggestive of herpes/atypical herpes with no lesions to culture, and
  - o the first presentation of genital symptoms when culture or antigen detection is negative or not available
- Screening in HIV-positive patients: **should generally be offered**.
- Screening in patients in partnerships or considering partnerships with HSV-2 infected people: **should generally be offered.**
- Screening in patients at-risk for STD/HIV (current STD, recent STD, high-risk behaviors): **should be offered to select patients.**
- Universal screening in pregnancy: **should generally not be offered.**
- Screening in general population: **should generally not be offered.**
- Herpes education and prevention counseling is necessary for all people being screened for HSV-2.

The complete guideline are available at: www.stdhivtraining.org/pdf/HSV_guidelines.pdf.
A summary of the guidelines is available at: www.stdhivtraining.org/pdf/HSV_guidelines_summary.pdf

Whooping Cough (from page 1)

Infants under one year of age are at highest risk for acquiring clinical pertussis and for pertussis-associated complications. Secondary bacterial pneumonia is the most common complication and is the cause of most of the pertussis-related deaths. Other complications include seizures and encephalopathy. Protecting infants from acquiring pertussis is of utmost importance. The following activities will help protect infants:

1. **Immunize infants with DTaP on schedule.** The best way to protect infants from pertussis is to give DTaP vaccine starting at 2 months of age with the second dose at 4 months of age and the third dose at 6 months of age. At least three doses of DTaP vaccine are needed to give adequate protection from pertussis; however, even one or two doses will provide some protection. An additional vaccine dose given at 12-15 months of age followed by a booster dose at 4-6 years of age are also required to maintain immunity throughout childhood.

2. **Protect infants from exposure to pertussis.** Educate parents about the importance of protecting their very young infants from pertussis exposure by minimizing contact with persons who have cold symptoms or a cough illness. It is believed that at least 7% of adult cough illnesses are caused by pertussis.

3. **Increase clinical suspicion for pertussis and order appropriate tests in all age groups.** Consider pertussis in any child, adolescent or adult that presents with a persistent cough illness of 2 weeks or more whether or not it is associated with coughing paroxysms. Consider pertussis in infants experiencing a cough illness of any duration.

   Only a positive culture or a positive polymerase chain reaction (PCR) test on nasopharyngeal secretions can be used for laboratory confirmation of pertussis. (Positive PCR must also be accompanied by positive clinical signs and symptoms.) It is better to directly plate the nasopharyngeal aspirate or swab onto special media (Bordet-Genou or Regan-Lowe agar), rather than using transport media. Healthcare providers should contact their laboratory now to assure that the appropriate media is available when needed. Although a positive direct fluorescent antigen (DFA) or similar direct antigen assay can be helpful, the poor specificity and sensitivity of these tests limit their usefulness.

4. **Report suspected and confirmed pertussis cases to public health officials in a timely manner — do not wait for lab confirmation.** When public health officials receive reports of cases and suspected cases of pertussis an investigation is initiated to determine the source and spread of the infection. Treatment of previously undiagnosed cases and antibiotic prophylaxis of persons that have been in close contact with the case are arranged to prevent the spread of the disease. Reporting of all cases and suspected cases of pertussis within one working day of diagnosis is required under the California Code of Regulations (Title 17, Section 2500). Reports should be made to the local health department. For most of the county, reports are made to the Los Angeles County Department of Health Services at 888-397-3993. For the cities of Long Beach and Pasadena, reports are made to the city health departments: Long Beach 562-570-4301 and 562-570-4302 and Pasadena 626-744-6128.

Greater attention to the above four interventions will greatly reduce the incidence of pertussis and its complications. For additional information on pertussis, nasopharyngeal specimen collection, laboratory tests, and reporting, please contact the Los Angeles County Immunization Program at 213-351-7800. Additional information can also be found on the Immunization Program's web site at:
www.lapublichealth.org/ip/vpds/pertussis.pdf

Harbor-UCLA Rated Top Performer

"Exceptional" Citations for Access to Care, Physician Productivity, Patient Satisfaction

A national study of medical centers operations and physician productivity has ranked Harbor-UCLA as one of the top three performers among those studied. The University HealthSystem Consortium conducted the "Ambulatory Clinic Operational Effectiveness and Physician Productivity Project" to examine the interaction of various operational performance metrics and to identify the strategies and tactics in place at organizations that demonstrated operation effectiveness and high levels of physician productivity.

