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Compiled and Prepared by:

Allen Emanuel, M.P.H.
Epidemiologist, Center for Assessment and Preparedness, Columbus Public Health

Radhika Nagisetty, M.P.H.
Communicable Disease Epidemiologist, Franklin County Board of Health

240 Parsons Avenue
Columbus, Ohio 43215

www.publichealth.columbus.gov

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Introduction

Communicable diseases are illnesses caused by microorganisms, such as bacteria, viruses and parasites, and are transmitted from an infected person/animal and/or contaminated food or water source to another person or animal. Most communicable diseases spread from direct contact with the bacteria or viruses that are carried in bodily fluids (e.g., blood) or expelled into the air (in the form of respiratory droplets) by an infected person. Some diseases can be spread only indirectly through contaminated food and water sources. Other diseases are introduced into the body by animals or insects carrying the infectious agent.

This annual summary represents the 2007 communicable disease data reported to state and local public health agencies as required by Ohio Administrative Code 3701-3-02. Only selected communicable diseases determined to be of public health significance are reportable; therefore, the data presented here do not represent all cases of communicable disease that occur among residents in Columbus and Franklin County. Additionally, only confirmed cases of disease have been analyzed for this summary. The data are considered provisional but provide valuable insight into these diseases.

The summary is intended to be a resource for individuals and our public health partners for whom communicable diseases are of concern. Further information on communicable disease may be obtained by contacting either Columbus Public Health or the Franklin County Board of Health.

For over eight years, the Columbus and Franklin County Health Departments have joined forces to make the reporting, tracking and investigation of communicable disease cases easier and more convenient through the Communicable Disease Reporting System (CDRS). This provides early identification of potential outbreaks and new trends in infectious diseases. The Communicable Disease staff ensures proper investigation, timely case follow-up of all reports and preventive interventions to reduce secondary cases.

KEY FINDINGS ARE SUMMARIZED BELOW:

- In 2007, a total of 2,183 cases of communicable disease (excluding sexually transmitted diseases and tuberculosis) were reported and confirmed among Franklin County residents.
- Franklin County's rate of confirmed communicable diseases in 2007 was 195 cases per 100,000 people.
- The incidence rates of sexually transmitted diseases (gonorrhea, chlamydia, and syphilis) and hepatitis C rank high among all the counties in the state.
- The rate of pertussis increased significantly to 26.8 cases per 100,000 in 2007 from 14.4 cases per 100,000 in 2006.
- The rate of varicella decreased significantly to 5.1 cases per 100,000 in 2007 from 11.4 cases per 100,000 in 2006.

Quick Guide to Reportable Diseases in Ohio

This list of Reportable Infectious Disease was in effect for 2007; however, changes were made to the list and the new changes went into effect January 1, 2009. The latest version can located at http://www.odh.ohio.gov/pdf/IDCM/intro1.pdf

Know Your ABCs: a Quick Guide to Reportable Infectious Diseases in Ohio

From the Ohio Administrative Code 3701-3-02. Effective January 1, 2006

Class A Diseases

(1) diseases of major public health concern because of the severity of disease or potential for epidemic spread - report by telephone immediately upon recognition that a case, suspect case or positive laboratory result exists

- Anthrax
- Botulism, foodborne
- Cholera
- Diphtheria
- Measles
- Meningococcal disease
- Plague
- Rabies, human
- Rubella (not congenital)
- Severe acute respiratory syndrome (SARS)
- Smallpox
- Tularemia
- Viral hemorrhagic fever (VHF)
- Yellow fever

Any unexpected pattern of cases, suspected cases, deaths or increased incidence of any other disease of major public health concern, because of the severity of disease or potential for epidemic spread, which may indicate a newly recognized infectious agent, outbreak, epidemic, related public health hazard or act of bioterrorism.

(2) diseases of public health concern needing timely response because of potential for epidemic spread - report by the end of the next business day after the existence of a case, suspect case or positive laboratory result is known

