



CONNECTICUT EPIDEMIOLOGIST

State of Connecticut Department of Health Services
Frederick G. Adams, D.D.S., M.P.H. Commissioner

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WANTED: PHYSICIAN WRITERS

The June 1989 issue of **CONNECTICUT MEDICINE**, the journal of the Connecticut State Medical Society, will be devoted to the topic of **Lyme disease**. Connecticut physicians are invited to share in writing their concerns and experiences with Lyme disease. Specific comments would be appreciated on the impact of Lyme disease on the practice of medicine in Connecticut and opinions on the issue of whether tick bites should be treated prophylactically with antibiotics. Submissions should be in the form of letters to the editor and should be sent by April 14 to Robert U. Massey, M.D., Editor, **CONNECTICUT MEDICINE**, 160 St. Ronan Street, New Haven, CT 06511. For further information, call Matt Cartter, M.D., Epidemiology Program Coordinator, DHS at 566-5058.



INFLUENZA UPDATE

In January 1989, the first cases of influenza were confirmed by the state laboratory. Of the five influenza viruses isolates, four were influenza type A and one was influenza type B. Three of the four type A isolates were H3N2 subtypes while the fourth isolate was an H1N1 subtype.

Nationally, influenza B has predominated during this influenza season, with most reported illnesses occurring in children. The impact that this year's influenza B activity will have on older

persons and persons at high risk of serious complications or death is unknown. However, excess mortality has occurred in each of the influenza B epidemics since 1979.

An increased risk for Reye syndrome in children and teenagers when aspirin is used to treat influenza symptoms has been reported in years when type B influenza has predominated. Parents, teenagers and children who self-medicate, and health-care workers should be aware of this possible serious complication associated with aspirin use.



CONTROL OF INFLUENZA IN NURSING HOMES INCLUDING USE OF AMANTADINE

The Influenza Branch at CDC has developed guidelines for the control of influenza A in nursing homes which supplement the annually published ACIP guidelines (MMWR 1988;37:361-4,369-73).

During the winter influenza season, especially when influenza is present in the surrounding community, nursing home staff should:

1. Develop a system to monitor the incidence of febrile respiratory illness among residents or staff so that increases in incidence can be quickly detected.

2. Post signs in appropriate locations reminding visitors that they should refrain from visiting the nursing home when they have an acute respiratory illness.

3. Reassign staff members ill with acute febrile respiratory symptoms to duties with no resident contact or send them home.

4. Keep residents with acute febrile respiratory illness out of common areas such as dining rooms or sitting rooms and exclude them from group activities.

When an influenza-like outbreak begins in a nursing home, staff should:

1. Assess clinical features of illness for consistency with influenza; i.e., fever, headache, myalgia and malaise in addition to respiratory symptoms.

2. Determine which influenza viruses are circulating in the community by contacting the local health department. Also report the influenza-like illness outbreak to the local and state health departments. Obtain advice about collecting clinical specimens for diagnosis.

3. If influenza A is determined to be a likely cause of the outbreak, administer amantadine to all residents, whether immunized or not, and to staff (especially unimmunized staff who have contact with residents) as soon as possible.

a) The amantadine dosage for adults under age 65 years is 200 mg daily: for persons age 65 years and older and those with active seizure disorders, it is no more than 100 mg daily. Persons with significant kidney dysfunction should receive even lower dosages, based on creatinine clearance, as described in the drug package insert.

b) If influenza A is confirmed, residents and staff should continue taking amantadine at least until 48 hours after resolution of influenza signs and symptoms in the latest case in the home and preferably until influenza A

activity has declined in the surrounding community. If influenza A is not confirmed or if residents continue to become ill despite amantadine prophylaxis, discontinuation of the drug should be considered.

c) Monitor residents on amantadine for development or worsening of signs and symptoms that may represent amantadine toxicity: confusion, delusions, marked personality change, hostility, agitation, hallucinations, nausea and vomiting, and ataxia/loss of balance/falling. Should any of these develop, immediate consideration should be given to discontinuation of amantadine for affected residents.

d) Monitor residents and staff on amantadine for less serious side effects: nervousness, irritability, insomnia, fatigue, depression, decreased appetite. Often these side effects are mild and transient, but in some cases they may be troublesome enough to warrant reducing the amantadine dosage or discontinuing the drug.

Questions concerning these recommendations can be directed to the Epidemiology Program (566-5058).

