

South Dakota Tuberculosis Control Program Annual Report, 2014

By Kristin Rounds, Tuberculosis Control Coordinator, South Dakota Department of Health

During the last ten years, South Dakota averaged 14 cases of tuberculosis (TB) per year. During 2014, there were eight cases of TB reported to the South Dakota Department of Health, which is the second consecutive year that the lowest number of cases was reported in the State. Figure 1 shows the 10-year trend of TB cases reported in South Dakota.

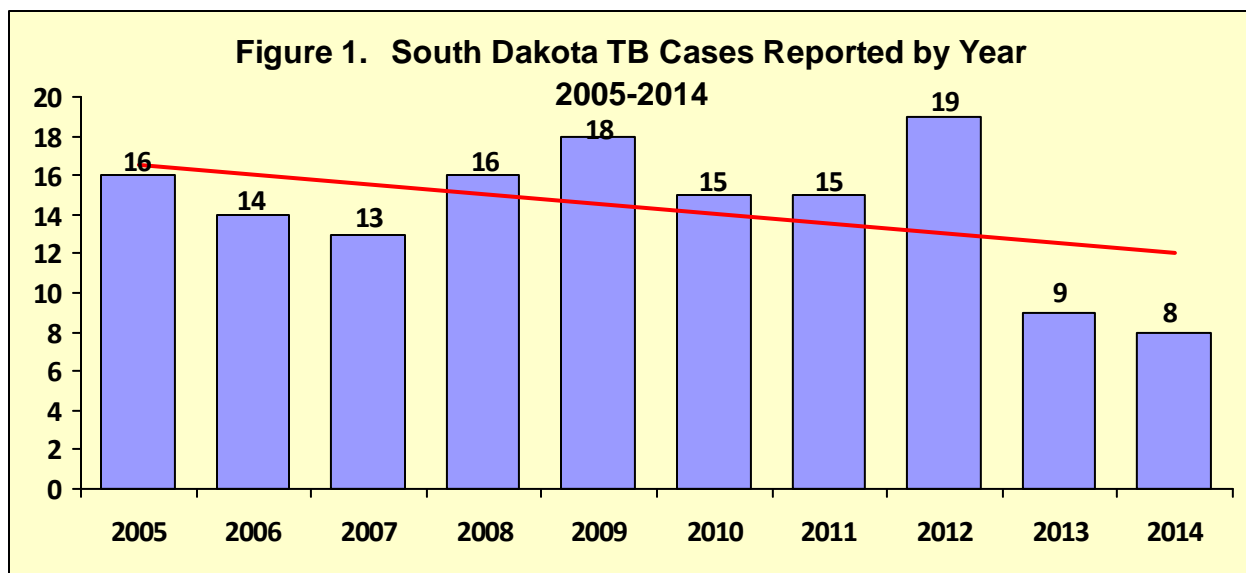
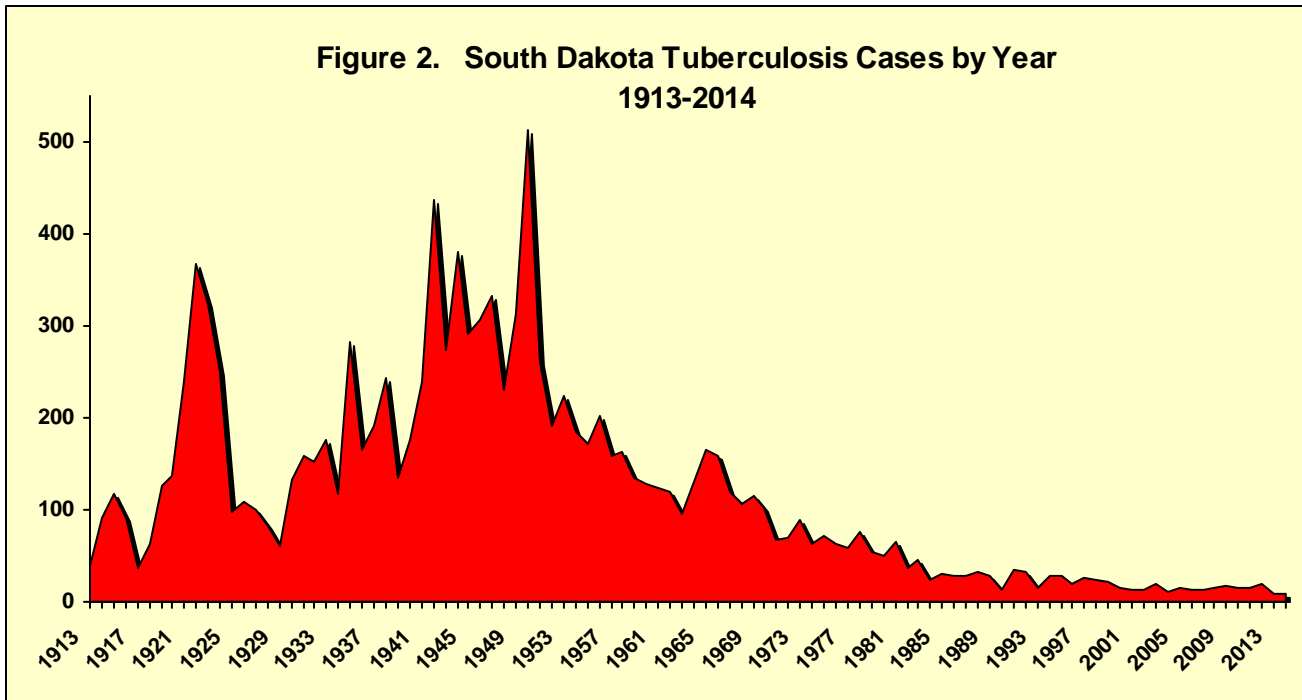


Figure 2 illustrates the 100-year history of tuberculosis cases in South Dakota. Since the 1950's there has been a dramatic decrease of cases due to the developmental of anti-tuberculosis medications. Case reductions are also a result of mandatory reporting of suspected TB cases to the Department of Health, case management, new treatment regimens and comprehensive contact investigations to ensure those exposed receive prompt intervention efforts.

For more information visit <http://doh.sd.gov/diseases/infectious/TB/> or contact the following staff:

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The most recent data available nationally and regionally is from calendar year 2013. 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.

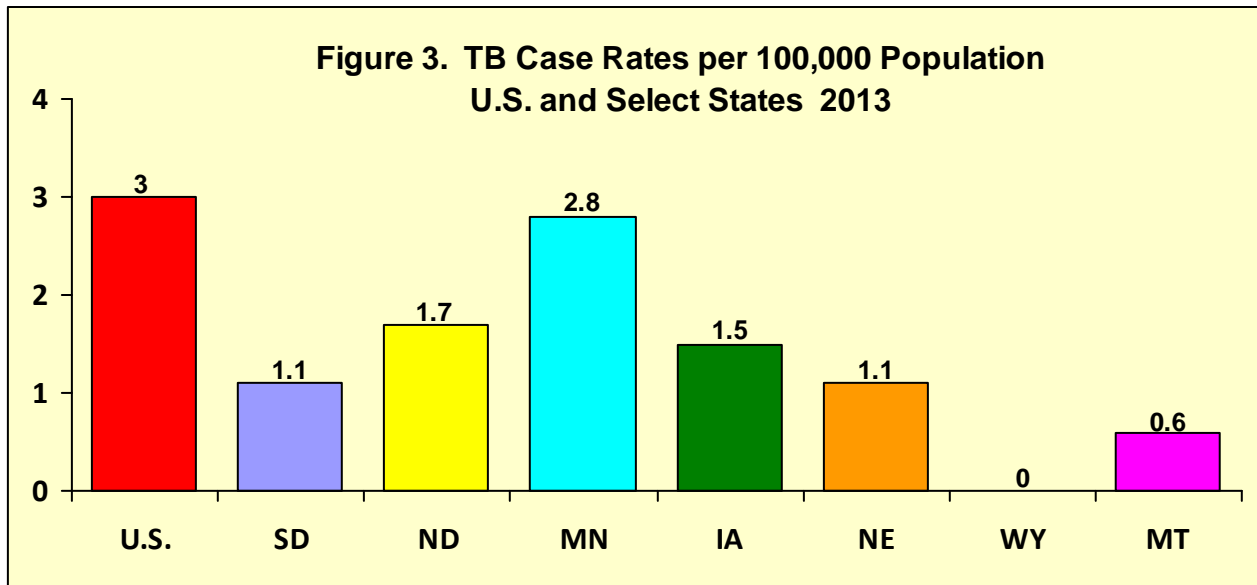
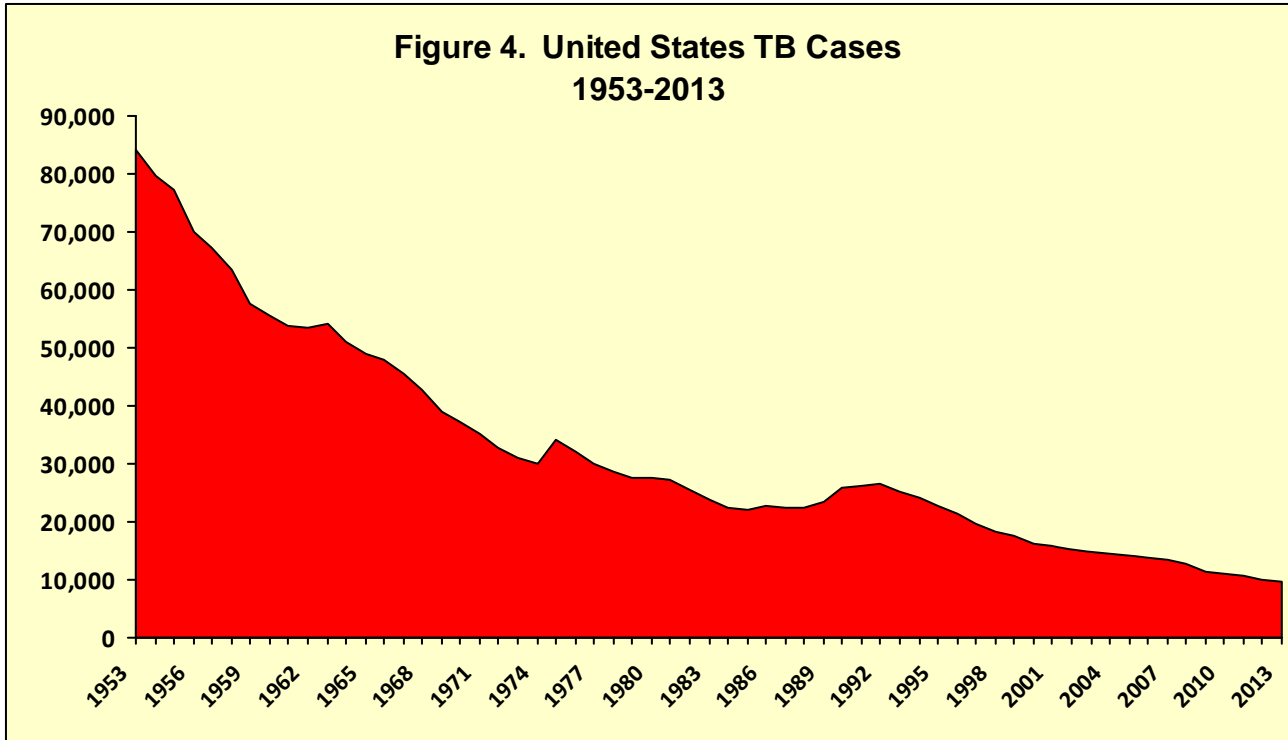


