Kentucky
Epidemiologic Notes & Reports

Cabinet for Health and Family Services
Department for Public Health
Division of Epidemiology & Health Planning

Volume 39 Number 7 August 2004

SURVEILLANCE AND VACCINE RECOMMENDATIONS FOR INFLUENZA SEASON 2004-05

Peggy Dixon, RN, CIC

Surveillance

Surveillance reporting for the current influenza season will begin the **first week in October 2004;** surveillance will actually begin the last week in September.

In June 2004, the Council of State and Territorial Epidemiologists (CSTE) voted to make pediatric influenza-associated deaths a nationally notifiable condition.

The Centers for Disease Control and Prevention (CDC) continues its previously issued recommendations for evaluating, reporting, laboratory testing and enhanced influenza surveillance for state health departments for suspected H5N1 cases among travelers with severe unexplained respiratory illness returning from H5N1-affected countries. For additional information please see: http://www.phppo.cdc.gov/han/archivesys/viewmsgv.asp?alertnum=00204.

Primary Changes and Updates in the Recommendations for Influenza Vaccine

The 2004 recommendations include the following new and updated information:

1) Influenza vaccine is recommended for healthy children 6-23 months of age and close contacts of children 0-23 months of age.

2) Inactivated vaccine is preferred over live, attenuated influenza vaccine (LAIV) for vaccinating household members, health-care workers, and others who have close contact with severely immunosuppressed persons.

3) Persons at high risk of influenza complications, who are not severely immunosuppressed, may administer LAIV. If a health-care worker receives LAIV, the health-care worker should refrain from contact with severely immunosuppressed patients for 7 days.

August Notes & Reports.....

Surveillance and Vaccine Recommendations for Influenza Season 2004-05 1
Death Certificate Reporting 2
The Kentucky Health Alert Network 3
Inadvertant Intradermal Administration of Tetanus Toxoid-Containing Vaccine Instead of Tuberculosis Skin Tests 4
Selected Reportable Diseases 5
APTIMA Amplified Chlamydia and Gonorrhea Testing .. 5
Influenza Viral Culture Kits 6

4) The 2004-05 trivalent vaccine for the United States contains A/New Caledonia/20/99-like (H1N1), A/Wyoming/3/2003 (H3N2), and B/Jiangsu/10/2003-like viruses.

5) The vaccine supply will be assessed, and CDC will make recommendations in the summer preceding the 2004-05 influenza season regarding the need for tiered timing of vaccination of different risk groups.

2004 recommendations from the *Prevention and Control of Influenza* may be viewed in its entirety on the CDC website at http://www.cdc.gov, Morbidity and Mortality Weekly Report Recommendations and Reports April, 2004/Vol.53; 1-40, and May 28, 2004/Vol.53/RR-6.

Information regarding influenza vaccine can be obtained at CDC/National Immunization Program's website at http://www.cdc.gov/nip/flu. Information regarding national influenza surveillance, prevention, detection, and control is available at http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm.

For information regarding ordering, distribution, information statements and recommendations for **Vaccines for Children Program (VFC)** influenza vaccine, please contact: The Kentucky Immunization Program at 502/564-4478.

(Continued on Page 3)

DEATH CERTIFICATE REPORTING- RESPONSIBILITY OF FUNERAL SERVICE LICENSEES, MEDICAL CERTIFIERS AND CORONERS IN THE FILING OF A KENTUCKY CERTIFICATE OF DEATH

Effie Hudson, Quality Assurance Representative

Requirements of Kentucky Revised Statutes 213.076

The funeral director, coroner, or the person acting as such who first takes custody of a dead body is responsible for the completion of items 1 through 22 on a Kentucky Certificate of Death. This same person should present the certificate of death to the doctor or coroner within five days of the death for the completion of items 23 through 30 f. The medical certifier should complete, sign and return the completed certificate within (5) five working days to the funeral director or the person who presented it to them and signed line 21. Effective July 15, 2002 two additional questions, 28 d and 28 e, were added to the certificate of death regarding diabetes. These two questions are required to be answered by the medical certifier. If the medical certifier fails to complete any of the required items which are 23 a, 23 b, 28 Part 1, 28 d and 28 e the certificate should be sent back to the certifier by the funeral home for the missing or incomplete information.

Many certificates of death are not acceptable by the Office of Vital Statistics due to simple errors and minor mistakes such as stamped signatures, certifier's signing with colored ink and items 28 d and e being incomplete. All certificates of death must be signed with **black** ink. The Funeral Service Licensee should return incomplete certificates to the medical certifier for completion or initiate a new certificate if signed with colored ink, stamped signature or defaced in any manner.