Harbor-UCLA Medical Center was one of the twenty-six academic medical centers that voluntarily participated in this study of which there were four components:

1. Access to Care
2. Productivity
3. Patient Satisfaction
4. Ambulatory Care Finances

At the completion of the study, Harbor-UCLA was selected as one of three "best performers," along with the Medical College of Georgia and the University of Massachusetts Medical Centers. Harbor achieved "exceptional" performance levels (top 5th percentile) in three areas: Access to Care, Productivity, and Patient Satisfaction.

The specific performances were:

1. Low clinic cancellation rates (with rare exceptions, clinics are not cancelled)
2. High number of patient visits (when measured per physician, per available exam rooms, and per available number of support staff)
3. High patient satisfaction rates (when asked if they would recommend their clinics to others)

Harbor was particularly singled out for its use of productivity targets for each of its clinics. These targets were established in conjunction with each clinic's medical director, and were based upon expected physician productivity, available staffing and available number of clinic exam rooms. Productivity is monitored monthly by an interdisciplinary Ambulatory Care Council. In the seven years since this initiative was established, total ambulatory care visits have increased by 25%.

(UHC) is an alliance of 118 Academic Medical Centers (private and public) which, among other services, conducts benchmarking studies on a number of different clinical and operational topics.

Pitfalls in the Diagnosis and Management of Tuberculosis and Lessons Learned

A recent case in the community points out the need for a high index of suspicion for tuberculosis (TB) and the importance of proper infection control procedures when dealing with patients in whom TB should be suspected.

TB remains a major cause of morbidity and death in the world. Even with cases generally declining in the US, it remains a serious problem. Thus, medical professionals must be knowledgeable about the reporting requirements and appropriate diagnostic procedures for TB.

Case:

A 30 year-old African-American presented to his physician in January 2004 with progressive cough, fevers, chills, and weight loss. He had a history of a positive tuberculin skin test (TST) and recent incarceration. His chest X-ray at the time showed extensive upper lobe infiltrates on one side. He was treated for community-acquired pneumonia. However, when he did not improve, he was referred to a pulmonologist in February. The patient was a former smoker, and the pulmonologist decided to take the patient directly to bronchoscopy. The broncho-alveolar washings were smear negative for acid-fast bacilli (AFB), and showed no malignant cells. The pulmonologist then referred the patient to a tertiary center for further work-up. Induced sputa there were smear-positive for AFB, and the patient was started on four-drug self-administered therapy for TB in late March. Some of the dosages were subtherapeutic according to the latest 2003 American Thoracic Society/CDC guidelines for the treatment of TB.[1] These were corrected when he finally came to the attention of the local public health center in early May, but subsequent smears and cultures remained positive for several weeks. His specimens eventually grew fully drug-sensitive M. tuberculosis.

This case points out several pitfalls in the diagnosis and management of TB. First, pulmonary TB should have been suspected from the start, and based upon this suspicion, should have been reported to public health within one working day (California Codes and Regulations, Title 17, Section 2500). A high level of suspicion for TB is important in Southern California because the TB case rate in Los Angeles County is twice that of the United States. Because the patient had a history of a previously positive TST and incarceration (a risk factor for tuberculosis), TB should have been strongly considered.

The second oversight was in proceeding directly to bronchoscopy before collecting sputa for AFB tests. In fact, properly induced sputa maybe more sensitive than bronchoscopy.[2-4] Obviously, bronchoscopy should be done if needed, but only after induced sputa have been collected and are AFB smear-negative. Sputum induction, when done properly, is cheaper than bronchoscopy, maybe more sensitive in detecting smear-positive cases, and eliminates the need for an invasive procedure that may also pose infectious risks to health care workers in the bronchoscopy suite.