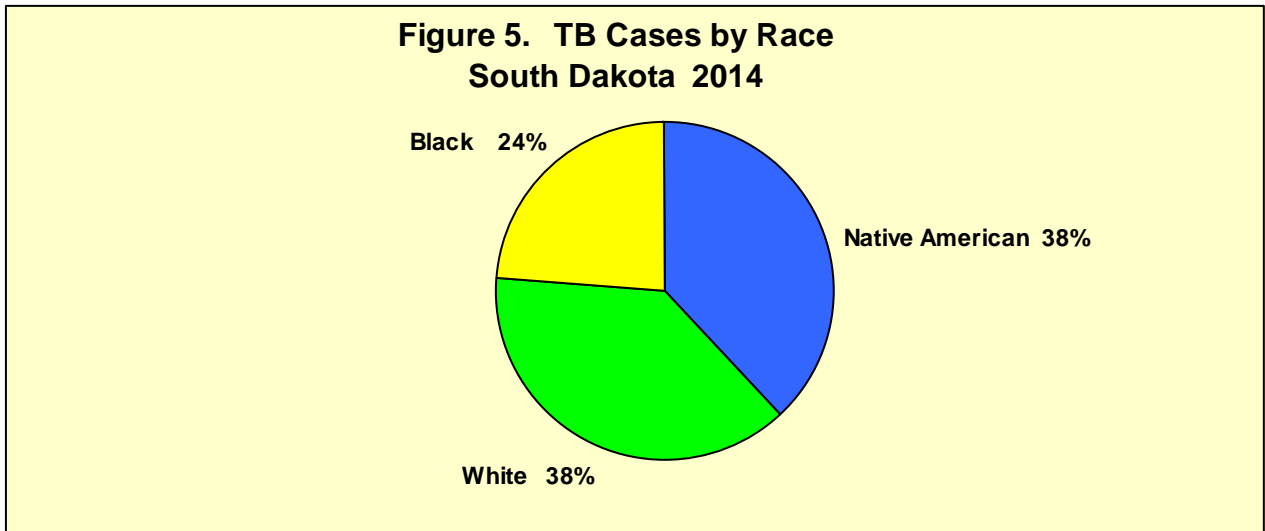
Figure 4 illustrates the historical trend of decreasing TB cases reported in the United States. In 2013 there were 9,582 TB cases reported in the US which was the lowest year on record, representing a 3.6% decrease from 2012. During 2013, 18 states reported increased case counts from 2012. The four states of California, Texas, New York and Florida accounted for 51% of the national case total. During 2013, 1% 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 2013, 65% of TB cases nationally were in foreign-born persons, the highest percentage ever reported.



Native Americans have historically reported the highest percentage of TB cases by race however in 2014 they contributed 38% of the total TB cases reported. Table 1 and Figure 5 provide information on TB cases by race in 2014.

**Table 1. TUBERCULOSIS CASES REPORTED BY SEX AND RACE
SOUTH DAKOTA 2014**

Race	Male	Female	Total	% of Cases
Native American	1	2	3	38%
White	2	1	3	38%
Black	2	0	2	24%
Asian	0	0	0	0%
Total	5	3	8	100%



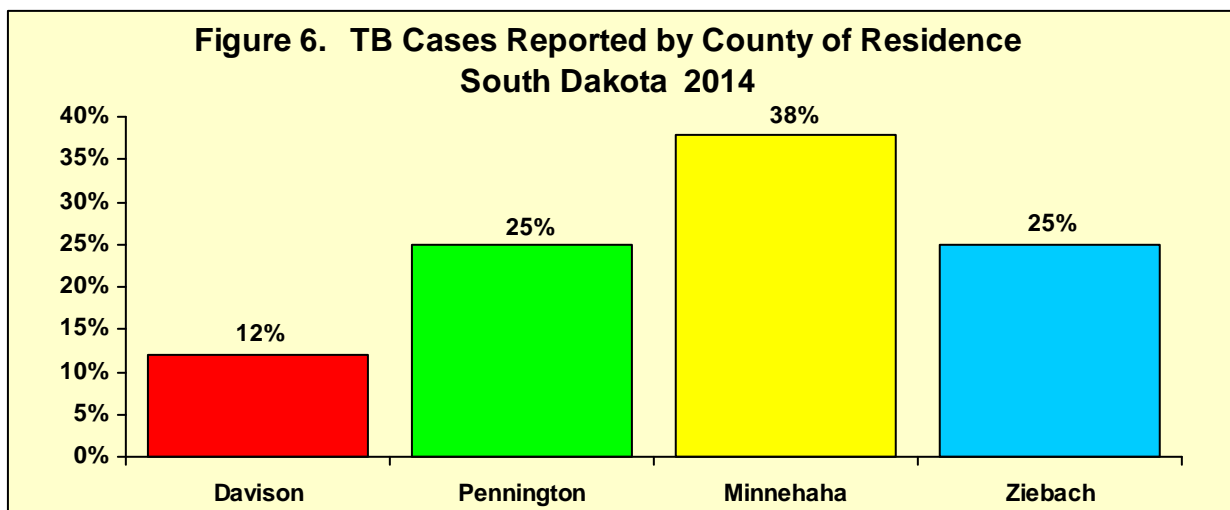
The TB incidence rate, which measures the number of TB cases per 100,000 population, is the best measure for determining the progress towards the elimination of TB in South Dakota. Historically, Native American TB case rates have dropped considerably while white cases have consistently remained low. 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 2009-2014

Race	2009	2010	2011	2012	2013	2014
US Case Rate (All Races)	3.8	3.6	3.4	3.2	3.0	Not available*
SD All Races	2.2	1.8	1.8	2.3	1.1	1.0
SD Native American	10.3	15.0	6.1	9.7	6.1	3.7
SD White	0.9	0.3	0.7	0.9	0.1	0.4
SD Black	64.5	24.6	13.6	20.4	13.6	13.6
SD Asian	17.4	0.0	39.4	26.3	13.1	0.0
All Other SD Races	0.0	0.0	0.0	0.0	0.0	0.0

*2014 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 2014.

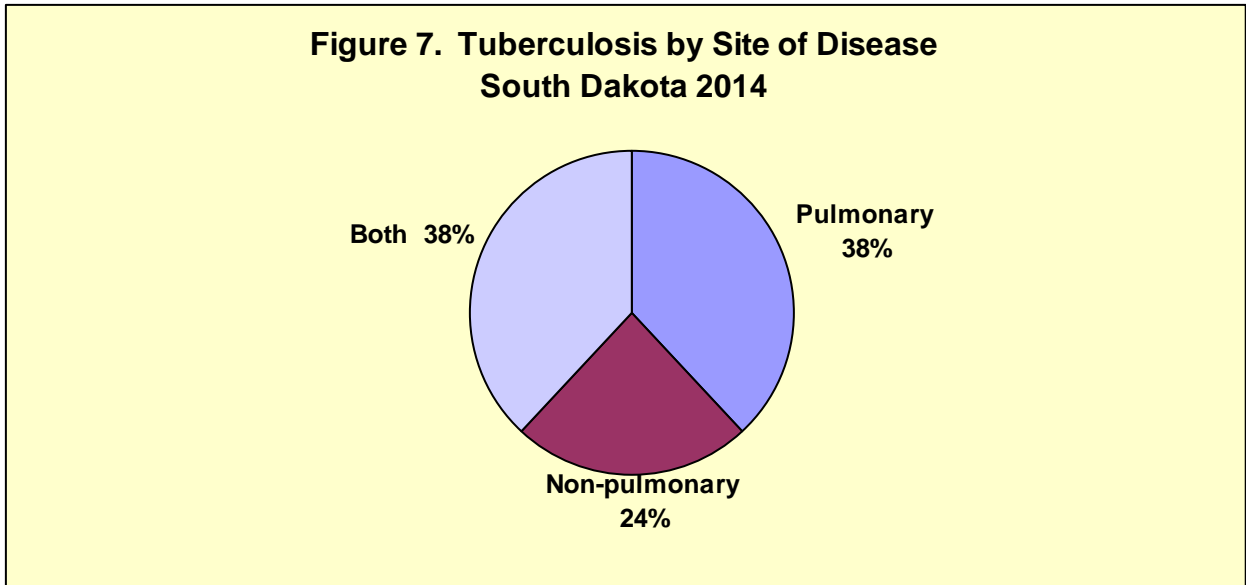


Tuberculosis cases in South Dakota have historically been located in a few geographic locations that consistently report the majority of TB cases. These include Minnehaha County which reports the highest number of foreign-born TB cases and Shannon, Todd and Pennington counties which report the highest number of Native American TB cases. Figure 6 and Table 3 provide additional information on the counties of residence of the TB cases in 2014.

