Oneida County Health Department

PUBLIC HEALTH UPDATE

May 2015 Surveillance | June 2015 Newsletter

Special points of interest:

- Lyme disease is on the rise in Oneida County with 35-50% of the tick population infected
- CDC has released new STD treatment guidelines.
- New videos are available to answer immunization questions.
- NYSDOH releases Health Advisory for Avian Influenza

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LYME DISEASE IN ONEIDA COUNTY

Spring and summer are here, it's time for Lyme updates.

Symptoms/Diagnosis-

http://www.cdc.gov/lyme/healthcare/clinicians.html

Lyme disease can be difficult to diagnose for a number of reasons. Many of the **common symptoms** associated with the disease, such as headaches, dizziness, and joint/body pain, also occur with other diseases. The most distinct symptom of Lyme disease—the circular red rash known as *erythema migrans* (EM) does not appear in at least one quarter of people who are actually infected with Lyme bacteria. Also, current diagnostic tests do not always detect early Lyme disease , because a patient with a working immune system may not have antibodies for *B. burgdorferi* for 4 -6 weeks after a tick bite.

Treatment

According to the Infectious Disease Society of America, after antimicrobial prophylaxis, serologic testing is not recommended. The provider may prescribe a single dose of doxycycline to adult patients (200 mg dose) and to children that are 8 years old or older if **all** the following circumstances exist:

1) the attached tick can be reliably identified as an adult or nymphal *Ixodes scapularis* tick that is estimated to have been attached for at least 36 hours
2) prophylaxis can be started within 72 hours of the time that the tick was removed
3) ecologic information indicates that the local rate of infection of these ticks is greater or equal to 20% and doxycycline treatment is not contraindicated with the pt.

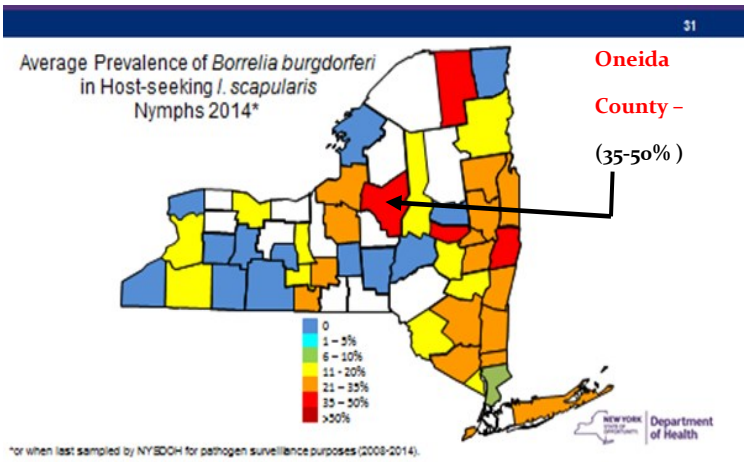
Treatment:

http://cid.oxfordjournals.org/content/43/9/1089.full

Ixodes scapularis tick, when infected with *Borrelia burgdorferi* bacteria can cause Lyme disease. **Tick infection rate in Oneida County in 2014 was 36% in nymphal deer ticks**

In 2014 in Oneida County, there were 38 confirmed and 10 probable cases of Lyme.

There were 2 cases of Babesiosis in 2014 in Oneida County.



Tick Surveillance in Oneida County

As part of annual surveillance efforts, staff from NYSDOH collect and test ticks from a particular site and test for *Borrelia burgdorferi. Of 14 nympyhal deer ticks collected in summer of 2014, 5 were positive, an infection rate of 36%. This information is at one location at one time and should not be used to broadly predict disease risk for a larger area, such as county or town.*

ANSWERING IMMUNIZATION FAQs

Q: Why do newborns get Hepatitis B vaccine?

A: If a newborn acquires Hepatitis B passing through the birth canal, there is a 90% chance of developing cirrhosis and liver cancer in it's lifetime. Before the recommendation for routine vaccination in 1991, 18,000 infants under age one year acquired Hepatitis B each year either through the birth process or through casual contact with Hepatitis B carriers. Because of this recommendation, Hepatitis B in the <19 year old age group has been nearly eliminated.

Q: Do babies get too many vaccines?

A: Babies get up to 26 vaccines in the first few years of their lives. However, it is not the number of shots they get, but the immunological component of each vaccine that must be considered. Each vaccine has approximately 160 immunological components. As newborns enter the birth canal and beyond, they are exposed to trillions of bacteria to which they make an immunologic response. Bacteria can have between 2,000-6,000 immunological components. The common cold is a greater immunological challenge than all vaccines combined. Therefore, the response to this very valid question by parents, is no.

