

{ Cluster of Syphilis Cases Identified in Tulsa County }

Syphilis is a sexually transmitted disease affecting about 32,000 Americans annually. It most commonly affects heterosexual men and women and is spread from person-to-person through direct contact with an ulcer-like lesion called a chancre that typically occurs on the external genitals, vagina, anus, or rectum. Syphilis infection increases the likelihood of HIV transmission, and when left untreated it can cause severe neurological and cardiac complications and even death.

In August, a Tulsa physician noted a cluster of syphilis cases among her **male patients who have sex with men (MSM)** and notified the Oklahoma State Department of Health (OSDH). To investigate, routine surveillance data was reviewed from all syphilis case reports in Oklahoma from 1999 to August 30, 2005. Cases were classified into primary, secondary, early latent, and tertiary according to standard CDC definitions. For the purpose of analysis, cases meeting the definition of primary, secondary, or early latent syphilis were grouped into acute syphilis.

In Tulsa, there has been a steady decrease in cases of acute syphilis from 71 cases in 1999 to 23 cases in 2004. However, in the first 8 months of 2005 there were 20 cases (annualized to 33 cases for the year) suggesting the first annual increase. Of the 2005 cases, 77% were male, had an average age of 38 (range 16-66), 42% were non-Hispanic white, and 42% of cases were diagnosed by a private physician suggesting high economic status. Nine (45%) occurred in MSM. In comparison, Oklahoma County syphilis cases during this time were less commonly male (56%), younger (age 36, range 11-100), less commonly non-Hispanic white (13%), less commonly diagnosed by a private physician (11%), and less commonly MSM (12%).

We conclude there is an increase in syphilis cases in Tulsa in the first 8 months of 2005, and this increase was attributable to an increase among the MSM population. A similar increase, however, was not seen in Oklahoma City, a comparably sized metropolitan area.

There are 2 major limitations to this study. First, being based on physician reporting, underreporting is likely. However, if physician reporting and testing rates remained constant, this should be a neutral bias. A second limitation are the low numbers of syphilis cases, and year-to-year variations occurring by chance alone, cannot be completely ruled out. Despite these limitations, the findings of this investigation

suggest some troubling trends for syphilis in Oklahoma. The overall increase of cases of syphilis suggests a reversal of previously successful syphilis reduction strategies and the reemergence of the disease in a population not previously affected.

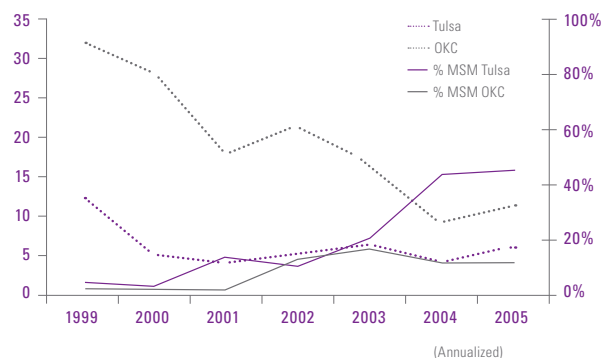
Increases in syphilis among the MSM have been reported in several other U.S. cities in recent years.¹ The increase in syphilis in the MSM population of Tulsa may signal the start of a similar demographic shift in Oklahoma.

Prevention efforts must focus on decreasing high-risk sexual behavior among these at-risk groups. The OSDH has developed a public awareness campaign that focuses on educating the MSM population of their risks of contracting and spreading syphilis and ways of reducing their risk through the use of barrier protection and early treatment. Additionally, the OSDH recommends that providers offer syphilis, HIV, and other STD testing and treatment for persons at risk. The OSDH is also supporting community outreach by offering free syphilis and STD testing and treatment as well as partner notification and counseling referral services.

*prepared by **Kay Holladay**, MPH, **Mark Turner**, MPH, HIV/STD Service & **Brett Cauthen**, MD, State Epidemiologist

¹Centers for Disease Control and Prevention, STD Surveillance 2003, Trends in Reportable Sexually Transmitted Diseases in the United States, 2003 – National Data on Chlamydia, Gonorrhea and Syphilis.

