Kentucky
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR PUBLIC HEALTH
DIVISION OF EPIDEMIOLOGY
& HEALTH PLANNING
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CDC Releases Draft: Interim Smallpox Response Plan

The Centers for Disease Control and Prevention (CDC) released its "Interim Smallpox Response Plan and Guidelines," outlining strategies for responding to a smallpox emergency, in late November 2001. The plan, which is a working draft, has been sent to all state bioterrorism coordinators, health officers, epidemiologists, and immunization program managers for review and comment. The plan identifies many of the federal, state, and local public health activities that would need to be undertaken in a smallpox emergency. Included are response plan implementation, notification procedures for suspected cases, CDC and state and local responsibilities and activities, and CDC vaccine and personnel mobilization.

The plan also provides state and local public health officials with a framework that can be used to guide their smallpox planning and readiness efforts, as well as guidelines for many general public health activities that would be initiated during a smallpox emergency. The plan was developed in conjunction with state epidemiologists, bioterrorism coordinators, immunization program managers, and health officials. Many of the strategies and concepts were used successfully in the global eradication of smallpox, which was achieved in 1980.

The "Interim Smallpox Plan" will remain a working document that will be updated regularly to reflect changes in overall public health resources for responding to a smallpox emergency. Public health authorities will be notified when updated drafts are available.

The executive summary for the CDC "Interim Smallpox Plan" states that because state and local health officials are "at the heart of an effective response to a smallpox emergency, their input is currently being sought." State, local, and private health officials are being asked to:

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—Identify additional tools that would be useful to their state and local plans;

—Identify and describe gaps in the overall plan, proposed activities, and guidelines;

—Identify concepts, approaches, activities, or guidelines that require clarification or further explanation;

—Assess the proposed strategies and guidelines with respect to state and local plans;

—Assess resources and resource needs;

—Identify additional elements, steps, or activities that should be undertaken in response to a smallpox emergency.

The foremost public health priority during a smallpox outbreak would be control of the epidemic. Doctors, health care workers, and hospital personnel have been trained to identify infectious diseases, verify their diagnosis, and then respond appropriately. The same system would identify any possible outbreak of smallpox. The plan does not call for mass vaccination in advance of a smallpox outbreak because the risk of side effects from the vaccine outweigh the risks of someone actually being exposed to the smallpox virus.

—Courtesy of the CDC Office of Communication November 2001

"The global public health community, in a landmark effort 21 years ago, eradicated smallpox from the planet. Today, we find ourselves preparing for a difficult-to-imagine event, an intentional release of smallpox. Although such a release might be unlikely, we must prepare for it so that the spread of illness will be minimized."

—Dr. Jeffrey P. Koplan,
CDC Director

New Bioterrorism Web Resource Introduced For Clinicians, Lab Professionals & Public

The Centers for Disease Control and Prevention (CDC) has unveiled a redesigned Web site offering both new and updated bioterrorism resources for health professionals and the public.

The site, at www.bt.cdc.gov, addresses the need for up-to-date and accurate information on health threats arising from exposure to biological, chemical, or radiological agents.

Designated Official Federal Site

The redesigned site, which focuses on Public Health Preparedness and Emergency Response, is the official federal site for medical, laboratory, and public health professionals to reference when providing information to the public and for updates on protocols related to health threats such as anthrax.

According to the CDC, the site was redesigned in response to "overwhelming demand from the public and professionals for credible information during the anthrax crisis." In October 2001, the CDC experienced more than a 100% increase in traffic to its main Web site. It registered more than 9.1 million visits, making it the most visited federal government site in the nation that month.

The new site offers easy-to-use categories requested by key audiences, including clinicians. The CDC will continue to add information as part of its increased role in responding to health threats that involve biological, chemical, or radiological agents.

EDITORS' CORRECTION

In the 2001 Subject Index for *Epidemiologic Notes & Reports*, which appeared in the December issue (Volume 36, Number 12), the November entries were omitted. The following articles were in November 2001 issue:

- The ABCs of Diabetes Control
- Arthritis: A Major Public Health Challenge
- Kentucky Department for Public Health Bioterrorism Activity Update
- Useful Websites on Bioterrorism

We apologize for any inconvenience or confusion the omission may have caused.

Cervical Health Month Emphasizes Pap Testing

By Trisha Mullins, CNM
Clinical Coordinator/Consultant
Kentucky Women's Cancer Screening Project

(Copies of this article may be freely distributed for patient education.)

