UNITED STATES MARINE CORPS
I MARINE EXPEDITIONARY FORCE
U. S. MARINE CORPS FORCES, PACIFIC
BOX 555300
CAMP PENDLETON, CA 92055-5300

IN REPLY REFER TO:
I MEFO 6220.12
SURGEON
DEC 14 2009

I MARINE EXPEDITIONARY FORCE ORDER 6220.12

From: Commanding General
To: Distribution List

Subj: MEDICAL SURVEILLANCE AND NOTIFIABLE EVENT REPORTING

Ref: (a) DoD Directive 6490.2 of 21 Oct 2004
(b) BUMEDINST 6200.17
(c) ASD(HA) Policy 07-001 of 17 Jan 2007
(d) Tri-Service Reportable Diseases Guidelines and Case Definitions of May 2004 (NOTAL)
(e) OPNAVINST 3100.6I

Encl: (1) Medical Event Report (MER) Submission Requirements
(2) Preventive Medicine Points of Contact
(3) Tri-service List of Reportable Events
(4) NDRSi Access SAAR Form DD 2875 with Instructions

1. Situation. Disease and Non-Battle Injury (DNBI) are the primary causes of casualties in peacetime and during conflict. The mission of the medical departments assigned to Marine units is to preserve the fighting force, in part by preventing DNBI. Monitoring for and timely reporting of significant events that may adversely affect mission accomplishment and shape commanders' decision making are vital military medicine functions. A robust preventive medicine (PM) program is essential to carry out this mission. Everyone in the medical department is in the business of preventing disease. The primary purpose of surveillance is to serve as an objective "early warning system" at the unit level to alert medical personnel and commanders of unusual disease or injury rates. Immediate recognition of abnormally high rates enables medical and command personnel to focus efforts to determine the case and implement corrective actions before DNBI reaches significant or epidemic proportions. MERs are required for select diseases and injuries due to their potential to compromise operational readiness, present hazards to the military or civilian community, result in quarantine, or generate inquiries to the Chief, BUMED. Submission of a MER does not relieve the reporting command or unit of reporting requirements in reference (e).

a. The primary objectives of medical surveillance and reporting are:

(1) Timely and proficient public health response to medical events that ultimately reduce morbidity and mortality. A successful medical surveillance program depends on regular monitoring of trends and early notification of suspected or confirmed medical events.

(2) Estimation of the distribution, trends, and risks associated with significant medical events.

(3) Development and assessment of policy and resource allocation for the prevention and control of communicable diseases.

2. Mission. To provide policy concerning medical surveillance practices, processes, and reporting requirements. This includes monitoring of daily sick call entries, external civilian patient visits, Preventive Medicine Representative (PMR) logs, garrison field events, and reporting of MER submission requirements.

3. Execution

a. I MEF Surgeons Office shall ensure that the Major Subordinate Command (MSC) Surgeons Offices maintain an effective and robust internal medical surveillance program. Aid stations shall monitor all patient visits (internal and external) and incorporate into routine medical surveillance activities as required to ensure complete success. Procedures and processes described in reference (c) and enclosure (1) will be implemented.

b. Major Subordinate Command (MSC) Surgeons:

(1) Shall implement medical event reporting guided by enclosure (1).

(2) Ensure providers report medical events to their chain of command's preventive medicine or public health representatives.

(3) Perform medical event surveillance at the local level. Have organic preventive medicine assets conduct response activities including follow-up of suspect cases, as well as, case contacts, as appropriate.

(4) Submit MERs, as outlined in reference (d) and enclosure (1) when a reportable medical event is suspected or

confirmed. Reference (d) outlines case definitions for reportable conditions. Formats for the minimal MERs and outbreak report requirements, if the Navy Disease Reporting System, internet (NDRSi) program is not available, are provided in Appendices B and C to enclosure (1).

(5) Request consultative epidemiologic services from the Preventive Medicine Departments of Naval Hospital Camp Pendleton or Naval Hospital 29 Palms as needed to control disease outbreaks or to investigate unusual health-related conditions. If assistance is unavailable or beyond their scope of services, contact Navy Environmental and Preventive Medicine Unit (NEPMU) #5. Report medical events to local civilian public health authorities according to State and local regulations through the hospital preventive medicine departments.

c. Operational Unit Regimental, Group and Flight Line Aid Stations:

(1) Advise their respective commanding officers and medical officers of the requirements of this order to facilitate the reporting of significant medical events via MERs as appropriate.

(2) Ensure that providers report medical events in Appendix A to enclosure (1) to their chain of command's preventive medicine or public health representative.

(3) If a Preventive Medicine Technician is assigned, perform medical event surveillance and public health response activities including follow-up of suspect cases and case contact investigation, treatment and follow-up as appropriate.

(4) Submit MERs, as outlined in reference (d) and enclosure (1) when a reportable medical event is suspected or confirmed. Reference (d) outlines case definitions for reportable conditions. Though reporting via Navy and Marine Corps Public Health Center's (NMCPHC), NDRSi website is preferred; if internet connectivity is not available, alternate forms of reporting ARE required. Alternate reporting methods and formats for the minimal MERs and outbreak report requirements, if the NDRSi program is not available, are provided in Appendices B and C to enclosure (1).

(5) Request consultative epidemiologic services from your MSCs Preventive Medicine Offices as needed to investigate unusual health-related conditions.

4. Administration and Logistics

a. The intent of this Order is not to discontinue the fundamentals of DNBI monitoring or collection efforts but to suspend the need for weekly reporting and shift to the use of NDRSi for the reporting of conditions that are of significant importance. DNBI reporting will still be conducted paperless and will be done at the aid station level. Weekly reports will be given to the SMDR and Surgeon after review of the appropriate logs. It is these individuals who will then deal with identified concerns at their local levels. Concerns requiring a greater scope of investigative efforts will be forwarded up to their Surgeons Office Preventive Medicine personnel who will take for action.

b. Access to NDRSi. Access to NDRSi is obtained by completing the DD2875 form System Authorization Access Request (SAAR). Account information and training materials are provided at:
http://www.nmcphc.med.navy.mil/prevmed/epi/reporting_tools.htm.

c. A minimum of two personnel per aid station are required to have access in order to maintain ability to create MERs so that urgent reports can be sent within 24 hours. Further information on MER submittal can be found in enclosure (1).

5. Command and Signal

a. Cancellation. I MEF Order 6220.2B.

b. Applicability. This Order applies to all organic medical departments assigned and under operational or administrative control of the Commanding General, I MEF. Units deployed under the operational control of a geographical combatant commander will refer to and follow the disease surveillance practices and reporting requirements of that combatant command.

c. Report. The medical event report (MER) is assigned report control symbol NAVMED 6220-3.

d. Access Verification Report. Once implemented, each unit will submit an access verification report to their MSC Surgeons office. This spreadsheet/report will ensure that there are a minimum of two personnel onboard with access to NDRSi at all times. Each MSC Surgeons Office will submit a consolidated report and submit on Fridays to the I MEF Surgeons Office. This necessity will be active for 30 days from the date this Order is signed.

After 30 days, add this requirement to the MEDSITREP and report monthly.

G. M. RYAN
Chief of Staff

Distribution: Lists I/II

I MEF MEDICAL EVENT REPORT (MER) SUBMISSION REQUIREMENTS

1. The requirement to submit MERs extends to all active duty personnel and reservists on active duty.

2. Medical departments providing outpatient medical care to the Marines must submit a MER when:

a. A Tri-service reportable condition, as listed in reference (d), is suspected or confirmed.

b. Notified of a significant communicable disease outbreak among the military population (your unit), which may impact the health and readiness of military personnel. An outbreak is defined as the occurrence, in a community or region (battalion or regiment), of cases of an illness or other health-related events in excess of normal expectancy.

3. A MER shall be submitted by the medical department of the unit with primary responsibility for the health of the affected individual. The cognizant NEPMU for the I MEF and its subordinate elements is NEPMU-5 in San Diego.

4. Reporting Procedures

a. Authorized methods of reporting include:

(1) NDRSi is the preferred method for submitting MERs. Account information and training materials are provided at http://www-nmcphc.med.navy.mil/prevmed/epi/Reporting_tools.htm. Assistance may be obtained by contacting your preventive medicine section of the surgeons' office. The I MEF Preventive Medicine Technician or Officer can assist as well and if unavailable, contact the Navy and Marine Corps Public Health Center. Their information can be found in enclosure (2).

(2) For commands that do not have adequate internet access Naval messages or standard correspondence (via mail, e-mail, or fax) can be submitted ensuring that the information contained in appendix B of this enclosure is provided. The primary action addressee is the responsible NEPMU. If a reporting unit is home ported in the area of one NEPMU, but deploys to the area of another, the MER must be addressed to the NEPMU responsible for that geographic area of deployment. Follow appropriate Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Privacy Act regulations when communicating personal health information.

(3) In situations where timeliness is critical, MERs may be reported via telephone or e-mail with follow-on correspondence to the responsible NEPMU. See enclosure (2) for contact information.

b. If an operational unit must send an urgent MER by message, it should be sent

unclassified. If the message is classified, as much information as possible should be designated unclassified. Include declassification instructions to allow for subsequent computer storage and epidemiological analysis.

c. All MERs sent via message traffic must be identified by report control symbol NAVMED 6220-3 in the subject line.

5. Timeliness of Reporting

a. Routine Reports. Most reportable medical events are routine and should be submitted as soon as practical. These events must be submitted within 30 days of diagnosis. As soon as reports are entered into NDRSi, they are visible to the cognizant NEPMU and NMCPHC.

b. Urgent Reports. Appendix A to enclosure (1) identifies medical events that must be reported within 24 hours to the responsible NEPMU.

6. Submit one outbreak report for clusters of individually reportable diagnoses. Submission of individual MERs for each case is not required unless indicated by the cognizant NEPMU. Maintain individual identifiers locally. A suspected outbreak occurring among military personnel is considered an urgent reportable medical event. Report all suspected outbreaks as soon as possible and within 24 hours to the responsible NEPMU by the most expeditious means available. The format and minimal information required for this reporting is provided in Appendix C to enclosure (1).

I Marine Expeditionary Force and
Navy Preventive Medicine Points of Contact

1. I MEF Surgeons' Office
   Comm: (760) 725-9000 (main office)
   (760) 763-4749 (Preventive Medicine)
   DSN: 361 for 763 and 365 for 725
   FAX: (760) 725-9164

2. 1st Marine Division Preventive Medicine
   Comm: (760) 725-5209
   DSN: 365-XXXX

3. 1st Marine Logistics Group Preventive Medicine
   Comm: (760) 725-3663
   DSN: 365-XXXX

4. 3rd Marine Air Wing Preventive Medicine
   Comm: (858) 755-7444
   DSN: 267

5. Officer in Charge
   Navy Environmental and Preventive Medicine Unit TWO
   1887 Powhatan Street
   Naval Station
   Norfolk, VA 23511-3394
   Comm: (757)953-6600; DSN 377-6600; FAX (757) 953-7212
   Secure Telephone (STU-III) (757) 445-0774; DSN 564-0774
   E-mail: NEPMU2NorfolkThreatAssessment@med.navy.mil
   SIPRNET: DNBI-nepmu2@nehc.navy.smil.mil
   PLAD: NAVENPVNTMEDU TWO NORFOLK VA

6. Officer in Charge
   Navy and Environmental and Preventive Medicine Unit FIVE
   3235 Albacore Alley
   San Diego, CA 92136-5199
   Comm: (619) 556-7070; DSN 526-7070; FAX (619) 556-7071
   Secure Telephone (STU-III) (619) 556-9694; DSN 526-9694
   E-mail: ThreatAssessment@nepmu5.med.navy.mil
   PLAD: NAVENPVNTMEDUNEPMU FIVE SAN DIEGO CA

7. Officer in Charge
   Navy Environmental and Preventive Medicine Unit SIX
   1215 North Road
   Pearl Harbor, HI 96860-4477
   Comm: (808) 473-0555; DSN (315) 473-0555; FAX: (808) 473-2754
   Secure Telephone (STU-III) (808) 473-3503; DSN (315) 473-0555
   E-mail: fleet/fmfsupport@med.navy.mil
   SIPRNET: fdpmu@nepmu6@navy.smil.mil

PLAD: NAVENPVNTMEDU SIX PEARL HARBOR HI

8. Commanding Officer
Navy and Marine Corps Public Health Center
620 John Paul Jones Circle, Suite 1100
Portsmouth, VA 23708-2103
Comm: (757) 953-0700; DSN 377-0700; FAX (757) 953-0685
E-mail: epi@nehc.mar.med.navy.mil
SIPRNET: plansops@nehc.navy.smil.mil
PLAD: NAVMCPUBHLTHCEN PORSTMOUTH VA

TRI-SERVICE REPORTABLE EVENTS

GUIDELINES & CASE DEFINITIONS

Prepared by:
Armed Forces Health Surveillance Center (AFHSC)

JUNE 2009

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1.0 Overview

A reportable event may represent an inherent, significant threat to public health and military operation. These events have the potential to affect large numbers of people, to be widely transmitted within a population, to have severe/life threatening clinical manifestations, and to disrupt military training and deployment. Timely, accurate reporting of probable, suspected or confirmed cases ensures proper identification, treatment, control, and follow-up of cases.

Reportable events were chosen based by Tri-Service consensus and recommendations about notifiable diseases from the Centers for Disease Control and Prevention (CDC), the Council of State and Territorial Epidemiologists (CSTE), and events that military public health experts have identified as representing a significant threat to the military that deserve additional emphasis for surveillance (References 1 - 4). The principal goal of this document is to achieve data consistency and standardization of reportable events tracking across each Service, and to aid local reporting installations by providing programmatic guidance.

As part of the ongoing effort to consolidate Department of Defense (DoD) medical surveillance data, the following sections are included in this *Tri-Service Reportable Events* document:

- Reportable event selection criteria (Section 2)
- Medical events surveillance & the use of ICD-9 codes (Section 3)
- Service point-of-contact (Section 4)
- Compendium of case definitions (Section 5)
- Criteria for standardized data elements (Section 6)
- Reportable disease ICD-9 codes & synonyms (Section 7)
- References (Section 8)

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2.0 Selection Criteria for Reportable Medical Events

The Tri-Service list of reportable medical events (Section 5) was selected based on the selection criteria below. Representatives of each Service's medical department applied the criteria to each medical event/condition that was considered for mandatory reporting:

1. There must be a clear case definition and a single standard code (from the International Classification of Diseases, 9th revision).
2. An intervention must be available and/or a public health response indicated.
3. A sufficient, timely source of the required information must not already exist.
4. The condition/event must also meet one of the following criteria:
    - It represents an inherent, significant threat to public health by having the potential to affect large numbers of people, to be widely transmitted within a population, or to have severe/life threatening clinical manifestations, or
    - It represents a significant military operational threat by having the potential to disrupt military training, deployment, or operations, or
    - It is commonly reportable by state or federal laws, regulations, or guidelines.

Individual services may require reporting of additional conditions; refer to service-specific instructions for details.

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3.0 Medical Events Surveillance and the Use of ICD-9 Codes

Medical Events Surveillance:

This list of *Tri-Service Reportable Events* contains specific diseases and environmental exposures that have clear case definitions, laboratory criteria for diagnosis, and associated ICD-9 codes. Events among all utilizers of the military healthcare system (e.g., service members, family members, retirees, civilian federal government employees) should be reported (unless otherwise noted).

Use of ICD-9 Codes:

The use of ICD-9 codes in medical event surveillance is intended to assist in the search for cases of the reportable disease in healthcare encounter related databases. Other ICD-9 codes may also be needed to find additional reportable medical events in these databases. For example, to identify cases of Invasive Group A Streptococcal disease not coded as ICD-9 038.0, consider looking for cases coded 482.31 or 041.01. *As long as cases so coded meet the case definition*, all such cases should be reported as "Streptococcus, Group A, Invasive – 038.0", regardless of ICD-9 code. Commonly used ICD-9 codes and synonyms for each event/condition can be found in Section 7.

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4.0 Service Points-of-Contact

In order to address Service-specific needs, each Service will continue to be responsible for implementing its own reporting system, data collection, and quality assurance. The collected data will be integrated into the Defense Medical Surveillance System (DMSS) database, where it will be available to all three Services for further reporting and analysis.

Consult the following individual Service points of contact with suggested changes to this *Tri-Service Reportable Events* document and/or service-specific questions about guideline implementation:

Air Force:	Reportable Disease Project Officer USAF School of Aerospace Medicine DSN 240-3471 (COM 210-536-3471)
Army:	Reportable Disease Project Officer Armed Forces Health Surveillance Center DSN 584-3240 (COM 301-319-3240)
Navy/MC:	Reportable Disease Project Officer Navy Marine Corps Public Health Center DSN 377-0700 (COM 757-953-0700)
Coast Guard:	Reportable Disease Project Officer Coast Guard Headquarters, CG-1121 DSN: NA (COM 202-475-5172)

The *Tri-Service Reportable Events* document is available at the Armed Forces Health Surveillance Center (AFHSC) website (URL: http://www.afhsc.mil). Inquiry forms for changes, additions, or deletions to the *Tri-Service Reportable Events* document are also available on the AFHSC website. Personnel with recommendations to change the Tri-Service list should complete an inquiry form and forward the form through the Service Reportable Disease Project Officer to the Armed Forces Health Surveillance Center.

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5.0 Case Definitions

Definition of terms-

- **Clinical Description**

  Background information on event/condition.

- **Clinical Case Definition**

- **Laboratory Criteria for Diagnosis**

  Supportive/presumptive laboratory results: specified laboratory results that are consistent with the diagnosis, yet do not meet the criteria for laboratory confirmation.

- **Case Classification**

  A set of criteria that must be fulfilled in order to identify a person as a case of a particular disease/condition. Case classification can be based on clinical, laboratory, or combined clinical and laboratory criteria.

  Clinically compatible case: a clinical syndrome generally compatible with the disease, as described in the clinical case definition. (Note: if "clinical case definition" is not available, a clinical syndrome compatible with "clinical description" is sufficient).

