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## **MEMORANDUM**

**TO:** Local Health Departments, Regional Offices of the Illinois Department of Public Health (IDPH), Infection Control Professionals, Infectious Disease Physicians, Hospital Laboratory Professionals

**FROM:** Communicable Disease Control Section

**DATE:** August 11, 2011

**SUBJECT:** **Communicable Diseases in Illinois April - June 2011**

### **Infectious Disease in Review**

**Welcome, Yoran and Nicole!**

*New staff in the Division of Infectious Disease*

Welcome to our new CDC Epidemic Intelligence Service officer, Yoran Grant, PhD. She comes to us from the New York City HIV/AIDS program. She will be working primarily with the IDPH Division of Infectious Disease and you may hear from her in the course of her two years at IDPH. Greetings also go to our new epidemiologist, Nicole Gualandi, MS/MPH, RN, CIC. Nicole comes to us from Saint Francis Medical Center in Peoria where she was an Infection Preventionist. She will be working for the Communicable Disease Control Section on outbreak investigations and various surveillance issues.

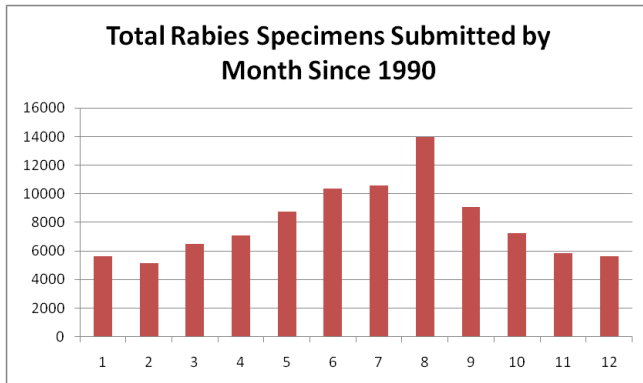
### **In the Good Old Summertime**

*Summer is the time for increased case counts for some diseases*



While summer is a good time to relax, some diseases are more prevalent during the hot weather than any other time of year. Of course, arboviral diseases, such as West Nile Virus, which are linked to the life cycle of the mosquito, occur during warm weather. As people spend more time engaging in recreational water sports, waterborne

disease outbreaks are more likely.



The number of animals submitted for rabies testing also peaks in the summer (see graph). As a reminder, please remember that rabies testing on animals should be limited to situations such as animals with neurologic disease, skunks for surveillance, wild animals (not small rodents or rabbits) that have exposed a person or domestic animal or dogs, cats or ferrets that have bitten someone in an unprovoked manner. Healthy dogs, cats and ferrets that have bitten someone in

a provoked manner should be observed for 10 days. Following these guidelines will eliminate unnecessary testing.

Finally, with more picnics and outside dining, keeping food at safe temperatures can be more difficult. While many people take vacations in the summer, some diseases are working harder.

## Let's Segue into Talking About Dengue

### *Guidelines for the submission of Dengue specimens*

Please remember that specimens from suspect dengue cases need to be forwarded to the IDPH virology laboratory. Dengue antibody testing can cross react with other arboviruses and the state lab tests to rule out cross reaction. However, there is a need to ask about travel history and symptoms to see if the person will meet case definition. The IDPH virology lab has limited reagents and we need to make sure that we only test those that are likely to be counted as cases, so approval is needed before testing. Individuals with history of travel to dengue endemic countries or states and presence of symptoms of dengue are criteria for testing at the IDPH lab. Please send a filled CDC-DASH form along with all dengue specimens for testing because the state lab forwards them to CDC for confirmatory testing. The form is available in the intranet under CD Forms >> Laboratory Submission Forms >> Specimens for CDC Laboratory. Please be aware that results from the CDC tests may take weeks before confirmation and specimens that are resulted as "non-specific" at the IDPH lab will undergo confirmatory testing at the CDC laboratory in Puerto Rico which may take longer.

## What Exactly Is a Case?

*Case definitions have changed for several diseases*

case *noun* [kās] an instance of disease or injury <a case of pneumonia>

def-i-ni-tion *noun* [def-uh-nish-uh-n] the formal statement of the meaning or significance of a word, phrase, etc.