Every year in the United States more than 4,000 women die from cervical cancer. Last year in Kentucky, over 200 new cases of cervical cancer were diagnosed and, in 1999, 88 Kentucky women died from this disease. During January, which was designated Cervical Health Month, the Kentucky Cabinet for Health Services placed emphasis on encouraging women to receive a Papanicolaou test, the screening test for cervical cancer, in order to prevent some of the needless deaths that occur in from this disease each year.

Most of the cervical cancers diagnosed in the U.S. occur in women who have not had a Pap test within the last five years, according to the Centers for Disease Control and Prevention. This is an unfortunate statistic since cervical cancer is preventable and, if detected early enough, curable. So why do women still die from this disease, the second most common malignancy found in females?

The first question we need to answer is: What causes cervical cancer? Experts agree that infection with specific strains of the Human Papilloma Virus (HPV) is the strongest risk factor for cervical cancer. Over 80 different strains of HPV have been identified, with some strains causing genital warts and/or low-grade cervical lesions. Another dozen or so different strains, identified as "high risk," are associated with causing cervical cancer. Yet in spite of these known facts, the majority of women have never heard of HPV or its link to cervical cancer.

The HPV viruses are contact viruses, and the ones that cause cervical cancer are transmitted through intimate contact with a partner who has the virus. Initial exposure to HPV may not be from a recent sexual partner. It is also possible that even a long-term partner was infected years earlier and prior to an existing relationship. Most women at risk for cervical cancer are those with a persistent viral infection lasting over a period of several years. In fact, the most common age to become infected with HPV is between 18 and 28, but the most common age for diagnosis of actual cervical cancer is much later in life. Contact with the HPV virus does not always cause infection. The immune system offers protection

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Cervical Health Month Emphasizes Pap Testing

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even if there is contact with the virus. However, people whose immune systems are compromised are at greater risk of becoming infected with HPV. Studies have shown that approximately 80% of HIV/AIDS positive patients also have HPV infection. Some other conditions that may compromise the immune system include diabetes, other chronic illnesses, prolonged use of steroid drugs, or recent chemotherapy. Exposure to the HPV virus among pregnant women and those taking birth control pills creates somewhat greater risk for infection due to hormonal changes that take place in the cervix.

Other circumstances, known as "co-factors," increase the risk of cervical cancer. Some co-factors that have been identified include:

- Failure to receive regular Pap tests
- Smoking
- Sexual intercourse at a young age (younger than age 18)
- Multiple sexual partners in a lifetime (three or more)
- A sexual partner with a history of multiple lifetime partners
- Multiple episodes of vaginal/cervical infections, particularly sexually transmitted infections
- Some recent research has indicated that low levels of folic acid and/or Vitamin C may play a role.

What can be done to decrease the chance of getting cervical cancer? To a certain extent, an individual can decrease the number of risk factors by altering behavior. For example, if a woman is a smoker, quitting will reduce her risk.

In addition and almost certainly, the most important factor in preventing cervical cancer is to receive regular Pap tests. The Pap test is the standard screening test to detect not only cancer, but also the pre-cancerous changes (dysplasia) that take place before malignancy occurs. Dysplasia is categorized as mild, moderate, or severe, based on the number of cervical cell layers affected. Cervical cancer is diagnosed only if all the cell layers (and beyond) are affected.

Because the Pap test is only a screening tool, a woman diagnosed with dysplasia is usually scheduled for a diagnostic procedure known as a colposcopy. During colposcopy an instrument is used to magnify the cervix so that biopsies can be taken in the affected area. Another helpful diagnostic test is HPV DNA typing to determine if a woman has the high-risk pre-malignant types of HPV virus. Prompt treatment of any pre-malignant lesions results in a virtual 100% cure rate.

Dealing with the Pap test examination and the possibility of getting abnormal results can be stressful to most women. Emotional reactions to HPV alone can be complicated and confusing. However, avoiding regular screenings for cervical cancer or failing to follow through with evaluation and treatment of dysplasia may result in much more anguish and even possible death.

Cervical cancer is preventable. Every woman should begin having Pap tests at age 18 or earlier if sexually active. The Kentucky Women's Cancer Screening Project recommends yearly Pap testing on any woman with a cervix. Many private health care providers recommend yearly screenings for three consecutive years, then once every three years if results are normal on low risk women. Individual health care providers may vary in their recommendations on screening intervals for patients.