Rate of Syphilis in Tulsa and OKC



{ Improvements Vital to Reduce Perinatal Hepatitis Transmission }

In 2003, national data showed that 23,269 infants in the U.S. were born to hepatitis B positive women and 175 of those infants were born in Oklahoma. Ninety percent of those infants infected at birth will develop chronic hepatitis B infection. An estimated 15%-25% of these carriers will die prematurely of liver failure due to chronic active hepatitis, cirrhosis, or primary hepatocellular carcinoma. Perinatal transmission in the U.S. is uncommon. This is due in part to a comprehensive strategy started in 1991 to eliminate hepatitis B that recommended prenatal testing of all pregnant women for hepatitis B to identify newborns at risk for contracting the disease. Transmission can be prevented (85%-95% efficacy rate) by the timely administration of the **hepatitis B vaccine** (HBV) and **hepatitis B immune globulin** (HBIG) within 12 hours after birth, which should be administered to all infants born to women with infectious hepatitis B (HBsAg positive). With consistent use of these guidelines, perinatal transmission of hepatitis B in the U.S. would become rare.¹ However, in Oklahoma, many infants of women who have a documented positive Hepatitis B surface Antigen (HBsAg) or unknown status at the time of delivery do not receive the appropriate intervention and the result is often the infection of a newborn. This report describes one such case in Oklahoma and discusses recommendations to prevent future transmission. Better communication between the clinician providing prenatal care and the delivery facility may prevent many of these infections.

In July 2004, a male infant born in an Oklahoma City hospital to a HBsAg-positive mother was not immediately given immunoprophylaxis. Three months after his birth, the Oklahoma State Department of Health (OSDH) was notified and the incident was investigated. It was determined that several breakdowns in communication occurred that contributed to the possible transmission of hepatitis B to the infant at birth. The mother's hepatitis B status was documented in only one place on the perinatal record that was sent to the delivery facility and the original lab result was not included in the record. The infant did not receive HBIG and was given the HBV birth dose 26 hours after delivery. In January 2005, the infant tested positive for the HBsAg and in March 2005, the infant was positive for the Hepatitis B e Antigen that is an indicator for high viral load. Further testing will reveal whether or not the infant is chronically infected.

Oklahoma regulations require that a positive HBsAg be reported to the OSDH within one working day. Reports in women of childbearing age are evaluated for pregnancy status. Once a mother with hepatitis is identified, the OSDH provides free HBIG and the birth dose of HBV to her newborn infant. Follow-up of the mother and infant is done until the infant has completed the entire hepatitis B vaccine series and serological testing is complete.

The Oklahoma State Department of Health recommends that clinicians providing obstetrical and pediatric services perform the following:

- Screen for hepatitis B **early** and with **every** pregnancy.
- **Retest** negative mothers at time of admission to labor and delivery if they continue high-risk behaviors (i.e. multiple sex partners, injectable drug use, or household or sexual contact with hepatitis B carrier).
- Include the **actual lab result** in the copy of the prenatal record that is sent to the delivery facility.
- **Flag the chart** in such a way that all caretakers are aware of the woman's infectious state and the risk for the newborn if the woman is positive.

Recommended Follow-up for Infants Based on Mother's Hepatitis B Status

HBsAg-Negative	-Administer birthdose of HBV within 24 hours and follow routine immunization schedule for series completion
HBsAg-Positive	-Administer HBV and HBIG within 12 hours of birth -2nd and 3rd doses should be given 1-2 mos. and 6 mos. respectively after the 1st dose -Testing for HBsAg and HBsAb recommended at 9-15 mos. of age (3-9 mos. after the 3rd dose) to monitor the success of the therapy
HBsAg-Unknown	-Test mother "stat" -Administer HBV within 12 hours of birth -Give HBIG as soon as possible if need indicated by mother's test results

It is imperative that pregnant women infected with hepatitis B virus are reported to the OSDH with the first pregnancy as well as subsequent pregnancies by laboratories and clinicians. Only with intense coordination and communication can we hope to decrease the risk to Oklahoma newborns for hepatitis B infection.

For additional information or questions related to hepatitis B and perinatal transmission, contact Debbie Purton, RN, Perinatal Hepatitis B Coordinator at 405.271.4636.

*prepared by **Debbie Purton** RN, BSN Perinatal Hepatitis B Coordinator, HIV/STD Service

¹ CDC Epidemiology and Prevention of Vaccine-Preventable Diseases, 8th ed., January 2004.

