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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Nosocomial Transmission of Group Y *Neisseria meningitidis* in Cancer Patients — Connecticut

Within a 4-day period, 2 oncology patients in adjacent rooms in the Clinical Research Center at Yale-New Haven Hospital had bacteremia caused by group Y *Neisseria meningitidis*.

Patient A: A 52-year-old man with diffuse lymphocytic lymphoma was admitted to a 3-bed room in the Center on August 2, 1977, because of shortness of breath, productive cough, and large bilateral pleural effusions. The respiratory findings were attributed to the malignancy; serum immunoglobulin levels were depressed. On August 18, the patient developed copious, non-purulent sputum production and a temperature of 38 C. Chest X ray showed a retrocardiac density, but sputum grew only normal flora; blood cultures showed no growth. Antibiotic therapy was not started. On August 24, blood and sputum cultures were obtained again for evaluation of fever. The next day the patient had a respiratory arrest and was resuscitated; cephalothin and gentamicin therapy was begun. On August 26, group Y *N. meningitidis* sensitive to sulfadiazine was recovered from both blood and sputum cultures, and the patient was placed in a private room on respiratory isolation.

Patient B: A 66-year-old man with diffuse histiocytic lymphoma was hospitalized August 12-24 in the adjacent room to patient A for evaluation of obstructive jaundice. His findings were thought to be caused by the malignancy, and he was treated with cyclophosphamide and vincristine. On August 28, 4 days after discharge, the patient was readmitted to a 3-bed room at the opposite end of the floor because of the recent onset of sore throat, nausea and vomiting, and temperature of 38.9 C. Chest X ray was normal, but the white blood cell (WBC) count was 200 cells/mm³ with 4% polymorphonuclear leukocytes. Oxacillin, carbenicillin, and gentamicin therapy was begun, and 6 hours after admission the patient was transferred to a private room for protective isolation. On August 30, blood cultures drawn on admission grew group Y *N. meningitidis* sensitive to sulfadiazine. Patients A and B said that they had seen each other only at a distance.

N. meningitidis infection had not been observed previously in patients at the Center. Because nosocomial transmission of the organism seemed possible, nasopharyn-

geal swab specimens were obtained on August 30 from persons in the following categories: 1) patients hospitalized in the Center at any time from August 10 to the day of sampling, 2) hospital personnel exposed to these patients during the same period, and 3) family contacts and visitors of patients with positive cultures. Specimens were plated on modified Thayer-Martin agar—chocolate agar with vancomycin, colistin, nystatin, and trimethoprim (VCNT) antimicrobial mixture (Gibco Diagnostics, Madison, Wisconsin) and IsoVitalex Enrichment* (Baltimore Biological Laboratories, Cockeysville, Maryland); *N. meningitidis* isolates were then serogrouped.

N. meningitidis organisms were isolated from the nasopharynx of 5-12% of persons in each category (Table 1). However, 4 of 5 patients (patient B and 3 additional patients, patients C, D, and E) had serogroup Y isolates sensitive to sulfadiazine; 1 employee but no family contacts or visitors had this serogroup. No cases occurred after prophylaxis of patients, selected personnel, and family contacts of culture-positive patients.

TABLE 1. Results of nasopharyngeal swab specimens for *Neisseria meningitidis*, Connecticut, August 30, 1977

Category	No. cultured	No. and percent positive all serogroups	No. and percent positive serogroup Y
Patients	42	5 (12)	4 (10.0)
Personnel	349	27 (8)	1 (0.2)
Family contacts and visitors	38	2 (5)	0 (0.0)

The Center has 20 beds in 12 rooms located along a single hallway. Patients A and B and 2 asymptomatic infected patients, C and D, were located in 3 adjacent rooms at the end of the hall. Patients A and C exchanged bed locations when patient A was transferred to a private room; therefore, these 2 patients were only briefly in the same room. Patient D was never in the same room with an affected patient. After discharge, patient B was readmitted to a 3-bed room at the opposite end of the floor for 6 hours

*Use of trade names is for identification only and does not constitute endorsement by the Public Health Service, U.S. Dept of Health, Education, and Welfare.

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until transfer; the third asymptomatic infected patient (patient E) was admitted to that room on the same day. The 5 patients said that they had not had contact with one another and doubted that they had been even as close as a few feet of one another. All infected patients were admitted after patient A became symptomatic, so they could not have been the source of the outbreak. The 1 employee infected with serogroup Y took food carts to the floor but did not deliver trays; he could not be linked to the outbreak.