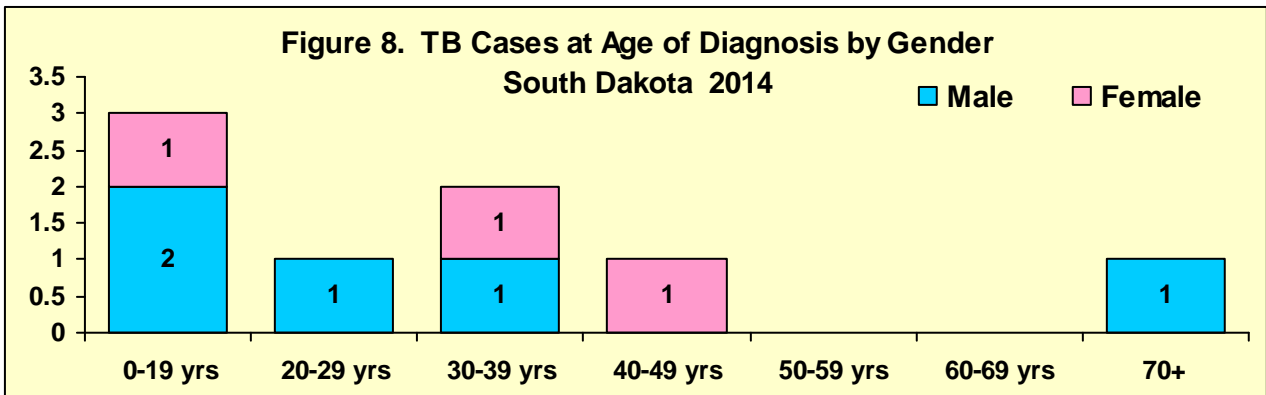
**Table 3. TB CASES REPORTED BY COUNTY OF RESIDENCE
SOUTH DAKOTA 2014**

County	# of TB Cases	County	# of TB Cases
Davison	1	Pennington	2
Minnehaha	3	Ziebach	2

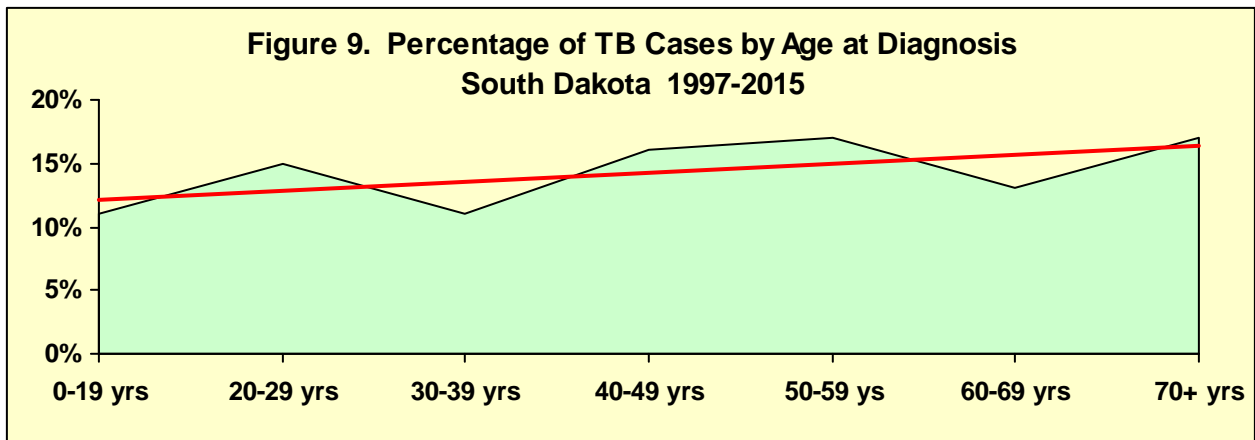
Tuberculosis remains primarily a pulmonary disease with approximately 85% of cases nationally reported as pulmonary disease and 15% as non-pulmonary disease. South Dakota has historically reported a higher percentage of non-pulmonary TB disease. In 2014 this trend continued with 2 cases (24%) reported as non-pulmonary sites of disease as described in Figure 7. The non-pulmonary sites of disease reported in 2014 included bone, liver, peritoneal, pleural, renal and lymphatic TB.



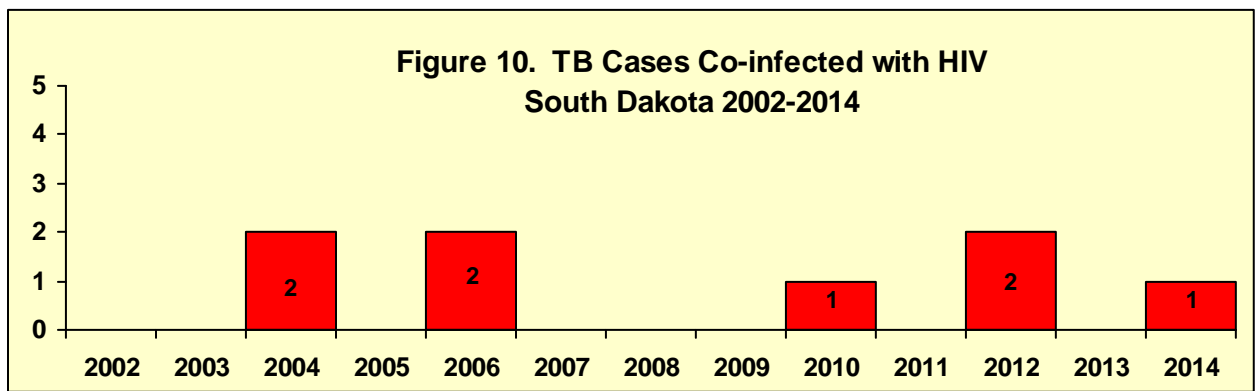
The average age of a TB case in 2014 was 31 years of age. This is a significant decrease in age as compared to 2013 when the average age was 48 years of age. There was one child less than 10 years of age reported during this time period. Figure 8 illustrates the age at diagnosis by gender for tuberculosis cases reported in 2014.



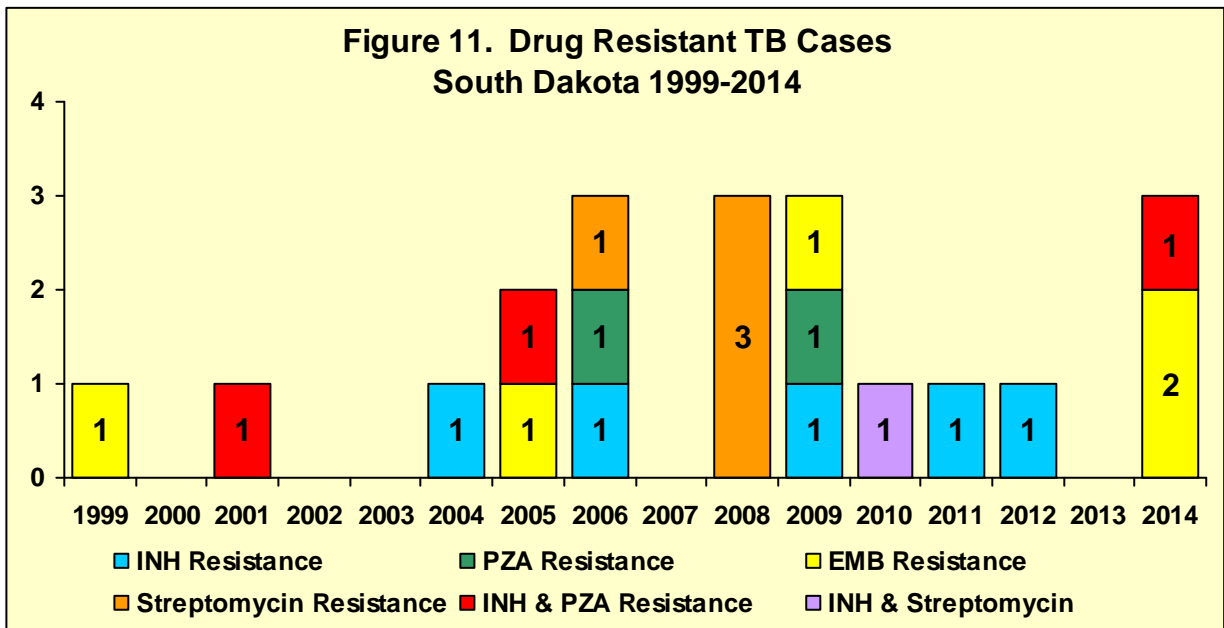
Historically most tuberculosis cases are diagnosed as adults in South Dakota. Figure 9 shows the majority of TB cases diagnosed in South Dakota were 40 years of age or older at the time of diagnosis from 1997 through 2014.



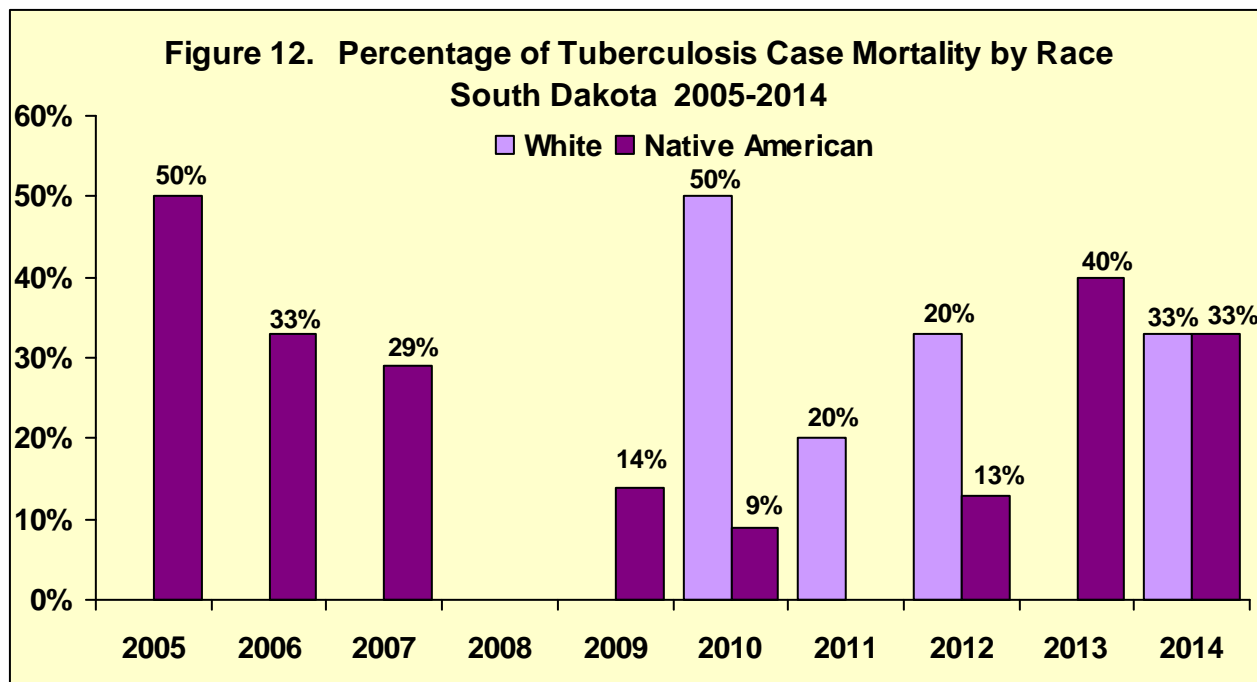
Co-infection with HIV is an important risk factor for the development of active TB. Because of this, all TB cases diagnosed in South Dakota are offered HIV testing. Co-infected TB cases require more monitoring for toxicity and are frequently treated with second-line TB medications. Figure 10 describes the number of TB cases co-infected with HIV since 2002 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 1999 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 2005 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.

