Indiana Department of Health

CLINICIAN UPDATES

GUY CROWDER, MD, MPHTM
CHIEF MEDICAL OFFICER

ERIC HAWKINS, MS
STATE EPIDEMIOLOGIST

4/25/2025

OUR MISSION:

To promote, protect, and improve the health and safety of all Hoosiers.

OUR VISION:

Every Hoosier reaches optimal health regardless of where they live, learn, work, or play.

Indiana Department of Health

Conflict of Interest Statement

No members of the planning committee and no presenters have a financial interest/arrangement or affiliation that could be perceived as a real or apparent conflict of interest related to the content or supporters of this activity.

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Accreditation Statement

The Indiana Department of Health is accredited by the Indiana State Medical Association to provide continuing medical education for physicians.

Designation Statement

The Indiana Department of Health designates this live activity for a maximum of *1 AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CMEs

CME credits are available for physicians participating in this webinar.

Once you complete the REDCap survey (link will be added to the chat during the Clinician Update), the IDOH enters your name into the Accreditation Council for Continuing Medical Education (ACCME) Program and Activity Reporting System (PARS). PARS is your entry point into the digitized world of CME.

To access the CME credit from this webinar, please go to PARS - ACCME (This will allow you to monitor CMEs awarded and entered into ACCME's PARS) and/or Homepage (cmepassport.org) (This will allow you to monitor CME credits and find other available opportunities to gain CMEs.)

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MEASLES GLOBAL AND NATIONAL TRENDS

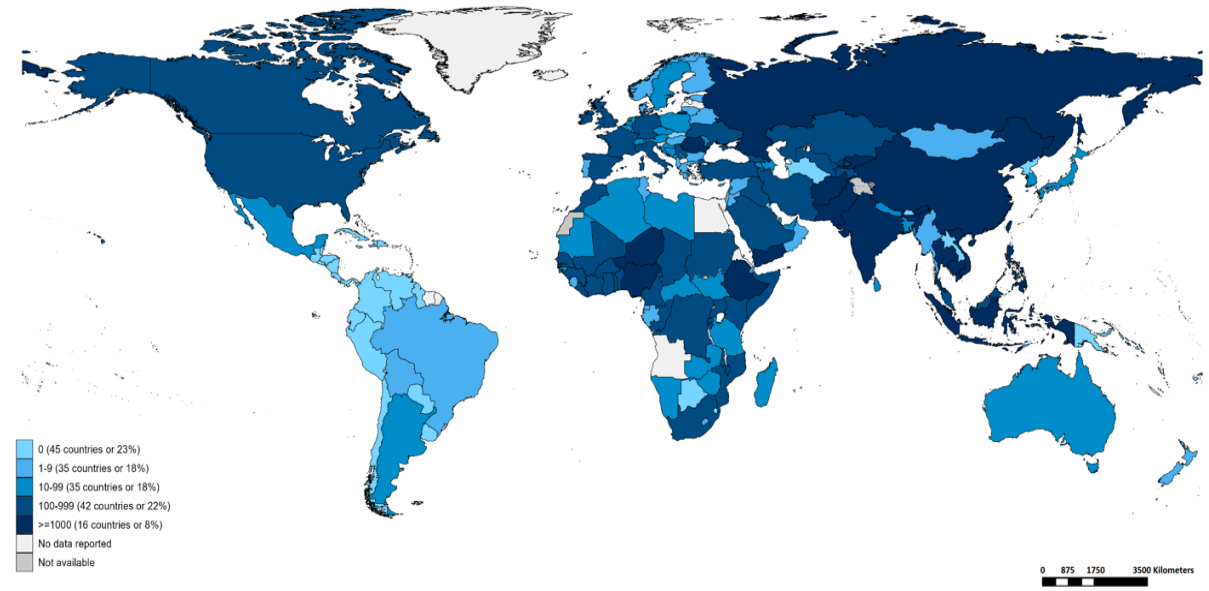
4/25/2025

IHAN and FAQ for Providers

- See the following link for the recent Indiana Health Alert Network (IHAN) about measles
  - https://www.in.gov/health/files/Measles-IHAN-April-2025.pdf
- See the following link for frequently asked questions:
  - https://www.in.gov/health/idepd/files/Measles-FAQs-for-Healthcare-Providers_March2025.pdf
- To sign up for IHAN messages
  - https://ihan-in.org/agreement.php

Global Trends per WHO as of 4/2025

Number of Reported Measles Cases (Last 6 months)



World Health Organization

Map production: World Health Organization, 2025. All rights reserved
Data source: IVB Database

Disclaimer: The boundaries and names shown and the designations used on this map do notimply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Country	Cases*
Yemen	10,794
India**	7,201
Pakistan	6,217
Ethiopia	5,309
Afghanistan	5,236
Thailand	5,142
Kyrgyzstan	4,502
Romania	4,077
Indonesia	2,751
Nigeria	1,892

Notes: Based on data received 2025-04 - Surveillance data from 2024-09 to 2025-02 - * Countries with highest number of cases for the period - **WHO classifies all suspected measles cases reported from India as measles clinically compatible if a specimen was not collected as per the algorithm for classification of suspected measles in the WHO VPD Surveillance Standards. Thus numbers might be different between what WHO reports and what India reports.

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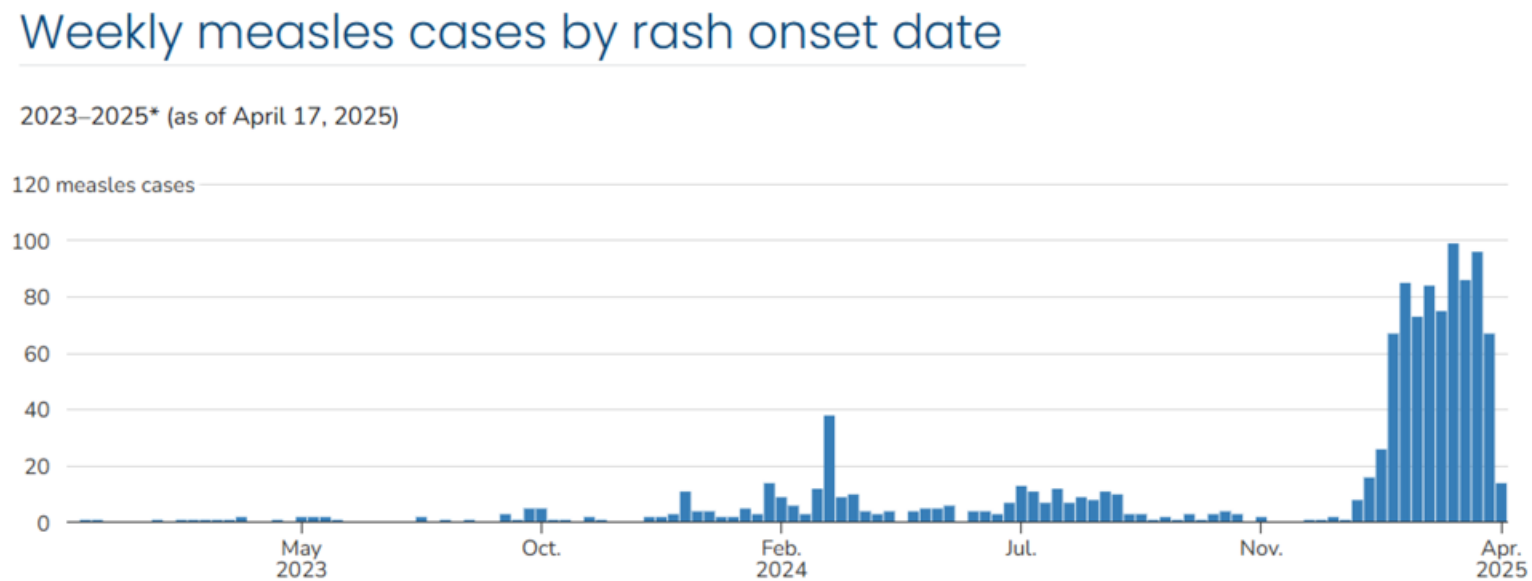
WHO Measles and Rubella PPT 04 25

Current US Measles Trends

- As of April 18, a total of 800 measles cases were reported by 25 jurisdictions in 2025
  - This includes 16 outbreaks that account for 94% of cases (751 of 800)
  - 3 deaths



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Measles Overview

- **Pathogen**: Rubeola virus
- **Transmission**: Airborne – virus can suspend in air for up to two hours
  - Sharing airspace with infected individual/breathing contaminated air
  - Touching infected surface
- **Incubation period**: Averages 10-12 days (range of 7-21 days)
- **Infectious period**: 4 days prior to rash onset through 4 days after rash onset
  - Day of rash onset = day 0
- **Seasonality**: No seasonality
  - May be associated with times of high travel (ex: spring break) or situations involving close living quarters with unvaccinated persons (ex: summer camp)
- **Treatment**: Supportive medical care
  - For severe measles cases (ex: hospitalized children), vitamin A doses can be used

Signs & Symptoms

People with measles often experience:

- High fever, usually over 101°F
  - Can spike to 104°F or above
- Cough
- Coryza (runny nose)
- Conjunctivitis (red, watery eyes)
- Koplik spots

Measles in fully or partially vaccinated persons may present differently.

This patient presented on the third pre-eruptive day with "Koplik spots" indicative of the beginning onset of measles.

Measles rash on a child's face.

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https://www.cdc.gov/measles/signs-symptoms/photos.html

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MEASLES SITUATIONAL UPDATE

CHRIS TARRAND
DIRECTOR OF FIELD EPIDEMIOLOGY

4/25/2025

Indiana Measles Resources and Information

The Indiana Department of Health is investigating an outbreak of measles and working with local health officials to help stop the spread of infection. The current reported cases are connected to each other but at this time there are no known links to outbreaks in other states.

2025 Measles Outbreak Cases

County	Cases
Allen	8

This table will be updated weekdays by 2 p.m. Data are provisional and subject to change.

Measles is caused by a highly contagious virus that spreads easily from person to person. It is an airborne disease, meaning it spreads through the air when an infected person breathes, coughs, sneezes, or talks. The virus can stay alive in the air and on surfaces for up to two hours. If one person has it, up to 9 out of 10 people nearby will become infected if they are not protected. Two doses of MMR (measles, mumps, rubella) vaccine are highly effective at preventing measles.

- Indiana Immunization Data Dashboards
- Indiana School Vaccine Requirements
- Information on measles vaccination from the Centers for Disease Control and Prevention

Measles Cases in Indiana

- Indiana Department of Health (IDOH) has confirmed eight cases of measles in Indiana this month (two additional from last week)
- Five minors and three adults in Allen County
- All eight cases are connected to each other and at this time there are no known links to outbreaks in other states. All five minors were unvaccinated, and the three adults' vaccination status is unclear. All are recovering well.
- State and local public health officials are working together on the investigation to contact those with known exposure to help prevent further spread of infection
- There was exposure at a nearby school
- **The risk to the general public remains low**

Indiana Department of Health

https://events.in.gov/event/idoh-news-release-indiana-department-of-health-confirms-5-new-measles-cases

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MEASLES IMMUNIZATION RECOMMENDATIONS AND UPDATES

DAVID McCORMICK
DIRECTOR OF IMMUNIZATIONS

4/25/2025

Measles Vaccination Recommendations

Children

- First dose at 12-15 months, second dose 4-6 years (minimum 28-day interval between each dose)

Adults

- Born before 1957: Immunity is assumed to be present from natural infection
- Born 1957-1968: A single dose recommended if no documentation of live vaccine administration or not contraindicated, or check a titer
- Born after 1968:
  - If received two documented doses of MMR, no additional doses needed
  - If no documentation: Provide additional dose if not medically contraindicated or check a titer. In some cases, a second dose may be needed.

Centers for Disease Control and Prevention (CDC) recommends that healthcare workers have two documented doses of MMR.

Frequently Asked Questions about MMR Vaccine

- Should I administer a dose to a child below the age of 12 months?
- Does my patient need a booster dose?
- Does my patient have to be four years old to receive the second dose?
- Does a second dose given before my patient's fourth birthday count for the school immunization entry requirement for kindergarten?

