



EpiNotes

Fall 2010

North Carolina Department of Health and Human Services | Division of Public Health | www.epi.state.nc.us/epi

North Carolina Awarded CDC Program Collaboration and Service Integration Grant

In August of this year, the Communicable Disease Branch was one of six sites nationwide that was awarded funding under a new Centers for Disease Control and Prevention (CDC) grant called Program Integration and Service Integration (PCSI). This is a three year project to increase program collaboration and integrate prevention, testing and treatment services for STDs, HIV, hepatitis and tuberculosis which may have intersecting transmission risks.

The CD Branch will use these funds to enhance integrated data collection and analysis between CD Branch programs, and to improve collaboration and communication between funded projects. Funds will also directly support four local health departments to expand their services.

Dr. Peter Leone (HIV/STD Medical Director) will serve as PCSI champion for this project and will provide oversight to integrated screening and prevention activities, chair the PCSI Steering Committee and consult with the Communicable Disease Branch Head, Evelyn M. Foust, on further integration of surveillance and field service activities. Dr. Jason Stout (TB Medical Director) will serve as the Vice Chair of the PCSI steering committee.

The objectives of this project are to (1) maximize prevention opportunities by increasing the delivery of integrated screening for populations at risk for multiple infections, (2) reduce concurrent transmission of HIV, viral hepatitis and sexually transmitted diseases, (3) reduce STD related HIV infections, and (4) reduce HIV- associated TB disease.

Grant funds will be used to support Wake, Pitt, Guilford and Mecklenburg Counties in expanding services in their adult health clinics by offering hepatitis C and TB Quantiferon testing to persons at risk for these

infections. These health departments will develop screening criteria based on local and state data to determine which patients will benefit most from these additional screening services. They will also provide referral services to link any patients who test positive for these infections to primary care or social services as needed.

The project will support the development of a PCSI steering committee to provide guidance over PCSI activities. The committee will be chaired by Dr. Leone and will include staff from the CD Branch, UNC Hospital, Duke Medicine and designated program counties.

Two new positions will be created within the CD Branch to support PCSI activities. An epidemiologist will be added to work with the CD Branch's lead epidemiologist, TB medical director and the HIV/STD medical director to encourage coordinated collection of data, assure data quality, assist with evaluation activities and report data on interim and annual progress reports. The second position will be a PCSI Coordinator who will work with the PCSI Steering Committee, the Communicable Disease branch head, and the Epidemiology section chief to improve communication and coordination of work between locally funded HIV, viral hepatitis, HIV/STD and TB programs. The PCSI Coordinator also

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will attempt to identify opportunities for meaningful collaboration and will provide day-to-day oversight of program activities. Holly Watkins will serve as the interim PCSI Coordinator until a permanent position is hired.

Contact Holly Watkins at 919-715-0136 for additional details.

Submitted by:

*Pete Moore, Communicable Disease Branch
Senior CDC Public Health Advisor*

CDC Grant for Assessment and Planning to Develop Climate Change Program for Human Health Protection

There is a widespread consensus that the world's climate is changing. Regional climate changes may have already affected physical and biological systems in many parts of the world, so it is imperative that governmental agencies prepare for the potential harmful effects of climate change.

infrastructure, policies and protocols to adapt to the public health consequences of climate change. 3) to increase the awareness of key decision makers in North Carolina on the impacts on public health caused by climate change. 4) to evaluate the entire process utilizing performance standards that will integrate the essential services of public health.

North Carolina has a complex geography that includes vast coastal and mountainous areas, a mixture of urban and rural areas, and a wide range of residents at varying socio-economic levels with vulnerable populations. All of these factors may increase our risks of adverse effects of climate change. Responding to this vulnerability will require a comprehensive planning effort. To that end, the Occupational and Environmental Epidemiology Branch (OEEB) in the Epidemiology Section of the NC Division of Public Health has received a three-year CDC grant to assess and develop climate change programs to protect public health in North Carolina.



The goal is to develop a strategic plan to minimize the public health impacts of climate change. The plan will deal with health disparities, involve key partners, and include health communication strategies tailored to target communities in North Carolina. The plan will encompass efforts of North Carolina state and local government systems across the state. It will use established national guidelines with an eventual goal of developing a

national plan based on the use of scientifically based environmental health indicators. When enacted, the plan will enable North Carolina to develop the appropriate organizational procedures and infrastructure necessary to protect its residents from the adverse effects of climate change.