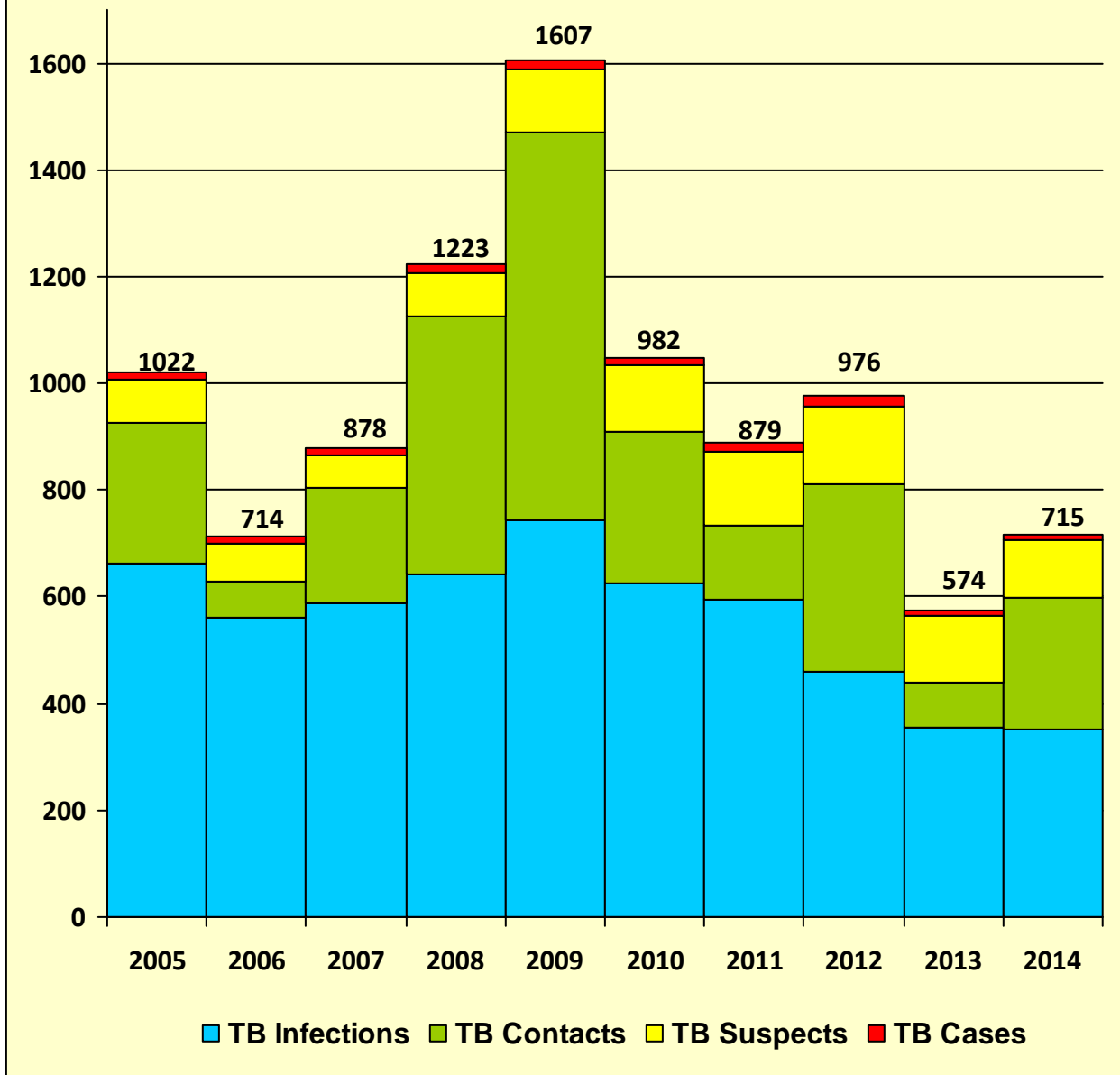


The workload in the TB Control Program consists of four categories of patients:

- 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])

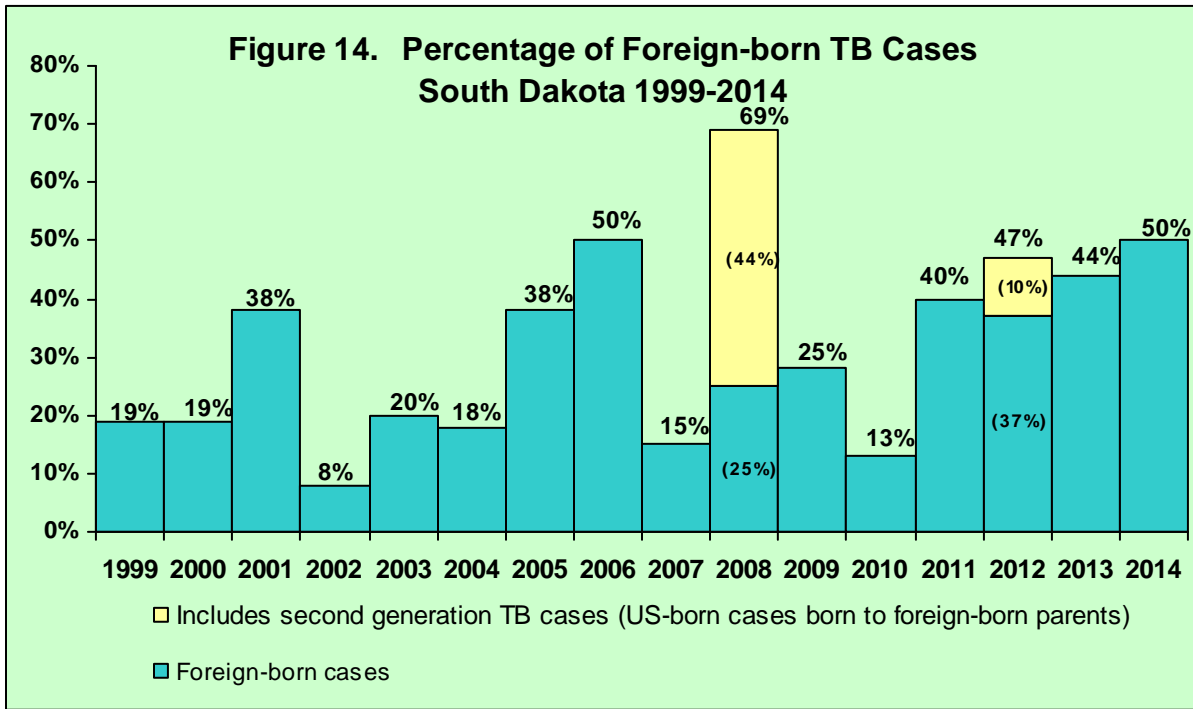
Disease Intervention Specialist (DIS) staff are responsible for ensuring appropriate investigation, treatment and follow-up of these individuals statewide. Figure 13 describes this cumulative caseload which is divided among 19 DIS staff illustrating that the active TB cases and suspect TB cases represent 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.

