

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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Flu is Here!

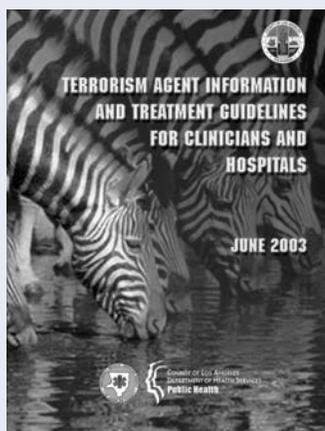
Prepare Now for an Early and Severe Season

Early indicators suggest that this will be a particularly severe influenza season. This is due in large part to a novel viral strain currently circulating across the nation—and expected to appear in Los Angeles County. Influenza viruses are constantly mutating, and this year, some antigenic drift has been detected in the type A H3N2 strain (A/Fujian/411/2002). This viral strain is not included in the current vaccine, although the vaccine contains a related H3N2 strain (A/Moscow/10/99), which may still afford some protective immunity. Moreover, since the influenza vaccine contains *three* viral strains, and since the remaining two correspond to other viruses in circulation, vaccination is still the best method of

illness protection during these winter months. Since it can take up to 14 days for vaccination to protect against influenza, those at increased risk for complications (e.g., infants, the elderly, and those with chronic medical conditions) who have not already received influenza vaccination this season should be vaccinated as soon as possible.

There are several antiviral medications which are effective for both treatment and prophylaxis against influenza. A comparison of influenza antivirals is provided on the CDC website at: www.cdc.gov/ncidod/diseases/flu/fluoviral.htm

Continued on page 2



Bioterrorism Information Manual Now Available

Healthcare facilities and clinicians need to be aware of and prepared for bioterrorism. Since individual healthcare providers may be the first to recognize and respond to a bioterrorist event, early detection by astute clinicians and rapid reporting to the local health department will be critical in minimizing the impact of a bioterrorism event or other infectious disease emergency.

The Los Angeles County Department of Health Services has recently published a clinicians' manual, *Terrorism Agent Information and Treatment Guidelines for Clinicians and Hospitals*, which provides a comprehensive resource for information on biological, chemical and radiological terrorism. This book can serve as an important guide for responding to and seeking information in the event of an attack.

This manual is available to you for immediate reference in electronic form on the websites www.ladhs.org and www.labt.org. If you would like to receive a printed copy of this manual, free of charge, please send your name and mailing address via email to bt@dhs.co.la.ca.us or via fax to 213-580-0194.

As always, to report outbreaks or a case of any reportable disease, call the Communicable Disease Reporting System Hotline at 888-397-3993. If you suspect a possible bioterrorist incident, **immediately** contact the Los Angeles County Acute Communicable Disease Control Program at 213-240-7941 (M-F 8-5) or 213-974-1234 (after hours) and ask to speak to the physician-on-call. ☎

THE PUBLIC'S HEALTH

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Influenza (from page 1)

Worldwide outbreaks attributed to novel Fujian strain

The U.S. is not the first country to be affected by the Fujian strain of influenza. In June and July of 2003, nearly all areas of Australia reported large influenza outbreaks due to this novel strain. This strain also accounted for record rates of illness in New Zealand, and more recently, notable influenza outbreaks in the United Kingdom (U.K.) and Canada.

Within the U.S., Fujian influenza outbreaks have occurred in Texas, Colorado, and as close as Northern California. As of mid-December, the majority (71%) of nationwide isolates antigenically typed are the Fujian H3N2 strain. In addition, nationwide surveillance shows influenza cases occurring earlier and at higher rates than previous years; while highly variable, patient visits due to influenza-like illness are already at rates higher than baseline expectations.

Young children are particularly susceptible to influenza because most have little or no history of past exposure and are typically not vaccinated. Thus, they usually have limited protective immunity. This is especially problematic during seasons when novel strains are circulating. In early November, the U.K. reported several sudden deaths among children attributed to Fujian influenza infection. And as of December 3, Colorado reported five deaths among children attributed to influenza type A (H3N2), both Panama-type and Fujian-type.

Influenza in Los Angeles County

Locally, there has been a notable increase in sporadic influenza cases occurring across our county. All of the confirmed cases have been identified as influenza type A. To date, only one isolate has been typed as H3N2 and full strain typing is still pending so it is unknown whether the Fujian strain is present in our county. Nearly all of the reported cases in Los Angeles County have been pediatric cases (mostly under 14 years of age). Also of note is the range of symptoms reported by these cases; many have reported gastrointestinal symptoms (e.g., vomiting, nausea, stomach cramps) not usually associated with respiratory illness. Pediatricians should, therefore, be cautious in diagnosing gastrointestinal illnesses, particularly among those with concurrent respiratory symptoms.

