



Mississippi Morbidity Report

Zika Virus: Updated Recommendations for Preconception Counseling and Prevention of Sexual Transmission

Key Messages:

- **NEW RECOMMENDATION:** CDC now recommends that all men with possible Zika virus exposure who are considering attempting conception with their partner, regardless of symptom status, wait to conceive until at least 6 months after symptom onset (if symptomatic) or last possible Zika virus exposure (if asymptomatic).
- Women with possible Zika virus exposure are recommended to wait to conceive until at least 8 weeks after symptom onset (if symptomatic) or last possible Zika virus exposure (if asymptomatic).
- Couples with possible Zika virus exposure, who are not pregnant and do not plan to become pregnant, who want to minimize their risk for sexual transmission of Zika virus should use a condom or abstain from sex for the same periods for men and women described above.
- Women of reproductive age who have had or anticipate future Zika virus exposure who do not want to become pregnant should use the most effective contraceptive method that can be used correctly and consistently.
- Pregnant women with a partner who has traveled to an area with active Zika virus transmission should use condoms during sex or abstain from sex for the duration of the pregnancy.

Background:

The Centers for Disease Control and Prevention (CDC) has recently provided updated guidance for preconception counseling and prevention of sexual transmission of Zika virus. Zika virus infection during pregnancy can be transmitted to the fetus and has been linked to microcephaly and other significant birth defects. As of October 13, 899 pregnant women with Zika virus infection have been reported to the US Pregnancy Registry (from US States and the District of Columbia). There have been 23 live infants with birth defects born to infected mothers and 5 pregnancy losses with birth defects reported through the Zika Pregnancy registry (see <http://www.cdc.gov/zika/hc-providers/registry.html> for information regarding the US Zika Pregnancy Registry). No infections among pregnant women have been reported in Mississippi (see the Mississippi Zika Epidemiology section below for full case counts).

In the US States as of October 19, there are more than 3,800 travel-associated cases and 137 locally acquired mosquito-borne cases (Florida) reported in the US. Although Zika virus is primarily transmitted through the bite of an infected *Aedes aegypti* mosquito, it can also be transmitted from an infected person to their sexual partner. Sexual transmission has been documented to sexual partners of both infected females and males

(symptomatic or asymptomatic), but the majority of sexual transmission has been reported from infected males to their partners. Zika virus RNA has been detected in semen up to 188 days after symptom onset. These findings have led to the updated guidelines for the prevention of sexual transmission and infection during pregnancy. As of October 12, there have been 32 cases of sexual transmission of Zika reported in the US.

The CDC continues to collect data and research, and updates their guidelines as new data becomes available. The updated recommendations for preconception counseling and sexual prevention are provided in the key messages section.

CDC Report: The following is excerpted and adapted from the CDC Morbidity and Mortality Report “Update: Interim Guidance for Preconception Counseling and Prevention of Sexual Transmission of Zika Virus for Persons with Possible Exposure – United States, September 2016”. For the full guidance please see <http://www.cdc.gov/mmwr/volumes/65/wr/mm6539e1.htm>.

Most of the following recommendations are directed to people that live in or travel to areas with active Zika transmission. CDC maintains an updated list of areas with active Zika virus transmission online at <http://www.cdc.gov/zika/geo/index.html>

Update: Interim Guidance for Preconception Counseling and Prevention of Sexual Transmission of Zika Virus for Persons with Possible Zika Virus Exposure — United States, September 2016

For Couples Planning to Conceive Who Do Not Live in Areas with Active Zika Virus Transmission

Men and women wanting to become pregnant should avoid all unnecessary travel to Zika-affected areas.

Women with possible exposure through personal travel to a Zika-affected area or through sexual contact with a traveler to a Zika-affected area should wait at least 8 weeks from symptom onset (if symptomatic) or last possible exposure (if asymptomatic), before trying to conceive. Women with ongoing exposure to Zika through travel or sex should receive preconception counseling from their health care provider.

