



Epidemiological Bulletin

March 2006

Volume 5 / Number 1

New Diagnostic Tests Available from San Mateo County Public Health Laboratory

Bruce Fujikawa, DrPH, Lab Director
Beth Schulz, RN, MPH, Communicable Disease Control Officer

The San Mateo County Public Health Laboratory is the communicable disease reference lab for San Mateo County, providing routine and specialized laboratory services for the detection, control, and prevention of infectious diseases. Examples of work done at the lab include HIV serology and viral load, tuberculosis, chlamydia, gonorrhea, parasitology, mycology, rabies, and water bacteriology. Public Health Laboratory staff provide consultation about lab issues to providers and laboratories Monday-Friday 8AM-5PM at (650) 573-2500.

New diagnostic tests currently available from the San Mateo County Public Health Lab to providers include:

- Chlamydia and Gonorrhea from Throat, Rectum, and Self-Collected Vaginal Swabs
- Herpes Simplex Virus (HSV) RT-PCR
- RT-PCR Influenza A & B Assay
- RT-PCR Norovirus Assay
- R-Mix for Respiratory Viruses

R-Mix for Respiratory Viruses

R-Mix is a cell culture technique that can isolate seven different viral respiratory pathogens:

- Adenovirus
- Influenza A and B
- Parainfluenza Types 1, 2, and 3
- Respiratory Syncytial Virus (RSV)

If you would like a specimen tested, please submit a nasopharyngeal or throat swab on a synthetic (e.g., Dacron, polyester) swab in viral transport media (VTM) and keep refrigerated until shipped on cold pack. Do not freeze the specimen. Results are available within 24 to 48 hours. The test has a sensitivity of 99.5% and specificity of 100%.

RT- PCR Influenza A & B Assay

Rapid real-time reverse transcription polymerase chain reaction (RT-PCR) assay for influenza A & B assay is performed using the same specimens collected for R-Mix. In the event of a respiratory outbreak, the Public Health Laboratory will initially use R-Mix to determine the etiological agent. If influenza is identified, additional specimens from the outbreak will be tested using the RT-PCR Influenza A & B assay. Subtyping for H1, H3, and H5 antigen will be done on all Influenza A isolates.

Results are available within one working day, depending upon time of specimen submission and number of specimens submitted.

(continued on page 2)



San Mateo County Health Department
Disease Control & Prevention • Epidemiology Unit
225 - 37th Avenue • San Mateo, California 94403
Telephone: 650.573.2346 • Fax: 650.573.2919
epidemiology@co.sanmateo.ca.us
http://www.smhealth.org/epi_bulletin

(Laboratory, continued)

RT-PCR Norovirus Assay

Norovirus can be detected using the RT-PCR assay. Identification of the virus can be best made from stool or emesis specimens taken within 48 to 72 hours after onset of symptoms, although good results can be obtained from samples taken as long as five days after symptom onset. Stool or emesis specimens should be collected unpreserved in a sterile container and stored at room temperature or refrigerated.

Results are available within one working day, depending upon time of specimen submission and number of specimens submitted.

Herpes Simplex Virus (HSV) RT-PCR

HSV DNA can be detected from cerebrospinal fluid (CSF) or localized lesions. If you would like a specimen tested, please submit 1-2 ml of CSF in a sterile, leak proof container or a synthetic (e.g., Dacron or polyester) swab of lesion fluid in viral transport media (VTM). Keep refrigerated until shipped on cold pack.

Results are available within one working day, depending upon time of specimen submission and number of specimens submitted.

Chlamydia and Gonorrhea from Throat, Rectum, and Self-Collected Vaginal Swabs

Swab specimens collected from throat and rectal sites will be tested using Gen-Probe's Aptima II amplified nucleic acid assay. Specimens are collected with the same swabs and transport media used for genital sites.

Vaginal swabs collected by the patient under medical supervision (i.e., not collected at home) can be submitted for nucleic acid amplification of *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (GC). Special collection kits provided by the manufacturer are available from the Public Health Laboratory. Results are available within 48 hours.

The test for chlamydia is 96.6% sensitive and 97.4% specific; the test for gonorrhea is 100% sensitive and 99.4% specific.

Tests currently under development include Pertussis RT-PCR and QuantiFERON® -TB Gold test.

