Escherichia coli O157
Outbreak from Uncooked Spinach

28 September 2006 (Donald Kaye)—Beginning with the first case on 19 August 2006, a total of 187 cases of illness due to Escherichia coli O157:H7 infection, presumably caused by ingestion of uncooked spinach, have been reported to the Centers for Disease Control and Prevention, including 29 cases of hemolytic uremic syndrome, 97 hospitalizations, and 1 death.

All spinach implicated in the current outbreak has been traced back to fresh bagged and washed spinach and spinach-containing products from Natural Selection Foods of San Juan Bautista, California. Frozen and canned spinach have not been implicated in this outbreak.

As of 26 September 2006, cases of E. coli O157:H7 infection have been reported in 26 states in the United States, and 1 case in Canada has been reported. These states and their numbers of reported cases are as follows: Arizona (7 cases), California (1), Colorado (1), Connecticut (3), Idaho (4), Illinois (1), Indiana (9), Kentucky (8), Maine (3), Maryland (3), Michigan (4), Minnesota (2), Nebraska (9), Nevada (1), New Mexico (5), New York (11), Ohio (24), Oregon (6), Pennsylvania (8), Tennessee (1), Utah (18), Virginia (2), Washington (3), West Virginia (1), Wisconsin (47), and Wyoming (1).

Malaria—Great Exuma, Bahamas, May–June 2006

22 September 2006 (Morbidity and Mortality Weekly Report)—In the Caribbean region, malaria has been eliminated from all islands except Hispaniola, the island consisting of Haiti and the Dominican Republic. However, even Caribbean islands where malaria is no longer endemic remain at constant risk for reintroduction of the disease because of their tropical climate, presence of competent malaria vectors, and proximity to other countries where malaria is endemic. This susceptibility was underscored by the recent outbreak of malaria on the island of Great Exuma in the Bahamas. During May–June 2006, a total of 19 malaria cases were identified. Four were in travelers from North America and Europe. On 19 September, after 3 months with no report of new cases, the Centers for Disease Control and Prevention rescinded its previous recommendation that US-based travelers take preventive doses of chloroquine before, during, and after travel to Great Exuma.

Active case detection was conducted on Great Exuma during 6–30 June; however, no case of malaria was diagnosed later than 19 June. On Great Exuma, 15 persons were determined infected with Plasmodium falciparum. Ages ranged from 16 to 66 years (median, 36 years); 84% were males. All patients were initially treated with chloroquine and doxycycline; the latter was subsequently replaced by primaquine to eliminate gametocytes and thus prevent further transmission. All 15 patients recovered.

A parasite prevalence survey was conducted on Great Exuma in a community of immigrants from Haiti, from which anecdotal reports of illness had been received. Of 159 persons who consented to testing, 29 adults were determined infected with P. falciparum. This finding prompted mass treatment with chloroquine and primaquine of 203 persons within that community.

Mosquito-control interventions were intensified beginning 30 May. These measures included spraying (1) at all potential breeding sites, (2) within a quarter-mile radius of patients with confirmed cases, and (3) within a half-mile radius of patients detected through contact tracing, initially with a water-based pyrethroid insecticide, and later with malathion 96.5%. In addition, all bodies of fresh water on Great Exuma, neighboring Little Exuma, and surrounding cays (reefs) were treated with temephos to eliminate larvae.

Editor’s note from Morbidity and Mortality Weekly Report. The Bahamas consist of approximately 700 islands and 2400 cays stretching between Florida and Haiti. Persons from Hispaniola and other countries have emigrated to the Bahamas, where malaria is not endemic and only 1 imported case was reported in 2005. However, because of frequent travel and relocation among countries, health-care providers in the Bahamas and other countries where malaria is not endemic should remain alert to the risk for this disease, especially in travelers and immigrants. Introduced malaria is much less common than imported malaria but of greater epidemiologic significance. Introduced malaria typically occurs when infected travelers return home and transmit the infection to local Anopheles mosquitoes, which subsequently transmit it to local residents. Left unchecked, this process can result in reestablishment of endemic malaria in countries that have previously eliminated the disease because these areas have climatic conditions favorable to transmission and Anopheles species that are receptive to malaria parasites. In the United States, 1320 cases of imported malaria were reported in 2004, and 63 episodes of introduced malaria were detected from 1957 to 2003.