School Immunization Requirements

Indiana Department of Health

Required and Recommended School Immunizations, Indiana 2025-2026

Indiana Department of Health

Updated 11.12.2024

Grade	Required		Recommended
Pre-K	3 Hepatitis B 4 DTaP (Diphtheria, Tetanus and Pertussis) 3 Polio	1 Varicella (Chickenpox) 1 MMR (Measles, Mumps and Rubella) 2 Hepatitis A	Annual influenza COVID-19
K-5	3 Hepatitis B 5 DTaP 4 Polio	2 Varicella 2 MMR 2 Hepatitis A	Annual influenza COVID-19
6-11	3 Hepatitis B 5 DTaP 4 Polio 2 Varicella	2 MMR 2 Hepatitis A 1 MCV4 (Meningococcal) 1 Tdap (Tetanus, Diphtheria and Pertussis)	Annual influenza 2 or 3 HPV (Human papillomavirus) COVID-19
12	3 Hepatitis B 5 DTaP 4 Polio 2 Varicella	2 MMR 2 Hepatitis A 2 MCV4 1 Tdap	Annual influenza 2 or 3 HPV 2 MenB (Meningococcal) COVID-19

HepB: The minimum age for the third dose of Hepatitis B is 24 weeks of age.

DTaP: Four doses of DTaP/DTP/DT are acceptable if fourth dose was administered on or after the fourth birthday.

Polio*: Three doses of Polio are acceptable for all grade levels if the third dose was given on or after the fourth birthday and at least six months after the previous dose.
*For students in grades K-12, the final dose must be administered on or after the fourth birthday and be administered at least six months after the previous dose.

Varicella: Physician documentation of disease history, including month and year, is proof of immunity for children entering preschool through 12th grade. Parent report of disease history is not acceptable.

Tdap: There is no minimum interval from the last Td dose.

MCV4: Individuals who receive their first dose on or after their 16th birthday only need one dose of MCV4.

Hepatitis A: The minimum interval between first and second dose is six calendar months. Two doses are required for all grade levels.

For additional immunization information, visit: **in.gov/health/immunization**
or call **1 (800) 701-0704** during normal business hours.

HPV Efforts

Indiana Department of Health

888-227-4439

Logged in: DAVID MCCORMICK

Organization: PUBLIC HEALTH (1)

Date: April 26, 2024

- **Main**
  - Home
  - Logout
  - Select Application
  - Select Organization
  - Select Facility
  - Select Pin
  - Help
- **Dashboard**
- **Message**
- **Favorites**
- **Patient**
  - Search/Add
  - Demographics
  - Remote Registry
  - Manage Population
- **Vaccinations**
  - View/Add
  - Forecast

Patient

Name:	DAVE MCCORMICK	SIIS Patient ID:	13202175
Date of Birth:	07/06/2014	Age:	9 yrs
Guardian:	JAMIE MCCORMICK	Organization Level Status:	Active

+ Patient Specific Reports

Print Page View Print Page

Vaccination Forecast

The forecast automatically switches to the catch-up schedule when a patient is behind schedule.

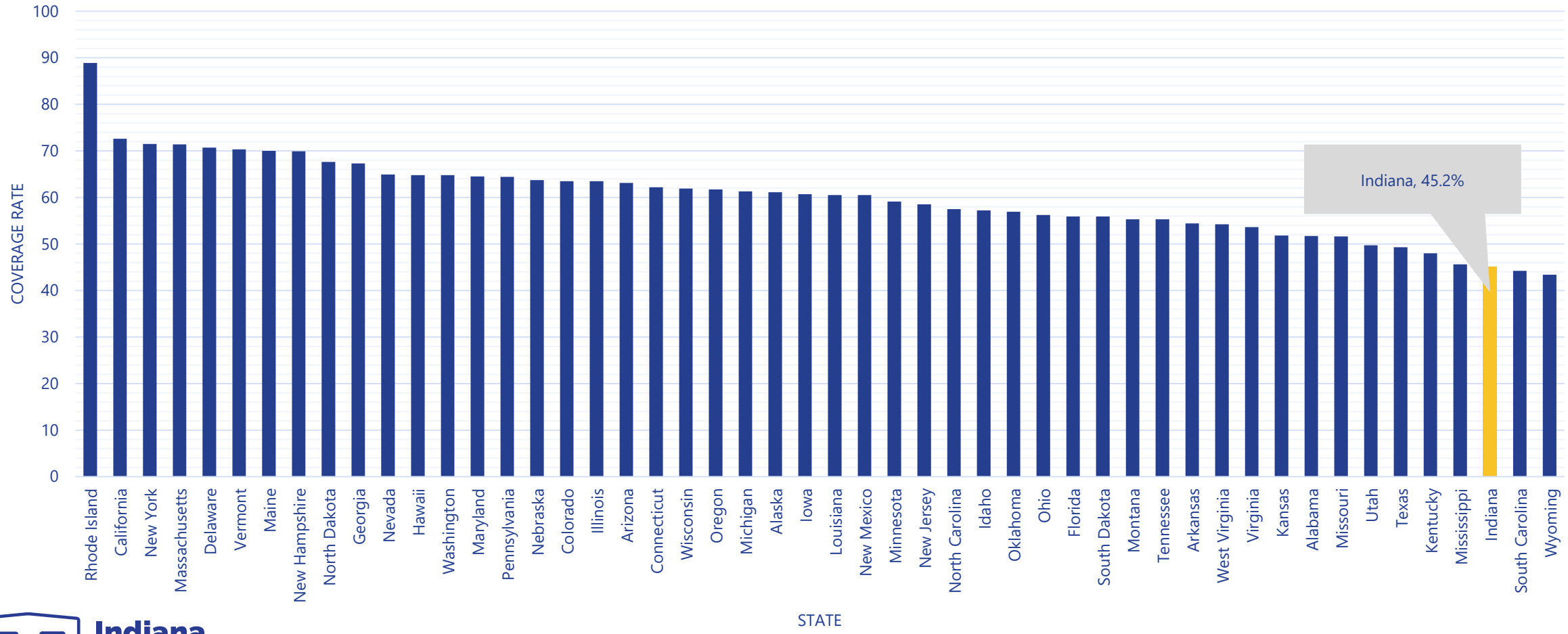
Vaccine Group	Forecasted Dose	Recommended Date	Minimum Valid Date	Overdue Date	Status
HEP-B 3 DOSE	1	Past Due	07/06/2014	08/02/2014	Past Due
POLIO	1	Past Due	08/17/2014	10/06/2014	Past Due
HEP-A	1	Past Due	07/06/2015	08/02/2016	Past Due
MMR	1	Past Due	07/06/2015	10/06/2015	Past Due
VARICELLA	1	Past Due	07/06/2015	10/06/2015	Past Due
Coronavirus (SARS-CoV-2)(COVID-19)	1	Due Now	12/12/2020	07/06/2024	Due Now
Tdap	1	Due Now	07/06/2021	07/06/2024	Due Now
FLU	1	07/01/2023	07/01/2023	07/01/2023	Past Due
HPV	1	07/06/2023	07/06/2023	07/31/2027	Due Now
MENINGOCOCCAL	1	07/06/2025	07/06/2025	07/31/2027	Not Yet Due
MENINGOCOCCAL B	1	07/06/2030	07/06/2024	08/05/2030	Not Yet Due

Vaccination View/Add

(* - Historicals , # - Adverse Reaction , !1 - Warning , !2 - Warning , !3 - Warning , + - Entered by School Nurse , ^ - Compromised Vaccination)

Documented By:

HPV One Dose Coverage Among Adolescents Age 13-17 (2016)



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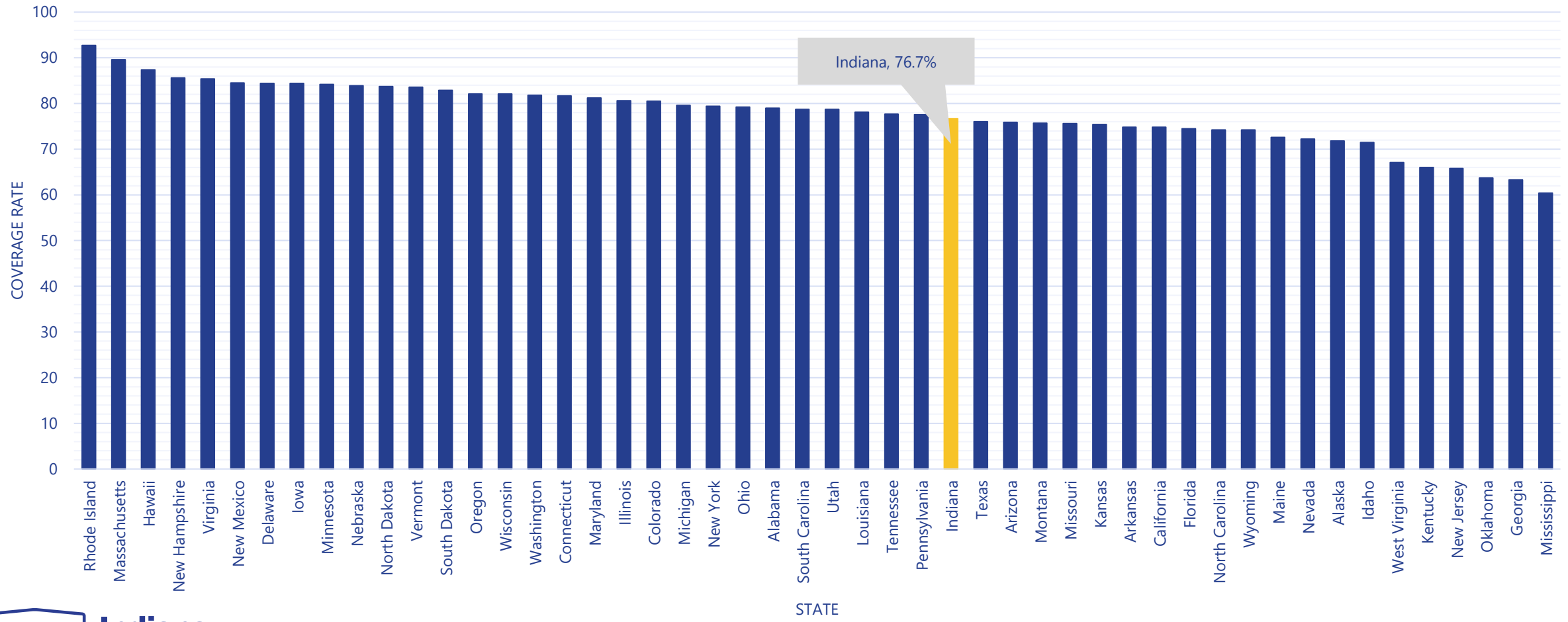
HPV One Dose Coverage Among Adolescents Age 13-17 (2023)