{ Influenza and Other Respiratory Virus Surveillance Update Oklahoma, 2005 - 2006 }

The first case of culture confirmed influenza for the 2005-06 season was detected in the northeastern region of the state on December 5, 2005. The weekly proportion of patient visits for influenza-like illness (ILI) reported by sentinel physicians remained below threshold levels until the week ending December 31, 2005, when ILI exceeded 2.5%. Due to relatively high activity localized in the northeastern region of the state, ILI rose to 4.8% during the week ending January 7, 2006. The highest proportion of persons with ILI to date has been adults aged 25 to 64 years accounting for 44.4% of reported ILI cases. The percent positivity of influenza testing at sentinel laboratory sites has consistently increased from 9.3% on December 24, 2005, to 34.2% for the week ending January 28, 2006. The State Public Health Laboratory (PHL) routinely conducts viral culture for respiratory viruses. To date, 91% (10/11) of influenza isolates submitted to the PHL have been type A (H3N2). In addition, the PHL has confirmed two positive respiratory cultures for parainfluenza type 1, one echovirus type 6, and one coxsackievirus B4.

A noteworthy finding of respiratory virus surveillance has been an early detection of the beginning of Oklahoma's annual respiratory syncytial virus (RSV) season. Significant RSV activity began in late October and increased until activity started to decline in late January. Typically, the state's RSV season begins in January and lasts 2-3 months. RSV test positivity rates as reported by eight hospital laboratories have remained above the threshold since the week ending October 22, 2005, with the positivity rate peaking at 44.2% during the week ending January 7, 2005, (mean of 22.3%). RSV activity has now started to decline with test positivity of 19.5% reported during the week ending January 28, 2006. Current recommendations indicate that RSV-IGIV or the anti-RSV humanized murine monoclonal antibody may be given during this time to prevent serious complications in high-risk infants, children younger than 24 months with chronic lung disease, and certain premature infants.¹ However, use of anti-RSV humanized murine monoclonal antibody is generally preferred due to the ease of administration.¹ Altering environmental factors, such as eliminating exposure to tobacco smoke, can also decrease the severity of disease. Respiratory virus surveillance data is collected on a weekly basis from 17 physicians and 10 laboratory sentinel sites. Summary findings are posted on the weekly update section of the influenza surveillance Website. To access the weekly surveillance summary and other influenza information for healthcare professionals, please visit the Influenza Facts, Resources, and Updates Webpage at <<www.health.ok.gov/program/cdd/flu/index>>.

*prepared by **Renee Powell**, M.P.H., Epidemiologist, CDD

¹Pediatrics, Vol. 112 No. 6 Revised Indications for the Use of Palivizumab and Respiratory Syncytial Virus Immune Globulin Intravenous for the Prevention of Respiratory Syncytial Virus Infections December 2003, pp. 1442-1446

{RHINO}

Reportable Health Information and Notification in Oklahoma

The **Reportable Health Information and Notification in Oklahoma (RHINO)** system is a **Health Alert Network (HAN)** for use by the Oklahoma State Department of Health (OSDH). A HAN is used to provide vital health information to health care professionals and public health partners. Oklahoma established a HAN to enhance emergency response capabilities as we attempt to fight terrorism and protect the public from disease. The purpose of a HAN is to provide continuous information access and emergency communication.

The RHINO system is part of a nationwide network of HANs that follow guidelines and policies set from the Centers for Disease Control and Prevention (CDC). Oklahoma's HAN is unique from other HANs but must meet criteria such as contacting key stakeholders in a timely manner; and must be capable of sharing confidential information in a secure format.

HAN began in 1999 when 33 States and 3 City/County Health Departments were funded to develop capabilities for emergency communication and continuous access to public health information. The HAN has now grown to include all 50 States, 8 U.S. Territories, and 4 City/County Health Departments.¹

The RHINO system consists of the following:

- A secure Website where users have the ability to:
- View alerts, advisories, updates, and events.
- Use the included document library as a resource to share sensitive information through controlled access groups.
- Update their own professional or personal information to ensure the delivery of alerting messages.
- Electronic capabilities to rapidly send broadcast messages via fax, email, and telephone.

The current network of users includes physicians, physician assistants, nurse practitioners, laboratorians, veterinarians, all public health nurses, county health department personnel, law enforcement, federal and state officials, and emergency contact persons in other states. These professions may obtain access to the RHINO Website by contacting Kim Mitchell, HAN Coordinator, at 405.271.4060 or Kimberm@health.ok.gov. Additional groups such as nursing homes, assisted living centers, emergency medical personnel, first responders and public safety cannot log on to the Website but will receive targeted, essential information via fax.

