Reportable Diseases, MN Rule 4605.7040

**Reportable Diseases**

**A. Pathogens**

1. Anthrax (*Bacillus anthracis*)
2. Botulism (*Clostridium botulinum*)
3. Brucellosis (*Brucella* spp.)
4. Cholera (*Vibrio cholerae*)
5. Dengue virus infection
6. Diphtheria (*Corynebacterium diphtheriae*)
7. E. coli (enterohemorrhagic [Shiga toxin-producing] E. coli, enteroinvasive E. coli, enteroinvasive E. coli, enterotoxigenic E. coli)
8. Guillain-Barre syndrome
9. Hepatitis (all primary viral types including A, B, C, D, and E)
10. Histoplasmosis (*Histoplasma capsulatum*)
11. Human immunodeficiency virus (HIV) infection
12. Influenza (all viral subtypes) (possibly due to infectious cause)
13. Kawasaki disease
14. Legionellosis (*Legionella pneumophila*)
15. Leprosy (*Mycobacterium leprae*)
16. Listeriosis (*Listeria monocytogenes*)
17. Lymphocytic choriomeningitis virus (LCMV) infection
18. Malaria (*Plasmodium* spp.)
19. Meningitis (caused by viral agents)
20. Meningococcal disease (*Neisseria meningitidis*)
21. Meningococcal sepsis
22. Meningitis (caused by bacterial agents)
23. Mumps
24. Neisseria gonorrhoeae infection
25. Neutropenic fever (possibly due to infectious cause)
26. O157:H7, other enterohemorrhagic *E. coli* disease
27. O157:H7 and other enterohemorrhagic *E. coli* infection
28. Orthopox virus infection
29. Pertussis (*Bordetella pertussis*)
30. Plague (*Yersinia pestis*)
31. Poliomyelitis
32. Rabies (animal and human cases and suspected cases)
33. Salmonellosis, including typhoid (*Salmonella* spp.)
34. Severe Acute Respiratory Syndrome (SARS)
35. Septic shock syndrome
36. Shiga toxin-producing *E. coli* (STEC) infection
37. Staphylococcus aureus (vancomycin-intermediate [VISA], vancomycin-resistant [VRSA], and death or critical illness due to community-associated *S. aureus* in a previously healthy individual)
38. Staphylococcal disease (all invasive disease caused by *S. aureus* and *S. epidermidis*)
39. Staphylococcal scalded skin syndrome
40. Staphylococcal toxic shock syndrome
41. Syphilis (*Treponema pallidum*)
42. Typhus (*Rickettsia* spp.)
43. Varicella-zoster disease (1. Primary [chickenpox]: unusual case confirmed cases)
44. Toxoplasmosis (*Toxoplasma gondii*)
45. Transmissible spongiform encephalopathy
46. Tuberculosis (*Mycobacterium tuberculosis*)
47. Vibriosis (*Vibrio* spp.)
48. Vibrio parahaemolyticus infection
49. Vibrio vulnificus infection
50. West Nile virus
51. Yellow fever
52. Zika virus

**B. Indicators**

1. Unusual or increased case incidence of any infectious illness
2. Unusual or increased case incidence of any suspect infectious illness
3. Unusual or increased case incidence of antibiotic-resistant infections
4. Unusual or increased case incidence of unusual or invasive infections

**Sentinel Surveillance**

*At sites designated by the Commissioner*

- Methicillin-resistant *Staphylococcus aureus* (invasive only)
- Carbapenem-resistant Enterobacteriaceae (CRE) and *Acinetobacter* b

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**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 651-201-5414.

**To Send an Isolate to MDH:**

If you are sending an isolate by U.S. mail, use regulatory compliant transport packaging and send to: PO Box 64975, St. Paul, MN 55164-0975. For cultures you are carrying, use transport packaging appropriate for the specific courier and send to: 601 North Robert Street, St. Paul, MN 55101. For further information, call the Public Health Laboratory Specimen Handling Unit at: 651-201-4673.

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**Antimicrobial Susceptibilities of Selected Pathogens, 2010**

*Antibiotics (at sites designated by the Commissioner)*

- Methicillin-resistant *Staphylococcus aureus* (invasive only)
- Carbapenem-resistant Enterobacteriaceae (CRE)
- Carbapenem-resistant *Acinetobacter* b

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**For criteria for reporting laboratory confirmed cases of influenza, see**

[www.health.state.mn.us/uvidep/epidemiolreportedinflu.html](http://www.health.state.mn.us/uvidep/epidemiolreportedinflu.html)

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Examples of Susceptibility Testing

**Campylobacter jejuni**
- Ciprofloxacin susceptibility was determined for all isolates (n=207). Only 12% of isolates from patients returning from foreign travel were susceptible to quinolones. Most susceptibilities were determined using 2009 CLSI breakpoints for Campylobacter. Susceptibilities for gentamicin were based on an MIC £ 4 μg/mL and susceptibility to amoxicillin and ampicillin were based on an MIC £ 2 μg/mL.

