Epi Update

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In This Issue

Epidemiology and Environmental Health Strike Teams: Overwhelming Outbreak 2008

Lauren Ball, D.O., M.P.H.

This summer the Regional Domestic Security Task Force (RDSTF) Epidemiology and Environmental Health Strike Teams participated in Overwhelming Outbreak, 2008, a field exercise prepared by a team from the Bureau of Epidemiology (BOE), the Division of Environmental Health (EH), and the contractor for the drill, Florida State University's Center for Disaster Risk Policy. BOE and EH Strike Team members worked together to solve a very large simulated outbreak of severe gastroenteritis due to Salmonella bacteria, transmitted through contaminated ice used in drinks. The strike teams performed well, and the BOE is using lessons learned from the exercises to drive the next round of trainings for county health department (CHD) epidemiology staff and regional strike team members. Some example lessons learned include:

1) Not all BOE Strike Teams have deployed to the exercises with the proper field supplies/Go-Kits. In spite of this, the teams were able to investigate the Overwhelming Outbreak and identify the risk factor(s) and offer containment strategies;
2) Most regions had difficulties with their communications equipment. The walkie-talkie repeaters were not properly set up and they were not useful for communications. The teams used cell phones for back-up communications, which was also problematic due to issues with signal strength;
3) Calculators would be useful in the Epi Go-Kits, if there is no access to computers;
4) Standardization of forms, computer programs, and other tools across teams and regions is important to some strike team members; for example, what specific computer programs and forms should be used to collect information.
5) Some participants did not get an opportunity to fill out Incident Command Structure forms.

Hear more about lessons learned in the Field Drills in the December Epidemiology Grand Rounds.

Florida is a leader in public health preparedness, having formed the first environmental health and epidemiology strike teams in the country that are typed using the National Incident Management System (NIMS) typing methodology. The seven Florida RDSTF Regions have each formed and rostered both environmental health and epidemiology strike teams. All regions have at least one environmental health and one epidemiology strike team.

Epidemiology and environmental health strike teams from unaffected regions will be activated during a statewide emergency to serve in the affected RDSTF Region in Florida. When a region is affected by an emergency, the personnel who work in the affected region will usually be following their CHD's Emergency Response Plan and/or tending to their personal needs. The environmental health and epidemiology strike teams may also be activated as part of a State Emergency Medical Assistance Compact (EMAC), as was done this summer when environmental health strike teams were deployed to Iowa to assist in the disaster response to the flooding.

The BOE is currently working with the Office of Public Health Preparedness (OPHP) to provide a web presence focused on strike team needs and activities. The bureau is also working with OPHP on proposals for additional regional training focused on Emergency Response and epidemiology strike teams. This training will also be applicable to all CHD epidemiology staff. Staff members do not need to be an epidemiology strike team member to attend. Regional Public Health and Medical co-chairs and the epidemiology strike team contacts in each region will be contacted for feedback and coordination in providing the epidemiology strike teams with discipline-specific training.

Dr. Lauren Ball is a Medical Epidemiologist with the Acute Disease Section, Bureau of Epidemiology.

Meet Dr. Lauren Ball

Lauren Ball, D.O., M.P.H. worked as an industrial hygienist after receiving her bachelor's degree in Biology and Environmental Science. She then enrolled in medical school and simultaneously pursued an M.P.H. in Community Health Education. After one year of a family practice residency, Dr. Ball was accepted into the Centers of Disease Control and Prevention (CDC) Epidemic Intelligence Service (EIS) and assigned to the National Center for Environmental Health. She also completed her Preventive Medicine Residency with the CDC, assigned to both the Communicable Disease Epidemiology Section in the Washington State Department of Health and to the Northwest Center for Public Health Practice at the University of Washington, where she concentrated on Public Health Informatics. She returned to the CDC in Atlanta and worked in a preparedness-funded position in the Division of Parasitic Diseases concentrating on waterborne bioterrorism. Dr. Ball participated in the CDC's 9/11 response. In 2002, Dr. Ball briefly worked with Research Triangle Institute on a proposal for the World Trade Center Health Registry, which was successfully awarded. Dr. Ball then relocated to Florida and began working as a private consultant in the field of Occupational Safety and Health and Preventive Medicine. Dr. Ball is active with her professional medical society and is currently the Vice Chair for the Division of Public Health/General Preventive Medicine and a Fellow of the American Osteopathic College of Occupational and Preventive Medicine.