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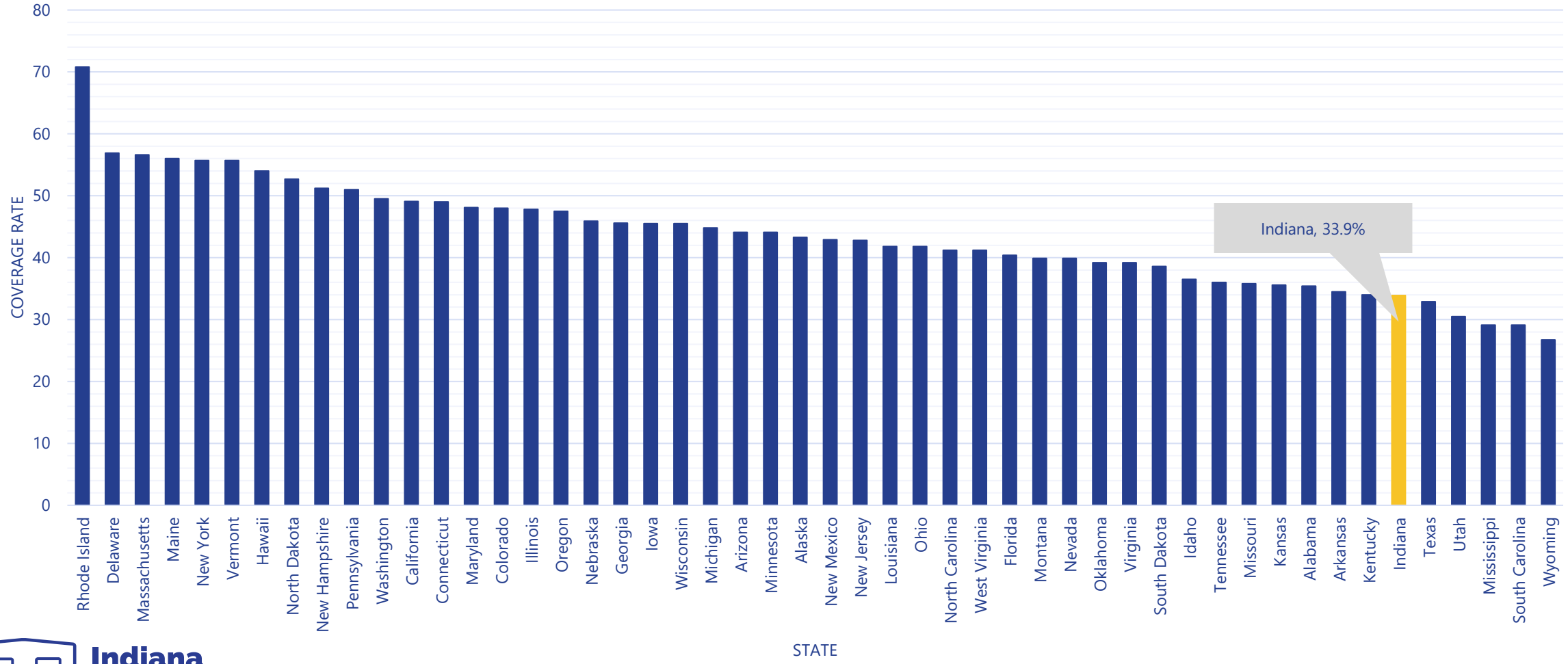
HPV UTD Coverage Among Adolescents Age 13-17 (2016)



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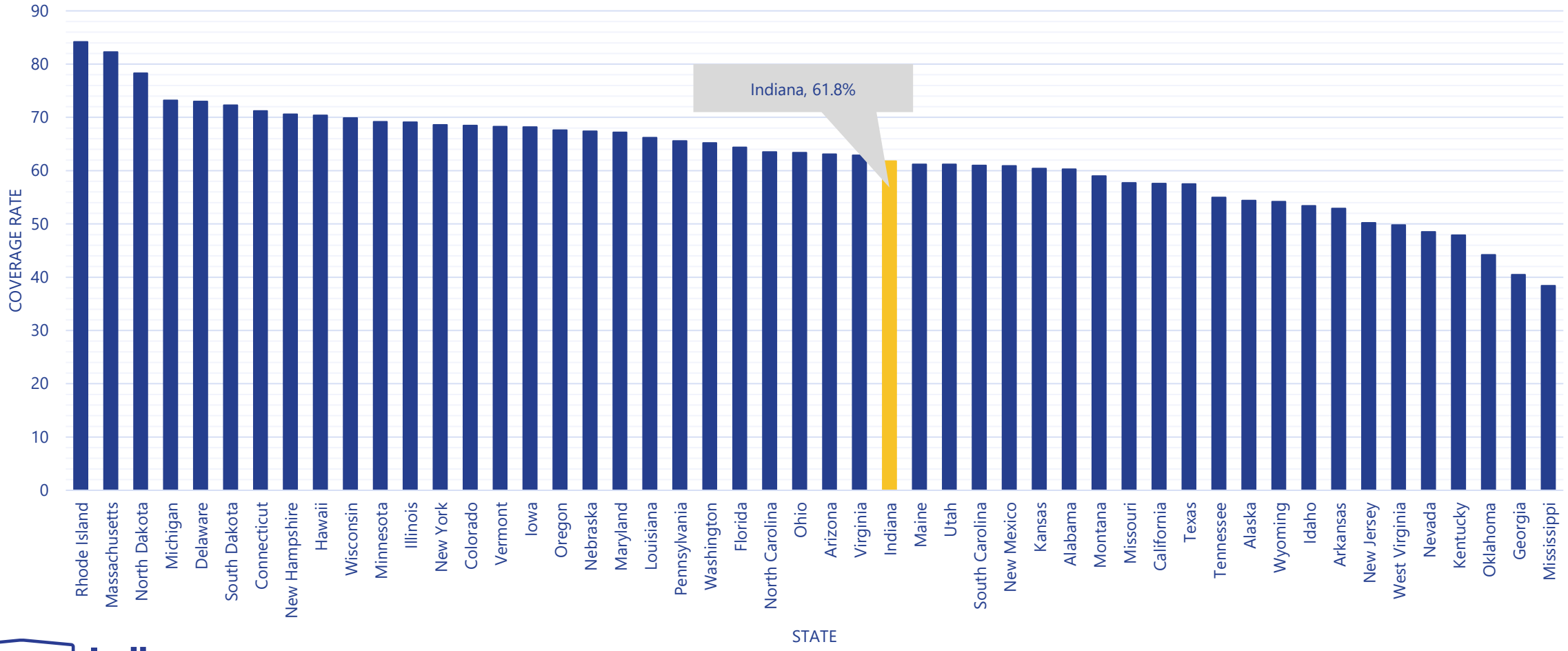
HPV UTD Coverage Among Adolescents Age 13-17 (2023)



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THINK TBD:
TICKBORNE DISEASE REMINDERS FOR INDIANA CLINICIANS

KIRA RICHARDSON
VECTOR-BORNE AND ZOONOTIC DISEASE EPIDEMIOLOGIST

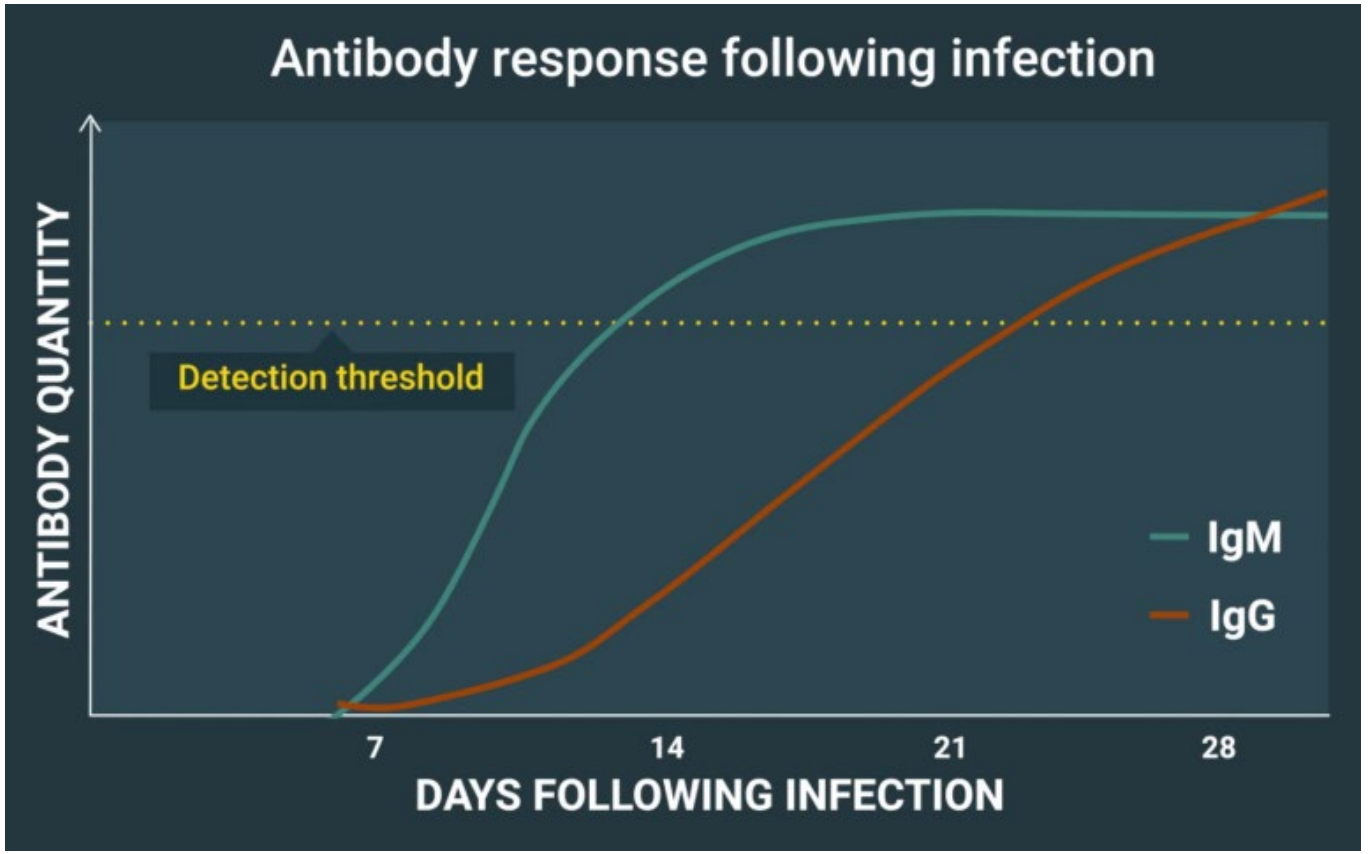
4/25/25

Why Think TBD

- Tickborne diseases are increasing in Indiana
- Clinical presentations can be nonspecific
- Three critical reminders for providers:
    1. Choose the right **tests**
    2. Don’t overlook **babesiosis**
    3. Know when **doxycycline** PEP is appropriate

Testing: Choose Wisely

Use appropriate timing–serology may be negative early in disease



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[APHL: Suggested Reporting Language, Interpretation and Guidance For Lyme Disease Serologic Test Results]

Testing: Choose Wisely

Follow recommended testing algorithms and order FDA approved diagnostic tests

Figure 1. Standard Two-Tiered Testing

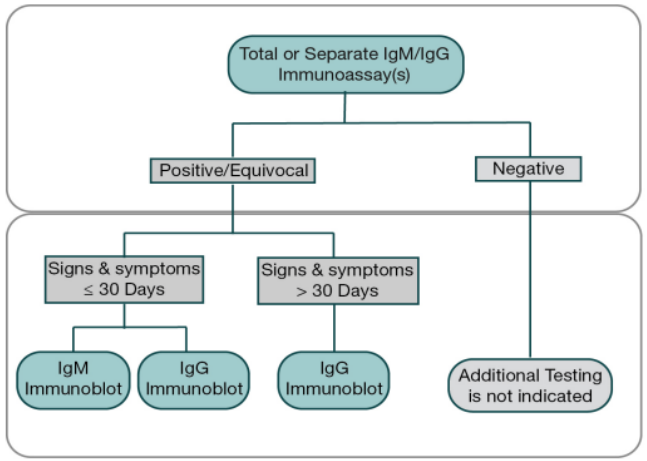


Figure 2. MTTT Algorithm 1 - Two Total IgM/IgG Immunoassays

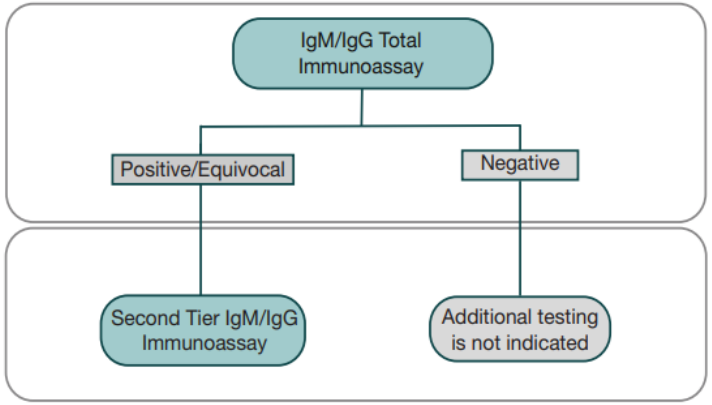
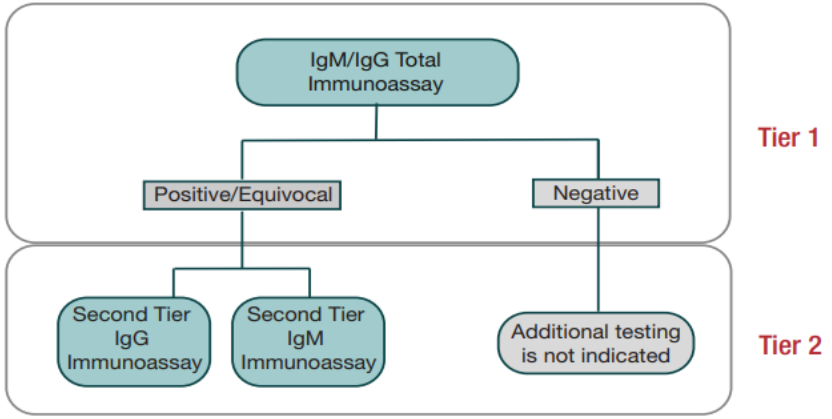