Q: Do I need to avoid being around infants after a Shingles vaccine?

A: The Shingles vaccine contains the same varicella virus as the chickenpox or varicella vaccine but in far greater doses. Even though small amounts could be shed from the inoculation site, if the area is covered by a bandage until it is dry , there is no reason one can't be in the home of an infant or even an immunocompromised person.

Q:Why is the HPV vaccine given to 11-12 year olds?

A: Parents know the human papilloma virus is transmitted sexually and will ask to delay it until the child is sexually active. HPV is a prophylactic rather than therapeutic vaccine given in 3 doses ,and a 6 months window should occur prior to sexual activity. There is a high percentage of adolescents who have sex by age 15. Providers should emphasize the cancer preventing effect of the HPV vaccine.

Adapted from new online video series from the Vaccine Education Center with Paul Offitt, MD Children's Hospital, Philadelphia, PA

♦ For more information and videos go to: www.immunize.org

2015 SEXUALLY TRANSMITTED DISEASES GUIDELINES

These new guidelines for the treatment of persons who have or are at risk for sexually transmitted diseases (STDs) were updated by CDC after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta on April 30–May 2, 2013. The information in this report updates the *MMWR* 2010 recommendations. These updated guidelines discuss **1)** alternative treatment regimens for *Neisseria gonorrhoeae*; **2)** the use of nucleic acid amplification tests for the diagnosis of trichomoniasis**; 3)** alternative treatment options for genital warts; **4)** the role of *Mycoplasma genitalium* in urethritis/cervicitis and treatment-related implications; **5)** updated HPV vaccine recommendations and counseling messages; **6)** the management of persons who are transgender; **7)** annual testing for hepatitis C in persons with HIV infection; **8)** updated recommendations for diagnostic evaluation of urethritis; and **9)** re-testing to detect repeat infection. Physicians and other health-care providers can use these guidelines to assist in the prevention and treatment of STDs.

The new document (137 pages) can be viewed at *http://www.cdc.gov/std/tg2015/default.htm*

When printed products become available, you can order them from CDC-INFO on Demand or NYSDOH will be distributing to providers.

Oneida County Health Department *has completed participation in a NYSDOH incentive program to determine the rate of adherence to CDC treatment regimen , i.e. Gonorrhea treated with 2 drugs administered within 2 days. Also being monitored is the entry of Syphilis lab reports into the Syphilis Serology Registry on the Health Commerce System. As of April 30,2015 the OCHD has met the 90% goal on the above objectives and continues surveillance on all lab reports of sexually transmitted diseases in the county.*

Oneida County Communicable Disease Surveillance—MAY 2015

DISEASE	MAY 2015	*YTD 2015	**YTD 2014	DISEASE	MAY 2015	*YTD 2015	**YTD 2014
Tuberculosis	0	1	1	Influenza A	2	1,364	751
Giardia	2	6	25	Influenza B	13	347	613
Rabies Exposure	5	13	52	Lyme	1	4	4
Salmonella	1	8	7	Pertussis	0	9	6
Chlamydia	54	250	310	Cryptosporidiosis	3	4	3
Campylobacter	2	3	6	Syphilis	2	7	1
Hepatitis C (chronic)	31	60	59	Gonorrhea	9	46	38
Hepatitis C (acute)	0	1	1	*YTD– Year to date as of May 31, 2015	**YTD-Year to date as of May 31, 2014		

CLINICAL SERVICES

406 Elizabeth Street
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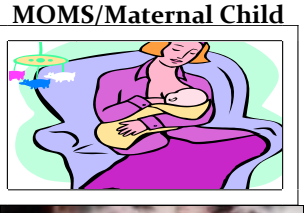
Public Health
Prevent. Promote. Protect.

STD

MOMS/Maternal Child



All previous newsletters are posted at http://www.ocgov.net Go to *Health Department* then click on *For Providers*

Etc. etc

Passport Health

If you are traveling and need vaccination/ counseling, call 855-729-2479. OCHD no longer provides travel clinic services.

NYSDOH has released an informational message to Local Health Dept. regarding travelers from Liberia who will now self monitor after entry into US. More information forthcoming.

See attached information.

Since May 2015, the Republic of Korea has been investigating an outbreak of MERS. It is the largest known outbreak of MERS outside the Middle East.