  Epidemiologically linked case: a case in which a) the patient has had contact with one or more persons who either have/had the disease or have been exposed to a point source of infection (i.e., a single source of infection, such as an event leading to a foodborne-disease outbreak, to which all confirmed case-patients were exposed) and b) transmission of the agent by the usually modes of transmission is plausible. A case may be considered epidemiologically linked to a laboratory-confirmed case if at least one case in the chain of transmission is laboratory confirmed.

  Suspected: a case that is classified as suspected for reporting purposes.

  Probable: a case that is classified as probable for reporting purposes.

  Confirmed: a case that is classified as confirmed for reporting purposes.

- **Required Comments**

  Additional information should be included in the reporting form. If information is unavailable, indicate so in the appropriate section. For events requiring relevant travel/deployment history, please note the incubation period when collecting this information.

  Note: Incubation period is the time interval between initial contact with the infectious organism and the first appearance of symptoms associated with the infection.

- **Additional Considerations**

5.1 AMEBIASIS

ICD-9: 006 Reference 5

Clinical Description

Infection of the large intestine by *Entamoeba histolytica* may result in an illness of variable severity ranging from mild, chronic diarrhea to fulminant dysentery. Infection also may be asymptomatic. Extraintestinal infection can also occur (e.g., hepatic abscess).

Laboratory Criteria for Diagnosis

1. ***Intestinal Amebiasis:*** (any of the following)
   - Cysts or trophozoites of *E. histolytica* in stool, or
   - Trophozoites in tissue biopsy or ulcer scrapings by culture or histopathology, or
   - Immunoassay for parasite antigen in stool.
2. ***Extraintestinal Amebiasis:*** Demonstration of *E. histolytica* trophozoites in extraintestinal tissue.

Case Classification

1. **Intestinal Amebiasis:**
   - ***Confirmed:*** A clinically compatible case that is laboratory-confirmed.
2. **Extraintestinal Amebiasis:**
   - ***Confirmed:*** A parasitologically- confirmed infection of extraintestinal tissue, or in symptomatic persons (with clinical or radiographic findings consistent with extraintestinal infection), demonstration of specific antibodies against *E. histolytica* as measured by indirect hemagglutination or other reliable immunodiagnostic test (e.g., enzyme-linked immunosorbent assay [ELISA]).

Note: Asymptomatic intestinal carriage of E. histolytica should not be reported. In asymptomatic persons, a positive serologic test does not necessarily indicate extraintestinal amebiasis.

Required Comments

Document the site of infection and relevant travel/deployment history (Note: the incubation period of amebiasis is commonly 2-4 weeks, with a range of a few days to several months or years).

Additional Considerations

None.

5.2 ANTHRAX

ICD-9: 022 References 1, 6, 7

Clinical Description

An illness with acute onset characterized by several distinct clinical forms, including the following:

- *Cutaneous*: a skin lesion evolving during a period of 2-6 days from a papule, through a vesicular stage, to a depressed black eschar
- *Inhalation*: a brief prodrome resembling a viral respiratory illness, followed by development of hypoxia and dyspnea, with radiographic evidence of mediastinal widening
- *Intestinal*: severe abdominal distress followed by fever and signs of septicemia
- *Oropharyngeal*: mucosal lesion in the oral cavity or oropharynx, cervical adenopathy and edema, and fever

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *Bacillus anthracis* from a clinical specimen or
- Anthrax electrophoretic immunotransblot (EITB) reaction to the protective antigen and/or lethal factor bands in one or more serum samples obtained after onset of symptoms or
- Demonstration of *B. anthracis* in a clinical specimen by immunofluorescence or
- PCR-positive by an FDA approved test.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Specify the clinical form of anthrax and include the patient's anthrax immunization history. Document the site and source of infection.

Additional Considerations

None.

5.3 BOTULISM

ICD-9: 005.1

References 1, 6, 7

Clinical Description

Clostridium botulinum causes three major forms of illness characterized by the route of infection: food-borne, infantile, wound.

Botulinum toxin exposure results in an illness of variable severity. Common symptoms are diplopia, blurred vision and bulbar weakness. Symmetric paralysis may progress rapidly. In infants (aged ≤1 year), constipation, poor feeding and "failure to thrive" may be followed by progressive weakness, impaired respiration and death.

Laboratory Criteria for Diagnosis

Any of the following:

- Detection of *C. botulinum* toxin in serum, stool or patient's food, or
- Isolation of *C. botulinum* from stool or a wound.

Case Classification

Probable: A clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours).

Confirmed: 1) A clinically compatible case that is laboratory-confirmed or 2) a clinically compatible case that occurs among persons who ate the same food as persons who have laboratory-confirmed botulism.

Required Comments

Specify the clinical form of botulism. Indicate whether case is probable or confirmed. Document the source of infection if known.

Additional Considerations

None.

5.4 BRUCELLOSIS

ICD-9: 023 References 1, 6, 7

Clinical Description

An illness characterized by acute or insidious onset of fever, night sweats, undue fatigue, anorexia, weight loss, headache, arthralgia and myalgia.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *Brucella* sp. from a clinical specimen or
- Fourfold or greater rise in *Brucella* agglutination titer between acute and convalescent serum specimens obtained ≥ 2 weeks apart and studied at the same laboratory or
- Demonstration by immunofluorescence of *Brucella* sp. in a clinical specimen.

Case Classification

Probable: A clinically compatible case that is epidemiologically linked to a confirmed case or that has supportive serology (i.e., *Brucella* agglutination titer of ≥ 160 in one or more serum specimens obtained after onset of symptoms).

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Indicate whether case is probable or confirmed. Document relevant travel/deployment history (Note: the incubation period of brucellosis is usually 5-60 days, with a range of 1-2 months to several months).

Additional Considerations

Document the source of infection and potential occupational exposure (e.g., veterinarian, lab worker, etc.).

5.5 CAMPYLOBACTER INFECTION

ICD-9: 008.43

References 5, 9

Clinical Description

Predominant symptoms of Campylobacter infections include diarrhea, abdominal pain, malaise, and fever. Stools may contain visible or occult blood. Mild infection last 1 or 2 days and resembles viral gastroenteritis.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *Campylobacter jejuni* from any clinical specimen or
- EIA for antigen in stool.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

Document the source of infection, if known, and whether case is part of an outbreak.

5.6 CHLAMYDIA TRACHOMATIS, GENITAL INFECTIONS

ICD-9: 099.41 Reference 1

Clinical Description

Infection with *Chlamydia trachomatis* may result in urethritis, epididymitis, cervicitis, acute salpingitis, or other syndromes when sexually transmitted; however, the infection is often asymptomatic in women. Perinatal infections may result in inclusion conjunctivitis and pneumonia in newborns. Other syndromes caused by *C. trachomatis* include lymphogranuloma venereum and trachoma.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *C. trachomatis* by culture, or
- Demonstration of *C. trachomatis* in a clinical specimen by detection of antigen or nucleic acid.

Case Classification

Confirmed: A case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

None.

5.7 CHOLERA

ICD-9: 001 Reference 1

Clinical Description

An illness characterized by diarrhea and/or vomiting; severity is variable.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of toxigenic (i.e., cholera toxin-producing) *Vibrio cholerae* O1 or O139 from stool or vomitus, or
- Serologic evidence of recent infection.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Note: Illnesses caused by strains of V. cholerae other than toxigenic V. cholerae O1 or O139 should not be reported as cases of cholera. Only confirmed cases should be reported.

Required Comments

Document relevant travel/deployment history (Note: the incubation period of cholera is usually 2-3 days, with a range of a few hours to 5 days) outside the U.S. Also, document the etiologic agent of the case (either *V. cholerae* O1 or *V. cholerae* O139).

Additional Considerations

Cholera cases may be internationally reportable per International Health Regulations.

5.8 COCCIDIOIDOMYCOSIS

ICD-9: 114 Reference 1

Clinical Description

Infection may be asymptomatic or may produce an acute or chronic disease. Although the disease initially resembles an influenza-like or pneumonia-like febrile illness primarily involving the bronchopulmonary system, dissemination can occur to multiple organ systems.

Clinical Case Definition

One or more of the following:

- Influenza-like signs and symptoms (e.g., fever, chest pain, cough, myalgia, arthralgia, and headache)
- Pneumonia or other pulmonary lesion, diagnosed by chest radiograph
- Erythema nodosum or erythema multiforme rash
- Involvement of bones, joints, or skin by dissemination
- Meningitis
- Involvement of viscera and lymph nodes

Laboratory Criteria for Diagnosis

Any of the following:

- Cultural, histopathologic, or molecular evidence of presence of *Coccidioides* species, or
- Coccidiodal skin-test conversion from negative to positive after onset of clinical signs and symptoms, or
- Positive serologic test for coccidioidal antibodies in serum or cerebrospinal fluid, or other body fluids by any of the following:
  - Detection of coccidiodal immunoglobulin M (IgM) by immunodiffusion, enzyme immunoassay (EIA), latex agglutination, or tube precipitin or
  - Detection of coccidiodal immunoglobulin G (IgG) by immunodiffusion, EIA, or complement fixation.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

Document the source of infection.

5.9 COLD WEATHER INJURIES

ICD-9: 991.3 (Frostbite)
991.4 (Immersion Foot)
991.6 (Hypothermia)

Reference 10

INCLUDES: Service Member cases only.

Note: Multiple types of cold weather injuries may occur to the same individual. Enter the report for the most severe injury (Hypothermia>Frostbite>Immersion) and specify additional injuries in the comment field.

Clinical Description

- *Hypothermia:* Reduction of body temperature to below 95°F. It can result from either dry-land whole body exposure or immersion in cold water. Freezing temperatures are not required to produce hypothermia.

- *Freezing Peripheral Injuries:* Freezing injuries (e.g. frostbite) only occur due to exposure to temperatures below freezing. They result from the freezing of tissue fluids in the skin and/or subcutaneous tissues.

- *Non-Freezing Peripheral Injuries:* Localized non-freezing injuries, usually of extremities (e.g., trench foot, immersion foot) occur due to prolonged vasoconstriction in response to cold that leads to tissue injury and destruction. These injuries develop over a period of hours to days. They may occur at temperatures below or above freezing and can occur at temperatures as high as 60°F with prolonged exposure. Injury is accelerated by exposure to damp conditions. (Note: the term "trench foot" is also sometimes used to describe a tropical foot injury or "jungle rot.")

Clinical Case Definition

- *Hypothermia*: Reduction of core body temperature to 95°F or lower. Temperature should have been measured by rectal, esophageal, or other central method.

- *Frostbite*: A localized freezing injury that typically occurs in a relatively rapid fashion and occurred due to exposure to temperatures below freezing. Although is has often been classified as 1-4th degree injury, final classification often takes weeks

and is not helpful for immediate treatment. More recently it has been classified as superficial and deep. Do not delay reporting to determine classification.

- Superficial: Partial or full thickness freezing of the epidermis without involvement of the underlying tissue. Mobility is unaffected, and blistering may occur.
- Deep: Full thickness freezing of the epidermis accompanied by freezing of subcutaneous tissue and which may involve muscles, tendons, and bones as severity increases.

- *Immersion / Trench Foot*: Non-freezing injury of a localized area, typically the foot or hand.

Laboratory Criteria for Diagnosis

Cold injuries are diagnosed clinically.

Case Classification

Confirmed: A clinically compatible case with an appropriate history of cold exposure.

Required Comments

Note if injury was duty related.

Additional Considerations

Document the type(s) of injury(s), core body temperature and method measured (for hypothermia), classification of frostbite, anatomic location of injury(s) and environmental and other circumstances that contributed to occurrence.

5.10 CRYPTOSPORIDIOSIS

ICD-9: 007.4 Reference 1

Clinical Description

An illness caused by the protozoan *Cryptosporidium parvum* and characterized by diarrhea, abdominal cramps, loss of appetite, low-grade fever, nausea, and vomiting. Infected persons may be asymptomatic. The disease can be prolonged and life-threatening in severely immunocompromised persons.

Laboratory Criteria for Diagnosis

Any of the following:

- *Cryptosporidium* oocysts in stool by microscopic examination, or
- *Cryptosporidium* in intestinal fluid or small-bowel biopsy specimens, or
- *Cryptosporidium* oocyst or sporozite antigens by immunodiagnostic methods, e.g., ELISA, or
- *Cryptosporidium* by PCR techniques, or
- *Cryptosporidium* demonstration of reproductive stages in tissue preparations.

Case Classification

Confirmed: A case that is laboratory confirmed.

Required Comments

None.

Additional Considerations

None.

5.11 CYCLOSPORA INFECTION

ICD-9: 007.5 Reference 1

Clinical Description

An illness of variable severity caused by the protozoan *Cyclospora cayetanensis* and commonly characterized by watery diarrhea, loss of appetite, weight loss, abdominal bloating and cramping, increased flatus, nausea, fatigue, and low-grade fever. Vomiting also may be noted. Relapses and asymptomatic infections can occur.

Note: Direct person-to-person transmission is unlikely because Cyclospora oocysts are not infectious at the time of excretion.

Laboratory Criteria for Diagnosis

Any of the following:

- *Cyclospora* oocysts in stool by microscopic examination, or
- *Cyclospora* in intestinal fluid or small bowel biopsy specimens, or
- *Cyclospora* demonstration of sporulation, or
- *Cyclospora* DNA (by PCR) in stool, duodenal/jejunal aspirates or small bowel biopsy specimens.

Case Classification

Confirmed: A case that is laboratory confirmed.

Required Comments

None.

Additional Considerations

Document the source of infection and whether the case is part of an outbreak.

5.12 DENGUE FEVER

ICD-9: 061 References 5, 8, 9

Clinical Description

An acute febrile illness of 2-7 days duration with 2 or more of the following: headache, retro-orbital pain, myalgia, arthralgia, rash, haemorrhagic manifestations, leucopenia. The principal vector is the *Aedes aegypti* mosquito and transmission usually occurs in tropical or subtropical areas. Severe manifestations (e.g., dengue hemorrhagic fever and dengue shock syndrome) are rare but may be fatal.

Clinical Case Definition

Dengue Hemorrhagic Fever (DHF): A probable or confirmed case of dengue with hemorrhagic tendencies evidenced by one or more of the following:

- Positive tourniquet test
- Petechiae, ecchymoses or purpura
- Bleeding from mucosa, gastrointestinal tract, injection sites or other sites
- Hematemesis, melena, and thrombocytopenia (100,000 cells per mm^3 or less) plus evidence of plasma leakage due to increased vascular permeability manifested by one or more one of the following:
  - A ≥ 20% rise in average hematocrit for age and sex
  - A ≥ 20% drop in hematocrit following volume replacement treatment compared to baseline
  - Signs of plasma leakage (pleural effusion, ascites, and hypoproteinemia)

Dengue Shock Syndrome (DSS): All the above criteria for DHF plus evidence of circulatory failure manifested by either:

- Rapid and weak pulse with narrow pulse pressure (≤ 20 mm Hg), or
- Hypotension for age, cold, clammy skin and altered mental status.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of dengue virus from serum, plasma, leukocytes, or autopsy samples, or
- Demonstration of a fourfold or greater change in reciprocal IgG or IgM antibody titers to one or more dengue virus antigens in paired serum samples, or
- Demonstration of dengue virus antigen in autopsy tissue by immunohistochemistry or by viral nucleic acid detection
- Detection of viral genomic sequences in autopsy tissue, serum or CSF samples by polymerase chain reaction (PCR).

Case Classification

Probable: A case compatible with the clinical description with one or more of the following:

- A reciprocal IgG antibody titer >=1280
- A positive IgM antibody test on a single acute (late) serum or convalescent serum to one or more dengue virus antigens.

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Indicate whether case is probable or confirmed, whether the case is complicated by DHF or DSS, relevant travel/deployment history (Note: the incubation period of dengue fever is commonly 4-7 days, with a range of 3-14 days), and the dengue serotype (if known).

Additional Considerations

None.

5.13 DIPHTHERIA

ICD-9: 032 Reference 1

Clinical Description

An upper respiratory tract illness characterized by sore throat, low-grade fever, and an adherent membrane of the tonsil(s), pharynx, and/or nose.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *Corynebacterium diphtheriae* from a clinical specimen, or
- Histopathologic diagnosis of diphtheria.

Case Classification

Confirmed: 1) A clinically compatible case that is either laboratory-confirmed or 2) a clinically compatible case that is epidemiologically linked to a laboratory-confirmed case.

Note: Respiratory disease caused by nontoxigenic C. diphtheriae should be reported as diphtheria. Cutaneous diphtheria should not be reported.

Required Comments

Include the patient's diphtheria immunization history.

Additional Considerations

Specify the patient's age in months if < 1 year, source of infection, and document relevant travel/deployment history (note: the incubation period of diphtheria is usually 2-5 days).

5.14 E. COLI, SHIGA TOXIN-PRODUCING (INCLUDES O157:H7)

ICD-9: 008.04

Reference 1

Clinical Description

An infection of variable severity characterized by diarrhea (often bloody) and abdominal cramps. The illness may be complicated by hemolytic uremic syndrome (HUS) or thrombotic thrombocytopenic purpura (TTP). Asymptomatic infections may also occur.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *Escherichia coli* O157:H7 from a clinical specimen (*Escherichia coli* O157:H7 isolates may be assumed to be Shiga toxin-producing) , or
- Isolation of other *E. coli* from a clinical specimen with demonstration of toxin production or the presence of Shiga toxin genes.

Note: Strains of E. coli O157:H7 designated "NM" have lost the flagella "H" antigen and become nonmotile.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

When available, O and H antigen serotype characterization should be reported.

Additional Considerations

Document the source of infection and whether the case is part of an outbreak.

5.15 EHRLICHIOSIS / ANAPLASMOSIS

ICD-9: 082.4 Reference 1

Clinical Description

A tick-borne illness characterized by acute onset of fever and one or more of the following symptoms or signs: headache, myalgia, malaise, anemia, leucopenia, thrombocytopenia, or elevated hepatic transaminases. Nausea, vomiting, or rash may be present in some cases. Intracytoplasmic bacterial aggregates (morulae) may be visible in the leukocytes of some patients.

