

Epidemiological Profile of Tuberculosis in South Dakota, 2012

By Kristin Rounds, Tuberculosis Control Coordinator, SD Department of Health

During the last ten years, South Dakota averaged 16 cases of tuberculosis (TB) per year. During 2012, there were 19 cases of TB reported to the South Dakota Department of Health, which is the most number of cases reported since 2003. Figure 1 shows the 10-year trend of TB cases reported in South Dakota.

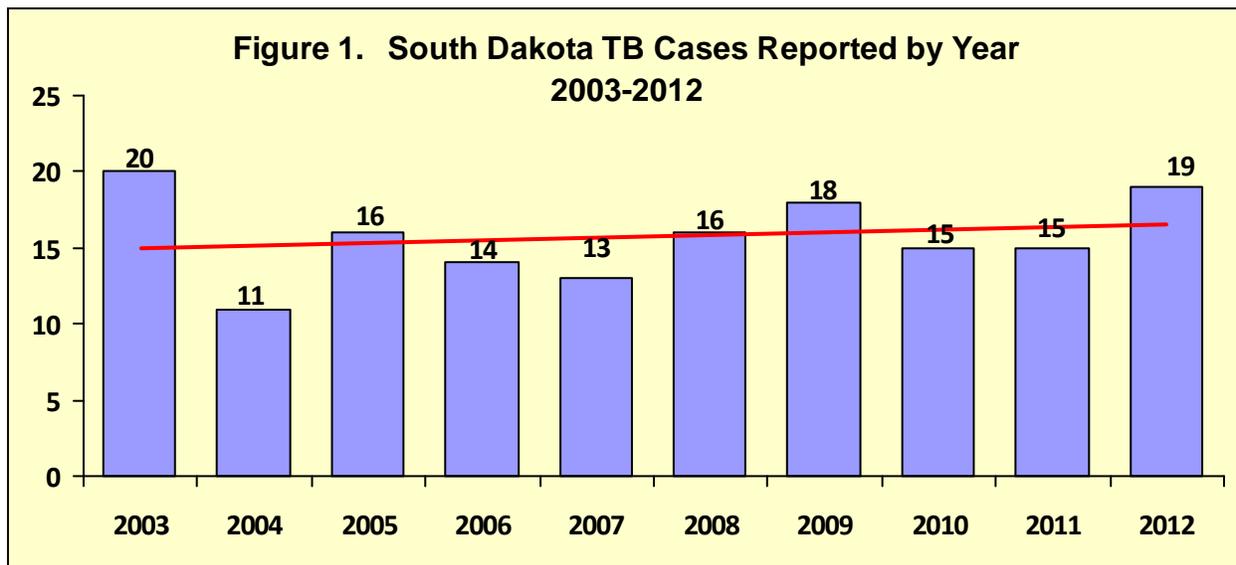
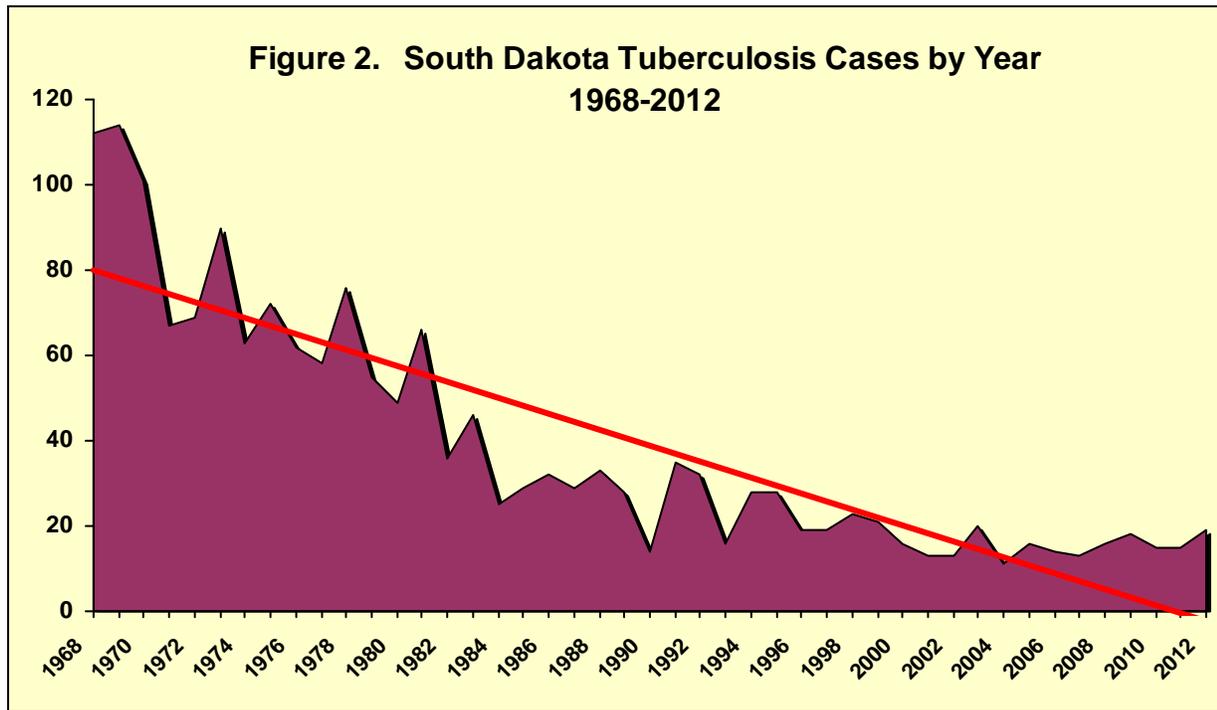


Figure 2 (next page) illustrates the historical decreasing trend of reported tuberculosis cases in South Dakota since 1968. This dramatic decrease is a result of mandatory reporting of suspected TB cases to the Department of Health along with case management, treatment and comprehensive contact investigations to ensure those exposed to tuberculosis receive prompt treatment and appropriate intervention efforts.



The most recent data available nationally and regionally is from calendar year 2011. Figure 3 provides a comparison of the TB case rate per 100,000 population for the United States as well as a regional comparison of South Dakota and our border states of North Dakota, Minnesota, Iowa, Nebraska, Wyoming and Montana. Please note that South Dakota has the second highest TB case rate behind Minnesota when comparing these 7 states.

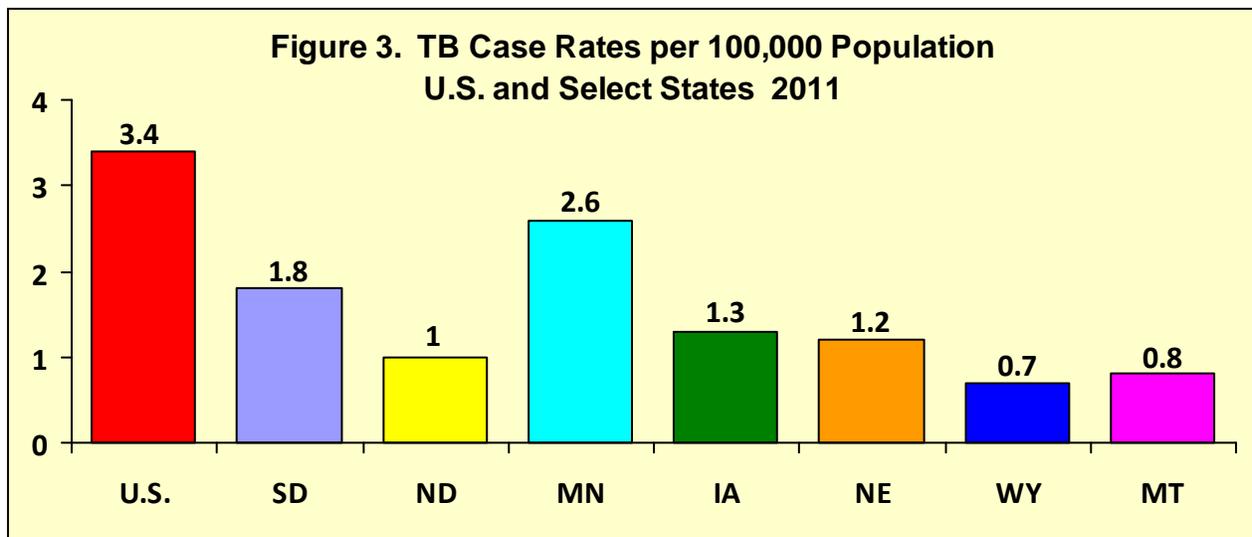
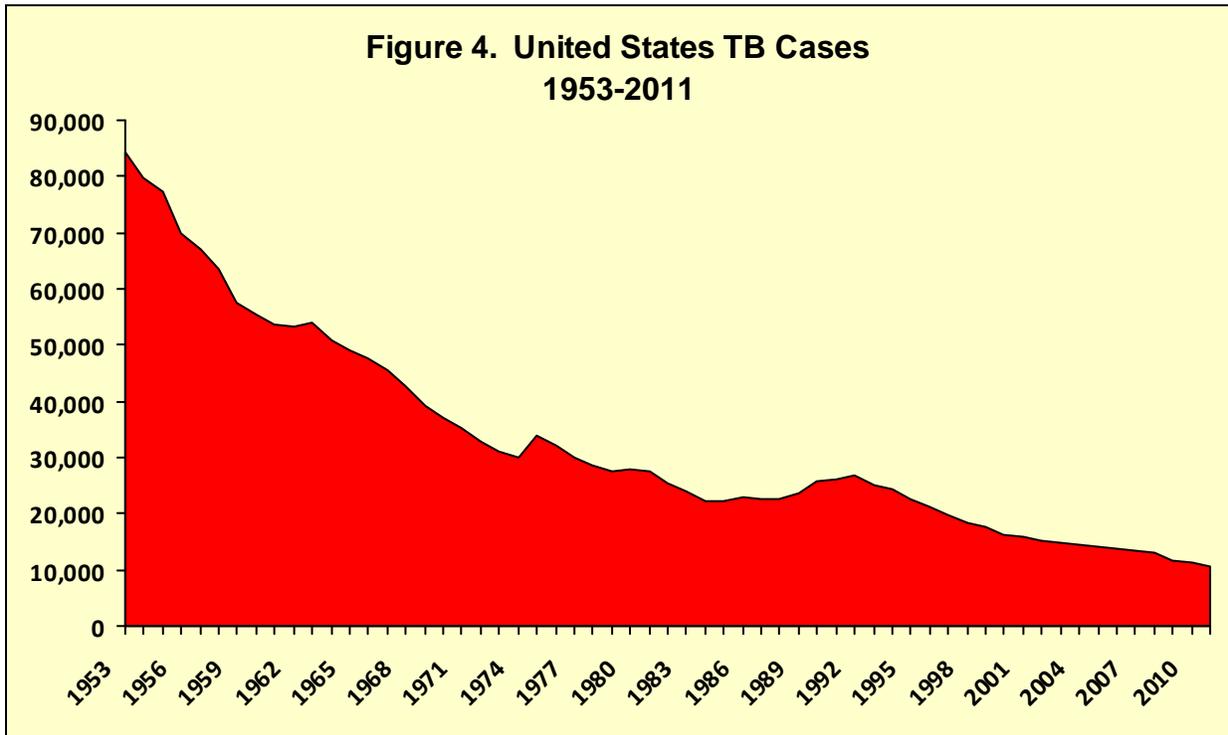