Continued on page 3

Influenza (from page 2)

Healthcare facilities are advised to prepare for a severe influenza season. Because, for most people, influenza infection will resolve without complications, the public should be reminded to refrain from seeking treatment at emergency rooms unless truly necessary—since doing so can greatly impact our already beleaguered emergency system and needlessly spread illness to those most vulnerable. The Hospital Association of Southern California, in conjunction with DHS, has published guidelines to manage hospital overflow due to communicable disease. See www.hasc.org/resources/download.cfm?ID=357 

**Information on influenza in Los Angeles County is available at:
www.lapublichealth.org/acd/flu.htm**

Recommendations for Healthcare Facilities

All acute care hospitals are urged to take steps to reduce the likelihood of an influenza-related outbreak occurring at their facility. The following recommendations have been drafted by the California Department of Health Services based on past experiences during seasons with novel influenza strains in circulation.

- Institute a respiratory hygiene program (see adjoining table), most importantly asking that all patients with respiratory symptoms wear surgical masks and physically segregating them from other patients to the extent possible.
- Urge all healthcare workers receive influenza vaccination.
- Order more influenza vaccine if necessary and urge physicians to vaccinate high risk patients (e.g., a hospital-based program for inpatients).
- Establish walk-in influenza clinics to triage and treat patients away from the Emergency Department.
- Consider visitor restrictions as respiratory illnesses increase in the community.
- Review vacation requests for the winter holidays to ensure adequate staffing in the event of an outbreak occurring over this period, and consider methods to identify and mobilize additional staff.
- If program flexibility is needed to address a community-wide outbreak, apply for such flexibility to the appropriate Licensing and Certification District Office.
- Review inventories of supplies and equipment, such as ventilators, which might be in short supply during an outbreak.
- Consider postponing elective surgery if hospital capacity is exceeded.

Components of a Respiratory Hygiene Program

- Place a box of surgical masks as close to the entry as possible.
- Provide masks to all patients with symptoms of a respiratory illness with instructions on their proper use and disposal.
- For patients who cannot wear a surgical mask, provide tissues with instructions to cover the nose and mouth when coughing or sneezing.
- If possible, provide a small paper or plastic bag for mask and tissue disposal.
- Provide a readily accessible waterless hand hygiene product and instruct patients to decontaminate their hands after dealing with respiratory secretions and before their contact with a health-care worker.
- Separate patients with respiratory illness from other patients by either placing them into a cubicle, examination room or some physical separation by at least 3 feet.

Pediatric cases of acute encephalopathy associated with flu and pediatric deaths associated with flu should be reported to:

**Acute Communicable Disease Control
(213) 240-7941**

Advances in pediatric HIV testing: Assembly Bill 1676

On October 9, 2003, before leaving office, Governor Gray Davis approved Assembly Bill (AB) 1676 which public health officials hope will improve prenatal human immunodeficiency virus (HIV) testing rates in California and help prevent mother-to-child HIV transmission. AB 1676 was supported by numerous HIV/AIDS organizations as well as the California Medical Association, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.

This new bill replaces the 1996 Senate Bill (SB) 889 which mandated the offering of voluntary HIV counseling and testing to all pregnant women and the documentation of the offer in their medical charts. AB 1676 goes beyond SB 889, making HIV testing a routine part of prenatal care by including it among the battery of tests California law requires for all pregnant women. Existing law requires a blood specimen to be tested for rhesus (Rh) blood type and the presence of hepatitis B surface antigen. This new law requires that the blood specimen also be tested for the presence of HIV. Under the new law, the woman must be informed of: the purpose of testing, the routine nature of the test, the risk of perinatal transmission of HIV, and the risks and the benefits of the test—including that approved treatments are known to significantly decrease the risk of perinatal transmission of HIV. Women have the right to refuse testing. The acceptance of testing must be documented and maintained in their medical records.

If during the final prenatal care or at the time of delivery, the medical records do not document a test for HIV, the healthcare provider (e.g., physician, surgeon, etc.) is required to request an HIV test with the woman's consent documented in her medical chart.

There are several reasons why AB 1676 is an important addition to HIV prevention. First, for nearly a decade, zidovudine (ZDV) has proven suc-

We strongly urge all prenatal care providers to learn more about AB 1676 and make HIV testing a routine part of prenatal care and care at labor and delivery—especially for women with no documentation of an HIV test.

