QUARTERLY REPORT

MARION COUNTY HEALTH DEPARTMENT
Health & Services Building
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Marion County OREGON

4th Quarter

December 2001

Vital Statistics Quarter Ending: December 2001	4th Quarter		Year to Date	
	2001	2000	2001	2000
BIRTHS				
TOTAL DELIVERIES	1222	1163	4877	4638
Delivery in Hospital	1218	1109	4834	4406
Teen Deliveries (10-17 years)	54	54	227	232
DEATHS				
TOTAL	641	612	2482	2406
Medical Investigation	51	48	182	188
Homicide	02	02	09	08
Suicide	12	13	35	38
Accident - MVA	08	08	29	31
Accident – Other	04	06	33	29
Natural/Undetermined/Pending	25	19	76	82
Non-Medical Investigation (All Natural)	590	564	2300	2212
Infant Deaths	02	01	11	14
Fetal Deaths	04	03	15	18
COMMUNICABLE DISEASES				
E-Coli: 0157	07	0	12	39
Hepatitis A	01	03	16	13
Acute Hepatitis B	08	06	29	15
Chronic Hepatitis B	08	21	48	38
Meningococcus	0	06	10	14
Pertussis	06	02	12	10
Tuberculosis	06	01	17	12
SEXUALLY TRANSMITTED DISEASE				
PID (Pelvic Inflammatory Disease)	01	19	16	66
Chlamydia	223	189	789	805
Gonorrhea	12	16	60	67
AIDS	06	06	08	15

2001-TheYear in Review

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Health Officer

2001 will live in our memories as a year of momentous events in our country. As we enter the new year, let's take a look at a couple of the important public health issues of 2001 and take note of what may be coming in 2002.

Adult and Childhood Immunizations

Vaccine production and distribution delays continue to present challenges to physicians and public health clinics attempting to reduce the burden of vaccine-preventable diseases.
First some good news.
Despite an initial delay in distribution of influenza vaccine, a total of 87 million influenza vaccine doses have been produced for the 2001-02 season.
Influenza vaccine from all three of the manufacturers licensed to distribute in the U.S. is now available and ready for immediate shipment.
The influenza season is underway with most states reporting only sporadic or regional influenza activity.
Isolates from this year so far are predominately type A (H3N2) and are a close match with this year's vaccine strains.

Continued

In Oregon, of 120 isolates evaluated at the Oregon State Public Health Laboratory this year, 7% are positive for Type A influenza.
This compares with 21 positive isolates of 129
(6 type A and 15 type B) or 16% for the same time last year.

IT'S NOT TOO LATE TO VACCINATE!

Individuals at risk for complications of influenza (persons over 65 years of age and persons 2-65 years with underlying medical conditions), as well as others who want to reduce their risk of getting influenza this year and deferred vaccination due to initial shipping delays may still be vaccinated.
Call Marion County Health Department at **(503) 588-5342**
for more information or to schedule an appointment.

Shortages for diphtheria and tetanus toxoid vaccines (Td) are expected to continue into mid-2002.
The shortage began in 2000 when two manufacturers stopped production.
Currently there are only two licensed suppliers in the U.S.
Requirements for children aged 7 years and older who need a dose of diphtheria and tetanus containing vaccine under the Oregon School Immunization Law have been temporarily suspended during this shortage.
When vaccine supplies normalize, children whose Td doses have been deferred should be recalled and vaccinated according to the appropriate schedule for age.

Prevnar, the 7-valent pneumococcal vaccine licensed in February 2000, is also currently in short supply across the nation.
Priority for vaccination with Prevnar should be given to high-risk children (sickle cell disease, chronic cardiopulmonary disease and other immunosuppressive conditions) who should be vaccinated according to the recommended schedule.
Healthy children should be vaccinated with two or three doses depending on vaccine availability.
Booster doses should be deferred at this time.
Supplies may not be sufficient for a return to the "routine" schedule until mid-2002.
(See table)

Bioterrorism

A major public health threat emerged in October of 2001 with the report of the first case of inhalational anthrax in the U.S. in nearly 25 years.
Twenty-two cases of anthrax (inhalational and cutaneous) were identified as of December 5, 2001.
Direct exposure to a *B. anthracis* containing envelope was likely in the first nine of 11 inhalational cases.
The source of exposure remains unknown in the most recent two inhalational cases.
Approximately 85 million pieces of mail were processed on the days after the implicated envelopes passed through the New Jersey and District of Columbia sorting facilities until they were closed.
Both of these facilities had evidence of widespread environmental contamination with *B. anthracis*.
Despite the high volume of mail distributed to metropolitan areas around the contaminated facilities, active surveillance has not identified additional anthrax cases among the approximately 10.5 million residents in New Jersey, District of Columbia, Pennsylvania, Maryland, or Virginia.
Sampling in Oregon postal facilities revealed no evidence of anthrax and no other testing in Oregon has been positive for anthrax.
Although no new cases of anthrax have been reported since mid-November, this outbreak has highlighted the need to plan for the response to a bioterrorism event both at the federal and local levels.
Response at the national level has included:

- Appropriation of more than $1 billion designated for states to help prepare their public health infrastructure to respond in the event of a bioterrorism event.
- Stepped-up production of smallpox vaccine to ensure adequate supplies to vaccinate the nation by 2003.
- Creation of the Office of Public Health Preparedness to coordinate agencies' response to future incidents.

Recognition of and response to a bioterrorism event will depend (as it did with the first diagnosed case in Florida) on the ability of clinicians to identify cases rapidly and report them immediately to public health officials.
Most of these diseases are not encountered regularly, if ever, (as is now the case with smallpox).
To help meet the challenge of bioterrorism, get to know the signs, symptoms, and presentation of the "A" list (CDC's list of the most likely agents to be used in a bioterrorism attack which includes, anthrax, smallpox, plague, tularemia, and botulism).
The CDC has unveiled a redesigned Web site this month with both new and updated bioterrorism resources for health professionals and the public.
Visit www.bt.cdc.gov for-up-to-date and accurate information on health threats arising from exposure to biological, chemical, or radiological agents.
Marion County Health Dept is also maintaining a resource library of videos.
For more information, call
(503) 588-5621.
You can link with other information resources including:
CDC and Johns Hopkins Center for Civilian Biodefense by visiting the health department web site at
www.open.org/mhealth/whatsnew/bt.htm

Notices to Readers — Continued

TABLE 1. Updated recommendations for pneumococcal conjugate vaccine use among healthy children during moderate and severe shortages — Advisory Committee on Immunization Practices, 2001

Age at first vaccination	No shortage*	Moderate shortage	Severe shortage
<6 months	2, 4, 6, and 12–15 months	2, 4, and 6 months (defer 4th dose)	2 doses at 2–month interval in 1st 6 months of life (defer 3rd and 4th doses)
7–11 months	2 doses at 2–month interval; 12–15 month dose	2 doses at 2–month interval; 12–15 month dose	2 doses at 2–month interval (defer 3rd dose)
12–23 months	2 doses at 2–month interval	2 doses at 2–month interval	1 dose (defer 2nd dose)
>24 months	1 dose should be considered	No vaccination	No vaccination
Reduction in vaccine doses used†		21%	46%

* The vaccine schedule for no shortage is included as a reference. Providers should not use the no shortage schedule regardless of their vaccine supply until the national shortage is resolved.

† Assumes that approximately 85% of vaccine is administered to healthy infants beginning at age <7 months; approximately 5% is administered to high-risk infants beginning at age <7 months; and approximately 10% is administered to healthy children beginning at age 7 to 24 months. Actual vaccine savings will depend on a provider's vaccine use.