Dr. Ball joined BOE in May 2008 as the supervisor of the Investigations Unit, Acute Disease Section. Dr. Ball reports to Dr. Hopkins, works with our regional epidemiologists, Robyn Kay, Roger Sanderson, and Tim Doyle, and has been assigned as lead BOE contact for Epidemiology Strike Teams. You can reach Dr. Ball at lauren_ball@doh.state.fl.us or 850.245.4408.

Norovirus Illness Cluster Associated with a Local Bar-B-Que Restaurant, Orange County, Florida, April 2008

Leah Eisenstein, M.P.H. and Dean Bodager, R.S., D.A.A.S., M.P.A.

Introduction

On April 3, 2008 the Orange County Health Department's (OCHD) Division of Environmental Health (EH) received a call from a manager at Company A reporting that seven employees were experiencing a gastrointestinal (GI) illness after they ate a lunch prepared by and delivered from a local bar-b-que restaurant (Restaurant A) on April 1. Reports of illnesses in four other cohorts who had eaten food prepared at the same restaurant were subsequently received by various divisions in OCHD.

Methods
A custom questionnaire was administered to five cohorts from four different companies who ate meals prepared by Restaurant A on April 1 and 2. The questionnaire was administered via telephone interviews for two cohorts (from Company A) and was self-administered for the remaining companies B, C, and D cohorts. Each cohort was defined as all people who ate any food from the meal prepared by Restaurant A, which included friends or family members who ate leftover food. An ill person was defined as anyone who experienced vomiting and/or diarrhea within one week of having eaten food prepared by Restaurant A on April 1 or 2. Epi Info Version 3.4.3 (November 26, 2007) was used to manage and analyze data.

Stool specimens were collected between April 7 and April 9 from five ill people (two who ate the meal on April 1 at Company A, one who ate the meal on April 2 at Company A, and two who ate the meal on April 2 at Company C) and one ill food worker identified during the investigation. Of the six specimens that were submitted, two were tested for enteric bacteria and norovirus, three were tested for norovirus only, and one was tested for enteric bacteria only. In addition to clinical specimens, the Bureau of Laboratories (BOL) - Jacksonville collected and tested leftover food from the meals eaten by Company B on April 1 and 2.

An OCHD Environmental Health Inspector and a Florida Department of Business and Professional Regulation (DBPR) inspector conducted a joint environmental inspection of the implicated Restaurant A location on April 4. Multiple interviews were conducted by OCHD Epidemiology staff with the manager of the location regarding food preparation procedures, employee practices, and potentially ill food workers.

Results
Five distinct cohorts with ill people who ate food prepared by Restaurant A on April 1 or 2 were identified: Company A (lunch on April 1), Company A (lunch on April 2), Company B (lunch on April 1), Company C (lunch on April 2), and Company D (lunch on April 1 and some people ate leftovers from April 1). For companies B, C, and D, the number of people who ate could only be estimated. Table 1 presents the estimated size of the cohorts, number of responses, number of ill people, and attack rates based on the responses. Of note, Company B had a lunch prepared on April 2 that was not followed by any illnesses.

