For diseases that require immediate reporting call 24 hours a day, 7 days a week: 651-201-5414 or 1-877-676-5414.

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: 651-201-5414 or 1-877-676-5414 or fax form to 651-201-5743.
- If you are using a courier, use transport packaging appropriate for the specific courier and send to: 601 North Robert Street, St. Paul, MN 55155.
- www.health.state.mn.us

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<th>SENTINEL SURVEILLANCE*</th>
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<td>*Diseases reportable for sentinel surveillance are reportable based on the resident of the patient or the specific health care facility. Sentinel surveillance is not statewide reportable.</td>
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**REPORT WITHIN ONE WORKING DAY**

**Amelobiasis (En-tromboa histolytica/dispar)**

**Antimicrobial Susceptibilities of Selected Pathogens, 2016**

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**REPORT IMMEDIATELY BY TELEPHONE**

**Anthrax** (Bacillus anthracis)

**Botulism** (Clostridium botulinum)

**Brucellosis** (Brucella spp.)

**Cholera** (Vibrio cholerae)

**Diphtheria** (Corynebacterium diphtheriae)

**Freely-living amebic infection** (including at least: Acanthamoeba spp., Naegleria fowleri, Balamuthia mandrillaris, Sappinia diploidea)

**Hemolytic uremic syndrome**

**Measles** (rubella)

**Meningococcal disease** (Neisseria meningitidis) (invasive)

**Middle East Respiratory Syndrome (MERS)**

**Orthopox virus**

**Plague** (Yersinia pestis)

**Polymyelitis**

**Q fever** (Coxiella burnetii)

**Rabies** (animal and human cases and suspected cases)

**Rubella** and congenital rubella syndrome

**Severe Acute Respiratory Syndromes (SARS)**

**Smallpox** (variola)

**Tularemia** (Francisella tularensis)

**Unusual or increased case incidence of any suspect infectious illness**

**Viral hemorrhagic fever** (including but not limited to E bola virus disease and Lassa fever)

**REPORTABLE DISEASES, MN RULE 4605.7040**

**FOOTNOTES**

Submission of clinical materials required. Submit isolates of: or, if an isolate is not available, submit material containing the infectious agent in the following order of preference: a patient specimen; nucleic acid; or other laboratory material. Call the MDH Public Health Laboratory at 651-201-4953 for instructions.
Quinolone susceptibility was determined for all isolates (n=985); isolates that were screened as nalidixic acid-susceptible were assumed to be 100% susceptible. For cases in which treatment is required and susceptibility is unknown or an ampicillin and trimethoprim/sulfamethoxazole-resistant strain is isolated, amoxicillin or ampicillin or trimethoprim/sulfamethoxazole is effective; amoxicillin is less effective because of its rapid absorption from the gastrointestinal tract (Ray, 2001). Isolates with no zone of inhibition of bacterial growth using 15 μg of ciprofloxacin were considered to have decreased susceptibility. An increased risk of adverse effects with decreased susceptibility has been reported in adults; recently, national, recently published reports in the US (June, 2015-AMARIP) (http://www.cdc.gov/azithromycin). Antimicrobial treatment for Shiga toxin-producing Escherichia coli (STEC) O157:H7 infection is not recommended.

### Trends, Comments, and Other Pathogens

#### Campylobacter spp.

Campylobacter species susceptibility was determined for all isolates (n=165) where isolates that screened as nalidixic acid-susceptible were assumed to be ciprofloxacin-susceptible. Only 20% of isolates from patients returning from foreign travel (n=157) were susceptible to quinolones. Campylobacter jejuni isolates from 2 Minnesota residents were blaVIM-positive isolates were Minnesota residents; all but 10 (25%) were susceptible to clindamycin and did not exhibit inducible clindamycin resistance. For community-associated cases (46/180 isolates), 2% (1/46) had high-level resistance (MIC >256 μg/ml), 63% (84/134) of isolates were susceptible to clindamycin by broth microdilution; however, among 58 isolates that exhibited inducible clindamycin resistance for a total of 54% (72/134) that were susceptible to clindamycin and did not exhibit inducible clindamycin resistance. For community-associated cases (46/180 isolates), 2% (1/46) had high-level resistance (MIC >256 μg/ml), 63% (84/134) of isolates were susceptible to clindamycin by broth microdilution; however, among 58 isolates that exhibited inducible clindamycin resistance for a total of 54% (72/134) that were susceptible to clindamycin and did not exhibit inducible clindamycin resistance.