Available evidence indicates that during May–June 2006, Great Exuma experienced an outbreak of introduced malaria that was successfully contained and terminated. The observations that all cases were caused by P. falciparum and a substantial proportion of patients were immigrants from Haiti suggest that malaria was introduced by those immigrants. All patients treated with chloroquine responded to the treatment, which is a further suggestion that the parasites originated from Haiti, where P. falciparum has remained sensitive to chloroquine. P. falciparum causes 99% of malaria cases in Haiti and the Dominican Republic. Conversely, P. vivax causes...
94% of cases in Mexico and Central America.

**Everyone between 13 and 64 Should Be Screened for HIV: CDC**

21 September 2006 (Reuters Health)—Everyone in the US between the ages of 13 and 64 years should undergo routine screening for HIV infection, the US Centers for Disease Control and Prevention (CDC) announced today as part of an update on their guidelines for HIV testing.

All health-care providers should also incorporate routine, voluntary HIV screening into their daily practice, the CDC officials reported in a report, dated 22 September 2006.

About 25% of HIV-positive adults in the US are unaware of their infection, Dr. Bernard M. Branson and his colleagues indicate. They note that patients who are unaware of their infection are significantly more likely to transmit HIV than those who know their HIV status, and that 30% of new infections could be reduced annually if infected persons who know their HIV status adopt changes in high risk behaviors.

Along with routinely testing a more broad population, the researchers also stipulate that this should be a voluntary approach, with the patient permitted to decline testing after appropriate counseling. The CDC no longer requires written consent. If the patient declines an HIV test, this decision should be documented in the medical record.

They also suggest that persons at high risk be tested annually, and that clinicians should be alert to patients with symptoms of acute HIV infection, which resemble those of influenza, mononucleosis, and other viral illnesses. In such cases, before they have seroconverted, these patients should be tested for HIV RNA in plasma.

Mother-to-child HIV transmission has declined tremendously since 1991, but 240 cases still occur each year. The guideline authors currently advise that HIV screening be included in the routine prenatal screening tests for all pregnant women during their first trimester, with another test in the third trimester. If the patient refuses testing, the clinician should address the reasons for opting out, such as lack of perceived risk, fear of partner violence, or potential discrimination.

If the woman’s HIV status is still unknown at the time of labor, she should be screened with a rapid HIV test and receive antiretroviral prophylaxis. Newborns should also be tested as soon as possible so that prophylaxis can be initiated.

Dr. Jeff Schouten, Board Chair of the Academy of HIV Medicine, raised the issue of funding for the increased care. “Testing more people obviously takes money, and CDC doesn’t have it,” Dr. Schouten adds. “Who’s going to pay for it?”


**Bird Flu Experts Call for Sharing Virus Samples**

26 September 2006 (Reuters [Stephanie Nebehay])—International experts called on countries to share freely all influenza virus samples and genetic sequencing data, key to developing a vaccine against a potential bird flu pandemic.

The appeal was among recommendations issued by the World Health Organization’s (WHO) new influenza pandemic task force, whose experts held a first, closed-door meeting in Geneva.

The 21-member task force was launched last May to advise the WHO’s director-general on technical issues amid fears that the H5N1 virus could spark a human pandemic and could kill millions.

“They endorsed proposals for best practices in sharing of influenza viruses and specimens and genetic sequences,…” David Heymann, WHO’s acting special representative on avian influenza, told a news briefing.

Under WHO’s system, virus samples should be shared by laboratories free of charge and any candidate viruses for vaccine production given to drugmakers at no cost.

But health officials have expressed concern that some developing countries are reluctant to release H5N1 animal and human virus information, with China often named as a holdout. The viruses remain the property of countries, and before any of the genetic sequence data is made available, the WHO seeks a country’s specific permission to have the genetic sequence data posted on publicly accessible websites.

Some developing countries have voiced concerns that they may lose out on lucrative drugs’ patents if data are handed over to Western pharmaceuticals.

**Editor’s comment.** The importance of being able to track changes in the virus cannot be overemphasized. It is critical in tracking the pathogenicity characteristics of the virus as it mutates and to have available appropriate virus for selection for vaccine production.