The third pitfall was having this patient on self-administered therapy. Studies have shown clinicians are not able to predict patients' compliance with treatment.[5] Directly observed therapy (DOT), which public health clinics in Los Angeles County provide free of charge to patients unable to pay, should be considered the standard of care for the treatment of active TB. Failure to initiate DOT may result in acquired drug resistance and treatment failure. In our experience, the vast majority of patients for whom DOT is recommended are happy to cooperate once they understand the benefits of DOT.

A fourth problem was the use of sub-therapeutic dosages of anti-TB drugs in this patient, which may have contributed to his prolonged infectiousness. Sub-therapeutic dosing can also lead drug resistance and treatment failure.

Fortunately, the physicians at the hospital immediately notified public health of the case once they knew his smear-positive status, thereby facilitating our

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TB Case Study (from page 8)

effort to locate, screen, and appropriately treat his contacts. Reporting is each physician's moral, ethical, and legal duty because delay or failure to report communicable diseases has resulted in outbreaks. California Code of Regulations, Title 17, Section 2500 requires the reporting of TB suspects and cases within one working day. Also, The Medical Board of California has made failure to report in a timely manner a citable offense under the California Code of Regulations, Title 16, Section 1364.10.

TB remains a major cause of morbidity and death in the world. Even with cases generally declining in the US, it remains a serious problem. Thus, medical professionals must be knowledgeable about the reporting requirements and appropriate diagnostic procedures for TB. The management of active TB requires a thorough understanding of the treatment guidelines and a close working relationship with public health. Clinicians should feel free to refer TB cases and suspects to public health which routinely offers DOT to ensure adherence to therapy.

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5. CDC. Core Curriculum on Tuberculosis 2003; 39-51.

Reporting of West Nile Virus now Mandated in Los Angeles County

West Nile virus (WNV) infection, when documented by laboratory findings, has been added to the list of mandated reportable diseases and conditions in Los Angeles County (California Code of Regulations, Title 17, Sections 2503 and 2505). Physicians and laboratories must report patients with a positive WNV test within one (1) working day using a standard Confidential Morbidity Report (CMR). Reports can be submitted by facsimile (888-397-3778) or called into our Morbidity Department during normal business hours (888-397-3993).

While WNV infection is of great concern, the likelihood of infection and disease progression is, nonetheless, rare-only one in every five persons infected with WNV will experience symptoms. Testing for WNV should only be performed on patients with the following signs or symptoms:

- aseptic meningitis,
- encephalitis or acute flaccid paralysis, or
- West Nile fever (characterized by headache, fever, muscle pain, and often rash, with symptoms lasting more than 7 days).

In light of the expected increases in human cases of WNV to occur in our county this season, this enhanced surveillance is an important method of improving timely disease identification and enacting localized prevention efforts to limit additional cases.

West Nile virus information is changing almost daily. For the latest in surveillance, reporting and prevention findings, visit: www.lapublichealth.org/acd/VectorWestNile.htm

For questions, contact Acute Communicable Disease Control at 213-240-7941, Mon-Fri 8:00am - 5:00pm

DHS Runs First Full-Scale Smallpox Vaccination Drill

About 1000 "patient volunteers" arrived at the Carson Community Center last month as a team of 200 DHS staff put into practice the department's Strategic National Stockpile (SNS) Dispensing/Vaccination Center (DVC) Plan which outlines the process of distributing, dispensing and recovering SNS material. The exercise tested the department's ability to vaccinate a large number of residents in a community setting - a requirement of the county's Smallpox Preparedness, Response and Recovery Plan.

The exercise tested the department's ability to vaccinate 250 people an hour. Carson was selected because it has a facility that is ideal for testing the community vaccination center model. Additionally, Carson has large natural gas and oil refineries within its borders -- potential "target" areas and the city has held previous exercises to practice its emergency response procedures. An estimated 10,000 hours of staff time was involved in the planning, training and actual exercise. Preparations for the drill began late last year with 30 different county (Sheriff, Parks and Recreation and Mental Health departments) and non-county (Glendale Fire Department, Pasadena and Long Beach health departments, Air Force, Kaiser Permanente and the City of Carson) agencies participating during the planning process and actual drill.