For more information, see WHO: Middle East respiratory syndrome coronavirus (MERS-CoV) in the Republic of Korea.

NYSDOH Health Advisory

CDC HAN 378 – Bird Infections with Highly-Pathogenic Avian Influenza A (H5N2), (H5N8), and (H5N1) Viruses: Recommendations for Human Health investigations and response.

See attached advisory.

Under the Leadership of

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We're on the Web!

Hours:

8:30 am - 4:00 pm

Monday through Friday

Find us on Facebook

Informational Message: Changes to Enhanced Ebola Virus Disease (EVD) Entry Screening and Monitoring

NYSDOH is advising local health departments (LHDs) that the United States government (USG) is modifying its enhanced Ebola entry screening and monitoring program for travelers from Liberia. On May 9, 2015, the World Health Organization (WHO) declared the end of the Ebola outbreak in Liberia after 42 days (two incubation periods) passed since the last Ebola patient was buried. There are currently no known cases of Ebola in Liberia, and the risk of Ebola for routine travelers returning from Liberia is now considered low. Per WHO guidance, Liberia is maintaining a system of heightened surveillance for a further 90 days, and will continue Ebola surveillance. The Centers for Disease Control and Prevention (CDC) changed its country classification for Liberia on May 13, 2015, to a country with former widespread transmission, and current, established control measures.

As of June 17, 2015, while travelers from Liberia entering the United States will continue to be funneled through the five U.S. airports conducting enhanced entry screening (New York JFK, Washington-Dulles, Newark International, Chicago O'Hare, and Atlanta Hartsfield-Jackson), changes to the USG's enhanced Ebola entry screening and monitoring program will take effect. Travelers from Liberia will continue to have their temperatures taken and be asked questions about travel history and possible exposures to Ebola. Travelers will also provide their contact information so that the health department at their destination can connect with them, if needed. However, under the modified entry screening, travelers from Liberia with no enhanced risk factors will receive a version of the Check and Report Ebola (CARE) kit that includes information about Ebola, a thermometer, and contact information for state and local health departments, but will not receive a cell phone. Travelers will be encouraged to watch their health for 21 days after leaving Liberia ("self-monitoring") and to contact their local health department if they have a fever or any other symptoms consistent with Ebola. NYSDOH will no longer receive or send notifications for Liberian-only travelers.

The USG will continue to evaluate the need for continued screening of travelers from Liberia at regular intervals in order to consider whether additional step-down measures may be warranted. Entry screening and monitoring will not change for travelers entering the United States from Guinea or Sierra Leone---including travelers from Liberia who have also traveled to either Guinea or Sierra Leone within the previous 21 days. Liberia will continue to conduct exit screening procedures for travelers departing Liberia and refer travelers for evaluation or care as appropriate.

LHDs who are monitoring travelers from Liberia, regardless of whether it is active or direct active monitoring, can suspend their efforts effective June 17, 2015, pending telephone confirmation with the traveler of the following information:

- Monitored individuals traveled only to Liberia within the past 21 days. No travel to Guinea or Sierra Leone was undertaken during this time.
- They did not have contact with anyone with Ebola and confirm 'no' answers to all the exposure assessment questions delineated in the CDESS EVD Traveler Monitoring Supplemental Form.

Prior to release from monitoring, staff should request that with the exception of a true medical emergency (in which case 911 should be used), Liberian travelers first contact the LHD, if they become ill before 21 days have elapsed. In these situations, LHDs should work with their regional epidemiologist to evaluate the need for further evaluation at a hospital. During evenings, weekends or holidays, LHDs should contact the NYSDOH Public Health Duty Officer at 1-866-881-2809.

No changes are being implemented by the USG for travelers from Guinea and Sierra Leone, who should continue to be monitored by LHD staff, in accordance with their risk status. These individuals will continue to receive a full CARE kit, including cell phone. NYSDOH will continue to advise LHDs of new travelers via email during workdays and via telephone and email weekends and holidays.

If you have any questions, please contact your regional epidemiologist or the Bureau of Communicable Disease Control at 518-473-4439.

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 3, 2015

TO: Healthcare Providers, Hospitals, and Local Health Departments

FROM: New York State Department of Health (NYSDOH) Division of Epidemiology

HEALTH ADVISORY:
CDC HAN 378 – Bird Infections with Highly-Pathogenic Avian Influenza A (H5N2), (H5N8), and (H5N1) Viruses: Recommendations for Human Health Investigations and Response

For healthcare facilities, please distribute immediately to the Infection Control Department, Emergency Department, Infectious Disease Department, Director of Nursing, Medical Director, Primary Care Providers, and all patient care areas.

