



Communicable Disease

THE ^ COMMUNIQUÉ

McHenry County Department of Health April, 2006 www.mcdh.info

COMMUNICABLE DISEASE EMERGENCY NOTIFICATION INFORMATION

Urgent Public Health issues shall be reported immediately (within 3 hours) to the McHenry County Department of Health and include the following:

- * Anthrax (suspected or confirmed)
- * Botulism (foodborne)
- * Plague
- * Q-fever
- * Smallpox
- * Tularemia
- * Any suspected Bioterrorist threat or event

REGULAR OFFICE HOURS (Monday – Friday 8am – 4:30pm) (815) 334-4500

Please call one of the following:
Mary Lou Ludicky, Communicable Disease Coordinator
Mary Ann Randolph, Investigator
Diane Doty-Brown, Investigator
Barbara Birmingham, Investigator
Susan Heger, TB Nurse
Sherrie Gallas, Epidemiologist

AFTER OFFICE HOURS (Monday – Friday 4:30pm – 8am; Saturday, Sunday and Holidays) (815) 344-7421

Ask to speak to the Communicable Disease “On-Call” person.

Mission

The Communiqué is a newsletter intended to prevent morbidity and mortality of infectious diseases by providing data and recommendations to clinicians, laboratories, infection control personnel and others who diagnose, treat or report infectious diseases in McHenry County.

We welcome comments and suggestions. Please call if you wish to be added to our mailing list. Contact Mary Lou Ludicky at 815-334-4500 or mlludick@co.mchenry.il.us



BUG OF THE MONTH *Streptococcus pneumoniae*

S. pneumoniae is a gram-positive coccus that replicates in chains. Ninety serotypes of *S. pneumoniae* have been identified. Serotypes 6, 14, 18, 19, and 23 are the most prevalent, accounting for 60-80% of infections (University of Wisconsin: 2003). *S. pneumoniae* has found its ecological niche by colonizing the nasopharynx. 40% of healthy adults and healthy children will have pneumococci present upon culturing. Colonization of the nasopharynx is present throughout the year, but the rate increases in the midwinter period. Usually, the pneumococci adhere tightly to the nasopharyngeal epithelium. For some individuals, however, progression into the lungs or middle ear occurs, causing illness.

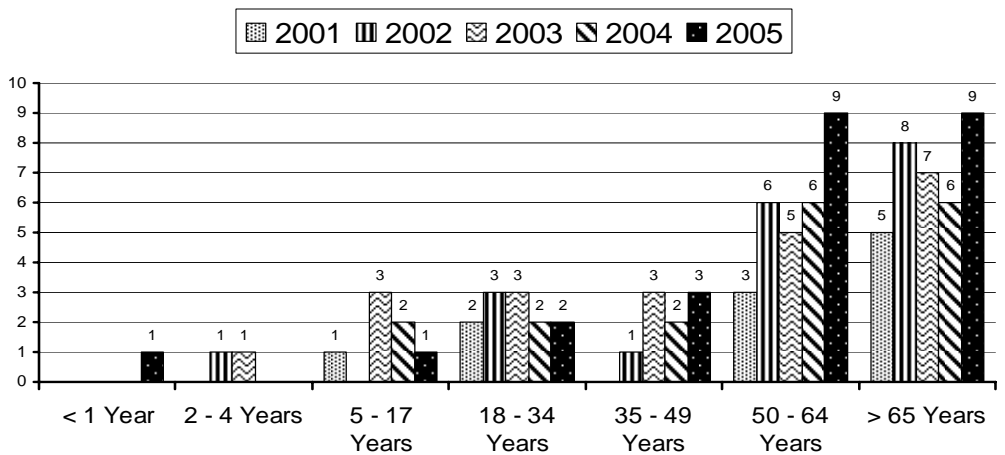
Illness: *Streptococcus pneumoniae* is the most common cause of otitis media; the leading cause of community acquired pneumonia; the leading cause of bacterial meningitis among children under 5; and can also cause bacteremia, sinusitis, peritonitis and arthritis. Death occurs in 14% of hospitalized adults with invasive disease. Nationally, in 2001, about 48,000

cases of invasive disease and 6800 deaths were estimated as a result of pneumococcal infections. In Illinois, 2100 cases were estimated during 2001, with 300 deaths.

Transmission and incubation: Pneumococci are transmitted from person to person by the inhalation of respiratory droplets from an infected person. This usually requires extensive, close contact. Daycare centers are likely places of spread for toddlers; crowded living conditions such as military barracks, prisons, homeless shelters and nursing homes are associated with epidemics. The incubation period is from 1-3 days.