Pertussis RT-PCR

Pertussis can be detected using the RT-PCR assay that will be available in the Public Health Laboratory beginning in Spring 2006. Providers are requested to submit NP/throat swabs. Results will be available within 24 hours.

QuantiFERON® -TB Gold test

The QuantiFERON® -TB Gold test is an indirect test for *M.tuberculosis* (TB) infection based on measurement of a cell-mediated immune response in TB-infected individuals. Unlike the tuberculin skin test (TST), false positive results are less likely and additional patient visits for TST reading and booster TST are not required. The result is unaffected by subjective interpretation, previous BCG vaccination, and cross-reactivity with most other mycobacteria. Disadvantages include increased cost compared to TST and the need to draw a blood specimen that must be submitted to the lab in less than 12 hours for incubation.

Whole blood ≥ 5 ml should be collected in a heparinized (i.e., green top) tube and submitted to the Public Health Laboratory at room temperature less than 12 hours after collection. Results are available within 48 hours. The test has a sensitivity of 87.6% and specificity of 99.2%.

For more information on the Public Health Laboratory testing program, contact Bruce Fujikawa at (650) 573-2500.

Bacterial Meningitis Prevalence and Vaccination

Tracy Marshall Morton, MPH, Epidemiologist

Meningococcal disease is caused by the gram-negative intracellular diplococci bacteria *Nisseria meningitidis*, and is the leading cause of bacterial meningitis in people 2 to 18 years old in the United States. The bacteria causes meningitis, an infection and inflammation of the fluid surrounding the brain and spinal cord. The bacteria are spread through the exchange of respiratory and throat secretions (i.e., coughing, kissing), but are not spread by casual contact or breathing the air where an infected person has been. People in the same household or anyone with direct contact with a patient's oral secretions is at increased risk of acquiring the infection.

In the United States, 2,500 to 3,000 people get meningococcal disease annually; about 10-15% of these people die, despite antibiotic treatment.

Between 1990 and 2005, there were 41 cases of bacterial meningitis reported among residents of San Mateo County. There has been a median of two cases per year, ranging from 0 to 8 cases. In the United States, 2,500 to 3,000 people get meningococcal disease annually; about 10-15% of these people die, despite antibiotic treatment. Of those surviving the illness, approximately 11-19% lose appendages, suffer hearing loss or mental disabilities, develop nervous system problems, or suffer seizures or strokes.

Risk of disease decreases after one year of age but increases again in adolescence and young adulthood. The 1990s saw an increase in the case rate among young adults aged 18-23 years old. Although the majority of meningococcal disease cases were sporadic, the 1990s also had an increase in the frequency of school-related outbreaks among children, adolescents, and young college-aged adults. Other risk factors for disease include immune deficiencies (such as asplenia), active or passive exposure to tobacco smoke, low socioeconomic status, concurrent respiratory tract infection, and crowding, including congregate settings such as military barracks and college dormitories. The table below summarizes the rates of meningococcal disease in U.S. young adults and students.

**Rates of Meningococcal Disease in Students and Young Adults
United States, September 1998 - August 1999**

Risk Group	Case Count	Rate*
People aged 18-23 years old	304	1.4
Non-students aged 18-23 years old	211	1.4
All college students	96	0.6
Undergraduate college students	93	0.7
Freshman college students	44	1.9
College dormitory residents	48	2.3
College freshmen living in dormitories	30	5.1

* Per 100,000 population

Source: Bruce M, Rosenstein N, Capparella J, et al. JAMA 2001 Aug 8; 286(6):688-93.

Meningococcal Vaccine

Due to the serious consequences of meningococcal disease, primary prevention through the use of meningococcal vaccine is important for people at highest risk. Two meningococcal vaccines are currently available for use in the United States:

(continued on page 4)

(Vaccination, continued)

- Meningococcal polysaccharide vaccine (MPSV4)
- Meningococcal conjugate vaccine (MCV4)

Both vaccines prevent four types of meningococcal disease, including two of the three most common types in the United States. Both vaccines also protect against disease in about 90% of vaccine recipients. MCV4 is expected to give better, longer lasting protection. MCV4 is also thought to be better at preventing infection spread from person to person. It is important to remember that meningococcal vaccines cannot prevent all types of disease, but can protect many people who might become ill if they did not receive the vaccine. The table below describes the current meningococcal vaccine recommendations from the Centers for Disease Control and Prevention (CDC).