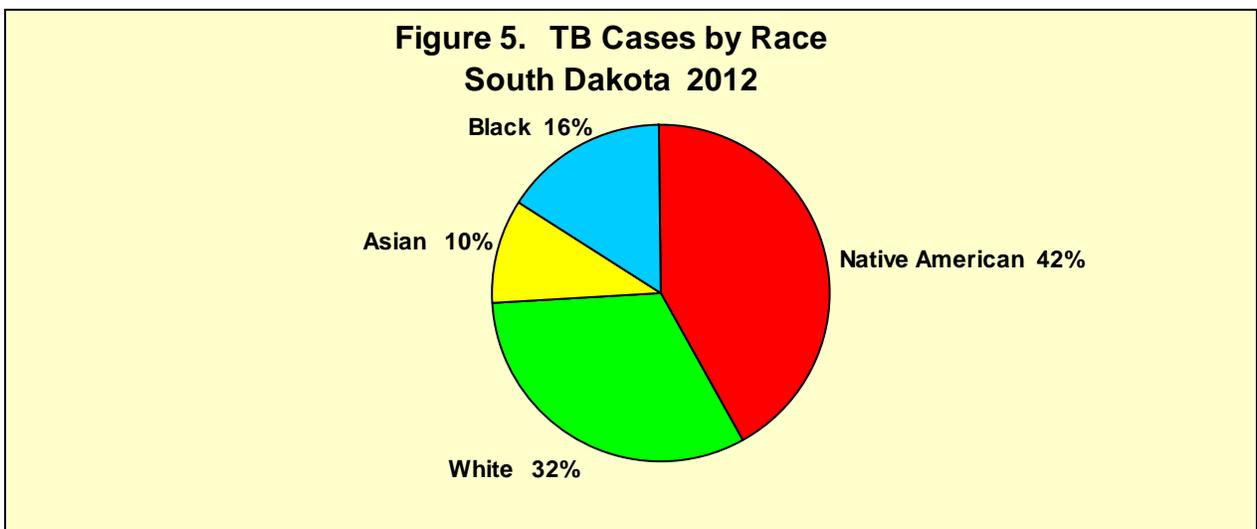
Figure 4 (next page) illustrates the historical trend of decreasing TB cases reported in the United States. In 2011 there were 10,528 TB cases reported in the US which was the lowest year on record, representing a 5.8% decrease from 2010. During 2011, 18 states reported increased case counts from 2010. The 4 states of California, Texas, New York and Florida accounted for 50% of the national case total. During 2011, 1.3% of the reported cases had primary multi-drug resistance which is defined as resistance to the TB medications of at least isoniazid and rifampin. During 2011, 62% of TB cases nationally were in foreign-born persons, the highest percentage ever reported.



Native Americans have historically had the highest percentage of TB cases by race and in 2012 they contributed 42% of the total TB cases reported. Table 1 and Figure 5 provide information on TB cases by race in 2012.

**Table 1. TUBERCULOSIS CASES REPORTED BY SEX AND RACE
SOUTH DAKOTA 2012**

Race	Male	Female	Total	% of Cases
Native American	2	6	8	42%
White	3	3	6	32%
Black	0	3	3	16%
Asian	1	1	2	10%
Total	6	13	19	100%



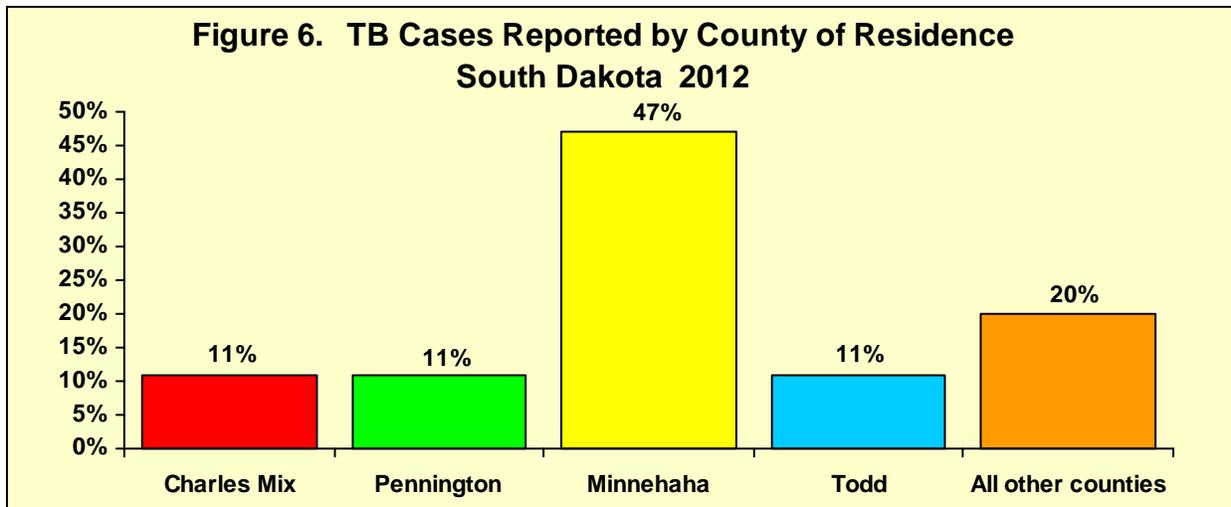
The TB incidence rate, which measures the number of TB cases per 100,000 population, is the best measure for determining the progress towards the elimination of TB in South Dakota. Historically, Native American TB case rates have dropped considerably while white cases have consistently remained low. The Black, Asian and other races mainly represent TB cases born outside of the United States who were diagnosed in South Dakota. Table 2 provides additional information on TB case rates for the last 6 years.

Table 2. TUBERCULOSIS MORBIDITY INCIDENCE RATES PER 100,000 BY RACE & YEAR SOUTH DAKOTA 2007-2012

Race	2007	2008	2009	2010	2011	2012
US Case Rate (All Races)	4.4	4.2	3.8	3.6	3.4	Not available*
SD All Races	1.7	2.1	2.2	1.8	1.8	2.3
SD Native American	10.3	5.9	10.3	15.0	6.1	9.7
SD White	0.4	0.1	0.9	0.3	0.7	0.9
SD Black	32.3	161.3	64.5	24.6	13.6	20.4
SD Asian	17.4	17.4	17.4	0.0	39.4	26.3
All Other SD Races	0.0	0.0	0.0	0.0	0.0	0.0

*2012 US case rate data is not yet available.

The South Dakota TB elimination goal is to reduce tuberculosis cases to an incidence of no more than 3.5 cases per 100,000 by the year 2015. In addition there is a special population target goal of reducing Native American tuberculosis cases to less than 15 cases per 100,000 by 2015. As referenced in Table 2, both of these objectives have been met in 2012.

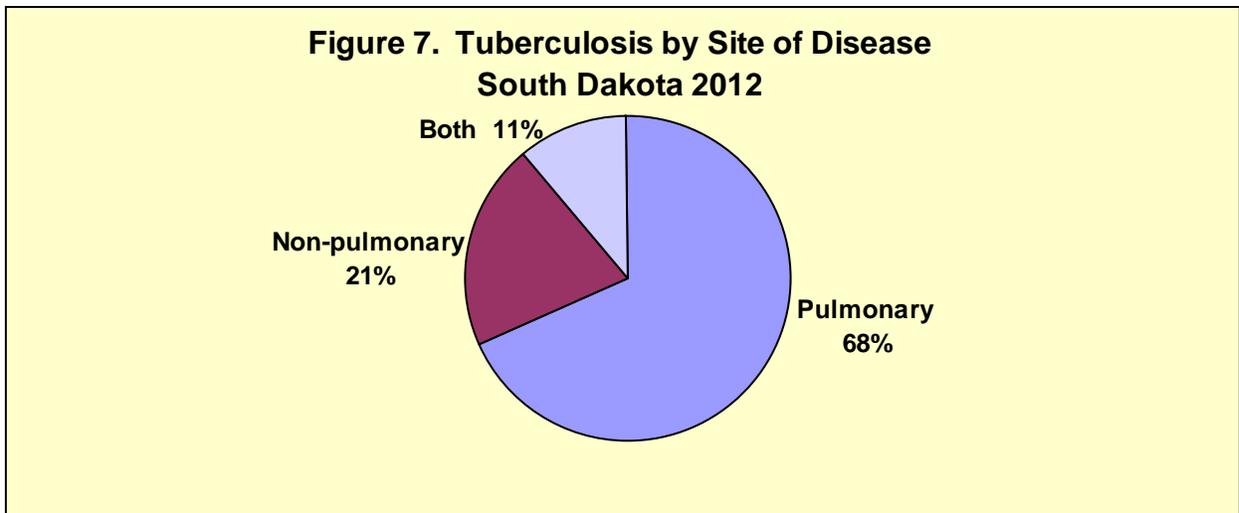


Tuberculosis cases in South Dakota have historically been located in a few geographic locations that consistently report the majority of TB cases. These include Minnehaha County which reports the highest number of foreign-born TB cases and Shannon, Todd and Pennington counties which report the highest number of Native American TB cases. Figure 6 and Table 3 provide additional information on the counties of residence of the TB cases in 2012.