- Arboviral neuroinvasive and non-neuroinvasive disease
  - Eastern equine encephalitis virus disease
  - LaCrosse virus disease (other California serogroup virus disease)
  - Powassan virus disease
  - St. Louis encephalitis virus disease
  - West Nile virus disease (also current infection)
  - Western equine encephalitis virus disease
- Other arthropod-borne disease
- Chancroid
- Coccidioidomycosis
- Cyclosporiasis
- Dengue
- *E. coli* O157:H7 and other enterohemorrhagic (Shiga toxin-producing) *E. coli*
- Foodborne disease outbreaks
- Granuloma inguinale
- *Haemophilus influenza* (invasive disease)
- Hantavirus
- Hemolytic uremic syndrome (HUS)
- Hepatitis A
- Hepatitis B, perinatal
- Influenza-associated pediatric mortality
- Legionnaires' disease
- Listeriosis
- Lymphogranuloma venereum
- Malaria
- Meningitis, aseptic, including viral meningoencephalitis
- Mumps
- Pertussis
- Poliomyelitis (including vaccine associated cases)
- Psittacosis
- Q fever
- Rubella (congenital)
- Salmonellosis
- Shigellosis
- *Staphylococcus aureus*, with resistance or intermediate resistance to vancomycin (VRSA, VISA)
- Syphilis
- Tetanus
- Tuberculosis (TB), including multi-drug resistant tuberculosis (MDR-TB)
- Typhoid fever
- Waterborne disease outbreaks

(3) diseases of significant public health concern -- report by the close of the working week after the existence of a case, suspect case or positive laboratory result is known

- Amebiasis
- Botulism, wound
- Botulism, infant
- Brucellosis
- Campylobacteriosis
- Chlamydia infections (urethritis, epididymitis, cervicitis, pelvic inflammatory disease, neonatal conjunctivitis and pneumonia)
- Creutzfeldt-Jakob disease (CJD)
- Cryptosporidiosis
- Cytomegalovirus (CMV) (congenital)
- Ehrlichiosis
- Encephalitis, other viral
- Encephalitis, postinfection
- Giardiasis
- Gonococcal infections (urethritis, cervicitis, pelvic inflammatory disease, pharyngitis, arthritis, endocarditis, meningitis and neonatal conjunctivitis)
- Hepatitis B
- Hepatitis C
- Hepatitis D (delta hepatitis)
- Hepatitis E
- Herpes (congenital)
- Kawasaki disease (mucocutaneous lymph node syndrome)
- Leprosy (Hansen disease)
- Leptospirosis
- Lyme disease
- Meningitis, including other bacterial
- Mycobacterial disease, other than tuberculosis (MOTT)
- Reye syndrome
- Rheumatic fever
- Rocky Mountain spotted fever (RMSF)
- Streptococcal disease, group A, invasive (IGAS)
- Streptococcal disease, group B, in newborn
- Streptococcal toxic shock syndrome (STSS)
- *Streptococcus pneumoniae,* invasive disease (ISP)
- Toxic shock syndrome (TSS)
- Toxoplasmosis (congenital)
- Trichinosis
- Typhus fever
- Varicella
- Vibriosis
- Yersiniosis

Class B Disease - report *the number of cases by the close of each working week*

- Influenza

Class C Diseases - *report an outbreak, unusual incidence or epidemic by the end of the next business day*

- Blastomycosis
- Conjunctivitis, acute
- Histoplasmosis
- Nosocomial infections of any type
- Pediculosis
- Scabies
- Sporotrichosis
- Staphylococcal skin infections
- Toxoplasmosis
- Outbreak, unusual incidence, or epidemic of other infectious diseases of known etiology not categorized as Class A, Class B or Class C

Except as otherwise required for the Class A(1) diseases, reports of cases, suspect cases and positive laboratory results shall be in writing, and shall include the name and address of the case, suspect case, or person from whom the specimen was taken. A Board of Health may accept verbal reports by telephone or other electronic systems approved by the Director within the same time limitations. Reports shall include supplementary information relevant to the case or laboratory reports as needed to complete official surveillance forms provided or approved by the Director.

Cases of AIDS (acquired immune deficiency syndrome), AIDS-related conditions, HIV (human immunodeficiency virus) infection, perinatal exposure to HIV, and CD4 T-lymphocytes counts <200 or 14% must be reported on forms and in a manner prescribed by the Director.