Table 1. Characteristics, GI Illness Cluster, Orange County, April 2008

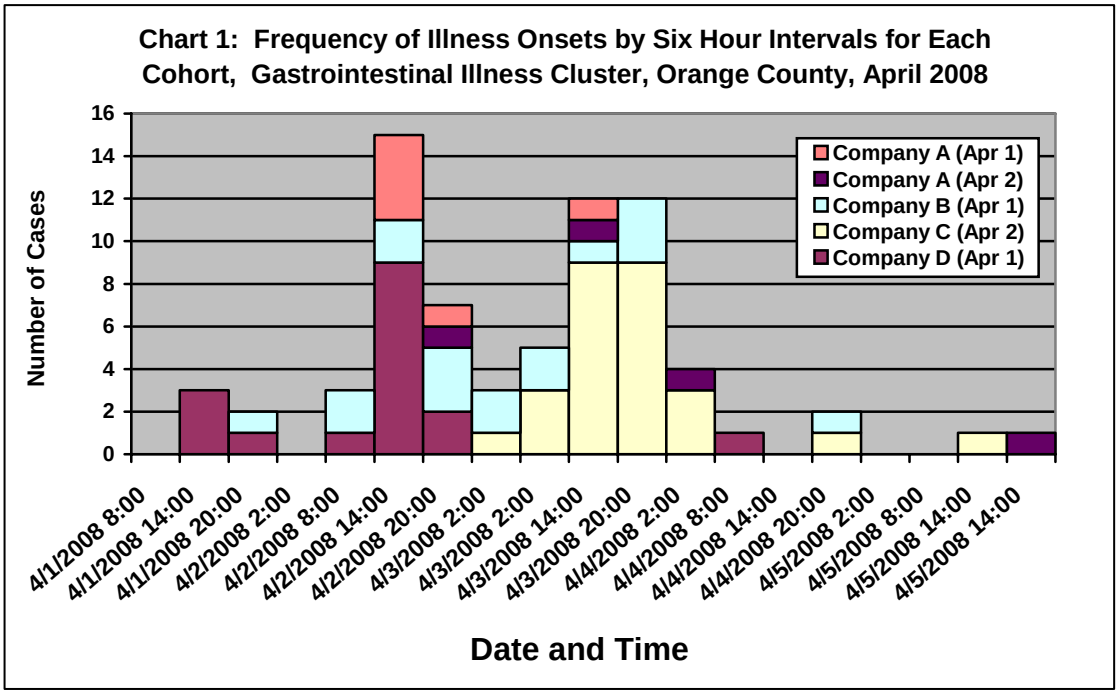
	Estimated Total Number of People	Number of Responses (% of Estimated Total)		Number Ill	Attack Rate
Company A (April 1)	7	7	(100.0%)	6	85.7%
Company A (April 2)	10	7	(70.0%)	3	42.9%
Company B (April 1)	62	43	(69.4%)	29	67.4%
Company C (April 2)	60	59	(98.3%)	29	49.2%
Company D (April 1)	32	23	(71.9%)	17	73.9%
Total	171	139	(81.3%)	84	60.4%

Eighty-four (60.4%) of the 139 respondents reported GI illness. Additionally, there were three secondary cases in family members of cases. Age reported by 81 (96.4%) ill people ranged from 15 to 86 years old, with an average age of 42.8 years and a median age of 43 years. Of those who reported illness, 52 (61.9%) were male. Signs and symptoms reported are shown in Table 2. Eight (9.5%) people sought medical care and two (2.4%) were hospitalized. Duration of illness reported by 51 (60.7%) of the 84 ill people ranged from 12 to 120 hours, with an average of 64.2 hours and a median of 72 hours.

Table 2. Frequency of Symptoms, GI Illness Cluster, Orange County, April 2008 (N=84)

	Number	%
Diarrhea	73	86.9%
Nausea	66	78.6%
Abdominal cramps/pain	65	77.4%
Loss of appetite	64	76.2%
Weakness	61	72.6%
Vomiting	59	70.2%
Gas	53	63.1%
Fatigue	52	61.9%
Sweating	46	54.8%
Headache	46	54.8%
Chills	45	53.6%
Body aches	44	52.4%
Dizziness	40	47.6%
Fever	31	36.9%

The date and time of onset was reported by 70 (83.3%) ill people. The incubation periods ranged from two to 81.5 hours, with an average of 32.4 hours and a median of 30.3 hours. The incubation period was calculated based on the first time that Restaurant A food was eaten (those who ate leftovers at a later time were not included in incubation period calculations). There was only one instance of a person who ate leftover food that had not been eaten in the original meal. Chart 1 shows the frequency of onsets by date and time for each cohort.



Food-specific attack rates were calculated for each of the common foods served to the cohorts. Table 3 depicts the statistically significant data for each cohort and all cohorts combined. Having eaten coleslaw was a predictor of illness in each cohort and overall had a highly statistically significant risk ratio of 4.26 (2.26-8.02; p=<0.0000000001). Overall, having eaten beans was also statistically significant (p=0.0013), but with a much lower risk ratio of 1.87 (1.17-2.99). Having eaten pork was statistically significant in the cohort from Company B, but this association was not seen in any other cohort.