Submitted by:

*Kenneth Rudo, PhD and Mina Shehee, PhD
Medical Evaluation and Risk Assessment Unit,
Occupational and Environmental Epidemiology Branch*

The OEEB climate change grant has several objectives: 1) to identify strengths and weaknesses of the North Carolina public health system to address the health effects of climate change. 2) to develop a comprehensive strategic plan to enable North Carolina to adopt

Environmental Public Health Tracking

During the 20th century, the disease burden in the United States has shifted from infectious diseases such as diarrhea and tuberculosis to non-infectious diseases such as asthma and cancer. This shift was orchestrated in large part by the implementation of public health practices including disinfection of drinking water, wastewater treatment, food safety, and pest control, as well as the development of antimicrobial therapies.

In addition to diseases such as asthma and cancer, other environmentally associated diseases have also become more prevalent and concerning. During the second half of the 20th century, an increase in the development and production of innovative industrial chemicals has occurred. Although beneficial in many respects, low concentrations of these chemicals have migrated to the environment, homes, and workplaces. The health impact of long-term, low dose exposure to many of these chemicals remains unknown. (1) Even though the science is still not clear on the health impacts of these chemicals and their exposures it is imperative to determine their impacts because of their prevalence and potential toxicities.

According to the PEW Environmental Health Commission 2000 report, the environmental public health system in the United States is “fragmented, neglected, and ineffective.” Moreover, in its present form, the environmental public health system does not have the capability to respond to current and emerging environmental threats. Therefore, the commission recommended (among several recommendations) that the Centers for Disease Control and Prevention (CDC) establish a network system that could track diseases associated with environmental contaminants. Based upon the recommendations of the PEW report, the CDC has developed and implemented a national environmental public health tracking system. (1)

According to the CDC, “Environmental public health tracking is the ongoing collection, integration, analysis, and dissemination of data from environmental hazard monitoring, human exposure tracking, and health effect surveillance.” In its basic approach, environmental public health tracking (EPHT) identifies a hazard (a chemical) in the environment, determines the risk of exposure through the dose-response of that hazard (risk assessment and/or biomonitoring), and identifies persons who have adverse health effects associated with the exposure (epidemiologic surveillance). This

approach helps to determine the identity and location of the contaminants, the means and methods of people’s exposure to the contaminants, and the population that is being affected by the contaminants. (1,2)

The ultimate goal of EPHT is to identify, respond to, and reduce the burden of environmentally-associated diseases using interventions and community-based health education activities in the most effective way. By using EPHT, it is possible to integrate environmental and health data into a standardized network that can be used by federal, state, and local health agencies to determine community-level hazard maps and disease trends. In order to establish this network, it is necessary to: set up a dedicated internet technology infrastructure, procure environmental and health data through memoranda of agreements with programs across state government (referred to as data partners), develop a database using data from the data partners, implement the database through secure and public web-based portals, develop and analyze a core set of indicators (Table 1), link data by geographic information system (GIS) analyses, and finally, implement (“going live”) the network. (4)

Participating partners (“Data Partners”) in this process are typically non-infectious disease and environmental programs who are the “owners” of the data (Table 2). Data used by the tracking network follows the guidelines setup by the data partners (i.e. memoranda of agreements) and the national environmental public health network. The tracking network provides several benefits to participating programs including access to analytical tools, opportunities for collaboration, increased efficiency, increased audience reach, an enhanced metadata registry, and finally, positive health outcomes. (3) Moreover, EPHT geocodes the data! Sensitive information requiring stringent privacy and HIPPA oversight is integrated throughout the network. Users, both public and secure, have access to data that is deemed appropriate for each user by the data partners.

CDC funds approximately 30 states and cities across the country to take part in the EPHT program. Presently, North Carolina is not a funded state; however, several state agencies are starting activities to enable North Carolina to become a funded state. These agencies include the N.C. Division of Public Health and the N.C.