Meningococcal Vaccine Recommendations				
Vaccine	Quadrivalent	Approved Age Group	Schedule	Administration
MPSV4	Serogroups A, C, Y, W-135	≥ 2 years old	1 dose*	subcutaneous injection
MCV4	Serogroups A, C, Y, W-135	11-55 years old	1 dose	intramuscular injection

* Selective revaccination

Source: Centers for Disease Control and Prevention, Meningococcal Vaccine Information Sheet, 10/7/2005.

Vaccination Recommendations

- MCV4 is recommended for all children at their routine preadolescent visit (11-12 years old).
- If no previous history of MCV4 vaccination exists, a dose is recommended at high school entry.
- Other risk groups that should be considered for vaccination include:
 - College freshmen living in dormitories
 - Microbiologists who are routinely exposed to meningococcal bacteria
 - U.S. military recruits
 - Anyone traveling to, or living in, part of the world where meningococcal disease is common, such as parts of Africa
 - Anyone who had a damaged spleen, or whose spleen has been removed
 - Anyone who has terminal complement component deficiency (an immune system disorder)
 - People who might have been exposed to meningitis during an outbreak

MCV4 is the preferred vaccine for people 11-55 years old in the above risk groups, but MPSV4 can be used if MCV4 is not available. MPSV4 should be used for children 2-10 years old and adults over 55, who are at risk.

There have been a few reports of Guillain-Barré Syndrome (GBS) in recipients of the new vaccine. However, the target age for MCV4 is the same age group that is known to have a higher prevalence of GBS, and the number of affected individuals is not greater than the number that would be expected without vaccination. Further information for clinicians about this is available at: www.cdc.gov/nip/vacsafe/concerns/gbs/gbs-menaetra-facts.pdf.

**For further questions regarding the meningococcal vaccine, please contact
the San Mateo County Immunization Program at
(650) 573-2878**

Sources

- California Department of Health Services, Meningococcal Disease Prevention Plan, September 2002.
- Bruce MG, Rosenstein NE, Capparella JM, Shutt KA, Perkins BA, Collins M. Risk factors for meningococcal disease in college students. JAMA. 2001 Aug 8;286(6):688-93.
- Centers for Disease Control and Prevention, Meningococcal Vaccine Information Sheet, 10/7/2005. Available at: www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm.

Agents of Bioterrorism: Anthrax (*Bacillus anthracis*)

Carl Hess, Preparedness Coordinator

This article was prepared to provide an overview to the general public of anthrax, a potential bioterrorism agent. More information can be found at the Centers for Disease Control and Prevention's (CDC) *Emergency Preparedness and Response* website: <http://www.bt.cdc.gov/agent/agentlist.asp>

What is anthrax?

Anthrax is a serious disease caused by *Bacillus anthracis*, a spore-forming bacterium. A bacterium is a very small organism made up of one cell. A spore is a cell that is dormant (asleep) but may come become active when present in the right conditions.

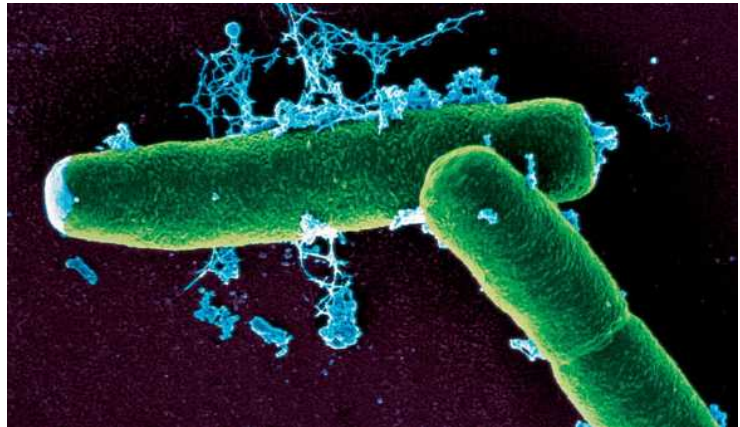
There are three types of anthrax infection:

- Cutaneous (skin)
- Gastrointestinal (digestive)
- Inhalation (lungs)

How do you get anthrax?

Anthrax is not known to spread from one person to another. However, it can be spread to humans via animals or by use of weapons.