According to data collected through the Patient Services Reporting System, local health departments in Kentucky screened over 101,000 women for cervical cancer in fiscal year 2001. Seven of these women had invasive cervical cancers. High-grade or pre-malignant lesions. were detected in 195 women; many others had low-grade infections.

More information about Pap testing may be obtained from local health departments. Or call the Kentucky Women's Cancer Screening Project at 1-800-462-6122.

EIA IgG Replaces the FTA-ABS for Syphilis Confirmation

On January 1, the Department for Public Health's Division of Laboratory Services (DLS) instituted the use of the Enzyme Immunoassay (EIA) Immunoglobulin G "IgG" as the primary confirmatory test for syphilis. The newly adopted test replaces Fluorescent Treponemal Antibody-Absorption (FTA-ABS) and, according to the Division, the change should resolve some of the problems that have been encountered with the use of the latter test.

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IgG Replaces the FTA-ABS

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DLS Director Samuel Gregorio, DRPH, said the advantages of using the EIA "IgG" test include higher sensitivity and less subjectivity for interpreting test results. The disadvantage of the "IgG" is that it may be slightly less sensitive in detecting early stage syphilis disease, he said, but the Division's testing procedures will compensate for this. The EIA "IgM" test will be very useful when testing for suspected congenital syphilis infection. Extensive comparative laboratory testing was performed to insure high sensitivity and specificity of these tests. As is always the case, the Director said, test results should not be interpreted without taking clinical signs and symptoms into consideration.

The Division made the following points in announcing specimen processing procedures for the new syphilis serology test:

- The VDRL will remain as the screening test; results will be reported non-reactive or by the titre (number of dilutions) if reactive.
- All reactive VDRL results, regardless of titre, will be tested using the EIA "IgG" as the confirmatory test. Results of the IgG will be reported as Negative, Reactive, or Equivocal (borderline/doubtful).
- Any specimen with a negative or equivocal IgG result will be tested by the EIA "IgM" test and the Treponema pallidum-Passive Particle Agglutination (TP-PA) test.
- If both the TP-PA and the EIA "IgM" test are non-reactive, the specimen will be reported as non-reactive. If both are reactive, the specimen will be reported as reactive. If one test is positive and the other is negative, then, and only then, will the FTA-ABS be used to determine a result. FTA-ABS results will be reported as being reactive or non-reactive.

Submitters who have already performed a positive screening test on a specimen may submit a split sample of the same specimen to the DLS for confirmation testing. The reason for requesting confirmatory testing must be indicated on the submission form. The Division will do the confirmatory testing following the guidelines above. Questions about the processing of specimens or interpretation of laboratory results should be directed to Brenda Shipp, Microbiology Section Supervisor, at (502) 564-4446 ext. 4462.

Assisted Living Certification Reaches 62 Communities

In the year and a half since a new state law went into effect requiring the certification of all assisted living communities in Kentucky, 62 of these facilities have been certified.

The law requires a community to file an application and pay a nonrefundable fee of $20 per living unit (a minimum of $300 and a maximum of $1600) to the Office of Aging Services in the Cabinet for Health Services. Along with its application, the community must file a floor plan that identifies living units, a central living and dining area, and a laundry facility. A copy of a blank lease, accompanied by copies of any documents incorporated by reference and any written material used to advertise, also must be submitted. The application materials are then reviewed by Aging Services and a site visit is scheduled.

The Office of Aging Services urges owners of all assisted living communities in Kentucky to seek state certification as soon as possible. At the very least they should have a letter from the office authorizing operation until a certification visit can be made.

Under KRS 194A.700-729, any assisted living community that provides services without receiving certification or without filing a current application may be fined up to $500 per day. For additional information, call Joy Feist, Branch Manager, Office of Aging Services, at 502-564-6930.

Don't Forget!