Laboratory Criteria for Diagnosis

1. **Ehrlichia chaffeensis** infection (formerly included in the category Human Monocytic Ehrlichiosis [HME]): (any of the following)
    - Serological evidence of a fourfold change in immunoglobulin G (IgG)-specific antibody titer to E. chaffeensis antigen by indirect immunofluorescence assay (IFA) between paired serum samples (one taken in first week of illness and a second 2-4 weeks later), or
    - Detection of E. chaffeensis DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay, or
    - Demonstration of ehrlichial antigen in a biopsy or autopsy sample by immunohistochemical methods, or
    - Isolation of E. chaffeensis from a clinical specimen in cell culture.
2. **Ehrlichia ewingii** infection (formerly included in the category Ehrlichiosis [unspecified, or other agent]):
    - Because the organism has never been cultured, antigens are not available. Thus, Ehrlichia ewingii infections may only be diagnosed by molecular detection methods: E. ewingii DNA detected in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay.
3. **Anaplasma phagocytophilum** infection (formerly included in the category Human Granulocytic Ehrlichiosis [HGE]): (any of the following)
    - Serological evidence of a fourfold change in IgG-specific antibody titer to A. phagocytophilum antigen by indirect immunofluorescence assay (IFA) in paired serum samples

(one taken in first week of illness and a second 2-4 weeks later), or

- Detection of A. phagocytophilum DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay, or
- Demonstration of anaplasmal antigen in a biopsy/autopsy sample by immunohistochemical methods, or
- Isolation of A. phagocytophilum from a clinical specimen in cell culture.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Document relevant travel/deployment history (Note: the incubation period of ehrlichiosis/anaplasmosis ranges from 7 to 14 days), particularly noting the geographic location of the patient when known tick bites occurred and/or of recent field exercises.

Additional Considerations

None.

5.16 ENCEPHALITIS, ARBOVIRAL

ICD-9: 062 (Encephalitis, Mosquito-borne)
063 (Encephalitis, Tick-borne)
066.4 (West Nile Virus)

References 5 - 7

INCLUDES: Mosquito-borne Encephalitis, Tick-borne Encephalitis, West Nile Virus, Chikungunya, and others.

EXCLUDES: Bacterial Meningoencephalitis, RMSF, Rift Valley Fever, Rabies, are all reported separately.

Clinical Description

Encephalitis is a broad category of central nervous system infections. Symptoms can include headache, confusion or other alteration in sensorium, nausea, and vomiting. Signs may include fever, meningismus, cranial nerve palsies, paresis or paralysis, sensory deficits, altered reflexes, convulsions, abnormal movements, and coma of varying degree.

Arboviral infections may result in a febrile illness of variable severity associated with neurologic symptoms ranging from headache to aseptic meningitis or encephalitis. The seasonality of arboviral transmission is variable and depends on the geographic location of exposure, the specific cycles of viral transmission, and local climatic conditions.

Laboratory Criteria for Diagnosis

Any of the following:

- Fourfold or greater change in virus-specific serum antibody titer, or
- Isolation of virus from, or demonstration of viral antigen or genomic sequences in, tissue, blood, cerebrospinal fluid (CSF), or other body fluid, or
- Virus-specific immunoglobulin M (IgM) antibodies demonstrated in CSF by antibody-capture enzyme immunoassay (EIA), or
- Virus-specific IgM antibodies demonstrated in serum by antibody-capture EIA and confirmed by demonstration of virus-specific serum immunoglobulin G (IgG) antibodies in the same or a later specimen by another serologic assay (e.g., neutralization or hemagglutination inhibition).

Case Classification

Probable: Viral transmission is likely, with the following supportive serology: a stable (≤twofold change) elevated antibody titer to an arbovirus (e.g., ≥ 320 by hemagglutination inhibition, ≥ 128 by complement fixation, ≥ 256 by immunofluorescence, ≥ 160 by neutralization, or ≥ 400 by enzyme immunoassay IgM).

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Specify the etiologic agent of encephalitis (e.g., Tick-borne Encephalitis [TBE], Japanese Encephalitis [JE]) and include the patient's encephalitis immunization history. Indicate whether case is probable or confirmed. Document relevant travel/deployment (Note: the incubation period of encephalitis, arboviral is usually 5-15 days) and exposure histories (e.g., field exercises).

Additional Considerations

None.

5.17 FILARIASIS

ICD-9: 125 Reference 11

INCLUDES: Onchocerciasis and Loa-loa.

Clinical Description

Filarial infections are an insect-borne group of diseases, including those caused by the organisms *Wuchereria bancrofti, Brugia malayi, Loa-loa* and *Onchocerca volvulus*.

- *Infections caused by Wuchereria and Brugia:* Classical filariasis; caused by lymphatic-dwelling filariae transmitted by mosquitoes. Acute clinical symptoms may include recurrent fevers, lymphadenitis and retrograde lymphangitis, or tropical pulmonary eosinophilia syndrome characterized by nocturnal "asthma", low-grade fever and eosinophilia.

- *Loa-loa and Onchocerciasis:* Transmitted by flies. Loa-loa is characterized by transient swellings and pruritis, often with eosinophilia. Onchocerciasis causes fibrous subcutaneous nodules, pruritis, pigmentation changes, and blindness in severe infections.

Laboratory Criteria for Diagnosis

Microfilaria-positive, antigen-positive or biopsy-positive clinical specimen.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Specify the etiologic agent of filariasis and document relevant travel/deployment history (Note: the incubation period of filariasis ranges from 3-12 months).

Additional Considerations

None.

5.18 GIARDIASIS

ICD-9: 007.1 Reference 1

Clinical Description

An illness caused by the protozoan *Giardia lamblia* and characterized by diarrhea, abdominal cramps, bloating, weight loss, or malabsorption. Infected persons may be asymptomatic.

Laboratory Criteria for Diagnosis

Any of the following:

- *G. lamblia* cysts in stool, or
- *G. lamblia* trophozoites in stool, duodenal fluid, or small-bowel biopsy, or
- *G. lamblia* antigen in stool by a specific immunodiagnostic test (e.g., ELISA).

Case Classification

Confirmed: A case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

Document the source of infection (e.g. the patient's camping/travel history).

5.19 GONORRHEA

ICD-9: 098 Reference 1

Clinical Description

A sexually transmitted infection commonly manifested by urethritis, cervicitis, or salpingitis. Infection may be asymptomatic, particularly in women.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of typical gram-negative, oxidase-positive diplococci (presumptive *Neisseria gonorrhoeae*) from a clinical specimen, or
- Demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or nucleic acid, or
- Observation of gram-negative intracellular diplococci in a urethral smear obtained from a male.

Case Classification

Confirmed: A case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

None.

5.20 HAEMOPHILUS INFLUENZAE, INVASIVE DISEASE

ICD-9: 038.41 Reference 1

EXCLUDES: Conjunctivitis

Clinical Description

Invasive disease caused by *Haemophilus influenzae* may produce any of several clinical syndromes including meningitis, bacteremia, epiglottitis, or pneumonia. Invasive infection does NOT include conjunctivitis.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *H. influenzae* from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF]; or less commonly, from joint, pleural, or pericardial fluid), or
- A positive result on an NHI and API/NH antigen tests (now considered adequately sensitive and specific to be used for diagnosis), or
- A positive result on a FDA-approved PCR-based diagnostic test.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

Document the clinical form of the infection. For children < 1 year, specify age in months. For all children, include the patient's Hib immunization history.

5.21 HANTAVIRUS DISEASE

ICD-9: 079.81 References 1, 5

INCLUDES: Hantavirus Pulmonary Syndrome, Korean Hemorrhagic Fever, and Hemorrhagic Fever with Renal Syndrome.

Clinical Description

1. **Hantavirus Pulmonary Syndrome (HPS):** Commonly referred to as hantavirus disease, HPS is a febrile illness characterized by bilateral interstitial pulmonary infiltrates and respiratory compromise usually requiring supplemental oxygen and clinically resembling Acute Respiratory Disease Syndrome (ARDS). The typical prodrome consists of fever, chills, myalgia, headache, and gastrointestinal symptoms. Typical clinical laboratory findings include hemoconcentration, left shift in the white blood cell count, neutrophilic leukocytosis, thrombocytopenia, and circulating immunoblasts.

2. **Hemorrhagic Fever with Renal Syndrome (HFRS, includes Korean Hemorrhagic Fever):** Characterized by acute onset of fever, lower back pain, hemorrhagic manifestations, and renal involvement. The disease has five clinical phases: febrile, hypotensive, oliguric, diuretic and convalescent.

Clinical Case Definition

1. **HPS:** One or more of the following:

   - A febrile illness (i.e., temperature greater than 101.0°F) characterized by bilateral diffuse interstitial edema that may radiographically resemble ARDS with respiratory compromise requiring supplemental oxygen, all developing within 72 hours of hospitalization and occurring in a previously healthy person.
   - An unexplained respiratory illness resulting in death, with an autopsy examination demonstrating noncardiogenic pulmonary edema without an identifiable cause.

   Since the clinical illness is nonspecific and ARDS is common, a useful screening guideline is that in general, a predisposing medical condition (e.g., chronic pulmonary disease, malignancy, trauma, burns, or surgery) is more

likely to cause ARDS than HPS. Patients who have such underlying conditions and ARDS need not be tested for hantavirus.

2. **HFRS:**

- A febrile illness characterized by variable hemorrhagic symptoms, shock, proteinuria, leukocytosis, hemoconcentration, thrombocytopenia and an elevated BUN.

Laboratory Criteria for Diagnosis

Any of the following:

- Detection of hantavirus-specific IgM or rising titers of hantavirus-specific IgG, or
- Detection of hantavirus-specific RNA sequence by PCR in clinical specimens, or
- Detection of hantavirus antigen by immunohistochemistry.

Note: Laboratory testing should be performed or confirmed at a reference laboratory.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Specify the form of hantavirus disease (pulmonary or hemorrhagic/renal) and document relevant travel/deployment history (Note: the incubation period of hantavirus is usually 2-4 weeks, with a range of a few days to 2 months), including field exercises and outdoor activity.

Additional Considerations

None.

5.22 HEAT INJURIES

ICD-9: 992.0 (Heat Stroke)
992.9 (Heat Injury, Unspecified)

References 12, 13

INCLUDES: Service Member cases only.

EXCLUDES: Cases of simple parade syncope (heat syncope), heat edema, miliaria rubra, and sunburn. Cases of heat exhaustion in the absence of medical intervention or lost duty are also excluded.

Clinical Description

1. **Heat Injury**: Evidence of organ or tissue damage that occurs during exercise in hot conditions or during prolonged exposure to heat.

2. **Heat Stroke**: Central nervous system injury caused by heat stress exposure.

Clinical Case Definition

1. **Heat Injury:** Reportable cases run the spectrum of moderate to severe heat injury associated with strenuous exercise and environmental heat stress resulting in tissue or end-organ damage. Cases are characterized by organ (liver, renal) & tissue (muscle, gut) injury that is supported by laboratory abnormalities. In the absence of laboratory support, cases with clinical suspicion of tissue or organ injury should be reported in this category.

2. **Heat Stroke:** Severe heat stress injury, specifically including injury to the central nervous system, characterized by central nervous system dysfunction and often accompanied by heat injury to other organs and tissue.

Laboratory Criteria for Diagnosis

Heat injuries are diagnosed clinically.

Case Classification

Confirmed: A clinically compatible case.

Note: All heat injuries that require medical intervention or result in lost duty time are reportable.

Required Comments

Note if duty related.

Additional Considerations

Document the patient's core body temperature, the precipitating activity, and medication/supplement use.

5.23 HEMORRHAGIC FEVER

ICD-9: 065

References 6, 7, 11

INCLUDES: Arenaviral hemorrhagic fevers of South America (Junin, Machupo, Guanarito, Sabia hemorrhagic fevers), Arthropod-borne viral hemorrhagic fevers (e.g., Crimean Congo fever), Omsk Hemorrhagic Fever (OHF), Kyasanur Forest Disease (KFD), Lassa fever, and Ebola-Marburg viral diseases.

EXCLUDES: Dengue Hemorrhagic Fever (report under Dengue), Korean Hemorrhagic Fever (report under Hantavirus), Hemorrhagic Fever with Renal Syndrome (report under Hantavirus), Chikungunya (report under Encephalitis, Arborvitae), and Yellow Fever.

Clinical Description

Hemorrhagic fever is a broad category of viral diseases that present with varying degrees of fever, headache, malaise, and often a hemorrhagic crisis. The diseases are usually zoonotic, with transmission via an arthropod bite or aerosolization of virus from infected rodent excreta.

Laboratory Criteria for Diagnosis

Laboratory suspected:

- PCR-positive test.

Laboratory confirmed: (any of the following)

- Isolation of virus from blood, tissue or organs in mouse or cell culture, or
- Serologic diagnosis (specifics vary by disease).

Case Classification

Suspected: A clinically compatible case that meets the suspected laboratory criteria.

Confirmed: A clinically compatible case that meets the confirmatory laboratory criteria.

Required Comments

Specify the etiologic disease agent, indicate whether case is suspected or confirmed, and document relevant travel/deployment history (Note: the incubation period of hemorrhagic fever ranges from 2-17 days).

Additional Considerations

Document the source of infection. Hemorrhagic fever cases may be internationally reportable per International Health Regulations.

5.24 HEPATITIS A

ICD-9: 070.1

Reference 1

Clinical Description

A viral disease with abrupt onset of fever, malaise, anorexia, nausea and abdominal discomfort, followed within a few days by jaundice and/or elevation of serum aminotransferase levels (AST/ALT). Severity ranges from asymptomatic to severe, generally increasing with patient age.

Laboratory Criteria for Diagnosis

Any of the following:

- IgM antibody to Hepatitis A virus (anti-HAV) positive, or
- Fourfold or greater rise in antibody titer in paired sera.

Case Classification

Confirmed: 1) A clinically compatible case that is laboratory-confirmed or 2) a clinically compatible case that occurs in a person who has an epidemiologic link to a person who has laboratory-confirmed hepatitis A (i.e., household or sexual contact with an infected person during the 15-50 days before the onset of symptoms).

Required Comments

Include the patient's Hepatitis A immunization history.

Additional Considerations

Document whether patient is food handler, a day care provider, or is an employee at a long term care facility. Also document relevant travel/deployment history (Note: the incubation period of hepatitis A is usually 28-30 days, with a range of 15-50 days).

5.25 HEPATITIS B, ACUTE

ICD-9: 070.3 Reference 1

Clinical Description

Only a small proportion of acute Hepatitis B infections may be clinically recognized; 30-50% of adults and < 10% of children with acute Hepatitis B infection will have icteric disease. In those with clinical illness, the onset is usually insidious with anorexia, vague abdominal discomfort, nausea and vomiting, sometimes arthralgias and rash, often progressing to jaundice. Fever may be absent or mild.

Laboratory Criteria for Diagnosis

Any of the following:

- IgM antibody to hepatitis B core antigen (anti-HBc) positive, or hepatitis B surface antigen (HBsAg) positive, or
- A positive result on an FDA-approved nucleic acid diagnostic test.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Note: Persons who have chronic hepatitis or who are identified as HbsAg positive should not be reported as having acute viral Hepatitis B unless they have evidence of acute illness compatible with viral hepatitis.

Required Comments

Include the patient's Hepatitis B immunization history.

Additional Considerations

Document potential occupational exposure (e.g., health care worker).

5.26 HEPATITIS C, ACUTE

ICD-9: 070.51 Reference 1

Clinical Description

A viral disease normally presenting with insidious onset of anorexia, vague abdominal discomfort, nausea and vomiting, but progressing to jaundice less frequently than hepatitis B. Approximately 75% of acute cases are inapparent, although subsequent chronic liver disease occurs in > 60% of cases.

Laboratory Criteria for Diagnosis

One of the following:

- Antibodies to hepatitis C virus (anti-HCV) screening-test-positive with a signal to cut-off ratio predictive of a true positive as determined for the particular assay as defined by CDC (URL for the signal to cut-off ratios: http://www.cdc.gov/ncidod/diseases/hepatitis/c/sc_ratios.htm), or
- Hepatitis C Virus Recombinant Immunoblot Assay (HCV RIBA) positive, or
- Nucleic Acid Test (NAT) for HCV RNA positive.

AND, meets the following two criteria:

- IgM antibody to hepatitis A virus (IgM anti-HAV) negative, and
- IgM antibody to hepatitis B core antigen (IgM anti-HBc) negative.

Note: Some persons may not test positive for anti-HCV for 6-9 months after the onset of symptoms.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed and is not known to have chronic hepatitis C.

Required Comments

None.

Additional Considerations

Document potential occupational exposure (e.g., health care worker).

5.27 INFLUENZA

ICD-9: 487 Reference 8

INCLUDES: Cases among DoD personnel for whom vaccination is mandatory (such as service members, medical personnel, personnel afloat, etc) or case among any MHS beneficiary by a novel strain only.

Clinical Description

An acute viral disease of the respiratory tract characterized by fever, headache, myalgia, prostration, coryza, sore throat, and cough.

Clinical Case Definition

Sudden onset of fever ≥100.5°F accompanied by cough or sore throat in the absence of other diagnoses.

Laboratory Criteria for Diagnosis

Any of the following:

- Direct antigen detection by immunofluorescent antibody staining (direct or indirect) of respiratory specimens, or
- Antigen detection by immunohistochemical (IHC) staining for influenza viral antigens in respiratory tract tissue from autopsy specimens, or
- Influenza virus isolation in tissue cell culture from respiratory specimens, or
- Detection of influenza-specific RNA by RT-PCR testing of respiratory specimens, or
- Four-fold rise in influenza hemagglutination inhibition (HI) antibody titer in paired acute and convalescent sera.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Include the patient's influenza immunization history.

Additional Considerations

Include virus type (A or B) and, if available, subtype (e.g., H1N1). Document whether influenza virus is a new variant or subtype. New subtype influenza cases are always internationally reportable per International Health Regulations.

