

Reportable Diseases, MN Rule 4605.7040

Report Immediately by Telephone

Anthrax (*Bacillus anthracis*) a
Botulism (*Clostridium botulinum*)
Brucellosis (*Brucella* spp.) a
Cholera (*Vibrio cholerae*) a
Diphtheria (*Corynebacterium diphtheriae*) a
Hemolytic uremic syndrome a
Measles (rubeola) a
Meningococcal disease (*Neisseria meningitidis*)
(all invasive disease) a, b
Orthopox virus a
Plague (*Yersinia pestis*) a
Poliomyelitis a
Q fever (*Coxiella burnetii*) a
Rabies
(animal and human cases and suspected cases)
Rubella and congenital rubella syndrome a
Severe Acute Respiratory Syndrome (SARS)
(1. Suspect and probable cases of SARS. 2. Cases of
health care workers hospitalized for pneumonia or acute
respiratory distress syndrome.) a
Smallpox (variola) a
Tularemia (*Francisella tularensis*) a
Unusual or increased case incidence of any
suspect infectious illness a

a Submission of clinical materials required. If a rapid, non-culture assay is used for diagnosis, we request that positives be cultured, and isolates submitted. If this is not possible, send specimens, enrichment broth, or other appropriate material. Call the MDH Public Health Laboratory at 612-676-5396 for instructions.

b Isolates are considered to be from invasive disease if they are isolated from a normally sterile site, e.g. blood, CSF, joint fluid, etc.

c Report on separate Sexually Transmitted Disease Report Card.

d Report on separate HIV Report Card.

e For criteria for reporting laboratory confirmed cases of influenza, see www.health.state.mn.us/divs/idepc/dtopics/reportable/index.html.

Report Within One Working Day

Amebiasis (*Entamoeba histolytica/dispar*)
Anaplasmosis (*Anaplasma phagocytophilum*)
Arboviral disease (including but not limited to,
LaCrosse encephalitis, eastern equine encephalitis,
western equine encephalitis, St. Louis encephalitis,
and West Nile virus)
Babesiosis (*Babesia* spp.)
Blastomycosis (*Blastomyces dermatitidis*)
Campylobacteriosis (*Campylobacter* spp.) a
Cat scratch disease (infection caused by *Bartonella* spp.)
Chancroid (*Haemophilus ducreyi*) c
***Chlamydia trachomatis* infection c**
Coccidioidomycosis
Cryptosporidiosis (*Cryptosporidium* spp.) a
Cyclosporiasis (*Cyclospora* spp.) a
Dengue virus infection
***Diphyllobothrium latum* infection**
Ehrlichiosis (*Ehrlichia* spp.)
Encephalitis (caused by viral agents)
Enteric *E. coli* infection
(*E. coli* O157:H7, other enterohemorrhagic [Shiga toxin-producing]
***E. coli*, enteropathogenic *E. coli*, enteroinvasive *E. coli*,**
enterotoxigenic *E. coli*) a
***Enterobacter sakazakii* (infants under 1 year of age) a**
Giardiasis (*Giardia lamblia*)
Gonorrhea (*Neisseria gonorrhoeae*) c
***Haemophilus influenzae* disease**
(all invasive disease) a
Hantavirus infection
Hepatitis (all primary viral types including A, B, C, D, and E)
Histoplasmosis (*Histoplasma capsulatum*)
Human immunodeficiency virus (HIV) infection, including
Acquired Immunodeficiency Syndrome (AIDS) a, d
Influenza
(unusual case incidence, critical illness, or laboratory
confirmed cases) a, e
Kawasaki disease
***Kingella* spp. (invasive only) a**
Legionellosis (*Legionella* spp.) a
Leprosy (Hansen's disease) (*Mycobacterium leprae*)
Leptospirosis (*Leptospira interrogans*)

