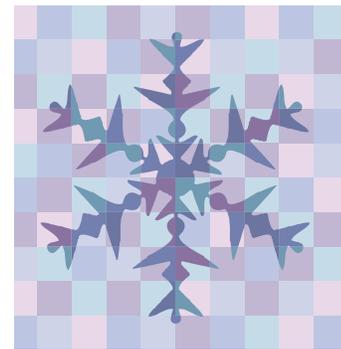


Advances in Laboratory Detection of *Trichomonas vaginalis*

An estimated 3.7 million women and men are infected with *T. vaginalis* in the United States. Trichomoniasis can cause urethritis in men and vaginitis in women, and is associated with increased acquisition and transmission of HIV and other STDs. It is also linked with preterm delivery of low birth weight infants. Trichomoniasis can be cured with nitroimidazole antibiotics, usually in a single dose.



In August 2013, APHL published an issue brief, [Advances in Laboratory Detection of *Trichomonas vaginalis*](#). This issue brief provides an overview and characteristics of the various diagnostic methods for detecting *T. vaginalis*. The traditional method for diagnosis of trichomoniasis has been wet mount. Wet mount is inexpensive, but sensitivity varies based on the individual performing the test, the quality of the microscope used, and how promptly the slide is interpreted. Other rapid tests include the OSOM *Trichomonas* Rapid Test (CLIA waived) and the Affirm VPIII Microbial Identification Test (moderate complexity). Nucleic acid amplification tests (NAATs) are the most sensitive tests available for detection of *T. vaginalis*. The APTIMA *Trichomonas vaginalis* Assay was FDA-cleared in 2011 for use with female specimens. There is no testing approved for male specimens. Sensitivity and specificity of NAATs testing is 95–100%.

MT Public Health Laboratory has verified the APTIMA molecular assay for the detection of *T. vaginalis* using endocervical and vaginal specimens collected in APTIMA transports. The CPT code is 87661, and the price of the test is \$44.00. Testing can be run in tandem with *Chlamydia trachomatis* and/or *Neisseria gonorrhoeae* Direct Detection by APTIMA Amplification

Current recommendations for *T. vaginalis* testing and screening, along with detailed clinical treatment recommendations, can be found in CDC's [STD Treatment Guidelines](#). If you have questions regarding testing at MTPHL, please call 800-821-7284.

Cepheid Xpert MTB/RIF

Now that the FDA has approved the Cepheid Xpert MTB/RIF assay for the simultaneous detection of *Mycobacterium tuberculosis* (MTB) and rifampin (RIF) resistance, we would like to point your attention to the following two documents:

The APHL fact sheet, [Laboratory Considerations for Use of Cepheid Xpert® MTB/RIF Assay](#), which was published in November 2013, is “intended to guide laboratories on integrating the Cepheid Xpert® MTB/RIF assay into existing TB testing practices” and includes key points laboratorians or clinicians need to consider when adopting or performing the assay. In addition, the [2013 APHL tool](#), *Mycobacterium tuberculosis: Assessing Your Laboratory*, is an updated self-assessment to help laboratories ensure they are handling and testing specimens for *Mycobacterium tuberculosis* safely and properly.

If you have questions regarding MTPHL TB testing, please call us at 800-821-7284.



Fee Changes!

Updated laboratory fees are effective February 1, 2014. Specimens collected on and after February 1st will be billed at the new rate. For the new fee schedule, visit our website: www.lab.hhs.mt.gov.

Montana Communicable Disease Weekly Update

Release date: 1/24/2014



DISEASE INFORMATION

Summary – MMWR Week 3 - Ending 1/18/2014 Preliminary disease reports received at DPHHS during the reporting period January 12–18, 2014 included the following:

- **Vaccine Preventable Diseases:** Influenza hospitalizations (22), Pertussis (4), Varicella (2)
- **Invasive Diseases:** (0)
- **Enteric Diseases:** Campylobacteriosis (4), Salmonellosis (1)
- **Hepatitis:** (0)
- **HIV Disease**:** (2)
- **Vector-borne Diseases:** (0)
- **Animal Rabies:** (0)
- **Travel Related Conditions:** (0)

* Weekly updated Montana Influenza Summary is included as an attachment to the weekly update.