No baby should be born with HIV infection.

cessful in substantially reducing the transmission of HIV from mother to child when given to the mother prenatally, during labor and delivery, and then to the newborn for 6 weeks after birth. This effective preventative treatment makes it essential to identify and test women during prenatal care so that treatment can be initiated if tests are positive. Second, the CDC recently reported that women are most likely to be tested prenatally if the provider recommends the test as a routine part of prenatal care. Several studies have shown that the most important factor in a woman's acceptance of the HIV test is how strongly the provider recommends the test. By making the test a standard part of prenatal care, the doctors can more easily encourage universal and routine testing of all pregnant women. Third, this law reinforces the importance of HIV testing during labor and delivery if there is no documentation of an HIV test in the medical records. Since women with no prenatal care are at the highest risk of transmitting HIV to their newborns, HIV testing and the initiation of treatment to the HIV-positive mother during labor and delivery and to the newborn are essential to reduce the risk of HIV transmission. If

Continued on page 5

Pediatric HIV Testing (from page 4)

the mother tests positive for HIV, she can also be counseled not to breastfeed her baby. HIV testing at labor and delivery can be done with an expedited EIA test, or the newly approved OraQuick® rapid HIV test. The new rapid test uses a finger-prick amount of blood and can provide results within 20 minutes.

Despite our substantial successes in reducing mother-to-child transmission of HIV, there are still gaps in the prevention system—there is continuing HIV infection among infants in Los Angeles County. As of August 2003, the DHS Pediatric Spectrum of HIV Disease project identified 12 HIV-infected infants born between January 2001 and June 2003. Four of these infants were born out-

side our county. Of the 8 born in Los Angeles County, 3 had no prenatal care. Of the 5 infants with prenatal care, only 1 had a prenatal diagnosis of HIV infection. If HIV testing were a routine part of care both during the prenatal period and at labor and delivery, treatment could have prevented some of these transmissions from mother to child. ☞

For further information, please contact:

- Toni Frederick, Pediatric Spectrum of HIV Disease Project: 213-351-7320
- Azita Naghdi, Pediatric HIV Reporting Project: 213-351-7863

The Gateway Program: *Improving the Health of Children in Los Angeles County*

The Child Health and Disability Prevention (CHDP) Program of Los Angeles County provides many preventive health examinations to low-income children throughout our county. CHDP is part of California's version of the federal program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and is outlined in Title 17 of the California Health and Safety Code.

Beginning July 1, 2003, CHDP introduced the new **Gateway** process. CHDP serves as a "gateway" to get more children into Healthy Families and Medi-Cal by automatically pre-enrolling eligible children into temporary fee-for-service, full scope Medi-Cal for up to two months. The **Gateway** process also allows a family to request a Healthy

Families/Medi-Cal application so that they can apply for permanent health insurance coverage for their child.

Over 2,500 providers in Los Angeles County are approved to provide CHDP health assessments at over 1,100 provider sites, including the DHS comprehensive medical centers, community clinics, and private provider offices. All CHDP providers must first be Medi-Cal providers. To ensure a high standard of care, CHDP requires its providers to follow strict, comprehensive guidelines.

Though the **Gateway** enrollment system was fully operational as of July 1, 2003, CHDP providers are not required to enroll children into **Gateway** until January 1, 2004. This transition period was implemented to help providers feel more comfortable with incorporating the **Gateway** process. However, as of November 2003, over 75% of CHDP Providers in Los Angeles County are using the **Gateway** system. As a result, over 81,000 children have been enrolled into the **Gateway** system between July 1 and November 15, 2003. ☞

For more information about the CHDP program and Gateway, call Aletha Wild at (626) 569-6027.

If you are interested in becoming a CHDP provider, call (800) 993-2437.

Vaccine Storage and Handling

The Importance of Proper Vaccine Storage

Proper vaccine storage and handling are critical components of successful immunization efforts. Vaccines that have lost their potency, which can occur from exposure to inappropriate temperatures, will not protect recipients and will leave them vulnerable. Once a vaccine has lost its potency, returning it to proper storage conditions will not restore its effectiveness.