- Anthrax from animals: Humans can become infected with anthrax by handling products from infected animals or by breathing in spores from infected animal products (e.g., wool). The recent case of inhalation anthrax reported in Pennsylvania (see: www.bt.cdc.gov/agent/anthrax/han022406.asp) is an example of this. The patient is believed to have become infected while making drums from unprocessed domestic and imported animal hides (cow and goat). People also can become infected with gastrointestinal anthrax by eating undercooked meat from infected animals.
- Anthrax as a weapon: Anthrax can also be used as a weapon. This happened in the United States in 2001 when anthrax was deliberately spread through the U.S. Postal Service by sending letters with powdered anthrax. This incident caused 22 cases of anthrax infection.



Scanning, electron micrograph (SEM) of *Bacillus anthracis*, the cause of the disease anthrax in humans and livestock (available at: http://srs.dl.ac.uk/Annual_Reports/AnRep01_02/anthrax.htm)

How dangerous is anthrax?

The CDC classifies agents with recognized bioterrorism potential into three priority areas (A, B, and C). Anthrax is a Category A agent, defined as one that:

- Poses the greatest possible threat of high mortality (illness)
- May spread across a large area or a population easily
- Has the potential to cause panic and social disruption
- Needs a great deal of planning to protect the public's health

In most cases, early treatment with antibiotics can cure cutaneous anthrax. Even if untreated, 80% of people who become infected with cutaneous anthrax will survive. Gastrointestinal anthrax is more serious; 25-60% of cases lead to death. Inhalation anthrax is the most severe form of infection. Although case-fatality estimates are based on

(continued on page 6)

(Anthrax, continued)

incomplete information, the rate is extremely high, approximately 75%, even with all possible supportive care, including appropriate antibiotics.

What are the symptoms of anthrax?

The symptoms of anthrax differ by the type of infection:

- Cutaneous: The first symptom is a small sore that develops into a blister. The blister then develops into a skin ulcer with a black area in the center. The sore, blister, and ulcer do not hurt.
- Gastrointestinal: The first symptoms are nausea, loss of appetite, bloody diarrhea, and fever, followed by severe stomach pain.
- Inhalation: The first symptoms of inhalation anthrax are cold- or flu-like symptoms and can include a sore throat, mild fever, and muscle aches. Later symptoms include cough, chest discomfort, shortness of breath, tiredness, and muscle aches. (Caution: Do not assume that just because a person has cold or flu symptoms that they have inhalation anthrax.)

What is the incubation period?

Symptoms can appear within seven days of coming in contact with the bacterium for all three types of anthrax infection. For inhalation anthrax, symptoms can take as long as 42 days to manifest.

How is anthrax treated?

Antibiotics are used to treat all three types of anthrax infection. Early identification and treatment are important.

- Prevention after exposure: Treatment is different for a person who is exposed to anthrax, but is not yet sick. Healthcare providers will use antibiotics (such as ciprofloxacin, levofloxacin, doxycycline, or penicillin) combined with the anthrax vaccine to prevent anthrax infection.
- Treatment after infection: Treatment is usually a 60-day course of antibiotics. Successful treatment depends on the type of anthrax and how soon after exposure treatment begins.

Can anthrax be prevented?

There is a vaccine to prevent anthrax, but it is not yet available for public use. Anyone who may be exposed to anthrax, including certain members of the U.S. armed forces, laboratory workers, and workers who may enter or re-enter contaminated areas, may receive the vaccine. Also, in the event of an attack using anthrax as a weapon, exposed people would receive the vaccine.

What should I do if I think I have anthrax?

If you are showing symptoms of anthrax infection, call your healthcare provider immediately.

What should I do if I think I have been exposed to anthrax?

Contact local law enforcement immediately if you think that you may have been exposed to anthrax. This includes being exposed to a suspicious package or envelope that contains powder.

What is the government doing to prepare for a possible anthrax attack?

Anthrax spores are easy to produce, easy to distribute, and have a history of weaponization. As a result, the CDC has set aside special funding for emergency planning and response to an anthrax attack, called the Cities Readiness Initiative (CRI).

(continued on page 7)

(Anthrax, continued)

The CDC has identified several major metropolitan areas of the United States as recipients of CRI funding in recognition that, in the event of a major anthrax terrorist attack, a regional response will be necessary. Counties surrounding major cities have, in turn, received funding and are mandated to plan on a regional basis. San Mateo County is one of the “collar counties” to the City of San Francisco and is currently working on a region-wide coordinated effort to plan for mutual aid.

