

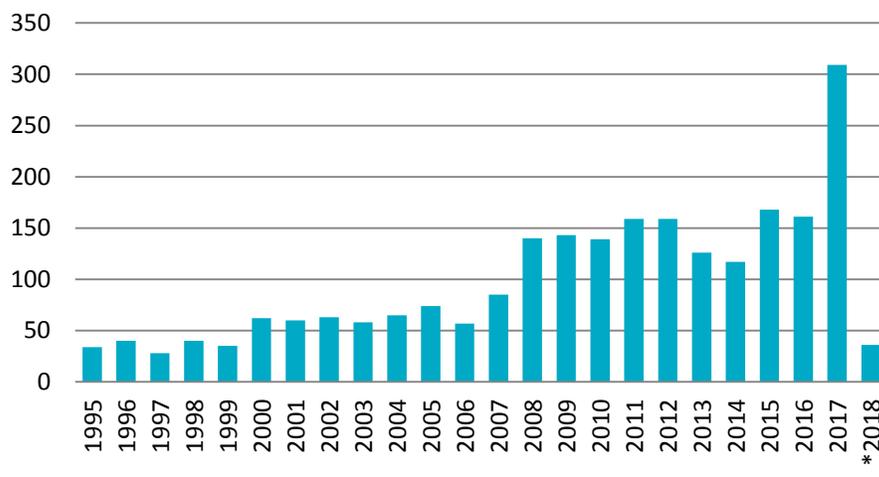
COCCIDIOIDOMYCOSIS

Coccidioidomycosis, commonly known as Valley Fever, is a fungal infection, usually of the lungs, with a clinical picture that ranges from asymptomatic to influenza-like symptoms to severe disease. People become infected by breathing in microscopic *Coccidioides* spores. The fungus lives in the soil in the southwestern United States and parts of Mexico and Central and South America. It is [highly endemic](#) in southern Arizona and California's San Joaquin Valley.

Transmission in endemic areas is most likely to occur when soil has been disturbed due to high winds, dust storms, earthquakes, construction, excavation, or agricultural activities.

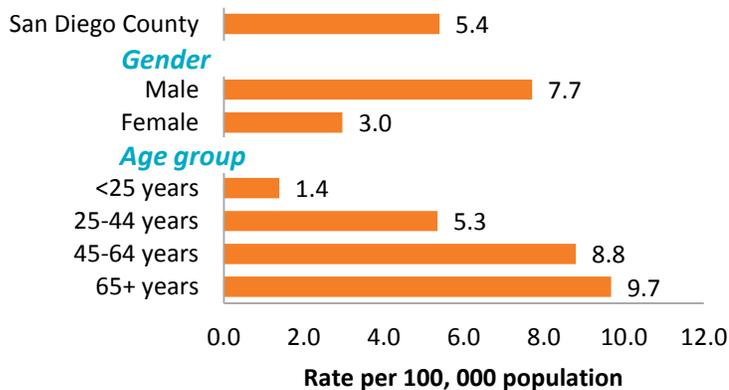
About 40% of acute cases have symptoms such as fatigue, cough, shortness of breath, headaches, myalgias, night sweats, and rash appearing one to three weeks after exposure. Most persons who become ill recover on their own without treatment, but in 5-10% of cases, the disease may cause complications or become chronic. Rarely, the infection may disseminate and affect other parts of the body, most often bones or joints, soft tissues, and meninges.

Figure 1. Coccidioidomycosis Cases, San Diego County, 1995-2018*



*2018 data are year-to-date; current as of 3/15/2018. Data are provisional and subject to change as additional information becomes available. Grouped by CDC disease years. A revision to the surveillance case definition for was adopted by California in June 2007; a single positive IgG result (in place of a rising IgG titer) became sufficient to meet laboratory criteria.

Figure 2. Coccidioidomycosis Rates, San Diego County, 2013-2017



Data current as of 3/15/2018. Data are provisional and subject to change as additional information becomes available. Grouped by CDC disease years. Population data source: SANDAG Population Estimates (2016 updates).