*prepared by **Kim Mitchell**, HAN Coordinator, CDD

¹CDC. Health Alert Network. <<www.phppo.cdc.gov/han>>.

{Hurricane Katrina Response in Oklahoma}

Rapid Needs Assessment of Evacuees at Camp Gruber, Muskogee County, Oklahoma

On August 29, 2005, Katrina, a category 4 hurricane, struck the Gulf of Mexico resulting in extensive damage to the New Orleans and surrounding areas. Damage from the hurricane displaced approximately 220,000 persons from the New Orleans area that needed assistance in relocating.¹ On September 4, 2005, Oklahoma received **1,589 evacuees to Camp Gruber**, a National Guard training facility. A primary objective of the public health response to disasters is to determine the medical and social needs of the population to focus resources appropriately, so the Oklahoma State Department of Health (OSDH) conducted a rapid needs assessment on the estimated 1,100 persons remaining in the evacuation center on September 8 and 9.

The evacuee center consisted of 11 occupied barracks and a convenience sample of all willing persons within each barrack was used. The questionnaire focused on both individual and household characteristics.

Data was collected on 197 households and 373 persons. Almost all (99%) of the households were Louisiana residents. Sixty-three percent (n=84) of households with more than one person were missing at least one household member. The survey demographics are listed in the table to the right. When compared to Orleans parish, Camp Gruber evacuees were significantly more likely to be male, black, and 45-64 years old. The adults were also significantly less likely to be employed and have finished high school.² Eighty-nine percent of adults (n=217) either reported no health insurance or public assistance (Medicare/Medicaid).

More than half of adults (56%) reported at least one chronic illness. Of adults, 14% (n=34) reported a mental illness that required medication pre-hurricane, 8 reported being physically or sexually assaulted since the hurricane, (42%) reported that they had witnessed someone severely injured or dead, and, 10% (n=20) reported that a family member or friend had died since the hurricane. Questions asked of adults to determine acute stress disorder included trouble sleeping, feeling isolated or distant from persons you normally interact with, and becoming jumpy or restless. Of those responding to all 3 questions, 50% (n=117) answered yes to at least 1 question.

Injuries, exacerbation of chronic medical conditions, and acute medical and mental health needs can result from disasters like Katrina. The results of this needs assessment have provided the information to direct future emergency relief and response activities so that we can be better prepared to deal with the multiple and complex problems of a large displaced community.

Demographics of Camp Gruber Evacuees

September 2005 compared to the Population of Orleans Parish, Louisiana

Variable	No.	% Camp Gruber	% Orleans Parish	OR	95% CI
gender					
male	209	56%	47%	1.45	1.17, 1.78
female	164	44%	53%		
total	373				
*age					
0-4	23	6%	7%	.89	.57, 1.38
5-24	104	28%	31%	.86	.68, 1.09
25-44	90	24%	30%	.78	.61, .99
45-64	123	34%	21%	1.49	1.19, 1.86
>64	30	8%	12%	.67	.45, .98
total	370				
*age unknown for 3 persons					
*race					
black	300	83%	67%	2.36	1.78, 3.13
non-black	62	17%	33%		
total	362				
*race unknown for 11 persons					
*ethnicity					
hispanic (of any race)	14	5%	3%	1.80	1.01, 3.15
non-hispanic	247	95%	97%		
total	261	100%			
*ethnicity unknown for 112 persons					

*prepared by **Joli Stone**, M.P.H., Epidemiologist, CDD & **Sara Russell**, M.S.N., M.P.H., R.N., EIS Officer, CDC

¹ Federal Emergency Management Agency. Hurricane Katrina response and recovery update, 2005. <<www.fema.gov/news/newsrelease.fema?id=18602>>.

² US Census Bureau. State and county quick fact: Orleans parish, Louisiana. 2005 Oct. <<<http://quickfacts.census.gov/qfd/states/22/22071.html>>>.

{ FACT SHEET: avian influenza }

What is avian influenza?

Avian influenza, or “bird flu,” is an infection caused by influenza A viruses, which normally infect only birds. These influenza A viruses are found in wild birds worldwide and are quite contagious among birds. In many wild species of birds, especially waterfowl (ducks, geese, gulls), infection with avian influenza does not result in illness, but infection in domesticated birds such as chickens, ducks, and turkeys may lead to serious disease and mortality.