Epidemiology: Physical factors predispose an individual to pneumococcal infection. These include immunosuppression, chronic illness such as diabetes and asthma, alcoholism, and age (infancy and aged). Of individuals 65 and over that develop pneumococcal pneumonia, about 20-30% will go on to develop bacteremia and 20% of those will die. Invasive pneumococcal disease is responsible for about 200 deaths nationally each year among children under 5 years old.

Number of Reported Cases of *S. pneumoniae* by Patient Age in McHenry County from April 1, 2001 Through November 30, 2005 (n=95)

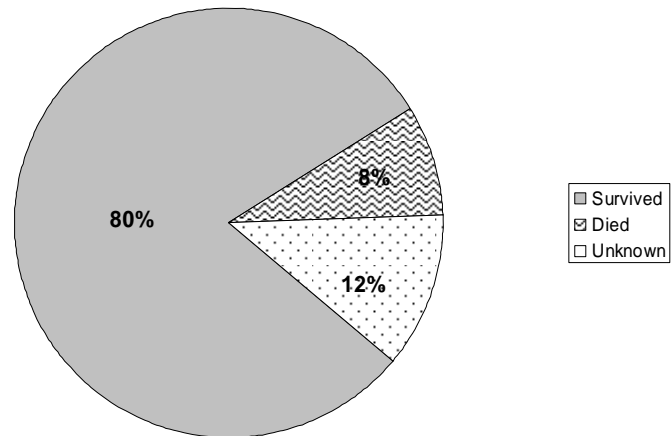


In Illinois, surveillance data for *S. pneumoniae* meningitis indicate an incidence rate of 0.5/100,000. The mean age of cases is 33; 45% were female and the majority of cases occurred in winter. The case fatality rate was 23%. In McHenry County, 107 cases of *S. pneumoniae* have been reported since April, 2001, when reporting became mandatory.

Drug Resistance: Up to 40% of infections are caused by pneumococci resistant to a least one drug and 15% are due to a strain resistant to 3 or more drugs. Seven serotypes of pneumococci account for most cases of drug resistant *Streptococcus pneumoniae* (6A, 6B, 9V, 14, 19A, 19F and 23 F) (CDC, 2002). In Illinois, data shows that penicillin resistance was found in 8% of cases, with 77% found to have intermediate resistance. All isolates were susceptible to ceftriaxone (Illinois Department of Health, 2003). Widespread overuse of antibiotics contributes to emerging drug resistance. The Institute of Medicine has declared antibiotic resistance one of the world's most pressing public health problems. The CDC has developed a website which focuses on this issue and which includes educational materials and technical information.
www.cdc.gov/drugresistance/community

Reporting: Effective April, 2001, all cases with sterile site isolation of *S. pneumoniae* has been required to be reported to the local health department within 7 days. This report includes information on demographics, illness, culture, underlying conditions, vaccine status and antimicrobial susceptibility. It is also important to report the case outcome. At this time, the Illinois

Survival Outcomes Among Reported Cases of *S. pneumoniae* in McHenry County from April 1, 2001 Through November 30, 2005 (n=95)



Department of Public Health (IDPH) is concerned that *S. pneumoniae* is still underreported. Of a total of 1872 invasive pneumococcal isolates identified statewide during April 2001-March 2002, only 701 (37%) of these cases were reported to local health departments. The IDPH recommendation is to report cases in as timely a manner as possible, include susceptibility data, submit fluoroquinolone non-susceptible isolates to IDPH laboratory for confirmation, and submit isolates from vaccinated children for serotyping at CDC.

Vaccination: Pneumococcal disease kills more people in the United States each year than all other vaccine preventable diseases combined. **The Pneumococcal Polysaccharide vaccine (PPV) for adults protects against 23 strains of *S. pneumoniae*.** According to the National

Health (2003), individuals should be vaccinated if:

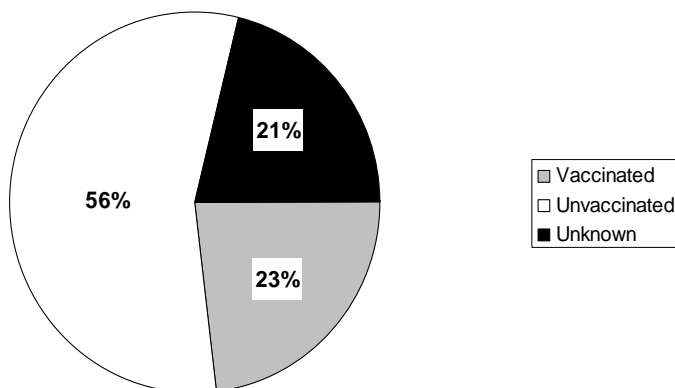
- They are 65 years of age or older or care for someone 65 years of age or older;
- Have a chronic illness, such as heart or lung disease or diabetes;
- Have a weak immune system due to illness or medication use;
- Are a resident or an employee of a nursing home or other long-term care facility.