The law states in 5 (a) that the physician, dentist, chiropractor, or coroner who certifies the cause of death shall return the certificate to the funeral director, or person acting as such, who, in turn, shall file the certificate directly with the Office of Vital Statistics. Medical certifiers should make certain all required questions listed above are complete before returning to the Funeral Service Licensee, or person acting as such. Often item 24 (Name and Address of Person Who Completed Cause of Death) is incomplete which requires the Office of Vital Statistics to return incomplete certificates or supplemental information sheets to the funeral director or person acting as such for the required information.

The Office of Vital Statistics has two Quality Assurance Representatives. The Quality Assurance Representatives are responsible for ensuring that certificates are complete and accurately filed in a timely manner according to statutes and regulations. Since August of 2003, the Office of Vital Statistics has received 980 incomplete certificates of death. These incomplete certificates of death received by the Office of Vital Statistics cause a hardship on families who are in desperate need of the requested certificates, for various personal reasons.

Kentucky Revised Statutes 213.991- Penalties

(3) Any person shall be guilty of a Class B misdemeanor who:

(a) Willfully and knowingly refuses to provide information required by this chapter or administrative regulations adopted hereunder:

(4) Repeated failure to comply with the requirements of this chapter shall be sufficient cause for the cabinet to file a report with the applicable medical, dental, chiropractic, or funeral director licensure board citing the omissions of lawful duty and requesting that the appropriate action be taken.

All medical certifiers should stay current on regulations and be attentive to detail when completing the certificate of death. This ensures certificates of death are filed accurately and complete without delay. The accuracy of statistical information is contingent upon proper certification of the cause of deaths in Kentucky. For further information contact the Office of Vital Statistics, Quality Assurance Staff at 502-564-4212 or Effie.Hudson@kygov

***Kentucky Epidemiologic Notes & Reports* is available online at http://chs.ky.gov/publichealth/newsletters-pub.htm**

THE KENTUCKY HEALTH ALERT NETWORK

Joan Lusk, PMP, Office of Information Technology - BT Program Manager

What is the Kentucky Health Alert Network (KY HAN)?

The HAN is mandated by the Centers for Disease Control and Prevention (CDC) as part of the federal Public Health Preparedness and Response for Bioterrorism grant. It is a web-based application for alerting the local public health personnel and local public health partners of a federal, state or local communities reportable disease or other infectious outbreak. There are three types of alerts: a public health emergency (high alert), a public health advisory (medium alert) or a public health update (low alert).

The HAN will simultaneously call out to a designated role-based person's e-mail, cell phone, pager, office phone, home phone, etc. up to five (5) devices for each type of alert (H, M, L). The Kentucky Department for Public Health (KDPH), Division of Epidemiology and Health Planning has purchased this software through the CDC from Virtual Alert, Inc. It is their Bioterrorism Readiness Suite (BTRS). However, the KDPH has named its system the Kentucky Health Alert Network (KY HAN).

The KY HAN is near development completion. We are currently testing it internally and developing the business rules around how the system will be managed, and what each role's responsibilities will be. Discussions continue on what process we will use to verify the identification of each public healthcare partner and provider's credentials, before allowing them access to the HAN.

Training of the state's system administrators, application administrators, and the KDPH senior staff is continuing through August 26, 2004, to solidify the operating business rules that will be applied to the KY HAN. The state's BT Training Coordinators are being trained, and they will then train the local Public Health Preparedness Planners (PHPPs) the week of August 30th – September 3rd.

The PHPPs have been and will continue gathering the local public health personnels' demographic information for the HAN's public health directory. The PHPPs will also assist in the identification and credentialing process and help to populate the HAN directory. As each new public health professional with the need for receiving an alert is identified and trained, he/she will be linked to their pre-defined role(s) in the HAN. Access to the HAN will then be given to the public health professional to complete and maintain his/her own demographic and alerting profile.

There will be further information published about the Kentucky Health Alert Network as this important statewide project moves forward into full implementation.

(Continued from Page 1)

INFLUENZA SEASON 2004-05

Requests for information regarding state surveillance, consultation and reporting of outbreaks of influenza-like illness (ILI) in long term care facilities, statistics, recommendations for vaccine for adults and antiviral drug use may be directed to: Peggy Dixon, Influenza Coordinator, Communicable Diseases Branch, 502/564-3261, extension 3583.

References

1. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2004; 53; 1-40.
2. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2004; 53(No. RR-6).
3. CDC. Update: influenza Activity---United States and worldwide, 2003-04 season, and composition of the 2004-05 influenza vaccine. 2004; 53(25); 547-552.

