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** NOTICE: This health alert provides written guidance for health care professionals and others who may need to take action to prevent or control a notifiable condition. It is not intended to provide guidance for the general public.*

Communicable Disease Update on Increased Respiratory Virus Activity, Outbreaks of Nontuberculous *Mycobacteria* Infections Associated with Dental Waterlines & Ebola Virus Disease (EVD) Outbreak in Uganda

Increased Respiratory Virus Activity, Especially Among Children, Early in the 2022-2023 Fall and Winter

Requested Actions:

Recommend and offer vaccinations against influenza and COVID-19 for all eligible persons aged 6 months or older

- Anyone who has not received an influenza vaccine this season or who is not up to date with COVID-19 vaccination should be vaccinated now.

Use diagnostic testing to guide treatment and clinical management

- Diagnostic testing should be considered for patients with suspected respiratory virus infections, particularly among hospitalized patients, those with factors placing persons at high risk for severe outcomes from flu and COVID-19, and those with severe or progressive illness. With multiple co-circulating respiratory viruses, particularly influenza and SARS-CoV-2, for which there are antiviral options recommended for specific groups, diagnostic testing can guide treatment and management to improve patients' clinical course and outcomes.
- Information to assist clinicians about when to consider respiratory virus testing is available [at Information for Clinicians on Influenza Virus Testing](#), [Respiratory Syncytial Virus for Healthcare Professionals](#), and [COVID-19 Testing: What You Need to Know](#). Information on RV/EV, EV-D68 testing was described in detail in a [HAN Health Advisory released on September 9, 2022](#).

Treat patients with suspected or confirmed influenza who meet clinical criteria with influenza antivirals

- CDC recommends influenza antiviral treatment as early as possible for any patient with confirmed or suspected influenza who is: a) hospitalized; b) an outpatient at higher risk for influenza complications; or c) an outpatient with severe, complicated, or progressive illness. Clinical benefit is greatest when antiviral

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treatment is administered as early as possible after illness onset (ideally within 48 hours), although antiviral treatment initiated later than 48 hours after illness onset can still be beneficial for some patients (e.g., outpatients at increased risk for complications and hospitalized patients). The CDC Influenza Antiviral Medications: Summary for Clinicians can be found at: [Influenza Antiviral Medications: Summary for Clinicians | CDC](#)

Treat outpatients and hospitalized patients with confirmed SARS-CoV-2 infection who are at increased risk for severe illness and meet age- and weight-eligibility requirements

- COVID-19 antiviral agents reduce risk for hospitalization and death when administered soon after diagnosis. The antiviral medications nirmatrelvir and ritonavir (Paxlovid) or remdesivir (Veklury) are the preferred treatment options for COVID-19 in patients with mild to moderate illness who are at increased risk for severe illness, including older adults, unvaccinated persons, and those with certain medical conditions.

To prevent RSV-associated hospitalizations, eligible high-risk children should receive palivizumab treatment in accordance with AAP guidelines.

- Children eligible for palivizumab include infants prematurely born at less than 29 weeks gestation, children younger than 2 years of age with chronic lung disease or hemodynamically significant congenital heart disease, and children with suppressed immune systems or neuromuscular disorders.

Background:

Currently, the U.S. is experiencing a surge and co-circulation of respiratory viruses other than SARS-CoV-2. CDC is tracking levels of respiratory syncytial virus (RSV), influenza, and rhinovirus/enterovirus (RV/EV) that are higher than usual for this time of year, especially among children and placing strain on health care systems. Co-circulation of respiratory syncytial virus (RSV), influenza viruses, SARS-CoV-2, and others could place stress on healthcare systems this fall and winter. CDC Influenza hospitalization data can be found at: [Laboratory-Confirmed Influenza Hospitalizations \(cdc.gov\)](#). CDC RSV hospitalization data can be found at: [RSV Surveillance Data - NREVSS | CDC](#). COVID-19 data from the Washington State Department of Health Dashboard can be found at: <https://doh.wa.gov/emergencies/covid-19/data-dashboard>. This early increase in disease incidence highlights the importance of optimizing respiratory virus prevention and treatment measures, including prompt vaccination, appropriate testing and antiviral treatment.

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References

RSV

[RSV Information for Healthcare Providers](#)

[RSV Trends and Surveillance](#)

[RSV Symptoms and Care](#)

Influenza

[Summary of Influenza Antiviral Treatment Recommendations for Clinicians](#)

[Information for Clinicians on Influenza Virus Testing](#)

[Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities](#)

[Influenza Preventive Steps](#)

COVID-19

[CDC COVID-19 Data Tracker](#)

[NIH COVID-19 Treatment Guidelines](#)

[COVID-19: People with Certain Medical Conditions](#)

[COVID-19: Test to Treat Locator](#)

[Indicators for Monitoring COVID-19 Community Levels and Making Public Health Recommendations](#)

Outbreaks of Nontuberculous Mycobacteria Infections Highlight Importance of Maintaining and Monitoring Dental Waterlines

Requested Action:

Medical Providers:

- Consider an odontogenic source for cervical lymphadenitis or lymphadenopathy and assess a history of dental care and procedures in all children presenting with lymphadenitis.
- Report lab confirmed infections suspected to be associated with receiving healthcare, including dental care, to Thurston County Public Health and Social Service's communicable disease reporting line.