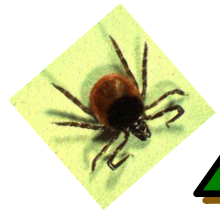
Usually, one dose of PPV is all that is needed. A second dose may be given if an individual received their first dose under the age of 65 and they are now 65 or older and 5 or more years have passed since that first dose. A second dose is also recommended for people who have: a damaged spleen or no spleen; sickle cell disease; HIV or AIDS; cancer; leukemia, lymphoma, multiple myeloma, kidney failure, nephritic syndrome, organ or bone marrow transplant; and are taking medication such as steroids or chemotherapy. This vaccine is not effective in children under the age of two. **Studies indicate this vaccine is underused.**

The Pneumococcal Conjugate vaccine protects against 7 strains of *S. pneumoniae*. It is approved for infants and toddlers and is given in 4 doses: one dose at 2 months, 4 months, 6 months and 12-15 months.

Additional information on this vaccine can be found at: www.cdc.gov/mmwr/preview/mmwrhtml/1/00047135.

Vaccination Status Among Reported Cases of *S. pneumoniae* in McHenry County from April 1, 2001 Through November 30, 2005 (n=95)





LYME DISEASE



With warmer weather approaching and increased time outside, exposure to ticks can increase. Ticks can be active anytime the temperature reaches 40 degrees. Every year, cases of Lyme Disease are reported in McHenry County, with most of these cases having exposure outside of the County. The bite of an infected deer tick (*Ixodes scapularis*), also known as the black legged tick, can transmit the bacterium *Borrelia burgdorferi*, which causes Lyme Disease. Deer ticks can become infected with the bacterium after feeding on small mammals infected with the disease. In order to transmit *B. burgdorferi* to humans, usually 24 hours of tick attachment is required.

The first sign of infection is usually a circular rash called [erythema migrans](#) or EM. This rash occurs in approximately 70-80% of infected persons and begins at the site of a tick bite after a delay of 3-30 days. A distinctive feature of the rash is that it gradually expands over a period of several days, reaching up to 12 inches (30 cm) across. The center of the rash may clear as it enlarges, resulting in a bull's-eye appearance. It may be warm but is not usually painful. Some patients develop additional EM lesions in other areas of the body after several days. Patients also experience symptoms of fatigue, chills, fever, headache, muscle and joint aches, and swollen lymph nodes. In some cases, these may be the only symptoms of infection.

Untreated, the infection may spread to other parts of the body within a few days to weeks, producing an array of discrete symptoms. After several months, approximately 60% of patients with untreated infection will begin to experience **musculoskeletal involvement** with intermittent bouts of arthritis, severe joint pain and swelling. Large joints are most often affected, particularly the knees. In addition, up to 5% of untreated patients may develop

chronic neurological complaints months to years after infection including any of the following, alone or in combination: lymphocytic meningitis; cranial neuritis, particularly facial palsy (may be bilateral); radiculoneuropathy; or, rarely, encephalomyelitis. Encephalomyelitis must be confirmed by demonstration of antibody production against *B. burgdorferi* in the CSF, evidenced by a higher titer of antibody in CSF than in serum. Headache, fatigue, paresthesia, or mildly stiff neck alone are not criteria for neurologic involvement. **Cardiovascular system** involvement can include: Acute onset of 2nd or 3rd-degree A-V conduction defects that resolve in days to weeks and are sometimes associated with myocarditis. Palpitations, bradycardia, bundle branch block, or myocarditis alone are not criteria for cardiovascular involvement.

Most cases of Lyme Disease can be cured with antibiotics, especially if treatment is begun early in the course of illness. Antibiotics commonly used for oral treatment include doxycycline, amoxicillin, or cefuroxime axetil. Patients with certain neurological or cardiac forms of illness may require intravenous treatment with drugs such as ceftriaxone or penicillin. About 30% of adults with late-stage disease have residual symptoms after treatment. One case reported to McHenry County Communicable Disease Program was not treated for 8 to 9 months after exposure and had developed intermittent joint pain.