**Figure 13. Cumulative # of TB Investigations by DIS
South Dakota 2005-2014**

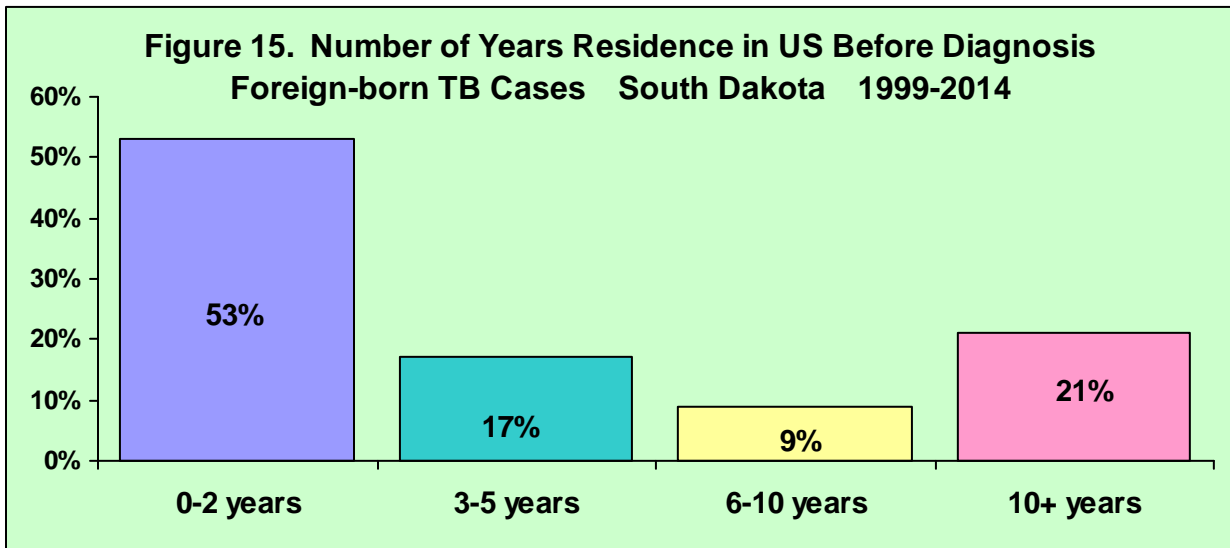


Analysis of Foreign-born TB Cases in South Dakota

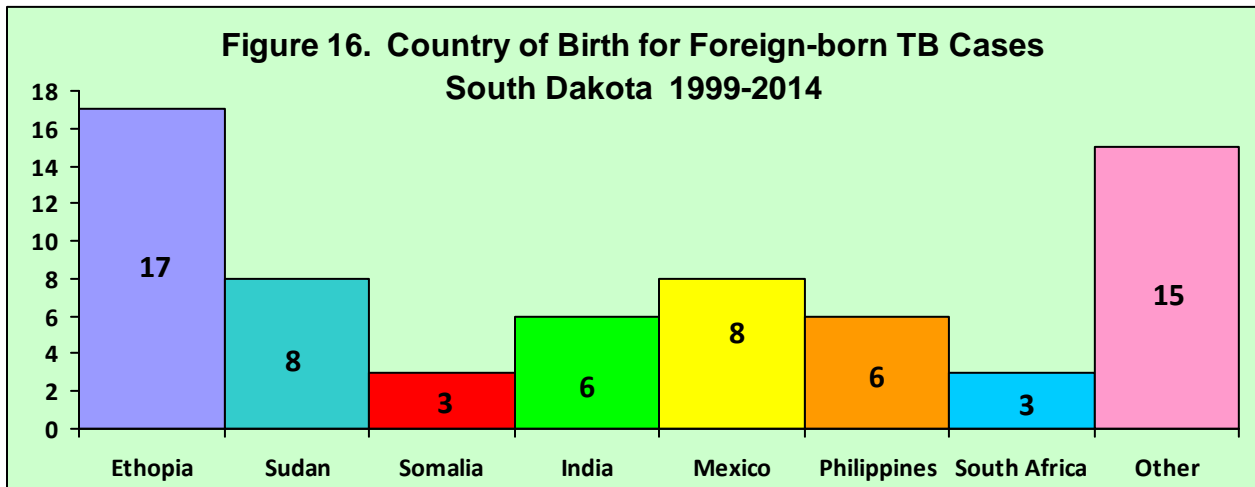
Tuberculosis cases who were born outside the United States continue to represent an important risk group in the United States as well as in South Dakota. Figure 14 describes the percentage of foreign-born TB cases in South Dakota. Second generation TB cases (US-born TB cases born to foreign-born parents) 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.



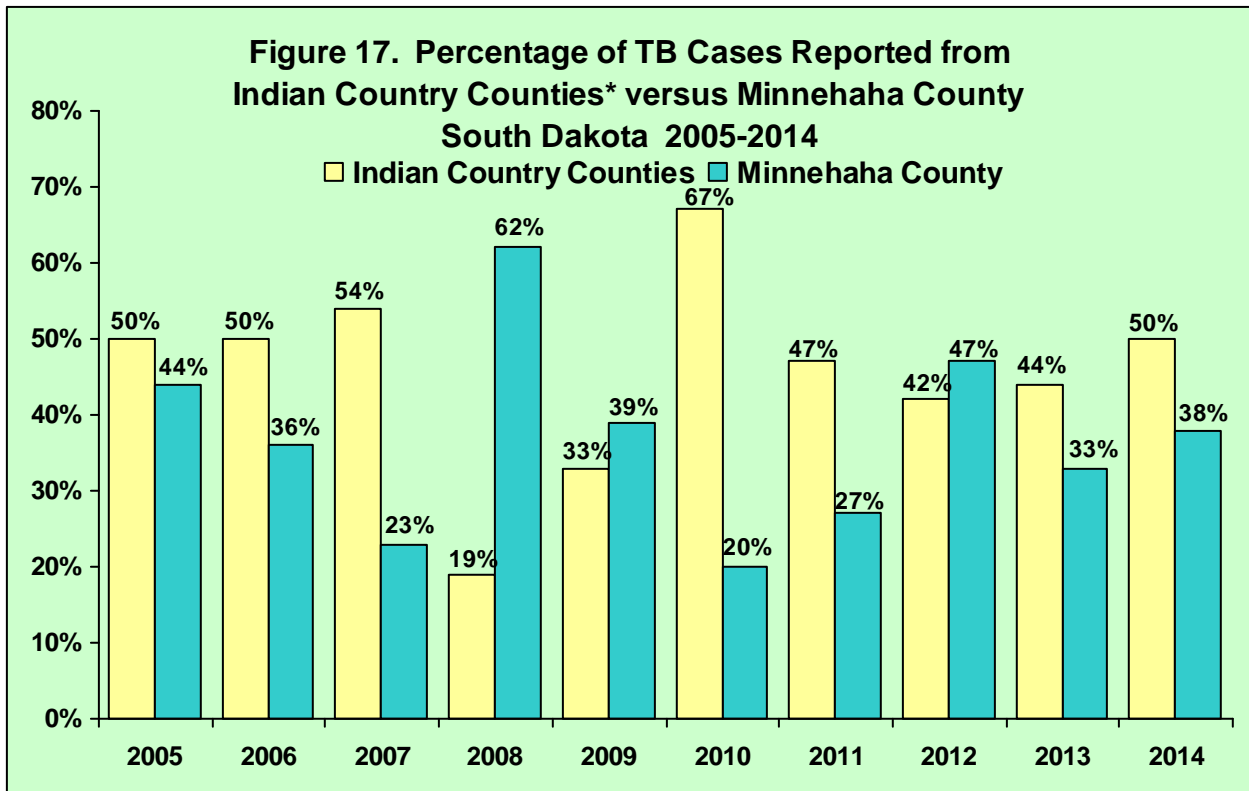
Most foreign-born persons who develop active TB usually do so within the first 2 years after arrival in the United States. Figure 15 describes that 70% of foreign-born TB cases since 1999 developed active TB within the first 5 years of their arrival. Because of this increased risk, these individuals 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 1999. Countries of birth for the “other” category include Afghanistan, China, El Salvador, Indonesia, Romania, Russia, Nepal, Mauritania, Vietnam, South Korea, Bhutan, Kenya and Palau.

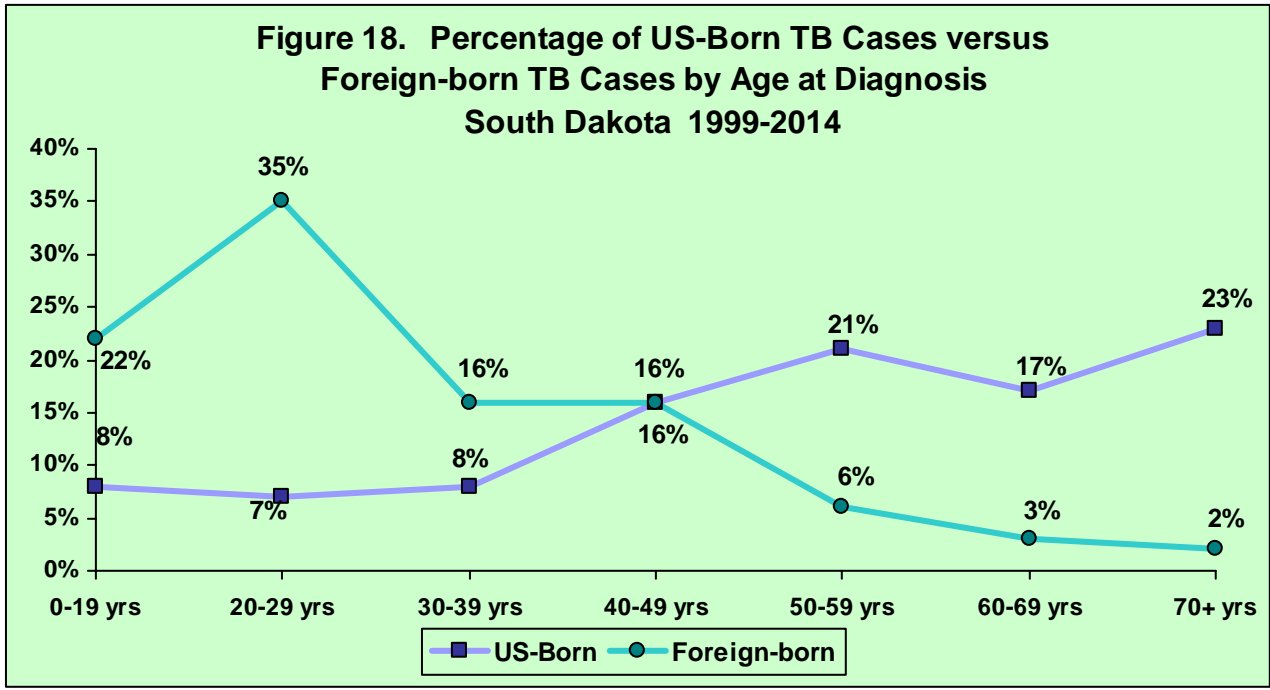


Another factor in the increase of foreign-born TB cases in South Dakota is the change geographically where TB cases are reported. Historically, the highest percentage of TB cases have been reported from counties that included and bordered American Indian Reservations. As Native American TB cases decreased and foreign-born TB cases increased, there has been a geographic shift of TB cases from Indian Country 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.

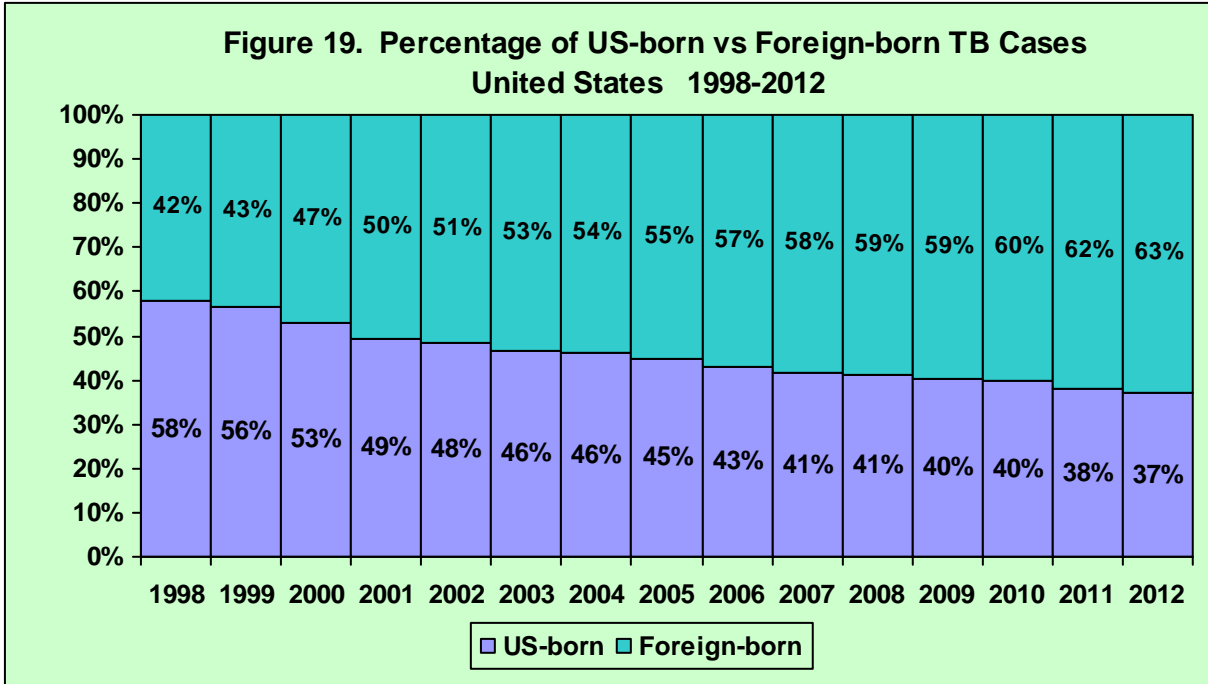


* Indian Country counties include Bennett, Brule, Buffalo, Charles Mix, Corson, Dewey, Jackson, Mellette, Moody, Pennington, Roberts, Shannon, Todd, Tripp, Walworth and Ziebach.