[Adapted from California Morbidity, State of California Department of Health Services, #11, March 25, 1988]



**SALMONELLA INFECTIONS,
HOSPITALS AND LONG TERM CARE
FACILITIES**

A number of recent Salmonella outbreaks, particularly in the northeastern U.S.A., have been caused by a strain of Salmonella, Salmonella enteritidis (SE), that may infect eggs inside the shell. This has raised concern about how to minimize the risk of developing Salmonella infection from consuming eggs that are possibly intrinsically contaminated. Salmonella infections are

more likely to develop into severe, life-threatening illness in the elderly.

In March 1988, a letter was sent from the Department of Health Services to all nursing home administrators in Connecticut with recommendations for the control of Salmonella in nursing homes. Since then, there have been two SE outbreaks in Connecticut nursing homes associated with eggs. Two procedural problems were identified in both facilities: pasteurized egg products were not used in place of pooled eggs as recommended; and eggs were not cooked to sufficient temperature. Both of these outbreaks might have been prevented had the March recommendations been fully followed. For this reason, it is important to reinforce these recommendations for long term care facilities and hospitals. The following recommendations should be reviewed by administrative, quality control, infection control and dietary personnel and implemented in all Connecticut hospitals and nursing homes:

1. Inform staff that eggs, like other raw food of animal origin, may cause Salmonella infections. Raw eggs should not be served. Recipes calling for (or specifying) raw eggs (e.g. Caesar salad, eggnog, hollandaise sauce, homemade ice cream, homemade mayonnaise) are to be considered high risk. **Pasteurized egg products should be substituted for raw eggs.**
2. Review menus, recipes, and foodhandling practices in your facility and in food services for the homebound elderly (e.g., meals-on-wheels, elderly day care) to prevent exposures to undercooked eggs. Remember, eggs are an ingredient in many foods. Recent egg associated SE outbreaks have occurred in commercially prepared jumbo stuffed shells, gefilte fish, riceballs, french toast, and Monte Cristo sandwiches. **When possible, pasteurized egg products should be used in these recipes.**
3. Primary egg recipes such as scrambled eggs or omelets may be safer if eggs are cracked individually for each order rather

than cracked in quantity and pooled. When advance cracking and pooling of eggs is unavoidable or when large quantities of scrambled eggs or omelets are made in batch, **pasteurized egg products should be substituted for raw eggs.**

It is recommended that eggs should be:

- * Boiled for seven minutes.
- * Poached for five minutes.
- * Fried for three minutes on each side until the yolk is not runny and the white is firm.
- * Scrambled eggs and omelets should be cooked to well done; they should be firm, not runny.
- * Eating eggs sunnyside up increases the risk of acquiring salmonellosis and should not be served.
- * The internal temperature of the eggs should be 165 degrees F.

4. Foods prepared in house that contain eggs, as well as all foods prepared outside the facility that might contain eggs should be thoroughly cooked to an internal temperature of 165 degrees F. This should be verified by temperature checks with probe thermometers.
5. Blenders used for raw eggs and pureed foods must be cleaned and sanitized before use with other foods. The use of separate blenders for raw foods of animal origin (including raw eggs) and ready-to-eat foods is a recommended alternative. Frequent cleaning and sanitizing of blenders is still necessary.
6. Treat raw poultry, beef and pork and fish as if they were always contaminated and handle accordingly. Minimize the potential for bacterial growth.
 - * Handle and store fresh, uncooked meat in such a way as to prevent blood from dripping on or contaminating other foods. These raw products should be stored on a bottom shelf.

- * Refrigerate foods promptly upon receipt, at 45 degrees F or less.
- * Minimize holding at room temperature by preparing foods as close to service time as possible. Do not hold products at an internal temperature of between 45 and 140 degrees F.
- * Avoid eating raw or undercooked meats.
- * Ensure that the correct internal cooking temperature is reached: poultry, stuffing and stuffed meats to 165 degrees F, pork and pork products to 150 degrees F, and beef roast to 145 degrees F. Remember, lower temperature requires longer holding time. Contact the Food Protection Program if you have questions concerning specific time and temperature requirements.
- * Rapidly cool potentially hazardous foods (meat, eggs, fish, poultry, dairy products and other foods which support the rapid growth of bacteria) to 45 degrees F within 4 hours. Subsequently, reheat foods to 165 degrees F.

- * Use a probe thermometer to measure internal temperatures and assure thorough cooking, rapid cooling, and proper holding and reheating temperatures.
 - * Clean and sanitize thermometer after use.
7. Avoid cross contamination of other foods.
- * Wash, rinse, and sanitize cutting boards, counters and other surfaces used for food preparation immediately after use to prevent cross contamination of other foods.
 - * Encourage careful handwashing (generate lather) before food preparation and especially between handling raw and ready-to-eat foods.

For questions or further information, please contact the Food Protection Program, Department of Health Services at 566-1258 or your local health department.

4

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