Many cases in McHenry County have had exposure in other areas, including Wisconsin. According to Wisconsin statewide surveillance, in 2005, 1441 cases of Lyme Disease were reported. The highest incidence was in the western part of the state. This 2005 total was a 23% increase from the 1,176 cases reported in 2004 and reflects both a record high for the state and a recent trend of increasing cases reported in Wisconsin. 74 cases were reported in 2003 in Illinois, with the

peak number of cases in May through July.

CDC currently recommends the following measures to prevent Lyme disease:

Avoid ticks: Ticks prefer wooded and bushy areas with high grass and a lot of leaf litter. These are areas to avoid. In such areas, if possible, stay in the center of a cleared trail to avoid contact with overgrown grass, brush, and leaf litter. Avoiding ticks is especially important during the peak season of May through July.

Use personal protection: Use insect repellent with 20-30% DEET on adult skin and clothing to prevent tick bites. Permethrin kills ticks on contact! One application to pants, socks, and shoes typically stays effective through several washings. Permethrin should not be applied directly to skin. Be sure to follow the label directions whenever using repellents. Wear long sleeves, long pants, and long socks to keep ticks on the outside of clothing. Tuck shirts into pants and pants into shoes or socks to keep ticks on the outside of clothing. Light clothing will help spot ticks. If one is outside for an extended period of time then tape pant legs where pants and socks meet so that ticks cannot crawl under clothes.

Do tick checks on yourself, children, pets and clothing. Check you clothes and skin whenever spending time in tick areas. Perform daily tick checks after being outdoors, even in one's own yard. Check young children that are unable to do this themselves, as well as pets. Remove any ticks from clothing before going inside. Inspect all parts of the body carefully, especially the armpits, scalp, and groin. Wash clothes in hot water to kill any ticks you may have missed. Ticks should be immediately removed with fine-tipped tweezers, as close to the skin as possible.

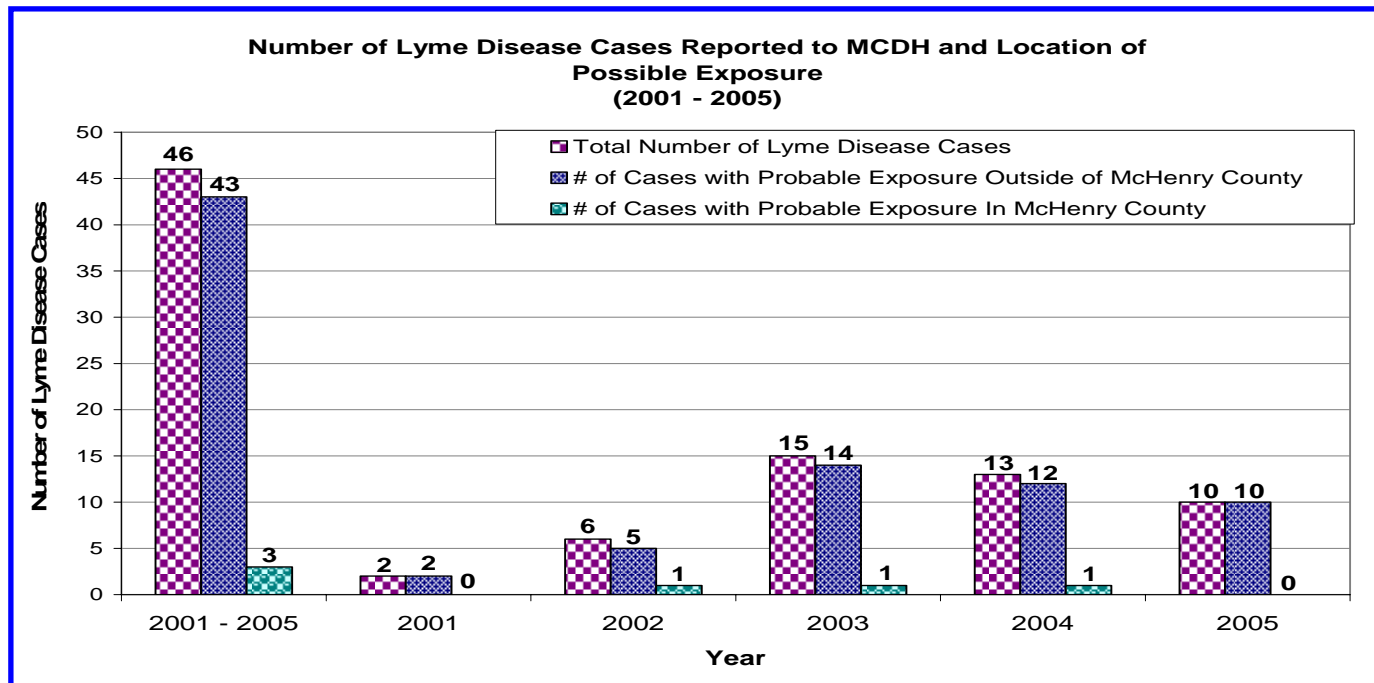
Don't use petroleum jelly, a hot match, nail polish, or other products to remove a tick.