As the above definitions point out, a case definition provides the precise meaning of an instance of disease. This is done by specifying what lab test results and / or symptoms must be met for a case to be classified as confirmed, probable, or rarely, suspect.

For 2011 there are several new case definitions. For instance, the case definition for Giardiasis has been changed to include that in order for a case to be considered confirmed, it must have a positive laboratory result *and* clinically compatible symptoms. Giardiasis records in INEDSS that have laboratory confirmation, but are asymptomatic or have no symptoms listed will be changed to Not A Case.

The case definition for acute Hepatitis A has been changed to include “dark urine” as a clinical sign, along with jaundice or ALT>200, one of which is required (along with a discrete onset of symptoms) to meet the acute case definition for hepatitis A. This change was effective in the national case definition for 2011. If one of these 3 clinical signs is NOT present, the case may be either “Asymptomatic” or “Symptomatic – Does Not Meet Case Definition”, but must be closed with a case status of “Not A Case – Lab Positive”. (The latter assumes there is a positive IgM-specific anti-HAV test result for the case, which is the basic laboratory requirement for opening a record of hepatitis A.)

There is also now a probable case definition for cryptosporidiosis. The complete case definitions for these and all reportable diseases may be found on the IDPH intranet.

## **Nothing Cryptic About Cryptosporidiosis**

### *Cryptosporidiosis outbreaks more prevalent in summer*

Cryptosporidiosis can be transmitted to people in a variety of ways including contact with animals and swimming in recreational water. Water-borne outbreaks of cryptosporidiosis increase in the summer months as recreational water use increases. When multiple cases of cryptosporidiosis are identified in a community, common sources of exposure should be evaluated. This may include contact with animals, especially calves, and swimming exposures. If a common recreational water source is identified a more thorough investigation should be initiated. Local health departments should contact both the IDPH Division of Environmental Health and the IDPH Communicable Disease Control section for resources on cryptosporidiosis outbreaks. A thorough investigation will allow prevention and control measures to be initiated and prevention of further cases. Cases can be advised not to swim in other recreational water facilities until they are no longer infectious. Case patients can cause additional recreational water venues to become contaminated if they continue to swim in multiple water venues. Please keep a close eye on your cryptosporidiosis cases during the summer months to quickly identify any clusters.

## **So Much *Salmonella*!**

### *Why so many multi-state Salmonella outbreaks reported?*

All *Salmonella* isolates from patients in Illinois are required to be submitted to our IDPH laboratories for confirmation, serotyping and DNA typing (PFGE-pulse field gel electrophoresis). PFGE is completed at the state laboratory on isolates of the most common *Salmonella* serotypes and on additional serotypes that are part of clusters.

These PFGE patterns are then uploaded from each state to CDC's national database called Pulsenet. These patterns are then compared within states and across states and even across country borders to identify clusters that would not have previously been identified without PFGE and without Pulsenet. In addition, the PFGE pattern from food isolates can be compared to human isolates. During the summer months, CDC notifies us of several *Salmonella* clusters per week and we also identify several clusters per week. When clusters are identified local health departments are asked to interview cases with a detailed questionnaire in addition to the standard *Salmonella* questions to identify suspect food vehicles or suspect food venues. For multi-state *Salmonella* outbreaks in 2011, this has resulted in the identification of papayas as the food vehicle for one outbreak and ground turkey as the food vehicle for an additional outbreak. Control measures included stopping contaminated papayas from entering the U.S. and the recall of a large quantity of ground turkey. We want to thank health care providers for testing patients with clinically compatible symptoms and laboratories for submitting isolates in a timely manner. The faster the isolates make it into our lab the faster the patient can be interviewed with a detailed food interview form if they are identified as part of a cluster. Since recall of food histories fades with time, timeliness of reporting and submitting of specimens is critical.

A big thanks to all of the local health departments who when asked have interviewed their cases with the long hypothesis generating questionnaires. Without the information collected on these forms the source of several multi-state clusters could not have been identified and public health actions, like recalls, would not have occurred.