Once inhalation exposure to anthrax has been determined, treatment is a simple regimen of antibiotics administered as quickly as possible. Ciprofloxacin, doxycycline, and penicillin are FDA-approved for the treatment of anthrax in adults and children. However, when dealing with a large population exposure, the “as quickly as possible”

portion of the treatment equation becomes a challenge. How do you treat 700,000 people (the population of San Mateo County) with antibiotics in an orderly way?

Large doses of antibiotics have, therefore, been stockpiled to treat anthrax victims. Resources have been deployed regionally, and there is a large cache available at the federal level. Once the medications are received locally, Points of Distribution (PODS) have been pre-identified as places to administer the antibiotics to the population. PODS are strategically located to serve as much of the population in the shortest time possible. The locations of the PODS will be made available to the public at the time of an event via the national emergency broadcast system.

The Epidemiology Unit is Pleased to Announce Our New Website! www.smhealth.org/epidemiology

On the website, you can find:

- Basic epidemiology information
- A glossary of epidemiological terms
- Reports and publications on a variety of health topics that affect residents of San Mateo County
- Archives of all previous issues of the *Epidemiologic Bulletin*
- Links to data sources related to health and epidemiology
- Links to epidemiological resources, including county services, disease information, demographic information, and professional and educational information

The screenshot shows the website interface for the San Mateo County Health Department. At the top, it says "Health Department County of San Mateo" with a "QuickSearch" button. Below that is a navigation menu with links for "COUNTY HOME", "LIVING HERE", "DOING BUSINESS HERE", "WORKING HERE", "VISITING", "GOVERNMENT", and "EMERGENCIES". The date "Friday, February 17, 2006" is displayed. The main content area is titled "Epidemiology Home" and features a graphic of a hand holding a magnifying glass over a globe, with the word "EPIDEMIOLOGY" written in a stylized font above it. To the right of the graphic are links for "What is Epidemiology?", "Epidemiological Data", "Epidemiological Reports", "Epidemiological Bulletin", and "Epidemiological Resources". On the left side, there is a green sidebar menu with various health services listed, including "Aging and Adult Services", "Correctional Health", "Emergency Medical Services", "Environmental Health", "Health Policy, Planning & Promotion", "Mental Health", "Public Health", "Clinical Services", "Disease Control & Prevention", and "Epidemiology". Under "Epidemiology", there are links for "What is Epidemiology?", "Epidemiological Data", "Epidemiological Reports", and "Epidemiological Bulletin". At the bottom of the page, there are sections for "Vision" and "Mission".

To find this information and much more, please visit
<http://www.smhealth.org/epidemiology>

We also invite any feedback about our website. Comments, ideas, and suggestions can be emailed to epidemiology@co.sanmateo.ca.us.

Asthma in San Mateo County

Dorothy Vura-Weis, MD, MPH, Assistant Health Officer

Asthma is a significant health problem in San Mateo County and the most common chronic disease causing school absences. Its importance relates to both the high prevalence and its impact on school attendance and readiness, work absenteeism, hospitalizations, and healthcare costs. This is a follow up article to the discussion of asthma prevalence and disparities in the previous edition of the *EpiBulletin* (Vol. 4, No. 4).

Hospitalization Rates

Asthma hospitalizations are considered a marker of both prevalence and access to adequate care, since almost all hospitalizations could be prevented by good management of chronic asthma and early treatment of exacerbations. In San Mateo County, hospitalization rates vary by zip code of residence; they are one and a half to two times higher in East Palo Alto, South San Francisco, and Daly City compared to the county overall.