Table 3. Statistically Significant Food Exposures, GI Illness Cluster, Orange County, April 2008

	Risk Ratio	95% CI	P-value
Company B (April 1 Lunch)			
Pork	3.09	0.92-10.39	0.0091*
Coleslaw	5.44	0.88-33.70	0.0028*
Company C (April 2 Lunch)			
Coleslaw	4.64	2.05-10.51	<0.0001
Company D (April 1 Lunch)			
Coleslaw	2.65	0.84-8.32	0.0212*
All Cohorts Combined			
Beans	1.87	1.17-2.99	0.0013
Coleslaw	4.26	2.26-8.02	<0.0001

* Fisher's exact p-value

All three of the specimens that were tested for enteric bacteria were negative for *Salmonella*, *Shigella*, *Campylobacter*, and *E. coli* O157:H7. Of the four specimens from cases that were analyzed for norovirus, three were positive for Norovirus type G2 by RT-PCR. Coleslaw collected from Company B (leftover from April 1) tested negative for norovirus by RT-PCR. Note that the protocols for viral analysis in food products are developmental and negative results are inconclusive.

The joint environmental site inspection of Restaurant A on April 4 revealed multiple breaches of proper sanitation practices. Baked beans were observed at 123º F in a steamer, which is an improper holding temperature for hot foods and is not sufficient to kill norovirus. Additionally, a three-compartment sink was observed to have dirty water in all compartments and there was no chemical test kit for chemical sanitizers used in the sink.

After multiple interviews by OCHD Environmental Health and Epidemiology staff, it was discovered on April 4 that an employee of Restaurant A who works in the kitchen left his shift early on the morning of April 1 due to a GI illness with vomiting and diarrhea that started the evening of March 31. A stool sample collected from this employee on April 9 tested negative for norovirus and was not analyzed for enteric bacteria.

Bivariate analysis revealed a highly statistically significant association between illness and having consumed coleslaw prepared on April 1. The combination of a laboratory-confirmed diagnosis and a statistically implicated food prompted another interview with the catering manager of Restaurant A regarding preparation of the coleslaw and the activities of the ill food worker. Routinely, coleslaw was prepared each morning by mixing pre-shredded cabbage, mayonnaise, vinegar, salt, and sugar in large plastic tubs. The mixing is done by hand, and it is unclear whether gloves are worn during preparation. The coleslaw prepared each morning is used to fill the delivery and catering orders for that day. Any coleslaw left over at the end of the day is refrigerated overnight, put into portion cups, and sold to patrons who come into the restaurant the following day.

The food associated with this illness cluster was served on April 1 and 2. Coleslaw served in the restaurant on April 1 would have been left over from the day before. Fresh coleslaw was prepared the morning of April 1 by the ill food worker for that day's deliveries and catering orders, including the orders for Companies A, B, and D. On April 2 the ill food handler did not come to work, due to his illness, so coleslaw preparation varied slightly from the usual routine. Leftover coleslaw prepared by the ill food handler on April 1 was portioned out for delivery orders (including Companies A and C) instead of served in the restaurant. A well food worker prepared fresh coleslaw for that day's catering orders (including Company B). These activities are consistent with the pattern of illness seen in the cohorts. On April 1 Companies A, B, and D received coleslaw prepared by the ill employee that morning. People who ate coleslaw in the restaurant on April 1 received coleslaw made the day before. On April 2 Companies A and C received leftover coleslaw that had been prepared by the ill employee the day before. Company B and people who ate in the restaurant on April 2 received coleslaw prepared that morning by a well employee. People who ate the catered lunch at Company B on April 2 did not get sick, which is consistent with receiving fresh coleslaw made by a well employee on April 2.

Discussion and Recommendations
This cluster of 84 GI illnesses is associated with food catered and delivered by Restaurant A on April 1 and 2. Five different cohorts were identified whose only common exposure was having eaten food prepared by this restaurant on April 1 and 2. Overall, people who ate the coleslaw prepared the morning of April 1 were more than four times as likely to become ill as people who did not eat the coleslaw and the association was highly statistically significant. Restaurant A reported that the employee who prepared this coleslaw on April 1 was experiencing a GI illness at that time. This food worker's stool sample tested negative for norovirus, though this does not rule out the possibility of a norovirus infection as nine days had passed since the onset of his illness and viral shedding may have been intermittent or absent at that point.