## **There Are Few Things Worse-a than MRSA**

### *Making the Reporting of Staph Accomplishable*

MRSA stands for Methicillin-resistant *Staphylococcus aureus* (MRSA). The IDPH Communicable Disease Control Section (CDCS) wants to help make MRSA cluster investigation reporting less challenging and more "accomplishable" for local health departments (LHD) – hence, the title of this article. As required by 77 Ill. Adm. Code 690.658, effective March 8, 2008, MRSA clusters occurring in a community setting, including, but not limited to, schools, correctional facilities, daycare settings, and sports teams are one of Illinois' mandatory reportable communicable diseases. For the purposes of that reporting rule, a MRSA cluster is defined as two or more laboratory-confirmed cases of community onset MRSA infection during a 14 day period for which an epidemiological link is readily apparent to the reporter.

When the LHD is notified of a reportable MRSA cluster, LHD disease investigators need to obtain pertinent information about each case, enter each case into I-NEDSS, contact the IDPH CDCS for an outbreak number, and ensure appropriate prevention/control measures are implemented in the setting associated with the cases. Resources that provide recommended control measures for various community settings are posted on the IDPH Communicable Disease Intranet and CDCS staff is available for phone consultation.

Two worksheets (see below) are now available on the IDPH Intranet (on the MRSA page in "CD Topics A-Z") to aid LHDs in collecting information needed to report MRSA cluster cases. We hope that these worksheets help Make *the Reporting of Staph Accomplishable!*

**MRSA Cluster Worksheet: Correctional Facility Cluster**

Instructions: Use of this worksheet is not mandatory, however, local health departments (LHD) and correctional facilities may find it streamlines their communication about clusters of MRSA cases associated with correctional facilities (refer to 77 Ill. Adm. Code 690.658). LHDs may use this worksheet to collect information needed to enter cases into I-NEDSS. Correctional facilities may use this worksheet to provide information to LHDs. Please use additional sheets if more than 2 cases are involved in the MRSA cluster.

**Notification Date (MM/DD/YYYY):** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Correctional Center:** \_\_\_\_\_

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**CASE #1**

- 1) Case name (first and last name): \_\_\_\_\_
  - 2) Date of birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_
  - 3) Did the case die? \_\_\_ If yes, was the death due to MRSA infection? \_\_\_\_\_
  - 4) Onset date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 5) Physician name (first and last name): \_\_\_\_\_
  - 6) Was case seen in an emergency department (ED)? \_\_\_\_\_ If yes, ED hospital name and city of the hospital: \_\_\_\_\_
  - 7) Was case admitted to a hospital? \_\_\_\_\_ If yes, was it the same as the ED Hospital? \_\_\_\_\_
    - a. If case was admitted to another hospital, admission hospital name and city of the hospital: \_\_\_\_\_
  - 8) Admission date (If admitted to a hospital) (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 9) Discharge date (if admitted to a hospital) (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 10) Specimen collection date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 11) Lab report date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 12) Lab name and city of the lab: \_\_\_\_\_
  - 13) Specimen source (e.g., blood, wound drainage, skin lesion, pustule, etc. AND anatomic location if applicable [for example: pustule – right thigh]): \_\_\_\_\_
  - 14) Name of housing unit at the correctional center associated with cluster of cases: \_\_\_\_\_
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**CASE #2**

- 1) Case name (first and last name): \_\_\_\_\_
  - 2) Date of birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_
  - 3) Did the case die? \_\_\_ If yes, was the death due to MRSA infection? \_\_\_\_\_
  - 4) Onset date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 5) Physician name (first and last name): \_\_\_\_\_
  - 6) Was case seen in an emergency department (ED)? \_\_\_\_\_ If yes, ED hospital name and city of the hospital: \_\_\_\_\_
  - 7) Was case admitted to a hospital? \_\_\_\_\_ If yes, was it the same as the ED Hospital? \_\_\_\_\_
    - a. If case was admitted to another hospital, admission hospital name and city of the hospital: \_\_\_\_\_
  - 8) Admission date (If admitted to a hospital) (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 9) Discharge date (if admitted to a hospital) (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 10) Specimen collection date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 11) Lab report date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - 12) Lab name and city of the lab: \_\_\_\_\_
  - 13) Specimen source (e.g., blood, wound drainage, skin lesion, pustule, etc. AND anatomic location if applicable [for example: pustule – right thigh]): \_\_\_\_\_
  - 14) Name of housing unit at the correctional center associated with cluster of cases: \_\_\_\_\_
-