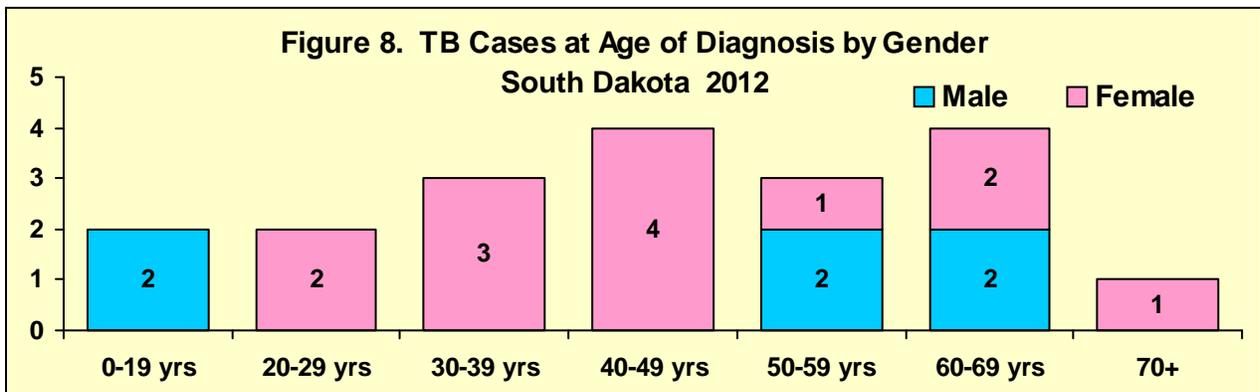
**Table 3. TB CASES REPORTED BY COUNTY OF RESIDENCE
SOUTH DAKOTA 2012**

County	# of TB Cases	County	# of TB Cases
Charles Mix	2	Mellette	1
Dewey	1	Minnehaha	9
Hand	1	Pennington	2
Lincoln	1	Todd	2
		TOTAL	19

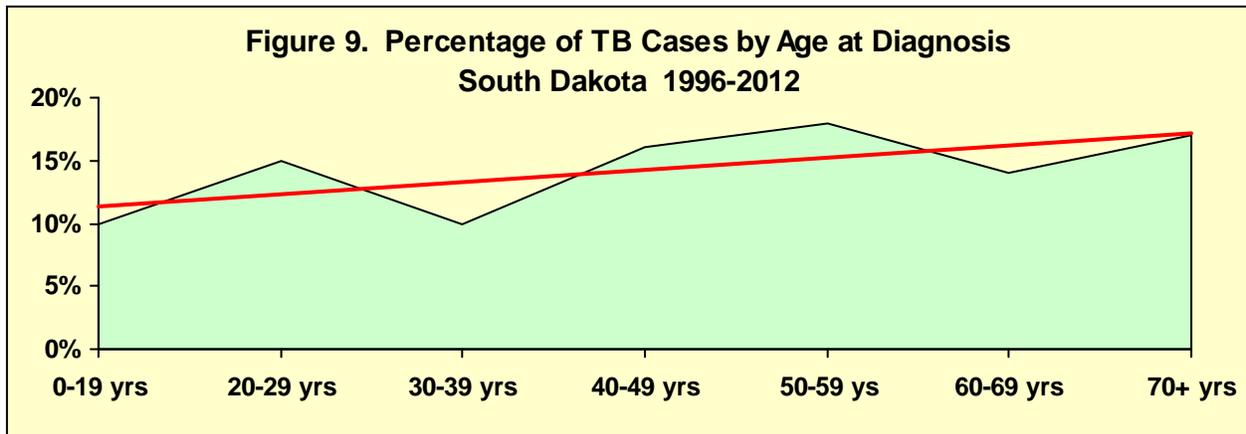
Tuberculosis remains primarily a pulmonary disease with approximately 85% of cases nationally reported as pulmonary disease and 15% as non-pulmonary disease. South Dakota has historically reported a higher percentage of non-pulmonary TB disease. In 2012 this trend continued with 6 cases (32%) reported as non-pulmonary or both pulmonary and non-pulmonary sites of disease as described in Figure 7. The non-pulmonary sites of disease in 2012 included TB reported in the eye, pancreas, lymph node and bone.



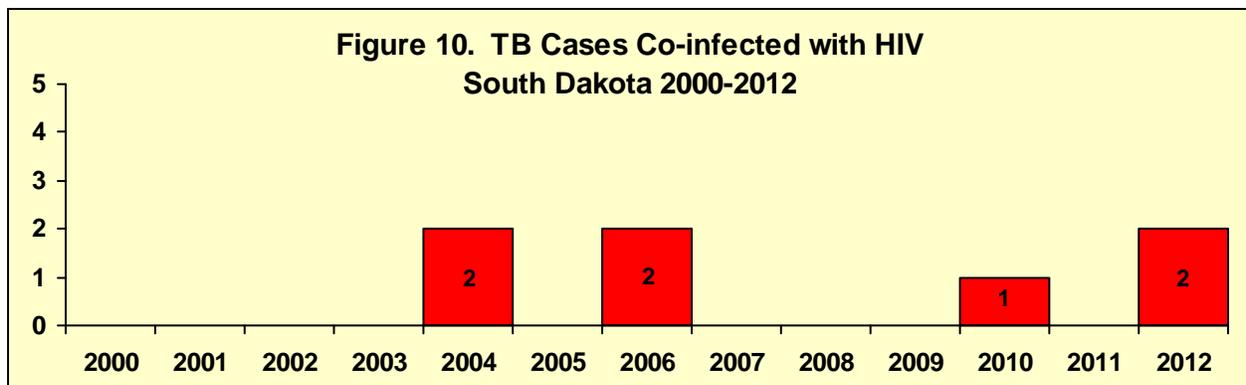
The average age of the TB case in 2012 was 45 years of age. This is a shift to older patients as compared to 2010 when the average age was 34 years of age. There were 2 children less than 10 years of age reported during this time period. Figure 8 illustrates the age at diagnosis by gender for tuberculosis cases reported in 2012.



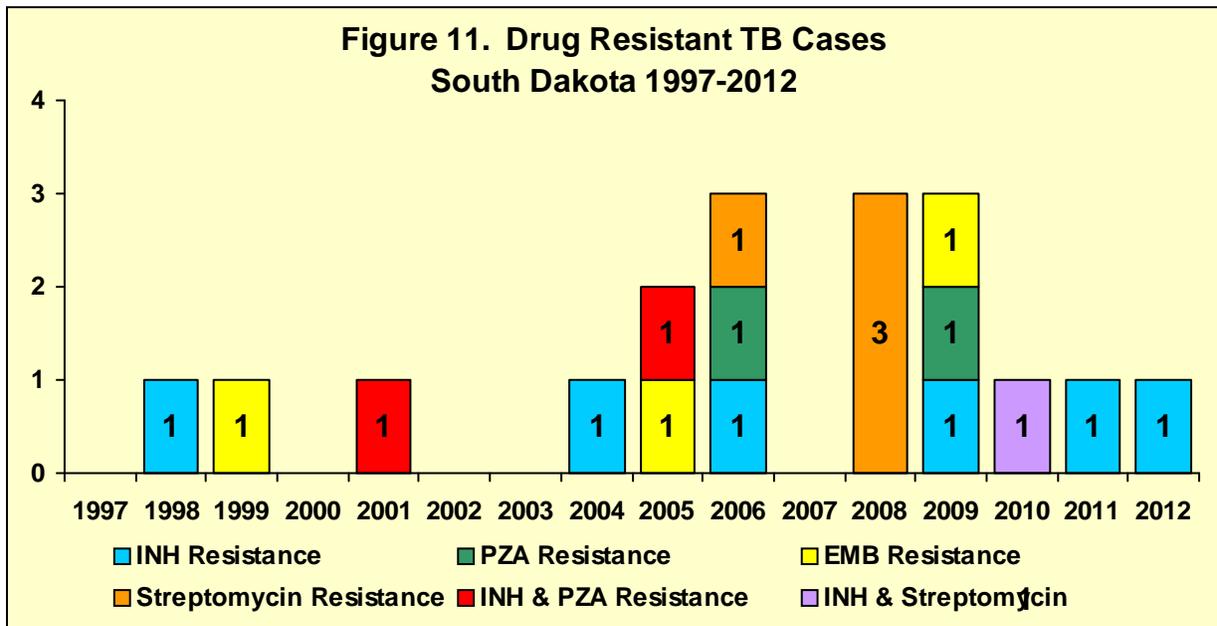
Historically most tuberculosis cases are diagnosed as adults in South Dakota. Figure 9 shows the majority of TB cases diagnosed in South Dakota were 40 years of age or older at the time of diagnosis from 1996 through 2012.



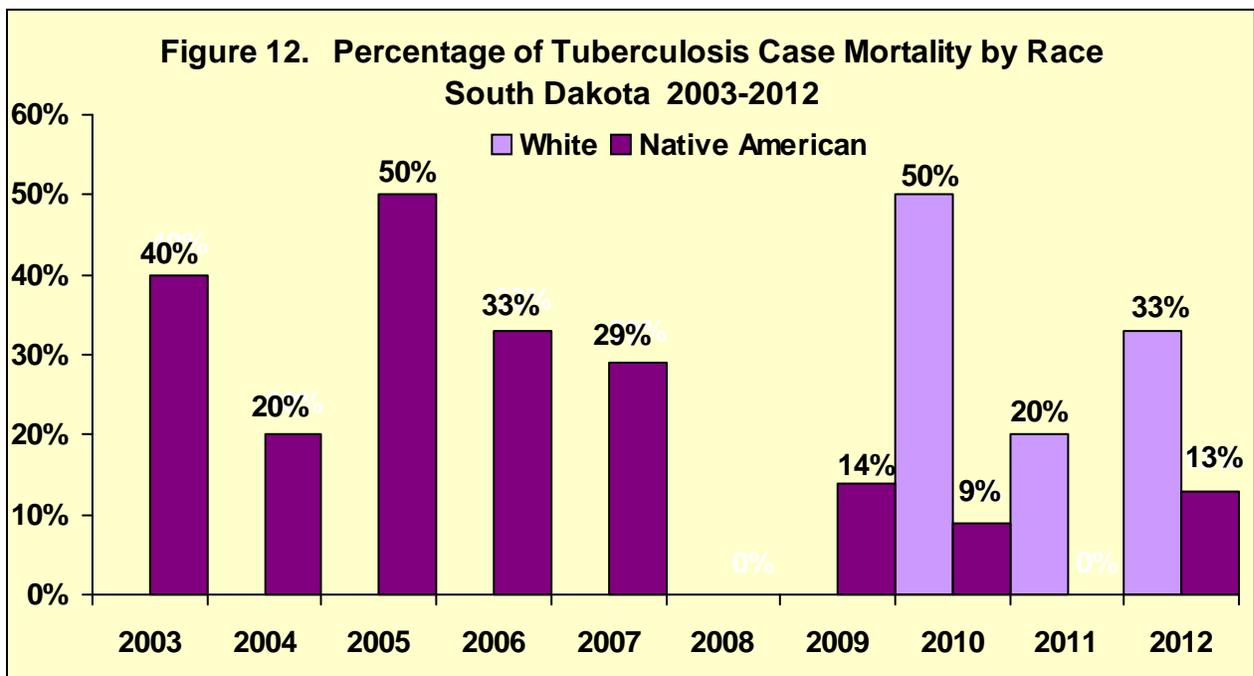
Co-infection with HIV is an important risk factor for the development of active TB. Because of this, all TB cases diagnosed in South Dakota are offered HIV testing. Co-infected TB cases require more monitoring for toxicity and are frequently treated with second line TB medications. Figure 10 describes the number of TB cases co-infected with HIV since 2000 documenting that HIV co-infected TB cases remain uncommon.