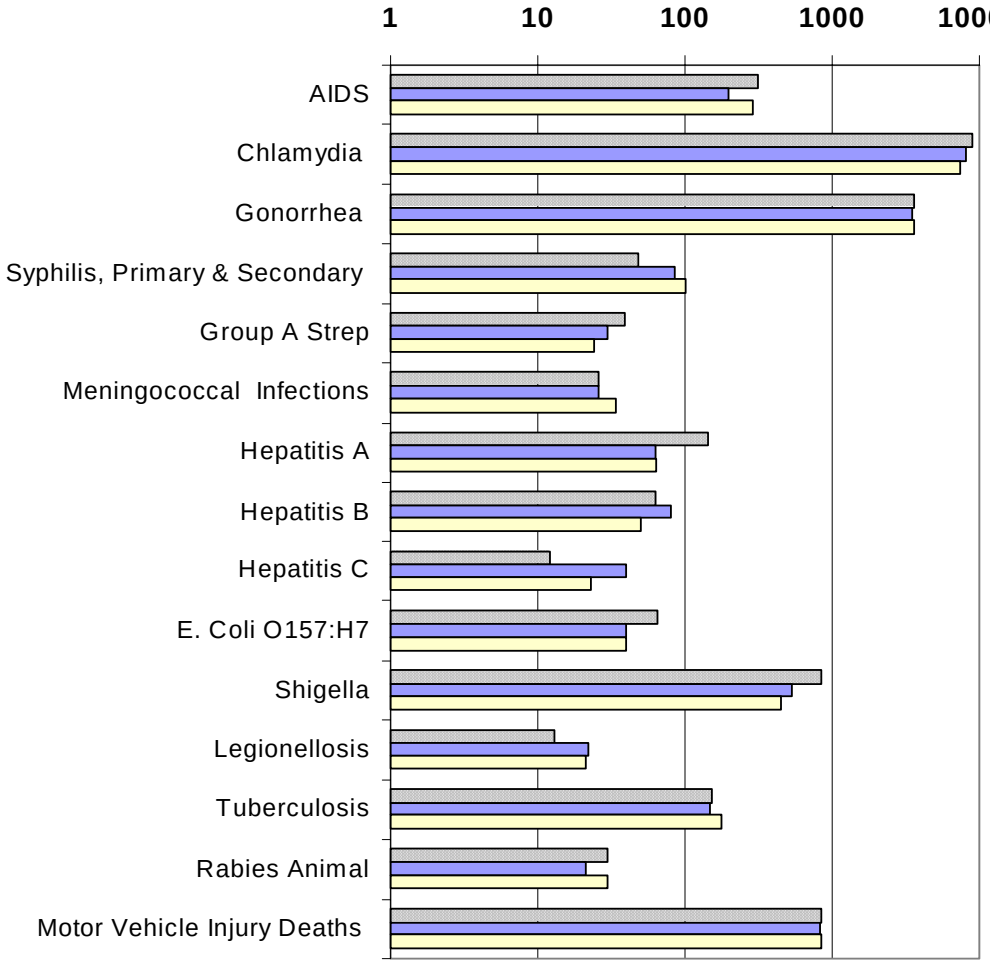
Website Offers Instant Access to EpiNotes

Each issue of *Kentucky Epidemiologic Notes & Reports* is promptly posted on the Department for Public Health's website, giving readers immediate access to information. The newsletter appears on the site well before the mailed version is printed and sent out.

Newsletter issues, dating from the most recent through 1996, are listed for Internet users by year and month of publication. Access requires the Acrobat Reader Plug-In (available as a free download).

http://publichealth.state.ky.us/newsletters-pub.htm

CASES OF SELECTED REPORTABLE DISEASES/CONDITIONS IN KENTUCKY, YEAR TO DATE THROUGH DECEMBER 2001 *



Vaccine Preventable Diseases	2001 YTD	2000 Annual Totals
Diphtheria	0	0
Haemophilus influenzae	2	12
Measles	2	0
Mumps	3	1
Pertussis	86	63
Polio	0	0
Rubella	0	1
Tetanus	0	1
Vector-Borne Diseases		
Arboviral encephalitis	0	2
Lyme Disease	23	13
Malaria	14	18
Rocky Mt. Spotted Fever	2	4
Tularemia	4	3

*Logarithmic Graph: In order to better display low incidence diseases on the same chart as diseases of higher incidence, a logarithmic scale is used.

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RETURN SERVICE REQUESTED

Rapid Response Team Events Planned

March Training Set for New Team Members

Information packets have been mailed to all Health Department directors regarding the annual Epidemiology Rapid Response training course, which is scheduled for March 5–7, 2002.

The three-day workshop is for **new** members and will introduce basic and new concepts in epidemiologic practices. The training will be held at the Health Services Building, 275 East Main Street, in Frankfort. For further information, please call Rebecca McCoy, R.N., B.S.N., at 502-564-3261, extension 3585.

Annual Conference Slated for May

Information will be sent out at a later date regarding the Epidemiology Rapid Response Team Annual Conference. The conference, which is for **all** Rapid Response team members, is scheduled for May 8-9 at Lake Barkley State Resort Park.