Create a tick-free back yard: Create tick-safe zones around homes, parks and recreational areas. Clear overgrown

grass, brush and leaf litter from the premises or trails. Use wood chips or gravel as a barrier between lawns and wooded areas. Mow lawns frequently and remove cut grass and leaves. Keep tables, swing sets, play equipment, etc. away from woods and trees. Remove

woodpiles or stack wood neatly in dry areas away from houses to prevent rodent harborage.

For additional information:
<http://www.cdc.gov/ncidod/dvbid/lyme/index.htm>



NEW ACIP PERTUSSIS RECOMMENDATIONS -- April, 2006

The Advisory Committee on Immunization Practices (ACIP) in March voted to recommend the administration of Tetanus and Diphtheria Toxoids and Acellular Pertussis (Tdap) to protect healthcare personnel (HCP) from pertussis and to reduce transmission in healthcare facilities. The ACIP recommendation is for HCP who work in hospitals or

ambulatory care settings and have direct patient contact to receive a single dose of Tdap as soon as feasible, at an interval as short as 2 years from the last dose of Td. Priority should be given to the vaccination of HCP who have direct contact with infants less than 12 months of age. Hospitals and ambulatory care facilities should provide Tdap for HCP,

using approaches that will maximize vaccination rates. Tdap is not licensed for use among adults 65 years and older, and ACIP does not recommend Tdap for this age group. Recommendations for the use of Tdap in adults 65 years and older will be updated as new data become available.

A big **THANK YOU** goes out to all of the schools, districts, pre-schools and day care centers who send us their weekly syndromic surveillance data. Your participation in this program is very much appreciated! The following is a list of the facilities who have participated during this school year. Our apologies if we inadvertently missed anybody.

| | | |
|---|--|--|
| Algonquin Road School Conley Elementary School Crystal Lake Community School Dist. #47 Crystal Lake Montessori Duker School Eastview Elementary Edgebrook Elementary Fox River Grove Middle School Harrison Elementary Harvard Junior High Hilltop Elementary Huntley High School Jefferson School Johnsburg Junior High | Lake in the Hills Elementary Landmark Elementary Light of Christ Preschool Locust Elementary Mackenben Elementary Marengo Elementary Marengo Middle School Martin Elementary Mary Endres Elementary May Chesak Elementary McHenry Middle School Montini Catholic Primary Center Neubert Elementary Nippersink Middle School | Parkland Middle School Richmond Grade School Ringwood Primary School Riverwood Elementary St. Joseph's Catholic School St. Margaret Mary Catholic School St. Thomas The Apostle School Thunderbird Nursery School Trinity Oaks Christian Academy Valley View Elementary Verda Dierzen Early Learning Ctr. Washington School |
| | | THANK YOU!!! |

IOWA MUMPS OUTBREAK

975 cases of mumps have been reported to the Iowa Department of Public Health as of Thursday, April 20th. The highest number of cases have been in Dubuque County. Mumps activity has also been detected in all states surrounding Iowa, except South Dakota. There is a wide age distribution among cases. However, the majority of cases are within the 18 – 24 year old age group (median age = 21 years). Twenty-one percent (21%) of the cases attend college. The majority of the cases (68%) have received two MMR vaccines. The most common symptom of mumps in these cases is swelling of the parotid gland near the ear (parotitis) (77%), followed by sublingual and submaxillary gland swelling (42%), sore throat (35%), and fever (33%). Less common symptoms include: headache (10%), cough (10%) and swelling of the testicles (orchitis) (5%).

The Illinois Department of Public Health is also investigating an increase in mumps disease. On average, 10 cases per year are reported. As of April 20th, there are 75 confirmed cases. The majority of Illinois cases are in the Rockford area, Kendall County and Lake Forest. There are no cases of mumps currently in McHenry County. We will provide updates as the situation progresses.