Inadvertent Intradermal Administration of Tetanus Toxoid-Containing Vaccines Instead of Tuberculosis Skin Tests

Reprinted from Weekly *MMWR* July 30, 2004/53(29);662-4

CDC and the Food and Drug Administration (FDA) have been notified about the potential for inadvertent administration of tetanus toxoid--containing vaccines (TTCVs) instead of tuberculin purified protein derivative (PPD) (Tubersol®, Aventis-Pasteur, Swiftwater, Pennsylvania; Aplisol®, Parkedale Pharmaceuticals, Rochester, Michigan) used for tuberculosis skin tests (TSTs). The Vaccine Adverse Event Reporting System (VAERS), a passive surveillance system jointly operated by CDC and FDA (*1*), detected clusters of medication errors in at least two states. These findings, along with another previously reported investigation involving the same error (*2*), suggest the need for health-care providers to take additional steps to minimize the risk for inadvertent intradermal injections of TTCVs.

In April 2004, five reports of medication error involving tetanus toxoid (TT) from a health-care provider were identified. Patients were vaccinated on three different dates; all experienced local reactions without complications. Another cluster reported to VAERS in June 2003 involved an undisclosed number of patients; a health-care provider confused tetanus and diphtheria toxoids (Td) vaccine for adult use (adsorbed) with PPD and administered Td intradermally. Patients with adverse reactions to these administrations had skin reactions interpreted as positive TSTs, which resulted in treatment with isoniazid (INH). Review of the lot numbers on products thought to be PPD revealed they were Td. Affected patients were identified and retested with PPD; all TSTs were negative. INH was discontinued, and no adverse reactions were observed.

As of March 2004, approximately 100 patients had been identified in reports ofTTCV administration instead of PPD. A total of 21 states have reported both clusters and single cases. Vaccines substituted mistakenly for PPD include Td (n = 13 reports), TT (n = 12), and diphtheria and tetanus toxoids, (DT) adsorbed (n = five). For reports of Td, TT, and DT, products involved included those manufactured by Aventis-Pasteur and Wyeth (Collegeville, Pennsylvania) and vaccines from other unspecified manufacturers. CDC and FDA have initiated a full review of adverse events caused by inadvertent administration of vaccines and PPD products reported to VAERS and the FDA MedWatch Program. A preliminary review indicates that multiple vaccines other than TTCVs have been involved.

Similarities in packaging of PPD and TTCVs might have contributed to the medication errors (*3,4*). Both products require refrigeration and often are stored side by side. Lack of availability of Td in single-dose syringes, resulting in provider purchase of multiple-dose vials, was cited as a contributing factor to medication error in one cluster. Conversely, at least eight reports have been documented of inadvertent substitution for vaccine products, resulting in intramuscular administration of PPD (FDA, unpublished data, 2004).

Health-care providers should consider ways to prevent vaccine misadministration. As more vaccines and combination products become available, the potential for medication errors might increase. Possible measures to prevent misadministration should include pharmacy dispensing of vaccines when feasible, physical separation of products, careful visual inspection and reading of labels, preparation of PPD for patient use only at time of testing, and improved record keeping of lot numbers of vaccines and other injectable products. Prevention of such errors through barcode scanning technology is the goal of a recent FDA rule requiring individual drug packages to have identifying barcodes (*5*). For health-care facilities that possess such technology, package scanning could help prevent errors made during pharmacy dispensing of products or during vaccine or PPD administration. In addition, the *Product Identification Guide for Routine Vaccines* is a helpful resource for distinguishing commonly used vaccine products; the guide can be ordered from the California Department of Health Services, telephone 619-594-5933. Adverse events associated with inadvertent vaccine administration can be reported to VAERS at http://www.vaers.org or by telephone, 800-822-7967. Adverse events after PPD administration can be reported to the FDA MedWatch program at http://www.fda.gov/medwatch or by telephone, 800-332-1088.

References

1. Chen RT, Rastogi SC, Mullen JR, et al. The Vaccine Adverse Event Reporting System (VAERS). Vaccine 1994;12:542--50.
2. Graham D, Dan B, Bertagnoll P, et al. Cutaneous inflammation caused by inadvertent intradermal administration of DTP instead of PPD. Am J Public Health 1981;71:1040--3.
3. Institute for Safe Medication Practices. Hazard alert! Confusion between tetanus diphtheria toxoid (Td) and tuberculin purified protein derivative (PPD) led to unnecessary treatment. Huntingdon Valley, Pennsylvania: Institute for Safe Medication Practices, 2003. Available at http://www.ismp.org/msaarticles/confusionprint.htm.
4. U.S. Food and Drug Administration. Mix up between Td and PPD. Rockville, Maryland: U.S. Department of Health and Human Services, U.S. Food and Drug Administration, 2003. Available at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/transcript.cfm?show=17#8.
5. U.S. Food and Drug Administration. FDA rules requires bar codes on drugs and blood to help reduce errors. Rockville, Maryland: U.S. Department of Health and Human Services, U.S. Food and Drug Administration, 2004. Available at http://www.fda.gov/oc/initiatives/barcode-sadr.