Reportable Disease Data 2005-2007 for Franklin County, Ohio

	2005		2006		2007	
Population	1,090,771		1,095,662		1,118,107	
DISEASE NAME	# of Cases	Case Rate*	# of Cases	Case Rate*	# of Cases	Case Rate*
HIV/AIDS*	274	25.1	222	20.3	259	23.2
Amebiasis	9	0.8	7	0.6	16	1.4
Anthrax	0	0.0	0	0.0	0	0.0
Botulism (foodborne)	0	0.0	0	0.0	0	0.0
Botulism (infant)	0	0.0	0	0.0	0	0.0
Brucellosis	0	0.0	0	0.0	0	0.0
Campylobacteriosis	88	8.1	101	9.2	73	6.5
Cholera	0	0.0	0	0.0	0	0.0
Chlamydia*	4,908	450.0	5,429	495.5	6,276	561.3
Cryptosporidiosis	33	3.0	17	1.6	27	2.4
Cytomegalovirus	0	0.0	1	0.1	5	0.4
Dengue	0	0.0	1	0.1	0	0.0
Diphtheria	0	0.0	0	0.0	0	0.0
E. coli O157:H7	9	0.8	24	2.2	6	0.5
E. coli Unspecified	2	0.2	7	0.6	2	0.2
Encephalitis, (primary viral)	1	0.1	1	0.1	1	0.1
Encephalitis, West Nile	0	0.0	1	0.1	0	0.0
Ehrlichiosis	N/A	N/A	N/A	N/A	1	0.1
Giardiasis	93	8.5	125	11.4	112	10.0
Gonorrhea*	3,155	289.2	3,286	299.9	3,817	341.4
Haemophilus influenzae-Type B	3	0.3	2	0.2	3	0.3
Hantavirus	0	0.0	0	0.0	0	0.0
Hemolytic uremic syndrome	0	0.0	3	0.3	0	0.0
Hepatitis A	7	0.6	7	0.6	10	0.9
Hepatitis B (acute, chronic, undetermined)*	77	7.1	97	8.9	120	10.7
Hepatitis C (acute, chronic, undetermined)*	812	74.4	826	75.4	1,000	89.4
Herpes (congenital)	N/A	N/A	N/A	N/A	1	0.1
Legionellosis	35	3.2	52	4.7	38	3.4
Leprosy	0	0.0	0	0.0	0	0.0
Leptospirosis	0	0.0	0	0.0	0	0.0
Listeriosis	3	0.3	0	0.0	6	0.5
Lyme disease	5	0.5	5	0.5	2	0.2
Malaria	5	0.5	6	0.5	8	0.7
Measles	0	0.0	0	0.0	0	0.0
Meningitis, aseptic (viral)	86	7.9	67	6.1	74	6.6
Meningococcal disease (N. meningitidis)	10	0.9	8	0.7	5	0.4
Meningitis (bacterial)	2	0.2	0	0.0	0	0.0

Reportable Disease Data 2005-2007 for Franklin County, Ohio

	2005		2006		2007	
Population	1,090,771		1,095,662		1,118,107	
DISEASE NAME	# of Cases	Case Rate*	# of Cases	Case Rate*	# of Cases	Case Rate*
Kawasaki Disease	0	0.0	0	0.0	2	0.2
Mumps	0	0.0	0	0.0	0	0.0
Pertussis	256	23.5	158	14.4	300	26.8
Plague	0	0.0	0	0.0	0	0.0
Polio	0	0.0	0	0.0	0	0.0
Psittacosis	0	0.0	0	0.0	0	0.0
Rocky Mountain Spotted Fever (RMSF)	0	0.0	0	0.0	0	0.0
Rubella (congenital)	0	0.0	0	0.0	0	0.0
Salmonellosis	110	10.1	110	10.0	120	10.7
Severe Acute Respiratory Syndrome (SARS)	0	0.0	0	0.0	0	0.0
Shigellosis	13	1.2	11	1.0	15	1.3
Smallpox	0	0.0	0	0.0	0	0.0
Streptococcus pneumoniae, invasive	105	9.6	113	10.3	125	11.2
Streptococcal disease-group A, invasive	18	1.7	28	2.6	35	3.1
Streptococcal disease-group B (perinatal)	11	1.0	9	0.8	6	0.5
Streptococcal toxic shock syndrome (STSS)	N/A	N/A	N/A	N/A	2	0.2
Syphilis*	105	9.6	103	9.4	69	6.2
Tetanus	0	0.0	0	0.0	0	0.0
Tuberculosis (TB)*	77	7.1	85	7.8	78	7.0
Tularemia	0	0.0	0	0.0	0	0.0
Typhoid Fever	2	0.2	3	0.3	1	0.1
Varicella*	N/A	N/A	125	11.4	57	5.1
Vibriosis	2	0.2	1	0.1	1	0.1
Yersiniosis	11	1.0	9	0.8	8	0.7
Yellow Fever	0	0.0	0	0.0	0	0.0

*Notes on specific diseases and rates

- Rates are per 100,000.
- Varicella: became a Class A reportable disease January 1, 2006. Prior to 2006, varicella was a Class B reportable disease, reported in aggregate form on a weekly basis
- Chlamydia, Gonorrhea, Syphilis, TB and HIV/AIDS data are from separate ODH sources.
- Syphilis numbers include primary and secondary cases only.
- Disease totals and calculated disease rates are limited to confirmed cases. Suspects and probable cases are not included.
- Population estimates obtained from the United States Census Bureau for each year were used in annual rate calculations.