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Department of Environment and Natural Resources. At the present time, only the Harmful Algal Blooms Illness Surveillance System (HABISS) in the Occupational and Environmental Epidemiology Branch is part of the CDC's EPHT network. This is a web-based surveillance system that integrates environmental data, toxin analyses by the State Laboratory of Public Health, and health effects associated with exposure to harmful algal blooms into a national database. In addition, North Carolina has established an EPHT Ad Hoc Working Group to explore possible indicators for the state. The working group consists of staff from the Heart Disease and Stroke Program, Asthma Program, the State Center for Health Statistics, and Occupational and Environmental Epidemiology Branch. This group will be expanded to include other programs during the next year to prepare for the next request for applications in 2011.

In 2010, North Carolina participated in the Association of State and Territorial Health Officials (ASTHO) Tracking Fellowship Program. This fellowship funds a state staff member to learn about tracking at a national workshop and visit a site to gain a better understanding about EPHT. As a fellowship project, "Climate Indicators for HAB Events" was completed in August 2010. This project focuses on the predictive nature of climate indicators for cyanobacterial (a.k.a blue-green algae) blooms in North Carolina. Predicting the likelihood of an algal bloom that produces toxin will greatly aid entities such as public water supplies that use fresh surface source waters, recreational sites such as lakes, and the general public in order to protect potentially exposed groups from the impacts of HABs. This protection will be particularly important for the most vulnerable populations, including children, the immune compromised, and the elderly. Household pets who are exposed by drinking contaminated water will also benefit from being protected.

A free, online CDC course about tracking (Tracking 101) can be found at National Environmental Health Association website, www.neha.org/research/pub_health_tracking.html for those wanting an in depth understanding of environmental public health tracking.

REFERENCES:

- (1). Environmental Health Perspectives, 112 (14): 1409 - 1413, 2004.
- (2). www.cdc.gov/nceh/tracking
- (3). Data Partnerships to Improve Health: Environmental Public Health Tracking, Association of State and Territorial Health Officials.

- (4). Environmental Public Health Indicators, Centers for Disease Control and Prevention, 2006.

Submitted by:

Mina Shehee, PhD

*Supervisor, Medical Evaluation and Risk Assessment Unit
Occupational and Environmental Epidemiology Branch*

Table 1. Example Core Environmental Public Health Tracking Indicators (4)

Hazard	Criteria pollutants in ambient air Motor vehicle emissions Tobacco smoke in homes with children Pesticide use and patterns of use Chemical spills Monitored contaminants in ambient and drinking waters
Exposure	Blood lead level (in children)
Health Effect	Carbon monoxide poisoning Deaths attributed to extremes in temperature Lead poisoning (in children) Pesticide-related poisoning and illness Melanoma Outbreaks attributed to ambient or drinking water contaminants
Intervention	Availability of mass transit Boil-water advisories Activity restrictions in ambient water (health-based) Implementation of sanitary surveys Compliance with pesticide application standards Policies that address indoor air hazards in schools

Table 2. Example Data Partners (3)

Health	Environmental
Vital Statistics	Division of Water Quality
Birth Defects Monitoring	Public Water Supply
Central Cancer Registry	Division of Environmental Health
Asthma Program	Division of Air Quality
Heart Disease and Stroke Program	Division of Waste Management
Pesticide Injury and Illness Surveillance	State Climate Office
Child and adult lead Programs	Department of Agriculture and Consumer Services
PH Preparedness and Response (disaster)	
Environmental Epidemiology (harmful algal blooms and climate)	
Local Health Departments	
State Laboratory of Public Health	

Tularemia in North Carolina

Tularemia, also known as rabbit fever or deerfly fever, is a zoonotic disease caused by the gram negative coccobacillus, *Francisella tularensis*. It presents as an acute febrile illness and can be fatal to both humans and animals. *F. tularensis* is distributed widely in wildlife and arthropod vectors throughout the US and most of the Northern Hemisphere. In the eastern U.S., rabbits and rodents are the primary reservoir hosts. Several tick and deerfly species may serve as both hosts and vectors. A review of North Carolina cases reveals that people usually become infected following handling of infected animals (especially rabbits) and animal (especially cat) bites. Transmission via tick bites is also possible, though less common.

Transmission:

People and domestic pets (especially cats) may become infected in the course of hunting wildlife. Humans are often inoculated via a knife cut or contamination of a pre-existing wound when skinning an infected animal or during handling of an infected carcass. Cat bite associated tularemia is well-documented.¹ Although the organism has been found in the saliva of dogs, no cases associated with a dog bite have been reported in the scientific literature.