*****

Cases of Selected Reportable Diseases and Motor Vehicle Injury Deaths in Kentucky
YTD Through July for Each Year

Disease	2004	2003	5-yr Median
AIDS	140	89	140
Chlamydia	3265	4845	4845
Gonorrhea	1416	2094	1942
Syphilis (Primary & Secondary)	26	24	26
Group A Streptococcus	48	32	25
Meningococcal Infections	5	10	12
Haemophilus influenzae, invasive	3	2	3
Hepatitis A	16	18	30
Hepatitis B	31	41	35
E.coli O157H7	17	12	17
Salmonella	187	217	187
Shigella	43	63	81
Tuberculosis	55	69	69
Animal Rabies	14	22	15
Motor Vehicle Injury Deaths	510	491	491

Disease	2004 YTD	Total in 2003
Diphtheria	0	0
Measles	0	0
Mumps	0	0
Pertussis	20	53
Polio	0	0
Rubella	0	0
Streptococcus pneumoniae	21	31
Tetanus	2	0

Disease	2004 YTD	Total in 2003
Rocky Mountain Spotted Fever	0	3
Lyme Disease	11	17
Ehrlichiosis	0	5
Tularemia	0	2
Arboviral Encephalitis	0	14
Malaria	1	11

APTIMA Amplified Chlamydia and Gonorrhea Testing

The Division of Laboratory Services Serology Section will implement an amplified test method for chlamydia and gonorrhea beginning October 4, 2004. Amplified testing will be provided for female endocervical, male urethral, and urine sources. The advantages for using this new method include: 1) increased analytical sensitivity, 2) ability to test urine samples, 3) longer specimen stability, and 4) ability to test bloody and mucoid specimens.

Supplies for the new test method will be sent to health departments by September 1. The box of supplies will include a training CD, collection kits, laboratory submission forms, and APTIMA collection guide sheets.

- Please discard all PACE 2C supplies and laboratory submission forms on October 1.
- Begin using the new APTIMA amplified collection kits and submission forms on October 4.
- The laboratory will stop accepting PACE 2C specimens after October 15.

The Division of Laboratory Services (DLS) will provide a training module on the T.R.A.I.N system beginning September 1. Contact Debbie Bohannon or David Knapp at 502-564-4990 if you need assistance using T.R.A.I.N.

If the Division of Laboratory Services can be of assistance please do not hesitate to call the laboratory at 502-564-4446 and speak to Brenda Shipp at ext 4462, Meloney Russell at ext 4405, or Leighann Bates at ext 4490.

KENTUCKY EPIDEMIOLOGIC NOTES & REPORTS
Printed With State Funds
by the
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Public Health
275 East Main Street
Frankfort, Kentucky 40621

PRSRT STD
U.S. Postage Paid
Lexington, KY
Permit No. 1

Kentucky Epidemiologic Notes and Reports, a monthly publication, is available without charge to subscribers. Although materials may be reproduced without permission, we appreciate acknowledgement. For more information call 502-564-3418.

Visit our Website:
http://chs.ky.gov/publichealth/newsletters-pub.htm

William D. Hacker, MD
Acting Commissioner, Department for Public Health

Kraig Humbaugh, MD, MPH
State Epidemiologist and Director,
Division of Epidemiology and Health Planning

Michael Auslander, DVM, MSPH
Interim Editor

RETURN SERVICE REQUESTED

Attention Local Health Departments!!!

INFLUENZA VIRAL CULTURE KITS

Influenza surveillance begins the first week of October. Please obtain kits now and distribute to local physicians. Strains of influenza can only be determined from cultures. Strain identification is necessary to detect epidemic or pandemic strains of influenza, to make informed decisions regarding the components of the next season's vaccine, and to determine whether strains of influenza are similar in all areas of the state.

Physicians are asked to keep the kits on hand and collect specimens on patients with influenza-like illnesses (ILI). Again this season, prepaid postage labels will be sent with the kits for mailing the specimens back to the state laboratory. Therefore, there will be no cost involved for collecting, submitting and testing the specimen for culture. Hopefully, more health care providers will be encouraged by the availability of this service, and will submit more specimens.

To request viral collection kits, please contact Diane Young, Division of Laboratory Services, at 502/564-4446, extension 4483.

State Epidemiologist -		Communicable Disease	502-564-3261	AIDS Information	1-800-420-7431
Kraig Humbaugh, MD, MPH	502-564-7243	Immunization Program	502-564-4478	HIV/AIDS Reporting	1-866-510-0008 (Toll Free)
State Public Health Veterinarian -		STD Program	502-564-4804		
Michael Auslander, DVM, MSPH	502-564-3418	TB Program	502-564-4276	HIV/AIDS Branch	502-564-6539

Division of Epidemiology/Health Planning 502-564-3418; 24HR/7Day Emergency—1-888-973-7678