Two shifts of about 100 staff each worked the various clinic stations in the center (triage, client education, vaccine administration, etc.) while another 30 staff evaluated the different aspects of the center's functioning. Another 43 ancillary staff attended to the logistics and organization such as managing the bus loads of "patients" brought in from the Artesia Transit Center, maintaining a safe and secure environment for the drill and registering volunteers.

The drill gave the department the chance to experience first hand the challenge of setting up a mass vaccinating center in a short period of time. Staff were able to test and evaluate the effectiveness of their procedures for crowd control and management, client education, client screening for potentially communicable conditions, and for contraindications to vaccination, client counseling on vaccination related issues and vaccine administration.

Other lessons learned: recognizing the importance of on-site briefing and training staff before they interact with the first clients (even though all staff had been pre-trained several weeks before the drill); the importance of reducing and simplifying the paper work associated with all aspects of center activities; the need for a sufficient number of trained unit leaders available to assist and answer questions from staff at each station, and the need for a better operational understanding and implementation of the incident command system at the staff level.

Nearly 1,000 people participated in the first full-scale mass smallpox vaccination drill on June 23 at the Carson Center.

The department plans to conduct one or more exercises each year on several components of our response plans.

For more information, contact: Stephanie Faren, MPH/MSN at 213-351-7800 or sfaren@ladhs.org.

Health Professionals and Child Abuse/Neglect:
Reporting Guidelines, Resources and Special Considerations

A fourteen-year-old girl is pregnant by a 26-year-old man. A school nurse, multiple physicians, nurses, and social workers see her by the time of birth. The birth certificate and vital statistics create a permanent public record. California law makes this pregnancy a required report because she was under 16 and he was over 21 when the pregnancy was conceived (Penal Code 261.5[d]).

Laws addressing ages and sex were passed in order to give definition to what is reportable. This includes sexual acts between a child under age 16 and another at least 10 years older and sexual intercourse between a child under age 16 and an adult who is 21 or older. (P.C.261.5[d]) Failure to detect the age of the older partner might remove the required status, but reporting is still optional.

Child abuse/neglect reports are to be made as soon as possible by phone to law enforcement and/or the Department of Children and Family Services (DCFS), hotline 800-540-4000, followed by written report forms in 36 hours. DCFS receives about 150,000 reports a year. About 10% are sent to civil court and a smaller number go to criminal court. The most common response to a report involves no sanctions but may involve services. Most cases involve physical abuse and neglect. Sexual abuse seems to have a higher rate of criminal sanctions than physcal abuse or neglect and most sexual abuse does not involve pregancy.

Reports require reasonable suspicion, not proof. Mandated reporters who fail to report may be punished by a fine of $1,000 and/or up to 6 months in jail. Reporting is an individual responsibility. Reporters are immune from liability for reports made in good faith (P.C. 11172[a]).

Mandated reporters include physicians, nurses, clinical social workers, public health workers who treat children, coroners, those who perform autopsies, dental professionals, therapists, emergency medical technicians, paramedics or any other person who is currently licensed under Division 2 of the Business and Professional Code. Mandated reporters entering employment must sign a statement provided and retained by their employers informing them of their responsibilities (P.C. 11165.5[a]). It is a crime for a supervisor to impede a mandated reporter's reporting duties or to subject the reporter to sanctions for reporting.

The investigating agency is obligated to provide the mandated reporter with follow-up on the results of the investigation, and action taken (P.C. 11170[b][2]). The identity of the mandated reporter is kept confidential. It may be helpful, however, to inform the family you are reporting, and continue to follow the child, particularly young or medically fragile children.

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Court order, parental consent or legal opinion may manage concerns about continued release of information.

Families with child abuse/neglect may also experience reportable domestic violence, elder and dependent adult abuse/neglect.