Disseminated coccidioidomycosis requires antifungal treatment; [treatment is also recommended](#) for patients in certain risk categories, such as those who are immunosuppressed, have comorbidities, or are of African or Filipino descent.

Although nationally reportable, coccidioidomycosis is reportable in fewer than 25 states. The majority of the 11,829 cases reported nationally in 2016 were from California and Arizona. California's 2016 count of 5,866 represented an [increase](#) from previous years, and the preliminary count of 7,958 for 2017 is higher still. In San Diego County, 2015 and 2016 saw increases in cases over 2013-14, but a much larger increase was observed in 2017 (309 compared to 161 in 2016 and 117 in 2014).

Continued on next page

The Monthly Communicable Disease Surveillance Report is a publication of the County of San Diego Public Health Services Epidemiology and Immunization Services Branch (EISB). EISB works to identify, investigate, register, and evaluate communicable, reportable, and emerging diseases and conditions to protect the health of the community. The purpose of this report is to present trends in communicable disease in San Diego County. To subscribe to this report, send an email to EpiDiv.HHSA@sdcounty.ca.gov.

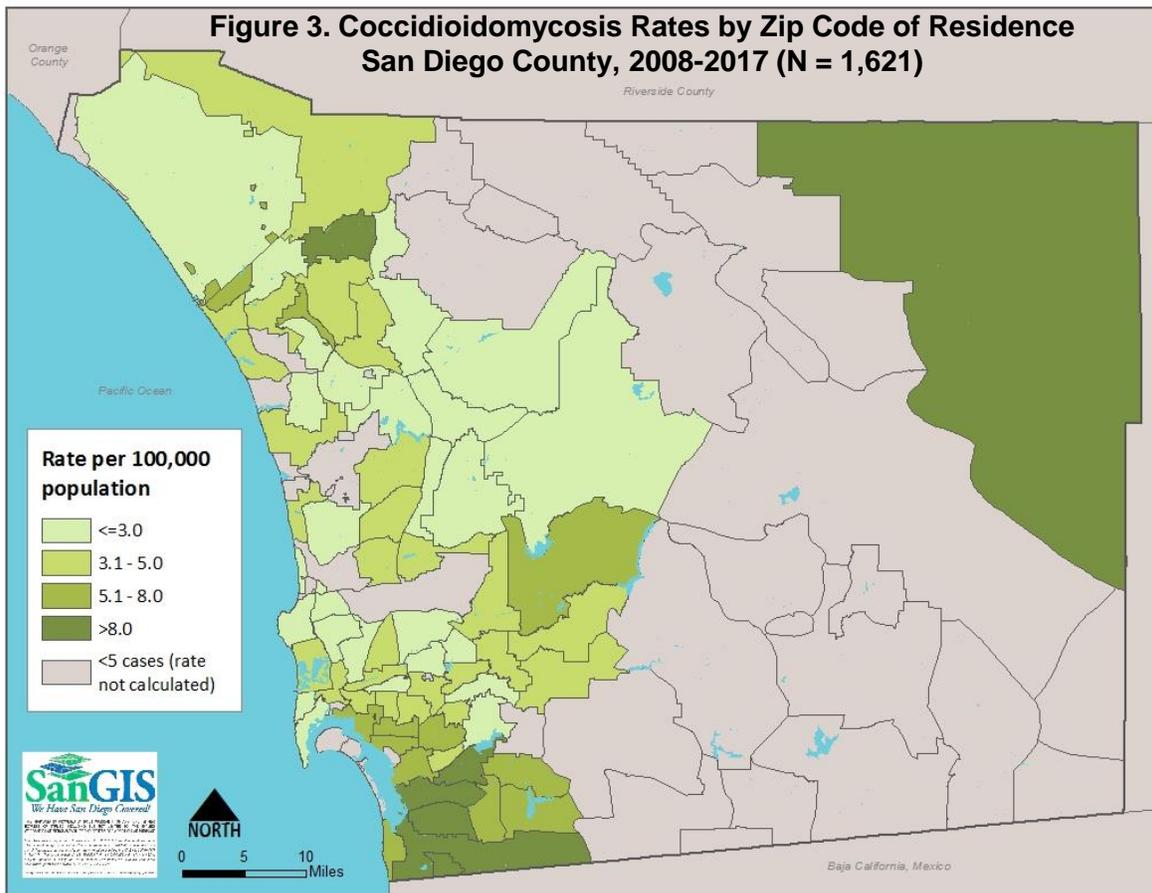


COCCIDIOIDOMYCOSIS, continued

The reasons for the increases are not fully understood, but may be attributed to changes in a combination of factors related to the environment, human activity, and diagnostics. Changes in temperature or rainfall may affect the growth and circulation of the fungus. More people may be susceptible if they have moved or traveled to endemic areas. Provider awareness and available diagnostics will affect testing and reporting patterns.