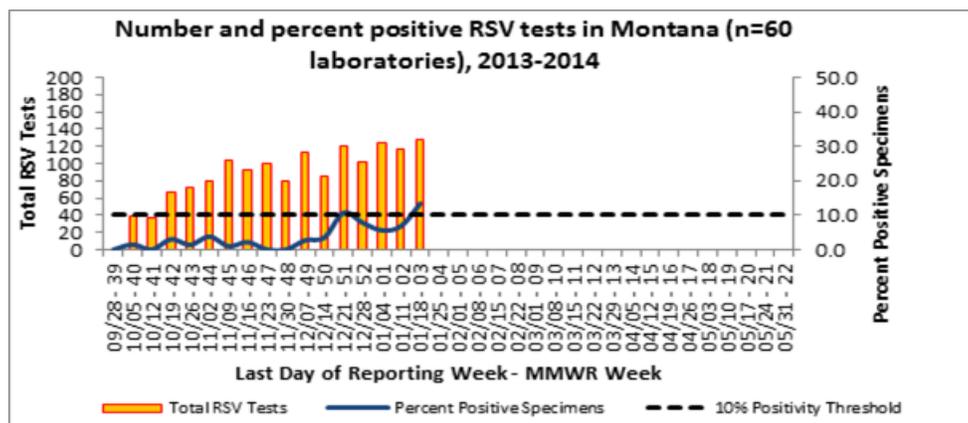
** A case is included if a new confirmatory test or report was received by DPHHS. Cases include both persons who were newly diagnosed and persons newly reported in Montana who may have been diagnosed in another state or country.

NOTE: The attached reports have multiple pages reflecting the following information: (1) cases for the past reporting week; (2) communicable diseases YTD; (3) clusters and outbreaks; and (4) a quarterly HIV/STD summary.

HOT TOPICS

Respiratory Syncytial Virus (RSV) First week above 10%: This week is the 16th reporting week for laboratories performing in-house RSV testing. All regions in Montana are at **non-seasonal activity** at this time with at least one confirmed laboratory result reported. Weekly updates and additional RSV and RSV prophylaxis information can be found at www.rsv.mt.gov.

- [This is the first week since MMWR Week 51 \(2013\) where the positivity rate has exceeded 10%. If this happens next week, resulting in two consecutive weeks of >10% positivity, the RSV season onset will officially begin.](#)



If you have any questions or comments, please contact Joel Merriman at 406-444-0274.

Influenza Hospitalizations/Unvaccinated Cases/Additional Reporting Information: As of January 18th, 192 Montanans were hospitalized for influenza related conditions with 23 reported in the week ending January 18th. As of today, we have four deaths reported. More information can be found in the attached Montana Weekly Influenza Summary. Please

continue to submit complete and timely reports. It is essential for our understanding of the impact of this year's seasonal influenza. Please see the attached Montana Weekly Flu Summary for more information.

Influenza Activity (See CDC Influenza News and Highlights attachment):

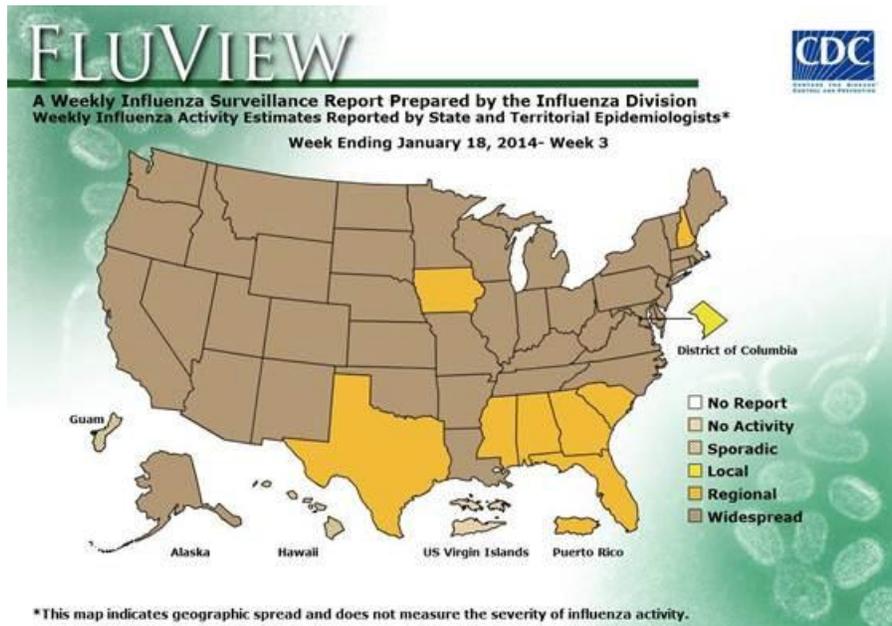
CDC estimates estimates of the annual burden of seasonal influenza