Health professionals should be aware of Child Abuse/Neglect reporting law and be familiar with its reporting guidelines.

Resources:

1. Your local hospital child abuse team may assist with consultation or training.
2. The DCFS hotline (800-540-4000) can help decide if a specific case is reportable.
3. Your local DCFS office can supply reporting forms. Keep them available.
4. Your public/private health facility may provide consultation or training.
5. DHS Child Abuse Prevention Program (CAPP): www.lapublichealth.org/mch/capp/capp.htm, (213) 639-6444, kwest@ladhs.org or sguine@ladhs.org.

References:

1)The California Child Abuse and Neglect Reporting Law, condensed version, 2003. Additional information contact Crime and Violence Prevention Center California Attorney General's Office, 1300 I St, Suite 1120, 916/324-7863, www.safestate.org

2) Child Abuse Neglect Guidelines, Identification and Case Management, Marilyn Peterson, LCSW and Michael Durfee, MD, Volcano Press 2003 (www.volcanopress.com). Funded in part by the California Department of Health Services Maternal Child Health Section, as guidelines for health professionals statewide.

3) Future notations on CAPP web www.lapublichealth.org/mch/capp/capp.htm.

(1) CAPP Directory of Health Professionals-Summer 2003

(2) The ICAN/District Attorney's Protocol for LAC - fall 2003

(3) The California Attorney General's Task Force on the Child Abuse and Neglect Reporting Act, CANRA - 2004.

Calendar

Epidemiology and Prevention of Vaccine-Preventable Diseases

This live, two-day course is designed to provide updates on schedules, contraindications, standard immunization practices, vaccine-preventable diseases, and vaccine management and safety. For each vaccine-preventable disease, participants will learn to describe the disease, list the groups at highest risk, identify those for whom routine immunization is recommended, describe characteristics of the vaccine used to prevent each disease, and discuss current immunization issues.

Registration form available at www.lapublichealth.org/ip/train&conf/EPVPD.pdf
Form must be mailed; no fax or telephone registrations will be accepted. Register by close of business on Nov 1, 2004.

Date: November 18-19, 2004
Time: 8:00 am - 5:00 pm
Location: Torrance Marriott
3635 Fashion Way
Torrance, CA 90503

This Issue . . .

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

Selected Reportable Diseases (Cases)[1] - February-March 2004

Disease	THIS PERIOD Feb-Mar 2004	SAME PERIOD LAST YEAR Feb-Mar 2003	Year to date - March 2004	Year to date - March 2003	YEAR END TOTALS 2003	2002	2001
AIDS[1]	354	372	535	472	2,590	1,719	1,354
Amebiasis	13	12	19	24	121	102	139
Campylobacteriosis	145	137	224	234	1,093	1067	1,141
Chlamydial Infections	6,284	5,914	9,572	9,341	36,585	34,680	31,658
Encephalitis	4	11	12	14	41	61	41
Gonorrhea	1,553	1,156	2,264	1,870	8,014	7,540	7,468
Hepatitis Type A	54	69	85	103	376	438	542
Hepatitis Type B, Acute	8	14	17	18	56	29	44
Hepatitis Type C, Acute	0	0	1	0	0	3	1
Measles	0	0	0	0	0	0	8
Meningitis, viral/aseptic	52	57	93	98	899	466	530
Meningococcal Infections	6	9	14	13	34	46	58
Mumps	0	2	0	2	10	16	17
Non-gonococcal Urethritis (NGU)	254	216	386	362	1,393	1,256	1,343
Pertussis	20	38	40	50	128	170	103
Rubella	0	0	0	0	0	0	0
Salmonellosis	160	140	236	231	996	956	1,006
Shigellosis	64	161	93	266	671	974	684
Syphilis, primary & secondary	63	70	99	113	448	355	181
Syphilis, early latent (<1 yr.)	52	57	80	98	377	348	191
Tuberculosis	113	115	115	130	949	1,021	1,046
Typhoid fever, Acute	0	4	1	5	16	33	17

1. Case totals are provisional and may vary following periodic updates of the database.

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