PUBLIC HEALTH Bulletin

COUNTY OF ORANGE ▯ HEALTH CARE AGENCY

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Lead poses risk to children's health

Recently, some candies (such as Chaca Chaca, Bolirindo and Tama Roca) have been reported to the California Department of Health Services (CDHS) Food and Drug Branch with elevated lead levels. Follow-up has been conducted to ensure that the products with lead are no longer being sold in California. However, various brands/types of Mexican or other imported candies are still being sold that may contain lead.

Items such as paint, dust, soil, home remedies, traditional pottery, metal or painted toys and jewelry, miniblinds, dried fruits, herbs and spices, crayons, insecticide chalk, candles, cosmetics or other items may also contain various amounts of lead.

Medical providers may use well-child and other visits as opportunities to ask parents whether their children may have been exposed to these items. In Orange County, immigrant children who have been in the US for one year or less are at high risk for lead poisoning even if their current environment is low risk for lead. If there is concern about possible exposure, the provider should consider ordering a blood lead test.

State of California guidelines minimally require the following:

For all Medi-Cal, Child Health Disability Prevention Program (CHDP), Healthy Families or Women, Infants, & Children (WIC) eligible children:

- Test at age 12 months ***and*** at age 24 months
- ***or*** between ages 25 and 72 months if not previously tested

For all other children:

Using the risk assessment questions that follow, assess children at age 12 months ***and*** at age 24 months ***or*** between the ages of 25 and 72 months if not previously assessed or tested.

- "Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently renovated?"
- If the response to the question is "Yes" or "Don't know," a blood lead test needs to be ordered on the high risk child. Given the chronic nature of lead poisoning, immigrant children (one year or less) should be considered "don't know."

In addition, any child may receive a blood

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CDC launches online bioterrorism training

Plague is the first of six potential bioterrorism agents for which The Centers for Disease Control and Prevention has developed an online training program. Launched in June 2004, the free plague training module is a series of eight lessons that are intended to help healthcare professionals recognize a terrorist event as it relates to the health of our communities. Being more prepared to quickly recognize an intentional biological, chemical, or radiological incident is critical to ensuring a prompt public health response to control the situation and prevent additional illnesses or deaths.

The target audience for the plague-training module is medical professionals in hospital and primary care settings (physicians, physician assistants, nurses, nurse practitioners, nurse-midwives), as well as veterinarians and other health care professionals. In addition to CME credits, nursing contact hours and CE Contact Hours for health education are offered for completion of the lessons.

The plague training module is found on the CDC's website at **www.bt.cdc.gov/agent/plague/trainingmodule**. Objectives of the plague-training module are to allow participants to:

- Identify where plague occurs naturally in order to recognize possible bioterrorism.
- Identify patient symptoms that will lead to a diagnosis of bubonic, pneumonic, or septicemic plague.
- Describe how to rule out other diseases when diagnosing plague.
- Identify the appropriate specimens to obtain in order to diagnose plague.
- Describe the medical management of confirmed plague cases.
- Describe the public health response needed for naturally occurring versus bioterrorist plague.
- Describe the diagnosis of plague in animals.

Future modules will cover anthrax, botulism, smallpox, tularemia and viral hemorrhagic fevers.

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Infections in health care settings targeted

The Centers for Disease Control and Prevention's campaign to prevent antimicrobial resistance in health care settings now includes specific recommendations for prevention among residents of long-term care facilities.

The recommendations fall into four categories and total 12 recommended steps.

Prevent Infection

- **Step 1.** Vaccinate
  - Give influenza and pneumococcal vaccinations to residents
  - Promote vaccination among all staff
- **Step 2.** Prevent conditions that lead to infection
  - Prevent aspiration
  - Prevent pressure ulcers
  - Maintain hydration
- **Step 3.** Get the unnecessary devices out
  - Insert catheters and devices only when essential and minimize duration of exposure
  - Use proper insertion and catheter-care protocols
  - Reassess catheters regularly
  - Remove catheters and other devices when no longer essential

Diagnose and Treat Infection Effectively

- **Step 4.** Use established criteria for diagnosis of infection
  - Target empiric therapy to likely pathogens
  - Target definitive therapy to known pathogens
  - Obtain appropriate cultures and interpret results with care
  - Consider *C. difficile* in patients with diarrhea and antibiotic exposure
- **Step 5.** Use local resources
  - Consult the infectious disease experts for complicated infections and potential outbreaks
  - Know your local and/or regional data
  - Get previous microbiology data for transfer residents

Use Antimicrobials Wisely

- **Step 6.** Know when to say "no"
  - Minimize use of broad-spectrum antibiotics
  - Avoid chronic or long-term antimicrobial prophylaxis
  - Develop a system to monitor antibiotic use and provide feedback to appropriate personnel
- **Step 7.** Treat infection, not colonization or contamination
  - Perform proper antisepsis with culture collection
  - Re-evaluate the need for continued therapy after 48-72 hours
  - Do not treat asymptomatic bacteriuria
- **Step 8.** Stop antimicrobial treatment
  - When cultures are negative and infection is unlikely
  - When infection has resolved