Testing is encouraged on persons with mumps-like symptoms, such as patients presenting with glandular swelling, without other apparent cause. Mumps should not be ruled out in someone who is vaccinated if they have symptoms clinically consistent with mumps. Asymptomatic persons do not need to be tested. The IDPH lab in Chicago can perform culture testing on saliva and is

preparing to begin PCR testing. Serology is also accepted.

State Rules and Regulations for Illinois specify that: “Respiratory isolation or an equivalent isolation procedure and a private room are required for 9 days after salivary gland involvement. Exclusion from school or workplace is required until 9 days after salivary gland involvement, if susceptible contacts (those not immunized) are present.”

For additional information go to the Iowa Department of Health website at: <http://www.idph.state.ia.us/adper/mumps.asp> or

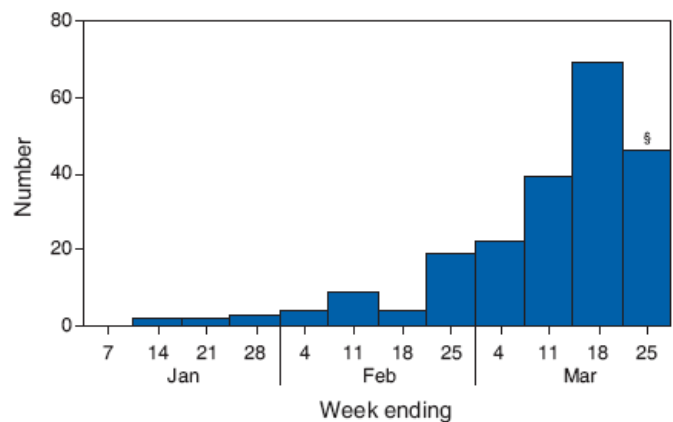
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5513a3.htm?>

Number of mumps cases, † by week of onset – Iowa, 2006

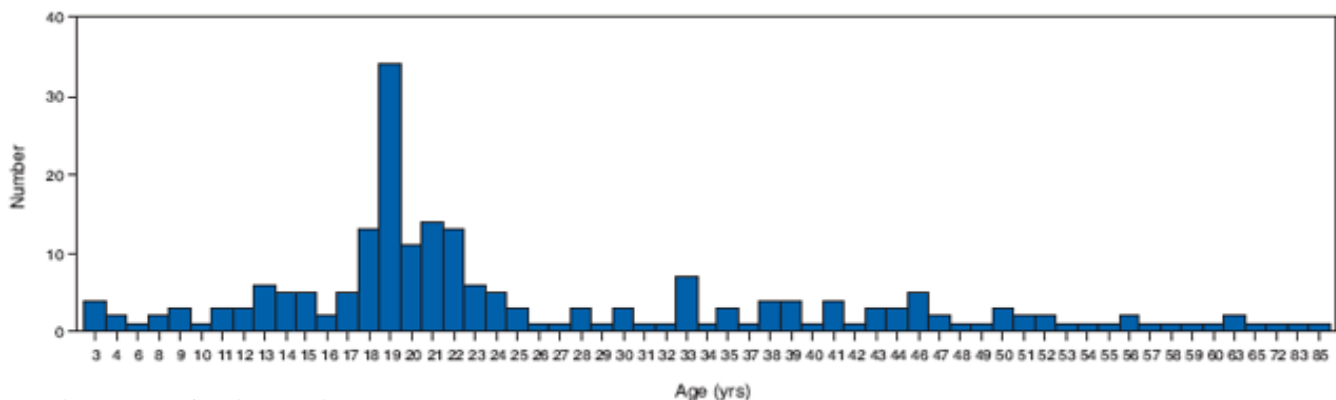
* N=219

† Includes confirmed, probable, and suspect cases. Case definitions were modified from Council of State and Territorial epidemiologists/CDC mumps case definitions for use in this outbreak. *Confirmed*: case that meets the clinical case definition (i.e., unilateral or bilateral tender, self-limited, swelling of the parotid or other salivary gland, lasting >2days and without other apparent cause) and is laboratory confirmed (i.e., by a positive IgM test result or positive viral culture) or epidemiologically linked to a confirmed case. A confirmed case can be asymptomatic if a mumps viral culture is positive. *Probable*: case that meets the clinical case definition but has noncontributory or no serologic or virologic testing and is not epidemiologically linked to a confirmed or probable case. *Suspect*: case with a positive IgM test result but no confirmation of the clinical definition.

§ Provisional data; cases being assessed for the week ending March 25, 2006.