Kern County had the highest rate of coccidioidomycosis in California in 2016, with over 2,000 cases reported for a rate of 251.7 per 100,000 population. The overall California rate in 2016 was 13.7 and the San Diego County rate was 4.9. Preliminary analysis of 2017 data shows an increase in the San Diego County rate to 9.3 cases per 100,000 population. Rates in males (7.7) in San Diego County over the past five years were more than double the rates among females (3.0), and rates were highest in those age 45 years and older.

The highest concentration of cases in San Diego County over the past ten years was in the southern region; the zip codes with the highest rates were 91902 (15.7), 92154 (13.2), and 92173 (12.5). Rates are based on zip code of residence at the time of report and may not reflect where exposure occurred.



Rates are based on 10-year aggregate counts due to small individual year counts for many zip codes. Rates are average annual rates of newly reported cases (may be acute or chronic). Rates based on small case counts may vary considerably and should be interpreted with caution. Location is location of residence when the case was reported to the County of San Diego Health and Human Services Agency, which may not be location of exposure. Reports where a state or federal detention facility is indicated as the address of residence are excluded from the calculation of rates by zip code. Data are provisional and subject to change as additional information becomes available; updated as of 3/5/2018. Grouped by CDC disease years.

Resources

- [Centers for Disease Control and Prevention \(CDC\) Coccidioidomycosis website](#)
- [2016 Infectious Diseases Society of America \(IDSA\) Clinical Practice Guideline for the Treatment of Coccidioidomycosis](#)
- [California Department of Public Health \(CDPH\) Coccidioidomycosis website](#)
- [Valley Fever Center for Excellence \(College of Medicine, University of Arizona\)](#)

MONTHLY COMMUNICABLE DISEASE REPORT

FEBRUARY 2018

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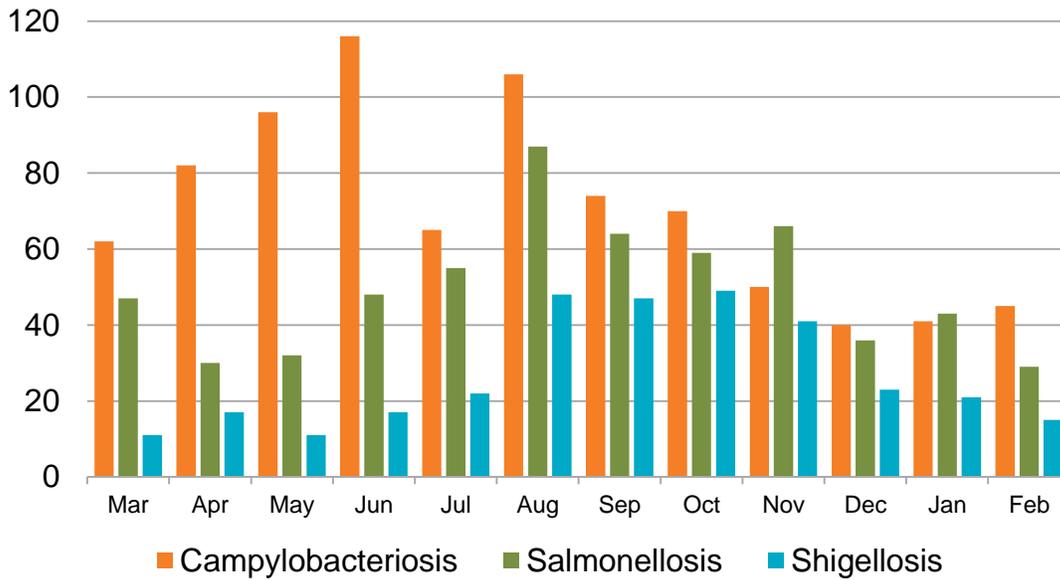