All culture positive TB isolates are tested for drug resistance to first-line TB medications including isoniazid (INH), rifampin (RIF), pyrazinamide (PZA), ethambutol (EMB) and streptomycin (SM). Multi-drug resistant TB is defined by CDC as resistance to at least INH and RIF and is a significant public health problem because of the difficulty in achieving a successful treatment outcome. Figure 11 shows drug resistant TB cases since 1997 illustrating that South Dakota most often has single drug resistant cases. No multi-drug resistant TB cases have been reported in South Dakota although the Department of Health has managed several MDR-TB cases reported in other states that have moved to South Dakota.



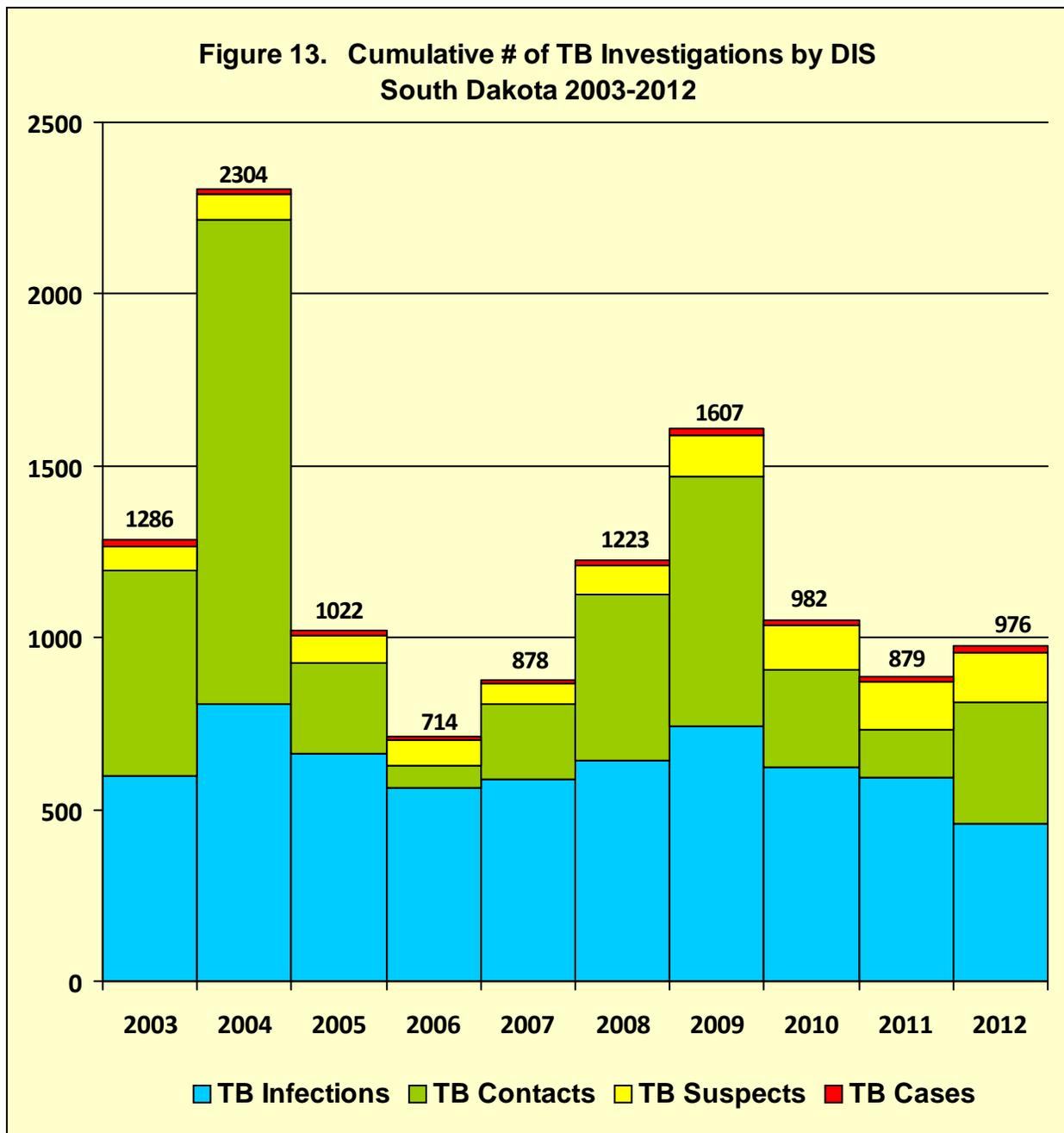
South Dakota has reported a higher than expected mortality rate during certain years, especially among Native American patients. Figure 12 shows the mortality rates by race since 2003 showing the higher trend among Native American cases. Mortality rates are calculated by the percentage of TB cases by race that die during the year of their diagnosis.



The workload in the TB Control Program consists of four categories of patients:

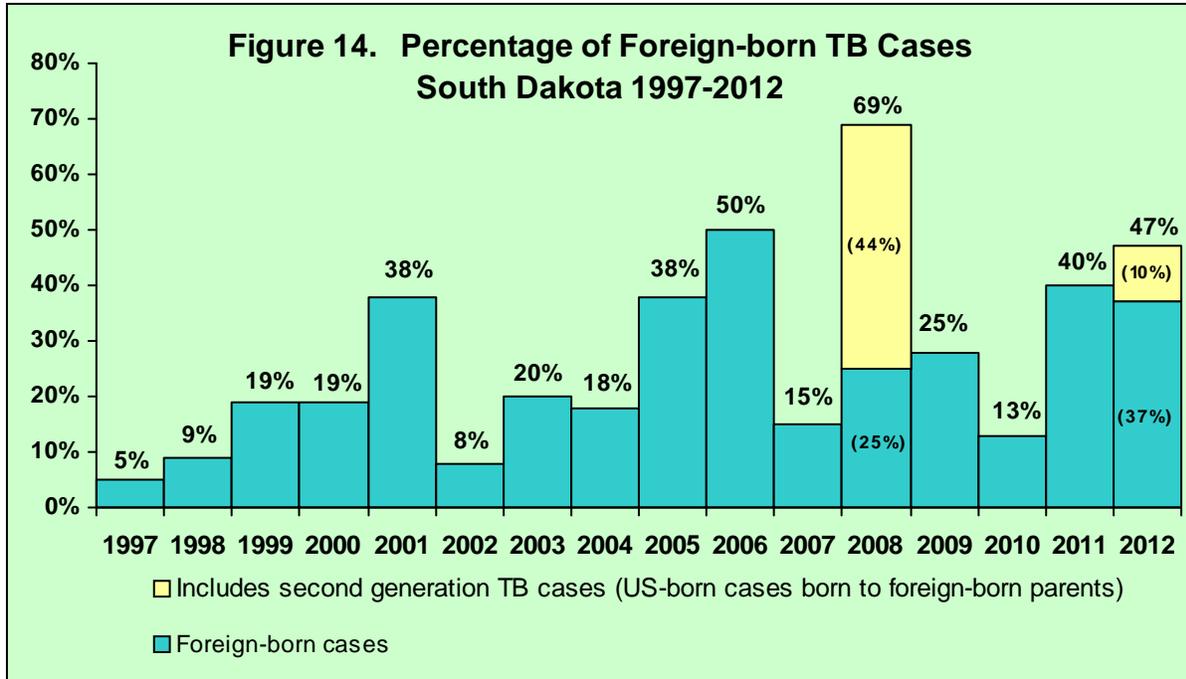
- 1) **TB cases** (persons diagnosed with active TB)
- 2) **TB suspects** (persons suspected of active TB with a pending diagnosis)
- 3) **TB contacts** (persons exposed to an infectious TB case)
- 4) **Latent TB infection** (persons reported with a positive TB skin test or positive IGRA test [interferon gamma release assay])

Disease Intervention Specialist (DIS) staff are responsible for ensuring appropriate investigation, treatment and follow-up of these individuals statewide. Figure 13 describes this cumulative caseload which is divided among 19 DIS staff illustrating that the active TB cases and suspect TB cases represent the smallest number of patients reported. TB contacts and patients with latent TB infection make up the greatest percentage of assigned workload for DIS staff within the TB Control Program.