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Dental Providers:

- Use sterile saline or sterile water as a coolant or irrigate for surgical procedures. For all non-surgical dental procedures, use water that meets CDC recommendations (i.e., <500 CFU/mL of heterotrophic water bacteria).
- Consider following more conservative recommendations from the American Academy of Pediatric Dentistry (AAPD), the American Association of Endodontists (AAE), and the Organization for Safety, Asepsis, and Prevention (OSAP) when performing non-surgical irrigation. Specific recommendations linked below.
- Discharge water and air for a minimum of 20-30 seconds after each patient from any device connected to the water system that enters the patient's mouth (e.g., handpieces, ultrasonic scalers, and air/water syringes).
- Ensure that your facility has an infection prevention plan including staff training, record keeping, policies, and standard operating procedures dedicated to monitoring water quality. Review the US Food and Drug Administration's (FDA) website on dental unit waterlines and consult with the dental unit manufacturer for appropriate methods and equipment to maintain the quality of dental water.
- Report lab confirmed infections suspected to be associated with receiving healthcare, including dental care, to Thurston County Public Health and Social Service's communicable disease reporting line.

Background:

On October 31, 2022, the Centers for Disease Control and Prevention (CDC) issued a HAN alert to emphasize the importance of maintaining and monitoring dental waterlines. This was in response to multiple outbreaks of nontuberculous *Mycobacteria* (NTM) post pulpotomy in pediatric dental clinics where dental treatment water contained high levels of bacteria.

Dental unit waterlines (narrow-bore plastic tubing that carry water to a handpiece, syringe, and scaler) are prone to biofilm formation. Biofilms occur in dental unit waterlines due to the long, small-diameter tubing and low flow rates used in dentistry in addition to frequent periods of water stagnation. These biofilms result in high levels of common waterborne bacteria in dental unit waterlines, some of which disease-causing microorganisms, including *Legionella*, *Pseudomonas aeruginosa*, and NTM.

Recent NTM outbreaks have involved young children, ages four to eight. Many of these children suffered severe infections with clinical diagnoses such as cervical lymphadenitis and mandibular or maxillary osteomyelitis, and required hospitalization, IV antibiotics, and

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surgery. Long-term complications from these infections included permanent tooth loss, hearing loss, facial nerve palsy, and incision fibrosis.

Due to the potential for biofilm in dental unit waterlines, the CDC recommends all dental unit waterlines be treated regularly with disinfectants to meet the Environmental Protection Agency's (EPA) regulatory standards for drinking water (i.e. <500 colony forming units CFU/mL of heterotrophic water bacteria). During surgical procedures involving the incision, excision, or reflection of tissue that exposes normally sterile areas of the oral cavity, the CDC recommends the use of sterile solutions and devices such as sterile bulb syringes, sterile tubing that bypasses dental unit waterlines, and sterile single-use devices.

Resources:

AAPD Recommendations: [BP PulpTherapy.pdf \(aapd.org\)](#)

AAE Recommendations: [AAE Position Statement on Vital Pulp Therapy \(netdna-ssl.com\)](#)

OSAP Recommendations: [Dental Unit Water Quality: Organization for Safety, Asepsis and Prevention White Paper and Recommendations– 2018 | Published in Journal of Dental Infection Control and Safety \(scholasticahq.com\)](#)

FDA Dental Waterlines: [Dental Unit Waterlines | FDA](#)

CDC HAI Reporting: [State-based HAI Prevention | HAI | CDC](#)

CDC Infection Prevention in Dental Settings: [Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care \(cdc.gov\)](#)

Ebola Virus Disease (EVD) Outbreak Update

Requested Actions:

- Systematically assess patients for the possibility of EVD through a [triage and evaluation process](#). Getting a thorough travel history is important for all acutely ill patients returning from an area with an active Ebola virus outbreak. Begin immediate infection control measures for acutely ill patients with a concerning travel history. A list of current EVD outbreaks can be found here: [Outbreaks | Ebola \(Ebola Virus Disease\) | CDC](#) In the absence of concern for a suspect EVD case, prior travel to Uganda should not be a reason to defer standard laboratory testing needed for routine patient care.