## MRSA Cluster Worksheet: Community Setting Cluster

Instructions: Use of this worksheet is not mandatory, however, local health departments (LHD) may find it streamlines their investigation of clusters of MRSA cases associated with community settings (refer to 77 Ill. Adm. Code 690.658). LHDs may use this worksheet to collect information needed to enter cases into I-NEDSS. Additional sheets may be used if more than 2 cases are involved in the MRSA cluster. (Note: Please refer to Correctional Facility Cluster worksheet if cases occur in a correctional facility.)

**Notification Date (MM/DD/YYYY):** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name and location (city) of community setting associated with cluster of cases:**

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### CASE #1

- 1) Case name (first and last name): \_\_\_\_\_
- 2) Date of birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_
- 3) Did the case die? \_\_\_ If yes, was the death due to MRSA infection? \_\_\_\_\_
- 4) Home address (street address with city and zip code):  
\_\_\_\_\_
- 5) Onset date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 6) Physician name (first and last name): \_\_\_\_\_
- 7) Was case seen in an emergency department (ED)? \_\_\_\_\_ If yes, ED hospital name and city of the hospital:  
\_\_\_\_\_
- 8) Was case admitted to a hospital? \_\_\_\_\_ If yes, was it the same as the ED Hospital? \_\_\_\_\_
  - a. If case was admitted to another hospital, admission hospital name and city of the hospital:  
\_\_\_\_\_
- 9) Admission date (If admitted to a hospital) (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 10) Discharge date (if admitted to a hospital) (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 11) Specimen collection date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 12) Lab report date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 13) Lab name and city of the lab: \_\_\_\_\_
- 14) Specimen source (e.g., blood, wound drainage, skin lesion, pustule, etc. AND anatomic location if applicable [for example: pustule – right thigh]): \_\_\_\_\_

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### CASE #2

- 1) Case name (first and last name): \_\_\_\_\_
- 2) Date of birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_
- 3) Did the case die? \_\_\_ If yes, was the death due to MRSA infection? \_\_\_\_\_
- 4) Home address (street address with city and zip code):  
\_\_\_\_\_
- 5) Onset date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 6) Physician name (first and last name): \_\_\_\_\_
- 7) Was case seen in an emergency department (ED)? \_\_\_\_\_ If yes, ED hospital name and city of the hospital:  
\_\_\_\_\_
- 8) Was case admitted to a hospital? \_\_\_\_\_ If yes, was it the same as the ED Hospital? \_\_\_\_\_
  - a. If case was admitted to another hospital, admission hospital name and city of the hospital:  
\_\_\_\_\_
- 9) Admission date (If admitted to a hospital) (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 10) Discharge date (if admitted to a hospital) (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 11) Specimen collection date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 12) Lab report date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_
- 13) Lab name and city of the lab: \_\_\_\_\_
- 14) Specimen source (e.g., blood, wound drainage, skin lesion, pustule, etc. AND anatomic location if applicable [for example: pustule – right thigh]): \_\_\_\_\_