Methicillin-resistant *Staphylococcus aureus*

Listeriosis (*Listeria monocytogenes*) a
Lyme disease (*Borrelia burgdorferi*)
Malaria (*Plasmodium* spp.)
Meningitis (caused by viral agents)
Mumps
Neonatal sepsis, less than 7 days after birth (bacteria isolated from a
sterile site, excluding coagulase-negative *Staphylococcus*) a, b
Pertussis (*Bordetella pertussis*) a
Psittacosis (*Chlamydophila psittaci*)
Retrovirus infection
Reye syndrome
Rheumatic fever (cases meeting the Jones Criteria only)
Rocky Mountain spotted fever (*Rickettsia rickettsii*, *R. canadensis*)
Salmonellosis, including typhoid (*Salmonella* spp.) a
Shigellosis (*Shigella* spp.) a
***Staphylococcus aureus* (vancomycin-intermediate *S. aureus* [VISA],**
vancomycin-resistant *S. aureus* [VRSA], and death or critical illness
due to community-associated *S. aureus* in a previously healthy
individual) a
Streptococcal disease (all invasive disease caused by Groups A and B
streptococci and *S. pneumoniae*) a, b
Syphilis (*Treponema pallidum*) c
Tetanus (*Clostridium tetani*)
Toxic shock syndrome a
Toxoplasmosis (*Toxoplasma gondii*)
Transmissible spongiform encephalopathy
Trichinosis (*Trichinella spiralis*)
Tuberculosis (*Mycobacterium tuberculosis* complex)
(Pulmonary or extrapulmonary sites of disease, including laboratory
confirmed or clinically diagnosed disease, are reportable. Latent
tuberculosis infection is not reportable.) a
Typhus (*Rickettsia* spp.)
Unexplained deaths and unexplained critical illness
(possibly due to infectious cause) a
Varicella-zoster disease (1. Primary [chickenpox]: unusual case
incidence, critical illness, or laboratory-confirmed cases. 2. Recurrent
[shingles]: unusual case incidence, or critical illness.) a
***Vibrio* spp. a**
Yellow fever
Yersiniosis, enteric (Yersinia spp.) a

Sentinel Surveillance (at sites designated by the Commissioner)

Antimicrobial Susceptibilities of Selected Pathogens 2004



Minnesota Department of Health
717 Delaware Street SE
Minneapolis, MN 55414
or
PO Box 9441
Minneapolis, MN 55440-9441
www.health.state.mn.us

To Report a Case:

Fill out a Minnesota Department of Health case report form and mail to the above address. For diseases that require immediate reporting, or for questions about reporting, call the Acute Disease Investigation and Control Section at: 612-676-5414 or 1-877-676-5414 or fax form to 612-676-5743.

To Send an Isolate to MDH:

If you are sending an isolate by U.S. mail, use regulatory compliant transport packaging and send to the above address. If you are using a courier, use transport packaging appropriate for the specific courier and send to: 717 Delaware Street SE, Minneapolis, MN 55414. To request pre-paid transport labels (both mail and courier) and packaging, or for other assistance, call the Public Health Laboratory Specimen Handling Unit at: 612-676-5396.

Note:

Please note that we are moving at the end of October 2005. Our addresses and phone numbers will change at that time. The 612-676-5414 phone number will function through April 2006.

The MDH Antibiogram is available on the MDH web site (<http://www.health.state.mn.us>). Laminated copies can be ordered from: Antibiogram, Minnesota Dept. of Health, Acute Disease Investigation and Control Section, 717 Delaware St. SE, Minneapolis, MN 55414.

Antimicrobial Susceptibilities of Selected Pathogens, 2004



Sampling Methodology

- † all isolates tested
- ‡ -1 isolate tested per week at MDH
- ‡ -10% sample of statewide isolates received at MDH
- # -20% sample of statewide isolates received at MDH
- § isolates from a normally sterile site

| | <i>Campylobacter</i> spp. ^{1*} | <i>Salmonella</i> Typhimurium ^{2†} | Other <i>Salmonella</i> serotypes (non-typhoidal) ^{2, ‡} | <i>Shigella</i> spp. [#] | <i>Neisseria gonorrhoeae</i> ³ | <i>Neisseria meningitidis</i> ^{4§} | Group A <i>Streptococcus</i> ^{†§} | Group B <i>Streptococcus</i> ^{5§} | <i>Streptococcus pneumoniae</i> ^{6†§} | <i>Haemophilus influenzae</i> ^{7†§} | <i>Mycobacterium tuberculosis</i> ^{8†} |
|---------------------------|---|---|---|-----------------------------------|---|---|--|--|--|--|---|
| Number of Isolates Tested | 60 | 160 | 44 | 12 | 333 | 24 | 130 | 297 | 478 | 45 | 138 |