What types of avian influenza viruses are there and which cause serious disease in birds?

Influenza A viruses are classified into subtypes based on certain proteins present on the outer layer of the virus. These proteins are hemagglutinin (H) and neuraminidase (N). There are 16 different H subtypes and 9 different N subtypes. Any combination of these two protein types is possible to form a virus subtype, for example H9N3, H7N7, or H5N1. The ability of avian influenza viruses to cause serious disease (pathogenicity) tends to vary with the makeup or subtype of the virus. Subtypes that are classified as “low path” cause mild symptoms of illness in birds such as ruffled feathers and a drop in egg production. “High path” virus subtypes cause more severe disease, spread rapidly through a flock, and kill a significant number of birds. Presently, only H5 and H7 subtypes are associated with severe disease outbreaks in birds.

How common is avian influenza?

Avian influenza outbreaks among poultry occur worldwide from time to time. Since 1997, more than 16 outbreaks of H5 and H7 influenza have occurred among poultry in the United States.

How is avian influenza controlled?

When avian influenza outbreaks occur in poultry, quarantine and depopulation (or culling) and surveillance around affected flocks by animal health officials are used to control and stop the spread of disease.

How does avian influenza spread?

Infected birds shed the influenza virus in their respiratory discharges and droppings. Birds may be infected when they come into contact with contaminated excretions or surfaces. The occurrence of human infections is rare since avian influenza viruses are adapted to birds and usually do not infect humans. Most cases of avian influenza in humans have resulted from contact with infected poultry or contaminated surfaces such as feed, water, equipment, cages, or clothing. Exposure to humans is considered most likely during slaughter, removing feathers, butchering, or preparation of infected poultry for cooking.

What are the symptoms of avian influenza in humans?

The symptoms of avian influenza in humans depend on the characteristics of the infecting virus. In most cases, the symptoms will be absent or mild consisting of fever, headache and eye inflammation (conjunctivitis). Rarely, symptoms may be more severe including high fever, cough, sore throat, pneumonia, acute respiratory distress, and other severe and life-threatening complications.

How commonly do avian influenza viruses affect humans?

Although avian influenza A viruses usually do not infect humans, several instances of human infections have been reported since 1997. Most cases of avian influenza infection in humans are thought to have resulted from direct contact with infected poultry or contaminated surfaces such as feed, water, equipment, cages, or clothing. These human cases of influenza have been in poultry workers and farmers who raise chickens, turkeys, or ducks, as well as in people who work in live bird markets.

Does the H5N1 avian influenza virus spread easily from birds to humans?

The H5N1 avian influenza virus does not easily spread from birds to humans. In 1997, the first case of spread from a bird to a human was seen during an outbreak of H5N1 avian influenza in poultry. There have been a little over 120 human cases in the current outbreak. However, this number is quite small when considering the population of birds affected and the many opportunities for human contact especially in areas where people raise their own chickens and ducks (backyard flocks). So far, spread of H5N1 avian influenza from person-to-person has only been identified in one small family cluster and did not extend beyond one person.

What is the Oklahoma State Department of Health doing to prepare for a possible outbreak of H5N1 avian influenza or other pandemic influenza threat?

The Oklahoma State Department of Health has developed a pandemic influenza management plan to address the public health response that would be needed during an influenza pandemic. This plan will be reviewed and revised regularly. For more information on the Oklahoma Pandemic Influenza Management Plan, see <<www.health.state.ok.us/program/cdd/flu/Oklahoma%20PIM%20Plan%20Final%20WEB%20DRAFT.pdf>>.



Antibiotic Susceptibility of Invasive *Streptococcus pneumoniae* Isolates from Sentinel Surveillance Laboratories, 01.98 - 07.05**