Number* of mumps cases, † by age of patient – Iowa, 2006



* N=215; Ages of 4 patients are unknown.

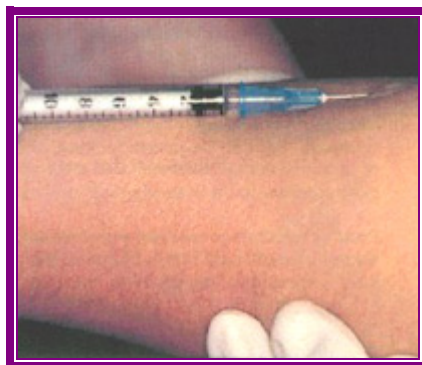
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TUBERCULOSIS: BCG DOESN'T MAKE MOST TB SKIN TESTS POSITIVE

There are many misconceptions about the usefulness of the BCG vaccination and how it affects the reading of a person's tuberculin skin test (TST). The countries with the lowest rate of tuberculosis in the world are the United States and the Netherlands, and they are the only countries that do not use the BCG vaccination. Russia usually tries to vaccinate their children at birth, at age 6-7, and at age 14 or 15, and yet there is a large tuberculosis disease rate in Russia. It is complicated by multi-drug resistant TB.

The initials BCG stand for *Bacillus Calmette-Guerin*. *Bacillus* is the family name for the bacterium. Calmette and Guerin are the names of the French doctor and veterinarian who developed the vaccine. They continually weakened the vaccine by "passaging" it from culture to culture, starting in 1906 and finally completing the task in 1921. Because the TB bacterium has a slow growth rate, the development of the vaccine took many years. Much controversy ensued about the use and efficacy of the vaccine because Dr. Calmette would not do scientific studies on humans. The effectiveness of the vaccine continues to be debated, but there have been studies done since the 1950's. The CDC concludes that the effectiveness of the BCG wanes after 5 years and there is no protection from tuberculosis in an adult who received BCG as a child. Studies have shown that BCG is not manufactured uniformly because there are many different strains from many different laboratories, so it is difficult to do comparison studies. It was also found that the closer to the equator studies were done, the less protection was provided by BCG. However BCG is highly protective in infants and children for the first 5 years after receiving the BCG. That is why many countries continue to give the

BCG vaccine. It is the most widely given vaccine in the world.



There is no way to predict if a tuberculin skin test is positive due to previous BCG vaccination or due to previous infection from the TB bacterium. Some people will have a negative reaction and some will have a positive reaction. If an adult lives or comes from a country where active TB is common, the CDC recommends that these adults are most likely to be positive due to TB infection and not because of BCG vaccination. Therefore preventive medication is recommended to all persons who have a positive skin test. If not treated, that person can go on to develop symptoms of active TB and become infectious.

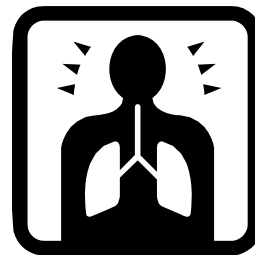
The United States' healthcare industry has a shortage of workers, especially registered nurses, and there are more foreign-born healthcare workers coming to the United States who have received BCG, have positive skin tests, have normal chest x-rays but have not received preventive treatment. It is possible for the bacteria to "wake up" (reactivate) if that person develops diabetes, cancer, pneumonia, HIV, or has a great deal of stress. In 2003 a New York nursery and maternity ward RN, who was foreign-born, had a known positive TB skin test for eleven years, a

normal chest x-ray, but took no preventive treatment. She developed symptoms in Sept. 2003 and was treated for asthma. Her symptoms persisted for 8 more weeks until a CT scan showed bilateral upper lobe disease. Further tests confirmed the diagnosis of *M. tuberculosis*, and she started a 4-drug regimen. The nurse potentially exposed 32 coworkers, 613 infants in the newborn nursery, and 900 patients in the maternity ward. It was difficult to locate all of the patients possibly exposed, but 5 of the infants had positive TSTs and 19 of the women from the maternity ward converted from negative to positive TSTs. The investigation of this case was time consuming and costly.

Preventive treatment involves taking a 300 mg INH tablet once a day for 6 to 9 months. The McHenry County Department of Health TB Clinic will provide free chest x-rays and other needed tests for those who have positive skin tests and will provide the preventive medication for free. Please call the TB Clinic for further information at 815-334-4500.