On June 2, 2015, CDC issued a Health Advisory (HAN 387; attached) titled "Bird Infections with Highly-Pathogenic Avian Influenza A (H5N2), (H5N8), and (H5N1) Viruses: Recommendations for Human Health Investigations and Response". The purpose of the advisory is to notify public health workers and clinicians of the potential for human infection with these newly-identified influenza viruses and to describe CDC recommendations for patient investigation and testing, infection control including the use of personal protective equipment, and antiviral treatment and prophylaxis. **To date, no highly pathogenic avian influenza (HPAI) H5 viruses have been detected among birds in New York.**

Highly-pathogenic avian influenza (HPAI) H5 viruses have been identified in birds in the United States since December 2014. These viruses have affected >200 backyard and commercial poultry flocks in 15 states. They have been detected only in wild birds in an additional five states. The majority of the outbreaks have occurred in the Midwest, and the public health departments of the affected states are actively investigating and following the health status of persons who have been exposed to infected birds. **To date, there have been no human infections with these recently-identified H5 viruses. CDC considers the risk to the general public from these newly-identified US HPAI H5 viruses to be low, however, close or prolonged contact with infected birds or their contaminated environments might increase the risk of infection**.

Novel influenza A virus infections are nationally notifiable. Healthcare providers should report any suspected infection with a novel influenza A virus, including these HPAI H5 viruses, to the local health department. Healthcare providers should consider the possibility of HPAI H5 infections in persons showing signs or symptoms of respiratory illness who have relevant exposure history. This exposure history would include **direct exposure to birds confirmed or suspected to have HPAI H5 infection (or contaminated environments); again, these viruses have not been detected in New York to date.**

Healthcare providers and facilities and health departments should monitor for announcements of HPAI detections in New York or nearby areas.

Questions about this advisory or HPAI can be directed to BCDC at 518-473-4439 during business hours or 866-881-2809 evenings, weekends and holidays.

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network (HAN)
June 2, 2015, 13:00 ET (1:00 PM ET)
CDCHAN-00378

Bird Infections with Highly-Pathogenic Avian Influenza A (H5N2), (H5N8), and (H5N1) Viruses: Recommendations for Human Health Investigations and Response

Summary: *Highly-pathogenic avian influenza A H5 viruses have been identified in birds in the United States since December 2014. The purpose of this HAN Advisory is to notify public health workers and clinicians of the potential for human infection with these viruses and to describe CDC recommendations for patient investigation and testing, infection control including the use personal protective equipment, and antiviral treatment and prophylaxis.*

Background

Between December 15, 2014, and May 29, 2015, the US Department of Agriculture (USDA) confirmed more than 200 findings of birds infected with highly-pathogenic avian influenza (HPAI) A (H5N2), (H5N8), and (H5N1)[1] viruses. The majority of these infections have occurred in poultry, including backyard and commercial flocks. USDA surveillance indicates that more than 40 million birds have been affected (either infected or exposed) in 20 states. These are the first reported infections with these viruses in US wild or domestic birds.

While these recently-identified HPAI H5 viruses are not known to have caused disease in humans, their appearance in North American birds may increase the likelihood of human infection in the United States. Human infection with other avian influenza viruses, including a different HPAI (H5N1) virus found in Asia, Africa, and other parts of the world; HPAI (H5N6) virus; and (H7N9) virus, has been associated with severe, sometimes fatal, disease. Previous human infections with other avian viruses have most often occurred after unprotected direct physical contact with infected birds or surfaces contaminated by avian influenza viruses, being in close proximity to infected birds, or visiting a live poultry market. Human infection with avian influenza viruses has not occurred from eating properly cooked poultry or poultry products. For more information on the origin of the recently-identified HPAI H5 viruses in the United States, their clinical presentation in birds, and their suspected clinical presentation in humans, please see http://www.cdc.gov/flu/avianflu/hpai/hpai-background-clinical-illness.htm.