#### Group A Streptococcus

The 365 isolates tested represent 94% of the 377 total cases. Among the 25% of erythromycin-resistant ciprofloxacin-susceptible or intermediate isolates, 10 had inducible clindamycin resistance for a total of 68% of isolates that were susceptible to clindamycin and did not exhibit inducible clindamycin resistance. 83% (30/36) of infant and maternal cases were susceptible to clindamycin and did not exhibit inducible clindamycin resistance.

#### Group B Streptococcus

370/402 (92%) of all early-onset infant, 100% (10/10) late-onset infants, 100% (4/4) of maternal, and 95% (475/506) of other invasive GBS cases were susceptible to clindamycin and did not exhibit inducible clindamycin resistance. For community-associated cases (46/180 isolates), 2% (1/46) had high-level resistance (MIC >256 μg/ml), 63% (84/134) of isolates were susceptible to clindamycin by broth microdilution; however, among 58 isolates that exhibited inducible clindamycin resistance for a total of 54% (72/134) that were susceptible to clindamycin and did not exhibit inducible clindamycin resistance.

### Mycobacterium tuberculosis (TB) complex

National guidelines recommend initial four-drug therapy for TB disease, at least until first-line drug susceptibility results are known. Of the 28 TB cases reported in 2010-resistant to at least one first-line drug, all (28/28) were excluded from this analysis and were not included in the polymicrobial analysis.

#### Methicillin-resistant Staphylococcus aureus (MRSA)

206 cases of invasive MRSA infection were reported in 2015 in Ramsey and Hennepin Counties. 87% (180/206) had an isolate submitted and antimicrobial susceptibility testing conducted. Of 180 cases with isolates tested, 8% (14/180) were pan-susceptible; 10% (18/180) were considered resistant by broth microdilution; however, among 132 erythromycin-resistant ciprofloxacin-susceptible or intermediate isolates, 12 had inducible clindamycin resistance for a total of 14% (17/124) that were susceptible to clindamycin and did not exhibit inducible clindamycin resistance. For community-associated cases (46/180 isolates), 2% (1/46) had high-level resistance (MIC >256 μg/ml), 63% (84/134) of isolates were susceptible to clindamycin by broth microdilution; however, among 58 isolates that exhibited inducible clindamycin resistance for a total of 54% (72/134) that were susceptible to clindamycin and did not exhibit inducible clindamycin resistance. In 2016, 4 isolates were confirmed as susceptible to ciprofloxacin. A single isolate from Minneapolis was ciprofloxacin-resistant (intermediate = 1.0 μg/ml, susceptible ≥ 2.0 μg/ml).

#### Neisseria meningitidis

In 2016, 1 case isolate was intermediately to both ampicillin (MIC = 25 μg/ml) and penicillin (MIC = 12 μg/ml). There were no ciprofloxacin isolates with resistance in 2016. Isolates to the meningococcal complex criteria for ampicillin, ciprofloxacin, levofloxacin, and rifampin apply to the USMLE and, in contrast, do not apply to therapy for patients with invasive meningococcal disease.

### Other organisms

#### Hemophilus influenzae

In 2015, 15 (10%) of isolates were resistant to ampicillin and produced lactose, 3 were susceptible to ampicillin only, 1 was susceptible to ampicillin and ceftriaxone, 5 were also resistant to ceftriaxone, and 2 were ceftriaxone-susceptible. 10 isolates were resistant to ceftriaxone (intermediate = 1.0 μg/ml, susceptible ≥ 2.0 μg/ml). 10 isolates were produced lactose from 2 Minnesota residents were identified in 2015, 77 positive and 1 positive serum samples from 1 Minnesota resident was isolated in 2015 for M. haemolytica.

### Escherichia coli O157:H7

Antimicrobial treatment for Shiga toxin-producing E. coli infection is not recommended.