The agent causing the illness was laboratory-confirmed to be Norovirus type G2. The incubation period (median=30.3 hours), symptoms, and duration described in this cluster are clinically consistent with norovirus infection.

Pathogens seen in foodborne disease outbreaks can be controlled by basic food preparation and handling measures. All food service establishments that prepare food must practice prescribed safe food hygiene and safety practices and procedures. It is imperative that food service facilities constantly and vigorously promote and insist on proper handwashing procedures by food workers during all phases of food preparation, display, and storage. This includes maintaining handwash sinks and providing soap and drying devices continuously. Ill food workers must be excluded from food preparation activities and should not be allowed to return to these activities for 72 hours after symptom resolution. Ensuring properly cleaned and sanitized food contact surfaces and proper temperature controls also greatly contribute to the elimination or reduction of viral particles on fomites or in food products.

Sources
CDC. Norovirus. June 6, 2006. Available at http://www.cdc.gov/ncidod/dvrd/revb/gastro/norovirus.htm (Accessed May 6, 2008).

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Florida Year-to-Date Mosquito-Borne Disease Summary Through September 17, 2008

Rebecca Shultz, M.P.H., Caroline Collins, Danielle Stanek, D.V.M., Carina Blackmore, D.V.M., Ph.D.

During the period from January 1 to September 17, 2008, the following arboviral activity: Eastern equine encephalitis virus (EEEV), West Nile virus (WNV), St. Louis encephalitis virus (SLEV), Highlands J virus (HJV), and California encephalitis group viruses (CEV), was recorded in Florida.

Escambia County has issued a mosquito-borne illness alert, and **Holmes, Jackson, Jefferson, Leon, Volusia, Walton, and Washington** counties have declared a mosquito-borne illness advisory due to increased arboviral activity.

EEEV Activity
A locally-acquired EEE case was confirmed in a Leon County resident in August. Positive samples from 85 sentinel chickens, 84 horses, two other mammals, three dead birds, and 71 live wild birds were received from 37 counties. EEEV was cultured from a pool of 50 *Culex salinarius* and a pool of 50 *Cx. nigripalpus*, both collected on February 13 in Volusia County and one pool of 50 *Culiseta melanura* collected on March 19 in Flagler County.

WNV/SLEV Activity
Two locally-acquired WNV neuroinvasive disease cases were confirmed in Escambia County residents in September. A Wakulla County resident was also found to have WNV disease, though it is likely that the infection was acquired out-of-state. Positive samples of WNV antibody from seven sentinel chickens and one

horse were received from four counties. Flavivirus-reactive samples from three live wild birds were received from Hillsborough, Okaloosa, and Santa Rosa counties. It was not determined whether the wild bird samples were reactive specifically to SLEV or WNV.

HJV activity
Positive samples from 44 sentinel chickens were received from 14 counties. HJV was isolated from three pools of 50 *Culex nigripalpus* collected on February 22, February 26, and March 28 in Volusia County and two pools of *Cs. melanura* collected on March 19 and May 7 in Flagler County.

CEV activity
LaCrosse encephalitis was confirmed in a Hillsborough County resident with travel history to North Carolina. This case was reported as a Florida case acquired out-of-state. La Crosse virus is in the California Encephalitis group of viruses. California serogroup virus was isolated from a pool of *An. crucians* collected on July 16 in Santa Rosa County.

Dead Bird Reports
The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. Since the first of January, 411 reports representing a total of 990 dead birds (34 crows, 54 jays, 51 raptors, and 851 others) were received from 56 of Florida's 67 counties. Please note that FWC collects reports of birds that have died from a variety of causes, not only arboviruses. Dead birds should be reported to www.myfwc.com/bird/.

See the following web site for more information: http://www.doh.state.fl.us/environment/community/arboviral/index.html. Also, the Disease Outbreak Information Hotline offers recorded updates on medical alert status and surveillance at **888.880.5782.**

Rebecca G. Shultz is the Arthropod-borne Disease Surveillance Coordinator with the Bureau of Community Environmental Health. Caroline Collins is an arbovirus program specialist with the Bureau of Community Environmental Health. Dr. Stanek is a medical epidemiologist in the Division of Environmental Health. Dr. Blackmore is the Bureau Chief in the Bureau of Environmental Public Health Medicine.