Prevent Transmission

- **Step 9.** Isolate the pathogen
  - Use Standard Precautions
  - Contain infectious body fluids (use appropriate Droplet and Contact isolation precautions)
- **Step 10.** Break the chain of contagion
  - Follow CDC recommendations for work restrictions and stay home when sick
  - Cover your mouth when you cough or sneeze
  - Educate staff, residents and families
  - Promote wellness in staff and residents
- **Step 11.** Perform hand hygiene
  - Use alcohol-based handrubs or wash your hands
  - Encourage staff and visitors
- **Step 12.** Identify residents with multi-drug resistant organisms (MDROs)
  - Identify both new admissions and existing residents with MDROs
  - Follow standard recommendations for MDRO case management

The CDC's Campaign to Prevent Antimicrobial Resistance is found on the CDC website at **www.cdc.gov/drugresistance/healthcare**.

Pediatric influenza vaccination urged

More than eight million infants and children should receive influenza vaccine each year, yet only one-third of these children actually receive the vaccine. This is the lowest vaccination rate for any recommended childhood vaccine in the United States. To support the recommendation of the Advisory Committee on Immunization Practices (ACIP) that influenza vaccine be given to all children ages six to 23 months, the National Foundation for Infectious Disease has developed a free online CME course entitled *Increasing Pediatric Influenza Immunization in Infants and Children*.

The online course is intended to be completed in two hours, and is available at **www.pedflumodels.com**. A CD-Rom of the course can be requested by calling (866) 686-6343 or by sending an e-mail to info@pedflumodels.com. The course is intended for family physicians, pediatricians, pediatric infectious disease specialists and others interested in lessening the burden of influenza in children. Subject matter is divided into four topics:

(1) influenza epidemiology and disease burden in children;
(2) safety, immunogenicity and efficacy of influenza vaccine in children;
(3) ten tips to increase influenza vaccination rates in your office; and
(4) increasing pediatric immunization rates with influenza vaccine clinics in a private practice.

Providers needed for influenza surveillance

Orange County health care providers are being sought to participate in a nationwide influenza surveillance network, with several benefits offered to participants in return for a few minutes of their time.

What is an influenza sentinel provider?

An influenza sentinel provider conducts surveillance for influenza-like illness (ILI) in collaboration with Orange County Public Health, the state health department and the Centers for Disease Control and Prevention. Data reported by sentinel providers, in combination with other influenza surveillance data, provide a national picture of influenza virus and ILI activity in the U.S.

What data do sentinel providers collect? How and to whom are data reported?

Sentinel providers report the number of patient visits for influenza-like illness by age group (0-4 years, 5-24 years, 25-64 years, $\geq$65 years) along with the total number of patient visits each week. These data are transmitted once a week via fax to Orange County Public Health, using a simple form that just involves checking boxes. Most providers report that it takes them **less than 30 minutes a week** to record and report their data. In addition, sentinel providers can submit specimens from a subset of patients for virus isolation **free of charge**.

Who can be an Influenza Sentinel Provider?

Providers of any specialty (e.g., family practice, internal medicine, pediatrics, infectious diseases) in any type of practice (e.g., private practice, public health clinic, urgent care center, emergency room, university student health center) are eligible to be sentinel providers. In addition, sentinel providers may be physicians, nurse practitioners, or physician assistants.

Why Volunteer?

Influenza viruses are constantly evolving and cause substantial morbidity and mortality (approximately 36,000 deaths) almost every winter. Data from sentinel providers are critical for monitoring the impact of influenza and, in combination with other influenza surveillance data, can be used to guide prevention and control activities, vaccine strain selection, and patient care. In addition, many agents of bioterrorism may present as influenza-like illnesses and monitoring ILI may help detect a bioterrorism event. Sentinel providers receive feedback on the data submitted, summaries of regional and national influenza data, and a free subscription to CDC's Morbidity and Mortality Weekly Report and Emerging Infectious Diseases journal. The most important consideration is that the data provided are critical for protecting the public's health.

For more information on participating in Influenza Sentinel Provider Surveillance, please contact Michele Cheung, M.D., MPH, Orange County Epidemiology, at 714-834-7729 or by e-mail at mcheung@ochca.com.

Influenza Vaccine Alert

The extreme shortage of influenza vaccine in the U.S. will make the 2004-05 flu season very challenging. The Orange County Health Care Agency (HCA) has adopted the State Health Officer's order (insert enclosed) to limit influenza vaccination to persons in high-risk categories. HCA has also been working with community health care providers to assess vaccine supply and, where possible, direct available vaccine to high-risk groups and individuals. Throughout the flu season, HCA will post current influenza-related information to its Internet site at www.ochealthinfo.com/epi/flu. Information will include recommendations for health care providers, prevention information and links to information from the Centers for Disease Control and California Department of Health Services.

West Nile Virus added to list of reportable diseases

Following the confirmation of the first human West Nile Virus infection in Orange County, County Health Officer Mark B. Horton, M.D., added West Nile Virus disease to the county's list of reportable diseases, as authorized under the California Health and Safety Code, Section 120175.