% Susceptible

| | <i>Campylobacter</i> spp. ^{1*} | <i>Salmonella</i> Typhimurium ^{2†} | Other <i>Salmonella</i> serotypes (non-typhoidal) ^{2, ‡} | <i>Shigella</i> spp. [#] | <i>Neisseria gonorrhoeae</i> ³ | <i>Neisseria meningitidis</i> ^{4§} | Group A <i>Streptococcus</i> ^{†§} | Group B <i>Streptococcus</i> ^{5§} | <i>Streptococcus pneumoniae</i> ^{6†§} | <i>Haemophilus influenzae</i> ^{7†§} | <i>Mycobacterium tuberculosis</i> ^{8†} |
|-----------------------------|---|---|---|-----------------------------------|---|---|--|--|--|--|---|
| β-lactam antibiotics | amoxicillin | / | / | / | / | / | / | / | 96 | / | / |
| | ampicillin | / | 61 | 93 | 33 | / | / | 100 | 100 | / | 76 |
| | penicillin | / | / | / | / | 6 | 92 | 100 | 100 | 82 | / |
| | cefexime | / | / | / | / | 100 | / | / | / | / | / |
| | cefuroxime sodium | / | / | / | / | / | / | / | 88 | 100 | / |
| | cefotaxime | / | / | / | / | / | / | 100 | 100 | 91 | 100 |
| | ceftriaxone | / | 95 | 98 | 100 | 100 | 100 | / | 91 | / | / |
| | meropenem | / | / | / | / | / | 100 | / | 89 | 100 | / |
| Other antibiotics | ciprofloxacin | 86 [†] | 99 | 100 | 100 | 92 | 100 | / | / | / | 100 |
| | levofloxacin | / | / | / | / | / | / | 99 | 99 | 99 | / |
| | azithromycin | / | / | / | / | 61 | / | / | / | / | 100 |
| | erythromycin | 98 | / | / | / | / | / | 98 | 66 | 81 | / |
| | clindamycin | / | / | / | / | / | / | 100 | 82/72 ⁵ | 94 | / |
| | chloramphenicol | / | 63 | 98 | 67 | / | 100 | / | 99 | 96 | / |
| | gentamicin | 98 | / | / | / | / | / | / | / | / | / |
| | spectinomycin | / | / | / | / | 100 | / | / | / | / | / |
| | tetracycline | 35 | / | / | / | 26 | / | / | / | 94 | 96 |
| | trimethoprim/sulfamethoxazole | / | 95 | 100 | 50 | / | 58 | / | / | 82 | 84 |
| | vancomycin | / | / | / | / | / | / | 100 | 100 | 100 | / |
| TB antibiotics | ethambutol | / | / | / | / | / | / | / | / | / | 99 |
| | isoniazid | / | / | / | / | / | / | / | / | / | 88 |
| | pyrazinamide | / | / | / | / | / | / | / | / | / | 95 |
| | rifampin | / | / | / | / | / | 100 | / | / | 100 | 96 |