## Epidemiology of Infectious Diseases

	2010					2011*		
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Year	Jan-Mar	Apr-Jun	Quarter % change#
Brucellosis	0	0	1	0	1	0	4	---
West Nile Virus Infection (WNV)	0	0	58	3	61	0	0	---
Cryptosporidiosis	46	49	189	50	334	32	46	-6%
Ehrlichiosis/Anaplasmosis	0	12	11	5	28	4	8	-33%
Giardiasis	169	163	236	123	691	114	72	-56%
Hepatitis A	13	10	19	6	48	12	10	0%
Hep C Acute	0	0	0	1	1	4	1	---
Histoplasmosis	36	29	17	34	116	30	20	-31%
Legionella	14	49	68	18	149	11	16	-67%
Listeriosis	5	3	11	7	26	5	5	67%
Lyme Disease	6	60	57	12	135	7	29	-52%
Malaria	9	14	29	8	60	11	17	21%
<i>Neisseria Meningitidis</i> , Invasive	7	10	2	5	24	10	6	-40%
Q Fever	2	2	1	1	6	0	1	-50%
Rabies- positive animals	1	31	77	6	115	4	13	-58%
Rabies- potential human exposure	38	104	218	58	418	41	94	-10%
Rocky Mountain Spotted Fever	0	17	18	2	37	3	14	-18%
Salmonellosis	275	650	670	387	1982	242	470	-28%
STEC O157:H7	8	19	34	19	80	7	21	11%
Shigellosis	473	122	145	101	841	53	32	-74%
<i>Streptococcus</i> , Group A, invasive	92	78	47	76	293	146	98	26%
Typhoid Fever	8	0	11	1	20	7	4	---
<i>Vibrio spp.</i> Non-cholera	1	2	9	1	13	1	1	-50%
Yersiniosis	7	6	2	7	22	3	4	-33%

<b>OUTBREAKS<sup>^</sup></b>	<b>83</b>	<b>33</b>	<b>44</b>	<b>144</b>	<b>304</b>	<b>85</b>	<b>26</b>	<b>-21%</b>
Foodborne Outbreaks	18	20	12	20	70	13	8	-60%
Waterborne Outbreaks	0	0	5	0	5	1	0	---
Person-to-person Outbreaks	61	12	25	133	231	68	14	17%

Not all reportable diseases are contained in this table.

\*2011 data are provisional and subject to change.

#Change from the same quarter of the previous year.

<sup>^</sup> Total number of outbreaks includes those with unknown mode of transmission.

## Highlights April to June 2011

- **Brucellosis** – There were four cases in the second quarter. Ages ranged from 32 to 81, with two cases being male and two female. All cases resided in Cook County and had April onset dates. All cases reported unpasteurized dairy with consumption in Mexico (2) or the U.S. (2). The unpasteurized dairy consumed in the U.S. was brought in from Mexico (1) or purchased in a Mexican grocery (1).
- **Cryptosporidiosis** – There were 46 cases of cryptosporidiosis in the second quarter (April-18, May-12, and June-16). Twenty-seven cases were female and the rest male. Cases ranged in age from less than one year to 87 years (mean = 44 years). Nineteen cases were admitted to the hospital. Cases were reported from 25 Illinois counties. Counties with multiple cases included Champaign, Cook, Kane, Kendall, Lee, Peoria and St. Clair. A small cluster of cases occurred in persons with contact with infected cattle.
- **Ehrlichia/Anaplasma** – The two *Anaplasma phagocytophilum* (formerly HGA) cases reported in the second quarter were in Du Page County residents with exposures that occurred in Wisconsin. Both cases were hospitalized and one case was female and one was male. The first onset was in May and the other in June. The 6 *Ehrlichia chaffeensis* (formerly HME) cases reported in the second quarter were residents of Shelby, Williamson, Jackson, Adams, Will, and Rock Island counties with age range of 31 years to 74 years; 3 are female and 3 are male. Onset dates were April (1), May (3), and June (2) with acquisition in Illinois (4), Missouri (1), and Wisconsin (1). Four cases were hospitalized.
- **Hepatitis A** - There were 10 cases reported in the second quarter (April-four, May-four, and June-two). Six were male and four were female. Ages ranged from less than one year to 87 years (mean = 36 years). Cases resided in five counties (six in Cook County and one each in Du Page, Kane, Macon, and Will). Three cases were hospitalized. There were no clusters in this quarter.
- **Histoplasmosis** – During the second quarter 20 cases of histoplasmosis were reported, five confirmed and fifteen probable cases. Eighty-five percent were male. Ages ranged from 18 to 81 (mean = 49). Cases resided in 14 jurisdictions. Jurisdictions with multiple cases included Chicago (4), Champaign-Urbana (2), Cook (2), and Kane (2). Sixteen cases were hospitalized. No outbreaks were identified.
- **Legionellosis** - There were 16 cases of legionellosis reported during the quarter, 15 confirmed and one suspect. 6 confirmed and the one suspect case were from Chicago or Cook Co., 3 cases were from Du Page Co. and one each from Christian, Henry, Kankakee, LaSalle, Mason and Rock Island counties. Cases were evenly divided between male and female. No outbreaks were reported in this quarter.
- **Listeriosis** – There were five cases of *Listeria monocytogenes* in the second quarter. Ages ranged from 57 to 84 years, with three female cases and two male cases. Cases resided in Cook (2), Will (2), and St. Clair Counties. Dates of onsets occurred in April (2), May (2), and June.
- **Lyme** - Twenty nine cases of Lyme disease were reported in residents of Illinois in the second quarter. Onsets of illness were in April (one), May (seven), and