In order to assure optimal potency of vaccines and to avoid wasting costly vaccines, they must be stored properly at all times. Vaccines have differing storage requirements. All of the childhood vaccines lose potency when exposed to temperatures warmer than the recommended storage temperature. Varicella vaccine is the most sensitive to heat, followed by measles-mumps-rubella (MMR). Many vaccines are also highly sensitive to cold temperatures. Some vaccines will lose their potency entirely if frozen. Vaccines destroyed by freezing include hepatitis A and B vaccines, inactivated polio vaccine (IPV), diphtheria, tetanus, and pertussis containing vaccines (DTaP, DT, Td, TT), pneumococcal polysaccharide vaccine (PPV), pneumococcal conjugate vaccine (PCV), inactivated influenza vaccine, and liquid *Haemophilus influenzae* type b (Hib) vaccines. Lyophilized Hib vaccines and their diluents also should not be frozen. Vaccines freeze at temperatures just below 32°F (0°C).

Proper maintenance and monitoring of refrigerator/freezer units are necessary to ensure vaccine potency. Refrigerator and freezer temperatures should be monitored and recorded at least twice daily—once in the morning and again in the afternoon. These readings should be compared to the acceptable ranges for vaccine storage. Refrigerators and freezers should be adjusted or repaired if they cannot maintain temperatures within the appropriate range.

Once a vaccine has lost its potency, returning it to proper storage conditions will not restore its effectiveness.

The acceptable refrigerator temperature range is between 35°F and 46°F (between 2°C and 8°C). The acceptable freezer temperature range is 5°F or colder (-15°C or colder) if varicella vaccine is in the freezer. Varicella vaccine will maintain minimal potency when stored continuously at refrigerator temperatures for up to three days.

If vaccines are inadvertently exposed to out-of-range temperatures, contact the manufacturer of the vaccines; or if vaccines were obtained from the State's Vaccines for Children (VFC) Program or the Los Angeles County Immunization Program, contact the respective agency for instructions. 

For more information and materials on vaccine storage and handling, including temperature log sheets and posters, contact the Immunization Program at (213) 351-7800.

In October of this year, the MMWR published an excellent article on vaccine storage: CDC. Guidelines for Maintaining and Managing the Vaccine Cold Chain. MMWR 2003; 52; 1023-1025. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm5242a6.htm



ANTIBIOTIC RESISTANCE INFORMATION CORNER

Treatment of otitis media with observation and a safety-net antibiotic prescription.

Siegel RM, Kiely M, Bien JP, Joseph EC, Davis JB, Mendel SG, Pestian JP, DeWitt TG. *Pediatrics*. 2003 Sep;112(3 Pt 1):527-31.

Available at: www.pediatrics.aappublications.org/cgi/content/full/112/3/527

Acute Otitis Media (AOM) is the most commonly treated bacterial infection among children. Studies have shown that antibiotics offer little clinical benefit for children with AOM as most cases will usually resolve by themselves. However, most parents believe that antibiotics are necessary to treat AOM and will insist on getting a prescription from a physician. This study presents a potential solution to this dilemma in which parents were given a safety-net antibiotic prescription (SNAP) to be filled if their children's AOM symptoms did not resolve after 48 hours of diagnosis. Among 175 children followed-up in the study, only 55 (31%) filled their antibiotic prescription. Previous AOM episodes were predictive of filling the prescription. Children with two or more previous AOM episodes were significantly more likely to have their prescriptions filled than children with one or no previous AOM episodes (83.9% vs 65.3%; $\chi^2 = 4.09$; $p < 0.04$). Compared with their previous experience, parents were overwhelmingly willing to treat AOM with pain medication alone: 78% of parents reported that the pain medication was effective and 63% reported that they would be willing to treat future AOM episodes without antibiotics and with pain medication alone. Results indicate that the strategy of providing a SNAP and offering pain control medication for immediate symptomatic treatment was acceptable to parents. The strategy can also reduce unnecessary antibiotic prescriptions for children with uncomplicated AOM. 

Patient education materials and other resources are available online at:

- Centers for Disease Control and Prevention - www.cdc.gov/drugresistance/community/
- Los Angeles County Acute Communicable Disease Control Program - www.lapublichealth.org/acd/antibio.htm
- California Medical Association (CMA) Foundation - www.aware.md/resource/index.asp
- Clinical Practice Guidelines Compendium (Pediatric and Adult) - www.aware.md/clinical/clinical_guide.asp

DHS Staff Recent Publications

Risk of Opportunistic Infection in the HAART Era Among HIV-Infected Latinos Born in the United States Compared to Latinos Born in Mexico and Central America *AIDS Patient Care and STDs 2003;17;267-275.*

Available at: www.ramiro.ingentaselect.com/vl=2751692/cl=33/nw=1/fm=docpdf/rpsv/cw/mal/10872914/v17n6/s2/p267

Authors: Amy Rock Wohl, MPH, PhD,* Sharon Lu MPH,* Jane Turner MPH,* Andrea Kovacs MD, Mallory Witt MD, Kathleen Squires MD, William Towner MD, Victor Beer MD.