| Table 1. Select Reportable Diseases | | 2018 | | | Prior Years | | |
|---|-------|---------------|-------------|--------------------|-------------|------------------------|------------|
| | | Current Month | Prior Month | Year-to-Date (YTD) | 2017 YTD | Avg YTD, Prior 3 Years | 2017 Total |
| Disease and Case Inclusion Criteria (C,P,S) | | | | | | | |
| Amebiasis | C | 1 | 2 | 3 | 1 | 3.0 | 10 |
| Botulism (Foodborne, Infant, Wound, Other) | C | 0 | 2 | 2 | 1 | 0.3 | 7 |
| Brucellosis | C,P | 0 | 0 | 0 | 2 | 1.0 | 4 |
| Campylobacteriosis | C,P | 45 | 41 | 86 | 125 | 99.7 | 885 |
| Chickenpox, Hospitalization or Death | C,P | 0 | 0 | 0 | 0 | 0.0 | 3 |
| Chikungunya | C,P | 0 | 0 | 0 | 1 | 0.3 | 2 |
| Coccidioidomycosis | C | 12 | 23 | 35 | 28 | 29.3 | 309 |
| Cryptosporidiosis | C,P | 5 | 4 | 9 | 2 | 2.7 | 54 |
| Dengue Virus Infection | C,P | 1 | 1 | 2 | 3 | 3.0 | 12 |
| Encephalitis, All | C | 4 | 3 | 7 | 9 | 11.3 | 42 |
| Giardiasis | C,P | 10 | 28 | 38 | 51 | 44.3 | 316 |
| Hepatitis A, Acute | C | 6 | 5 | 11 | 11 | 6.0 | 576 |
| Hepatitis B, Acute | C | 0 | 1 | 1 | 3 | 2.0 | 13 |
| Hepatitis B, Chronic | C,P | 60 | 85 | 145 | 147 | 141.7 | 883 |
| Hepatitis C, Acute | C,P | 0 | 0 | 0 | 0 | 0.3 | 6 |
| Hepatitis C, Chronic | C,P | 335 | 292 | 627 | 367 | 433.0 | 3,118 |
| Legionellosis | C | 2 | 6 | 8 | 12 | 8.3 | 66 |
| Listeriosis | C | 0 | 1 | 1 | 3 | 2.3 | 15 |
| Lyme Disease | C,P | 0 | 0 | 0 | 1 | 0.3 | 17 |
| Malaria | C | 0 | 0 | 0 | 1 | 0.7 | 8 |
| Measles (Rubeola) | C | 0 | 0 | 0 | 0 | 2.7 | 2 |
| Meningitis, Aseptic/Viral | C,P,S | 5 | 3 | 8 | 13 | 18.7 | 184 |
| Meningitis, Bacterial | C,P,S | 5 | 3 | 8 | 6 | 8.7 | 39 |
| Meningitis, Other/Unknown | C | 0 | 0 | 0 | 7 | 5.7 | 32 |
| Meningococcal Infection | C,P | 0 | 3 | 3 | 0 | 0.7 | 1 |
| Mumps | C,P | 0 | 3 | 3 | 4 | 1.7 | 15 |
| Pertussis | C,P,S | 50 | 92 | 142 | 101 | 142.3 | 1,163 |
| Rabies, Animal | C | 2 | 0 | 2 | 2 | 0.7 | 16 |
| Rocky Mountain Spotted Fever | C,P | 0 | 0 | 0 | 1 | 0.7 | 3 |
| Salmonellosis (Non-Typhoid/Non-Paratyphoid) | C,P | 29 | 43 | 72 | 52 | 54.0 | 576 |
| Shiga toxin-Positive Feces (without culture confirmation) | C,P | 0 | 1 | 1 | 3 | 2.0 | 26 |
| Shiga toxin-Producing E. coli (including O157) | C,P | 0 | 1 | 1 | 4 | 4.7 | 263 |
| Shigellosis | C,P | 15 | 21 | 36 | 50 | 30.3 | 335 |
| Typhoid Fever | C,P | 0 | 0 | 0 | 1 | 0.3 | 2 |
| Vibriosis | C,P | 1 | 0 | 1 | 5 | 4.3 | 50 |
| West Nile Virus Infection | C,P | 0 | 0 | 0 | 0 | 0.0 | 2 |
| Yersiniosis | C,P | 0 | 2 | 2 | 3 | 2.0 | 62 |
| Zika Virus | C,P | 0 | 1 | 1 | 3 | 3.3 | 22 |