As stated in Dr. Horton's order, the case definition of West Nile Virus disease is:

West Nile Virus disease, defined as an illness

1) Clinically compatible with
   a) West Nile Fever (WNF) — fever, headaches, myalgias, lymphadenopathy, rash, fatigue and weakness lasting at least seven days OR
   b) West Nile Neuroinvasive Disease (WNND) — meningitis, encephalitis or acute flaccid paralysis

AND with

2) Supportive laboratory results
   a) serum or CSF enzyme immunoassay (EIA) for WNV-specific IgM, OR
   b) fourfold or greater change in WNV-specific IgG titer (or equivalent change using alternate IgG method) between acute and convalescent sera, OR
   c) isolation of WNV or demonstration of WNV antigens or genomic sequences in tissue, blood, cerebrospinal fluid, or other body fluid.

WNV disease is reportable within one working day of identification by telephone, fax or mail to Orange County Epidemiology at:

Telephone (714) 834-8180
Fax (714) 834-8196
Or by Mail to P.O. Box 6128, Santa Ana, CA 92706-0128.

Aseptic meningitis and encephalitis of any etiology are currently reportable diseases under State law (California Code of Regulations, Title 17, Section 2500). The California Department of Health Services and the California Conference of Local Health Officers support the implementation of WNV disease reporting to improve surveillance and raise awareness of the disease.

Childhood *(Continued from Page 1)*

test at the provider's discretion or parental request.

According to Dr. Gilberto Chavez, Associate Director and State Epidemiologist of the California Department of Health Services (CDHS), "Lead is toxic to humans, especially infants, young children, and developing fetuses, in both short and long-term exposures and can result in learning disabilities and behavioral disorders that could last a lifetime."

Providers should be especially concerned about pregnant women and children who may have consumed contaminated imported candies or products, or who may have contact with leaded paint, dust, or soil.

According to the Orange County Childhood Lead Poisoning Prevention Program, almost all of the children found to have elevated blood lead levels in Orange County were discovered because a routine blood level was drawn as recommended by the guidelines.

Providers may also consider warning families to avoid the use of imported products such as candies to prevent ingestion of lead.

Questions regarding lead poisoning in children may be directed to your local Childhood Lead Poisoning Prevention Program. In Orange County, California, please contact (714) 834-8006.

ORANGE COUNTY REPORTED CASES OF SPECIFIED NOTIFIABLE DISEASES

Second Quarter (Weeks 1-26)
Number of Cases by Year of Report

DISEASE	2004	2003	2002	2001
AIDS[1]	107	139	107	157
AMEBIASIS	7	3	8	17
CAMPYLOBACTERIOSIS	105	110	118	133
CHLAMYDIA	2,952	2,691	2,887	2,568
CRYPTOSPORIDIOSIS	3	8	4	4
E-COLI 0157:H7	4	2	1	1
FOOD POISONING OUTBREAKS	16	19	38	17
GIARDIASIS	49	52	56	85
GONOCOCCAL INFECTION	439	325	360	287
H-FLU, INVASIVE DISEASE	3	2	2	2
HANSEN'S DISEASE, LEPROSY	0	0	0	0
HEPATITIS A (acute)	21	41	60	80
HEPATITIS B (acute)	15	14	30	24
HEPATITIS B (chronic)	500	631	651	779
HEPATITIS B (perinatal, acute & chronic)[2]	515	645	681	803
HEPATITIS C (acute)	4	3	2	5
HEPATITIS C (chronic)	743	786	841	1,339
HEPATITIS OTHER/UNSPECIFIED	2	3	8	6
HIV[3]	285	364	n/a	n/a
KAWASAKI DISEASE	11	17	12	7
LISTERIOSIS	7	1	8	8
MALARIA	6	2	7	5
MEASLES (RUBEOLA)	0	0	2	4
MENINGITIS, TOTAL	211	147	132	96
ASEPTIC MENINGITIS	192	124	103	77
MENINGOCOCCAL INFECTIONS	13	3	5	7
MUMPS	1	2	5	2
NON-GONOCOCCAL URETHRITIS	276	292	407	303
PERTUSSIS	41	35	40	5
PELVIC INFLAMMATORY DISEASE	20	20	40	25
RUBELLA	0	0	0	0
SALMONELLOSIS	118	87	121	118
SHIGELLOSIS	36	45	47	47
STREP, INVASIVE GROUP A	13	30	36	20
SYPHILIS, TOTAL*	111	140	179	106
PRIMARY	4	8	9	10
SECONDARY	13	8	6	14
EARLY LATENT	16	7	19	16
LATENT	1	7	1	5
LATE LATENT	76	109	142	61
CONGENITAL	1	1	2	0
NEUROLOGICAL	0	0	0	0
TUBERCULOSIS	59	56	90	78
TYPHOID FEVER, CASE	0	7	2	0

NA= Not Available [1] Source: CDC HARS Reporting System

[2] Previously included in Hepatitis B acute or chronic totals. Separate reporting started in 2002.

[3] Source: CDC HARS Reporting System. HIV case reporting began July 1, 2002; data is unavailable for previous years.

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