Men with possible virus exposure (either through personal travel to a Zika-affected area or sexual contact with a traveler), should wait at least 6 months from symptom onset (if symptomatic) or from last exposure (if asymptomatic). This represents a change in recommendation, and it is based on reports of the range of time after exposure that Zika virus RNA was detected in semen.

For Couples Who Are Not Pregnant and Are Not Planning to Become Pregnant in the Near Future

Couples with potential exposure to Zika virus who are not planning to become pregnant should either abstain from sex or use condoms correctly for at least 6 months (if the male was exposed) or 8 weeks (if the female was exposed).

Health care providers should also advise couples on methods to prevent unintended pregnancy. Patients should be counseled to use the most effective contraceptive method that can be used correctly and consistently. Long-acting reversible contraception, including implants and intrauterine devices are options to consider.

For Pregnant Women and Their Partners

Pregnant women should avoid all nonessential travel to Zika-affected areas (including areas of Florida with active transmission). Persons who live in or travel to Zika-affected areas and whose partner is pregnant should abstain from sex or use condoms correctly for the duration of the pregnancy.

Health care providers should routinely ask pregnant women about their own travel and their partner’s travel to Zika-affected areas. Pregnant women with possible Zika exposure either through personal travel or sex with a partner who traveled to a Zika-affected area should be tested for Zika virus infection, regardless of symptom status.

Mississippi Zika Virus Testing Recommendations:

The Mississippi State Department of Health (MSDH) provides Zika testing through the Mississippi Public Health Laboratory. All requests for Zika testing at the MPHL must come directly from the patient's clinician to the MSDH Office of Epidemiology for approval (601- 576-7725 or 601-576-7400 after hours).

Zika Virus Exposure:

For testing purposes Zika virus exposure is defined as personal travel to a Zika-affected area or sexual contact with someone who traveled to a Zika-affected area (see <http://www.cdc.gov/zika/geo/index.html> for areas with Zika).

Persons who should be tested:

- Men and non-pregnant women who develop one or more symptoms of Zika virus infection (rash, fever, arthralgias, or conjunctivitis) within 14 days of **Zika virus exposure**.
- Pregnant women with **Zika virus exposure**, regardless of the symptom status of themselves or their partner.

Persons who should be screened:

- Each pregnant woman should be questioned about possible Zika virus exposure at each prenatal visit.

See the Mississippi Health Alert Network Advisory issued August 4, 2016 for the Zika Testing Algorithm for Healthcare Providers and full testing recommendation available on the MSDH website at http://msdh.ms.gov/msdhsite/_static/resources/6804.pdf

Mississippi Zika Epidemiology:

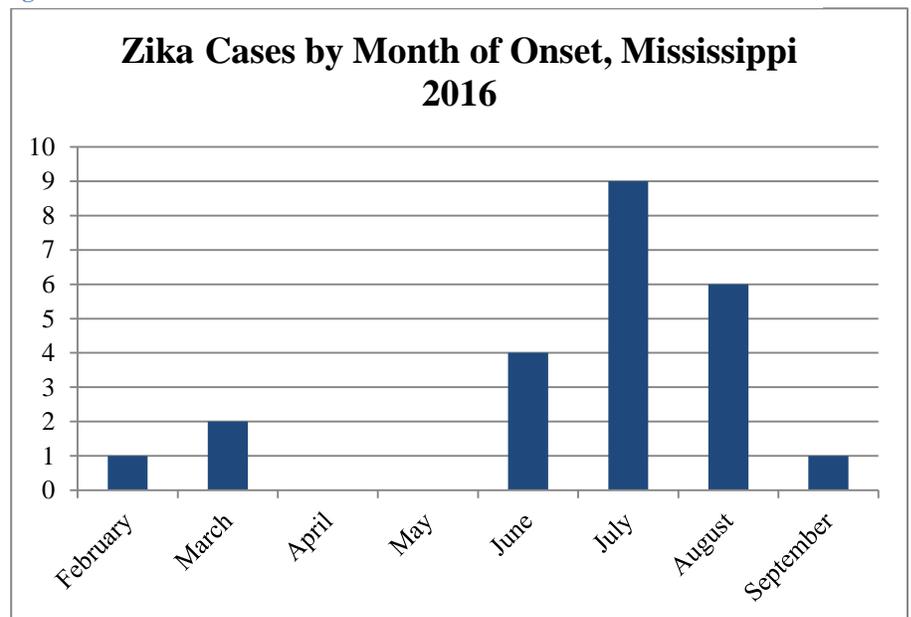
As of October 24, 2016, there have been 23 cases of acute Zika infection reported in Mississippi. All Mississippi cases are travel related, either through direct exposure from travel to a Zika-affected area (22 cases) or through sexual exposure to a symptomatic traveler (1 case). To date, there is no local transmission of Zika identified in Mississippi and there have been no reported infections among pregnant women.