Historically, most cases of tularemia in North Carolina were reportedly associated with tick bites. Although both *Dermacentor variabilis* (American dog tick) and *Amblyoma americanum* (lone star tick) can transmit tularemia in our state, a recent review of seven cases from 2007-2010 found that three cases were due to exposure to wild rabbits, two were due to cat bites, and two were unknown, although they both were reportedly hunters. All of these cases were evaluated multiple times before the diagnosis was made. It is important for clinicians to understand that there are multiple routes of exposure.

Transmission is also possible following ingestion of raw or undercooked meat of an infected animal; ingestion of contaminated natural waters; bites from ticks, deerflies and horseflies; and inhalation of contaminated dust or aerosols. Two groups at risk for inhalation exposure include laboratorians and yard workers. A highly publicized outbreak of primary pneumonic tularemia occurred on Martha's Vineyard in the summer of 2000. Epidemiologic investigation identified use of power lawn mowers and brush cutters as risk factors.² Tularemia has

a small infectious dose of 10-50 organisms which has led to concerns of it being used as a bioterrorism agent.

Symptoms and Clinical Findings:

In humans, tularemia can have diverse clinical manifestations depending on the route of exposure, virulence of the agent, and size of the inoculum. The incubation period is usually three to five days but may range from two to 10. Typically, the disease has a sudden onset and is influenza-like, with high fever, chills, fatigue, general body aches, headache and nausea. There is often an ulcer at the site of skin introduction, followed by one or more painful regional lymph nodes (ulceroglandular type). Sometimes, it presents only with enlarged lymph nodes with no obvious skin lesion or ulcer (glandular type). Ingestion of contaminated food or water may result in painful pharyngitis, with or without ulceration, abdominal pain, diarrhea, and vomiting (oropharyngeal type). Eye infections may cause painful purulent conjunctivitis with regional lymph node involvement (oculoglandular type). Inhalation of the agent may result in pneumonia (pneumonic type) and primary septicemia (typhoidal type) although pneumonia and septicemia may occur as a complication of any type. Septicemia may be complicated by meningitis, shock, ARDS, and multi-organ failure and is associated with severe and often fatal illness. Of the seven cases from 2007-2010, five were ulceroglandular, but two presented with glandular and pneumonic disease; one of these, who was found to be immunocompromised during hospitalization, developed meningitis and died.

Diagnosis

Although tularemia is rare in North Carolina (only nine cases reported since 2006), it should be suspected in any patient with a skin ulcer and febrile illness following skinning, dressing, or handling the carcass of a rabbit or rodent or following an animal bite, particularly a cat bite, that does not respond to recommended antibiotics for animal bites. One currently recommended post exposure prophylaxis antibiotic for cat bites is Augmentin (amoxicillin and clavulanic acid)³, which does not cover *F. tularensis*.

Clinicians should take a good history, making sure to inquire about animal, arthropod, and outdoor exposures, and look for evidence of an ulcerated lesion

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with accompanying enlarged lymph nodes. Acute and convalescent serologies should be obtained on suspect cases. Rapid assays (PCR on whole blood and serum and DFA on swabs of ulcers or wounds, aspirates, bronchial washings, etc.) can be performed by the NC State Laboratory of Public Health's Bioterrorism and Emerging Pathogens Lab (SLPH-BTEP) following consultation with a public health epidemiologist. Clinicians should make sure they accurately label samples and alert laboratory staff when tularemia is suspected.

Criteria for a confirmed case of tularemia include a clinically compatible illness with isolation of *F. tularensis* from a clinical specimen or a fourfold or greater rise in serum antibody titer to *F. tularensis* antigen. Criteria for a probable case of tularemia include a clinically compatible illness with a single elevated antibody titer or multiple elevated titers without a fourfold increase and no history of tularemia vaccination; or clinically compatible illness with detection of *F. tularensis* in a clinical specimen by fluorescent assay.

