

February 2017

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CHELAN-DOUGLAS PUBLIC HEALTH



Current Conditions of Interest

**TO REPORT A
NOTIFIABLE
CONDITION:**

Phone (509) 886-6400

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(509) 886-6499

“Always Working for a Safer and Healthier Community”

Meningococcal Meningitis

Neisseria meningitidis are gram-negative diplococcal bacteria. Serogroups A, B, C, Y, and W-135 cause almost all invasive disease worldwide; however, serogroups B, C and Y are the major causes of meningococcal disease in the United States.

Invasive meningococcal disease most commonly presents as meningitis, meningococemia, or both. Symptoms of meningococcal meningitis include acute onset of fever, headache, and stiff neck, often accompanied by nausea, vomiting, photophobia, and altered mental status. Symptoms of meningococemia (i.e., blood infection) include acute onset of fever often accompanied by hypotension and shock, and may include a petechial or purpuric rash, purpura fulminans, and multiorgan failure.

The incubation period is usually 3 to 4 days, but may range from 2 to 10 days.

Transmission occurs through respiratory droplets or by direct contact with nasopharyngeal secretions from a colonized person – symptomatic or otherwise. Close contacts of a case (e.g., household members or child care contacts) are at increased risk of becoming colonized/infected and developing illness. The attack rate for household contacts of cases is 500–800 times the rate that for the general population. Risk of disease in close contacts is highest during the 10-day period following exposure.

Persons can transmit the organism to others as long as meningococci are present in nasal or pharyngeal secretions. Cases should be considered infectious from the time they are exposed until 24 hours after initiation of treatment or chemoprophylaxis with appropriate antibiotics. Contacts exposed to the patient 7-10 days or more before his/her onset of illness are not at significantly increased risk.

Asymptomatic colonization of the upper respiratory tract provides the source from which the organism is spread. *N. meningitidis* organisms are carried in the nasopharynx of about 5–10% of the healthy population. Carrier rates of up to 25% have been documented in some groups in the absence of any cases of meningococcal disease. However, less than 1% of those colonized develop invasive disease. Therefore, colonization is common, but invasive disease is very rare.

CDC recommends **meningococcal conjugate vaccination** for:

- All preteens and teens at 11 to 12 years old with a booster dose at 16
- Children and adults at increased risk for meningococcal disease

CDC recommends **serogroup B meningococcal vaccination** for:

- People 10 years or older at increased risk for meningococcal disease

<https://www.cdc.gov/vaccines/vpd/mening/index.html>

In Early February Grant County Health District received a report of lab confirmed Meningococcal meningitis in a 5 month old infant.

The last case of Meningococcal disease in Chelan or Douglas counties was in 2015.

Meningococcal disease (invasive) is **IMMEDIATELY** notifiable and must be reported as soon as clinically suspected. Immediately reportable conditions requires a phone call to reach a live person at [the local health jurisdiction, 24/7](#).

More information can be found at the [Washington State DOH Meningococcal Pages](#)



2017 Reportable Conditions, Chelan-Douglas Counties

Chemoprophylaxis should be recommended for all household members and other persons deemed to have been exposed, regardless of their immunization status (see Section 5B). Since contacts are at highest risk of becoming ill immediately after the onset of the case, prophylaxis should be initiated as soon as possible, ideally less than 24 hours after identification of the index patient. Chemoprophylaxis is not recommended for persons who have had only brief or casual contact with the case. If such persons are anxious about their exposure, they should be advised that their risk of disease is extremely low and possibly referred to their own physician for further discussion if needed.

Rifampin, ciprofloxacin, and ceftriaxone are all appropriate drugs for chemoprophylaxis. They are 90–95% effective in reducing nasopharyngeal carriage of *N. meningitidis*.

Rifampin is the drug of choice for most children. Rifampin is not recommended for pregnant women. Those taking rifampin should be informed that the following side effects can occur: gastrointestinal upset, orange discoloration of urine and tears, discoloration of soft contact lenses, and decreased effectiveness of oral contraceptives.

Ciprofloxacin can be used for chemoprophylaxis of persons 18 years and older. Ciprofloxacin is not recommended for pregnant women.

Ceftriaxone can be used for children and adults (including pregnant women) to eradicate nasopharyngeal carriage if rifampin is contraindicated.

Table 3: Schedule for administering chemoprophylaxis against meningococcal disease

Drug	Age group	Dosage	Duration and route of administration*
Rifampin [†]	Children aged <1 mo	5 mg/kg body weight every 12 hrs	2 days
	Children aged ≥1 mo	10 mg/kg body weight every 12 hrs (max 600 mg/dose)	2 days
	Adults	600 mg every 12 hrs	2 days
Ciprofloxacin [§]	Adults (≥18 yrs old)	500 mg	Single dose
Ceftriaxone	Children aged <15 yrs	125 mg	Single IM dose
	Adults	250 mg	Single IM dose

* Oral administration unless indicated otherwise.

[†] Not recommended for pregnant women because it is teratogenic in laboratory animals. Because the reliability of oral contraceptives might be affected by rifampin therapy, consideration should be given to using alternative contraceptive measure while rifampin is being administered.

[§] Not usually recommended for persons aged <18 years or for pregnant women and lactating women because it causes cartilage damage in immature laboratory animals. Can be used for chemoprophylaxis of children when no acceptable alternative therapy is available. Recent literature review identified no reports of irreversible cartilage toxicity or age-associated adverse events among children and adolescents (Source: Burstein GR, Berman SM, Blumer JL, Moran JS. Ciprofloxacin for the treatment of uncomplicated gonorrhea infection in adolescents: does the benefit outweigh the risk? Clin Infect Dis 2002;35:S191–9).



CHELAN-DOUGLAS PUBLIC HEALTH

February 2017 Current Conditions of Interest

2017 Reportable Conditions, Chelan-Douglas Counties

2017	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
Chronic HCV	12												12
Campy	1												1
Salmonella													0
Shigella													0
E.coli													0
Giardia													0
Chronic HBV	1												1
Rabies Propy													0
Pertussis													0
Legionella													0
Listeria													0
Influenza Death	3												3
TB Disease													0
Cocci													0
Vibrio parahaemolyticus													0
Zika													0
Total													17
Not reported	73												73
OOJ	8												8

Not reported: Cases investigated but did not meet case definition for reporting.

OOJ (out of jurisdiction): Cases investigated but found to belong to another jurisdiction

2017	CT	HSV	GC	LGV	SYP	HIV
Jan	49	2	8	0	1	0
Feb						
Mar						
Apr						
May						
Jun						
JUL						
AUG						
SEP						
OCT						
NOV						
DEC						
	49	2	8	0	1	0

Current Mumps Outbreak Cases

County	Cases*
King County	176
Ferry County	3
Grant County	9
Pierce County	45
Snohomish County	4
Spokane County	165
Thurston County	1
Yakima County	1
Total	404

* Confirmed and probable cases in WA as of 2/8/2017 at 4:30 p.m.

Next update will be on Thursday, February 16, 2017

[Washington State Reportable Conditions Posters by Reporter](#)
[Washington State Reportable Conditions Forms and Guidelines](#)

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[WA DOH mumps outbreak page](#)