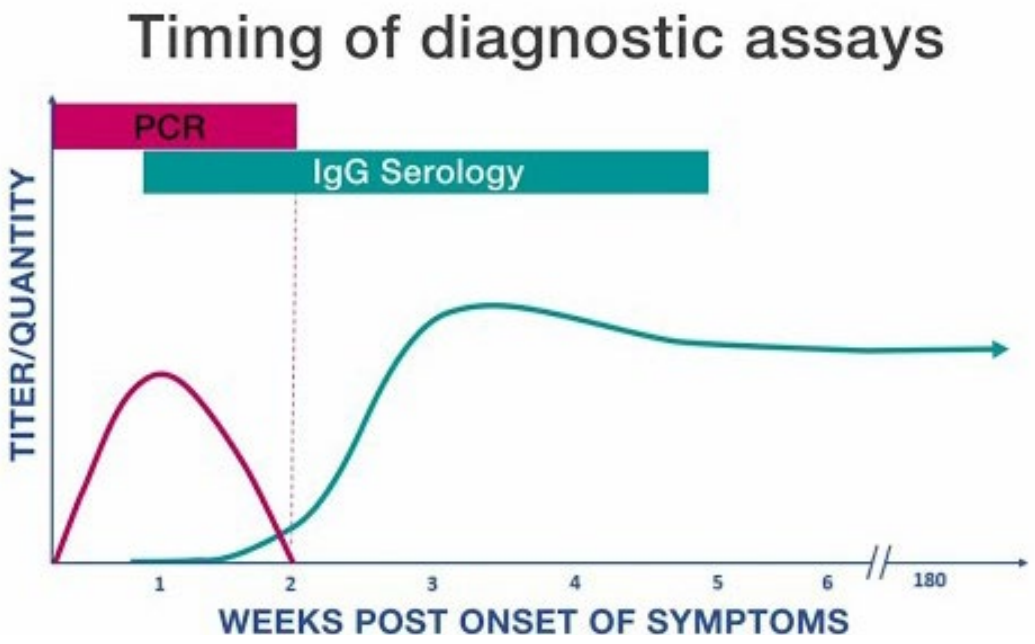
Figure 3: MTTT Algorithm 2 – Separate IgM and IgG Second Tier Immunoassays



Testing: Choose Wisely

Consider PCR in patients with acute febrile illness (e.g. rickettsial pathogens)

	PCR	IFA
Directly detects presence of pathogen	✓	
Detects antibodies to the pathogen		✓
Requires acute and convalescent samples to confirm disease		✓
Can confirm infection with only acute samples	✓	
Can be performed on many sample types	✓	
Sensitivity may be decreased following antibiotic therapy	✓	



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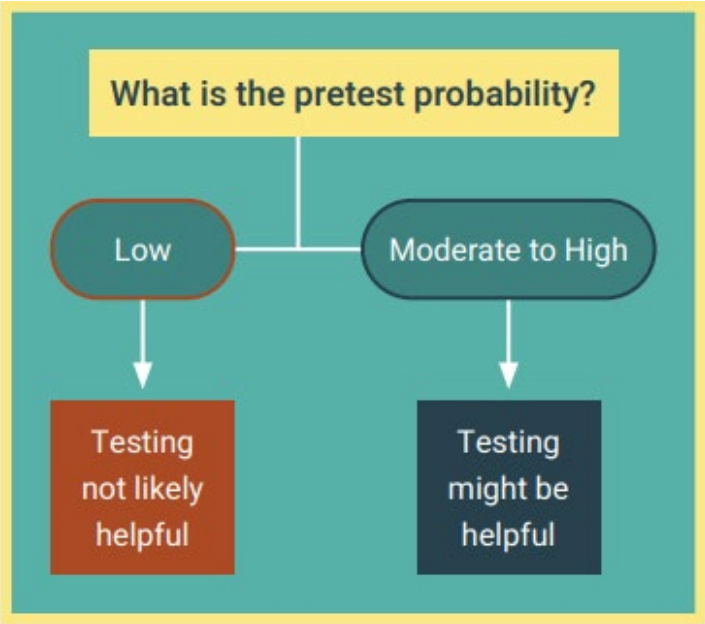
CDC: Rickettsial Disease Diagnostic Testing and Interpretation

Testing: Choose Wisely

Avoid unnecessary testing that can confuse the clinical picture
(i.e. “test of cure”, “tick bite ONLY”)



Pretest probability for Lyme disease is moderate to high when the following conditions are met:

- ☑ The patient has been in an area where Lyme disease is common. **AND**
- ☑ The patient had possible exposure to ticks. **AND**
- ☑ The patient has symptoms characteristic of Lyme disease.

Pretest probability for Lyme disease is lower when ANY of these conditions are met:

1. The patient has not been in an area where Lyme disease is common. **OR**
2. The patient had no possible exposure to ticks. **OR**
3. The patient is asymptomatic or has nonspecific symptoms that are not characteristic of Lyme disease.

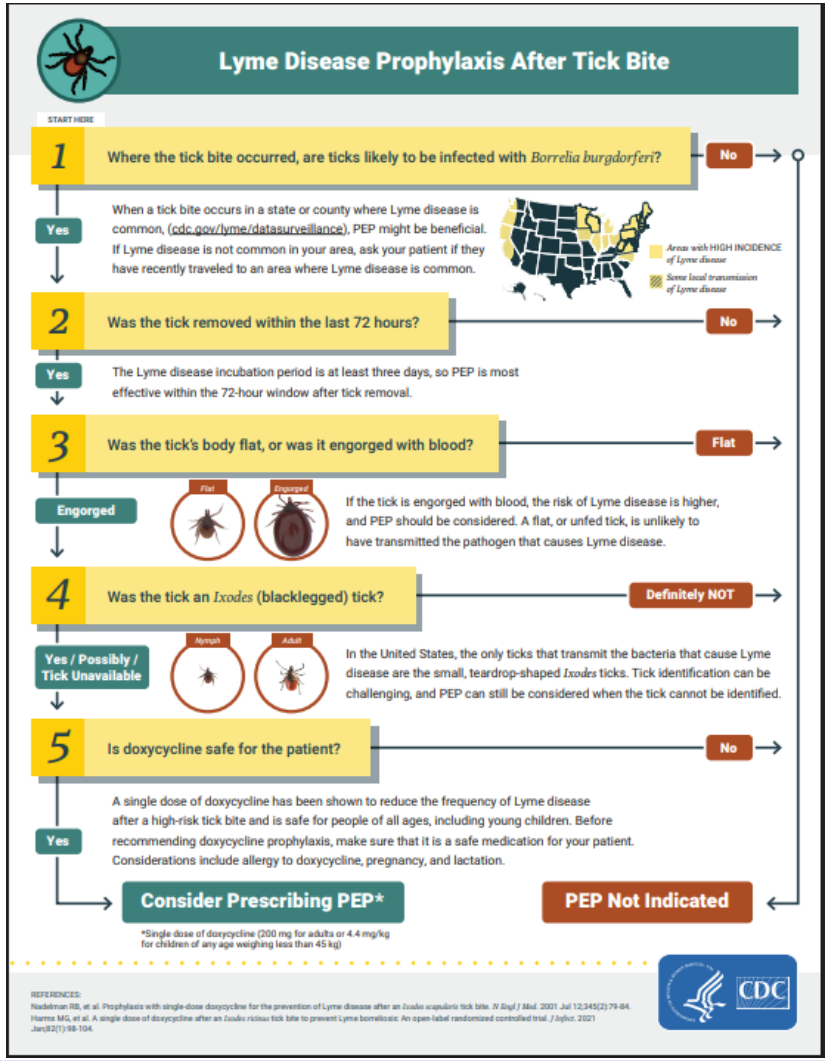
CDC: Lyme Pretest Probability

Babesiosis: Don't Overlook It

- Consider in febrile patients with no clear sources after transfusion
- Indiana blood supply is not screened for *Babesia*
- Immunocompromised or elderly patients may have more severe clinical presentation
- Use peripheral blood smear or PCR to confirm diagnosis

Doxycycline for Post-Exposure Prophylaxis (PEP)

- In certain circumstances, a single dose of doxy may prevent Lyme disease
- Recommended in States or counties with documented high tick infection rates



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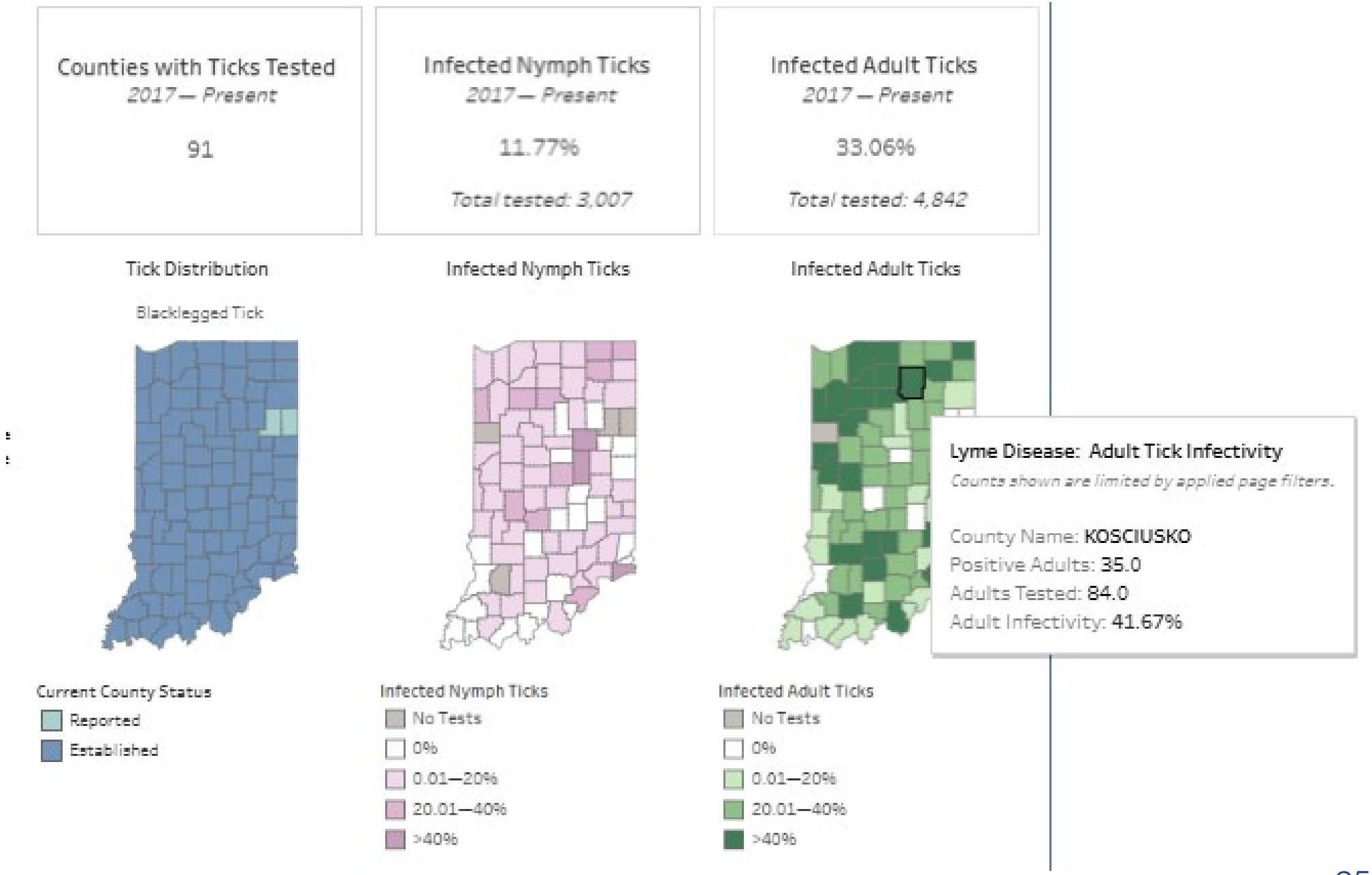
Lyme PEP After a Tick Bite



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Tick-borne Disease Surveillance Dashboard

Questions?