Reporting Requirements:

Tularemia in humans is immediately reportable by physicians and laboratories to local public health authorities and when diagnosed in animals by a veterinarian, it is reportable to the State Veterinarian.^{4,5}

Prevention

Veterinarians should be aware of signs of tularemia in cats (fever, depression, generalized lymphadenopathy,

lingual ulcers and panleukopenia) that have eaten or mouthed wild rabbits or rodents prior to the onset of clinical signs. Veterinarians should also educate owners about the benefits of keeping cats indoors and not letting them roam unsupervised outside. This will not only decrease the cats' risk of exposure to zoonotic diseases such as tularemia and rabies but also will reduce the risk of acquisition of other communicable diseases of cats.⁶

The general public should be knowledgeable about diseases transmitted by ticks and insects. Prevention of tularemia is just one more good reason to use repellents containing DEET when engaging in outdoor activities in NC.

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1. Capellan et. al., Tularemia from a cat bite: case report and review of feline-associated tularemia. *Clin Infect Dis.* 1993 Apr;16(4):472-5.
2. Feldman KA, Ensore RE, Lathrop SL, et al., An outbreak of primary pneumonic tularemia on Martha's Vineyard. *N Engl J Med.* 2001 Nov 29;345(22):1601-1606.
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4. 10A NCAC 41A .0101 REPORTABLE DISEASES AND CONDITIONS
5. 02 NCAC 52C .0603 REPORTABLE DISEASES
6. CSTE/NASPHV JOINT POSITION STATEMENT 1997-ID-18. Position Statement on Free-Roaming/Unowned/Feral/Stray Cats

Submitted by:

C. Gregory Smith MD, MPH, Carl Williams, DVM, Marilyn Haskell, DVM, MPH, Royden Saah, MS

Syphilis Increase in North Carolina

Several counties in North Carolina are continuing to see increases in early infectious syphilis. From January 1 through December 31, 2009, there were 937 cases of early infectious syphilis reported in North Carolina. Since January 2010, preliminary estimates indicate that almost 450 new cases of early infectious syphilis have been reported. This is a state epidemic with almost all 100 counties being affected. Because early syphilis is very infectious, it is critical to identify case patients early in their infections and intervene immediately with treatment, education, and cluster investigations.

In the urban counties, the epidemic is predominantly affecting males, suggesting transmission through men who have sex with men (MSM), but in Wayne County, cases are evenly split between males and females. Overall, case patient ages were younger than have been seen historically in syphilis cases in North Carolina. The highest rates were in 20-24 year olds (44.8/100,000) followed by 25-29 year olds. Increases in morbidity were noted for almost all demographic groups, but were most prominent among Black males. Among all males, 45 percent were already infected with HIV when diagnosed with early syphilis.

Persons with ulcerative sexually transmitted diseases, like syphilis, are more likely to transmit HIV if they are positive, or to become infected with HIV if a sex partner is HIV positive. Thus, there is serious concern that this growing syphilis epidemic will also lead to increases in new HIV infections in the state.

The increase in syphilis in 2009 occurred throughout the state and included many counties that follow Interstate highways 40 and 85 and several eastern counties. Forsyth, Mecklenburg, Wake, Guilford, Wayne and Durham counties each contributed at least 40 or more new early syphilis cases to the overall morbidity of the state. All of these counties except Durham had substantially more cases in 2009 compared to 2008; Forsyth County experienced a dramatic increase

in syphilis cases—over four-fold. Other counties that experienced notable increases between 2008 and 2009 included Gaston, Edgecombe and Pitt counties. Other counties had more cases in 2009 compared to 2008, but none had large numbers of cases.

The Communicable Disease Branch (CDB) has created a Syphilis Epidemic Response Team (Syphilis-ERT) composed of field staff, prevention, surveillance and epidemiology staff, the syphilis and HIV outbreak response staff, and Branch leadership. Also, the CDB has initiated a clinician education campaign to review the signs, symptoms and treatment for syphilis with frontline medical providers.

The North Carolina MSM (men who have sex with men) Task Force, comprised of many thought leaders from around the state, has been established in order to foster dialogue and effective partnership with the MSM community, currently at highest risk for syphilis and/or new HIV infection. This task force is developing strategies to reach the MSM population, because that's where we are seeing the largest increase in syphilis. They are creating appropriate prevention messages, reinforcing early awareness of signs and symptoms, linkage to care, and risk reduction.