To assess host and risk factors that may have influenced infection, the 5 infected patients were compared to the 8 uninfected patients located in the same 4 rooms at that time. No significant differences were noted between the 2 groups with respect to primary diagnosis, age, sex, WBCs, the number receiving chemotherapy or antibiotic therapy, or the number with upper-respiratory manipulation (i.e., IPPB or endotracheal or nasogastric tubes). In addition, infected patients actually spent less time in the same room with other infected patients than did uninfected patients.

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Editorial Note: Eighteen percent of *N. meningitidis* infections reported by the Meningococcal Disease Surveillance Group at CDC from 1973 to 1975 were caused by serogroup Y (1). In contrast to other serogroups, group Y infection is often manifested by respiratory symptoms, as shown by the 2 patients reported here, rather than by meningitis or meningococemia (2). This serogroup has been responsible for several outbreaks in military camps (2,3). Nosocomial transmission of *N. meningitidis* of any serogroup is rare and has been reported to occur only from extensive contact with an infected individual (4).

In the outbreak reported here, the clustering of 2 patients with *N. meningitidis* infection in adjacent rooms within a 4-day period suggested nosocomial transmission. This hypothesis was supported by finding 3 additional, asymptomatic patients infected with the implicated strain in the same or adjacent rooms. It seems likely that patient A with unrecognized meningococcal pneumonia was responsible for a heavy dispersal of organisms to patients in 3 adjacent rooms. The source of his infection is unknown. Patient B, a member of the original cluster, was readmitted with respiratory symptoms to a room at the opposite end of the hall and was probably responsible for infection of

Table I. Summary—Cases of Specified Notifiable Diseases: United States

[Cumulative totals include revised and delayed reports through previous weeks]

DISEASE	17th WEEK ENDING		MEDIAN 1973-1977††	CUMULATIVE, FIRST 17 WEEKS		
	April 29, 1978	April 30, 1977†		April 29, 1978	April 30, 1977†	MEDIAN 1973-1977††
Aseptic meningitis	27	50	38	595	509	608
Brucellosis	4	5	5	39	54	49
Chickenpox	5,151	6,624	5,990	70,993	106,081	96,652
Diphtheria	1	6	6	28	34	89
Encephalitis	Primary	8	12	177	197	252
	Post-Infectious	2	8	42	54	75
Hepatitis, Viral	Type B	306	200	4,805	5,258	3,579
	Type A	605	556	9,133	10,738	11,790
	Type unspecified	182	154	772	2,822	2,922
Malaria	13	10	4	139	118	86
Measles (rubeola)	1,291	2,441	1,229	11,127	27,933	14,325
Meningococcal infections, total	47	35	34	937	743	582
Civilian	47	35	34	926	739	567
Military	—	—	—	11	4	15
Mumps	468	556	1,368	7,317	10,180	27,212
Pertussis	26	13	—	650	235	—
Rubella (German measles)	1,054	928	724	6,188	13,843	7,348
Tetanus	—	—	—	17	15	15
Tuberculosis	699	679	680	9,285	9,548	9,935
Tularemia	2	2	2	23	30	30
Typhoid fever	11	9	7	134	117	106
Typhus, tick-borne (Rky. Mt. spotted fever)	8	14	7	24	47	27
Veneral Diseases:						
Gonorrhea	16,346	16,696	18,598	298,264	299,334	303,151
Civilian	249	381	463	7,444	8,746	9,527
Military	436	355	394	6,723	6,925	8,413
Syphilis, primary and secondary	5	4	4	97	98	113
Civilian	—	—	—	—	—	—
Military	5	4	4	97	98	113
Rabies in animals	75	89	86	884	893	893

Table II. Notifiable Diseases of Low Frequency: United States

	CUM.		CUM.
Anthrax: N.C. 1	2	Polio myelitis, total:	—
Botulism: Texas 2	41	Paralytic:	—
Congenital rubella syndrome*	9	Psittacosis: Calif. 1	40
Leprosy: Fla. 1, Calif. 2, Hawaii 1	36	Rabies in man:	—
Leptospirosis: Del. 1, Texas 1, Nev. 3	16	Trichinosis:	9
Plague:	1	Typhus, murine: Md. 2	12

† Delayed reports received for calendar year 1977 are used to update last year's weekly and cumulative totals.

†† Medians for Gonorrhea and Syphilis are based on data for 1975-1977.