Kira Richardson
317-234-9727
KirRichardson@health.in.gov

Respiratory Trends

Indiana Department of Health

Human Metapneumovirus

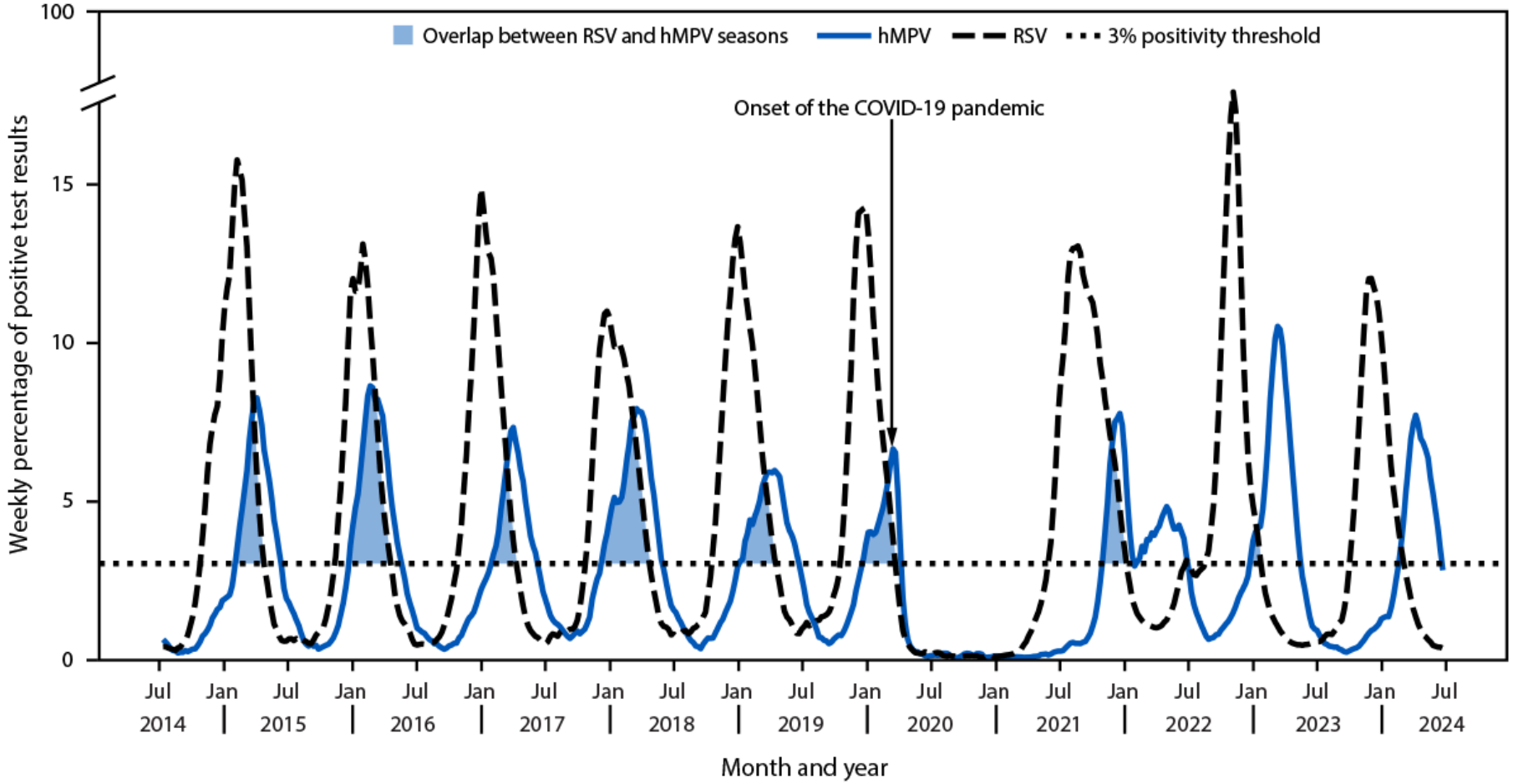
Human Metapneumovirus Seasonality and Co-Circulation with Respiratory Syncytial Virus — United States, 2014–2024

Weekly / April 3, 2025 / 74(11);182–187

Indiana Department of Health

https://www.cdc.gov/mmwr/volumes/74/wr/mm7411a1.htm?s_cid=mm7411a1_w

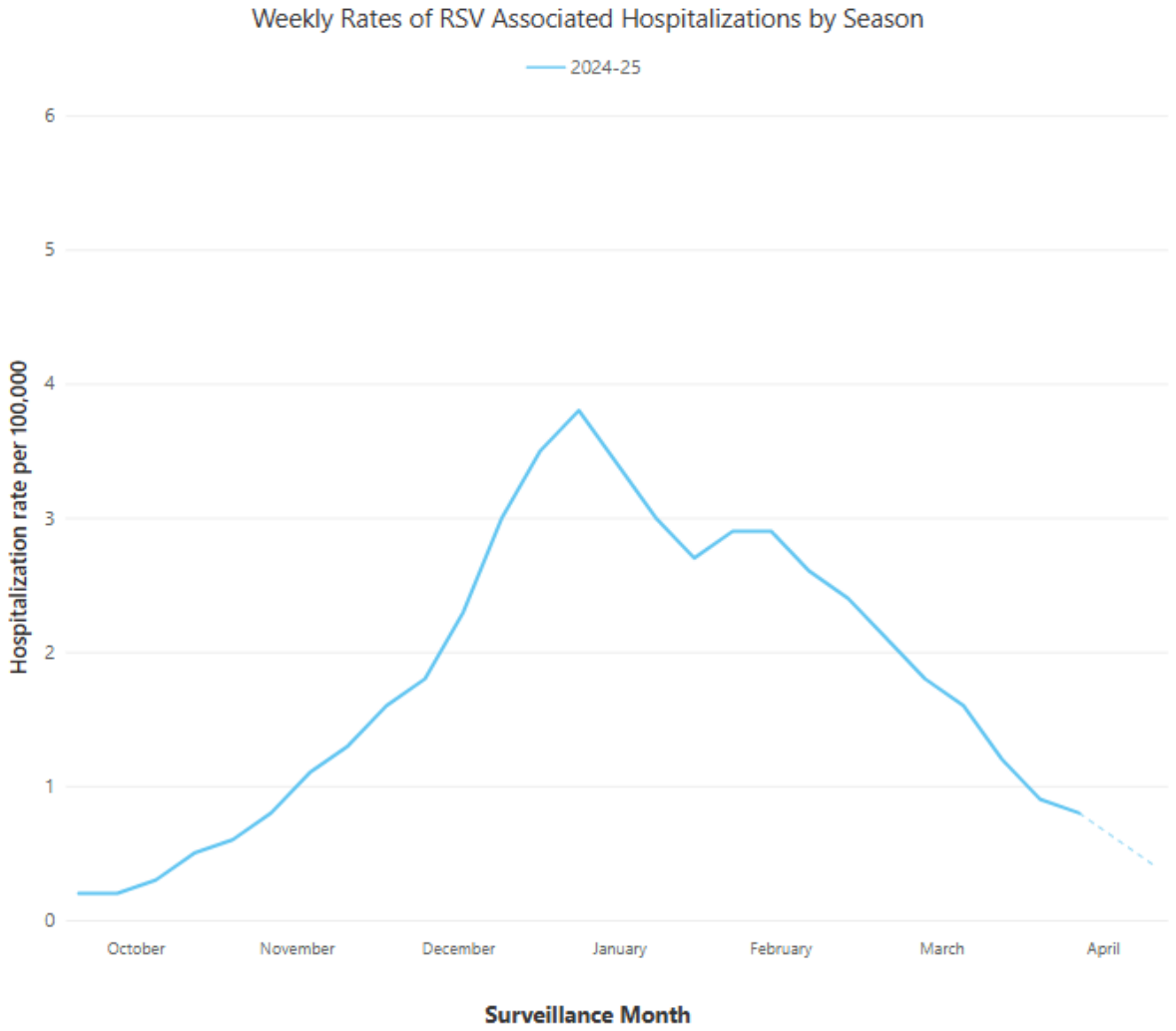
FIGURE. Weekly percentage of positive test results* for respiratory syncytial virus and human metapneumovirus — National Respiratory and Enteric Virus Surveillance System, United States, July 2014–June 2024†



Abbreviations: hMPV = human metapneumovirus; RSV = respiratory syncytial virus.

* Data were smoothed using a 3-week, centered moving average.

RSV-NET



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https://www.cdc.gov/rsv/php/surveillance/rsv-net.html

National Respiratory Snapshot

Overall respiratory illness activity in **the United States***

Low

What it is: A measure of how frequently a wide variety of respiratory symptoms and conditions are diagnosed by emergency department doctors, ranging from the common cold to COVID-19, flu, and RSV.

Why it matters: Summarizes the total impact of respiratory illnesses, regardless of which diseases are causing people to get sick.

Emergency department visits in **the United States**

COVID-19	Flu	RSV
Very Low Decreasing ↘	Low Decreasing ↘	Low Decreasing ↘

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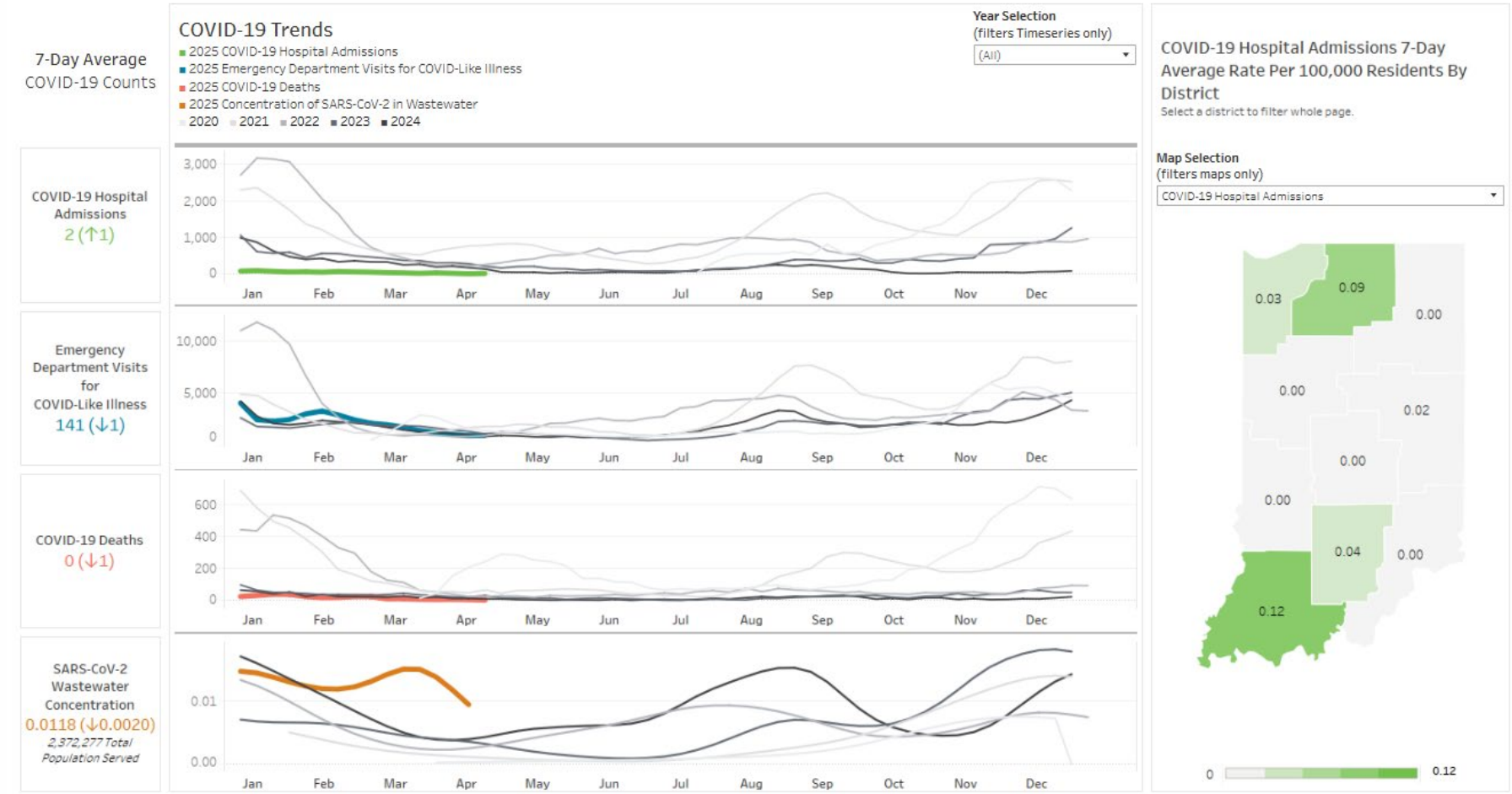
https://www.cdc.gov/respiratory-viruses/data/index.html

Indiana COVID-19 Home Dashboard

Data are updated as of 4/22/2025 and refreshed on a weekly basis every Wednesday by 5 p.m.