PERTUSSIS(WHOOPING COUGH)

Pertussis, also known as whooping cough, is a highly contagious bacterial infection of the respiratory tract caused by the bacterium *Bordetella pertussis*. Pertussis causes violent spells of coughing that may be followed by difficulty in breathing, vomiting, or "whooping." Transmission of pertussis occurs primarily by aerosol droplet and is most easily transmitted in the period starting 7 days after exposure to three weeks after the onset of spasmodic coughing. Seventy to 90 percent of susceptible household and other close contacts of a person with pertussis will develop the disease within 7 to 14 days, commonly 5 to 10 days. The disease may last up to 3 months and be complicated by pneumonia, seizures, or encephalopathy.

Because of immunity induced by pertussis, vaccine wanes 6 to 10 years after complete childhood vaccination, making adolescents and adults susceptible to infection and transmission. In recent years, older patients are accounting for higher percentages of pertussis cases. Given this, neonates and infants who are too young to have received full vaccination are at risk of infection from contact with infectious adults.

The number of pertussis cases reported in Franklin County nearly doubled, from 158 in 2006 to 300 in 2007. This resulted in an incidence rate of 26.8 cases per 100,000 population in 2007. Among the 300 cases with known age, 37% occurred among children under 4 years, while 34% of all the cases were among adolescents 10-19 years (Figure 1). Six of the 300 cases were hospitalized. Typically, after the start of the school year, the number of reported cases increases in Franklin County (Figure 2).

Figure 1
Pertussis Cases in Franklin County by Age and Gender 2007

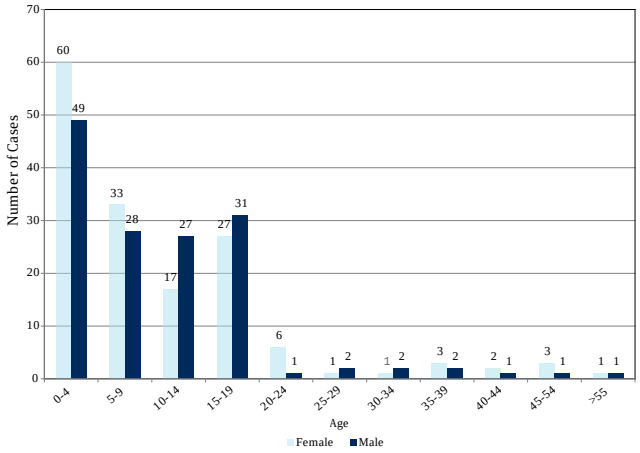
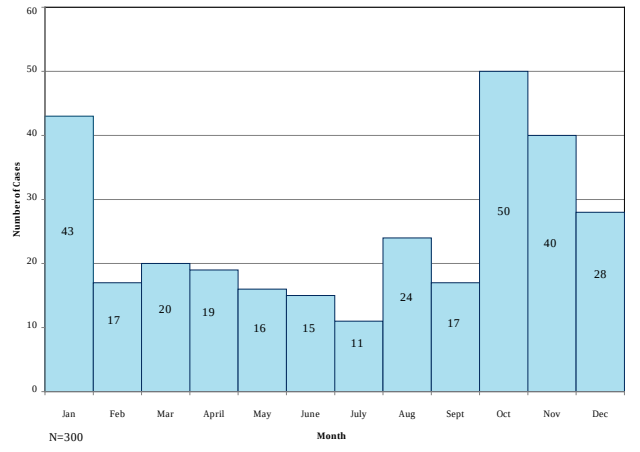