5.28 LEGIONELLOSIS

ICD-9: 482.84 Reference 1

Clinical Description

Legionellosis is associated with two clinically and epidemiologically distinct illnesses:

- Legionnaires Disease: Characterized by fever, myalgia, cough, and clinical or radiographic pneumonia.
- Pontiac Fever: A milder illness without pneumonia.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of any *Legionella* organism from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluids, or
- Detection of *Legionella pneumophila* serogroup 1 antigen in urine using validated reagents, or
- Fourfold or greater rise in specific serum antibody titer to *Legionella pneumophila* serogroup 1 using validated reagents.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Specify the form of illness (Pontiac fever or Legionnaires).

Additional Considerations

Document relevant travel/deployment history (Note: the incubation period of Legionnaire disease is usually 5-6 days, with a range of 2-10 days; Pontiac fever is usually 24-48 hours, with a range of 5-66 hours).

5.29 LEISHMANIASIS

ICD-9: 085.0 (Leishmaniasis, Visceral)
085.4 (Leishmaniasis, Cutaneous)
085.5 (Leishmaniasis, Mucocutaneous)
085.9 (Leishmaniasis, Unspecified)

References 8, 9, 14

Clinical Description

Leishmaniasis typically is a zoonosis with a variety of mammalian reservoir hosts, including canines and rodents. The vectors are female phlebotomine sand flies. Leishmaniasis is endemic from northern Argentina to southern Texas, in southern Europe, Asia, the Middle East, and Africa but not in Australia or Oceania.

Organisms of the genus *Leishmania* cause two major forms of disease:

1. **Cutaneous and Mucosal/Mucocutaneous:** Appearance of one or more lesions on uncovered parts of the body. The face, neck, arms and legs are the most common sites. A nodule appears at the site of inoculation, enlarges, and becomes an indolent ulcer. The sore remains in this stage for a variable time before healing, and leaves a depressed scar. Certain strains can disseminate and cause mucosal lesions in some individuals; these sequelae involve nasopharyngeal tissues and can be disfiguring.

2. **Visceral:** A chronic systemic illness with persistent irregular fever, hepatosplenomegaly, lymphadenopathy, pancytopenia and weight loss as its main symptoms.

Laboratory Criteria for Diagnosis

1. **Cutaneous and Mucosal/Mucocutaneous:** (any of the following)

   - Positive parasitology (stained smear or culture from the lesion), or
   - PCR-positive.

2. **Visceral:** (any of the following)

   - Positive parasitology (stained smears from bone marrow, spleen, liver, lymph node, blood or culture of the organism from a biopsy or aspirated material), or
   - Positive serology (rK39 assay).

Case Classification

1. **Cutaneous and Mucosal/Mucocutaneous:**

    - ***Confirmed:*** A case that has a clinically compatible lesion with parasitological confirmation of the diagnosis (positive smear or culture).

2. **Visceral:**

    - ***Confirmed:*** A case exhibiting clinical signs with serological and/or parasitological confirmation of leishmaniasis.

Required Comments

Document relevant travel/deployment history (Note: the incubation period of cutaneous/mucosal leishmaniasis is usually a week to many months; visceral leishmaniasis is generally 2-6 months, with a range of 10 days to years).

Additional Considerations

None.

5.30 LEPROSY

ICD-9: 030 Reference 1

Clinical Description

A chronic bacterial disease characterized by the involvement primarily of skin as well as peripheral nerves and the mucosa of the upper airway. Clinical forms of leprosy (or Hansen's disease) represent a spectrum reflecting the cellular immune response to *Mycobacterium leprae*. The following characteristics are typical of the major forms of the disease:

- *Tuberculoid:* One or a few well-demarcated, hypopigmented, and anesthetic skin lesions, frequently with active, spreading edges and a clearing center. Peripheral nerve swelling or thickening also may occur.
- *Lepromatous:* A number of erythematous papules and nodules or an infiltration of the face, hands, and feet with lesions in a bilateral and symmetrical distribution that progress to thickening of the skin.
- *Borderline (Dimorphous):* Skin lesions characteristic of both the tuberculoid and lepromatous forms.
- *Indeterminate:* Early lesions, usually hypopigmented macules, without developed tuberculoid or lepromatous features.

Laboratory Criteria for Diagnosis

Demonstration of acid-fast bacilli in skin or dermal nerve, obtained from the full-thickness skin biopsy of a lepromatous lesion.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Document the source and clinical form of the infection.

Additional Considerations

None.

5.31 LEPTOSPIROSIS

ICD-9: 100 References 5, 8

Clinical Description

An illness characterized by fever, headache, chills, myalgia, conjunctival suffusion, and less frequently by meningitis, rash, jaundice, or renal insufficiency.

Laboratory Criteria for Diagnosis

Any of the following:

- Fourfold or greater increase in Leptospira agglutination titer between acute and convalescent serum specimens obtained ≥ 2 weeks apart and studied at the same laboratory, or
- Demonstration of Leptospira in a clinical specimen by immunofluorescence, or
- Isolation and typing from blood or other clinical materials by culture of pathogenic leptospires, or
- Positive serology, preferably by the Microscopic Agglutination Test (MAT). Ideally, the panel of Leptospira strains used for antigens should be representative of the locally occurring strains, or
- Detection of leptospiral DNA by PCR.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Document relevant travel/deployment history (Note: the incubation period of leptospirosis is usually 10 days, with a range of 2-30 days) and fresh water exposure.

Additional Considerations

None.

5.32 LISTERIOSIS

ICD-9: 027.0 Reference 1

Clinical Description

In adults, invasive disease caused by *Listeria monocytogenes* manifests most commonly as meningitis or bacteremia; infection during pregnancy may result in fetal loss through miscarriage or stillbirth, or neonatal meningitis or bacteremia. Other manifestations can also be observed.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *L. monocytogenes* from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid) or in the case of miscarriage from placental or fetal tissue, or
- FDA-cleared Nucleic Acid Test (NAT).

Note: The usefulness of other laboratory methods such as fluorescent antibody testing or PCR to diagnose invasive listeriosis has not been established.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

For children ≤ 1 year, specify age in months.

5.33 LYME DISEASE

ICD-9: 088.81 Reference 1

Clinical Description

A systemic tick-borne disease with protean manifestations, including dermatologic, rheumatologic, neurologic, and cardiac abnormalities. The best clinical marker for the disease is erythema migrans (EM), the initial skin lesion that occurs in 60%-80% of patients.

Clinical Case Definition

Erythema Migrans: For purposes of surveillance, EM is defined as a skin lesion that typically begins as a red macule or papule and expands (over a period of days to weeks) to form a large round lesion, often with partial central clearing. A single primary lesion must reach ≥ 5 centimeters in size. Secondary lesions may also occur. Annular erythematous lesions occurring within several hours of a tick bite represent hypersensitivity reactions and do not qualify as EM.

For most patients, the expanding EM lesion is accompanied by other acute symptoms, particularly fatigue, fever, headache, mildly stiff neck, arthralgia, or myalgia. These symptoms are typically intermittent. The diagnosis of EM must be made by an experienced clinician. Laboratory confirmation is recommended for persons with no known exposure.

Late Manifestations: These include any of the following when an alternate explanation is not found:

- *Musculoskeletal System:* Recurrent brief attacks (weeks or months) of objective joint swelling in one or a few joints, sometimes followed by chronic arthritis in one or a few joints. Manifestations not considered as criteria for diagnosis include chronic progressive arthritis not preceded by brief attacks and chronic symmetrical polyarthritis. Additionally, arthralgia, myalgia, or fibromyalgia syndromes alone are not criteria for musculoskeletal involvement.
- *Nervous System:* Any of the following, alone or in combination: lymphocytic meningitis; cranial neuritis, particularly facial palsy (may be bilateral); radiculoneuropathy; or, rarely, encephalomyelitis. Encephalomyelitis must be confirmed by demonstration of antibody production against *B. burgdorferi* in the CSF, evidenced by a higher titer of antibody in CSF than in serum. Headache, fatigue, paresthesia, or mildly stiff neck alone is not a criterion for neurologic involvement.

- *Cardiovascular System:* Acute onset of high grade (2nd degree or 3rd degree) atrioventricular conduction defects that resolve in days to weeks and are sometimes associated with myocarditis. Palpitations, bradycardia, bundle branch block, or myocarditis alone is not a criterion for cardiovascular involvement.

Laboratory Criteria for Diagnosis

Any of the following:

- A positive culture for *B. burgdorferi*, or
- Two-tier serological tests, IFA, ELISA, then Western immunoblot, or
- Single-tier IgG immunoblot seropositivity interpreted using established criteria.

Case Classification

Confirmed: 1) A case that meets the clinical criteria for diagnosis of EM with a known exposure or 2) a case of EM with laboratory evidence of infection and without a known exposure or 3) a case with at least one late manifestation that has laboratory evidence of infection.

Exposure is defined as having been (≤ 30 days before onset of EM) in wooded, brushy, or grassy areas (i.e., potential tick habitats) in a county in which Lyme disease is endemic. A history of tick bite is not required.

Required Comments

None.

Additional Considerations

Document the patient's geographic location and likelihood of exposure to ticks in the preceding 1 year (e.g., during field exercises or other outdoor activities).

5.34 MALARIA (ALL)

ICD-9: 084.0 (Malaria, Falciparum)
084.1 (Malaria, Vivax)
084.2 (Malaria, Malariae)
084.3 (Malaria, Ovale)
084.6 (Malaria, Unspecified)

Reference 1

Clinical Description

Infections with the 4 human types of malaria can present symptoms sufficiently similar to make species differentiation impossible without laboratory studies.

Signs and symptoms are variable; however, most patients experience fever. In addition to fever, common associated symptoms include headache, back pain, chills, sweats, myalgia, nausea, vomiting, diarrhea and cough. Untreated *Plasmodium falciparum* infection can lead to coma, renal failure, pulmonary edema, and death. The diagnosis of malaria should be considered for any person who has these symptoms and who has traveled to an area in which malaria is endemic. Asymptomatic parasitemia can occur in long-term residents of areas in which malaria is endemic.

Laboratory Criteria for Diagnosis

Any of the following:

- Demonstration of malaria parasites in blood film, or
- Positive result on Binax Now test.

Note: Multiple smears/specimens taken over several days may be necessary for diagnosis.

Case Classification

Confirmed: A case that is laboratory-confirmed.

Note: Mixed-type infections should be reported separately (i.e., two reports for the same patient).

Required Comments

Document relevant travel/deployment history (Note: the incubation period of *P. falciparum* is usually 9-14 days; *P. vivax* and *P. ovale* 12-18 days; *P. malariae* 18-40 days; and all incubation periods may be

prolonged up to 2 months with suboptimal drug suppression). Also document prophylaxis regimen (if none, so state).

Additional Considerations

Specify species if known.

5.35 MEASLES

ICD-9: 055 Reference 1

Clinical Description

An acute, highly contagious viral rash illness with prodromal fever, conjunctivitis, coryza, and cough. Koplik spots on the buccal mucosa are also frequent. The rash typically appears on the 3rd to 5th day, beginning on the face and becoming generalized. Complications and secondary infections (otitis media, pneumonia, and encephalitis) are common.

Clinical Case Definition

All of the following:

- A generalized rash lasting ≥ 3 days, and
- A temperature ≥ 101.0 F (≥ 38.3 C), and
- Cough, coryza, or conjunctivitis.

Laboratory Criteria for Diagnosis

Any of the following:

- Positive serologic test for measles IgM antibody, or
- Significant rise (fourfold) in measles antibody level by any standard serologic assay, or
- Isolation of measles virus from a clinical specimen.

Case Classification

Confirmed: 1) A case that is laboratory-confirmed or 2) a case that meets the clinical case definition and is epidemiologically linked to a confirmed case.

Note: A laboratory-confirmed case does not need to meet the clinical case definition.

Required Comments

Include the patient's measles immunization history and document relevant travel/deployment history (Note: the incubation period of measles is usually 10 days, with a range of 7-18 days).

Additional Considerations

Specify the patient's age in months if < 1 year and any known measles contacts.

5.36 MENINGOCOCCAL DISEASE

ICD-9: 036.0 (Meningitis)
036.2 (Septicemia)

Reference 1

Clinical Description

Meningococcal disease typically presents in one of two forms: meningitis or septicemia. However, other manifestations might be observed.

- **Meningococcal Meningitis:** May follow an upper respiratory infection with the onset of fever, headache, vomiting, altered consciousness or other meningeal signs.
- **Meningococcal Septicemia:** May present gradually after a prodrome of cough, headache and sore throat progressing to spiking fever with chills, arthralgias, myalgias and acute prostration. A petechial rash may be present at the axillae, wrists and ankles, and may progress to a purpuric rash. Shock is not uncommon, and may lead to death. Fulminant meningococcemia may present abruptly with a petechial rash that progresses rapidly to purpura fulminans, shock, and death – often within hours.

Laboratory Criteria for Diagnosis

See below.

Case Classification

Suspected: (any of the following)

- Clinical purpura fulminans in the absence of a positive blood culture, or
- A clinically compatible case with gram negative diplococci from a normally sterile site (e.g., blood or CSF).

Probable: A clinically compatible case that has either:

- Evidence of *N. meningitidis* DNA using a validated polymerase chain reaction (PCR), obtained from a normally sterile site (e.g., blood or CSF), or
- Evidence of *N. meningitidis* antigen by immunohistochemistry (IHC) on formalin-fixed tissue or latex agglutination of CSF.

Confirmed: A clinically compatible case AND isolation of *Neisseria meningitidis* from a normally sterile site (e.g., blood or cerebrospinal fluid or, less commonly, synovial, pleural, or pericardial fluid) or skin scrapings of purpuric lesions.

Required Comments

Include the serogroup (A, B, C, Y, Z, W135) and include the patient's meningococcal immunization history. Indicate whether case is suspected, probable or confirmed.

Additional Considerations

Document relevant travel/deployment history (Note: the incubation period of meningococcal disease is commonly 3-4 days, with a range of 2-10 days) and any known exposures to other cases.

5.37 MUMPS

ICD-9: 072

Reference 1

Clinical Description

An acute viral disease characterized by fever, swelling and tenderness of one or more salivary glands. It can be complicated by orchitis, oophoritis, aseptic meningitis, encephalitis (rarely), mastitis, pancreatitis (usually mild) and in rare instances can lead to permanent nerve deafness.

Clinical Case Definition

An illness with acute onset of unilateral or bilateral tender, self-limited swelling of the parotid and or other salivary gland(s), lasting at least 2 days, and without other apparent cause.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of mumps virus from a clinical specimen, or
- Detection of mumps nucleic acid (e.g., standard or real time RT-PCR assays), or
- Positive serological test for mumps IgM antibody, or
- Demonstration of specific mumps antibody response in absence of recent vaccination, either a four-fold increase in IgG titer as measured by quantitative assays, or a seroconversion from negative to positive using a standard serologic assay of paired acute and convalescent serum specimens.

Case Classification

Confirmed: 1) A case that is laboratory-confirmed or 2) a clinically compatible case that is epidemiologically linked to a confirmed case.

Required Comments

Document the patient's MMR vaccination history and relevant travel/deployment history (note: the incubation period of mumps is about 16-18 days, with a range of 14-25 days).

Additional Considerations

Specify the patient's age in months if < 1 year and any known exposures to mumps.

5.38 NOROVIRUS

ICD-9: 008.63 References 9, 16

INCLUDES: Only single cases of disease should be reported under this category/event. Cases associated with an outbreak should be reported under the "Outbreak" category/event.

Clinical Description

An acute, highly contagious viral gastroenteritis characterized by vomiting, watery non-bloody diarrhea with abdominal cramps, and nausea. Vomiting is the most commonly reported symptom and occurs in more than 50% of cases. Low-grade fever also occasionally occurs. Dehydration is the most common complication, especially among the young and elderly, and may require medical attention. Symptoms usually last 24 to 60 hours. Recovery is usually complete and there is no evidence of any serious long-term sequelae. The incubation period for norovirus-associated gastroenteritis in humans is usually between 24 and 48 hours (median in outbreaks 33 to 36 hours), but cases can occur within 12 hours of exposure.

Laboratory Criteria for Diagnosis

Any of the following:

- Detection of virus in stool or vomitus by reverse transcriptase polymerase chain reaction (RT-PCR), or
- Fourfold or greater rise in antibody titer in paired sera, or
- Identification of virus in stool by electron microscopy (EM).

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

Document the source of infection (foodborne, person-to-person contact), general living/working conditions (e.g. training, deployed setting, in-garrison, dormitory residence, ship-board), day care atten-

dance/employment, healthcare employment, and/or food handler employment. Also report associated outbreak under "outbreak" report.

5.39 OUTBREAK

ICD-9: 136.9

Note: Report using the SSN of the Index (first) Case.

Description

An "outbreak" is defined as the occurrence of disease at a rate that is above the baseline/expected rate. The increase in the number of cases and rates that should trigger reporting will vary according to the characteristics of the host, agent, and environment. Likewise, the size and type of population exposed, susceptibility of the population to the agent, and the time and place of occurrence will influence the decision to report an outbreak. As a general rule, outbreaks that are of significant enough concern to cause an incident report to be sent to the medical activity Commander, Installation Commander, or Unit Commander should be reported. Also, a single case of a communicable disease long absent from a population or the first diagnosis of a disease not previously recognized requires immediate reporting and epidemiologic investigation. An unusual level of activity of any illness that may spread or appears to spread rapidly from one person to another or that may be caused by a common exposure should be reported, even if no specific disease has yet been diagnosed

Laboratory Criteria for Diagnosis

An outbreak may be considered to be laboratory confirmed when two or more cases have the same laboratory diagnosis of the etiologic agent.

Case Classification

Varies.

Required Comments

List location, source of outbreak, likely etiological agent, number affected, group affiliation (e.g., military unit, boy scouts), time course, and actions taken to mitigate outbreak.

Additional Considerations

None.

5.40 PERTUSSIS

ICD-9: 033 Reference 1

Clinical Description

An acute bacterial disease that typically begins as a "cold" with gradually worsening cough. The cough becomes paroxysmal, frequently with a characteristic "whooping" sound heard on inspiration, and may be followed by vomiting. Untreated, the illness lasts 1-2 months and may be complicated by pneumonia or neurologic sequelae.