- **Deaths:** 3,000-49,000
- **Hospitalizations:** 54,000-430,000
- **Cases:** 15-60 million

2013-2014 Season (National)

- **2009 H1N1 viruses are predominating for the 1st time since the pandemic**
- **Severity indicators reflecting hospitalizations and deaths are increasing**
- **Most (61%) hospitalizations are occurring in people 18 to 64 years old**
- **CDC has received several reports of severe illness in young and middle-aged adults, including pregnant women and people who are obese**

Influenza activity across the country and Montana remained high. Another southern tier state Texas went to “regional” status from Widespread this week along with other states that were the first to go to widespread status, but Arizona has gone from regional to Widespread. Most of the rest of the country remained at widespread.



For more information, the CDC FluView web page can be viewed at <http://www.cdc.gov/flu/weekly/>

The Montana Weekly Flu summary can be located at <http://www.dphhs.mt.gov/influenza/index.shtml>

INFORMATION/ANNOUNCEMENTS

Multi-state Foodborne Outbreaks Pilot Program: CDC is starting a pilot program assessing states' ability to complete cluster-specific interviews within 2 days. The goal is to improve timely submission of cluster specific questionnaires to enhance outbreak response. This only applies to a subset of multi-state foodborne outbreaks that occur on the large scale (e.g. Hepatitis A outbreak last summer). It is not anticipated that many cases associated with this would occur in Montana unless the state were the epicenter of a national outbreak, but if we do have cases, let our response be timely. Last year only one out of 6 such interviews was returned to CDC within 2 days.

When indicated, CDC will deploy a specific questionnaire a few of you will have seen in 2013. States will be aware of the participation and notice will not come by surprise. We have been told that once received, states have 2 days to respond to meet the timeline. They will consider when you first attempted to reach a case, how often you tried, when you completed the interview and when they received the completed form. We will work closely with you if this occurs. If you have any questions, please contact Dana Fejes at 406-444-3049.

MIDIS Quick Tip – Campylobacteriosis: a quick reminder on case definition: When you get a preliminary campylobacter result, such as an antigen (or EIA) positive campylobacter, this would be a SUSPECT case. Once our lab confirms the diagnosis, you will get a lab report stating something like "*Campylobacter jejuni* confirmed" and you can change the case status to "confirmed". If you receive a lab that states "*Campylobacter species* not confirmed" please leave the status as suspect. I see a lot of instances where the case is deemed probable, but unless you have a case with diarrheal illness compatible with campylobacteriosis that has *not been tested*, but is linked to a "confirmed" case, please do not use the probable case definition.

<http://wwwn.cdc.gov/NNDS/script/casedef.aspx?CondYrID=627&DatePub=1/1/2012>

24/7 AVAILABILITY

The Communicable Disease Epidemiology (CDEpi) Program is available 24 hours a day, 7 days a week, 365 days a year, primarily to assist local health jurisdictions. Local providers should call, including after normal business hours, their local health jurisdiction. The CDEpi 24-hour line is available as a back-up to the local health jurisdiction's 24-hour line. If you need CDEpi assistance, please call 406.444.0273. Phone calls to this number outside of normal business hours will be answered by the answering service. The answering service will immediately forward the message to CDEpi, and we will respond as quickly as possible.

Local health jurisdictions, please ensure that your local providers have your 24/7/365 contact information. And please inform CDEpi or the Public Health Emergency Preparedness Program of updates to your required 24/7 contact information.

This update is produced by the Montana Communicable Disease Epidemiology Program. Questions regarding its content should be directed to 406.444.0273 (24/7/365). For more information: <http://cdepi.hhs.mt.gov>