**Salmonella enterica**
- Antimicrobial treatment for enteric salmonellosis generally is not recommended.

**Neisseria gonorrhoeae**
- Routine resistance testing for Neisseria gonorrhoeae by MDH PHL was discontinued in 2008. Susceptibility results were obtained from the CDC Regional Laboratory in Cleveland, Ohio, and are for isolates obtained through the Gonococcal Isolate Surveillance Program. Isolates (n = 71) were received from the Red Door Clinic in Minneapolis. Numbers do not include two samples missing susceptibility results. Resistance criteria for ceftriaxone, ceffotaxime, cefuroxime, and azithromycin have not been established. Data reflect reduced susceptibility using provisional breakpoints (minimum inhibitory concentration ≥ 0.5 μg/mL for ≤ 2.0 μg/mL, respectively). Also, the number of gonorrhea isolates submitted for testing has decreased from >128 in 2008 to 73 in 2010.

**Neisseria meningitidis**
- In 2010, 1 case-isolate demonstrated intermediate susceptibility to penicillin and ceftriaxone. Three cases demonstrated resistance to trimethoprim/sulfamethoxazole. There were no 2010 case-isolates with ciprofloxacin resistance. In 2008, 2 isolates obtained from cases occurring in northeastern Minnesota had nalidixic acid MICs > 8 μg/mL and ciprofloxacin MICs of 0.25 μg/mL, indicative of resistance.

**Group A Streptococcus**
- The 142 isolates tested represent 98% of 158 total cases. Among 17 erythromycin-resistant, clindamycin-susceptible isolates, 2 (12%) had inducible resistance to clindamycin by D-test for a total of 89% that were susceptible to clindamycin and D-test negative (where applicable).

**Group B Streptococcus**
- 100% (31/31) of early-onset infant, 100% (14/14) of late-onset infant, 4% (3/77) of maternal, and 85% (337/396) of other invasive GBS cases were tested. Among 78 erythromycin-resistant, clindamycin-susceptible isolates, 37 (47%) had inducible resistance to clindamycin by D-test. Overall, 68% (289/425) were susceptible to clindamycin and were D-test negative (where applicable). 71% (34/48) of infant and maternal cases were susceptible to clindamycin and D-test were negative (where applicable).

**Streptococcus pneumoniae**
- The 625 isolates tested represent 89% of 696 total cases. Reported above are the proportions of case-isolate susceptible by meningitis breakpoints for ceftriaxone, cefuroxime (intermediate = 1.0 μg/mL, resistant = >2.0 μg/mL) and penicillin (resistant = >0.12 μg/mL). 40% (98/245) of case isolates were susceptible to ceftriaxone and cefuroxime. By nonmeningitis breakpoints (intermediate = 2.0 μg/mL, resistant = >4.0 μg/mL), 32% (287/890) of isolates were susceptible to penicillin. 18% (123/696) of isolates were resistant to rifampin at a single MIC of ≤ 2 μg/mL. Using meningitis breakpoints, 20% (126/625) of isolates were resistant to two or more antibiotic classes and 15% (96/625) were resistant to three or more antibiotic classes. (CLS also has breakpoints for oral penicillin V, refer to the most recent CLSI recommendations for information).

**Mycobacterium tuberculosis (TB)**
- National guidelines recommend initial four-drug therapy for TB disease, at least until first-line drug susceptibility results are known. Of the 12 drug-resistant TB cases reported in 2010, 10 (83%) were in foreign-born persons. There were no multidrug-resistant (MDR-TB) cases (i.e., resistant to at least isoniazid and rifampin) reported in 2010. There were no cases of extensively drug-resistant TB (XDR-TB) (i.e., resistance to at least INH, rifampin, any fluoroquinolones, and at least one second-line injectable drug) reported in 2010.

**Invasive methicillin-resistant Staphylococcus aureus (MRSA)**
- 332 cases of invasive MRSA infection were reported in 2010 in Ramsey and Hennepin Counties, of which 158 (48%) were from blood, 79% (262/332) had an isolate submitted and antimicrobial susceptibility testing was conducted. Of cases with an isolate, 89% (163/183) were epidemiologically classified as healthcare-associated. Susceptibilities were as follows: 100% to daptomycin, clindamycin, gentamicin, linezolid, mupirocin, trimethoprim, tetracycline, rifampin, ciprofloxacin, meropenem, cefotaxime, cefuroxime sodium, and ceftiraxone. 97% (324/332) were susceptible to clindamycin by D-test microdilution; however, an additional 17 isolates (5%) exhibited inducible clindamycin resistance (23% susceptible and negative for inducible clindamycin resistance).
- For community-associated (CA) cases (76% of 25 cases had isolates submitted), susceptibilities were as follows: 100% to daptomycin, clindamycin, gentamicin, linezolid, mupirocin, rifampin, tetracycline, trimethoprim/sulfamethoxazole, vancomycin, 95% to mupirocin (MIC ≤ 4 μg/mL), 13% to levofloxacin; 20% to erythromycin, 3% were susceptible to clindamycin by broth microdilution; however, an additional 17 isolates (10%) exhibited inducible clindamycin resistance (23% susceptible and negative for inducible clindamycin resistance).
- In addition to invasive MRSA surveillance, MDH received 2 reports of isolates (1 MRSA and 1 MSSA) with intermediate susceptibility to vancomycin (MIC £ 4 μg/mL).

**Carbenicillin-resistant Enterobacteriaceae (CRE)**
- Of Enterobacteriaceae submitted to the MDH Public Health Laboratory because of an elevated MIC to at least one carbapenem, 18 tested positive for CRE by PCR.

**Pneumocystis carinii (PCP)**
- Antimicrobial treatment for e. coli/D157 HT infection is not recommended.