Clinical Case Definition

A cough illness lasting ≥ 2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop", or post-tussive vomiting, without other apparent cause (as reported by a health professional).

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *Bordetella pertussis* from a clinical specimen, or
- Positive DFA, or
- Positive polymerase chain reaction (PCR) for *B. pertussis.*

Case Classification

Confirmed: 1) A case that is laboratory confirmed or 2) a clinically compatible case that is epidemiologically linked to a laboratory-confirmed case.

Required Comments

Include the patient's pertussis immunization history.

Additional Considerations

Specify the patient's age in months if < 1 year and any pertussis contacts.

5.41 PLAGUE

ICD-9: 020 References 1, 6, 7

Clinical Description

Plague is transmitted to humans by fleas or by direct exposure to infected tissues or respiratory droplets. The disease is characterized by fever, chills, headache, malaise, prostration, and leukocytosis, and has four major clinical forms:

- *Bubonic:* Lymphadenitis in the lymph nodes that drain the region of the infected flea bite. Most often (> 90%) inguinal; alternatively cervical or axillary.
- *Pneumonic:* May be primary or secondary. Primary pneumonic plague is acquired from person to person transmission by droplet spread. Secondary pneumonic plague arises as a complication of bubonic plague.
- *Septicemic:* May be a complication of any of the other forms of plague, or may be the presenting syndrome.
- *Pharyngeal:* Results from exposure to infectious droplets, usually from a patient with pneumonic plague.

Laboratory Criteria for Diagnosis

Laboratory presumptive: (any of the following)

- Elevated serum antibody titer(s) to *Yersinia pestis* fraction 1 (F1) antigen (without documented fourfold or greater change) in a patient with no history of plague vaccination, or
- Detection of F1 antigen in a clinical specimen by fluorescent assay.

Laboratory confirmed: (any of the following):

- Isolation of *Y. pestis* from a clinical specimen (buboes, blood, CSF or Sputum), or
- Passive hemagglutination test (PHA test) demonstrating fourfold or greater change in serum antibody titer specific for *Y. pestis* F1 antigen (HI test) in paired sera, or
- Positive FDA approved PCR test.

Case Classification

Suspected: A clinically compatible case without presumptive or confirmatory laboratory results.

Probable: A clinically compatible case with presumptive laboratory results.

Confirmed: A clinically compatible case with confirmatory laboratory results.

Required Comments

Indicate whether case is suspected, probable or confirmed. Document relevant travel/deployment history (Note: the incubation period of plague is usually 1-7 days but may be longer in those immunized who develop illness) including recent field exercises or outdoor activity where infected fleas might have been encountered.

Additional Considerations

Document the clinical form of the infection. Plague cases may be internationally reportable per International Health Regulations.

5.42 POLIOMYELITIS

ICD-9: 045.0 Reference 1

Clinical Description

A viral infection spread through fecal material, oral secretions, some aerosols and fomites that typically is asymptomatic or causes mild febrile disease. Poliovirus infections occasionally cause aseptic meningitis and one out of 200 infections from poliovirus type 1 results in paralytic poliomyelitis, characterized by acute onset of flaccid paralysis that is typically asymmetric and associated with a prodromal fever. The maximum extent of paralysis typically occurs within 3-4 days and any paralysis present after 60 days is likely to be permanent.

Clinical Case Definition

Acute onset of flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs, without other apparent cause, and without sensory or cognitive loss.

Laboratory Criteria for Diagnosis

Poliovirus isolate identified in an appropriate clinical specimen (e.g., stool, cerebrospinal fluid, oropharyngeal secretions), with confirmatory typing and sequencing performed by the CDC Poliovirus Laboratory, as needed.

Case Classification

Probable: A clinically compatible case without lab confirmation.

Confirmed: A case that is laboratory-confirmed.

Required Comments

Include the patient's poliomyelitis immunization history (OPV or IPV). Indicate whether case is probable or confirmed and whether patient has acute flaccid paralysis or not. Document relevant travel/deployment history (Note: the incubation period of poliomyelitis is commonly 7-14 days, with a range of 3-35 days).

Additional Considerations

Document the recent vaccination history (OPV or IPV) and relevant travel/deployment history of close contacts. Although inactivated poli-

ovirus vaccine (IPV) replaced oral poliovirus vaccine (OPV) in the U.S., OPV is still widely used in most countries. Vaccine-derived poliovirus (VDPV) may revert to a wild phenotype and has caused polio infections and outbreaks of paralytic poliomyelitis in several countries that no longer use OPV.

Wild type polio cases are always internationally reportable per International Health Regulations.

5.43 Q FEVER

ICD-9: 083.0 References 1, 6, 7

Clinical Description

An acute febrile rickettisal disease; exposure is usually via aerosol and may be unknown (especially for chronic infection). Often includes the presence of goats, sheep, or other livestock, especially during periods of parturition. Direct contact with animals is not required, and variable incubation periods may be dose dependent.

1. **Acute Q Fever**: Acute fever usually accompanied by rigors, myalgia, malaise, and a severe retrobulbar headache. Fatigue, nightsweats, dyspnea, confusion, nausea, diarrhea, abdominal pain, vomiting, non-productive cough, and chest pain have also been reported. Severe disease can include acute hepatitis, atypical pneumonia with abnormal radiograph, and meningoencephalitis. Pregnant women are at risk for fetal death and abortion. Clinical laboratory findings may include elevated liver enzyme levels, leukocytosis, and thrombocytopenia. Asymptomatic infections may also occur.
2. **Chronic Q Fever:** Infection that persists for more than 6 months. Potentially fatal endocarditis may evolve months to years after acute infection, particularly in persons with underlying valvular disease. Infections of aneurysms and vascular prostheses have been reported. Immunocompromised individuals are particularly susceptible. Rare cases of chronic hepatitis without endocarditis, osteomyelitis, osteoarthritis, and pneumonitis have been described.

Clinical Case Definition

1. **Acute Q Fever**: Acute fever and one or more of the following: rigors, severe retrobulbar headache, acute hepatitis, pneumonia, or elevated liver enzyme levels.
2. **Chronic Q Fever**: Newly recognized, culture-negative endocarditis, particularly in a patient with previous valvulopathy or compromised immune system, suspected infection of a vascular aneurysm or vascular prosthesis, or chronic hepatitis, osteomyelitis, osteoarthritis, or pneumonitis in the absence of other known etiology.

Laboratory Criteria for Diagnosis

1. **Acute Q Fever**:

   Laboratory confirmed: (any of the following)

   - Serological evidence of a fourfold change in immunoglobulin G (IgG)-specific antibody titer to *C. burnetii* phase II antigen by indirect immunofluorescence assay (IFA) between paired serum samples, (CDC suggests one taken during the first week of illness and a second 3-6 weeks later, antibody titers to phase I antigen may be elevated or rise as well), or
   - Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay (only in cases of recent infection), or
   - Demonstration of *C. burnetii* in a clinical specimen by immunohistochemical methods (IHC), or
   - Isolation of *C. burnetii* from a clinical specimen by culture.

   Laboratory supportive: (any of the following)

   - Has a single supportive IFA IgG titer of ≥ 1:128 to phase II antigen (phase I titers may be elevated as well), or
   - Has serologic evidence of elevated IgG or IgM antibody reactive with C. burnetii antigen by ELISA, dot-ELISA, or latex agglutination.

     Note: For acute testing, CDC uses in-house IFA IgG testing (cutoff of ≥ 1:128), preferring simultaneous testing of paired specimens, and does not use IgM results for routine diagnostic testing.

2. **Chronic Q Fever**:

   Laboratory confirmed: (any of the following)

   - Serological evidence of IgG antibody to C. burnetii phase I antigen ≥ 1:800 by IFA (while phase II IgG titer will be elevated as well; phase I titer is higher than the phase II titer), or
   - Detection of C. burnetii DNA in a clinical specimen via amplification of a specific target by PCR assay, or

- Demonstration of C. burnetii antigen in a clinical specimen by IHC, or
- Isolation of C. burnetii from a clinical specimen by culture.

Laboratory supportive: (any of the following)

- Has an antibody titer to C. burnetii phase I IgG antigen ≥ 1:128 and < 1:800 by IFA.

  Note: Samples from suspected chronic patients should be evaluated for IgG titers to both phase I and phase II antigens. Current commercially available ELISA tests (which test only for phase 2) are not quantitative, cannot be used to evaluate changes in antibody titer, and hence are not useful for serological confirmation. IgM tests are not strongly supported for use in serodiagnosis of acute disease, as the response may not be specific for the agent and the IgM response may be persistent. Complement fixation tests and other older test methods are neither readily available nor commonly used.

  Serologic test results must be interpreted with caution, because baseline antibodies acquired as a result of historical exposure to Q fever may exist, especially in rural and farming areas.

Case Classification

1. **Acute Q Fever**:
   - ***Probable:*** A clinically compatible case of acute illness (meets clinical evidence for acute Q fever) that has laboratory supportive results for past or present acute disease (antibody to Phase II antigen) but is not laboratory-confirmed.
   - ***Confirmed:*** 1) A clinically compatible case that is laboratory-confirmed case or 2) a clinically compatible case that is epidemiologically linked to a laboratory-confirmed case.
2. **Chronic Q Fever**:
   - ***Probable:*** A clinically compatible case of chronic illness (meets clinical evidence for chronic Q fever) that has laboratory supportive results for past or present chronic infection (antibody to Phase I antigen).
   - ***Confirmed:*** A clinically compatible case of chronic illness that is laboratory confirmed for chronic infection.

Required Comments

Indicate whether case is acute or chronic and probable or confirmed.

Additional Considerations

Document the source of infection, potential exposure to infected animals, and potential occupational exposure (e.g., veterinarian).

5.44 RABIES, HUMAN

ICD-9: 071 Reference 1

EXCLUDES: Animal bites requiring prophylaxis

Clinical Description

Rabies is an acute encephalomyelitis that almost always progresses to coma or death within 10 days after the first symptom.

Laboratory Criteria for Diagnosis

Any of the following:

- Detection by direct fluorescent antibody of viral antigens in a clinical specimen (preferably from the brain or the nerves surrounding hair follicles in the nape of the neck), or
- Isolation (in cell culture or in a laboratory animal) of rabies virus from saliva, cerebrospinal fluid (CSF), or central nervous system tissue, or
- Identification of a rabies-neutralizing antibody titer ≥ 5 (complete neutralization) in the serum or CSF of an unvaccinated person.

Note: Laboratory confirmation by all of the above methods is strongly recommended.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

Document history of animal bites or presence at probable locations of exposure (e.g., bat cave), and potential occupational exposure (e.g., veterinarian, animal control officer). Include the patient's relevant immunization history and type of rabies identified (implicated species).

5.45 RELAPSING FEVER

ICD-9: 087 Reference 15

Clinical Description

An arthropod-borne spirochetal disease characterized by a fever lasting 2-9 days that alternates with afebrile periods of 2-4 days. The total number of relapses varies from a single incident to over ten. Louse-borne disease lasts 13-16 days and the tick-borne usually lasts longer. Transitory petechial rashes are common during the initial febrile period.

Laboratory Criteria for Diagnosis

Any of the following:

- Demonstration of the infectious agent in darkfield preparations of fresh blood or stained thick or thin films, or
- Intraperitoneal inoculation of laboratory rats or mice with blood taken during the febrile period, or
- Isolation of organism through blood culture.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Document relevant travel/deployment history (Note: the incubation period of relapsing fever is usually 8 days, with a range of 2-15 days), with particular attention to the geographic locations of field exercises and outdoor activities.

Additional Considerations

Document exposure to lice or ticks.

5.46 RHEUMATIC FEVER (ACUTE)

ICD-9: 390 Reference 12

Clinical Description

Rheumatic fever is a delayed sequel to pharyngeal infection with Group A beta hemolytic streptococci. Usual acute manifestations are migratory polyarthritis, fever and carditis. Other typical manifestations are Sydenham's chorea, subcutaneous nodules and erythema marginatum.

Clinical Case Definition

Rheumatic fever is generally defined by the Jones criteria. These stipulate that the presence of either two major manifestations or one major and two minor manifestations, with evidence of a preceding streptococcal infection, is considered diagnostic of rheumatic fever.

- Major manifestations: Carditis, polyarthritis, chorea, erythema marginatum, subcutaneous nodules.
- Minor manifestations: Fever, arthralgia, previous rheumatic disease, elevated ESR or CRP, prolonged EKG P-R interval.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of Group A streptococcus from a throat culture, or
- Nucleic Acid Test-positive (Gen-Probe), or
- Positive antihyaluronidase (AH), anti-DNAse B, anti-NADase or anti-streptokinase (ASK), or
- Positive anti-streptolysin O test (ASO).

Case Classification

Confirmed: An illness characterized by a) two major manifestations or one major manifestation and two minor manifestations and b) supporting evidence of preceding group A streptococcal infection.

Note: Confirmation is clinical, based upon the presence of the Jones criteria as defined above with a history of preceding scarlet fever or other streptococcal infection, untreated pharyngitis, or an increased ASO titer. Laboratory testing alone is insufficient to make a diagnosis.

Required Comments

None.

Additional Considerations

Document relevant training/travel/deployment history (Note: the incubation period of acute rheumatic fever is usually 19 days).

5.47 RIFT VALLEY FEVER

ICD-9: 066.3 Reference 15

Clinical Description

A primarily mosquito-borne viral disease characterized by fever, chills, headache, myalgia, and arthralgia. May include retinitis, encephalitis and hemorrhage. May have biphasic fever.

Laboratory Criteria for Diagnosis

Any of the following:

- Viral isolation, or
- Plaque reduction neutralization assay, or
- Virus detection by antigen detection tests or RT-PCR), or
- Presence of specific IgM antibodies or fourfold or greater rise in specific IgG antibody titer.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Document relevant travel/deployment history (Note: the incubation period of rift valley fever is usually 3-12 days) outside the U.S.

Additional Considerations

Document relevant occupational exposure (lab/abbatoir worker).

5.48 ROCKY MOUNTAIN SPOTTED FEVER

ICD-9: 082.0 Reference 1

Clinical Description

A tick-borne febrile illness characterized by an acute onset of myalgia, headache, and a petechial rash that is present on the palms and soles in two-thirds of cases.

Clinical Case Definition

Any reported fever and one or more of the following: rash, headache, myalgia, anemia, thrombocytopenia, or any hepatic transaminase elevation.

Laboratory Criteria for Diagnosis

Laboratory confirmed: (any of the following)

- Serological evidence of a fourfold change in immunoglobulin G (IgG)-specific antibody titer reactive with *Rickettsia rickettsii* antigen by indirect IFA between paired serum specimens (one taken in the first week of illness and a second 2-4 weeks later), or
- Detection of *R. rickettsii* DNA in a clinical specimen via amplification of a specific target by PCR assay, or
- Demonstration of spotted fever group antigen in a biopsy or autopsy specimen by IHC, or
- Isolation of *R. rickettsii* from a clinical specimen in cell culture.

Laboratory supportive:

- Has serologic evidence of elevated IgG or IgM antibody reactive with R. rickettsii antigen by IFA, enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or latex agglutination.

Note: Acute illness is best detected by polymerase chain reaction (PCR) and immunohistochemical methods (IHC) in skin biopsy specimens, and occasionally by PCR in appropriate whole blood specimens taken during the first week of illness, prior to antibiotic treatment. Serology can also be employed for detection, however an antibody response may not be detectable in initial samples, and paired acute and convalescent samples are essential for confirmation. Current commer-

cially available ELISA tests are not quantitative, cannot be used to evaluate changes in antibody titer, and hence are not useful for serological confirmation. IgM tests are not strongly supported for use in serodiagnosis of acute disease, as the response may not be specific for the agent and the IgM response may be persistent. CDC uses in-house IFA IgG testing (cutoff ≥ 1:64), preferring simultaneous testing of paired specimens, and does not use IgM results for routine diagnostic testing.

Case Classification

Probable: A clinically compatible case that has supportive laboratory results.

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Document whether case is probable or confirmed.

Additional Considerations

Document the patient's geographic location and likelihood of exposure to ticks in the preceding 2 weeks (e.g., during field exercises or other outdoor activities). Exposure is defined as having been in potential tick habitats within the past 14 days before onset of symptoms. A history of a tick bite is not required.

5.49 RUBELLA

ICD-9: 056 Reference 1

Clinical Description

A mild febrile viral rash illness. Clinically, this is usually indistinguishable from febrile rash illness due to measles, dengue, parvovirus B19, human herpes virus 6, Coxsackie virus, Echovirus, adenovirus or scarlet fever. Children usually present few or no constitutional symptoms, but adults may experience a 1-5 day prodrome of low grade fever, headache, malaise, mild coryza and conjunctivitis. Rash is often absent in adults. Post-auricular, occipital, and posterior cervical lymphadenopathy is characteristic and precedes the rash by up to 10 days. Complications include arthritis, encephalitis, and thrombocytopenia and commonly occur primarily in adults. Congenital rubella syndrome occurs in up to 90% of infants born to pregnant women who acquire rubella during the first trimester of pregnancy.

Clinical Case Definition

All of the following:

- Acute onset of generalized maculopapular rash, and
- Temperature > 99.0° F; and
- Arthralgia/arthritis, lymphadenopathy, or conjunctivitis.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of rubella virus, or
- Significant rise between acute- and convalescent-phase titers in serum rubella immunoglobulin G antibody level by any standard serologic assay, or
- Positive serologic test for rubella immunoglobulin M (IgM) antibody.

Note: Serum rubella IgM test results that are false positives have been reported in persons with other viral infections (e.g., acute infection with Epstein-Barr virus, recent cytomegalovirus infection, and parvovirus infection) or in the presence of rheumatoid factor.

Case Classification

Confirmed: 1) A clinically compatible case that is laboratory-confirmed or 2) a clinically compatible case that is epidemiologically linked to a laboratory-confirmed case.

Required Comments

Include the patient's rubella immunization history and whether the case is congenital rubella syndrome. Document relevant travel/deployment history (Note: the incubation period of rubella is usually 14-17 days, with a range of 14-21 days).