Asthma-Related Hospitalization Rates, Selected San Mateo County Cities, 1998-2000

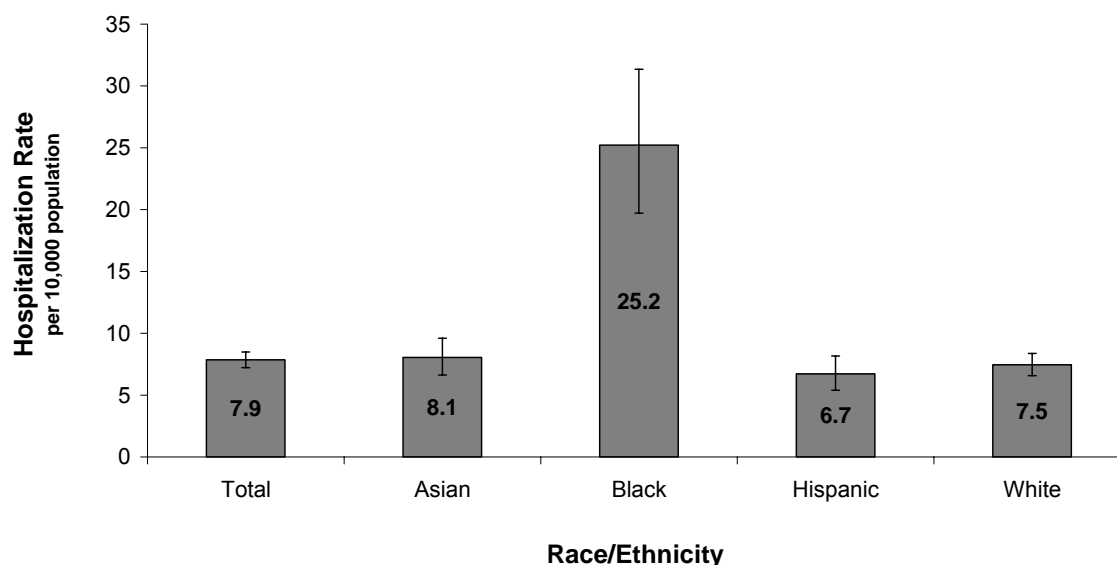
	Rate/10,000 All Ages	Compared to SMC	Rate/10,000 0-14 year old	Compared to SMC
San Mateo County Overall	7.85	—	13.08	—
East Palo Alto	15.05	1.92	25.76	1.97
South San Francisco	12.98	1.65	22.58	1.73
Daly City*	12.50*	1.59	19.10*	1.46

* Approximate rates for Daly City, combining zip codes 94014 and 94015

Source: California Department of Health Services Environmental Health Investigations Branch. Available at: http://www.ehib.org/cma/papers/Hosp_Cht_Book_2003.pdf.

There is also variation in hospitalization rates by race/ethnicity. In 2000, the age-adjusted hospitalization rates per 10,000 ranged from 7.0 to 26.5 cases per 10,000 population, as illustrated in the graph, below.

**Age-Adjusted Asthma-Related Hospitalization Rates
San Mateo County, 1998-2000**



Source: California Department of Health Services Environmental Health Investigations Branch. Available at: http://www.ehib.org/cma/papers/Hosp_Cht_Book_2003.pdf.

(continued on page 9)

(Asthma, continued)

Asthma-Related Activities in San Mateo County

San Mateo County Asthma Coalition

The San Mateo County Asthma Coalition was established in 2001 with support from a First 5 Commission grant. Originally addressing asthma in children up to five years of age, the focus has widened to include all ages.

The Coalition is open to everyone interested in reducing the burden of asthma in San Mateo County. Current participants include school nurses, healthcare providers, representatives from community organizations, public and environmental health department staff, and human services agency staff. The quarterly meetings offer presentations on asthma-related issues and networking for program staff to share their activities, identify problems, and discuss potential solutions.

San Mateo County Asthma Coalition Mission

To prevent and control asthma in San Mateo County by promoting change and collaboration at the individual, institutional, community, and policy level through education, awareness, empowerment, and advocacy.

**The next asthma coalition meeting will be
Thursday, April 13, 3:00 to 4:30PM in Belmont.
Human Services Office, Harvard Room
400 Harbor Blvd, Building B.
Call (650) 573-2737 for more information.**

East Palo Alto Asthma Task Force

The East Palo Alto Asthma Task Force was formed in response to the high rate of asthma in that city. Recent activities include a pilot project for home environmental evaluations by community health workers and use of the Environmental Protection Agency's *Tools for Schools* to evaluate indoor air quality in Ravenswood City School District. Through a grant from the First 5 Commission to the American Lung Association (now Breathe California), they recently completed a needs assessment and action plan to address asthma in East Palo Alto. For more information about the Task Force, contact Janine Bishop at jbishop@stanford.edu.