All numbers are provisional and reflect only those reported to IDOH. Numbers should not be characterized as a comprehensive total and may change as more data is reported.

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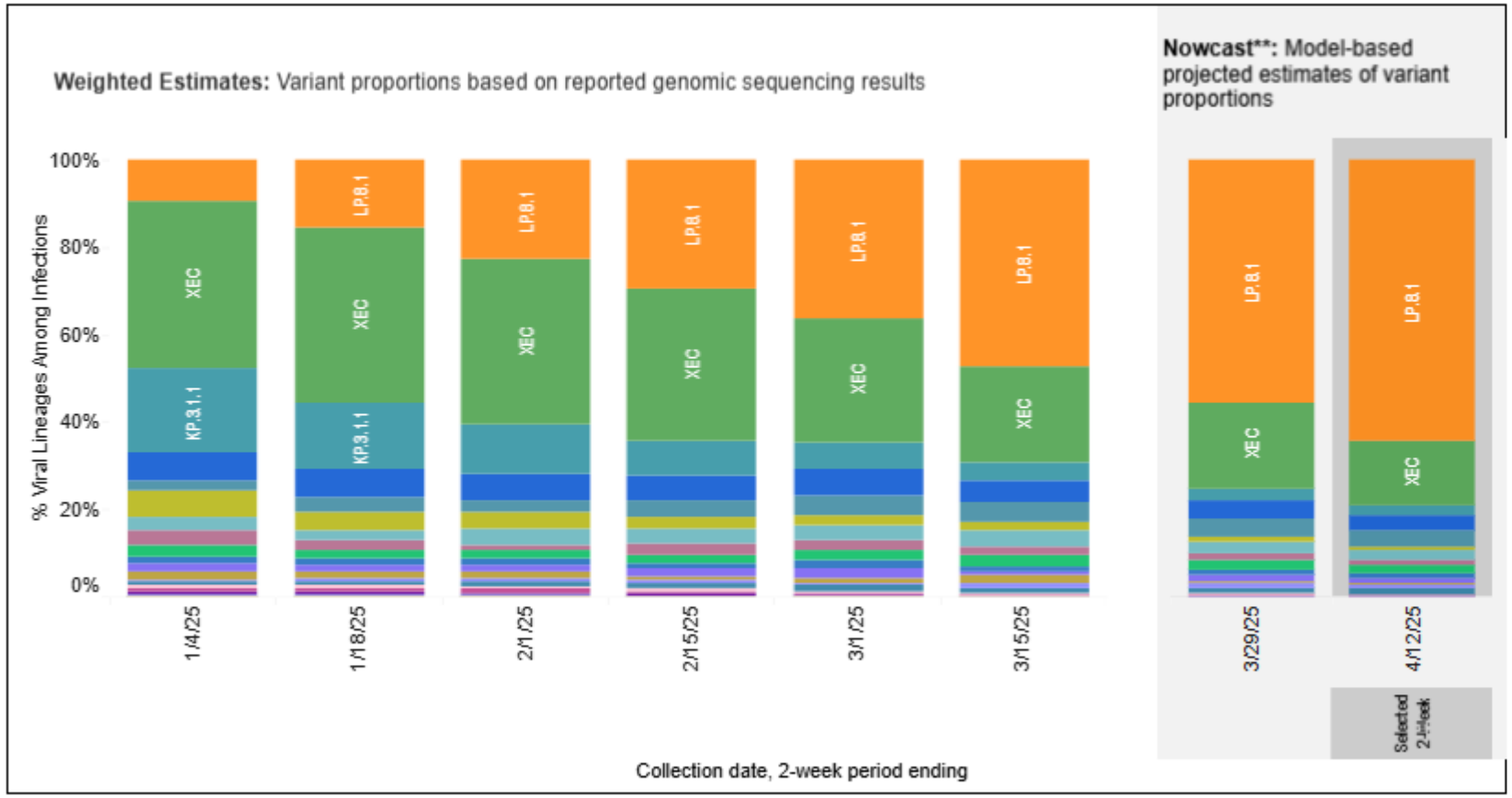
https://www.in.gov/health/idepd/respiratory-disease/coronavirus/covid-19-dashboard/

Weighted and Nowcast Estimates in United States for 2-Week Periods in 12/22/2024 – 4/12/2025

Hover over (or tap in mobile) any lineage of interest to see the amount of uncertainty in that lineage's estimate.



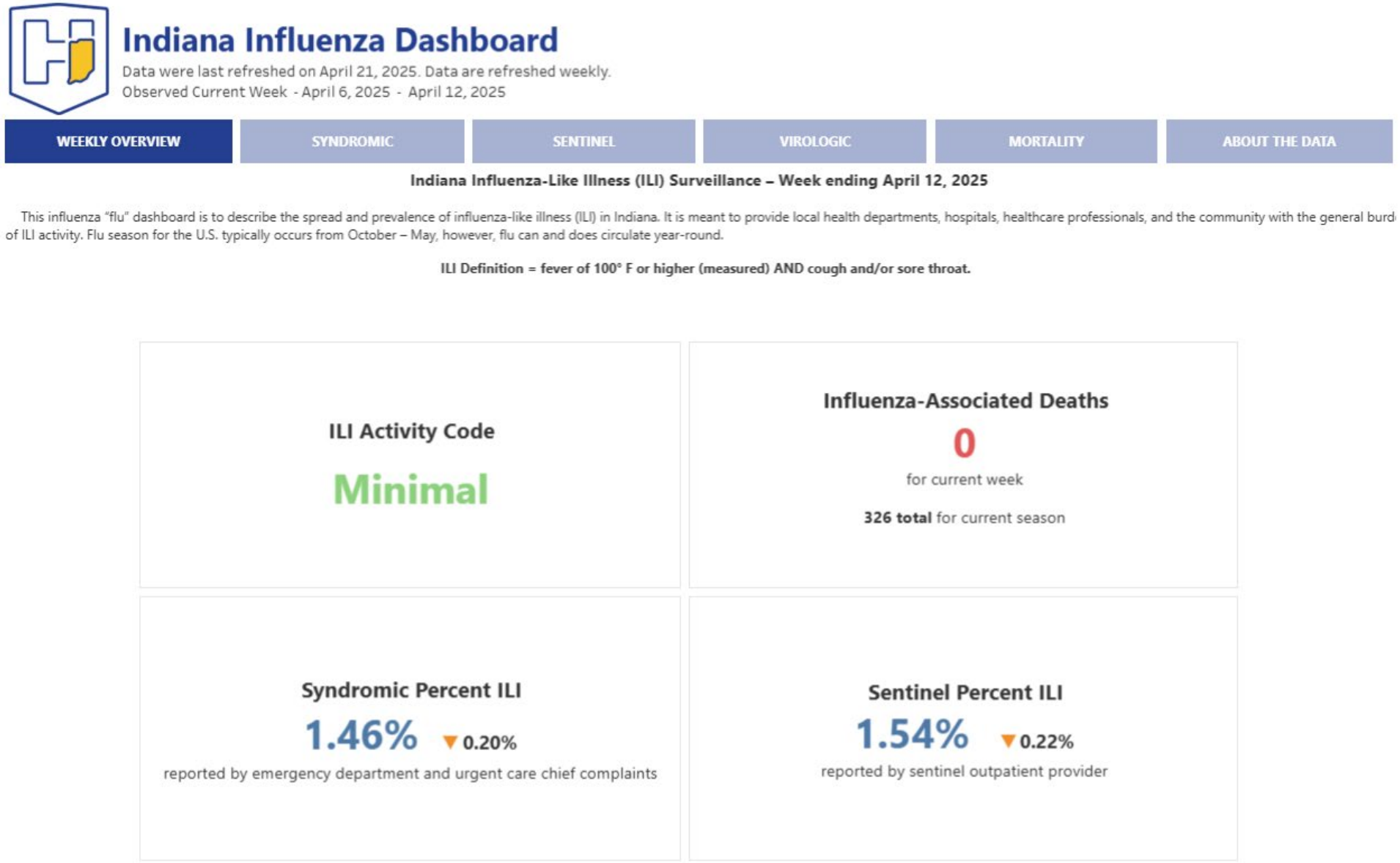
Nowcast Estimates in United States for 3/30/2025 – 4/12/2025

USA

WHO label	Lineage #	%Total	95%PI
Omicron	LP.8.1	64%	59–70%
	XEC	15%	12–18%
	MC.10.1	4%	1–9%
	LF.7	4%	2–7%
	LB.1.3.1	2%	1–4%
	KP.3.1.1	2%	1–3%
	XEC.4	2%	1–3%
	MC.28.1	1%	1–3%
	MC.19	1%	1–2%
	KP.3	1%	1–2%
	XEQ	1%	0–2%
	MC.1	1%	1–1%
	LF.7.2.1	1%	0–2%
	XEK	1%	0–1%
	JN.1.16	0%	0–1%
	JN.1	0%	NA

** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates

Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one 2-week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all 2-week periods displayed. While all lineages are tracked by CDC, those named lineages not enumerated in this graphic ar aggregated with their parent lineages, based on Pango lineage definitions, described in more detail here: https://web.archive.org/web/20240116214031/https://www.pango.network/the-pango-nomenclature-system/statement-of-nomenclature-rules.