Additional Considerations

Specify the patient's age in months if < 1 year, whether patient is pregnant, and location/nature of exposure.

5.50 SALMONELLOSIS

ICD-9: 003 Reference 1

EXCLUDES: *Salmonella typhi* and Salmonella *paratyphi.*

Clinical Description

An illness of variable severity commonly manifested by diarrhea, abdominal pain, nausea, and sometimes vomiting. Asymptomatic infections may occur, and the organism may cause extraintestinal infections.

Laboratory Criteria for Diagnosis

Isolation of *Salmonella* sp. from a clinical specimen

Case Classification

Confirmed: A case that is laboratory-confirmed.

Required Comments

When available, O and H antigen serotype characterization should be reported.

Additional Considerations

Document the source of exposure (Note: the incubation period of salmonellosis is usually 12-36 hours, with a range of 6-72 hours).

5.51 SCHISTOSOMIASIS

ICD-9: 120 Reference 8

Clinical Description

Schistosomiasis is a trematode disease caused by *Schistosoma* sp. It is the second most prevalent tropical disease (following malaria) and a leading cause of severe morbidity in large parts of Africa, Asia and South America. There are three primary varieties that cause disease in humans: *S. mansoni, S. haematobium* and *S. japonicum.* These organisms produce two clinical forms of the disease:

- **Urinary Schistosomiasis** gives rise to dysuria, frequency, and hematuria at the end of urination, and is usually caused by *S. haematobium.*
- **Intestinal Schistosomiasis** is normally accompanied by diarrhea, abdominal pain, and hepatosplenomegaly, and is caused by *S. mansoni* and *S. japonicum.*

Laboratory Criteria for Diagnosis

Demonstration of eggs in stool, urine, or biopsy specimens.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Specify the form of schistosomiasis and document relevant travel/deployment history (Note: the incubation period of schistosomiasis is usually 2-6 weeks).

Additional Considerations

Document relevant exposure to fresh water (i.e., wading, swimming, etc.) in an endemic area.

5.52 SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

ICD-9: 079.82

References 1, 15

Clinical Description

A severe respiratory infection often with associated gastrointestinal symptoms caused by a coronavirus. SARS typically presents with malaise, myalgia, and fever, quickly followed followed by respiratory symptoms including shortness of breath and cough.

Clinical Case Definition

- Early illness: Presence of two or more of the following features: fever (might be subjective), chills, rigors, myalgia, headache, diarrhea, sore throat, rhinorrhea.
- Mild-to-moderate respiratory illness:
  - Temperature of >100.4° F (>38° C), and
  - One or more clinical findings of lower respiratory illness (e.g., cough, shortness of breath, difficulty breathing)
- Severe respiratory illness:
  - Temperature of >100.4° F (>38° C), and
  - One or more clinical findings of lower respiratory illness (e.g., cough, shortness of breath, difficulty breathing), and
  - One or more of the following findings:
    - Radiographic evidence of pneumonia, or
    - Acute respiratory distress syndrome, or
    - Autopsy findings consistent with pneumonia or acute respiratory distress syndrome without an identifiable cause

Epidemiologic Criteria

Possible exposure: One or more of the following exposures in the 10 days before onset of symptoms:

- Travel to a foreign or domestic location with documented or suspected recent transmission of SARS-CoV2, or
- Close contact with a person with mild-to-moderate or severe respiratory illness and with history of travel in the 10 days before onset of symptoms to a foreign or domestic location with documented or suspected recent transmission of SARS-CoV2

Likely exposure: One or more of the following exposures in the 10 days before onset of symptoms:

- Close contact with a confirmed case of SARS-CoV disease or
- Close contact with a person with mild-moderate or severe respiratory illness for whom a chain of transmission can be linked to a confirmed case of SARS-CoV disease in the 10 days before onset of symptoms

Laboratory Criteria for Diagnosis

Any of the following:

- Detection by a validated test, with confirmation in a reference laboratory: (any of the following)
  - Serum antibodies to SARS-CoV in a single serum specimen, or
  - A four-fold or greater increase in SARS-CoV antibody titer between acute- and convalescent-phase serum specimens tested in parallel, or
  - Negative SARS-CoV antibody test result on acute-phase serum and positive SARS-CoV antibody test result on convalescent-phase serum tested in parallel

- Isolation in cell culture of SARS-CoV from a clinical specimen, with confirmation using a test validated by CDC, or

- Detection of SARS-CoV RNA by RT-PCR validated by CDC, with confirmation in a reference laboratory: (any of the following)
  - Two clinical specimens from different sources, or
  - Two clinical specimens collected from the same source on two different days.

Case Classification

Suspected: (SARS report under investigation)

- Patients from a high risk group for SARS infection with severe illness compatible with SARS without a clear epidemiological link, or
- Patients with mild to moderate or severe illness and that meet the epidemiologic criteria for possible exposure, or
- Patients who meet the clinical criteria for early or mild-moderate illness and the epidemiologic criteria for likely exposure to SARS-CoV.

Probable: A case that meets the clinical criteria for severe respiratory illness and the epidemiologic criteria for likely exposure to SARS-CoV

Confirmed: A clinically compatible case (i.e., early, mild-to-moderate, or severe) that is laboratory-confirmed

Required Comments

Indicate whether case is suspected, probable, or confirmed. Document relevant travel/deployment history (Note: the incubation period of SARS-CoV is usually 3-10 days).

Additional Considerations

Immediate isolation and notification of public health authorities must occur. SARS-CoV cases are always internationally reportable per International Health Regulations.

5.53 SHIGELLOSIS

ICD-9: 004 Reference 1

Clinical Description

An illness of variable severity characterized by diarrhea, fever, nausea, cramps, and tenesmus. Asymptomatic infections may occur.

Laboratory Criteria for Diagnosis

Isolation of *Shigella* sp. from a clinical specimen.

Case Classification

Confirmed: A case is laboratory-confirmed.

Both asymptomatic infections and infections at sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.

Required Comments

When available, O antigen serotype characterization should be reported.

Additional Considerations

Document relevant travel/deployment history (Note: the incubation period of shigellosis is usually 1-3 days, with a range of 12-96 hours and up to 1 week), the source of infection (if known) and day care attendance/employment.

5.54 SMALLPOX

ICD-9: 050 References 1, 6, 7

EXCLUDES: Vaccinations and Vaccine adverse events (report under "Vaccine Adverse Event" category)

Clinical Description

Smallpox is a severe contagious viral rash illness that was eradicated in 1977. High fever, headache, myalgia, abdominal pain and vomiting, and occasionally a transient blotchy erythematous rash herald the onset. After 3-4 days, the patient defervesces and appears to improve. At this time, painful mouth lesions occur on the buccal mucosa, followed by macules on the face and forearms that progress to papules. The rash spreads from the distal extremities to the trunk, and includes the palms and soles. After 3-4 days, the papules become vesicular and then pustular. The rash typically leaves scarring after healing.

Clinical Case Definition

An illness with acute onset of fever $\geq$ 101°F followed by a rash characterized by firm, deep seated vesicles or pustules in the same stage of development without other apparent cause. Clinically consistent cases are those presentations of smallpox that do not meet this classical clinical case definition: hemorrhagic type, flat type, and *variola sine eruptione.*

Laboratory Criteria for Diagnosis

Any of the following:

- PCR identification of variola DNA in a clinical specimen, or
- Isolation of smallpox (variola) virus from a clinical specimen (Level D laboratory only; confirmed by variola PCR).

Note: Indications for laboratory testing of patients with suspected smallpox should be followed as described in detail in Guide A of the CDC Smallpox Response Plan

(URL: http://www.bt.cdc.gov/agent/smallpox/response-plan/index.asp). *Laboratory diagnostic testing for variola virus should be conducted in Level C or D labs only. PCR diagnosis can be performed by USAMRIID or CDC.*

Case Classification

Suspected: A case with a generalized, acute vesicular or pustular rash illness with fever preceding development of rash by 1-4 days.

Probable: 1) A clinically compatible case or 2) a clinically consistent case that does not meet the clinical case definition and is epidemiologically linked to a confirmed case of smallpox.

Confirmed: 1) A case that is laboratory confirmed or 2) a clinically compatible case that is epidemiologically linked to a laboratory-confirmed case.

Note: A case may be excluded as a suspect or probable smallpox case if an alternative diagnosis fully explains the illness or appropriate clinical specimens are negative for laboratory criteria for smallpox.

Required Comments

Detailed history of possible exposures is required. Indicate whether case is suspected, probable or confirmed.

Additional Considerations

Smallpox cases are always internationally reportable per International Health Regulations.

5.55 STREPTOCOCCUS, GROUP A, INVASIVE

ICD-9: 038.0 Reference 1

EXCLUDES: Group A Streptococcal Pharyngitis, Rheumatic Fever, Streptococcal Toxic Shock Syndrome

Clinical Description

Invasive Group A streptococcal infections may manifest as any of various clinical syndromes, including pneumonia, bacteremia in association with cutaneous infection (e.g., cellulitis, erysipelas, or infection of a surgical or nonsurgical wound), deep soft-tissue infection (e.g., myositis or necrotizing fasciitis), meningitis, peritonitis, osteomyelitis, septic arthritis, postpartum sepsis (i.e., puerperal fever, endometritis), neonatal sepsis, and nonfocal bacteremia.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of Group A streptococcus (*Streptococcus pyogenes*) by culture from a normally sterile site (e.g., blood or cerebrospinal fluid, or, less commonly, joint, pleural, or pericardial fluid) or
- Nucleic acid test-positive on a sample from a normally sterile site.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

Specify the type of clinical presentation and note if nosocomial.

5.56 SYPHILIS

ICD-9: 090 (Syphilis, Congenital)
091 (Syphilis, Primary/ Secondary)
095 (Syphilis, Tertiary)
096 (Syphilis, Latent)

References 1, 17

Clinical Description

A complex disease caused by the bacteria *Treponema pallidum* that has a highly variable clinical course. The stage of syphilis is determined by the clinical signs and generally by the time elapsed since primary infection. Syphilis can be divided into the following classifications:

- **Primary:** A stage of infection characterized by one or more chancres (ulcers); chancres might differ considerably in clinical appearance.
- **Secondary:** A stage characterized by localized or diffuse muco-cutaneous lesions, often with generalized lymphadenopathy. The primary chancre may still be present.
- **Latent (early or late):** A stage in which organisms persist in the body of the infected person without causing symptoms or signs. Latent syphilis is subdivided into early, late, and un-known categories based on the duration of infection.
- **Tertiary:** Latent syphilis of long duration, usually past one year, that subsequently becomes clinical. Clinical signs depend upon the degree and organ system affected, but may be cardiac, neuro-logic, ophthalmic, auditory and gummatous in nature.
- **Congenital:** A condition caused by infection in utero. A wide spectrum of severity exists; only severe cases are clinically ap-parent at birth. An infant or child < 2 years may have signs such as hepatosplenomegaly, rash, condyloma lata, snuffles, jaundice, pseudoparalysis, anemia, or edema (from nephrotic syndrome and/or malnutrition). An older child may have syphilitic stigma-ta such as interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson teeth, saddle nose, rhagades, or Clutton joints.

Laboratory Criteria for Diagnosis

Any of the following:

- Demonstration of *T. pallidum* in clinical specimens by dark-field microscopy, direct fluorescent antibody (DFA-TP), or equivalent methods, or

- A positive non-treponemal test (RPR or VDRL) AND a positive treponemal test (FTA-ABS or MHA-TP).

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Note: Neurosyphilis should be reported by the stage of syphilis in which it presents (usually tertiary).

Required Comments

None.

Additional Considerations

Note if neurosyphilis is present.

5.57 TETANUS

ICD-9: 037 Reference 1

Clinical Description

Acute onset of hypertonia and/or painful muscular contractions (usually of the muscles of the jaw and neck) and generalized muscle spasms without other apparent medical cause.

Laboratory Criteria for Diagnosis

Diagnosis is made clinically from history and clinical signs. There is no detectable antibody response and the organism is rarely recovered from the site of infection.

Case Classification

Confirmed: A clinically compatible case reported by a health-care professional.

Required Comments

Include the patient's tetanus immunization history.

Additional Considerations

Include the patient's age in months if <1 year.

5.58 TOXIC SHOCK SYNDROME

ICD-9: 040.82 Reference 1

INCLUDES: Cases caused by both Staphylococcus aureus and Streptococcus pyogenes.

Clinical Description

1. **Staphylococcal Toxic Shock Syndrome (TSS):** A severe illness characterized by high fever, vomiting, profuse watery diarrhea and myalgia, followed by hypotension and shock. Often accompanied by a "sunburn-like" rash. Frequently, desquamation of the palms and soles occurs 1-2 weeks after the onset. The causative agent is *S. aureus*, although the organism is frequently not recovered.

2. **Streptococcal Toxic Shock Syndrome (STSS):** A severe illness with signs and symptoms as above for TSS. Associated with invasive or noninvasive Group A streptococcal (*Streptococcus pyogenes*) infection. STSS may occur with infection at any site but most often occurs in association with infection of a cutaneous lesion. Signs of toxicity and a rapidly progressive clinical course are characteristic, and the case-fatality rate may exceed 50%.

Clinical Case Definition

1. **Staphylococcal Toxic Shock Syndrome:** An illness with all 5 of the following clinical manifestations:
    - *Fever*: Temperature ≥ 102.0° F, and
    - *Rash*: Diffuse macular erythroderma, and
    - *Desquamation*: 1-2 weeks after onset of illness, particularly on the palms and soles, and
    - *Hypotension*: Systolic blood pressure ≤ 90 mm Hg for adults or less than fifth percentile by age for children aged less than 16 years; orthostatic drop in diastolic blood pressure ≥ 15 mm Hg from lying to sitting, orthostatic syncope, or orthostatic dizziness, and
    - *Multisystem involvement*: (≥ 3 of the following)
    - *Gastrointestinal*: vomiting or diarrhea at onset of illness
    - *Muscular*: severe myalgia or creatine phosphokinase level at least twice the upper limit of normal

- *Mucous membrane*: vaginal, oropharyngeal, or conjunctival hyperemia
- *Renal*: blood urea nitrogen or creatinine at least twice the upper limit of normal for laboratory or urinary sediment with pyuria (≥ 5 leukocytes per high-power field) in the absence of urinary tract infection
- *Hepatic*: total bilirubin, alanine aminotransferase enzyme, or aspirate aminotransferase enzyme levels at least twice the upper limit of normal for laboratory
- *Hermatologic*: platelets less than 100,000/mm3
- *Central nervous system*: disorientation or alterations in consciousness without focal neurologic signs when fever and hypotension are absent

2. **Streptococcal Toxic Shock Syndrome (STSS):** An illness with the following clinical manifestations occurring within the first 48 hours of hospitalization or, for a nosocomial case, within the first 48 hours of illness:
   - **Hypotension:** defined by a systolic blood pressure ≤ 90 mm Hg for adults or less than the fifth percentile by age for children aged < 16 years.
   - **Multi-organ involvement:** (≥ 2 of the following)

   - *Renal impairment*: Creatinine ≥ 2 mg/dL for adults or ≥ twice the upper limit of normal for age. In patient with preexisting renal disease, a greater than twofold elevation over the baseline level.
   - *Coagulopathy*: Platelets ≤ 100,000/mm3 or disseminated intravascular coagulation, defined by prolonged clotting times, low fibrinogen level, and the presence of fibrin degradation products.
   - *Liver involvement*: Alanine aminotransferase, aspartate aminotransferase, or total bilirubin levels ≥ twice the upper limit of normal for the patient's age. In patients with preexisting liver disease, a greater than twofold increase over the baseline level.
   - *Acute respiratory distress syndrome*: defined by acute onset of diffuse pulmonary infiltrates and hypoxemia in the absence of cardiac failure or by evidence of diffuse capillary leak manifested by acute onset of generalized edema, or pleural or peritoneal effusions with hypoalbuminemia.

- *Erythematous macular rash:* a generalized rash that may desquamate.
- *Soft-tissue necrosis:* includes necrotizing fasciitis or myositis, or gangrene.

Laboratory Criteria for Diagnosis

For Streptococcal Toxic Shock Syndrome (STSS) only: Isolation of group A *Streptococcus* from a normally sterile site (e.g., blood or cerebrospinal fluid or less commonly, joint, pleural, or pericardial fluid)

Case Classification

1. **Staphylococcal Toxic Shock Syndrome (TSS):**
   - ***Confirmed:*** Confirmation is clinical and is defined as a case in which the required clinical findings described above are present (including desquamation, unless the patient dies before desquamation occurs) in the absence of Group A Streptococcus.
2. **Streptococcal Toxic Shock Syndrome (STSS):**
   - ***Confirmed:*** A clinically compatible case that is laboratory-confirmed.

Required Comments

Specify the form of toxic shock syndrome (staphylococcal or streptococcal).

Additional Considerations

None.

5.59 TRICHINOSIS

ICD-9: 124 Reference 1

Clinical Description

A disease caused by ingestion of *Trichinella* sp. larvae. The disease has variable clinical manifestations. Common signs and symptoms among symptomatic persons include eosinophilia, fever, myalgia, and periorbital edema.

Laboratory Criteria for Diagnosis

Any of the following:

- Demonstration of *Trichinella* larvae in tissue obtained by muscle biopsy, or
- Positive serologic test for *Trichinella*.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Note: In an outbreak setting, at least one case must be laboratory confirmed. Associated cases should be reported as confirmed if the patient shared an epidemiologically implicated meal or ate an epidemiologically implicated meat product and has either a positive serologic test for trichinosis or a clinically compatible illness.

Required Comments

None.

Additional Considerations

Document the source of infection (e.g., poorly cooked meat).

5.60 TRYPANOSOMIASIS

ICD-9: 086 Reference 8

Clinical Description

An arthropod-borne protozoal disease with two distinct forms:

1. **African Trypanosomiasis** (Sleeping sickness): In the early stages, a painful chancre, which originates as a papule and evolves into a nodule may be found at the primary tsetse fly bite site. There may be fever, intense headache, insomnia, painless lymphadenopathy, anemia, local edema and rash. In the later stages, there are cachexia, somnolence and CNS signs. The disease may run a protracted course of several years in the case of *Trypanosoma brucei gambiense* (B56-0). In cases of *T. b. rhodesiense* (B56-1), the disease has a rapid and acute evolution. Both diseases are always fatal without treatment.