Hospital	Suscept.*	# Penicillin %	# Ceftriaxone %	# Cefotaxime %	# Erythromycin %	# TMP/SMZ %	Total # of isolates submitted
OKC AREA							
Columbia Bethany	S I R	4/5 (80) ^e 1/5 (20)	3/3 (100) ^e	1/2 (50) ^e 1/2 (50)	3/3 (100) ^d		5
Deaconess	S I R	63/90 (70) ^{b,e} 19/90 (21) 8/90 (9)	85/88 (97) ^e 1/88 (1) 2/88 (2)		24/29 (83) ^d 5/29 (17)	1/1 (100) ^d	90
Integrus Baptist	S I R	162/247 (66) ^{d,e} 54/247 (22) 31/247 (12)	230/244(94) ^e 13/244 (5) 1/244 (1)	3/3 (100) ^e	168/245 (69) ^d 77/245 (31)	5/8 (62) ^d 3/8 (38)	247
Integrus Southwest	S I R	128/170 (75) ^{d,e} 26/170 (15) 16/170 (10)	156/165 (95) ^e 7/165 (4) 2/165 (1)	3/3 (100) ^e	124/166 (75) ^d 1/166 (1) 41/166 (24)	1/2 (50) ^d 1/2 (50)	170
Mercy	S I R	57/96 (59) ^e 21/96 (22) 18/96 (19)	38/45 (84) ^e 4/45 (9) 3/45 (7)	39/54 (77) ^e 8/54 (15) 7/54 (13)	1/5 (20) 4/5 (80) ^e	6/25 (24) ^e 2/25 (8) 17/25 (68)	96
Midwest Regional	S I R	105/148 (71) ^e 36/148 (24) 7/148 (5)	6/7 (86) 1/7 (14) ^e	110/142 (77) ^e 25/142 (18) 7/142 (5)	13/14 (93) ^d 1/14 (7)	1/1 (100)	148
Norman Regional	S I R	75/121 (62) ^{e,o,m} 24/121 (20) 22/121 (18)	119/122 (98) ^e 3/122 (2)	63/69 (91) ^e 4/69 (6) 2/69 (3)	69/106 (65) ^d 1/106 (1) 36/106 (34)	64/108 (59) ^e 6/108 (6) 38/108 (35)	122
OU Medical Center Children's	S I R	66/111 (60) ^b 30/111 (27) 15/111 (13)	2/2 (100)	97/111 (87) ^b 9/111 (8) 5/111 (5)	72/109 (66) ^b 2/109 (2) 35/109 (32)	60/111 (54) ^b 9/111 (8) 42/111 (38)	111
OU Medical Center Everett Tower	S I R	54/76 (71) ^b 13/76 (17) 9/76 (12)		70/76 (92) ^b 4/76 (5) 2/76 (3)	57/76 (75) ^b 19/76 (25)	48/76 (63) ^b 4/76 (5) 24/76 (32)	76
St. Anthony	S I R	91/112 (81) ^{e,d,o} 12/112 (11) 9/112 (8)	102/105 (97) ^e 2/105 (2) 1/105 (1)	1/1 (100) ^e	90/110 (82) ^d 20/110 (18)	83/111 (75) ^d 4/111 (4) 24/111 (21)	112
VA-OKC	S I R	33/43 (77) ^{e,d,o} 5/43 (12) 5/43 (11)	15/16 (94) ^e 1/16 (6)	39/42 (93) ^e 2/42 (5) 1/42 (2)	31/42 (74) ^d 11/42 (26)	29/40 (72) ^d 1/40 (3) 10/40 (25)	43
OKC AREA TOTAL	S I R	838/1219 (69) 240/1219 (20) 141/1219 (11)	756/797 (95) 32/797(4) 9/797 (1)	426/503 (85) 53/503 (10) 24/503 (5)	652/905 (72) 4/905 (1) 249/905 (27)	297/483 (62) 26/483(5) 160/483 (33)	1219
TULSA AREA							
Hillcrest	S I R	73/84 (87) ^o 8/84 (9) 3/84 (4)	81/82 (99) ^o 1/82 (1)		41/48 (85) ^o 7/48 (15)	39/47 (83) ^o 2/47 (4) 6/47 (13)	84
St. Francis	S I R	57/88 (65) ^{d,e} 22/88 (25) 9/88 (10)	2/2 (100) ^e	71/86 (83) ^{d,e} 13/86 (15) 2/86 (2)			88
St. John	S I R	180/244(74) ^{d,e,o} 37/244 (15) 27/244 (11)	205/224 (91) ^e 13/224 (6) 6/224 (3)	166/193 (86) ^e 22/193 (11) 5/193 (3)	185/240 (77) ^{d,e} 3/240 (1) 52/240 (22)	149/236 (63) ^d 21/236 (9) 66/236 (28)	244
St. John Sapulpa (Bartlett Memorial)	S I R	5/6 (83) ^e 1/6 (17)	6/6 (100) ^e	6/6 (100) ^e	6/6 (100) ^d	2/6 (33) ^d 1/6 (17) 3/6 (50)	6
TULSA AREA TOTAL	S I R	315/422 (75) 68/422 (16) 39/422 (9)	294/314 (94) 14/314 (4) 6/314 (2)	243/285 (85) 35/285 (12) 7/285 (3)	232/294 (79) 3/294 (1) 59/294 (20)	190/289 (66) 24/289 (8) 75/289 (26)	422