CDC considers the risk to the general public from these newly-identified US HPAI H5 viruses to be low; however, people with close or prolonged unprotected contact with infected birds or contaminated environments may be at greater risk of infection. Until more is known about these newly-identified HPAI H5 viruses, public health recommendations are largely consistent with guidance for influenza viruses associated with severe disease in humans (e.g., HPAI H5N1 viruses that have caused human infections with high mortality in other countries). Currently, CDC considers these newly-identified HPAI H5 viruses as having the potential to cause severe disease in humans and recommends the following:

Clinicians should consider the possibility of HPAI H5 virus infection in persons showing signs or symptoms of respiratory illness who have relevant exposure history. This includes persons who have had contact with potentially-infected birds (e.g., handling, slaughtering, defeathering, butchering, culling, preparation

[1]The H5N1 virus isolated from US wild birds is a new mixed-origin virus (a "reassortant") that is genetically different from the HPAI H5N1 viruses that have caused human infections with high mortality in other countries (notably in Asia and Africa). No human infections with this new reassortant H5N1 virus have been reported in any country.

for consumption); direct contact with surfaces contaminated with feces or parts (carcasses, internal organs, etc.) of potentially-infected birds; and persons who have had prolonged exposure to potentially-infected birds in a confined space.

State health departments are encouraged to investigate potential human cases of HPAI H5 virus infection as described below and should notify CDC within 24 hours of identifying a case under investigation. Rapid detection and characterization of novel influenza A viruses in humans remain critical components of national efforts to prevent further cases, evaluate clinical illness associated with them, and assess any ability for these viruses to spread among humans.

People should avoid unprotected exposure to sick or dead birds, bird feces, litter, or materials contaminated with suspected or confirmed HPAI H5 viruses. All recommended personal protective equipment (PPE) should be worn when in direct or close contact (within about 6 feet) with sick or dead poultry, poultry feces, litter or materials contaminated with suspected or confirmed HPAI H5 viruses.

People exposed to HPAI H5-infected birds (including people wearing PPE) should be monitored for signs and symptoms consistent with influenza beginning after their first exposure and for 10 days after their last exposure. Influenza antiviral prophylaxis may be considered to prevent infection (see below). Persons who develop respiratory illness after exposure to HPAI H5-infected birds should be tested immediately for influenza by the state health department and be given influenza antiviral treatment (see below). State health departments are encouraged to investigate all possible human infections with HPAI H5 virus and should notify CDC promptly when testing for avian influenza in people.

Recommendations for Surveillance and Testing

Patients who meet clinical and exposure criteria should be tested for HPAI H5 virus infection by reverse-transcription polymerase chain reaction (RT-PCR) assay using H5-specific primers and probes. Additional persons in whom clinicians suspect HPAI H5 virus infection also may be tested.

Clinical Illness Criteria: Patients with new-onset influenza-like illness (ILI) or acute respiratory infection (ARI), which may include conjunctivitis, which has been associated with avian influenza in humans. Clinical presentation of persons infected with these HPAI H5 viruses may vary somewhat from seasonal influenza or infection with other novel influenza A viruses. Thus, clinicians are encouraged to consider a range of respiratory signs and symptoms when evaluating a patient with appropriate exposure for HPAI H5 virus infection.

Bird Exposure Criteria: Patients who have had recent contact[2] (within 10 days of illness onset) with potentially-infected (i.e., sick or dead birds, or flocks where HPAI H5 virus infection has been confirmed) in any of the following categories:

- Domestic poultry (e.g., chickens, turkeys, ducks, geese)
- Wild aquatic birds (e.g., ducks, geese, swans)
- Birds of prey (e.g., falcons) that have had contact with wild aquatic birds

Multiple respiratory tract specimens should be collected from persons with suspected HPAI H5 virus infection, including nasopharyngeal, nasal, and throat swabs. Patients with severe respiratory disease also should have lower respiratory tract specimens collected, if possible. For more information on surveillance and testing of persons under investigation for avian HPAI H5 virus infection, please see http://www.cdc.gov/flu/avianflu/severe-potential.htm.

Recommendations for Worker Protection

To reduce their risk of HPAI H5 virus infection, poultry workers and responders should avoid unprotected direct physical contact with sick or dead birds, and carcasses, feces, or litter from potentially-infected poultry. Poultry workers should wear recommended PPE when in direct contact with sick or dead birds, and carcasses, feces, or

[2]Contact may include: direct contact with birds (e.g., handling, slaughtering, defeathering, butchering, culling, preparation for consumption); or direct contact with surfaces contaminated with feces or bird parts (carcasses, internal organs, etc.); or prolonged exposure to birds in a confined space.

litter from potentially-infected poultry, and when going into any buildings with sick or dead poultry, or carcasses, feces, or litter from potentially-infected poultry. Workers should receive training on and demonstrate an understanding of when to use PPE; what PPE is necessary; how to properly put on, use, take off, properly dispose of, and maintain PPE; and the limitations of PPE. For additional guidance on worker protection, please see http://www.cdc.gov/flu/avianflu/h5/worker-protection-ppe.htm.