Other Asthma-Related Health Department Activities

- The Smoke-Free Start for Families (SFSF) program provides **FREE** comprehensive smoking cessation services for all San Mateo County residents. SFSF helps pregnant women, parents of young children, and other adult smokers who want to stop smoking and remain tobacco-free.
- The Health Department's asthma page (www.smhealth.org/asthma) has information, resources, and links to other useful sites.
- Health Department staff have collaborated with Breathe California to provide training for childcare providers and for public school teachers and nurses.

**If you have any questions or would like further information about
asthma activities in San Mateo County, please go to:**

**www.smhealth.org/asthma
or e-mail Dorothy Vura-Weis, MD, MPH at:
dvura-weis@co.sanmateo.ca.us**

Selected Reportable Diseases among San Mateo County Residents

	Year of Diagnosis		
	2005 (total)	2004	2003
Acquired Immune Deficiency Syndrome (AIDS)	19	34	43
Amebiasis	8	1	17
Anisakiasis	-	1	-
Anthrax	-	-	-
Botulism:			
- Foodborne	-	-	-
- Infant	-	-	-
- Wound	-	1	-
Brucellosis	1	1	1
Campylobacteriosis	163	210	228
Chlamydial Infection	1,473	1,485	1,364
Cholera	-	-	-
Ciguatera Fish Poisoning	-	1	-
Coccidioidomycosis	3	6	-
Cryptosporidiosis	6	11	5
Cysticercosis	-	2	-
Dengue	3	-	1
Ehrlichiosis	-	1	-
Encephalitis:			
- Arboviral	-	-	-
- Other Viral	-	-	-
E. Coli (O157:H7)	9	5	17
Foodborne Illness Outbreaks	2	7	6
Giardiasis	68	63	60
Gonococcal Infection	237	239	224
<i>Haemophilus influenzae Invasive Disease</i>	1	2	5
Hemolytic Uremic Syndrome (HUS)	1	1	-
Hepatitis: (acute)			
- Type A	12	17	18
- Type B	10	28	3
- Type C	2	-	-
- Type D	-	-	-
- Non-A / Non-B	-	-	-
- Other Viral	-	-	-
Kawasaki Syndrome	-	1	-
Legionellosis	1	-	2
Leprosy	3	1	1
Listeriosis	6	3	2
Lyme Disease	8	3	4
Malaria	4	1	4
Measles	-	-	1
Meningitis, Bacterial	3	2	-
Meningitis, Meningococcal	-	1	-

	Year of Diagnosis		
	2005 (total)	2004	2003
Meningitis, Viral	13	20	18
Mumps	-	-	-
Non-Gonococcal Urethritis (NGU)	67	64	37
Pertussis	54	48	24
Pelvic Inflammatory Disease (PID)	38	6	5
Psittacosis	-	-	-
Q Fever	1	1	2
Rabies:			
- Animal	-	-	1
- Human	-	-	-
Relapsing Fever	-	1	-
Rocky Mountain Spotted Fever	1	1	-
Rubella	-	-	-
Rubella Syndrome, Congenital	-	-	-
Salmonellosis	127	96	131
Scromboid Fish Poisoning	-	2	-
Shigellosis:			
- Group A	-	-	1
- Group B	10	16	11
- Group C	3	-	3
- Group D	39	24	30
- Group Unspecified	12	8	7
Smallpox	-	-	-
Syphilis:			
- Primary	2	5	9
- Secondary	8	4	5
- Early Latent	1	1	7
- Late & Late Latent	28	16	22
- Congenital	-	-	-
Tetanus	1	-	-
Toxoplasmosis	-	1	-
Tuberculosis	62	56	53
Tularemia	-	-	-
Typhoid Fever	4	1	6
Typhus Fever	1	-	-
Varicella (deaths only)	2	2	-
Vibrio Infections	2	6	3
Viral Hemorrhagic Fevers	-	-	-
West Nile Virus:			
- West Nile Fever	-	-	-
- Encephalitis	-	-	-
- Meningitis	1	-	-
Yersiniosis	3	-	1

Cases reported as of February 8, 2006.

Sources: Confidential Morbidity Report, HIV/AIDS Confidential Case Report Form, and Report of Verified Case of Tuberculosis.