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.



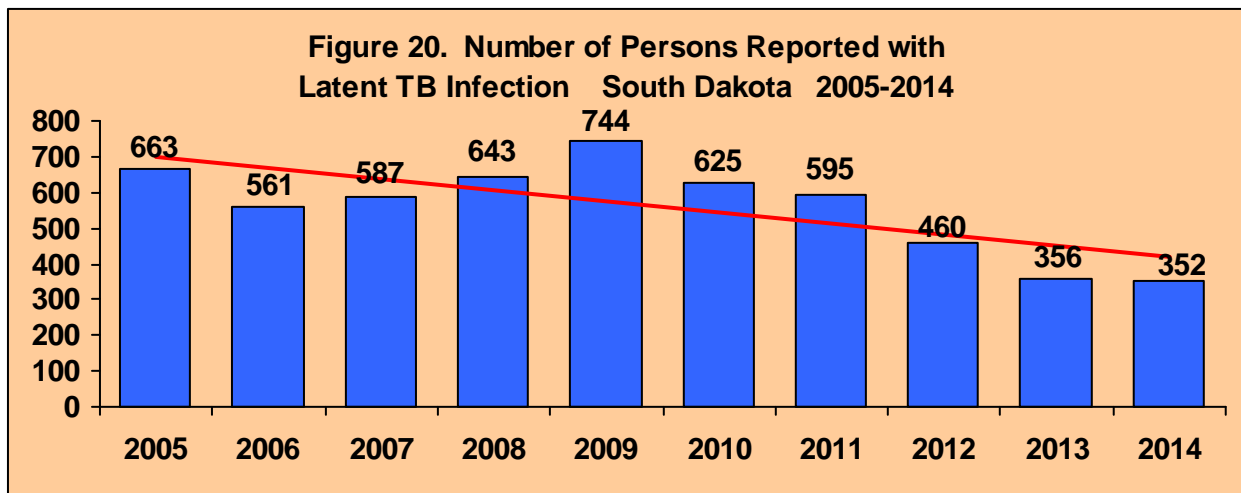
Foreign-born TB cases represent a unique challenge to the South Dakota TB Control Program because of cultural issues, language barriers and a greater likelihood of drug resistance. As these cases continue to increase in South Dakota, additional time and resources will need to be dedicated to address these unique issues. Figure 19 describes the ever increasing trend of the percentage of foreign-born TB in the United States since 1999.



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.



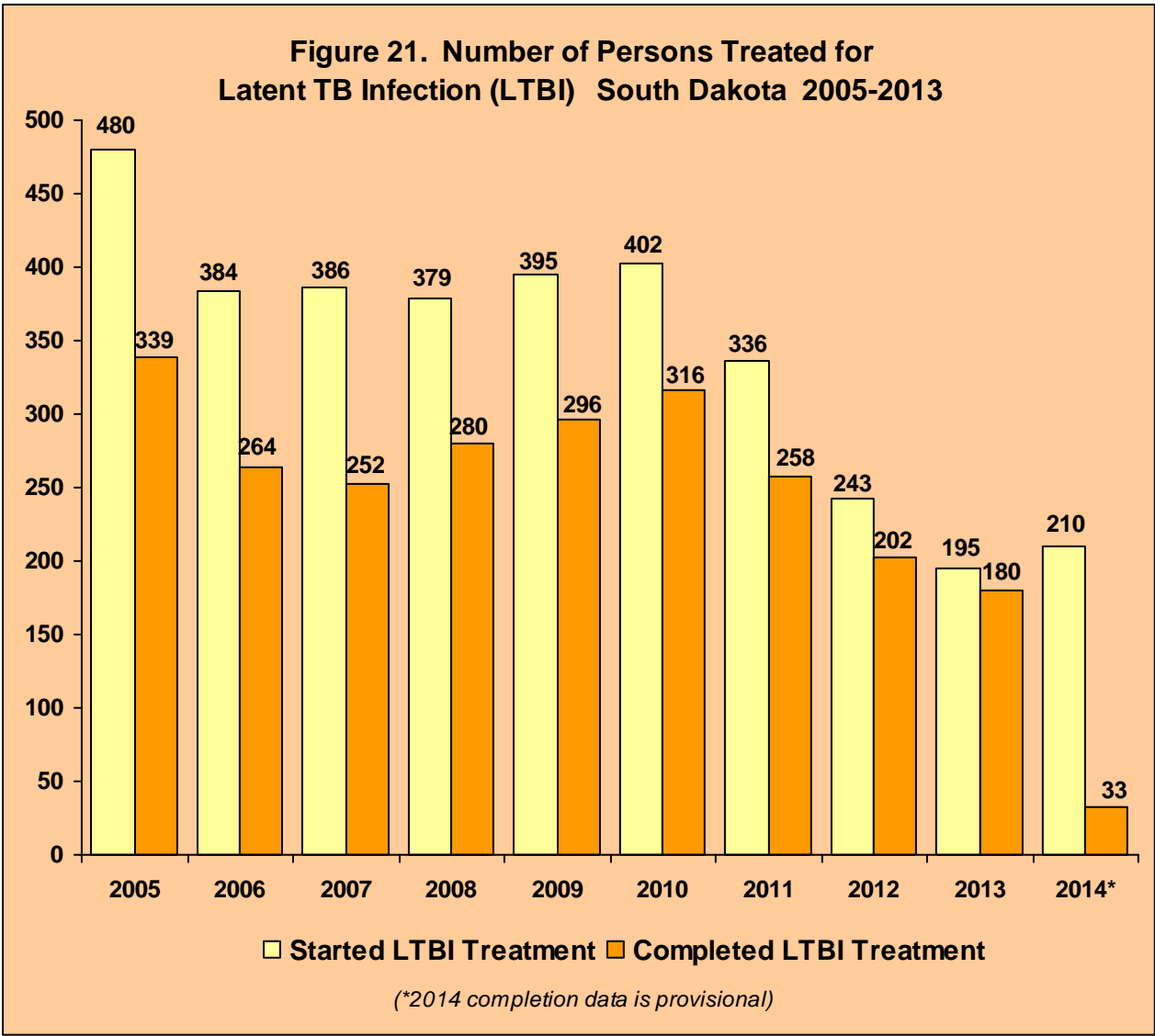
On August 2, 2011, the South Dakota Department of Health implemented an administrative rule change which changed the reporting requirement for latent TB infection. Prior to that, all persons diagnosed with latent TB infection were reportable to the South Dakota Department of Health. As of August 2, 2011,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