Upcoming Events

Bureau of Epidemiology Monthly Grand Rounds
Date: Last Tuesday of each month
Time: 10 a.m.-11 a.m.
Location: Building 2585, Room 310A
Dial-In Number: 877.646.8762 (password: Grand Rounds)
Upcoming Topics:
September: "Fetal Death Cluster in Bay County," presented by Bill Sappenfield, M.D., M.P.H. and Sohyun Park, Ph.D., M.S., R.D./K.D.A.
October: "Tobacco Use Among Floridians With Diabetes," presented by Tammie Johnson, M.P.H., Dr.P.H.(c)
November: "Racial Disparity in Breast, Cervical, and Colorectal Cancers in Florida," presented by Youjie Huang, M.D., Dr.P.H., M.P.H.
December: TBA
January: "Epidemiology and Environmental Health Strike Team Exercise Overview," presented by Lauren Ball, D.O., M.P.H.

Correction: Reportable Diseases in Florida

Errors were identified in the notifiable disease table published in the August/September 2008 Epi Update (Table 1. Provisional Cases* of Selected Notifiable Diseases, Florida, August 1-31, 2008). Below is a corrected version of this table.

Table 1. Provisional Cases* of Selected Notifiable Diseases, Florida, August 1-31, 2008

	Month				Cumulative (YTD)	
Disease Category	**2008**	**2007**	**Mean†**	**Median¶**	**2008**	**2007**
A. Vaccine Preventable Diseases						
Diphtheria	0	0	0	0	0	0
Measles	0	0	0	0	0	5
Mumps	0	1	1	1	10	10
Pertussis	41	24	22	21	174	165
Poliomyelitis	0	0	0	0	0	0
Rubella	0	0	0	0	2	0
Smallpox	0	0	0	0	0	0
Tetanus	1	2	0	0	1	3
Varicella	40	57	N/A	N/A	1,182	863
B. CNS Diseases & Bacteremias						
Creutzfeldt-Jakob Disease	1	1	1	0	12	11
H. Influenzae (invasive)	13	5	5	5	94	78
in those ≤5	0	2	1	1	12	12
Listeriosis	6	4	3	4	26	16
Meningitis (bacterial, cryptococcal, mycotic)	32	10	13	12	141	110
Meningococcal Disease	1	5	4	3	41	45
Staphylococcus aureus (VISA, VRSA)	0	0	N/A	N/A	0	0
Streptococcal Disease, Group A, Invasive	19	27	18	15	190	219
Streptococcus pneumoniae (invasive disease)						
Drug resistant	52	47	35	33	507	517
Drug susceptible	36	33	30	27	472	418
C. Enteric Infections						
Campylobacteriosis	120	114	108	114	719	714
Cholera	0	0	0	0	1	0
Cryptosporidiosis	70	138	57	35	265	362
Cyclospora	7	6	5	6	54	31
Escherichia coli, Shiga-toxin producing (STEC)**	16	14	10	10	105	90
Giardiasis	113	155	125	130	773	812
Hemolytic Uremic Syndrome	1	1	1	1	1	6
Salmonellosis	547	518	577	568	2,990	2,638
Shigellosis	62	206	156	148	606	1,694
Typhoid Fever	3	1	2	3	10	6
D. Viral Hepatitis						
Hepatitis A	20	21	31	35	114	106
Hepatitis B, Acute	22	25	37	38	229	253
Hepatitis C, Acute	2	7	5	5	40	35
Hepatitis +HBsAg in pregnant women	47	51	42	43	425	400
Hepatitis D, E, G	0	1	N/A	N/A	0	2

* Confirmed and probable cases based on date of report as reported in Merlin
Incidence data for 2008 is provisional, data for 2007 are finalized

† Mean of the same month in the previous five years

¶ Median for the same month in the previous five years

** Includes *E. coli* O157:H7; shiga-toxin positive, serogroup non-O157; and shiga-toxin positive, not serogrouped

†† Includes neuroinvasive and non-neuroinvasive

N/A indicates that no historical data is available to caculate mean and median

Table 1. (cont.) Provisional Cases* of Selected Notifiable Diseases, Florida, August 1-31, 2008