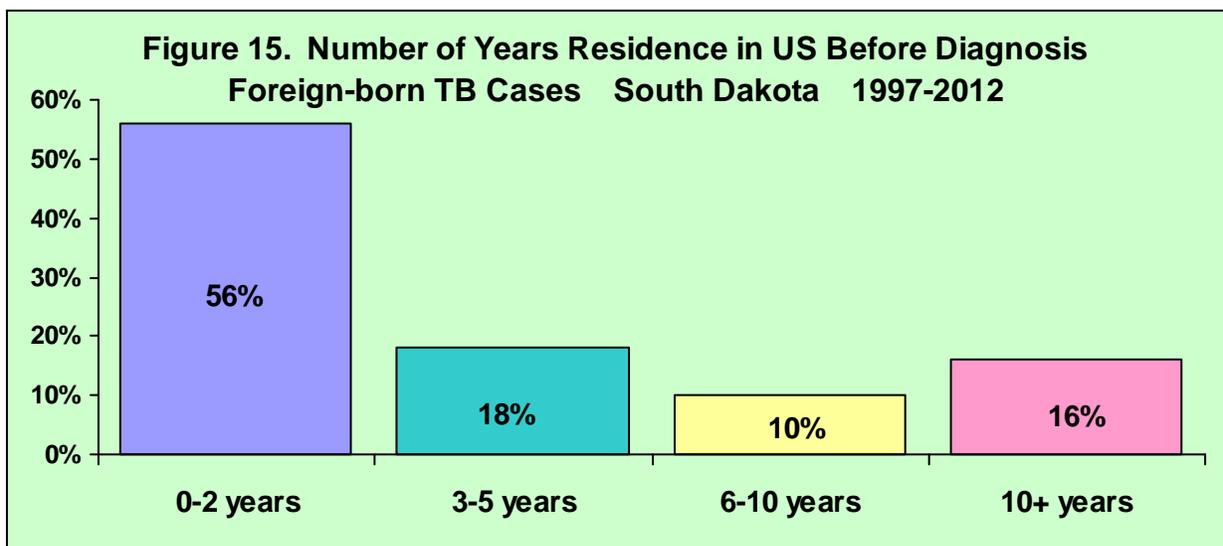


ANALYSIS OF FOREIGN-BORN TB CASES IN SOUTH DAKOTA

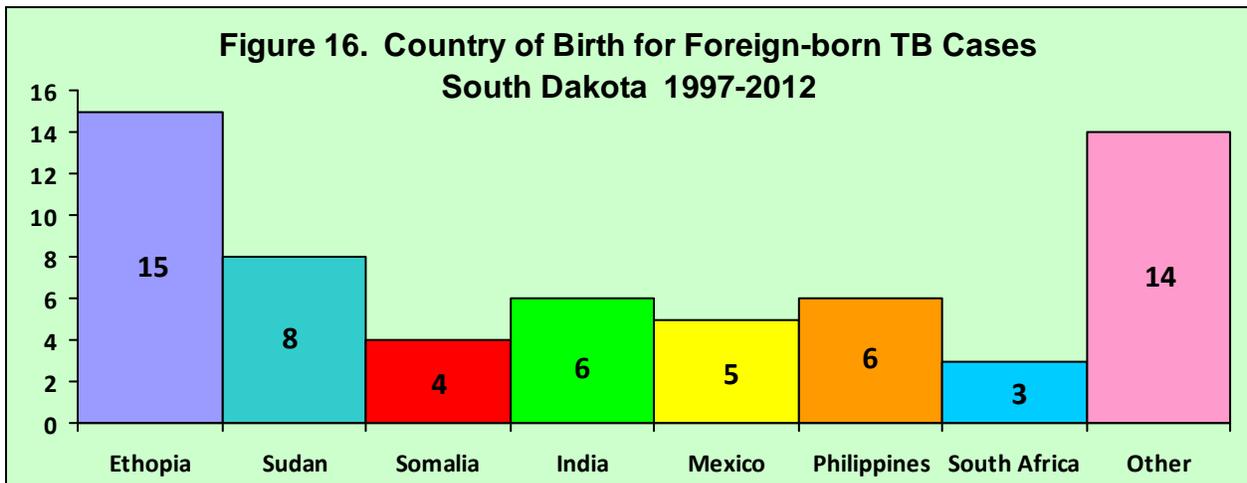
Tuberculosis cases who were born outside the United States continue to represent an important risk group in the United States as well as in South Dakota. Figure 14 describes the percentage of foreign-born TB cases in South Dakota. Second generation TB cases (US-born TB cases born to foreign-born parents) are a relatively new risk group that has been identified nationally. TB cases were first reported in this group in South Dakota in 2008 and then again in 2012.



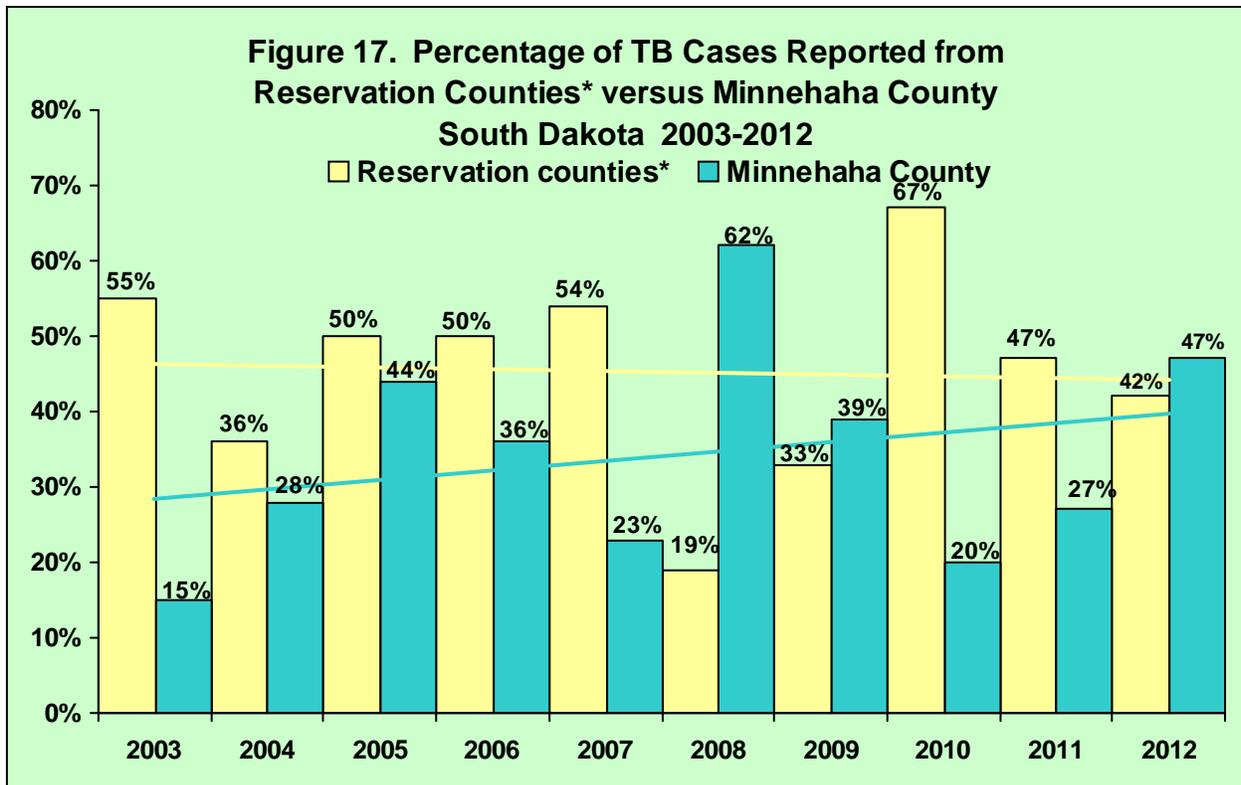
Most foreign-born persons who develop active TB usually do so within the first 2 years after arrival in the United States. Figure 15 describes that 75% of foreign-born TB cases since 1997 developed active TB within the first 5 years of their arrival. Because of this increased risk, these individuals are targeted for preventive TB program activities including targeted TB skin testing and preventive treatment programs.



Foreign-born TB cases continue to come from many areas of the world however the majority of the TB cases reported in South Dakota are of African descent. Figure 16 describes the country of birth for the foreign-born TB cases reported in South Dakota since 1997. Countries of birth for the “other” category include Afghanistan, China, El Salvador, Indonesia, Romania, Russia, Nepal, Mauritania, Vietnam, South Korea, Bhutan and Kenya.

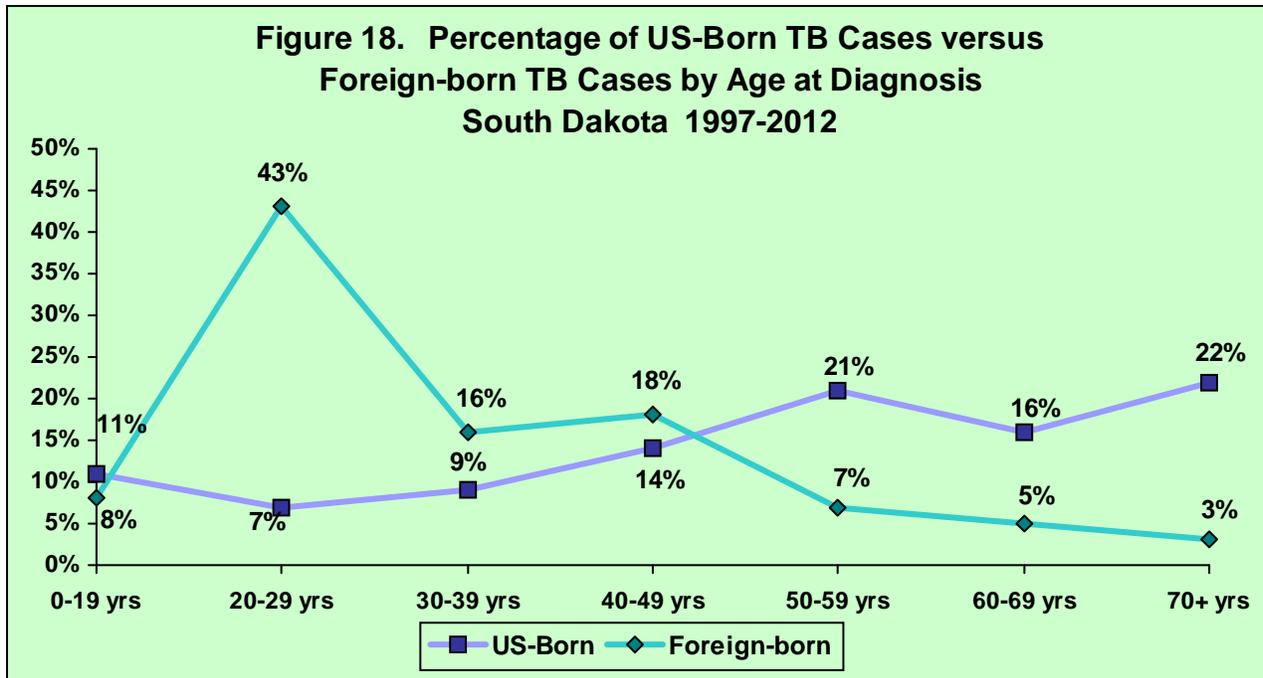


Another factor in the increase of foreign-born TB cases in South Dakota is the change in geography where TB cases are reported. Historically, the highest percentage of TB cases were reported from counties that included and bordered American Indian Reservations. As Native American TB cases decreased and foreign-born TB cases increased, there has been a geographic shift of TB cases from reservation counties to Minnehaha County as illustrated in Figure 17. This is due to the fact that most foreign-born persons who resettle in South Dakota do so in Minnehaha County.