Hospital	Suscept.*	# Penicillin %	# Ceftriaxone %	# Cefotaxime %	# Erythromycin %	# TMP/SMZ %	Total # of isolates submitted
OTHER PARTICIPATING HOSPITALS							
Ada-Carl Albert Indian Health Facility	S I R	13/16 (81) ^{d,e} 2/16 (13) 1/16 (6)	15/15 (100) ^d	11/11 (100) ^b	7/8 (88) ^b 1/8(12)	8/11 (73) ^b 1/11 (9) 2/11(18) ^b	16
Ardmore Mercy Memorial	S I R	79/106 (74) ^e 23/106 (22) 4/106 (4)	64/64 (100) ^e	86/88 (98) ^e 2/88 (2)	3/9(33) ^d 6/9(67)	2/8 (25) ^d 1/8 (12) 5/8 (63)	106
Bartlesville Jane Phillips	S I R	24/28 (86) ^{d,e} 4/28 (14)	25/25(100) ^e	21/21 (100) ^e	18/27 (67) ^d 2/27(7) 7/27(26)	12/25(48) ^d 13/25(52)	28
Duncan Regional	S I R	4/7 (57) ^{e,o} 3/7 (43)	5/6 (83) ^e 1/6(17)		3/7 (43) ^d 4/7 (57)	4/7 (57) ^d 3/7 (43)	7
Enid St. Mary's	S I R	59/84 (70) ^{d,e} 16/84 (19) 9/84 (11)	67/75 (89) ^e 8/75 (11)	38/46 (83) ^e 8/46 (17)	33/41 (80) ^e 6/41 (15) 2/41 (5)	2/2 (100) ^e	84
Lawton Comanche Co.	S I R	35/56 (62) ^{b,m} 6/56 (11) 15/56 (27)	43/54 (80) ^{b,m} 8/54 (15) 3/54 (5)	39/50 (78) ^{b,m} 8/50 (16) 3/50 (6)	26/47 (55) ^m 21/47 (45)	26/45 (58) ^m 19/45(42)	56
McAlester Regional	S I R	37/48 (77) ^{e,o} 8/48 (17) 3/48 (6)	21/21 (100) ^e		9/17 (53) ^e 2/17(12) 6/17 (35)	7/17 (41) ^e 5/17 (29) 5/17 (30)	48
McCurtain Memorial	S I R	5/6 (83) ^{e,m} 1/6 (17)	6/6 (100) ^m	4/5 (80) ^m 1/5 (20)	5/6 (83) ^m 1/6 (17)	3/6 (50) ^m 2/6 (33) 1/6 (17)	6
Muskogee Regional	S I R	72/88 (82) ^m 10/88 (11) 6/88 (7)	77/81 (95) ^m 4/81 (5)	76/83 (92) ^m 7/83(8)			88
Muskogee VA	S I R	20/23 (87) ^{d,e} 2/23 (9) 1/23 (4)	5/5(100) ^d	2/2(100)	17/19 (90) ^d 2/19 (10)	12/19 (63) ^d 2/19 (11) 5/19(26)	23
Pauls Valley	S I R	14/24 (58) ^{d,o} 5/24 (21) 5/24 (21)	11/11 (100) ^d	1/2 (50) ^d 1/2 (50)	3/8(38) ^d 5/8 (62)	5/7 (71) ^d 2/7(29)	24
Shawnee Unity Health	S I R	58/81 (72) ^{d,e,m,o} 9/81 (11) 14/81 (17)	61/73 (83) ^{e,m} 10/73 (14) 2/73 (3)	47/57(82) ^m 10/57 (18)	52/79 (66) ^{d,e,m} 3/79 (4) 24/79 (30)	51/78 (65) ^{d,e,m} 6/78 (8) 21/78 (27)	81
Stillwater	S I R	53/83 (64) ^{d,e} 16/83 (19) 14/83 (17)	78/81 (96) ^e 3/81 (4)	1/1 (100) ^e	49/82 (60) ^d 1/82 (1) 32/82 (39)	48/79 (61) ^d 3/79(4) 28/79 (35)	83
OTHER PARTICIPATING HOSPITALS TOTAL	S I R	473/650 (73) 104/650 (16) 73/650 (11)	478/517 (92) 34/517 (7) 5/517 (1)	326/366 (89) 36/366 (10) 4/366 (1)	225/350 (64) 15/350 (4) 110/350 (32)	180/304 (59) 20/304 (7) 104/304 (34)	650
TOTAL	S I R	1626/2291 (71) 412/2219 (18) 253/2291 (11)	1528/1628 (94) 80/1628(5) 20/1628 (1)	995/1154 (86) 124/1154 (11) 35/1154 (3)	1109/1549 (72) 22/1549 (1) 418/1549(27)	667/1076 (62) 70/1076 (7) 339/1076 (31)	2291