Figure 2
Pertussis Cases in Franklin County by Month 2007

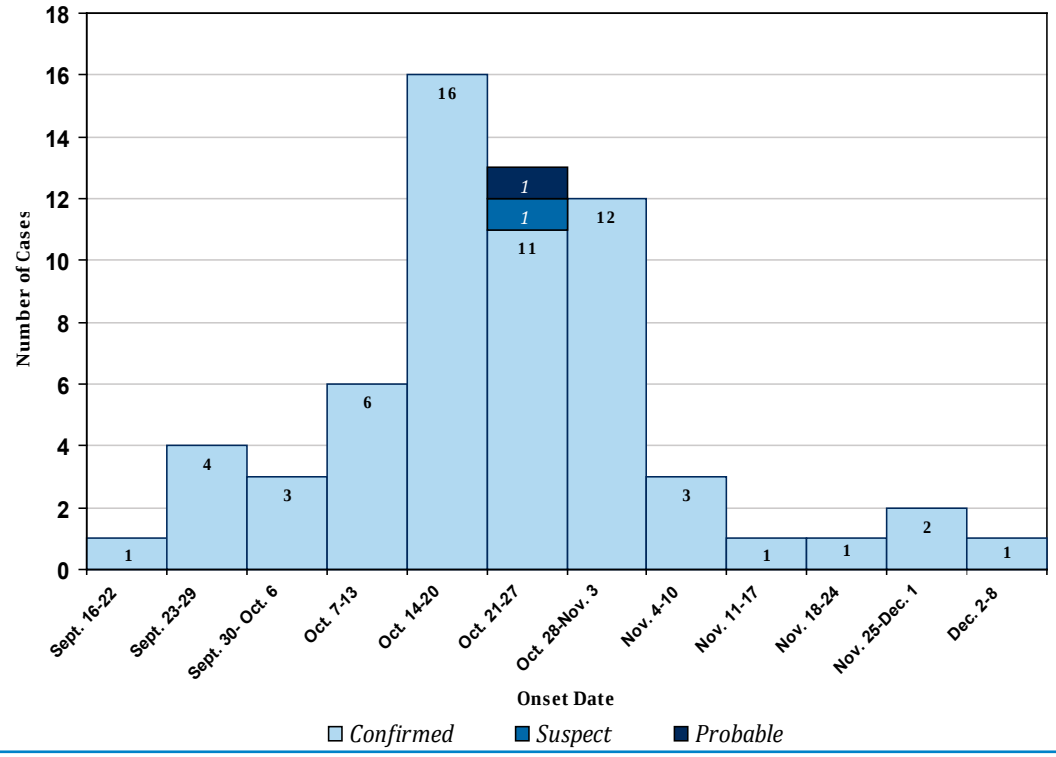


Worthington Pertussis Outbreak

On October 8, 2007, Columbus Public Health (CPH) was notified about a case of pertussis in a Worthington high school student with a symptom onset date of September 24, 2007. This index case was a member of a sport team at the local high school. (NOTE: Worthington is a suburb in the northern part of Franklin County that contracts with CPH for Public Health services.)

By October 10, 2007, four cases of Pertussis were confirmed among students at two high schools in the Worthington area. Due to the increasing number of cases confirmed among vulnerable children, CPH encouraged strict adherence to the Centers for Disease Control and Prevention's (CDC) recommendations for handling a Pertussis outbreak, by encouraging all close contacts of a confirmed case to receive prophylactic antibiotics. This included any member of any extracurricular activity that had a confirmed case of Pertussis. Throughout the course of the outbreak, CPH worked with the Worthington school district, Nationwide Children's Hospital (NCH) and the local media outlets to provide information and guidance to the public about Pertussis. A total of 65 confirmed cases of Pertussis were identified as a part of this outbreak in the Worthington area with the last case reported on December 26, 2007 (Figure 3).

Figure 3
Worthington Pertussis Cases by Illness Onset Date
2007



SALMONELLOSIS

Salmonellosis is a bacterial illness characterized by acute abdominal pain, diarrhea, and often fever that begins 12 hours to 5 days after infection. The majority of human infections are thought to result from the ingestion of fecally contaminated food or water. Undercooked or raw products of animal origin such as eggs, milk, meat, and poultry have been implicated as common sources of human salmonellosis. A wide range of domestic and wild animals are carriers of Salmonella, including poultry, swine, cattle, rodents, iguanas, tortoises, turtles, terrapins, chicks, dogs and cats. Though uncommon, person-to-person spread can occur in humans — via acutely ill patients, convalescent carriers and, especially mild and unrecognized cases. In general, the incidence of infection is highest in infants and young children.

Salmonella contamination can be prevented by thoroughly cooking all animal-derived foods, especially those from poultry. Cross-contamination can be avoided by hand washing after handling animals or raw poultry and thoroughly washing cutting boards and utensils with soap after contact with food.

In 2007, a total of 120 confirmed cases were reported in Franklin County with an incidence rate of 10.7 cases per 100,000 population. The ages ranged from less than 1 year to 90 years of age with a median age of 28 years. Sixty-seven percent of the cases were females (Figure 4).