	Month				Cumulative (YTD)	
Disease Category	**2008**	**2007**	**Mean†**	**Median¶**	**2008**	**2007**
F. Vector Borne, Zoonoses						
Dengue	3	7	3	2	24	22
Eastern Equine Encephalitits††	0	0	1	0	0	0
Ehrlichiosis/Anaplasmosis	1	2	1	1	8	11
Leptospirosis	0	0	0	0	0	0
Lyme Disease	19	5	6	5	49	13
Malaria	7	12	10	11	35	41
Plague	0	0	0	0	0	0
Psittacosis	0	0	0	0	3	0
Q Fever (acute and chronic)	0	0	0	0	0	2
Rabies, Animal	8	17	18	18	90	94
Rabies (possible exposure)	122	130	114	117	1,029	926
Rocky Mountain Spotted Fever	4	1	2	2	10	8
St. Louis Encephalitis††	0	0	0	0	0	0
Toxoplasmosis	2	0	1	1	7	3
Trichinellosis	0	0	0	0	1	0
Tularemia	0	0	0	0	0	0
Typhus Fever (epidemic and endemic)	0	0	0	0	0	1
Venezuelan Equine Enchephalitis††	0	0	0	0	0	0
West Nile Virus††	1	3	8	11	2	3
Western Equine Encephalitis††	0	0	0	0	0	0
Yellow Fever	0	0	0	0	0	0
G. Others						
Anthrax	0	0	0	0	0	0
Botulism-Foodborne	0	0	0	0	0	0
Botulism-Infant	1	0	0	0	1	0
Brucellosis	0	1	1	1	2	5
Glanders	0	0	0	0	0	0
Hansen's Disease (Leprosy)	0	0	0	0	5	4
Hantavirus Infection	0	0	0	0	0	0
Legionella	13	17	15	11	96	95
Melioidosis	0	0	0	0	0	0
Vibriosis	13	19	16	17	64	60

* Confirmed and probable cases based on date of report as reported in Merlin
Incidence data for 2008 is provisional, data for 2007 are finalized

† Mean of the same month in the previous five years

¶ Median for the same month in the previous five years

†† Includes neuroinvasive and non-neuroinvasive

N/A indicates that no historical data is available to caculate mean and median

Note: The 2008 case counts are provisional and are subject to change until the database closes. Cases may be deleted, added, or have their case classification changed based on new information and therefore the monthly tables should not be added to obtain a year to date number.

This Month on EpiCom

Christie Luce

EpiCom is located within the Florida Department of Health's Emergency Notification System (FDENS). The Bureau of Epidemiology encourages *Epi Update* readers not only to register on the EpiCom system by emailing the Florida Department of Health Emergency Notification System Helpdesk at FDENS-help@doh.state.fl.us, but to sign up for features such as automatic notification of certain events. Users are invited to contribute appropriate public health observations related to any suspicious or unusual occurrences or circumstances through the system. EpiCom is the primary method of communication between the Bureau of Epidemiology and other state medical agencies during emergency situations. Following are selected recent postings:

- Investigation of a gastroenteritis outbreak, Volusia County
- Suspected foodborne outbreak at a local middle school, Leon County
- Malaria in a resident with travel to Nigeria, Santa Rosa County
- Hepatitis A, Hillsborough County

- Rabid fox, Martin County
- Bacterial infections linked to a dialysis center, Osceola County
- Outbreak of gastroenteritis at a sorority house on a local university campus, Leon County
- Infant botulism, Duval County
- Three cases of cryptosporidiosis in a family, Hillsborough County
- Probable pertussis case, Escambia County
- *Vibrio vulnificus*, Volusia County
- Rabies exposure due to contact with a cat, Alachua County
- Rabies in a kitten, Palm Beach County
- Pertussis cases, Polk County
- Lead Paint Standard violations and recalls online: http://www.doh.state.fl.us/environment/community/lead/The_Lead_Alert_Network.htm.

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Epi Update *is the peer-reviewed journal of the Florida Department of Health, Bureau of Epidemiology, and is published monthly on the Internet. Current and past issues of Epi Update are available online: http://www.doh.state.fl.us/disease_ctrl/epi/Epi_Updates/index.html. The current issue of Epi Update is available online: http://www.doh.state.fl.us/disease_ctrl/epi/Epi_Updates/2008/AugustSeptember2008EpiUpdate.pdf. For submission guidelines or questions regarding Epi Update, please contact Gail Morales at Gail_Morales@doh.state.fl.us.*