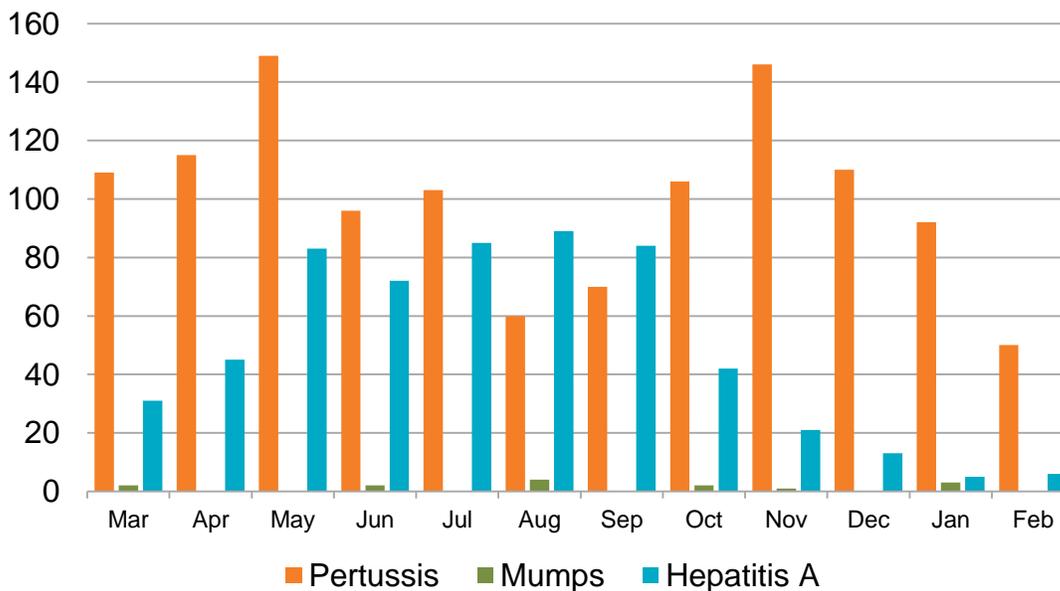
Case counts are provisional and subject to change as additional information becomes available. Cases are grouped into calendar months and calendar years on the basis of the earliest of the following dates: onset, lab specimen collection, diagnosis, death, and report received. Counts may differ from previously or subsequently reported counts due to differences in inclusion or grouping criteria, late reporting, or updated case information. Inclusion criteria (C,P,S = Confirmed, Probable, Suspect) based on Council of State and Territorial Epidemiologists/Centers for Disease Control and Prevention (CSTE/CDC) surveillance case criteria.