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- Include EVD in the differential diagnosis in patients with travel to Uganda in the past 21 days who have clinical symptoms such as fever, headache, muscle and joint pain, fatigue, loss of appetite, gastrointestinal symptoms, or unexplained bleeding.
- Consider alternative diagnoses such as [malaria](#), typhoid fever, meningococemia, COVID-19, influenza, or common causes of gastrointestinal and febrile illnesses in a patient with recent travel and follow standard evaluation and management procedures for these conditions.
- If EVD is suspected, patient(s) should be isolated in a private room with a private bathroom or covered, bedside commode. Follow [CDC's PPE guidance for confirmed Ebola patients](#).
- Ensure healthcare personnel are aware of how EVD can be transmitted in the health care setting. Healthcare personnel can be exposed by touching a patient's body fluids, contaminated medical supplies and equipment, or contaminated environmental surfaces. Splashes to unprotected mucous membranes (for example, the eyes, nose, or mouth) are particularly hazardous. Procedures that can increase environmental contamination with infectious material or [create aerosols](#) should be minimized.
- Travelers with possible exposure to Ebola virus may need public health monitoring and movement controls depending on the risk of exposure and clinical presentation. Clinicians should immediately contact Thurston County Public Health and Social Services for suspected EVD cases and contact 360-867-2500 Monday- Friday 8am-5pm excluding holidays or 1-800-986-9050 after hours.

Background:

On September 20, 2022, the Ministry of Health of Uganda officially declared an outbreak of EVD caused by Sudan virus (species Sudan ebolavirus) in Mubende District, Central Uganda. As of November 5, 2022, a total of 132 confirmed cases of EVD have been identified in Uganda; 39% of confirmed cases have died.

Ebola Virus Disease (EVD) is a rare and deadly disease in people and nonhuman primates. The viruses that cause EVD are located mainly in sub-Saharan Africa. A person infected with EVD is not contagious until [symptoms](#) appear. Symptoms may include fever, headache, muscle and joint pain, fatigue, loss of appetite, gastrointestinal symptoms, or unexplained bleeding. Sudan virus is spread through **direct contact** (through broken skin or mucous membranes) with the body fluids (blood, urine, feces, saliva, droplet, or other secretions) of a person who is sick with or has died from EVD, with the body fluids of infected animals (including those that died from EVD), or with objects like needles that are contaminated with the virus. EVD is **not** spread through airborne transmission.

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In the absence of early diagnosis and appropriate supportive care, EVD is a disease with a high mortality rate. Occasional outbreaks have occurred mostly on the African continent. With intense supportive care and fluid replacement, mortality rates may be lowered. There is currently no Food and Drug Administration (FDA)-licensed vaccine to protect against Sudan virus infection. There is also currently no FDA-approved treatment for Sudan virus.

As of November 10, 2022, there have been no EVD cases associated with this outbreak identified in the United States.

Resources:

General Ebola Information

[General Resources for Ebola Virus Disease](#)

Clinician Resources

[Ebola Virus Disease Information for Clinicians in U.S. Healthcare Settings](#)

[Screening Patients for Ebola Virus Disease](#)

[CDC – Malaria – Guidance for Malaria Diagnosis in Patients Suspected of Ebola Infection in the United States](#)

[Considerations for Discharging People Under Investigation \(PUIs\) for Ebola Virus Disease](#)

Infection Prevention Resources

[Interim Guidance for U.S. Hospital Preparedness for Patients Under Investigation \(PUIs\) or with Confirmed Ebola Virus Disease](#)

[Infection Prevention and Control Recommendations for Hospitalized Patients Under Investigation \(PUIs\) for Ebola Virus Disease \(EVD\) in U.S. Hospitals](#)

[Personal Protective Equipment \(PPE\) | Public Health Planners | Ebola \(Ebola Virus Disease\) | CDC Cleaning and disinfecting](#)

[Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus](#)

[Guidance for U.S. Laboratories for Managing and Testing Routine Clinical Specimens When There is a Concern about Ebola Virus Disease | For Laboratory Personnel | Ebola \(Ebola Virus Disease\) | CDC](#)

[Procedures for Safe Handling and Management of Ebola-Associated Waste](#)

COMMUNICABLE DISEASE UPDATE

COMMUNICABLE DISEASE CONTROL AND PREVENTION SECTION
THURSTON COUNTY PUBLIC HEALTH AND SOCIAL SERVICES DEPARTMENT
412 LILLY RD NE
OLYMPIA, WA, 98506-5132
DISEASE REPORTING: (360)786-5470



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THANK YOU FOR REPORTING

TO REPORT A NOTIFIABLE CONDITION IN THURSTON COUNTY	
Voice mail for reporting non-immediately reportable conditions (24 hours a day)	Phone: 360-786-5470 Fax: 1-833-418-1916
Day time immediately reportable conditions – Call detailed information to the 24-hour Notifiable Condition Reporting Line at 360-786-5470. Messages are picked up hourly. If a call back can't wait call 360-867-2500 and ask staff to locate a Communicable Disease staff.	Phone: 360-786-5470
After hours immediately and 24-hour reportable conditions or a public health emergency	Call 1-800-986-9050
No one is available with Thurston County Public Health and condition is immediately notifiable	1-877-539-4344

Communicable Disease Updates are posted online at: <http://bit.ly/CDUpdatePHSS>