Indiana Department of Health

https://www.in.gov/health/idepd/respiratory-disease/influenza/influenza-dashboard/

Indiana Influenza Dashboard

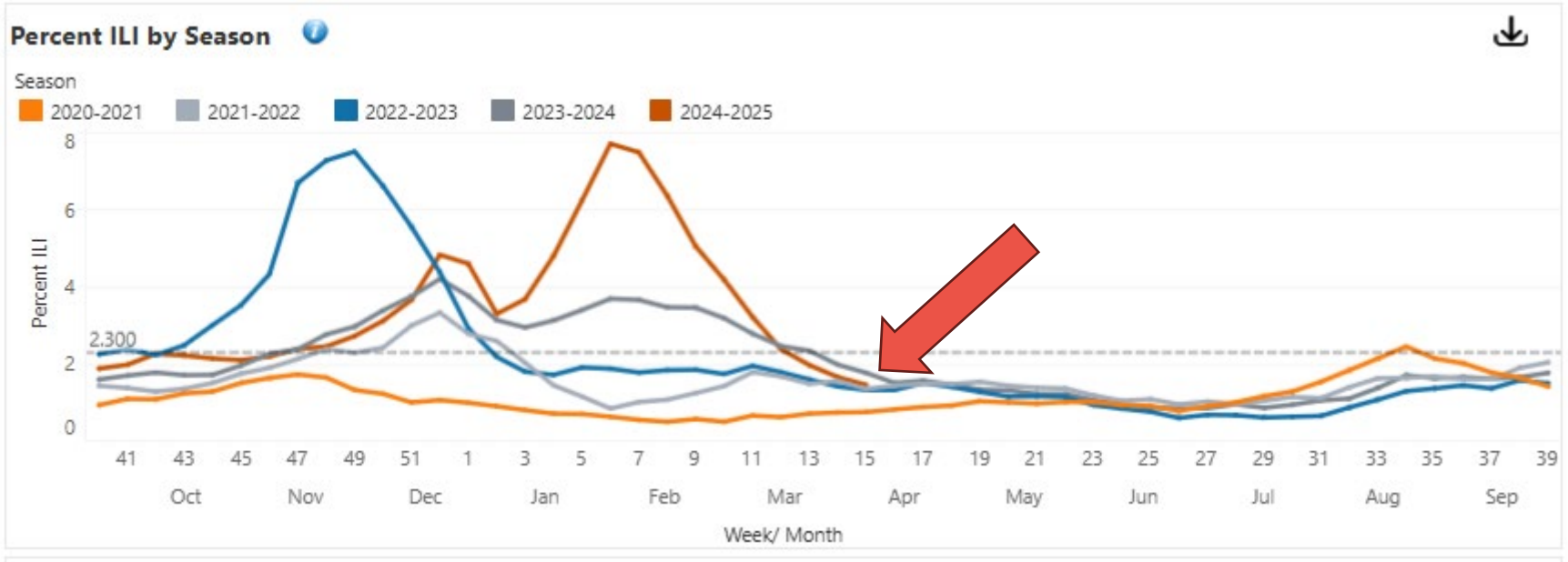
Data were last refreshed on April 21, 2025. Data are refreshed weekly.
Observed Current Week - April 6, 2025 - April 12, 2025

WEEKLY OVERVIEW | SYNDROMIC | SENTINEL | VIROLOGIC | MORTALITY | ABOUT THE DATA

Emergency Department and Urgent Care Visits for ILI

The Indiana Department of Health (IDOH) uses a system called ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics) to track and monitor syndromic surveillance for ILI. In ESSENCE, a visit is classified as ILI when a patient presents with a chief complaint of fever (greater than or equal to 100 °F) accompanied by a cough and/or sore throat, or complaining of "influenza". Epidemiologists at IDOH analyze data from 119 emergency departments and 23 urgent care facilities across the state.

Download all seasons data here.



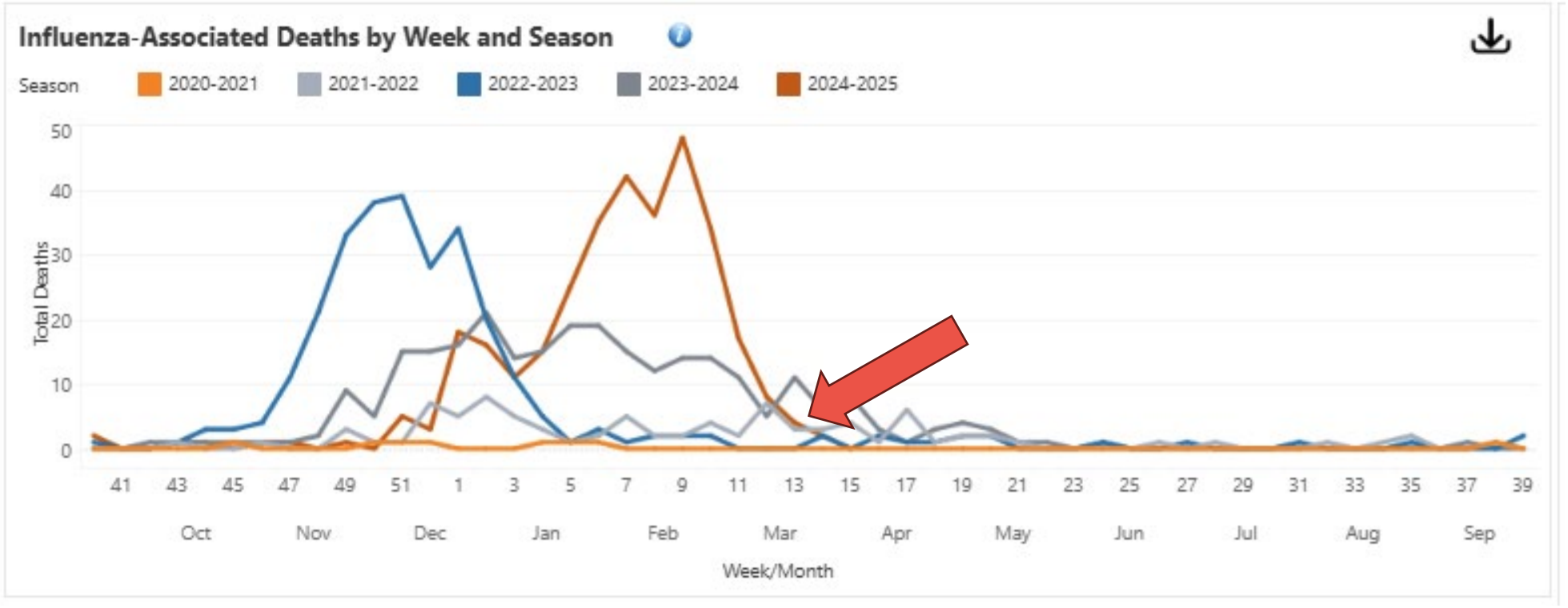
Indiana Department of Health

https://www.in.gov/health/idepd/respiratory-disease/influenza/influenza-dashboard/

Indiana Influenza Dashboard

Data were last refreshed on April 21, 2025. Data are refreshed weekly.
Observed Current Week - April 6, 2025 - April 12, 2025

WEEKLY OVERVIEW | SYNDROMIC | SENTINEL | VIROLOGIC | MORTALITY | ABOUT THE DATA



Indiana Department of Health

Pediatric Influenza-Associated Encephalopathy

- Monday, Feb. 24, CDC released a Call for Cases regarding pediatric influenza-associated encephalopathy and encephalitis
- CDC is investigating several reports of **pediatric influenza-associated encephalopathy and encephalitis** including acute necrotizing encephalopathy since January 2025.
- There is no national surveillance or surveillance in Indiana for pediatric influenza-associated encephalopathy and encephalitis to know if these cases are within or above what is expected.
- Cases of pediatric influenza-associated encephalopathy and encephalitis can be reported to CDC at severeflu@cdc.gov or sent to Layne Mounsey at LMounsey@health.in.gov (Indiana's influenza coordinator)
  - If sending directly to CDC, DO NOT include any HIPPA identifiers

Criteria for Pediatric Influenza-Associated Encephalopathy & Encephalitis

Criteria for reporting pediatric influenza-associated encephalopathy and encephalitis cases:

1. Age <18 years
2. Admitted to an acute care hospital or pronounced dead between October 1, 2024, and May 30, 2025.
3. Laboratory-confirmed influenza virus infection within 14 days preceding hospital presentation, during hospitalization, or in respiratory specimens collected post-mortem
4. Documented neurologic abnormalities (meeting 1 or more of the following):
   - Diagnosis of encephalopathy or encephalitis
   - Neurologic signs or symptoms
   - Neuroimaging abnormalities
   - Electroencephalogram abnormalities
   - Abnormal brain autopsy findings, if available for children who have died

Report Cases or Questions:

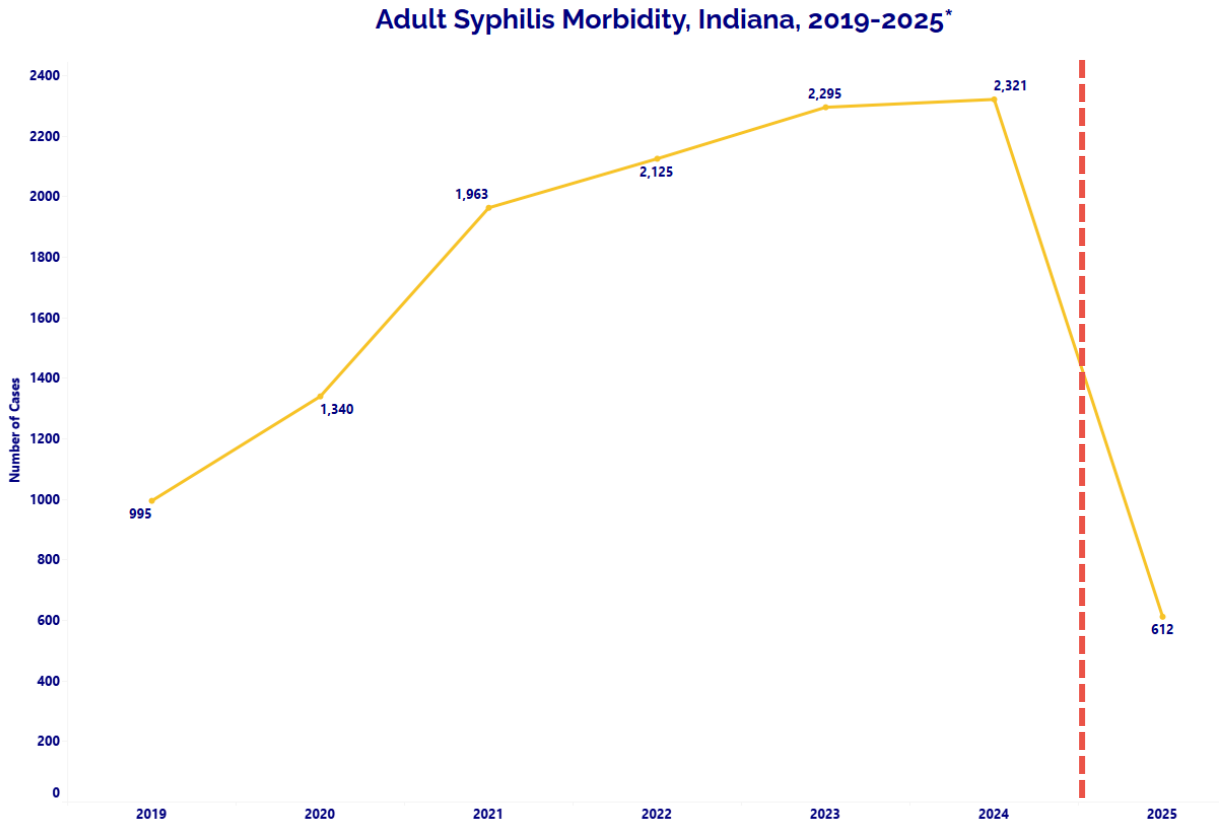
Layne Mounsey, MPH
Respiratory Epidemiologist & Influenza Coordinator
LMounsey@health.in.gov

Syphilis

Indiana Department of Health

Adult Syphilis Morbidity

- Rates of adult syphilis have been on the rise since 2014 in Indiana, reaching 33.9 (per 100,000) in 2023.
  - **There have been 612 cases of adult syphilis reported in 2025*, down 1.3% compared to this time last year.**