* The following delayed reports will be reflected in next week's cumulative totals: Cong. rubella syn.: N.H. +1, Trichinosis: Iowa -1 (1978), Tenn. -1 (1977)

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a patient in that room. In contrast to past experience, affected patients apparently did not have close contact. Thus, airborne transmission of the organism seems likely, but droplet spread or chance association is also possible.

Respiratory isolation is generally recommended for hospitalized patients with suspected *N. meningitidis* infection and may be particularly important for patients with meningococcal pneumonia.

International Notes

Smallpox Surveillance – Worldwide

As of April 14, 1978, no cases of smallpox have been reported to the World Health Organization (WHO) from anywhere in the world since the last case had onset of rash on October 26, 1977, in Merka town, Somalia. However, a total of 2 years of effective surveillance must elapse before this last endemic area can be confirmed to be smallpox-free.

Worldwide, since January 1, 1976, smallpox cases have been detected only in certain areas of Ethiopia, Kenya, and Somalia (Figure 1). One year and 9 months has elapsed since cases were detected in Ethiopia; 1 year and 1 month has elapsed since 5 cases were detected in Kenya after an importation from Somalia; and 6 months has passed since the last case was found in Somalia.

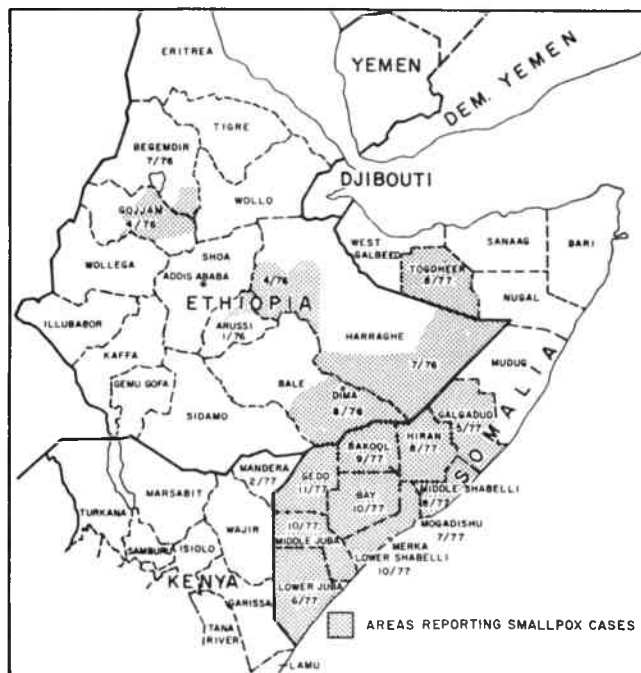
With the apparent interruption of transmission of the disease on a global basis, smallpox activities are being directed toward promptly certifying and providing authoritative endorsement of this historic event. In January 1978 the Executive Board of WHO endorsed the recommendations of a consultant group on worldwide certification of smallpox eradication which met in October 1977. Recognizing that this certification is based on verifying that 2 years has elapsed with no case of smallpox being detected by a surveillance system which would have detected any case had it occurred, the recommendations called for the establishment of a Global Commission. This independent group of experts is to monitor and review the following steps to be undertaken in 1978 and 1979: (1) certification by international commissions in the 15 countries not yet visited by commissions; (2) special documentation or visits to be required for 16 countries; (3) the request for statements from other countries declaring their smallpox-free status.

If no more cases of smallpox are detected, the countries

References

1. Meningococcal Disease Surveillance Group: Analysis of endemic meningococcal disease by serogroup and evaluation of chemoprophylaxis. *J Infect Dis* 134:201-204, 1976
2. Koppen GM, Ellenbogen C, Gebbhart RJ: Group Y meningococcal disease in United States Air Force recruits. *Am J Med* 62:661-666, 1977
3. Smilack JD: Group-Y meningococcal disease. *Ann Intern Med* 81:740-745, 1974
4. Artenstein MS, Ellis RE: The risk of exposure to a patient with meningococcal meningitis. *Milit Med* 133:474-477, 1968

FIGURE 1. Eastern Africa: The world's last known smallpox foci by area and dates of last cases, as of April 14, 1978



of Somalia, Ethiopia, Djibouti, Kenya, Yemen, and Democratic Yemen will be eligible for certification in October 1979. These will be the last of the 15 countries to be certified by an international commission, and priority attention is being given to surveillance in these areas.

Reported by the World Health Organization in the *Weekly Epidemiological Record* 53:97-99, 108, 1978.