2. **American Trypanosomiasis** (Chagas' disease): The main clinical signs are fever, malaise, hepatosplenomegaly and lymphadenopathy in the acute phase. Many patients present without clinical signs. An inflammatory response at the site of infection (chagoma) may last up to 8 weeks. Chronic infection can lead to myocarditis and meningoencephalitis.

Laboratory Criteria for Diagnosis

1. **African Trypanosomiasis:**
   - *Presumptive*: serological: card agglutination trypanosomiasis test (CATT) for *T. b. gambiense* only or immunofluorescent assay (IFA) for *T. b. rhodesiense* mainly and possibly for *T. b. gambiense*.
   - *Confirmative*: parasitological: detection (microscopy) of trypanosomes in blood, lymph nodes aspirates or CSF.
2. **American Trypanosomiasis:** (any of the following)
   - Positive parasitology (direct, xenodiagnosis, blood culture), or
   - Positive serology for *Trypanosoma cruzi* antibodies (IgM) by indirect haemagglutination test (IHA), indirect immunoflourescent antibody test (IFAT), direct agglutination test (DA), or ELISA.

Case Classification

1. **African Trypanosomiasis:**

   - ***Suspected:*** A clinically compatible case and/or a history of exposure.
   - ***Probable:*** A case with a positive serology with or without clinical symptoms in persons without previous history of trypanosomiasis diagnosis or treatment.
   - ***Confirmed:*** A case with positive parasitology, with or without clinical symptoms.

     Note: In the early stage or even early in the late stage of the disease there are often no clinical signs or symptoms which can be associated with the disease. Suspicion is then based on local risk of contracting the disease and local disease historical background

2. **American Trypanosomiasis:**

   - ***Probable:*** (Endemic areas) a case with unexplained fever, hepatosplenomegaly and a *chagoma* (inflammation at site of infection).
   - ***Confirmed:*** A clinically compatible case that is laboratory-confirmed.
   - ***Congenital:*** A newborn with positive parasitology (direct, xenodiagnosis, culture).

Required Comments

Specify the form of trypanosomiasis, indicate whether case is suspected, probable, confirmed or congenital and document relevant travel/deployment history to endemic areas (Note: the incubation period of African trypanosomiasis is usually 3 days to a few weeks and longer for *T.b. rhodesiense*; American trypanossomiais 5-14 days).

Additional Considerations

None.

5.61 TUBERCULOSIS, PULMONARY

ICD-9: 011 Reference 1

EXCLUDES: Latent Tuberculosis Infection which includes personnel that are screening test positive (TST/PPD+ or FDA-approved blood assay+) without evidence of active disease)

Clinical Description

A chronic bacterial infection caused by *Mycobacterium tuberculosis*, characterized pathologically by the formation of granulomas. The most common site of infection is the lung, but other organs may be involved. Specific symptoms of pulmonary tuberculosis include cough, chest pain and hemoptysis. Systemic symptoms also include fever, chills, night sweats, fatigue and weight loss.

Clinical Case Definition

All of the following:

- A positive tuberculin skin test or an FDA-approved blood assay for M. Tuberculosis (unless immunocompromised), and
- Other signs and symptoms compatible with tuberculosis (e.g., an abnormal and unstable [worsening or improving] chest radiograph, or clinical evidence of current disease), and
- Completed diagnostic evaluation, including: history, physical exam, smear and culture, Mantoux skin test and CXR.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of *M. tuberculosis* from a clinical specimen, or
- Demonstration of *M. tuberculosis* from a clinical specimen by nucleic acid amplification test.

Case Classification

Probable: Clinical signs and symptoms of pulmonary tuberculosis with demonstration of acid-fast bacilli in a clinical specimen when a culture has not been or cannot be obtained.

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments:

Indicate whether case is probable or confirmed.

Additional Considerations

Document the patient's history of exposure to a known or suspected case, travel to or origin from highly endemic countries, potential occupational exposure (e.g., health care worker), evidence of multi-drug resistance, and history of tuberculosis vaccine (i.e., BCG).

5.62 TULAREMIA

ICD-9: 021

References 1, 6, 7

Clinical Description

A zoonotic bacterial disease with a variety of clinical manifestations related to the route of introduction and the virulence of the disease agent:

- Percutaneous: From the bite of an arthropod. Normally presents as an indolent ulcer at the site of introduction along with swelling of the regional lymph nodes.
- Ingestion: Normally produces a painful pharyngitis, abdominal pain, diarrhea, and vomiting.
- Inhalation: May be followed by pneumonic involvement or a primary septicemia. Blood-borne organisms may localize in the lung and pleural spaces.

Laboratory Criteria for Diagnosis

Any of the following:

- Fourfold or greater rise in specific serum antibodies *F. tularensis* antigen, or
- Isolation of *F. tularensis* in a clinical specimen, or
- Detection of *F. tularensis* in ulcerative exudate, lymph node aspirate, or other clinical specimen by fluorescent assay, or
- PCR-positive (by FDA-cleared test).

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

None.

Additional Considerations

Document the clinical manifestation and the patient's history of possible exposure (hunting, known arthropod bites, etc.).

5.63 TYPHOID FEVER

ICD-9: 002 Reference 1

INCLUDES: *Salmonella typhi* and *Salmonella paratyphi*

Clinical Description

An illness caused by *Salmonella typhi* (may be reported as *S. enterica* serovar Typhi, abbreviated *S.* Typhi) or *S.* Paratyphi characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and nonproductive cough. However, many mild and atypical infections occur. Carriage of *S. typhi* (*S.* Typhi) or *S.* Paratyphi may be prolonged.

Laboratory Criteria for Diagnosis

Isolation of *S.* Typhi or *S.* Paratyphi from blood, stool, or other clinical specimen.

Note: Serologic evidence alone is insufficient for diagnosis. Isolation of the organism is required for confirmation.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Note: Asymptomatic carriage of S. Typhi or *S.* Paratyphi *should not be reported as typhoid fever.*

Required Comments

Indicate species and include the patient's typhoid immunization history. Also document relevant travel/deployment history (Note: the incubation period of typhoid fever is usually 8-14 days, with a range of 3-60 days; paratyphoid fever 1-10 days).

Additional Considerations

Document the source of infection and potential occupational exposure.

5.64 TYPHUS FEVER

ICD-9: 080

References 8, 9

Clinical Description

A group of arthropod-borne rickettsial diseases with four clinically distinct presentations, each with its own specific infectious agent and vector:

1. **Epidemic (Louse-borne) Typhus:** (*Rickettsia prowazekii.)* Characterized by headache, chills, prostration, fever and general pain. A macular eruption appears on the fifth to sixth day, initially on the upper trunk followed by spread to the entire body, but usually sparing the face, palm, and soles. The infectious agent is transmitted by body lice.

2. **Murine Typhus Fever:** (*R. typhi.)* Similar to louse-borne typhus, but often milder. The infectious agent is transmitted by fleas.

3. **Scrub Typhus:** (*Orientia tsutsugamushi*) Often produces a primary "punched out" skin ulcer (eschar) corresponding to the primary attachment of an infected mite. The acute onset of symptoms follows within several days, characterized by fever, headache, profuse sweating, conjunctival injection and lymphadenopathy. A dull red maculopapular eruption appears on the trunk late in the first week, gradually extending to the extremities.

4. **Tick-borne Typhus:** (*R. conorii, sibirica* and *australis.*) Tick-borne typhus has a clinical presentation similar to that seen in scrub typhus, frequently with an ulcer at the site of the tick bite.

Laboratory Criteria for Diagnosis

For *R. prowazekii, R. typhi, R. conorii, R. sibirica, or R. australis ONLY:*

- Fourfold or greater rise in antibody titer to *R. prowazekii, R. typhi, R. conorii, R. sibirica, or R. australis* antigen by IFA, complement fixation (CF), latex agglutination (LA), microagglutination (MA), or indirect hemagglutination antibody (IHA) test in acute- or convalescent-phase specimens ideally taken at least 3 weeks apart, or
- Positive PCR assay to *R. prowazekii, R. typhi, R. conorii, R. sibirica, or R. australis*, or

- Demonstration of positive IF of skin lesion (biopsy) or organ tissue (autopsy), or
- Isolation of *R. prowazekii, R. typhi, R. conorii, R. sibirica, or R. australis* from clinical specimen.

For *O. tsutsugamushi ONLY:*

- Isolation of O. tsutsugamushi by inoculation of patient blood in white mice (preferably treated with cyclophosphamide at 0.2 mg/g intraperitoneally or intramuscularly on days 1, 2 and 4 after inoculation, or
- Serologic detection of specific IgM.

  Note: Serological tests are complicated by the antigenic differences between various strains of the causal agent.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Specify the form of typhus and document relevant foreign travel/deployment history (Note: the incubation period of typhus fever is usually 10-12 days, with a range of 6-21 days).

Additional Considerations

Document history of arthropod exposure.

5.65 VACCINE ADVERSE EVENT

ICD-9: 979

INCLUDES: Only adverse events resulting in hospitalization, a life-threatening event, time lost from duty more than 24 hours, an event related to suspected contamination of a vaccine vial, and/or an event warranting permanent medical exemption.

Clinical Description

An adverse health event subsequent to a vaccination.

Laboratory Criteria for Diagnosis

None.

Case Classification

Confirmed: Any adverse event, subsequent to a vaccination and diagnosed as such by a health care provider, that results in an admission to a health care facility or results in loss from duty for one or more days (serious adverse events).

Note: A vaccine adverse event is one resulting in hospitalization, a life-threatening event (for example, anaphylaxis), time lost from duty more than 24 hours, an event related to suspected contamination of a vaccine vial, and an event warranting permanent medical exemption (that is, a contraindicating event). Further, health care providers are encouraged to report other adverse events that the provider considers unexpected in nature or severity.

Reports of mild expected reactions are NOT required (for example, low-grade, self-limited fever of less than 24 hours duration; temporary local soreness, redness, or minor swelling at the site of immunization) because they are already expected.

Required Comments

Include the suspected vaccine(s), lot number(s) of the vaccine(s) administered, and a description of the event.

Additional Considerations

Per AFJI 48-110, AR 40-562, BUMEDINST 6230.15A, CG COMDTINST M6230.4F "Immunizations and Chemoprophylaxis,"

vaccine adverse events must also be reported to the CDC/FDA's Vaccine Adverse Events Reporting System (VAERS) via service-specific guidelines.

5.66 VARICELLA

ICD-9: 052 Reference 1

INCLUDES: Service Member cases only.

Clinical Description

An illness with acute onset of mild constitutional symptoms, slight fever and generalized papulovesicular rash.

Clinical Case Definition

An illness with acute onset of diffuse (generalized) papulovesicular rash without other apparent cause.

Laboratory Criteria for Diagnosis

Any of the following:

- Isolation of varicella virus from a clinical specimen, or
- Direct fluorescent antibody (DFA), or
- Polymerase chain reaction (PCR), or
- Positive IgM Serology, or
- Significant rise in serum varicella immunoglobulin G (IgG) antibody level by any standard serologic assay.

Case Classification

Confirmed: 1) A clinically compatible case that is laboratory-confirmed or 2) a clinically compatible case that is epidemiologically linked to a confirmed or probable case.

Note: Two probable cases that are epidemiologically linked would be considered confirmed, even in the absence of laboratory confirmation.

Required Comments

Include the patient's varicella immunization history.

Additional Considerations

Document the patient's exposure history. Laboratory confirmation of varicella cases is not routinely recommended; laboratory confirmation is recommended for fatal cases and in other special circumstances

5.67 YELLOW FEVER

ICD-9: 060 Reference 1

Clinical Description

A mosquito-borne viral illness characterized by acute onset and constitutional symptoms followed by a brief remission, then a recurrence of fever with hepatitis and albuminuria. Renal failure, shock, and generalized hemorrhaging are possible.

Laboratory Criteria for Diagnosis

Any of the following:

- Fourfold or greater rise in yellow fever antibody titer in a patient who has no history of recent yellow fever vaccination and cross-reactions to other flaviviruses have been excluded, or
- Presence of yellow fever specific IgM, or
- Demonstration of yellow fever virus, antigen, or genome in tissue, blood, or other body fluid.

Case Classification

Confirmed: A clinically compatible case that is laboratory-confirmed.

Required Comments

Include the patient's yellow fever immunization history. Document relevant travel/deployment history (Note: the incubation period of yellow fever is 3-6 days).

Additional Considerations

Yellow fever cases may be internationally reportable per International Health Regulations.

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6.0 Required Data Elements

To assure consistency of the Tri-Service data, this section lists the minimum required data elements for each report, along with recommended reporting guidelines for each element. Each service may add its own additional data fields for internal analysis without compromising eventual data integration.

6.1 DEMOGRAPHIC DATA

1. **Case Number**
   Unique case identifier.

2. **Patient's First and Last Name**

3. **FMP/SSN**
   Family member prefix code and sponsor social security number.

4. **Patient Beneficiary Category**
   From beneficiary category list (e.g., A11, N15).

5. **Race/Ethnicity**
   White, black, Hispanic, Asian, American Indian, other.

6. **Patient's Sex/Gender**

7. **Date of Birth**
   Four-digit year, month, day.

6.2 MEDICAL DATA

1. **Diagnosis**
   ICD-9 based diagnosis code.

2. **Date of Onset**
   If unsure of date of onset, date of presentation is an adequate substitute.

3. **Confirmation**
   Yes, no or pending. Do not delay transmitting a report pending laboratory confirmation. Unconfirmed cases are not included for analysis or further reporting; reports must therefore be updated when confirmation becomes available.

   Indicate case status (i.e., suspected, probable, confirmed) in the Required Comments section.

4. **Method of Confirmation**
   Biopsy, slide, serology, culture, clinical, other.
   For example, heat injuries do not have laboratory criteria for diagnosis so indicate "clinical" in the method of confirmation field.

5. **Travel History**
   Specify country where disease was probably acquired, when applicable. See individual case definitions to determine the time period for which reporting of travel destinations is required, generally 1-2 incubation periods.

6.3 COMMENTS

Text comments. Content will vary by condition; see case definitions for minimum suggested content.

Comments are important for data interpretation and should be provided whenever possible.

7.0 ICD-9 Codes & Synonyms

(Also refer to Section 3 on the use of ICD-9 codes)

Condition	Synonyms	ICD-9 Codes
Amebiasis		006, 006.0, 006.1, 006.2, 006.3, 006.4, 006.5, 006.6, 006.8, 006.9
Anthrax		022, 022.0, 022.1, 022.2, 022.3, 022.8, 022.9
Botulism	Infant botulism	005.1
Brucellosis	Malta fever; Mediterranean fever; Undulant fever	023, 023.0, 023.1, 023.2, 023.3, 023.8, 023.9
Campylobacter infection	Vibrionic enteritis	008.43
Chlamydia trachomatis, genital infections		099.41
Cholera		001, 001.0, 001.1
Coccidioidomycosis	Desert fever / rheumatism; San Joaquin valley fever; Valley fever	114, 114.0, 114.1, 114.2, 114.3, 114.4, 114.5, 114.9
Cold weather injuries	Immersion foot; Trench foot	991.0, 991.1, 991.2, 991.3, 991.4, 991.6
Cryptosporidiosis		007.4
Cyclospora infection		007.5
Dengue fever	Breakbone fever; Dengue hemorrhagic fever	061, 065.4
Diphtheria		032, 032.0, 032.1, 032.2, 032.3
E. coli, Shiga toxin-producing		008.04

Condition	Synonyms	ICD-9 Codes
Ehrlichiosis / anaplasmosis	Senetsu fever	082.4, 082.40, 082.41, 082.49
Encephalitis, arboviral	Japanese B encephalitis; Tick-borne encephalitis (TBE); West Nile encephalitis	062, 062.0, 062.1, 062.2, 062.3, 062.4, 062.5, 062.8, 062.9, 063, 063.0, 063.1, 063.2, 063.8, 063.9, 066.41
Filariasis	Loa loa; Onchocerciasis	125, 125.0, 125.1, 125.2, 125.3, 125.9
Giardiasis		007.1
Gonorrhea		098, 098.0, 098.1, 098.4, 098.5, 098.6, 098.7, 098.8
Haemophilus influenzae, invasive disease	Hemophilis meningitis	038.41, 041.5, 320.0, 464.0, 482.2, 711.0
Hantavirus disease	Hemorrhagic fever with renal syndrome; Korean hemorrhagic fever	079.81
Heat injuries	Heat exhaustion	992.0, 992.3, 992.4, 992.5
Hemorrhagic fever	Crimean Congo fever; Ebola-Marburg disease; Guanarito virus; Junin virus; Kyasanur forest disease; Lassa fever; Machupo virus; Omsk hemorrhagic fever; Sabia virus	065, 065.0, 065.1, 065.2, 065.3, 065.4, 065.8, 065.9
Hepatitis A	Catarrhal jaundice; Epidemic hepatitis / jaundice; Infectious hepatitis	070.0, 070.1
Hepatitis B, acute	Serum hepatitis	070.2, 070.3

Condition	Synonyms	ICD-9 Codes
Hepatitis C, acute	Parenterally transmitted non-A non-B hepatitis; Post transfusion non-A non-B hepatitis	070.41, 070.51
Influenza		487, 487.0, 487.1, 487.8
Legionellosis	Legionnaires disease; Pontiac fever	482.84
Leishmaniasis	Kala-azar	085.0, 085.1, 085.2, 085.3, 085.4, 085.5, 085.9
Leprosy	Hansen disease	030, 030.0, 030.1, 030.2, 030.3, 030.8, 030.9
Leptospirosis	Hemorrhagic jaundice; Mud fever; Weil disease	100, 100.0, 100.8, 100.81, 100.89, 100.9
Listeriosis		027.0
Lyme disease	Tick-borne meningopolyneuritis	088.81
Malaria (all)		084.0, 084.1, 084.2, 084.3, 084.6
Measles	Hard measles; Morbilla; Red measles; Rubeola	055, 055.0, 055.1, 055.2, 055.7, 055.8, 055.9
Meningococcal disease	Cerebrospinal fever; Meningococcal meningitis	036.0, 036.1, 036.2
Mumps	Infectious parotitis	072, 072.0, 072.1, 072.2, 072.3, 072.7, 072.8, 072.9
Norovirus	Norwalk-like virus; Norwalk-like agent	008.63
Outbreak		136.9
Pertussis	Whooping cough	033, 033.0