For more information, please contact Connie Jones at Constance.Jones@dhhs.nc.gov.

Submitted by:
Connie Jones
Branch Outbreak Coordinator

North Carolina Healthcare-Associated Infections Project (ARRA Funds)

Much work has been done during the past six months to establish the ground work for the Healthcare-Associated Infections (HAI) Project. An HAI Advisory Group has been formed and membership is growing each week. Currently there are representatives from the N.C. Legislature; Public Health; N.C. Quality Center; Statewide Program for Infection Control and Epidemiology (SPICE); Duke Infection Control Outreach Network (DICON); Society for Healthcare Epidemiology of America (SHEA); Association for Professional in Infection Control and Epidemiology, Inc – N.C. Chapter (APIC-NC); Division of Medical Assistance; N.C. Medical Society; N.C. Hospital Association; N.C. Division of Health Service Regulation; Blue Cross Blue Shield of North Carolina; Perinatal Quality Collaborative of North Carolina; consumers; Indian Health; N.C. Lab Response Forum; and the Carolina Center for Medical Excellence. The Advisory Group has just completed reviewing the State HAI Plan and will release the revised plan before the end of the year.

A HAI coordinator and epidemiologist have been hired for the project. Constance (Connie) D. Jones, RN, CIC is the new coordinator. Connie has experience in both healthcare infection prevention and communicable disease nursing. Most recently she was the communicable disease nurse for Guilford County

Public Health. Levi Njord is the new epidemiologist. Levi is a graduate of London School of Health and Hygiene and a doctoral candidate at UNC-CH School of Public Health.

The group has identified two priority prevention targets for surveillance. These targets are Central Line-associated Bloodstream Infections (CLABSI) and Catheter-associated Urinary Tract Infections (CAUTI). Data for these two targets will be collected from healthcare facilities that participate in collaboratives sponsored by the N.C. Quality Center and reported through the CDC National Healthcare Safety Network (NHSN). The collaboratives assist healthcare facilities in implementing infection prevention guidelines for appropriate insertion and care of both central lines and urinary catheters, thus reducing the risk of healthcare-associated infection occurring. Data submitted to NHSN will be validated by SPICE; the validation process will be through chart audits of reported data.

More information on the HAI Project will be shared in the coming months.

Submitted by:

*Constance (Connie) D. Jones, RN, CIC
HAI Coordinator*

News from the OCME Toxicology Section

The Office of the Chief Medical Examiner is pleased to introduce new staff members Dr. Sandra Bishop and Dr. Justin Brower. Dr. Bishop joined the staff as deputy chief toxicologist in August 2009. She earned her PhD in Forensic Sciences from Ohio University in Athens, OH in 2004. She worked as a toxicologist with the Department of the Navy in 2004 and 2005 then she moved to the Toxicology Unit at the City of Los Angeles Police Department. She served as an adjunct professor in the Department of Criminal Justice and Criminalistics at California State University-Los Angeles. Dr. Bishop is qualified as an expert witness to testify in the fields of toxicology, alcohol analysis and alcohol impairment.

Dr. Brower joined the staff as laboratory supervisor in September 2009. He earned his PhD in Chemistry from the University of Nevada in Reno, NV in 2001. He continued post-doctoral training at the University of California-Irvine from 2001-2004. From 2004 through 2009, he was the director of Chemistry at Argolyn Bioscience in Durham, NC. Dr. Brower has a proven track record in advanced chemistry techniques and instrumentation, critical skills for the Tox Lab supervisor.

Following the release of the National Academies of Science Report on Strengthening Forensic Science in the United States, Congressional hearings and White House consultations are taking place in Washington, DC, that will shape the future of all branches of the forensic sciences, including toxicology. The discussions will focus on issues of research, accreditation, certification, and funding, among others. In response, the American Academy of Forensic Science Toxicology Section, the American Board of Forensic Toxicologists and

the Society of Forensic Toxicologists have created the Forensic Toxicology Coordinating Council (FTCC) to improve communication between the main forensic toxicology organizations, to promote the rapid exchange of information and to represent the needs and issues affecting the forensic toxicology community. Dr. Ruth Winecker, chief toxicologist, has been named a member of the Scientific Working Group (SWGTOX) of the FTCC. SWGTOX will provide technical advice to Congress on any proposed policies that affect forensic toxicology.