Quarantine Measures

The following changes should be made in the *Supplement – Health Information for International Travel*, MMWR Vol. 26, August 1977:

BULGARIA

Smallpox – Under code delete >6 mos. Insert >1 yr.

CENTRAL AFRICAN REPUBLIC

Change name to CENTRAL AFRICAN EMPIRE.

CHINA, PEOPLE'S REPUBLIC OF

Delete note.

Cholera – Change code to II. Insert: A Certificate is required ALSO from travelers arriving or transiting from:

Africa: Algeria; Angola; Benin; Cameroon, United Republic of; Cape Verde; Comoros; Ghana; Kenya; Liberia;

Malawi; Morocco; Mozambique; Nigeria; Rhodesia; Upper Volta; Yemen

Asia: Bangladesh, Burma, Democratic Kampuchea, Gaza Strip, India, Indonesia, Jordan, Malaysia, Nepal, Philippines, Singapore, Sri Lanka, Syrian Arab Republic, Thailand, Vietnam

Europe: Portugal, Spain

Yellow fever – Insert code II. Insert: A Certificate is required ALSO required from travelers arriving or transiting from:

Africa: Angola; Benin; Burundi; Cameroon, United Republic of; Central Africa Empire; Chad; Congo; Djibouti; Equatorial Guinea; Ethiopia; Gabon; Gambia; Ghana; Guinea; Ivory Coast; Liberia; Mali; Niger; Rwanda; Senegal; Sierra Leone; Somalia; Sudan; Togo; Uganda; Tanzania, United Republic of; Upper Volta; Zaire

Quarantine Measures — continued

Americas: Bolivia, Brazil, Colombia, Costa Rica, Ecuador, French Guiana, Guyana, Panama, Paraguay, Peru, Surinam, Venezuela

COLOMBIA

Smallpox — Change code to II.

GERMANY, FEDERAL REPUBLIC OF (WEST)

Smallpox — Delete note. Insert: A Certificate is required ALSO from air travelers who within the preceding 14 days have been in:
Africa: Ethiopia, Somalia

GUINEA-BISSAU

Cholera — Delete code II. Insert: none.

HONDURAS

Smallpox — Delete note. Insert: A Certificate is required ALSO from travelers who within the preceding 14 days have been in a country any part of which is infected.

INDIA

Yellow fever — Insert: A Certificate is required ALSO from travelers arriving from all countries any part of which is infected. Africa: Delete Central African Republic. Insert Central African Empire.

INDONESIA

Yellow fever — Insert: A Certificate is required ALSO from travelers arriving from countries in the endemic zones (see pp. 60-61).

ISRAEL

Smallpox — Africa: Insert: Kenya, Somalia
Asia: Delete all information.

ITALY

Cholera — Delete all information. Insert none.
Smallpox — Africa: Insert Kenya.

JAMAICA

Smallpox — Under code insert >1 yr. Africa: Delete Afars and the Issas, French Territory of. Insert Djibouti.

JORDAN

Smallpox — Change code to II. Insert: A Certificate is required ALSO from travelers who within the preceding 14 days have been in a country any part of which is infected. Travelers passing through Jordan to enter Saudi Arabia must satisfy Saudi Arabia's requirements on entry to Jordan.

KUWAIT

Cholera — Delete code II. Insert none.

LAOS

Change name to LAO PEOPLE'S DEMOCRATIC REPUBLIC.

LEBANON

Smallpox — Delete all information. Insert code II.

LIBYAN ARAB REPUBLIC

Change name to Libyan Arab Jamahiriya.

MONTSERAT

Yellow fever — Under code insert >1 yr.

MOZAMBIQUE

Cholera — Delete all information. Insert code I.

REUNION

Smallpox — Delete all information. Insert code II. Insert: A Certificate is required ALSO from travelers who within the preceding 14 days have been in a country any part of which is infected.

SAMOA, AMERICAN

Yellow fever — Insert: A Certificate is required ALSO from travelers who within the preceding 7 days have been in a country any part of which is infected.

Errata, Vol. 27

- No. 14, p121** In the article "Meningococcal Meningitis—Alaska, 1976-1977," first paragraph, there was a case of meningococcal meningitis due to group W135, not group W138, as written.
- No. 16, p138** The credits for the article, "Decontamination of CPR Training Mannequins," should read as follows: JE Conte, Jr, MD, RK Ockner, MD, School of Medicine, University of California, San Francisco; Phoenix Laboratories Div, Bur of Epidemiology, CDC.

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