Condition	Synonyms	ICD-9 Codes
Plague	Pestis	020, 020.0, 020.1, 020.2, 020.3, 020.4, 020.5, 020.8, 020.9
Poliomyelitis	Infant paralysis	045, 045.0, 045.1, 045.2, 045.9
Q fever	Query fever	083.0
Rabies, human	Hydrophobia; Lyssa	071
Relapsing fever		087, 087.0, 087.1, 087.9
Rheumatic fever, acute		390, 391.0, 391.1, 391.2, 391.8, 391.9, 392.0, 392.9
Rift valley fever		066.3
Rocky mountain spotted fever	Sao Paolo fever	082.0
Rubella	Congenital rubella syndrome; German measles	056, 056.0, 056.7, 056.8, 056.9, 771.0
Salmonellosis		003, 003.0
Schistosomiasis	Bilharziasis	120, 120.0, 120.1, 120.2, 120.3, 120.8, 120.9
Severe acute respiratory syndrome	SARS; SARS-CoV	079.82
Shigellosis	Bacillary dysentery	004, 004.0, 004.1, 004.2, 004.3, 004.8, 004.9
Smallpox		050, 050.0, 050.9
Streptococcus, group A, invasive		038.0, 041.01, 482.31
Syphilis	Lues	090, 091, 092, 093, 094, 095, 096, 097
Tetanus	Lockjaw	037

Condition	Synonyms	ICD-9 Codes
Toxic shock syndrome	Streptococcal toxic shock syndrome	040.82
Trichinosis	Trichinellosis; Trichiniasis	124
Trypanosomiasis	Chagas's disease; Sleeping sickness	086, 086.0, 086.1, 086.2, 086.3, 086.4, 086.5, 086.9
Tuberculosis, pulmonary		011, 011.0, 011.1, 011.2, 011.3, 011.4, 011.5, 011.6, 011.7, 011.8, 011.9
Tularemia	Deer fly fever; Rabbit fever	021, 021.0, 021.1, 021.2, 021.3, 021.8, 021.9
Typhoid	Enteric fever; Typhus abdominalis	002.0, 002.1, 002.2, 002.3, 002.9
Typhus fever	Boutonneuse fever; South African tick typhus; Tsutsugamushi; Typhus exanthematicus	080, 081.0, 081.1, 081.2, 081.9
Vaccine adverse event		978.0, 978.1, 978.2, 978.3, 978.4, 978.5, 978.6, 978.8, 978.9, 979, 979.0, 979.1, 979.2, 979.3, 979.4, 979.5, 979.6, 979.7, 979.9
Varicella	Chickenpox	052, 052.0, 052.1, 052.7, 052.8, 052.9
Yellow fever		060, 060.0, 060.1, 060.9

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PROCEDURES FOR OBTAINING USER ACCOUNTS FOR THE NAVY AND MARINE CORPS PUBLIC HEALTH CENTER (NMCPHC) NAVAL DISEASE REPORTING SYSTEM-INTERNET (NDRSi)

INTRODUCTION: Due to Health Insurance Portability and Assurance Act (HIPAA) and the Privacy Act requirements, the Navy and Marine Corps Public Health Center requires assurance from the requesting command or unit that access to sensitive personal and health information will be protected.

A copy of the DD Form 2875 System Authorization Access Request (SAAR) can also be downloaded from NMCPHC's website at http://www-nmcphc.med.navy.mil/Preventive_Medicine/reportingtools.aspx, or request by e-mailing the NDRS HelpDesk at ndrs@nehc.med.navy.mil.

Special Instructions for Completing and Submitting **DD Form 2875**

One form per account user must be sent to NMCPHC. This form consists of two pages with information and one page of instructions. Once the form is verified, NMCPHC will activate the user account via phone or e-mail. Users will then sign in and set up their profile and account.

- "User" is defined as anyone requesting access to the NDRS internet system.

1. NDRSi users are to complete Part I and initial block 27. Part II must be completed and signed by a Supervisor delegated with "By Direction" authority of the Unit Commander, such as a department head or higher. For US Coast Guard, this will be the CHSD or DMOA. *Exclude blocks 21 – 25 and all of Part's III and IV.
2. Users will also need to notify NMCPHC of when they will leave, transfer, or no longer require access so that their account may be terminated or changed to new location. Military members and Contractors are to specify their PRD or contract expiration date in block 16a.
3. Forms will be maintained by the NDRS Administrator.

Users may send the DD-2875 by one of the following methods below. If these options do not meet your current IT/communications environment, please contact the NDRS HelpDesk at ndrs@nehc.med.navy.mil or by phone at 757-953-0954/DSN 377-0954:

a. **FAX** – NMCPHC will contact the official listed in Part II to verify the request and activate the NDRS user account (FAX: **757-953-0685** or DSN 377-0685).

b. **E-MAIL** – Because the form includes personal information, the form must be sent by encrypted e-mail or with only last four of SSN in block 2. Complete, sign, scan, and email the form to tracey.isaiah@med.navy.mil.
   * If form is sent by the signing official in Part II, NMCPHC will activate the local user account immediately. If sent by the user, NMCPHC will need to contact the signing official for verification and will not activate the account until such verification is provided.

c. **MAIL** – NMCPHC will contact the official listed in Part II to verify the request and activate the user account. Mail form to:
   Navy and Marine Corps Public Health Center
   Attn: NDRS HelpDesk
   620 John Paul Jones Circle, Suite 1100
   Portsmouth, VA 23708

******If you haven't received a response within 24hrs, please call the HelpDesk at 757-953-0954 or 757-953-0717******

SYSTEM AUTHORIZATION ACCESS REQUEST (SAAR)

PRIVACY ACT STATEMENT

AUTHORITY: Executive Order 10450, 9397; and Public Law 99-474, the Computer Fraud and Abuse Act.
PRINCIPAL PURPOSE: To record names, signatures, and Social Security Numbers for the purpose of validating the trustworthiness of individuals requesting access to Department of Defense (DoD) systems and information. NOTE: Records may be maintained in both electronic and/or paper form.
ROUTINE USES: None.
DISCLOSURE: Disclosure of this information is voluntary; however, failure to provide the requested information may impede, delay or prevent further processing of this request.

TYPE OF REQUEST ☐ INITIAL ☐ MODIFICATION ☐ DEACTIVATE ☐ USER ID	DATE *(YYYYMMDD)*
SYSTEM NAME *(Platform or Applications)*: Naval Disease Reporting System internet (NDRSi)	LOCATION *(Physical Location of System)*: NMC Public Health Center

PART I *(To be completed by Requestor)*

1. NAME *(Last, First, Middle Initial)*		2. SOCIAL SECURITY NUMBER
3. ORGANIZATION	4. OFFICE SYMBOL/DEPARTMENT	5. PHONE *(DSN or Commercial)*
6. OFFICIAL E-MAIL ADDRESS	7. JOB TITLE AND GRADE/RANK	
8. OFFICIAL MAILING ADDRESS	9. CITIZENSHIP ☐ US ☐ FN ☐ OTHER	10. DESIGNATION OF PERSON ☐ MILITARY ☐ CIVILIAN ☐ CONTRACTOR

USER AGREEMENT

I accept the responsibility for the information and DoD system to which I am granted access and will not exceed my authorized level of system access. I understand that my access may be revoked or terminated for non-compliance with DoD security policies. I accept responsibility to safeguard the information contained in these systems from unauthorized or inadvertent modification, disclosure, destruction, and use. I understand and accept that my use of the system may be monitored as part of managing the system, protecting against unauthorized access and verifying security problems. I agree to notify the appropriate organization that issued my account(s) when access is no longer required.

11a. TRAINING AND AWARENESS CERTIFICATION REQUIREMENTS *(Complete as required for user or functional level access.)* ☐ I have completed Annual Information Awareness Training. DATE *(YYYYMMDD)*	
11. USER SIGNATURE	12. DATE *(YYYYMMDD)*

PART II - ENDORSEMENT OF ACCESS BY INFORMATION OWNER, USER SUPERVISOR OR GOVERNMENT SPONSOR *(If individual is a contractor - provide company name, contract number, and date of contract expiration in Block 16.)*

13. JUSTIFICATION FOR ACCESS
The Requestor agrees to comply with block 27.
Please provide the Unit Identification Code (UIC's), Reporting Unit Code (RUC's), or OPFAC (USCG) of the clinic for which you report and/or monitor Medical Event Reports for:

FAX FORM TO: 757-953-0685 (DSN 377-0685)

14. TYPE OF ACCESS REQUIRED:
☒ AUTHORIZED ☐ PRIVILEGED

15. USER REQUIRES ACCESS TO: ☐ UNCLASSIFIED ☐ CLASSIFIED *(Specify category)*
☒ OTHER Sensitive medical information

16. VERIFICATION OF NEED TO KNOW: I certify that this user requires access as requested. ☐	16a. ACCESS EXPIRATION DATE *(Contractors must specify Company Name, Contract Number, Expiration Date. Use Block 27 if needed.)*	
17. SUPERVISOR'S NAME *(Print Name)*	18. SUPERVISOR'S SIGNATURE	19. DATE *(YYYYMMDD)*
20. SUPERVISOR'S ORGANIZATION/DEPARTMENT	20a. SUPERVISOR'S E-MAIL ADDRESS	20b. PHONE NUMBER
~~21. SIGNATURE OF INFORMATION OWNER/OPR~~	~~21a. PHONE NUMBER~~	~~21b. DATE *(YYYYMMDD)*~~

~~22. SIGNATURE OF IAO OR APPOINTEE~~	~~23. ORGANIZATION/DEPARTMENT~~	~~24. PHONE NUMBER~~	~~25. DATE *(YYYYMMDD)*~~

26a. NAME *(Last, First, Middle Initial)*	26b. SOCIAL SECURITY NUMBER

27. OPTIONAL INFORMATION *(Specify Privilege Level desired. DVS Facilitators/Schedulers - list ALL your Site IDs. See instructions for details.)*

I understand that to ensure the integrity, safety and security of Navy IT resources, when using those resources, I shall:
- Safeguard information and information systems from unauthorized or inadvertent modification, disclosure, destruction, or use.
- Protect Controlled Unclassified Information (CUI) and classified information to prevent unauthorized access, compromise, tampering, or exploitation of the information.
- Protect passwords for systems requiring logon authentication and safeguard passwords at the sensitivity level of the system for classified systems and at the confidentiality level for unclassified systems. Passwords will be classified at the highest level of information processed on that system.
- Virus check all information, programs, and other files prior to uploading onto any Navy IT resource.
- Report all security incidents immediately in accordance with local procedures and CJCSM 6510.01 (series).
- Access only that data, control information, software, hardware, and firmware for which I am authorized access and have a need-to-know, and assume only those roles and privileges for which I am authorized.
- Be subject to monitoring, and further understand that there is no expectation or right to privacy over the data and communications generated through my use. - Understand the information I'm viewing is for Official Use Only. Any misuse/unauthorized disclosure can result in civil/criminal penalty. I further understand that, when using Navy IT resources, I shall not:- Access commercial web-based e-mail (e.g. HOTMAIL, YAHOO!, AOL, etc.)
- Auto-forward official e-mail to a commercial e-mail account.
- Bypass, strain, or test IA mechanisms (e.g., Firewalls, content filters, anti-virus programs, etc.). If IA mechanisms must be bypassed, I shall coordinate the procedure and receive written approval from the Local IA Authority (CO or OIC).
- Introduce or use unauthorized software, firmware, or hardware on any Navy IT resource.
- Relocate or change equipment or the network connectivity of equipment without authorization from my Local IA Authority.
- Use personally owned hardware, software, shareware, or public domain software without authorization from the Local IA Authority. - Upload executable files (e.g., .exe, .com, .vbs, or .bat) onto Navy IT resources without the approval of the Local IA Authority.- Participate in or contribute to any activity resulting in a disruption or denial of service.
- Write, code, compile, store, transmit, transfer, or introduce malicious software, programs, or code.
- Put Navy IT resources to uses that would reflect adversely on the Navy (such as uses involving pornography; chain letters; unofficial advertising, soliciting or selling except on authorized bulletin boards established for such use; violation of statute or regulation; inappropriately handled classified information; and other uses that are incompatible with public service).

~~PART III - SECURITY MANAGER VALIDATES THE BACKGROUND INVESTIGATION OR CLEARANCE INFORMATION~~

28. TYPE OF INVESTIGATION		28a. DATE OF INVESTIGATION *(YYYYMMDD)*	
28b. CLEARANCE LEVEL		28c. IT LEVEL DESIGNATION ☐ LEVEL I ☐ LEVEL II ☐ LEVEL III	
29. VERIFIED BY *(Print name)*	30. SECURITY MANAGER TELEPHONE NUMBER	31. SECURITY MANAGER SIGNATURE	32. DATE *(YYYYMMDD)*

~~PART IV - COMPLETION BY AUTHORIZED STAFF PREPARING ACCOUNT INFORMATION~~

TITLE:	SYSTEM Naval Disease Reporting System internet (NDRSi)	ACCOUNT CODE
	DOMAIN	
	SERVER	
	APPLICATION	
	DIRECTORIES	
	FILES	
	DATASETS	
DATE PROCESSED *(YYYYMMDD)*	PROCESSED BY *(Print name and sign)*	DATE *(YYYYMMDD)*
DATE REVALIDATED *(YYYYMMDD)*	REVALIDATED BY *(Print name and sign)*	DATE *(YYYYMMDD)*

INSTRUCTIONS

The prescribing document is as issued by using DoD Component.

A. PART I: The following information is provided by the user when establishing or modifying their USER ID.

(1) Name. The last name, first name, and middle initial of the user.

(2) Social Security Number. The social security number of user.

(3) Organization. The user's current organization (i.e. DISA, SDI, DoD and government agency or commercial firm).

(4) Office Symbol/Department. The office symbol within the current organization (i.e. SDI).

(5) Telephone Number/DSN. The Defense Switching Network (DSN) phone number of the user. If DSN is unavailable, indicate commercial number.

(6)Official E-mail Address. The user's official e-mail address.

(7) Job Title/Grade/Rank. The civilian job title (Example: Systems Analyst, GS-14, Pay Clerk, GS-5)/military rank (COL, United States Army, CMSgt, USAF) or "CONT" if user is a contractor.

(8) Official Mailing Address. The user's official mailing address.

(9) Citizenship (US, Foreign National, or Other).

(10) Designation of Person (Military, Civilian, Contractor).

IA Training and Awareness Certification Requirements. User must indicate if he/she has completed the Annual Information Awareness Training and the date.

(11) User's Signature. User must sign the DD Form 2875 with the understanding that they are responsible and accountable for their password and access to the system(s).

(12) Date. The date that the user signs the form.

B. PART II: The information below requires the endorsement from the user's Supervisor or the Government Sponsor.

(13). Justification for Access. A brief statement is required to justify establishment of an initial USER ID. Provide appropriate information if the USER ID or access to the current USER ID is modified.

(14) Type of Access Required: Place an "X" in the appropriate box. (Authorized - Individual with normal access. Privileged - Those with privilege to amend or change system configuration, parameters, or settings.)

(15) User Requires Access To: Place an "X" in the appropriate box. Specify category.

(16) Verification of Need to Know. To verify that the user requires access as requested.

(16a) Expiration Date for Access. The user must specify expiration date if less than 1 year.

(17) Supervisor's Name (Print Name). The supervisor or representative prints his/her name to indicate that the above information has been verified and that access is required.

(18) Supervisor's Signature. Supervisor's signature is required by the endorser or his/her representative.

(19) Date. Date supervisor signs the form.

(20) Supervisor's Organization/Department. Supervisor's organization and department.

(20a) E-mail Address. Supervisor's e-mail address.

(20b) Phone Number. Supervisor's telephone number.

(21) Signature of Information Owner/OPR. Signature of the functional appointee responsible for approving access to the system being requested.

(21a) Phone Number. Functional appointee telephone number.

(21b) Date. The date the functional appointee signs the DD Form 2875.

(22) Signature of Information Assurance Officer (IAO) or Appointee. Signature of the IAO or Appointee of the office responsible for approving access to the system being requested.

(23) Organization/Department. IAO's organization and department.

(24) Phone Number. IAO's telephone number.

(25) Date. The date IAO signs the DD Form 2875.

(27) Optional Information. This item is intended to add additional information, as required.

C. PART III: Certification of Background Investigation or Clearance.

(28) Type of Investigation. The user's last type of background investigation (i.e., NAC, NACI, or SSBI).

(28a) Date of Investigation. Date of last investigation.

(28b) Clearance Level. The user's current security clearance level (Secret or Top Secret).

(28c) IT Level Designation. The user's IT designation (Level I, Level II, or Level III).

(29) Verified By. The Security Manager or representative prints his/her name to indicate that the above clearance and investigation information has been verified.

(30) Security Manager Telephone Number. The telephone number of the Security Manager or his/her representative.

(31) Security Manager Signature. The Security Manager or his/her representative indicates that the above clearance and investigation information has been verified.

(32) Date. The date that the form was signed by the Security Manager or his/her representative.

D. PART IV: This information is site specific and can be customized by either the DoD, functional activity, or the customer with approval of the DoD. This information will specifically identify the access required by the user.

E. DISPOSITION OF FORM:

TRANSMISSION: Form may be electronically transmitted, faxed, or mailed. Adding a password to this form makes it a minimum of "FOR OFFICIAL USE ONLY" and must be protected as such.

FILING: Original SAAR, with original signatures in Parts I, II, and III, must be maintained on file for one year after termination of user's account. File may be maintained by the DoD or by the Customer's IAO. Recommend file be maintained by IAO adding the user to the system.