REPORTABLE TB RISK FACTORS

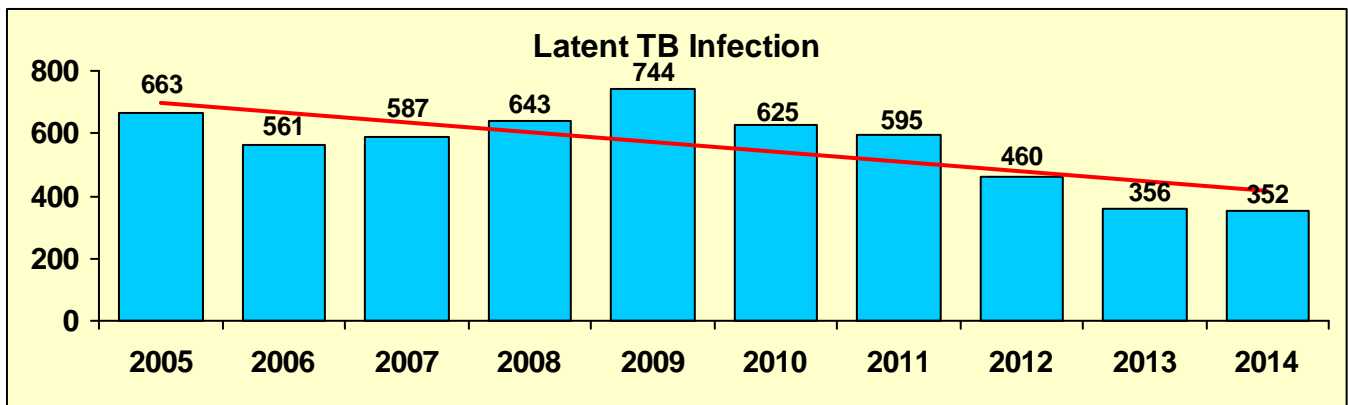
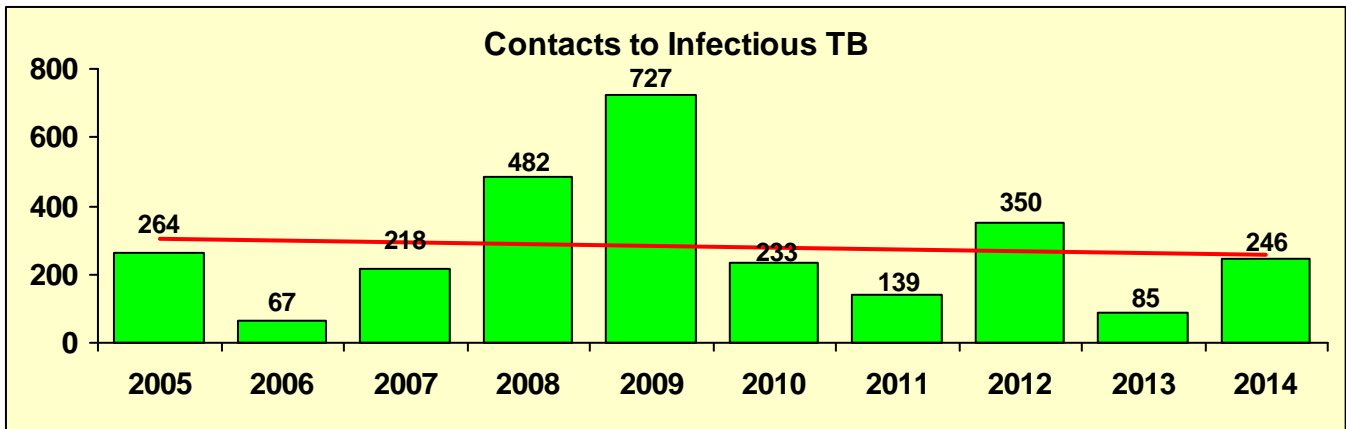
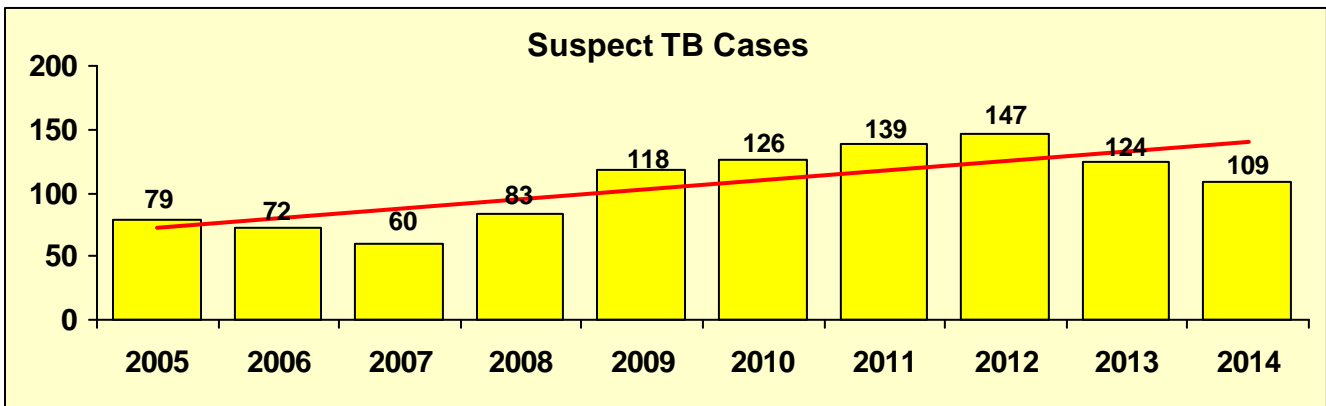
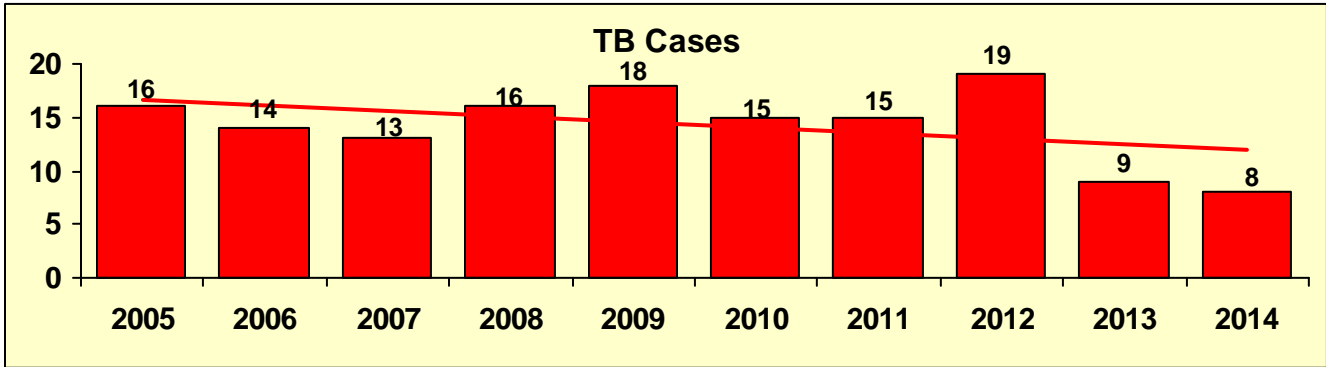
- Foreign-born persons who entered the US within the last 5 years
- Persons evaluated for tumor necrosis factor-alpha therapy
- Immunosuppressive therapies (i.e. high dose steroids)
- Radiographic evidence of prior TB
- Children less than 5 years of age
- Close contact to infectious TB
- HIV infection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

This reporting change allows 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 are eligible for Department of Health nurse case management and medication. Health care providers and facilities are asked to report only patients 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: <http://doh.sd.gov/diseases/infectious/tuberculosis>. 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.

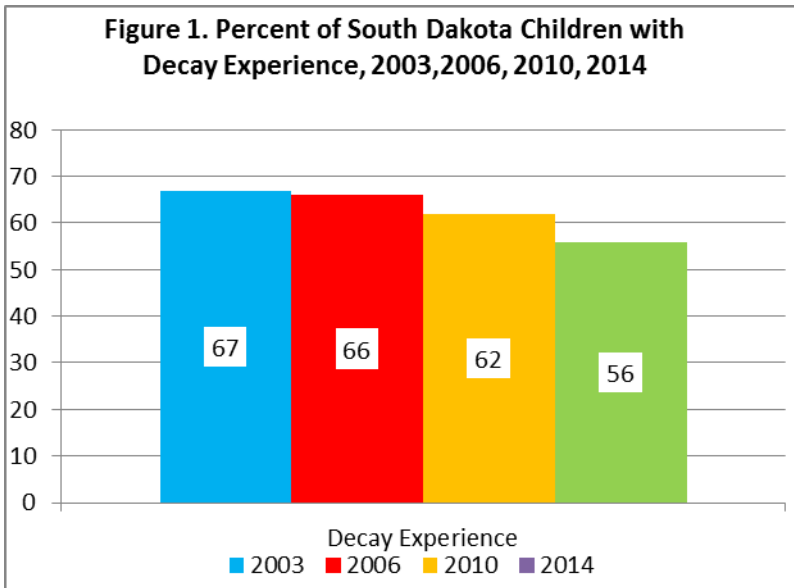


Summary of TB Control Program Caseload South Dakota 2005-2014

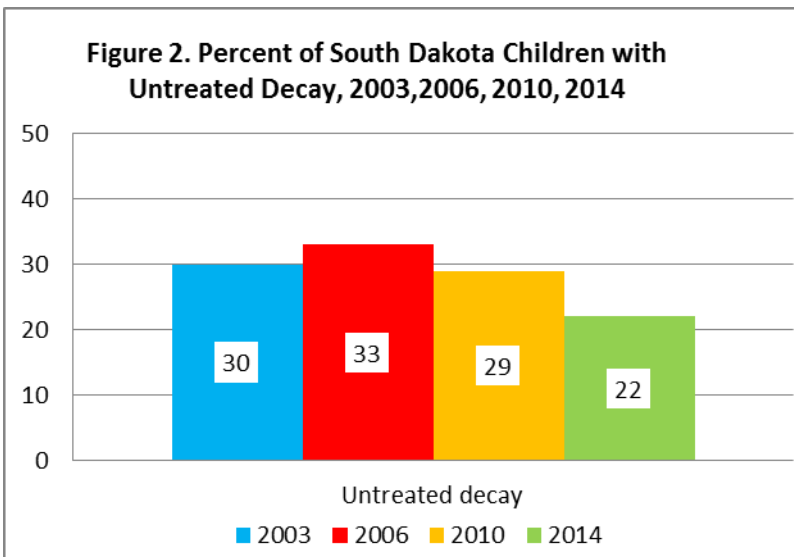


Oral Health in South Dakota 3rd Grade Children: 2014 Results and Recommendations

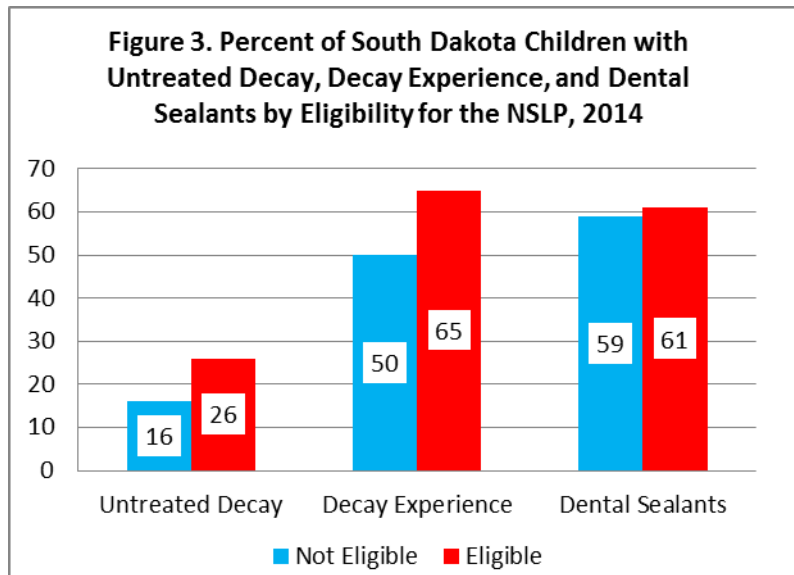
By Julie Ellingson, Oral Health Coordinator, South Dakota Department of Health and Ashley Miller, Chronic Disease Epidemiologist, South Dakota Department of Health



Good oral health is important for a child’s overall health, yet tooth decay still affects more than half of all South Dakota children by the time they reach 3rd grade. Tooth decay is preventable, but if left untreated, it can lead to difficulty in speaking, eating, concentrating and learning, loss of self-esteem, needless pain, lost school days, over use of emergency rooms and increased cost of care. To understand the oral health of youth in the state, the South Dakota Department of Health conducted its fourth Oral Health Survey of 3rd grade children. Previous surveys were conducted in 2003, 2006, and 2010. The survey included a parental questionnaire and a visual oral health screening of the 3rd grade students by a volunteer dental professional. This year 1,053 3rd grade children were screened at 36 participating elementary schools across the state with the majority of the students being 8-9 years of age.