The reported Mississippi cases each traveled (or had contact with a traveler) to parts of Central America

and the Caribbean primarily, including: Grenada, Nicaragua, Guatemala, Haiti, Jamaica, Puerto Rico, Honduras, Mexico, Saint Lucia, and Saint Thomas. The majority of the cases traveled during the summer months (see Figure).

Of the 23 reported cases, 14 are male (61%). The median age is 37 with an age range of 15-61 years. The most commonly reported symptom is rash, (23/23 reported). Fever is the second most commonly symptom reported (18/23), followed by arthralgias (15/23) and conjunctivitis (9/23).

Figure



2016-2017 Influenza Season Update:

The 2016-2017 influenza season has begun and this year there are some pertinent updates and information regarding influenza vaccine recommendations, healthcare worker vaccination rates and changes in adult influenza vaccine availability at the Mississippi State Department of Health clinics that are worth highlighting.

2016-2017 Influenza Vaccine Updates:

- Anyone 6 months of age and older should get a 2016-2017 flu vaccine
- Vaccination of people at high risk for developing complications related to influenza is especially important. People at higher risk include young children, pregnant women, people with chronic underlying health problems (e.g. asthma, heart disease) and people with extreme obesity (see http://www.cdc.gov/flu/about/disease/high_risk.htm for a full list of conditions)
- **Only injectable influenza vaccines are recommended this season. The LAIV (live attenuated nasal spray influenza vaccine) is not recommended for use this season because of concerns about its effectiveness.**
- Children 6 months through 8 years of age who have previously received 2 or more doses of any flu vaccine before July 1, 2016, only need one dose of 2016-2017 seasonal influenza vaccine.
- Persons with history of egg allergy can receive influenza vaccine with no additional precautions other than those recommended for other routine vaccines. For more severe allergies, please see full guidelines at the link below.

The complete list of CDC influenza updates for 2016-2017 may be found in the report, “Prevention and Control of Seasonal Influenza with Vaccines.” <http://www.cdc.gov/mmwr/volumes/65/rr/rr6505a1.htm>

Influenza Vaccines in Health Care Workers:

The CDC conducted a survey to estimate influenza vaccination coverage among US health care personnel for the 2015-2016 influenza season. Nationally, 79.0% of healthcare personnel across multiple disciplines and settings reported receiving an influenza vaccine during the 2015-2016 season. In Mississippi, based on data reported to MSDH through the National Healthcare Safety Network (NHSN) participating facilities, 85.82% of healthcare employees were vaccinated in the 2015-2016 season.

The survey showed that the healthcare setting and employer promotion made a noticeable difference in vaccination rates. Hospital workers (91.2%) were vaccinated at higher rates than those working in ambulatory settings (79.8%) and in long-term care settings (69.2%). When health care workers were required by their employer to be vaccinated, there was a vaccination rate of 96.5%. However, in settings where the vaccine was not required, offered or promoted, the rate was 44.9%. The CDC report “Influenza Vaccination Coverage Among Health Care Personnel — United States, 2015–16 Influenza Season” is available at <http://www.cdc.gov/mmwr/volumes/65/wr/mm6538a2.htm>

Influenza vaccination rates among health care personnel in long-term care settings, while improving over the last several years, are consistently lower when compared to health care personnel among other settings. Vaccinating personnel in these settings can reduce the risk of influenza infection in the facility residents and reduce the risk of outbreaks, leading to a reduction in influenza associated complications that can occur in this high risk resident population. Strategies to improve influenza vaccination in long-term care settings are

available in the CDC Influenza Toolkit for Long-Term Care Employers available at <http://www.cdc.gov/flu/toolkit/long-term-care/index.htm>.