Recommendations for Infection Control

For patients presenting for medical care or evaluation who have illness consistent with influenza and recent exposure to potentially-infected birds, standard, contact, and airborne precautions are recommended. For additional guidance on infection control precautions for patients who may be infected with HPAI H5 virus, please refer to guidance for infections with novel influenza A viruses associated with severe disease found at http://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm.

Recommendations for Influenza Antiviral Treatment and Chemoprophylaxis

Chemoprophylaxis with influenza antiviral medications **can be considered** for all persons meeting bird exposure criteria. Decisions to initiate antiviral chemoprophylaxis should be based on clinical judgment, with consideration given to the type of exposure and to whether the exposed person is at high risk for complications from influenza (http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm).

Chemoprophylaxis is not routinely recommended for personnel who used proper PPE while handling sick or potentially-infected birds or decontaminating infected environments (including animal disposal).

If antiviral chemoprophylaxis is initiated, **treatment dosing** for the neuraminidase inhibitors oseltamivir or zanamivir (one dose twice daily) is recommended instead of the typical antiviral chemoprophylaxis regimen (once daily).[3] For specific dosage recommendations for treatment by age group, please see Influenza Antiviral Medications: Summary for Clinicians (http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm) Physicians should consult the manufacturer's package insert for dosing, limitations of populations studied, contraindications, and adverse effects. If exposure was time-limited and not ongoing, five days of medication (one dose twice daily) from the last known exposure is recommended.

Treatment of Symptomatic Persons with Bird Exposure: Patients meeting bird exposure criteria who develop symptoms compatible with influenza should be referred for prompt medical evaluation and empiric initiation of influenza antiviral treatment with a neuraminidase inhibitor as soon as possible. Clinical benefit is greatest when antiviral treatment is administered early, especially within 48 hours of illness onset. **Antiviral treatment should not be delayed while waiting for laboratory testing results.** For detailed guidance, please see Interim Guidance of the Use of Antiviral Medications for the Treatment of Human Infection with Novel Influenza A Viruses Associated with Severe Human Disease (http://www.cdc.gov/flu/avianflu/novel-av-treatment-guidance.htm).

Monitoring and Chemoprophylaxis of Close Contacts of Persons with HPAI H5 virus infection: If a case of human infection with HPAI H5 virus is identified in the United States, recommendations for monitoring and chemoprophylaxis of close contacts of the infected person are different than those that apply to persons who meet bird exposure criteria. For detailed guidance, please see Interim Guidance on Follow-up of Close Contacts of Persons Infected with Novel Influenza A Viruses Associated with Severe Human Disease (http://www.cdc.gov/flu/avianflu/novel-av-treatment-guidance.htm).

Vaccination

No human vaccines for HPAI (H5N1), (H5N2), or (H5N8) are available in the United States. Efforts are underway to develop vaccines against these HPAI H5 viruses. Seasonal influenza vaccines do not provide any protection against human infection with HPAI H5 viruses.

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[3]This recommendation for twice daily antiviral chemoprophylaxis dosing frequency is based on limited data that support higher chemoprophylaxis dosing in animals for avian A (H5N1) virus (Boltz DA, et al JID 2008;197:1315) and the desire to reduce the potential for development of resistance while receiving once daily dosing (BazM, et al NEJM 2009;361:2296; Cane A et al PIDJ 2010;29:384; MMWR 2009;58:969).

For More Information

- General information about avian influenza viruses and how they spread (http://www.cdc.gov/flu/avianflu/avian-in-humans.htm)
- Past Outbreaks of Avian Influenza in North America (http://www.cdc.gov/flu/avianflu/past-outbreaks.htm)
- Transmission of Avian Influenza A Viruses Between Animals and People (http://www.cdc.gov/flu/avianflu/virus-transmission.htm)
- H5 Viruses in the United States http://www.cdc.gov/flu/avianflu/h5/index.htm
- General information about Avian Influenza viruses in birds http://www.cdc.gov/flu/avianflu/avian-in-birds.htm
- Avian Influenza: Information for Health Professionals and Laboratorians http://www.cdc.gov/flu/avianflu/healthprofessionals.htm

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention; highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##