A study of HIV-infected Latinos in treatment at four HIV clinics in Los Angeles County revealed that Latina women born in the U.S. were more likely than Central American-born Latinas to develop an opportunistic infection (OI) from 1996-2000. U.S.-born Latino men and women combined were also at greater risk for HIV encephalopathy and Kaposi's sarcoma. In addition to underreporting that may result from the use of English-based criteria for diagnosing HIV encephalopathy among Spanish-speaking patients, these highly active antiretroviral therapy (HAART) era data suggest that variation in OI risk among Latinos may also be explained by acculturation factors, such as negative lifestyle factors and the absence of social support systems. The results of this analysis suggest that risks for OIs in the HAART era may be different from the pre-HAART era when OI rate variation by national origin was explained by exposure to etiologic factors by county of birth, geographical inconsistencies in the diagnosis and reporting of OIs, and differential access to health care services for HIV by national origin. These findings are important as health care providers consider treatment and social support options and planners consider allocation of resources for HIV health services. 

* From the Los Angeles County HIV Epidemiology Program

HOSPITALIZED PEDIATRIC MRSA CASES NO LONGER REPORTABLE

From May 5, 2003 to November 7, 2003, hospitalized pediatric methicillin-resistant *Staphylococcus aureus* (MRSA) infections were reportable in Los Angeles County. This temporary reporting requirement was in response to the notable increase in community-acquired MRSA infections occurring both locally and nationwide.

The mandatory reporting of hospitalized pediatric MRSA cases has now ended. If you are aware of a case (occurring May 5 to November 7) that has not been reported, notification should be submitted immediately. All reports must be received by January 31, 2004.

Cases can be reported with a Confidential Morbidity Report (CMR) form (available at: www.lapublichealth.org/acd/reports/diseasePLUScmr.pdf) or directly to the Morbidity Unit (telephone 213-240-7821 or fax 888-397-3778). Reports should also include the MRSA antibiogram, and the isolate should be sent to the LAC Public Health Laboratory (313 North Figueroa Street, Los Angeles, CA 90012). As always, outbreaks of MRSA are still reportable—Acute Communicable Disease Control (ACDC) should be notified immediately to assist with containment and prevention of this communicable disease. For questions, contact ACDC at: 213-240-7941. 

This Issue . . .

<i>Influenza Vaccination</i>	1
<i>BT Information Manual</i>	1
<i>New Pediatric HIV Testing Law</i>	4
<i>CHDP Gateway Program</i>	5
<i>Vaccine Storage and Storing Information</i>	6
<i>Antibiotic Resistance Corner</i>	7
<i>DHS Staff Recent Publications</i>	7

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

Selected Reportable Diseases (Cases)¹ - July~August 2003

Disease	THIS PERIOD July-Aug 2003	SAME PERIOD LAST YEAR July-Aug 2002	YEAR TO DATE		YEAR END TOTALS		
			2003	2002	2002	2001	2000
AIDS ¹	537	374	1,780	1,180	1,787	1,354	1,648
Amebiasis	17	24	80	77	109	139	109
Campylobacteriosis	189	268	667	701	1,092	1,141	1,273
Chlamydial Infections	6,217	5,999	23,644	22,160	36,590	31,658	30,642
Encephalitis	3	18	31	48	63	41	49
Gonorrhea	1,345	1,253	4,924	4,797	7,985	7,468	7,212
Hepatitis Type A	47	64	234	340	482	542	839
Hepatitis Type B, Acute	6	1	42	16	27	44	65
Hepatitis Type C, Acute	0	0	1	2	3	1	28
Measles	0	0	0	0	0	8	5
Meningitis, viral/aseptic	319	127	599	399	669	530	491
Meningococcal Infections	4	5	20	35	46	58	53
Mumps	1	7	11	21	16	17	29
Non-gonococcal Urethritis (NGU)	236	205	888	830	1,398	1,343	1,575
Pertussis	10	20	89	92	167	103	102
Rubella	0	0	0	0	0	0	3
Salmonellosis	189	214	607	621	990	1,006	990
Shigellosis	79	142	453	421	922	684	849
Syphilis, primary & secondary	61	67	273	221	362	181	136
Syphilis, early latent (<1 yr.)	24	53	204	218	341	191	194
Tuberculosis	138	174	494	593	1,025	1,046	1,065
Typhoid fever, Acute	5	12	14	22	34	17	21

1. Case totals are interim 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.