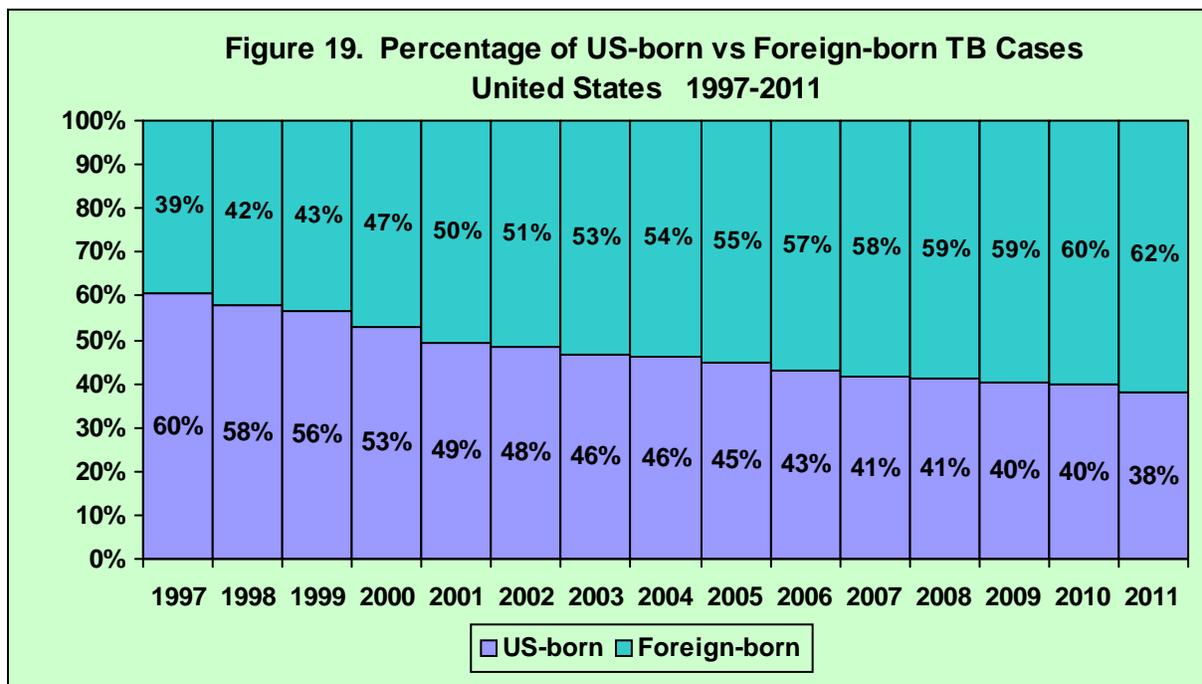


* Reservation counties include Bennett, Brule, Buffalo, Charles Mix, Corson, Dewey, Jackson, Mellette, Moody, Pennington, Roberts, Shannon, Todd, Tripp, Walworth and Ziebach.

Foreign-born TB cases are consistently reported in younger persons as compared to US born patients in South Dakota. This presents additional TB program management issues as these TB cases more commonly have young children who have been exposed at home and are typically employed requiring an investigation at their worksite which increases the number of contacts that must be screened and treated. Figure 18 illustrates that the majority of foreign-born TB cases are diagnosed while young adults.



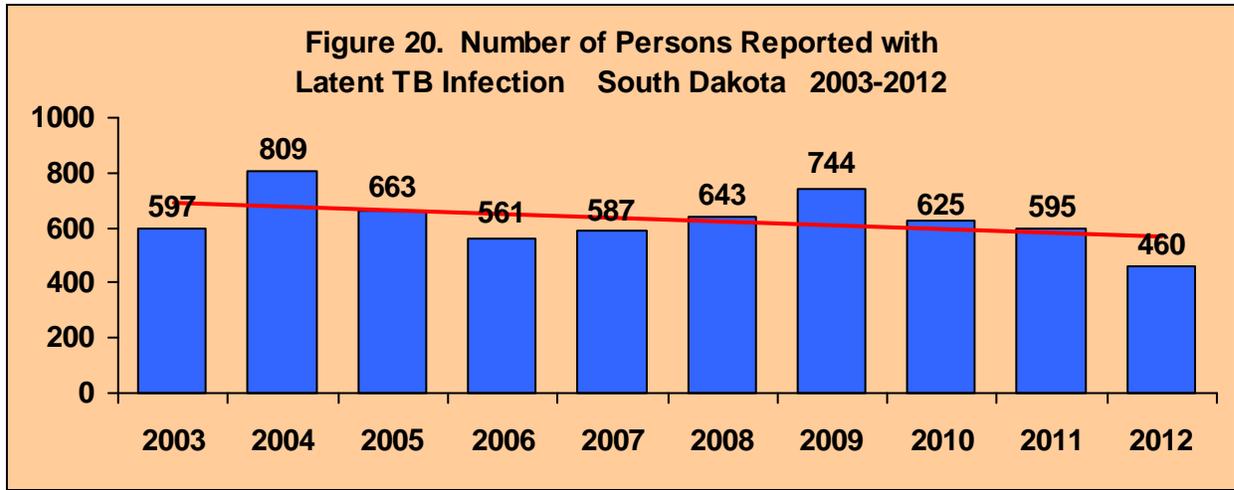
Foreign-born TB cases represent a unique challenge to the South Dakota TB Control Program because of cultural issues, language barriers and a greater likelihood of drug resistance. As these cases continue to increase in South Dakota, additional time and resources will need to be dedicated to address these unique issues. Figure 19 describes the ever increasing trend of the percentage of foreign-born TB in the United States since 1997.



LATENT TB INFECTION AND PREVENTION ACTIVITIES

Ensuring for appropriate treatment and follow-up of active TB cases and suspects is the highest priority of the Tuberculosis Control Program. However, in order to achieve TB elimination in South Dakota, an emphasis must be made on preventing future cases of TB. This is accomplished by follow-up of persons infected with latent TB infection. These individuals are infected with the TB bacteria (*Mycobacterium tuberculosis*) but have not yet developed an active form of the disease. By finding and treating these individuals, future TB cases can be prevented and therefore the TB Control Program dedicates time and resources to this preventive strategy.

Figure 20 presents the number of patients reported with latent TB infection (positive TB skin tests or positive IGRA testing) over the last 10 years. All of these individuals have the potential to develop active TB disease and potentially be infectious to others.



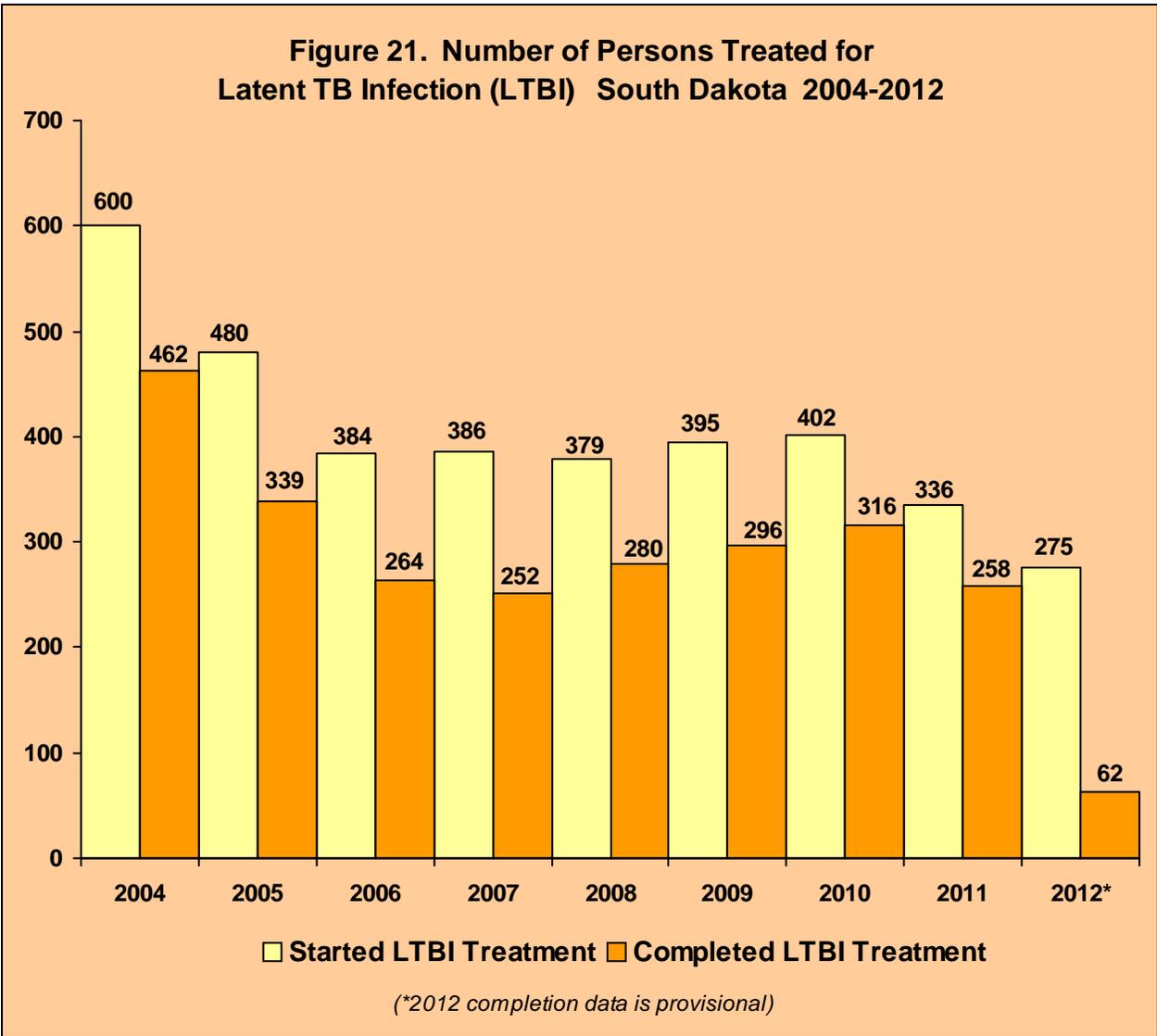
On August 2, 2011, the South Dakota Department of Health implemented an administrative rule change which changed the reporting requirement for latent TB infection. Prior to that, all persons diagnosed with latent TB infection were reportable to the South Dakota Department of Health. As of August 2, 2011, only patients with latent TB infection who have at least one of the following TB risk factors are now reportable:

REPORTABLE TB RISK FACTORS

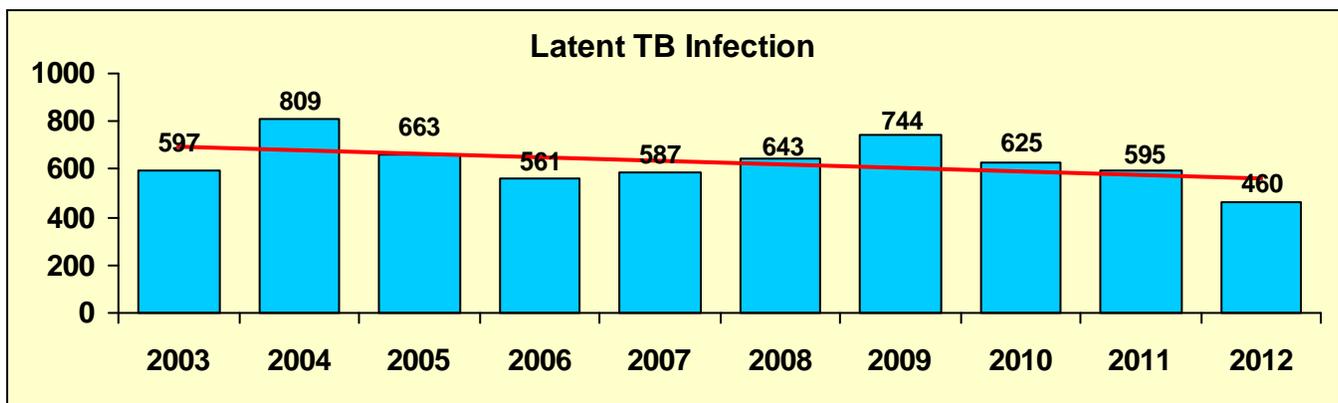
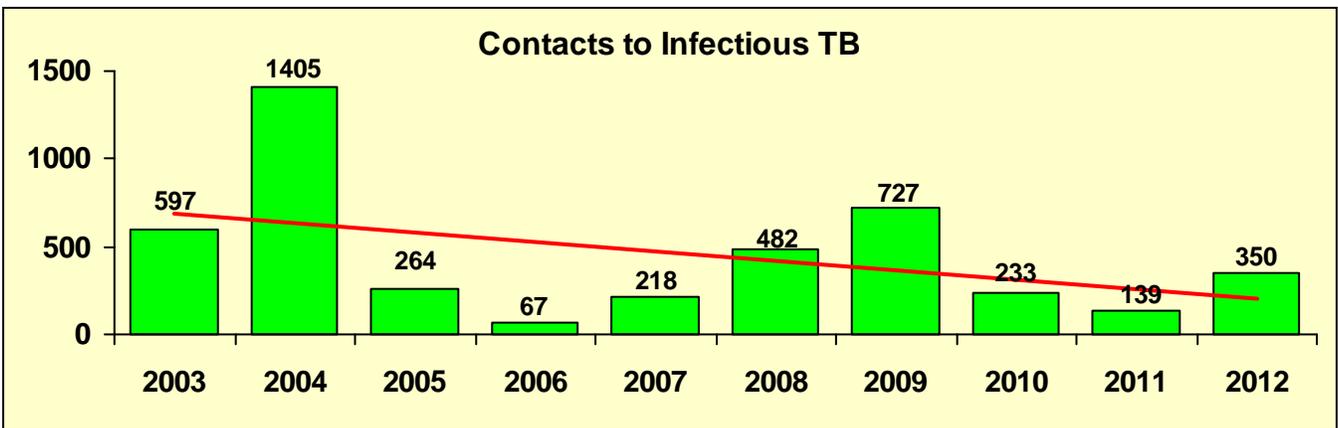
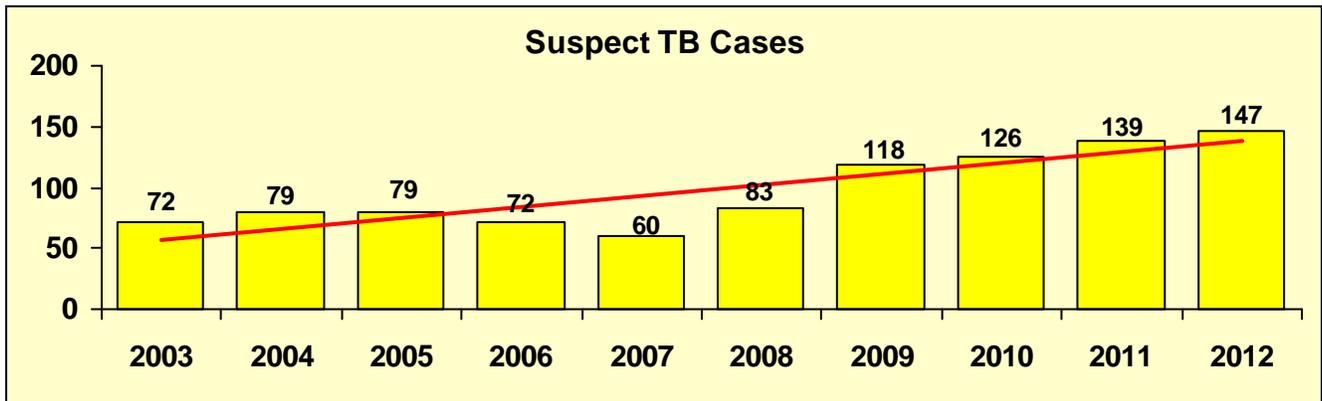
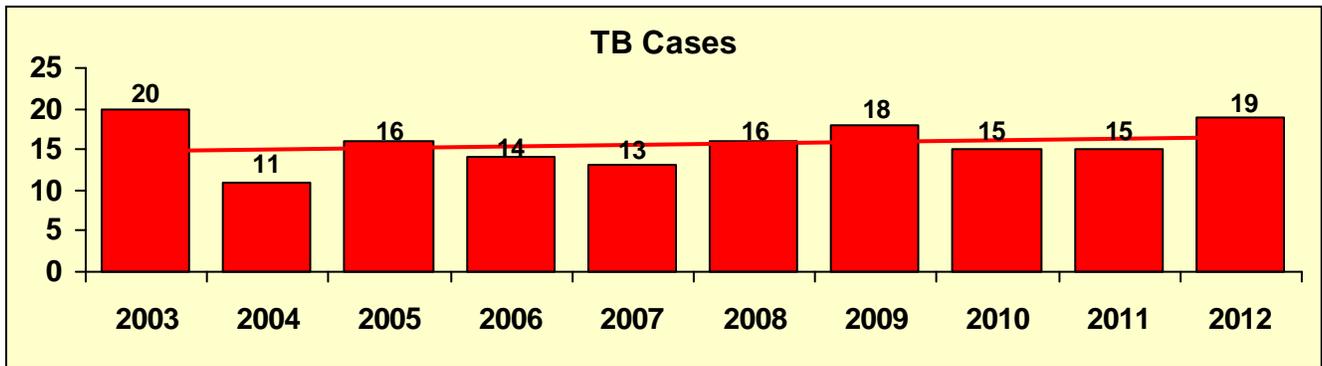
- ◆ Foreign-born persons who entered the US within the last 5 years
- ◆ Persons evaluated for tumor necrosis factor-alpha therapy
- ◆ Immunosuppressive therapies (i.e. high dose steroids)
- ◆ Radiographic evidence of prior TB
- ◆ Children less than 5 years of age
- ◆ Close contact to infectious TB
- ◆ HIV infection
- ◆ Diabetes
- ◆ Renal dialysis
- ◆ Silicosis
- ◆ Organ transplant
- ◆ Head and neck cancers
- ◆ Leukemia
- ◆ Hodgkin's disease

This reporting change will allow the Department of Health to focus staff time, medication and resources towards those patients who have the highest risk of developing active tuberculosis. Due to this change, only the above patients will be eligible for Department of Health nurse case management and medication. Health care providers and facilities are asked to report only patient with LTBI who meet this new reporting requirement by mailing or faxing the “*Latent Tuberculosis infection Report Form*” to the TB Control Program (reporting instructions are on the form). The form is available on the South Dakota Department of Health website: www.doh.sd.gov/tb. Patients who do not meet this reporting criteria should be referred to their private health care provider for evaluation and treatment at their own expense. All patients currently being managed by Department of health staff will be allowed to finish their prescribed course of treatment regardless of their risk factor status.

Figure 21 presents the number of patients with latent TB infection that started a course of preventive treatment as well as the number who completed this treatment. The treatment is usually done with Isoniazid (INH) which is provided free of charge to patients by the TB Control Program.



Summary of TB Control Program Caseload South Dakota 2003-2012



SOUTH DAKOTA HIV/AIDS SURVEILLANCE REPORT

JANUARY 2013

29 new HIV/AIDS cases were reported in 2012.

20 Males
9 Females

482 people are estimated to be living with HIV/AIDS in South Dakota.