** Preliminary data as of 10.12.05

* Susceptibility: **S** = Sensitive, **I** =Intermediate, **R** = Resistant

Susceptibility Method: a Agar Dilution d Bacterial Disk Diffusion (Kirby Bauer) m Antimicrobial Panel (MicroScan ®)
b Bacterial Broth Dilution e Antimicrobial Gradient Strip (E-test ®) o Oxacillin Disk Only

{ Summary of Selected Notifiable Disease Reports in Oklahoma }

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diseases/conditions	winter quarter ¹	year to date ²	5 year avg ³
AIDS	32	161	217.8
Campylobacteriosis	78	462	407.2
Chlamydial infections	1917	10360	10388.2
Cryptosporidiosis	10	44	21.6
<i>E.coli</i> O157:H7	6	26	26.8
Ehrlichiosis	0	30	26.8
Giardiasis	45	177	98.4
Gonorrhea	661	4043	4535.6
<i>H. influenzae</i> (all types)	11	64	53.2
<i>H. influenzae</i> , type B (kids < 5)	0	0	0
Hepatitis A	2	6	97.2
Hepatitis B	1	42	84.6
Hepatitis C	0	7	9.4
HIV infections	48	186	176.4
Meningococcal invasive	3	16	25.2
Rabies, animal	12	78	112.2
RMSF	0	52	104.2
Salmonellosis	76	408	469.4
Shigellosis	110	662	559.4
<i>Streptococcus</i> invasive group A	33	127	61
<i>Streptococcus pneumoniae</i> , invasive	172	641	441.2
Syphilis (primary)	6	17	47
Syphilis (secondary)	10	28	67
Syphilis (latent)	21	33	90
Tuberculosis	40	125	131.4

diseases of low frequency	year to date ²	5 year avg ³
Brucellosis	0	0.4
HUS	4	2.8
Legionellosis	7	10.2
Listeriosis	5	5.2
Lyme disease	0	0.8
Malaria	11	8
PAM	2	0.2
Psittacosis	0	0
Tularemia	14	11.2
Typhoid fever	1	1.2
Vibriosis	2	0.8
Yersiniosis (<i>Yersinia enterocolitica</i>)	2	3

no. of animal rabies cases by animal type	year to date ²	%
Bat	2	2.6
Cat	6	7.7
Cow	8	10.2
Dog	6	7.7
Goat	1	1.3
Horse	4	5.1
Skunk	51	65.4
Total	78	100

- 1. 10.01.05 through 12.31.05
- 2. 01.01.05 through 12.31.05
- 3. aggregate data for winter quarter of years 2000 through 2004

 cdd@health.ok.gov

James Michael Crutcher, MD, MPH
Commissioner of Health and State Health Officer

Joe Mallonee, MPH
Deputy Commissioner for Disease and Prevention Services

Brett Cauthen, MD, MPH
State Epidemiologist

Kristy Bradley, DVM, MPH
State Public Health Veterinarian and Deputy State Epidemiologist

Lauri Smithee, MES, MS
Director, Communicable Disease Division

Laurence Burnsed, MPH
Assistant Director, Communicable Disease Division

Julie Wood, MPH
Communications Officer, Editor, Communicable Disease Division

Oklahoma State Department of Health
Communicable Disease Division
1000 N.E. 10th Street
Oklahoma City, Oklahoma
73117-1299

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