Figure 4
Salmonellosis Cases in Franklin County by Age and Gender 2007

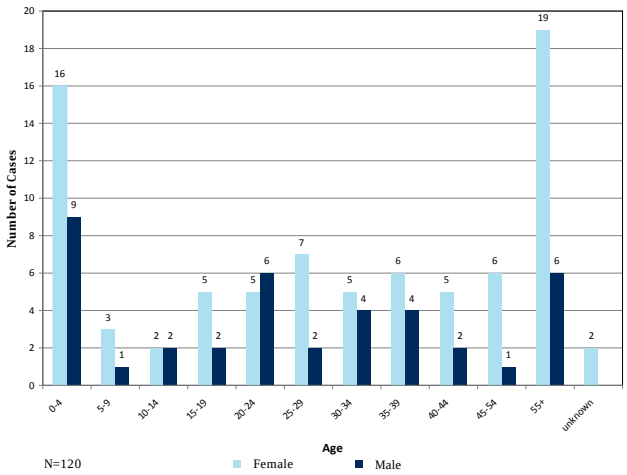


Figure 5
Salmonellosis Cases in Franklin County by Month 2007

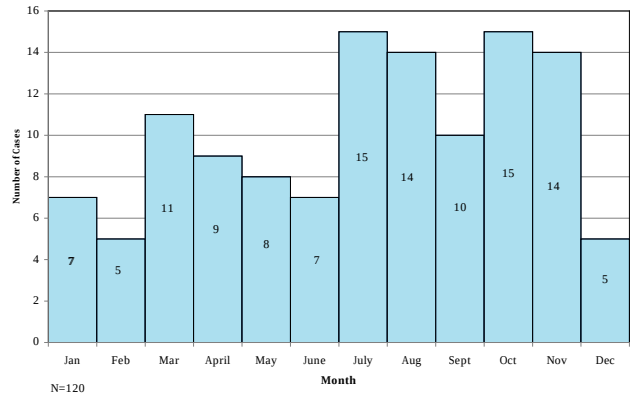
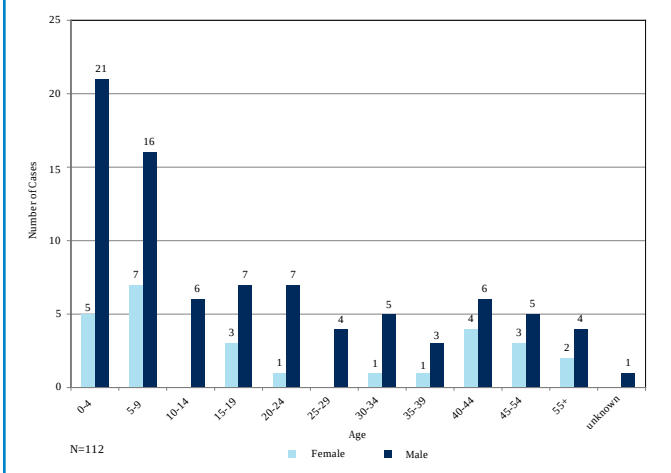


Figure 6
Giardiasis Cases in Franklin County by Age and Gender 2007

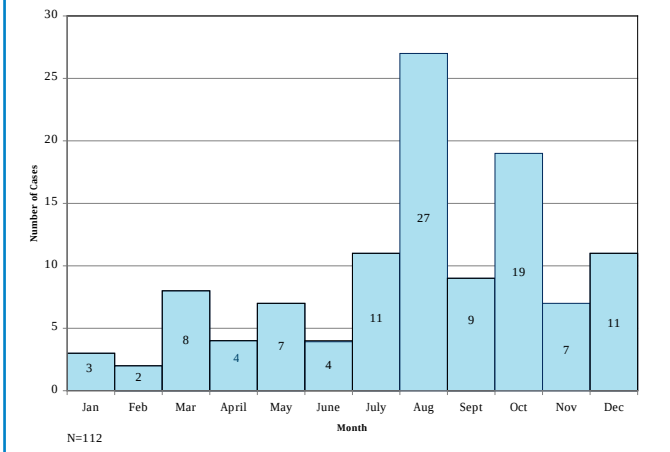


GIARDIASIS

Giardiasis is a diarrheal illness caused by a one-celled, microscopic parasite, *Giardia lamblia*. Once an animal or person has been infected, the most common symptoms are chronic diarrhea, abdominal cramps, bloating, and loose, pale, greasy stools. Symptoms appear 1-2 weeks after exposure to the protozoan. Asymptomatic infections and prolonged shedding in the feces are common. Transmission through the fecal-oral route, person-to-person, especially in institutions and day care centers, and animal-to-person are the principal modes of spread.

In 2007, a total of 112 confirmed cases were reported in Franklin County with an incidence rate of 10 cases per 100,000 population. The ages ranged from less than 1 year to 85 years of age with a median age of 14 years. Sixty-six percent of the cases were males (Figure 6).