Adult Influenza Vaccines at MSDH

For the 2016-2017 season, adult influenza vaccine will no longer be offered at county health department clinics except for those who are uninsured or underinsured and are at high risk for complications. The change has the result of the following:

- Influenza vaccine for insured adults is readily available through private physicians' offices and pharmacies;
- Private physicians' offices and pharmacies receive influenza vaccine much earlier than MSDH due to vaccine ordering requirements;
- The amount of adult influenza vaccine provided by MSDH has decreased over the last several years with increased availability of vaccine in other settings and improved insurance coverage.



Mississippi

Provisional Reportable Disease Statistics

Sept 2016

		Public Health District									State Totals*			
		I	II	III	IV	V	VI	VII	VIII	IX	Sept 2016	Sept 2015	YTD 2016	YTD 2015
Sexually Transmitted Diseases	Primary & Secondary Syphilis	3	0	3	2	3	2	0	4	2	19	24	233	160
	Early Latent Syphilis	1	3	5	1	17	4	0	6	2	39	33	371	305
	Gonorrhea	61	55	69	36	144	35	27	61	80	568	761	4,981	3,888
	Chlamydia	116	133	132	93	314	88	59	157	174	1266	2,340	14,145	11,590
	HIV Disease	0	0	4	4	9	0	2	4	3	26	39	313	433
Mycobacterial Diseases	Pulmonary Tuberculosis (TB)	0	1	0	0	1	0	0	2	1	5	4	32	41
	Extrapulmonary TB	0	0	0	0	0	0	0	0	0	0	0	7	5
	Mycobacteria Other Than TB	3	9	0	2	6	2	3	2	7	34	28	288	348
Vaccine Preventable Diseases	Diphtheria	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pertussis	0	0	0	0	0	0	0	0	0	0	0	2	10
	Tetanus	0	0	0	0	0	0	0	0	0	0	0	1	0
	Poliomyelitis	0	0	0	0	0	0	0	0	0	0	0	0	0
	Measles	0	0	0	0	0	0	0	0	0	0	0	0	0
	Mumps	0	0	0	0	0	0	0	0	0	0	0	1	0
	Hepatitis B (acute)	0	0	0	0	1	0	0	0	1	2	7	19	40
	Invasive <i>H. influenzae</i> disease	0	0	0	1	1	0	2	0	1	5	1	44	31
	Invasive Meningococcal disease	0	0	0	0	0	0	0	0	0	0	0	0	0
Enteric Diseases	Hepatitis A (acute)	0	0	0	0	0	0	0	0	0	0	1	1	1
	Salmonellosis	10	17	2	9	36	8	3	1	16	102	152	734	826
	Shigellosis	2	0	0	0	2	0	0	0	1	5	4	46	77
	Campylobacteriosis	1	1	1	2	5	0	0	0	5	15	20	153	143
	<i>E. coli</i> O157:H7/STEC/HUS	0	0	0	0	1	0	1	0	0	2	2	16	15
Zoonotic Diseases	Animal Rabies	0	0	1	0	0	0	0	0	0	1	1	2	3
	Lyme disease	0	0	0	0	0	0	0	0	0	0	0	0	2
	Rocky Mountain spotted fever	0	0	0	0	0	1	0	1	0	2	21	64	86
	West Nile virus	0	0	0	0	2	0	0	4	1	7	11	27	36

*Totals include reports from Department of Corrections and those not reported from a specific District.