June (21). Eleven cases were female, while 18 were male. Ages ranged from two years to 80 years (median = 30 years), with cases residing in 12 counties. Counties with multiple residents affected included McHenry (six), Du Page (five), Winnebago (four), Cook (three), and Will (two). The sites of tick exposure for nine cases were out-of-state with all of those exposures taking place in Wisconsin. Seventeen cases had tick exposures within Illinois. This included eight cases with exposures in the northeastern region of the state: McHenry (three), Cook (one), Du Page (one), Grundy (one), Will (one), and one exposure to multiple northeastern counties (one). Three cases reported exposure in the Rockford region: Lee (two), Ogle (one) and Winnebago (one). Three cases reported exposures in the Peoria region: Bureau (one), Peoria (one) and Woodford (one). Two cases reported exposure in the Marion region: Fayette (one) and Williamson (one). Three cases had an unknown site of exposure.

- **Malaria** – There were 17 cases of malaria reported in Illinois for the second quarter for 2011. The age range was 12-64 with a median of 37. Eighty-two percent are males who live in the counties of Cook (13), Dupage (1), Kane (1), Sangamon (1), and Will (1). Seven of the cases had onsets in April, five in May, and five in June. All of the cases reported out of the country travel exposures in the following countries: India (5), Ghana (3), Nigeria (2), Kenya (2), Pakistan (2), Liberia (1), Republic of Congo (1), and Ethiopia (1).
- ***N. meningitidis*** – Six cases of *N. meningitidis* were reported in the second quarter of 2011. Three were male and three were female. Ages ranged from 2 months to 54 (mean = 27 years). Cases resided in three counties (Cook, Will, and Winnebago). Cook County had multiple cases with four cases reported. Serogroups reported were Group B (5) and Group Y (1).
- **Q Fever** – One case of Q Fever was reported during April of the second quarter in an adult from Lee County.
- **Rabies, Potential Human Exposure** - There were 94 rabies, potential human exposures reported. Ages ranged from less than one year to 85 years of age. Fifty-five percent of exposures were to females. Exposed persons resided in 31 counties. The counties with the most exposures included Cook (eight), Du Page (eight), Will (eight) and Mclean (six). Most exposures were caused by bats (51 percent), followed by raccoons (14 percent) and dogs (14 percent). In 91 percent of the exposures, rabies PEP was started.
- **Rocky Mountain Spotted Fever** – Fourteen cases of RMSF were reported in the second quarter of 2011. All cases were classified as probable cases with a single titer positive for RMSF. Ten were male and four were female. Cases ranged in age from six years to 81 years (median age = 55 years). Onsets of illness occurred in April (six), May (three) and June (five). Five cases were hospitalized. Cases resided in eight counties (Adams, Clay, Jackson, Marion, Pike, Saline, St. Clair and Williamson). Exposures for nine cases with a known exposure location were Adams (one), Clay (one), Jackson (one), Marion (two), Pike (one), Pope (one), Saline (one), and St Clair (one). Six of the nine exposures were in the southern region of the state.
- **Salmonellosis** – In the second quarter, there were 470 *Salmonella* cases reported (April-157, May-132, and June-181). Twenty two were probable the rest

were confirmed cases. Ages ranged from less than one to 94 years (mean = 32). Fifty-two percent were female. Cases were reported from 58 Illinois counties. Counties reporting the most cases included Cook (186), Kane (45), Du Page (36) and Will (33). Thirty-five percent were hospitalized. Seventy-three serotypes were reported. The most common serotypes reported were Enteritidis (107) and Typhimurium (83). Interestingly, no outbreaks were associated with *Salmonella* during the second quarter.