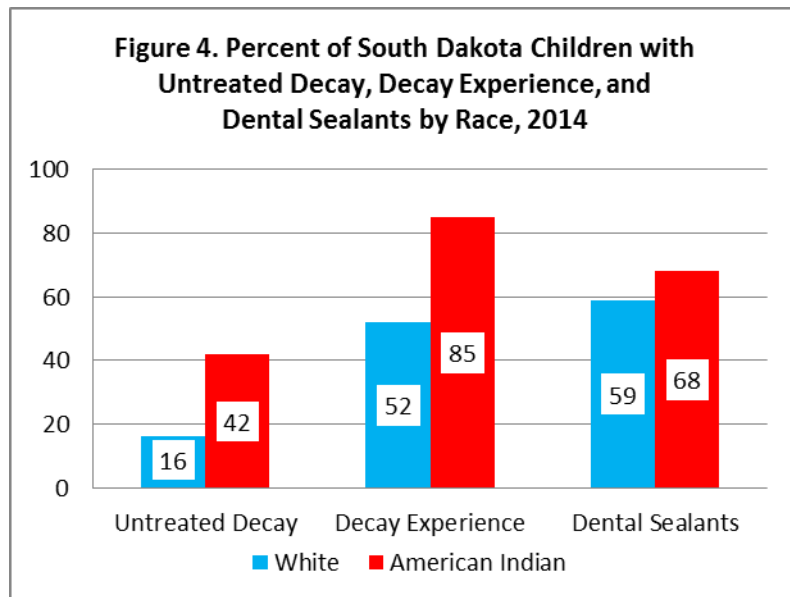
In 2014, over half of South Dakota’s 3rd graders had experienced dental decay; however, this was a decrease from the baseline survey in 2003 (Figure 1). In addition to the decrease in dental decay a decrease in untreated decay also occurred. Almost one in four 3rd grade children had untreated decay, which is a decrease from 29% the previous year (Figure 2). This means that in the 2013-2014 school year, an estimated 2,645 3rd grade children had untreated tooth decay. One way to prevent tooth decay among children is with evidence-based dental sealants. Dental sealants are a thin plastic coating applied to the chewing surface of the back teeth. Over half (56%) of 3rd grade children had dental sealants while 44% had not benefitted from that preventive treatment.



In addition to collecting information on untreated decay experience, this survey also looked at potential disparities within oral health. Eligibility for the National School Lunch Program (NSLP) was used as an indicator for socioeconomic status. When examined for differences between those eligible and not eligible for the national school lunch program, it was found that children on the NSLP had significantly higher

prevalence of untreated decay and decay experience. There was no difference in the prevalence of dental sealants between groups (Figure 3).

Significant disparities were also found among American Indian children. American Indian children have a significantly higher prevalence of decay experience and untreated decay compared to non-Hispanic white children; however, there is no significant difference in the prevalence of dental sealants (Figure 4). The lack of significance between groups in relation to dental sealants could suggest that AI/AN children and children in the NSLP are benefitting from school or community based dental sealant programs; however, they are not getting the benefit of early preventive services and are not able to access a dentist or dental clinic for restorative treatment.



Next steps or recommendations to address dental disease in children include the following:

- Increase awareness of the importance of oral health and general health.
- Improve partnerships between dental professionals and other health professionals to promote the oral health of children.
- Promote preventive activities such as water fluoridation, oral health education, fluoride varnish, healthy nutrition, dental sealants and school-based dental health clinics.

A more detailed report of the survey can be found at: <http://doh.sd.gov/prevention/assets/OralHealthSurvey2014.pdf>.

South Dakota Web-Based Data Query System

By Ashley Miller, Chronic Disease Epidemiologist, South Dakota Department of Health

It's official! The South Dakota Department of Health now has a web-based query system that was created and is maintained by the department's Office of Health Statistics. What's available there? Data! The query system includes statewide and county level health related data and was developed in order to make data easily accessible. Currently death and birth statistics are available from 2000-2012 as well as cancer incidence and mortality from 2001-2011. The site will be updated annually to reflect the most current year. Various demographics such as age, race, ethnicity and gender are included in the query system. The system can be found at: <http://doh.sd.gov/statistics/DataQuerySystem.aspx>

Birth Records

More specifically for birth data the following information can be found: number of births, crude rates, and fertility rate. A crude birth rate is the number of births per 1,000 people per year while a fertility rate is the number of live births per 1000 women between the ages 15-44. Births can be examined by occurrence of birth or county of residence of the mother. Other available birth statistics include: prenatal care, payment type, and tobacco use during pregnancy, method of delivery, marital status, education, birth weight, and gestation. Below is an example of a birth report that can be obtained through the query system.

BIRTHS REPORT	
Birth Year: Last 3 years	
Birth County: All counties	
Mother's Resident County: Brookings	
Age: All years	
Mother's Race: All races	
Ethnicity: All ethnicities	
Month Prenatal Care Started: All values	
Payment Type: All payment types	
Tobacco Use during Pregnancy: All values	
Method of Delivery: All methods	
Marital Status: All marital statuses	
Maternal Education: All education levels	
Gender: All	
Birth Weight in Grams: All weights	
Gestational Age: All ages	

Birth Year	Births
2010	379
2011	385
2012	404

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BIRTHS REPORT	
Birth Year: Last 3 years	
Birth County: All counties	
Mother's Resident County: Brookings	
Age: All years	
Mother's Race: All races	
Ethnicity: All ethnicities	
Month Prenatal Care Started: All values	
Payment Type: All payment types	
Tobacco Use during Pregnancy: All values	
Method of Delivery: All methods	
Marital Status: All marital statuses	
Maternal Education: All education levels	
Gender: All	
Birth Weight in Grams: All weights	
Gestational Age: All ages	

Birth Year	Crude Birth Rate
2010	11.9
2011	11.9
2012	12.4

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Death Records

Death data can be displayed by counts, crude death rate, and age-adjusted death rates. Crude death rates are the number of deaths out of the total population whereas age-adjusted death rates take into account the underlying make-up of the population. age-adjusted rates can be used for comparison between counties or with the state rate, but crude rates cannot. Deaths can be looked at by cause of death main group as well as by subgroups when available. In the example below under cause of death, accidents was selected and the subgroup 1 option. The report produces a table of nontransport accidents and transport accidents.

Cause of Death All

- Accidents (V01-X59, Y85-Y86)
- Acute bronchitis and bronchiolitis (J20-J21)
- Acute poliomyelitis (A80)
- Acute upper respiratory infections (J00-J06)
- Alzheimer's disease (G30)

Report Layout: Choose up to three from Rows and zero or one from Columns

Include Totals

Rows

- Gender
- ICD-10 Code
- Cause of Death (main group)
- Cause of Death (subgroup 1)
- Cause of Death (subgroup 2)
- (None)

Columns

(None)

Produce Report Reset Selections

DEATHS REPORT

Death Year: All years
Death County: All counties
Resident County: All counties
Age: All ages
Gender: All
Race: All races
Ethnicity: All ethnicities
Cause of Death: Accidents (V01-X59, Y85-Y86)

Cause of Death (Subgroups)	Deaths
Nontransport accidents (W00-X59, Y86)	2,709
Transport accidents (V01-V99, Y85)	2,263

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Cancer Records

Cancer incidence and mortality data is from the South Dakota Cancer Registry. In addition to demographics, data can also be examined by primary cancer site, sub-site group, and cancer stage at diagnosis. For more information specific to cancer registry data please visit the South Dakota Cancer Registry website at: <http://getscreened.sd.gov/registry/data/>.

CANCER INCIDENCE REPORT

Diagnosis Year(s): 2002 through 2011
County at Diagnosis: Lincoln, McCook, Minnehaha, Pennington, Yankton
Age: All ages
Gender: All
Race: All races
Primary Cancer Site: All sites
Subsite Group: All sites
Cancer Stage at Diagnosis: All stages

Resident County	Age-Adjusted Incidence Rate
Lincoln	488.1
McCook	487.5
Minnehaha	482.5
Pennington	477.3
Yankton	415.9

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The example at left examines age-adjusted cancer incidence rates by county for selected counties from 2002-2011 as can be seen in the report.

Any of these reports that are created can be easily exported to pdf or excel format. Plans to eventually include other data sets such as the Behavioral Risk Factor Surveillance System (BRFSS) are in development. There is a wealth of information available in this system that can be used for various projects including community needs assessments. For further information or if questions arise please contact Mark Gildemaster at mark.gildemaster@state.sd.us.

South Dakota Department of Health – Infectious Disease Surveillance

Selected Morbidity Report, 1 January – 31 December 2014

(provisional numbers) see <http://doh.sd.gov/statistics/disease-surveillance/>

	Disease	2014 year-to-date	5-year median	Percent change
Vaccine-Preventable Diseases	Diphtheria	0	0	n/a
	Tetanus	0	0	n/a
	Pertussis	107	58	+84%
	Poliomyelitis	0	0	n/a
	Measles	9	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	31	29	+7%
	Hepatitis B, acute	1	2	-100%
	Chlamydia	4110	3279	+25%
	Gonorrhea	847	599	+41%
	Syphilis, early	79	4	+>1000%
Tuberculosis	Tuberculosis	8	15	-47%
Invasive Bacterial Diseases	Meningococcal, invasive	2	3	-33%
	Invasive Group A <i>Streptococcus</i>	0	0	n/a
Enteric Diseases	<i>E. coli</i> , Shiga toxin-producing	41	42	-2%
	Campylobacteriosis	303	296	+2%
	Salmonellosis	164	183	-10%
	Shigellosis	615	7	+>1000%
	Giardiasis	130	111	+17%
	Cryptosporidiosis	151	138	+9%
	Hepatitis A	3	2	+50%
Vector-borne Diseases	Animal Rabies	21	40	-48%
	Tularemia	5	7	-29%
	Rocky Mountain Spotted Fever	3	1	+100%
	Malaria (imported)	5	5	0%
	Hantavirus Pulmonary Syndrome	0	0	0%
	Lyme disease	2	4	-200%
	West Nile Virus disease	57	21	+171%
Other Diseases	Legionellosis	9	8	+13%
	<i>Streptococcus pneumoniae</i> , invasive	88	89	-1%
	Additionally, the following were reported: Babesiosis (1); Chicken Pox (23); CRE (3); Chikungunya (2); EV-D68 (17); Hep B, chronic (42); Hep C (514); HUS (1); MRSA, invasive (126); Q Fever (5)			

Communicable diseases are obligatorily reportable by physicians, hospitals, laboratories, and institutions. The **Reportable Diseases List** is found at <http://doh.sd.gov/diseases/infectious/reporting-communicable-diseases.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".