Notes from Disease Control and Prevention (DCP)

DCP would like to welcome the following new staff members:

Ventura Amezquita

Ventura joined the AIDS Program in November 2005 as a Community Health Outreach Worker, focusing on reaching high-risk migrant workers and men who have sex with other men (MSM). He previously worked with El Concilio of San Mateo as the Coordinator of the GELAAM project (Gente Latina de Ambiente), an HIV prevention project focused on reaching Latino MSMs.

Laura Herrera

Laura started with the AIDS Program in November 2005 as a Community Health Outreach Worker, focusing on reaching high-risk women. She comes with a rich background in public health. Her last employment was with El Concilio of San Mateo County as Community Program Specialist with chronic diseases. She has also worked with the San Mateo County Smoke Free Start for Families program as a Community Program Specialist.

Jenifer Jackson

Jenifer has joined the AIDS Program as the Coordinator for the N.I.G.H.T. Program (Neighborhood Intervention Geared Towards High-Risk Testing). She will be coordinating mobile HIV, syphilis, and Hepatitis C testing for high-risk individuals in San Mateo County. She has worked in the field of HIV for almost ten years, for various organizations such as UCSF, Continuum HIV Services, Planned Parenthood, HERO, and the Maryland AIDS Administration.

Rensen Khoshabian

Rensen has been hired as an extra-help Laboratory Assistant. He is a recent graduate of Cal Poly, San Luis Obispo where he majored in Medical and Public Health Microbiology. He is fluent in Farsi and Assyrian.

Carla Mansfield, RN, PHN

Carla is the new Mobile Clinic Coordinator. She has a Master's Degree in Nursing from the University of California, San Francisco, with an emphasis on community health, and over 20 years nursing experience that includes both acute hospital service as well as public health. Her most recent experience was as a nurse consultant with the California Department of Health Services, Refugee Health Section.

Penny Rayas

Penny joined the AIDS Program in January 2006 as a Community Program Specialist, providing prevention case management to high-risk populations. She is also coordinating special events for the AIDS program. Penny comes to DCP from San Francisco General Hospital, where she was an Addictions Specialist. She is also pursuing her Ph.D. in Clinical Psychology.

Cara Silva, MPH

Cara is the new Senior Communicable Disease Investigator with DCP's Sexually Transmitted Disease (STD) Control Program. She worked for a number of years with the Colorado State Health Department as an HIV and STD Field Epidemiologist and as a Perinatal Hepatitis B Epidemiologist/Case Manager. She also has considerable experience with nonprofit public health organizations, serving as a Board of Director for the Colorado Public Health Association, Colorado Minority Health Forum, and HIV Care Link.

www.smhealth.org

MAIN PHONE NUMBER

(650) 573-2346

MAIN FAX NUMBER

(650) 573-2919

Epidemiology

Diana McDonnell, PhD, Editor	Tracy Morton, MPH, Editor
Sarah Knowles, PhD, MPH	Michael Leach, MPH
	Evelyn Tu, MPH

Communicable Disease Control

Vicky Camilleri, RN, Senior Public Health Nurse
Beth Schulz, RN, MPH, CD Control Officer

Mobile Clinic

Carla Mansfield, RN, Mobile Clinic Coordinator
Laura Salazar, MD, Medical Director

AIDS Program

Ellen Sweetin, Program Director

TB Control

Jackie Escalante, RN, Senior Public Health Nurse

Public Health Laboratory

Bruce Fujikawa, DrPH, Director

STD Control

Cara Silva, MPH, Senior CD Investigator

Health Emergency Planning

Carl Hess, Preparedness Coordinator

Administrative Assistance

Theresa Smith, Medical Office Supervisor

Health Officers

Scott Morrow, MD, MPH, Health Officer
Dorothy Vura-Weis, MD, MPH, Assistant Health Officer

Health Department Administration

Charlene Silva, Director of Health Services
Brian Zamora, MPH, Director, Public Health
John Conley, Deputy Director, Public Health

San Mateo County Health Department

Disease Control & Prevention

Epidemiology Unit

225 - 37th Avenue

San Mateo, CA 94403

What's Inside

Public Health Lab Update	p. 1
Bacterial Meningitis Vaccination	p. 3
Anthrax	p. 5
NEW Epi Website	p. 7
Asthma in San Mateo County	p. 8
Selected Reportable Diseases	p. 10
Staff Updates	p. 11

Save paper!

**Email epidemiology@co.sanmateo.ca.us
to receive the EpiBulletin electronically.**