Surveillance Case Definitions, 2012

Although each state has the authority to establish its own list of notifiable conditions for its jurisdiction, many surveillance case definitions are standardized at the national level. Definitions are developed at the annual Council of State and Territorial Epidemiologists (CSTE) meeting and adopted by Centers for Disease Control and Prevention (CDC). Washington maintains high concordance with the national case definitions. All the current changes in case definitions involve laboratory fields and become effective with cases being reported for 2012. Conditions affected are all reportable types of viral hepatitis and several bacterial and parasitic agents causing diarrhea.

**Hepatitis**

As a reminder, the case definition for acute viral hepatitis A, B, or C infection requires discrete onset of symptoms in addition to appropriate laboratory results. This clinical criterion should be considered present if the case cannot be interviewed but the testing was done due to jaundice, vomiting, diarrhea, or abdominal pain. To meet the case definition, a case patient with any acute viral hepatitis infection also should have jaundice or elevated liver aminotransferases, the specification for elevation depending on the hepatitis type.

For chronic hepatitis B, acute hepatitis C, and chronic hepatitis C, all nucleic acid testing is now included in a single field. All previous hepatitis laboratory field asking for nucleic acid test results are replaced with one field for any nucleic acid testing (qualitative, quantitative or genotype testing). Any positive entries for previous fields will be migrated to the new field to assist with analysis.

For acute hepatitis A, the laboratory criterion for liver function tests is changing to “elevated serum aminotransferase level” without specifying a cut-off value. This was the field in use several years ago. PHIMS will reactivate the field and include previous responses. In addition, any positive entries for the previous 2011 criterion of alanine aminotransferase (ALT) > 200 IU/L will be migrated to the new field to assist with data analysis.
In a related change, for **acute hepatitis B** the existing cut-off for ALT will drop from 200 to 100 IU/L. Any positive entries for the previous field regarding ALT will be migrated to the new field to assist with data analysis. The **acute hepatitis B** case definition adds asymptomatic seroconversion: “a documented negative hepatitis B surface antigen (HBsAg) laboratory test result within 6 months prior to a positive test [either HBsAg, hepatitis B ‘e’ antigen (HBeAg), or hepatitis B virus nucleic acid testing (HBV NAT) including genotype] result does not require an acute clinical presentation to meet the surveillance case definition” as a Confirmed case of acute hepatitis B. A new laboratory field will capture this criterion.

For **acute hepatitis C**, the absence of IgM antibody to hepatitis A virus and IgM antibody to hepatitis B core antigen (negative results) will be required only if those tests have been done. This is a change from requiring a negative screen for acute hepatitis A and acute hepatitis B. In addition, the **acute hepatitis C** case definition adds a category for asymptomatic seroconversion: “a documented negative HCV antibody laboratory test result followed within 6 months by a positive test (as described in the laboratory criteria for diagnosis) result does not require an acute clinical presentation to meet the surveillance case definition” as a Confirmed case of acute hepatitis C. A new laboratory field will capture this criterion.

**Agents Causing Diarrhea**

In some regions of the country there is a recent expanded commercial availability of non-culture based diagnostic methods such as enzyme immunoassay (EIA) and polymerase chain reaction. National case definitions have been changed to reflect both currently available and anticipated non-culture methods.

**Cryptosporidiosis** can be diagnosed by a variety of commercially available laboratory tests. The Confirmed case classification will require testing by a method with a high positive predictive value (PPV) which for 2012 will include detection of antigen by EIA in addition to the existing criteria: detection of organisms by light microscopy of stained specimens, detection of organisms by direct fluorescent antibody (DFA), or detection of *Cryptosporidium*-specific nucleic acid by polymerase chain reaction (PCR). Previously EIA supported a Probable cryptosporidiosis case classification. Starting in 2012 the Probable case classification will apply to detection of *Cryptosporidium* antigen by a screening test method, such as immunochromatographic card/rapid card test, or a laboratory test for *Cryptosporidium* of unknown method.
Beginning in 2012, three enteric conditions have a newly created Suspect case classification. Detection of the respective genus using a non-culture based method will meet the Suspect classification for campylobacteriosis, salmonellosis, and shigellosis without a requirement for meeting any clinical criteria. Note that previously a campylobacteriosis report meeting the clinical criteria and having a positive test through a non-culture based method was reported as a Probable case. EIA results for Campylobacter are being reported by laboratories in Washington currently but other non-culture based methods for enteric bacteria are not commonly available in our region.

Finally, under vibriosis, the organism Grimontia hollisae was previously classified as a Vibrio species but is now in its own genus within the same family. A confirming vibriosis laboratory test is identification of a pathogen in Vibrionaceae family (excluding toxigenic V. cholerae) by culture. In the species list in PHIMS, G. hollisae will simply be relabeled so all existing data will remain available for analysis.

The new national case definition changes apply to cases recorded for the reporting year 2012. Cases being reported for 2011 during January and February, 2012, should use the 2011 case definitions. To allow time for completing cases from 2011, the case definitions will become active for electronic reporting through PHIMS during the second week in February, 2012. Updated forms and guidelines from Communicable Disease Epidemiology will be posted at the same time.

For questions about case definitions, please contact our office for assistance: Communicable Disease Epidemiology at 206-418-5500 or 877-539-4344.

Below are links to CDC resources for notifiable conditions reporting.


Historical record of national case definitions: http://www.cdc.gov/osels/ph_surveillance/nndss/phs/infdis.htm#top