Disproportionately impacted by HIV/AIDS:

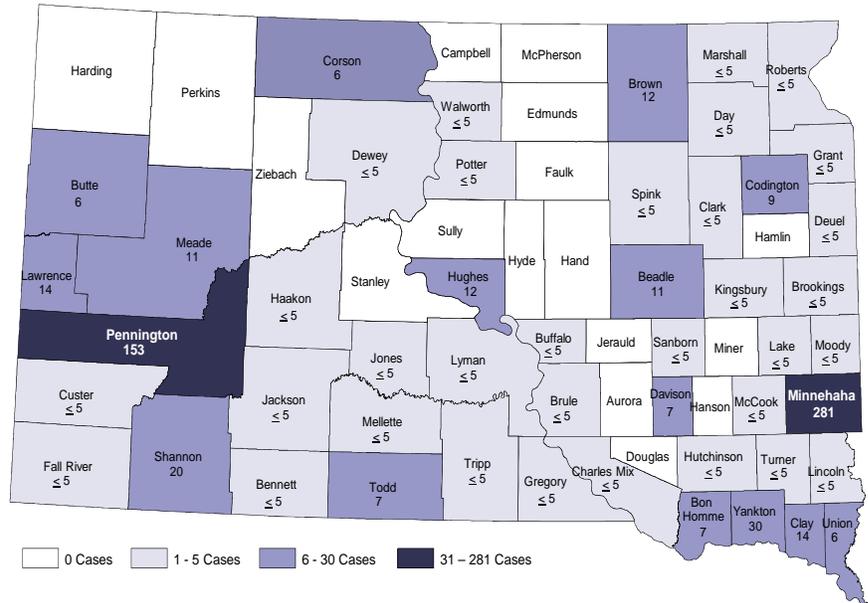
Blacks: 22% of living cases, <1% of the population

Native Americans: 14% of living cases, 9% of population

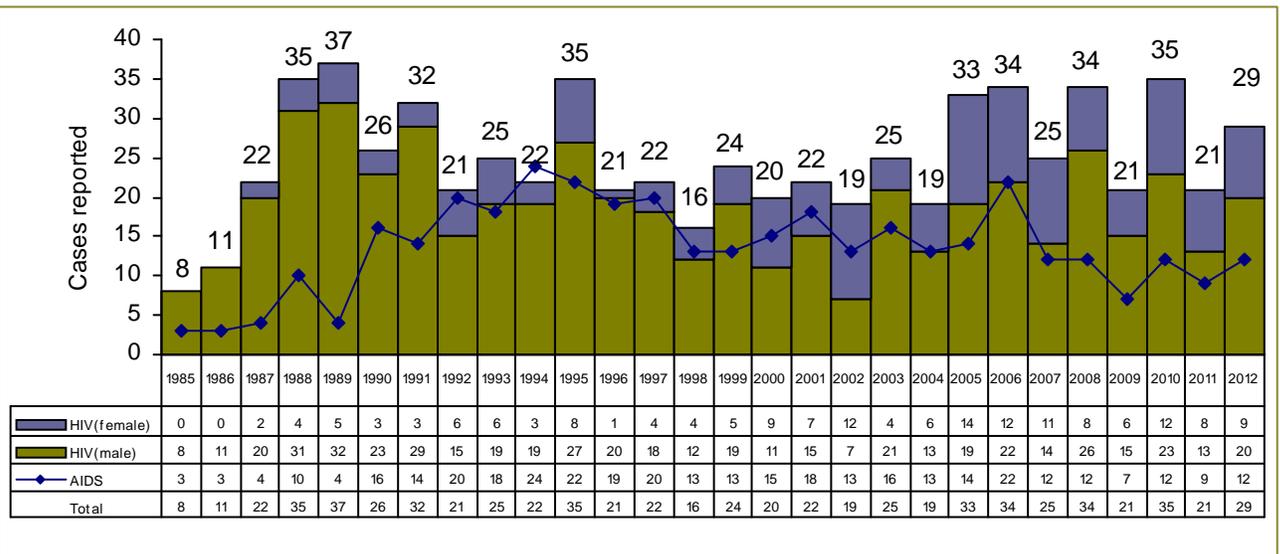
694 cumulative cases of HIV/AIDS were reported in SD from 1985-2012.

South Dakota HIV/AIDS Web site:
<http://doh.sd.gov/HIV/>

South Dakota Residents Reported Infected with HIV/AIDS: Cumulative Cases by County, 1985 - 2012



South Dakota Residents by Gender Infected with HIV and AIDS, 1985-2012



At the end of 2012, 694 SD residents had been reported as infected with HIV (521 male, 173 female) and 378 of those had also been diagnosed with AIDS. Some cases may have been reported as an HIV case in a different year than they were diagnosed with AIDS.



Characteristics of South Dakota HIV/AIDS Infected Persons as of December 31, 2012



	Total HIV/AIDS Diagnoses <i>Total number of persons diagnosed with HIV or AIDS (1985-2012)</i>		Persons Living with HIV/AIDS <i>Minimum estimate of persons living with HIV or AIDS</i>		Department of Health Confidential HIV Testing Centers <i>or call Toll Free 1-800-592-1861</i>
	Cases	Percent	Cases	Percent	
TOTAL	694	100%	482	100%	Aberdeen 402 S. Main St. Aberdeen, SD 57401 605-626-2373 1-866-805-1007 Rapid City 909 E. St. Patrick Rapid City, SD 57701 605-394-2289 1-866-474-8221 Watertown 2001 9th Avenue SW., Ste. 500 Watertown, SD 57201 605-882-5096 1-866-817-4090 Sioux Falls 1200 N. West Ave. Sioux Falls, SD 57104 605-367-5365 1-866-315-9214 Pierre 740 E. Dakota Pierre, SD 57501 605-773-5348 1-866-229-4927 Dupree Ziebach County Court House Dupree, SD 57623 605-365-5164 1-866-778-5157 CDC HOTLINE 1-800-232-4636 The South Dakota Department of Health is authorized by SDCL 34-22-12 and ARSD 44:20 to collect and process mandatory reports of communicable diseases. How to report: Secure Website: www.state.sd.us/doh/diseasereport Telephone: 1-800-592-1804 (Confidential answering device) or 1-800-592-1861 or 605-773-3737
Sex					
Female	173	25%	136	28%	
Male	521	75%	346	72%	
Race and Ethnicity					
American Indian	125	18%	69	14%	
Black	113	16%	106	22%	
Hispanic and Other **	28	4%	26	5%	
White	428	62%	281	58%	
Country of Origin					
United States	608	88%	393	82%	
Other	86	12%	89	18%	
Age Group	(Age at HIV Diagnosis)		(Age December 31, 2012)		
< 2 years	9	1%	2	1%	
2-12 years	10	1%	5	1%	
13-24 years	90	13%	7	2%	
25-44 years	442	64%	198	41%	
45-65 years	140	20%	252	52%	
>65 years	3	1%	18	4%	
Exposure Category					
Heterosexual	156	23%	137	28%	
IDU (Injection Drug User)	105	15%	68	14%	
MSM (Men who have Sex with Men)	290	42%	190	39%	
MSM & IDU	24	4%	17	4%	
Perinatal/Pediatric	13	2%	7	2%	
Transfusion/Hemophilia	20	3%	10	2%	
Unspecified	86	12%	53	11%	
HIV Prevention Region					
Central	37	5%	18	4%	
Northeast	64	9%	39	8%	
Southeast	367	53%	296	61%	
West	216	31%	129	27%	
Unknown/Other***	9	1%	0	0	

**Hispanic and Other denotes cases that are Asian, Hispanic, or Multi-race.

***Unknown/Other denotes cases in which the HIV/AIDS county is unknown or in a state other than South Dakota.

Due to rounding totals may not equal 100.

Questions regarding the surveillance report may be directed to Christine Olson 605-773-3737 or Christine.Olson@state.sd.us.

FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind — United States, 2013

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Persons aged 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to dose 4	Dose 4 to dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks		
Rotavirus ²	6 weeks	4 weeks	4 weeks ²		
Diphtheria, tetanus, pertussis ³	6 weeks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁵	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ⁵ if current age is younger than 12 months 8 weeks (as final dose) ⁵ if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁶	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated poliovirus ⁷	6 weeks	4 weeks	4 weeks	6 months ⁷ minimum age 4 years for final dose	
Meningococcal ¹³	6 weeks	8 weeks ¹³	see footnote 13	see footnote 13	
Measles, mumps, rubella ⁹	12 months	4 weeks			
Varicella ¹⁰	12 months	3 months			
Hepatitis A ¹¹	12 months	6 months			
Persons aged 7 through 18 years					
Tetanus, diphtheria; tetanus, diphtheria, pertussis ⁴	7 years ⁴	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human papillomavirus ¹²	9 years	Routine dosing intervals are recommended ¹²			
Hepatitis A ¹¹	12 months	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated poliovirus ⁷	6 weeks	4 weeks	4 weeks ⁷	6 months ⁷	
Meningococcal ¹³	6 weeks	8 weeks ¹³			
Measles, mumps, rubella ⁹	12 months	4 weeks			
Varicella ¹⁰	12 months	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

South Dakota Department of Health – Infectious Disease Surveillance

Selected Morbidity Report, 1 January – 31 December 2012

(provisional numbers) see <http://doh.sd.gov/ID/site.aspx>

	Disease	2012 year-to-date	5-year median	Percent change
Vaccine-Preventable Diseases	Diphtheria	0	0	n/a
	Tetanus	0	0	n/a
	Pertussis	67	58	+16%
	Poliomyelitis	0	0	n/a
	Measles	0	0	n/a
	Mumps	0	0	n/a
	Rubella	0	0	n/a
	<i>Haemophilus influenzae</i> type b	0	0	n/a
Sexually Transmitted Infections and Blood-borne Diseases	HIV infection	29	25	+16%
	Hepatitis B, acute	2	4	n/a
	Chlamydia	3,778	3,016	+25%
	Gonorrhea	658	382	+72%
	Syphilis, early	17	4	+325%
Tuberculosis	Tuberculosis	19	15	+27%
Invasive Bacterial Diseases	Meningococcal, invasive	0	3	n/a
	Invasive Group A <i>Streptococcus</i>	0	0	n/a
Enteric Diseases	<i>E. coli</i> , Shiga toxin-producing	47	47	0%
	Campylobacteriosis	275	296	-7%
	Salmonellosis	166	172	-3%
	Shigellosis	11	7	+57%
	Giardiasis	141	110	+28%
	Cryptosporidiosis	112	138	-19%
	Hepatitis A	0	0	n/a
Vector-borne Diseases	Animal Rabies	61	32	+91%
	Tularemia	5	8	-38%
	Rocky Mountain Spotted Fever	1	2	-50%
	Malaria (imported)	5	1	+400%
	Hantavirus Pulmonary Syndrome	1	0	n/a
	Lyme disease	4	1	+300%
	West Nile Virus disease	203	21	+867%
Other Diseases	Legionellosis	9	3	+200%
	Additionally, the following were reported: Chicken Pox (32); Dengue Fever (1); Erlichiosis (1); Hepatitis B, chronic (40); MRSA, invasive (85); Q Fever (2)			

Communicable diseases are obligatorily reportable by physicians, hospitals, laboratories, and institutions. The **Reportable Diseases List** is found at <http://doh.sd.gov/Disease/report.aspx> or upon request. Diseases are reportable by telephone, fax, mail, website, or courier.

Secure website: www.state.sd.us/doh/diseasereport

Telephones: 24 hour answering device 1-800-592-1804; for a live person at any time call 1-800-592-1861; after hours emergency 605-280-4810.

Fax 605-773-5509.

Mail in a sealed envelope addressed to the DOH, Office of Disease Prevention, 615 E. 4th Street, Pierre, SD 57501, marked "Confidential Medical Report".

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