Dr. Winecker also has been nominated by the Society of Forensic Toxicologists to become a member of the Interagency Working Group (IAWG) for the White House Subcommittee on Forensic Science. The purpose of the Subcommittee is to advise and assist bodies of the Executive Office of the President on policies, procedures and plans related to forensic science in the national security, criminal justice, and medical examiner/coroner systems at the local, state and federal levels. Emphasis will be placed on developing practical and timely approaches to enhancing the validity and reliability of the federal government's undertakings in forensic science and medical examinations and on how the Federal government, in collaboration with other entities, can help ensure that regional, state and local entities adopt best practices in forensic sciences. The Subcommittee's overarching goal will be to lead an interagency assessment of the Federal government's ability to implement or promote the implementation of the recommendations report and develop timely and specific recommendations for doing so.

Reported Communicable Diseases, North Carolina, January-September 2010 (by date of report)*

Disease	Year-to-Date (Third Quarter)			3 rd Quarter 2010	Comments / Note
	2010	2009	Mean (2005-2009)		
Brucellosis	1	0	2	0	
Campylobacter	583	509	524	233	
Chlamydia, laboratory reports	34,088	32,982	26,650	11,419	
Cryptosporidiosis	71	132	87	36	
Dengue	5	0	5	4	
E. coli Shiga Toxin-producing	46	88	90	23	
Ehrlichiosis, Granulocytic	17	3	1	9	
Ehrlichiosis, Monocytic	81	46	37	50	
Gonorrhea	11,355	11,315	11,482	3,984	
Haemophilus Influenzae	103	72	54	44	
Hepatitis A	41	34	57	12	
Hepatitis B	84	89	106	49	
Hepatitis B Carrier	420	725	680	160	
Hepatitis C, Acute	32	18	19	8	
HIV/AIDS	1,195	1,387	1,438	308	Note 1
Hemol.Urem.Syn/TTP	4	2	5	0	
Inf Adult Mortality	25	1	0	0	
Legionellosis	49	43	32	26	
Leprosy (Hansen's Disease)	1	0	0	0	
Leptospirosis	1	0	0	1	
Listeriosis	16	22	21	8	
Lyme Disease	65	87	48	31	
Malaria	34	21	23	20	
Meninccocal Invasive Disease	12	25	20	3	
Q Fever	1	1	3	1	
Rabies in animals	316	392	383	130	
RMSF	222	231	466	150	
Salmonellosis	1100	1410	1292	669	
Shigellosis	136	333	183	65	
Strep A	123	90	117	28	
Syphilis, Total	561	682	451	143	Note 2
Toxic Shock Synd.,Strep	8	3	6	3	
Tuberculosis	191	162	209	72	
Tularemia	3	1	1	1	
Typhoid, Acute	5	5	5	1	
V Vulnificus	7	3	3	6	
Vibrio, Other	10	9	10	6	
VISA/VRSA (Staph aureus)	2	2	1	0	
Whooping Cough	126	160	171	59	

* Preliminary data, as of 9/1/2009. Quarters defined as 13 week periods. Diseases reported in 2010 define those listed in this table. Notes: 1. Earliest report with HIV infection or AIDS diagnosis; 2. Includes primary, secondary and early latent syphilis. This table represents cases reported via the NC Electronic Disease Surveillance System (with the exception of HIV/AIDS, syphilis and Rabies in Animals). The date basis the date the event was marked as ready to report to the CDC.

Dr. Megan Davies, State Epidemiologist



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Division of Public Health | Epidemiology Section

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Epidemiology Section Office	(919) 733-3421
Communicable Disease Branch	(919) 733-3419
■ HIV/STD Program	(919) 733-7301
■ Tuberculosis (TB) Control	(919) 733-7286
Occupational and Environmental Epidemiology Branch	(919) 707-5900
State Laboratory of Public Health	(919) 733-7834
Office of the State Medical Examiner	(919) 966-2253
Public Health Preparedness and Response	(919) 715-0919
Public Health Preparedness and Response Emergency Number 365/7	(888) 820-0520
Rabies Emergency Number Nights, Weekends, Holidays	(919) 733-3419
Emergency Number Nights, Weekends, Holidays	(919) 733-3419