**Figure 4. Select Enteric Infections by Month
March 2017 – February 2018**

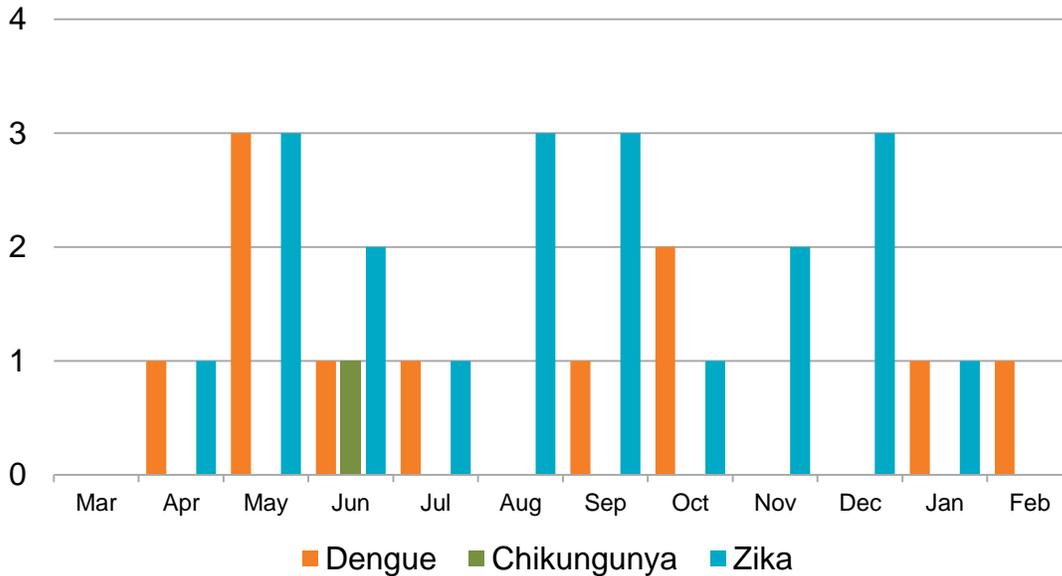


**Figure 5. Select Vaccine-Preventable Infections by Month
March 2017 – February 2018**



Case counts are provisional and subject to change as additional information becomes available. Cases are grouped into calendar months and calendar years on the basis of the earliest of the following dates: onset, lab specimen collection, diagnosis, death, and report received. Counts may differ from previously or subsequently reported counts due to differences in inclusion or grouping criteria, late reporting, or updated case information. Inclusion criteria (C,P,S = Confirmed, Probable, Suspect) based on Council of State and Territorial Epidemiologists/Centers for Disease Control and Prevention (CSTE/CDC) surveillance case criteria.

**Figure 6. Select Vector-Borne Infections by Month
March 2017 – February 2018**



All of these dengue, chikungunya, and Zika virus cases are travel-associated. For additional information on Zika cases, see the [HHSa Zika Virus webpage](#). **Case counts are provisional and subject to change as additional information becomes available.** Cases are grouped into calendar months and calendar years on the basis of the earliest of the following dates: onset, lab specimen collection, diagnosis, death, and report received. Counts may differ from previously or subsequently reported counts due to differences in inclusion or grouping criteria, late reporting, or updated case information. Inclusion criteria (C,P,S = Confirmed, Probable, Suspect) based on Council of State and Territorial Epidemiologists/Centers for Disease Control and Prevention (CSTE/CDC) surveillance case criteria.

Disease Reporting in San Diego County

San Diego County communicable disease surveillance is a collaborative effort among Public Health Services, hospitals, medical providers, laboratories, and the [San Diego Health Connect](#) Health Information Exchange (HIE). The data presented in this report are the result of those efforts.

Reporting is crucial for disease surveillance and detection of disease outbreaks. Under the California Code of Regulations, Title 17 (Sections [2500](#), [2505](#), and [2508](#)), public health professionals, medical providers, laboratories, schools, and others are mandated to report more than 80 diseases or conditions to San Diego County Health and Human Services Agency.

To report a communicable disease, contact the Epidemiology Program by phone at (619) 692-8499 or download and print a Confidential Morbidity Report form and fax it to (858) 715-6458. For urgent matters on evenings, weekends or holidays, dial (858) 565-5255 and ask for the Epidemiology Program duty officer. For more information, including a complete list of reportable diseases and conditions in California, visit the Epidemiology Program website, www.sdepi.org.

Tuberculosis, sexually transmitted infections, and HIV disease are covered by other programs within Public Health Services. For information about reporting and data related to these conditions, search for the relevant program on the Public Health Services website, <http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs.html>.