Sources: Lee B. Reichman, MD, MPH, from lecture given at IUATBLD, March 3, 2006, based on Dr. George Comstock's research from [Controlled Clinical Trials](#) 15, 1994

Guidelines for Preventing the Transmission of *Mycobacterium Tuberculosis* in Health-Care Settings, 2005



Influenza Update: Pandemic Information

And

Pandemic Influenza Planning

An estimated one third of the world's population (or \approx 500 million persons) were infected and had clinically apparent illnesses during the 1918–1919 influenza pandemic. The disease was exceptionally severe. Case-fatality rates were $>2.5\%$, compared to $<0.1\%$ in other influenza pandemics. Total deaths were estimated at \approx 50 million and were possibly as high as 100 million.

The impact of this pandemic was not limited to 1918–1919. All influenza A pandemics since that time, and indeed almost all cases of influenza A worldwide (except human infections from avian viruses such as H5N1 and H7N7), have been caused by descendants of the 1918 virus, including "drifted" H1N1 viruses and reassorted H2N2 and H3N2 viruses. The latter are composed of key genes from the 1918 virus, updated by subsequently incorporated avian influenza genes that code for novel surface proteins, making the 1918 virus indeed the "mother" of all pandemics. (Emerging infectious Diseases, January 2006)

The federal government has several Pandemic Influenza Websites with Resources:

1) To access a range of pandemic influenza resources on the Immunization Action Coalition website, go to:
<http://www.immunize.org/pandemic>

This website also includes the newsletter Pandemic Influenza Update.

(2) School District (K-12) Pandemic Influenza Planning Checklist was added to the Planning & Response Activities section of the federal government's pandemic and avian influenza website.

To access a web-text (HTML) version of the checklist, go to:
<http://www.pandemicflu.gov/plan/schoolchecklist.html>

(3) Home Health Care Services Pandemic Influenza Checklist was added to the Planning & Response Activities section of the federal government's pandemic and avian influenza website.

To access a ready-to-print (PDF) version of it, go to:
<http://pandemicflu.gov/plan/pdf/HealthCareChecklist.pdf>

To access a web-text (HTML) version, go to:
<http://pandemicflu.gov/plan/healthcare.htm>4) For healthcare "Medical Offices and Clinics Pandemic Influenza Planning Checklist" is available at
<http://www.pandemicflu.gov/plan/medical.html>

To access an array of pandemic and avian influenza resources on the federal government website, go to:
<http://www.pandemicflu.gov>

| MCHENRY COUNTY COMMUNICABLE DISEASES DECEMBER 1, 2005 – March 31, 2006 | | |
|--|------------|------|
| DISEASE | # OF CASES | |
| | FY06 | FY05 |
| AIDS/HIV | 3 | 8 |
| Amebiasis | 0 | 0 |
| Blastomycosis | 1 | 2 |
| Campylobacter | 15 | 10 |
| Chickenpox (adult only) | 0 | 1 |
| Chickenpox (school report) | 45 | 28 |
| Cryptosporidiosis | 0 | 1 |
| E. Coli 0157:H7 | 1 | 0 |
| Encephalitis | 1 | 0 |
| Giardia | 4 | 3 |
| Hepatitis A | 0 | 0 |
| Hepatitis B | 19 | 6 |
| Hepatitis C | 44 | 29 |
| Lyme Disease | 4 | 0 |
| Malaria | 0 | 1 |
| Aseptic Meningitis | 12 | 9 |
| Bacterial Meningitis | 3 | 1 |
| Mumps | 0 | 0 |
| Pertussis | 9 | 20 |
| Psittacosis | 0 | 0 |
| Salmonella | 11 | 7 |
| Shigella | 2 | 1 |
| Strep/Group A (invasive & wound) | 9 | 1 |
| Strep Pneumonia | 12 | 9 |
| TB Active | 3 | 2 |
| Chlamydia | 55 | 51 |
| Gonorrhea | 16 | 7 |
| Syphilis – Primary | 3 | 0 |
| Syphilis – Secondary | 0 | 0 |
| Syphilis – Latent | 2 | 2 |
| Syphilis -- Neuro | 0 | 0 |
| West Nile Virus | 0 | 0 |
| Yersiniosis | 0 | 0 |

McHenry County Department of Health
2200 N Seminary Avenue - Annex B
Woodstock Illinois 60098

BECOME PART OF OUR BROADCAST FAX NETWORK

Receive the latest health alerts on topics such as:

West Nile Virus Bioterrorism
Flu Updates Area Outbreaks
Other emerging infectious diseases



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Specialty _____
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Email _____

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Woodstock IL 60098
Fax to: 815-334-1884
Or email to: mlludick@co.mchenry.il.us