- ***E. coli* O157:H7** – There were 21 cases of STEC O157:H7 with onset during the second quarter of 2011. Two cases occurred in April, six in May and 13 in June. Thirteen jurisdictions had at least one case during this time period with only Chicago (4), Du Page (2) and Sangamon (4) reporting more than one case. Ages of cases ranged from one to 76 years with a median of 10 years and 52 percent of the cases were male. Eighteen cases of STEC non-O157 were identified during this time period from 13 different jurisdictions. Serogroups included O103 (8), O26 (6), O111 (2), O145 (1), and O45 (1).
- **Group A *Streptococcus*** – There were 98 cases of invasive group A strep infection (46 female, 51 male, and 1 unknown) reported in the 2<sup>nd</sup> quarter. Fifty-one cases were from Cook County, with Du Page having the next highest total with 7 cases. The remaining 40 cases were distributed among 23 counties, with 14 counties reporting 1 case each. There were no outbreaks associated with GAS in the second quarter.
- **Shigellosis** – There were 32 cases reported in the second quarter of 2011. Of these, 14 were serotype Sonnei. Nineteen cases were reported from Cook County. Of the 32 cases, 11 were female and 21 were male.
- **Typhoid fever** – There were four cases of Typhoid Fever from Kane (1), Du Page (1), Cook (1), and Chicago (1) in this quarter. Two had onset in April and two had onset in June. Three cases were male and one was female. Ages ranged from two to 38 years. Three cases reported travel out of the country to India and one case did not travel but had exposure to persons who were recently infected.
- **Vibrio** – One case of *Vibrio* was reported in the second quarter of 2011. This case resided in Cook County and was diagnosed with *V. parahaemolyticus*. The patient had consumed oysters prior to onset in June.
- **West Nile Virus** – There were no cases reported in the second quarter of 2011.
- ***Yersinia*** - There were four cases reported in the second quarter. Two had illness onsets in April and two had illness onset in May. Cases resided in Cook (2), Jackson, and Du Page Counties. Ages ranged from 8 months to 75 years. All cases were male.
- **Reported Outbreaks** - The provisional count of outbreaks in Illinois for the second quarter of 2010 is 26.
  - **Foodborne Outbreaks** - Eight foodborne outbreaks were reported in the second quarter. Outbreaks occurred in Bureau, Cook, Fulton, Kane, LaSalle, Livingston, Pike and Woodford Counties. One outbreak occurred

in April, six in May and two in June. Outbreaks were associated with restaurants (4), banquet halls (2) and a caterer.

- **Person-to-person Outbreaks** - There were 14 non-foodborne non-waterborne outbreaks reported in the second quarter. Thirteen of the outbreaks were person-to-person and one transmission was through animal contact. Of the fourteen outbreaks, only three of the person-to-person outbreaks were laboratory confirmed. Outbreaks occurred in the following counties: Champaign (1), Cook (2), Du Page (2), Ford (1), Kankakee (1), Knox (1), LaSalle (1), Macoupin (2), Madison (2), Sangamon (1), and St. Clair (1). There were two confirmed and four suspect norovirus outbreaks, one suspect GAS, one confirmed scabies, one suspect Staphylococcal scalded skin syndrome (SSSS), one suspected cryptosporidiosis outbreak, one suspect MRSA, and one unknown pathogen that caused an outbreak of conjunctivitis. Ten of the non-foodborne non-waterborne outbreaks occurred in long-term care or assisted living facilities, one occurred in a hospital, one in a prison, one norovirus outbreak occurred in a mental health acute care facility, and the conjunctivitis outbreak occurred among students of a school. Eight of the outbreaks occurred in April, four in May, and two in June.
- **Waterborne Outbreaks** – There were no waterborne outbreaks reported during the second quarter of 2011.
- **Outbreaks with other transmission mode** – Of the four outbreaks with different transmission modes, one was associated with animal contact, one with a laboratory exposure, and two where the means of transmission was unknown.