Trends, Comments and Other Pathogens

| | | |
|---|--|---|
| 1 | <i>Campylobacter</i> spp. | Ciprofloxacin susceptibility was determined for all isolates (n=823). Only 33% of isolates from patients returning from foreign travel were susceptible to quinolones. Susceptibilities were determined using 2004 CLSI (formerly NCCLS) breakpoints for <i>Enterobacteriaceae</i> . Susceptibility for erythromycin was based on an MIC ≤4.0µg/ml. |
| 2 | <i>Salmonella enterica</i> (non-typhoidal) | Antimicrobial treatment for enteric salmonellosis generally is not recommended. |
| 3 | <i>Neisseria gonorrhoeae</i> | In 2004, we tested 333 <i>Neisseria gonorrhoeae</i> isolates for antibiotic resistance including 245 (74%) from a Minneapolis STD clinic and 88 (26%) from a St. Paul STD clinic. The 333 isolates tested comprised approximately 11% of total gonorrhea cases reported in 2004. 38% (127) isolates were intermediate and 1% (2) were resistant to azithromycin. 8% (28) isolates were resistant to ciprofloxacin. |
| 4 | <i>Neisseria meningitidis</i> | Two isolates had intermediate susceptibility to penicillin (MIC of 0.12µg/ml) per the newly established CLSI (formerly NCCLS) breakpoints for <i>N. meningitidis</i> . |
| 5 | Group B <i>Streptococcus</i> (GBS) | 85% (22/26) of early-onset infant, 94% (17/18) of late-onset infant, 62% (8/13) of maternal, and 86% (250/289) of other invasive GBS cases were tested. All 297 isolates had an MIC of ≤0.5µg/ml to cefazolin. 82% (245/297) were susceptible to clindamycin by broth-microdilution. Among 50 erythromycin-resistant, clindamycin-susceptible strains, 31 isolates (62%) had inducible resistance to clindamycin by D-test. Overall 72% (214/297) were susceptible to clindamycin and were D-test negative (where applicable). 70% (21/30) of infant and maternal case isolates were susceptible to erythromycin and clindamycin and were D-test negative (where applicable). |
| 6 | <i>Streptococcus pneumoniae</i> | The 478 isolates tested represented 89% of 540 total cases. Of these, 9% (45/478) had intermediate susceptibility and 8% (40/478) were resistant to penicillin. Reported above are the proportions of case-isolates susceptible by meningitis breakpoints for cefotaxime and ceftriaxone (intermediate=1.0µg/ml, resistant ≥ 2.0µg/ml). By nonmeningitis breakpoints (intermediate=2.0µg/ml, resistant ≥ 4.0µg/ml) 97% (462/478) and 89% (425/478) of isolates were susceptible to cefotaxime and ceftriaxone, respectively. Isolates were screened for high-level resistance to rifampin at a single MIC; all were ≤ 2.0µg/ml. 13% (61/478) of isolates were resistant to two or more antibiotic classes and 8% (40/478) were resistant to 3 or more antibiotic classes. |
| 7 | <i>Haemophilus influenzae</i> | Although 24% of the isolates were ampicillin-resistant, all ampicillin-resistant isolates produced β-lactamase and were susceptible to amoxicillin-clavulanate, which contains a β-lactamase inhibitor. Three isolates were resistant to 2 or more antibiotics. |
| 8 | <i>Mycobacterium tuberculosis</i> (TB) | National guidelines recommend initial four-drug therapy for TB disease, at least until first-line drug susceptibility results are known. Of the 22 drug-resistant TB cases reported in 2004, 21 (95%) were in foreign-born persons, including four of five multidrug-resistant (MDR-TB) cases (i.e., resistant to at least INH and rifampin). None of the five MDR-TB cases was resistant to all four first-line TB drugs. |
| | Community-associated Methicillin-resistant <i>Staphylococcus aureus</i> (CA-MRSA) | Of 432 CA-MRSA isolates tested (277 from 2003 and 155/182 isolates submitted through September 2004), 26% were susceptible to erythromycin, 69% were susceptible to ciprofloxacin, 93% were susceptible to tetracycline, 99% were susceptible to rifampin, and 99% were susceptible to mupirocin using provisional MDH breakpoints (MIC <4µg/ml). All isolates were susceptible to trimethoprim/sulfamethoxazole, gentamicin, linezolid, synercid, and vancomycin. 84% (362/432) were susceptible to clindamycin by broth-microdilution. 29% (73/249) of erythromycin-resistant, clindamycin-susceptible isolates had inducible clindamycin resistance by D-test. Overall 67% (289/432) were susceptible to clindamycin and were D-test negative (where applicable). |
| | <i>Bordetella pertussis</i> | All 96 isolates tested were susceptible to erythromycin using provisional CDC breakpoints. |
| | <i>Escherichia coli</i> O157:H7 | Antibiotic treatment for <i>E. coli</i> O157:H7 infection is not recommended. |