Figure 7
Giardiasis Cases in Franklin County by Month 2007



Invasive Streptococcus pneumoniae

Streptococcus pneumoniae causes many clinical syndromes, depending upon the site of infection (e.g., acute otitis media, pneumonia, bacteremia, meningitis). Certain serotypes are more prevalent in adults; others are more prevalent in children. Throughout the past two decades, several serotypes have developed resistance to penicillin, to which they were formerly highly susceptible.

Humans are the reservoir of pneumococci, which are commonly found in the upper respiratory tract of healthy persons throughout the world. Pneumococci are transmitted from person-to-person by droplet spread, by direct oral contact and indirectly through articles freshly soiled with respiratory discharges. Although these routes of transmission are easily accomplished, illness among casual contacts and attendants of patients is infrequent.

Treatment with an antibiotic to which the infecting organism is sensitive can be expected to terminate communicability within 24 hours. The incubation period varies by type of infection and can be as short as 1-3 days.

The Franklin County incidence rate of invasive S. pneumoniae disease in 2007 was 11.2 cases per 100,000 population. This represents an 8.7% increase over the 2006 rate of 10.3 cases per 100,000. The reported cases ranged from less than 1 year old to 97 years of age, with 45% of the cases 55 years old or older (Figure 8). The median age range was 52 years. Fifty-three percent of the cases were females.

Figure 8
Invasive Streptococcus pneumoniae Cases in Franklin County by Age and Gender 2007

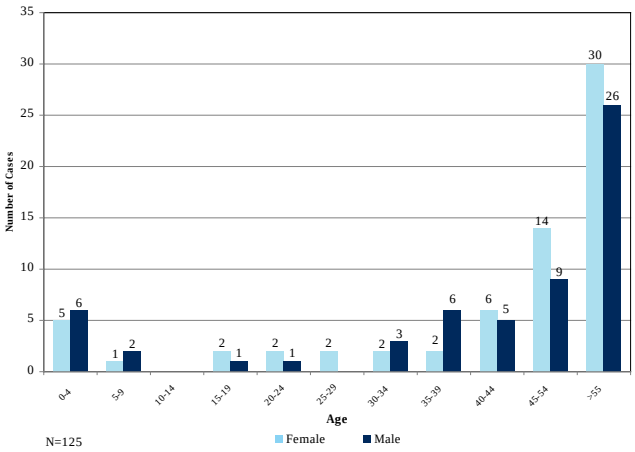
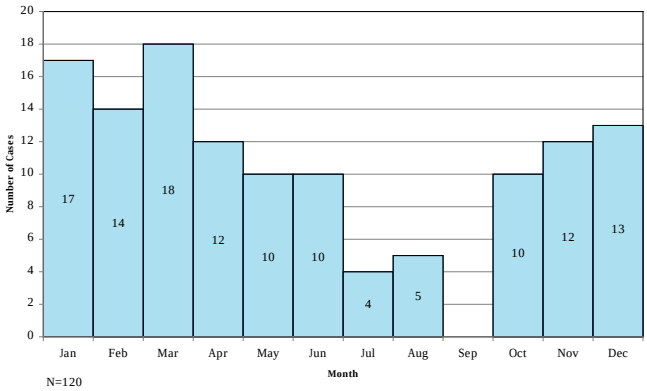


Figure 9
Invasive Streptococcus pneumoniae Cases in Franklin County by Month 2007



Timeliness of Disease Reports

According to the Ohio Infectious Disease Manual, "Surveillance is a comprehensive process which includes suspicion of an infectious disease, confirmation of disease, disease reporting, case investigation, prevention and control to limit the spread of disease. The ultimate goal of the process is to protect and improve the health of the public, using the knowledge of incident cases to prevent the spread of disease and ultimately, eliminate some diseases entirely."

Timeliness of disease reports is a key factor in achieving the goal. In order to reduce the burden of disease in our community and to implement appropriate interventions, the public health system relies on healthcare providers and laboratories to identify and report cases in a timely manner. Requirements for how quickly reports need to be made varies based on communicability and severity of disease.

Table 1 lists selected diseases and how long it took (using median and mean number of days) for a disease to be reported to the local health department after a healthcare provider diagnosis. E. coli, Hepatitis A, Mumps, Pertussis and Salmonella are Class A (2) reportable conditions required to be reported by the end of the next business day after the existence of a case is known. Measles, Meningococcal disease and Rubella are Class A (1) reportable conditions, due to their severity and the potential for epidemic spread; therefore, they are required to be reported immediately via telephone if a case, suspect case, or positive laboratory result exists.

Table 1. Franklin County Reporting Lags* for Selected Diseases, 2007

Reportable Condition	Reporting Requirement	Number of Confirmed Cases	Median (days)	Mean (days)	Missing Diagnosis Date
E. coli O157:H7	By end of next business day	6	5	8	67%
Hepatitis A	By end of next business day	10	3	5	40%
Measles	Immediately	0	n/a	n/a	n/a
Meningococcal disease	Immediately	5	3	5	80%
Mumps	By end of next business day	0	n/a	n/a	n/a
Pertussis	By end of next business day	300	2	3	53%
Rubella	Immediately	0	n/a	n/a	n/a
Salmonellosis	By end of next business day	120	5	6	76%

*Notes: Reporting Lag = ODRS Entry Date – Diagnosis Date**
**"Diagnosis date" defaulted to the following date fields (in order) if blank: lab specimen collect date, lab result date, onset date, LHD report date, ODH report date.

Analysis of the reporting lag (time between the diagnosis date and the ODRS entry date) shows that reporting requirements were not met for any of the selected diseases in Table 1. It should be noted that the median and mean lags for Franklin County were equal to or lower than those for all of Ohio.

Timeliness of Disease Reports

As shown in the notes for Table 1, the reporting lag is defined as the difference between the diagnosis date and when the case was entered into ODRS. If the diagnosis date field was empty, a proxy date was used. These fields were used (in this order) as the proxy: lab specimen collect date, lab result date, onset date, date reported to the local health department, and date reported to ODH. The diagnosis date field was blank (and a proxy date needed) for a minimum of 40% of cases up to a maximum of 80% of cases.

CPH and FCBH will periodically monitor the reporting lag times for these diseases. Regular monitoring will help with two key issues: late reporters and missing data. If specific reporters are found to be contributing to longer lags, this information will be shared with them, challenges to timely reporting will be identified and addressed, and closer monitoring of reports will follow. Additionally, filling in missing or incorrect dates is easier if caught before a data year is finalized.

Technical Notes

The Ohio Administrative Code 3701-3-02, 3701-5-05, and 3701-3-12 requires by law that communicable diseases be reported to local health departments. Reportable diseases are grouped by class. All the diseases in this summary are class A, which is defined as: Disease of major public health concern because of the severity of disease or potential for epidemic spread.

Case criteria and definitions
Case definitions are determined by the Council of State and Territorial Epidemiologists (CSTE) in conjunction with the CDC and are published in the MMWR [1997; 46(RR-10)]. Cases are grouped into the following categories:

Suspected case: a case for which a reportable condition is being considered in the differential diagnosis, but for which confirmatory laboratory testing has not yet been completed

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

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

For a complete list of reportable diseases in Ohio, please visit http://www.odh.ohio.gov.

Notes on specific diseases and rates
STDs, TB and HIV/AIDS data are from separate ODH sources. HIV/AIDS data are provisional and subject to change. Syphilis numbers include primary and secondary cases only.

Disease totals and calculated disease rates are limited to confirmed cases. Suspects and probable cases are not included in this report. Population estimates obtained from the United States Census Bureau for each year were used in annual rate calculations.

Diseases not included in the table
There were no confirmed cases in Franklin County of the following Class A reportable diseases; therefore, they were not included in the table: Creutzfeldt-Jakob disease, coccidioidomycosis, Q fever, rabies, Reye syndrome, rheumatic fever, rubella (not congenital), *Staph aureus* (VRSA, VISA), toxic shock syndrome (TSS), toxoplasmosis, and trichinosis. Class B and C reportable diseases are also not included in the table.

Notes on reporting systems
Data are from the Ohio Department of Health and the Communicable Disease Reporting system (CDRS, a joint effort between Columbus Public Health Department and the Franklin County Board of Health). Cases of sexually transmitted diseases, tuberculosis, AIDS, and HIV have separate reporting systems. Cases may have been excluded due to the reporting time, onset date, or when the supplemental information was received.

References

Centers for Disease Control and Prevention Coordinating Center for Infectious Diseases
http://www.cdc.gov/about/organization/ccid.htm

CDC's Summary of Notifiable Diseases:
http://www.cdc.gov/epo/dphsi/annsum/index.htm

The Ohio Department of Health Infectious Disease Control Manual:
http://www.odh.ohio.gov/healthResources/infectiousDiseaseManual.aspx

"Evaluation of reporting timeliness of public health surveillance systems for infectious diseases.", Ruth Ann Jajosky and Samuel L Groseclose, Published online at BioMed Central, 2004 July 26. doi: 10.1186/1471-2458-4-29. PMCID: PMC50925
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