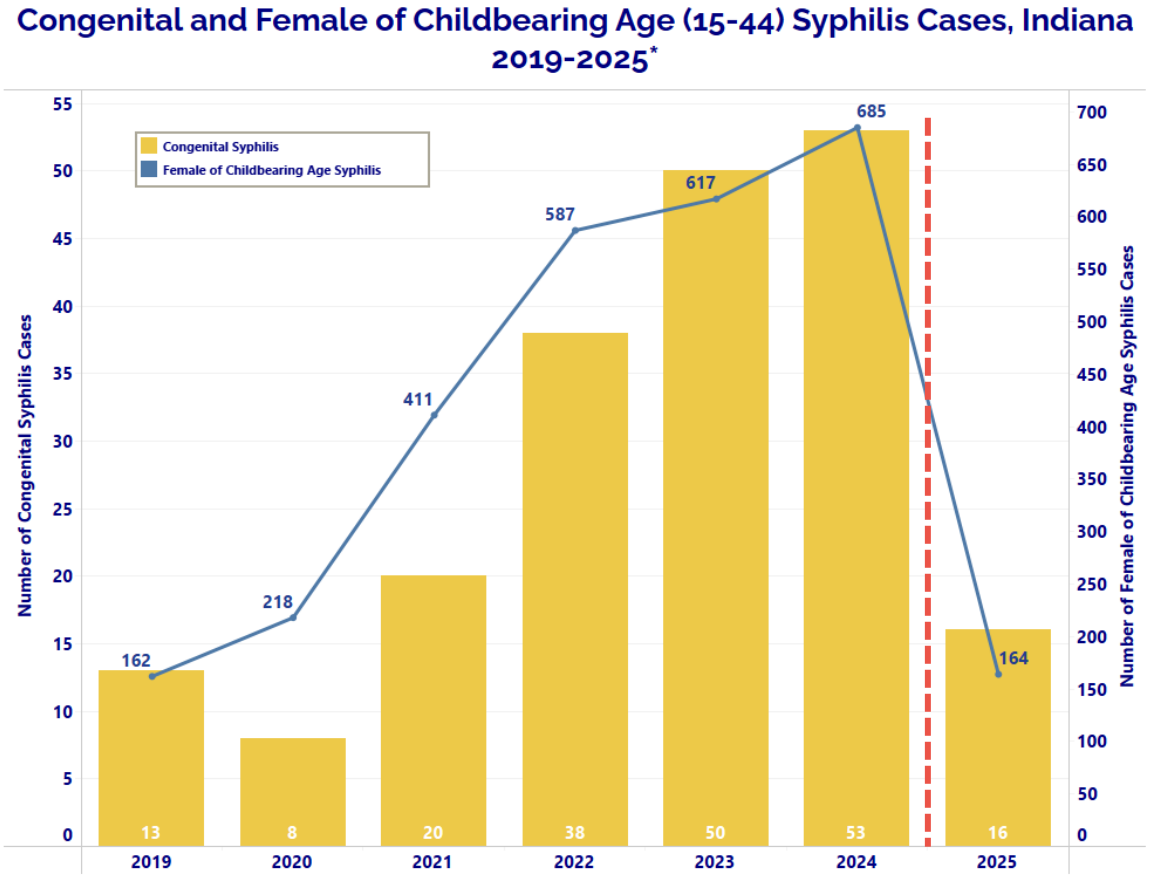


Indiana Department of Health

*2024 and 2025 STI data are preliminary and as of 04/15/2025.

Congenital & Female of Childbearing Age Syphilis Morbidity

- From 2019-2023 there was a 285% increase in congenital syphilis (CS) cases reported.
  - **There have been 16 cases of CS reported in 2025*, up 7% compared to this time last year.**
- Of the 16 CS cases reported this year, there have been no still births
- From 2019-2023 there was a 281% increase in syphilis cases among females of childbearing age (15-44 years old).
  - **There have been 164 cases of adult syphilis among females of childbearing age in 2025*, down 6% compared to this time last year.**



*2024 and 2025 STI data are preliminary and as of 04/15/2025.

Recommendations

- Perform syphilis testing on all patients upon finding a positive pregnancy test
- Test all pregnant women three times during pregnancy (at initial prenatal visit, again at 28-32 weeks of gestation, and then at delivery)
- Meet people where they are with syphilis testing and treatment outside of settings in which pregnant patients are typically encountered
    - This could include emergency departments, urgent cares, primary care visits, jail/prison intake, local health departments, community programs, and other addiction services
- Perform screening and treatment of all sexually active women and their partners for syphilis in counties with high syphilis rates
- Perform screening and appropriate treatment for those with other risk factors for syphilis (have unprotected sex and do not use condoms or do not use them correctly, have multiple sex partners, have a sex partner who has syphilis and have sex with a partner who has multiple sex partners)
- Treat all pregnant women who are infected with syphilis immediately upon diagnosis, according to their clinical stage of infection. Treatment must be with penicillin G benzathine (Bicillin LA).

Upcoming STI training opportunity

VIRTUAL STI INTENSIVE COURSE

Presented by the NYC STI Prevention Training Center

STI INTENSIVE COURSE

June 3rd-5th, 2025 — 8:45 AM-12:30 PM EST

The STI Intensive Course is a **three 1/2-day** didactic virtual course, which provides registered participants with training in the most recent advancements in sexual history taking, the diagnosis and management of viral and bacterial STIs, and STI & HIV prevention.

Target Audience: Physicians, physician assistants, nurse practitioners, nurses, and other clinical healthcare professionals who see patients with or at risk for sexually transmitted infections (STIs). Free CME/CNE is offered for this class.

Presented by the NYC Prevention Training Center core faculty

Presented by the NYC Prevention Training Center core faculty

Registration required

You must register for all three days; CME/CNE offered for attendance at all three days only.

https://courses.nnptc.org/class_information.html?id=4126

NEW YORK CITY STI HIV PREVENTION TRAINING CENTER

Indiana Department of Health

Click here to register: https://courses.nnptc.org/class_information.html?id=4126

Congenital Syphilis is Preventable

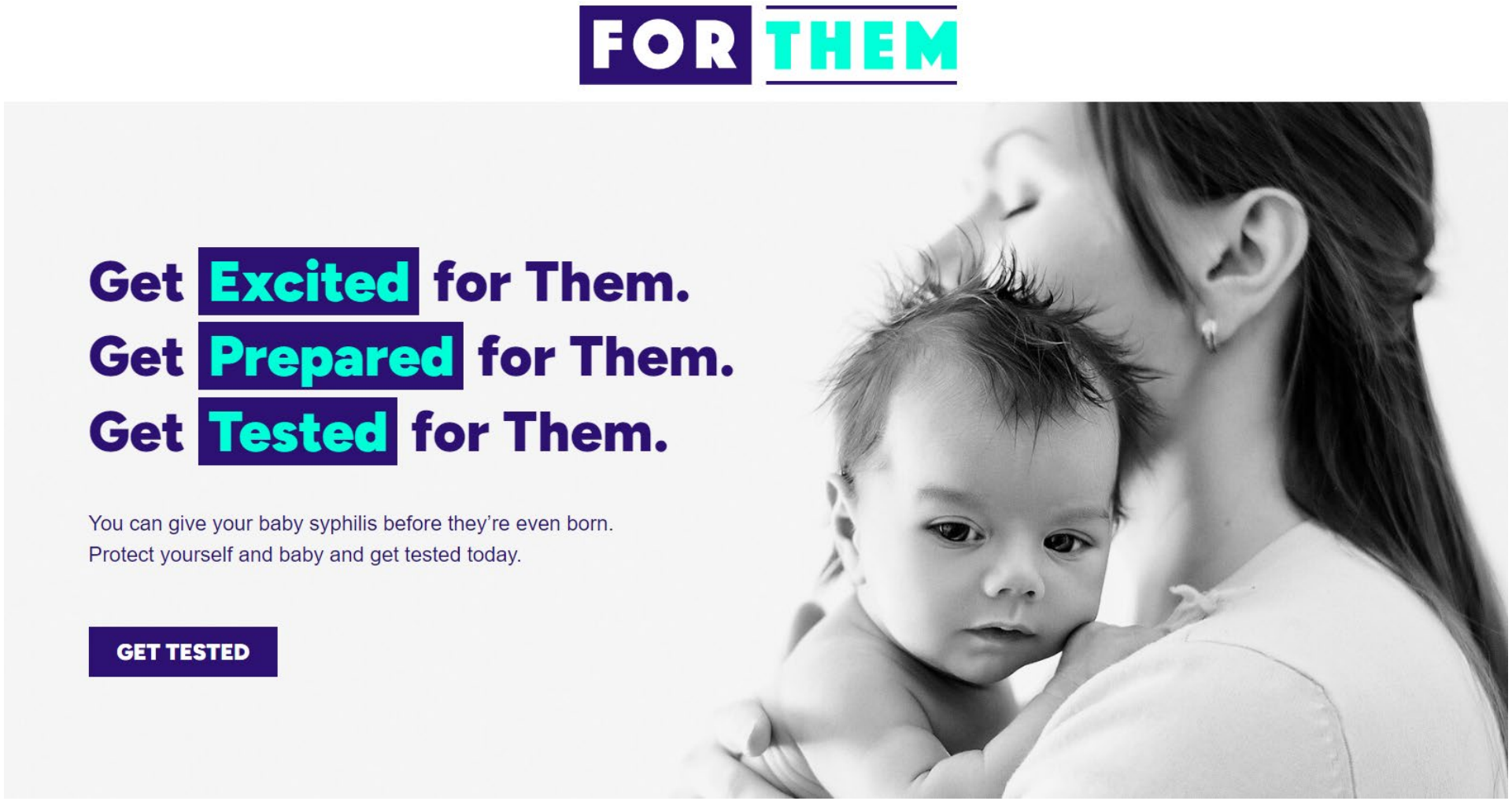
Toolkit can be found here: https://www.in.gov/health/audiences/clinicians/clinical-guidelines-and-references/congenital-syphilis-clinician-toolkit/

Includes:

- Dashboards (adult and congenital syphilis)
- Case definitions
- Treatment algorithm
- Clinical staging
- Treatment information

Indiana Department of Health

For Them: Syphilis Awareness Campaign



Indiana Department of Health

https://testforthem.org/for-them/

FDA authorizes first home test for chlamydia, gonorrhea, trichomoniasis


FDA NEWS RELEASE

FDA Grants Marketing Authorization of First Home Test for Chlamydia, Gonorrhea and Trichomoniasis

Today's Action also Opens the 510(k) Pathway for Other Home Tests for Sexually Transmitted Infections

- March 28, 2025
- The U.S. Food and Drug Administration granted marketing authorization to Visby Medical for the Visby Medical Women's Sexual Health Test.
- This is the first diagnostic test for chlamydia, gonorrhea and trichomoniasis that can be purchased without a prescription and performed entirely at home.
- The test is intended for females with or without symptoms and delivers results in approximately 30 minutes.
- The Visby Medical Women's Sexual Health Test correctly identified 98.8% of negative and 97.2% of positive *Chlamydia trachomatis* samples, 99.1% of negative and 100% of positive *Neisseria gonorrhoeae* samples and 98.5% of negative and 97.8% of positive *Trichomonas vaginalis* samples.

FDA approves new STI home test

Infectious Diseases of Public Health Importance

Indiana Department of Health

CDC Call for Cases: Ceftriaxone

Please report adverse events that meet all the following criteria, occurring from Sept. 1, 2024:

1. Occurred within 6 hours after receipt of injectable* ceftriaxone in a non-ICU setting
2. Resulted in death or required cardiopulmonary resuscitation**
3. Not attributed by the treating provider(s) to a cause other than ceftriaxone administration***

**including both intramuscular and intravenous routes of administration*

***cardiopulmonary resuscitation defined as the use of chest compressions and mechanical ventilation or provision of rescue breaths to maintain circulatory flow and oxygenation during cardiac arrest*

****such as known infection, other underlying medical condition, or exposure to a medication or medical product other than ceftriaxone*

Please make reports to IDOH by emailing:

Trent Gulley tgulley@health.in.gov and Haley Beeman hbeeman@health.in.gov.

Healthcare providers should report serious adverse events that might be associated with a medical product to FDA's MedWatch Program and to the product manufacturer

Indiana Department of Health

Outbreak of Cyclosporiasis Among Patrons of a Mexican-Style Restaurant, Alabama 2023

Summary

What is already known about this topic?

Cyclosporiasis is an intestinal illness caused by the parasite *Cyclospora cayetanensis*. In the United States, cyclosporiasis outbreaks are commonly associated with fresh, imported produce.

What is added by this report?

In June 2023, a total of 47 cases of cyclosporiasis were associated with consumption of food from a Mexican-style restaurant in Alabama. Analysis of case-control data identified cilantro as the likely food source. Collaboration among multiple states and their respective agencies enabled successful traceback of cilantro to a source in Mexico.

What are the implications for public health practice?

Cilantro imported from Mexico remains a food source of concern for cyclosporiasis. Distribution of potentially contaminated products via improper supply chain channels remains a public health challenge.

Cyclosporiasis MMWR

Norovirus Outbreaks Associated with Consumption of Oysters Harvested in Mexico, Dec 2023 – Jan 2024

Summary

What is already known about this topic?

Consumption of contaminated raw oysters is a common cause of foodborne illness outbreaks.

What is added by this report?

During December 2023–January 2024, approximately 400 persons across eight California local health jurisdictions reported gastrointestinal illness after consumption of raw oysters. The investigation identified two concurrent but unrelated outbreaks attributable to norovirus and other viral enteric pathogens. In the second outbreak, oysters might have been contaminated during wet storage of live oysters at a location separate from the original growing area.

What are the implications for public health practice?

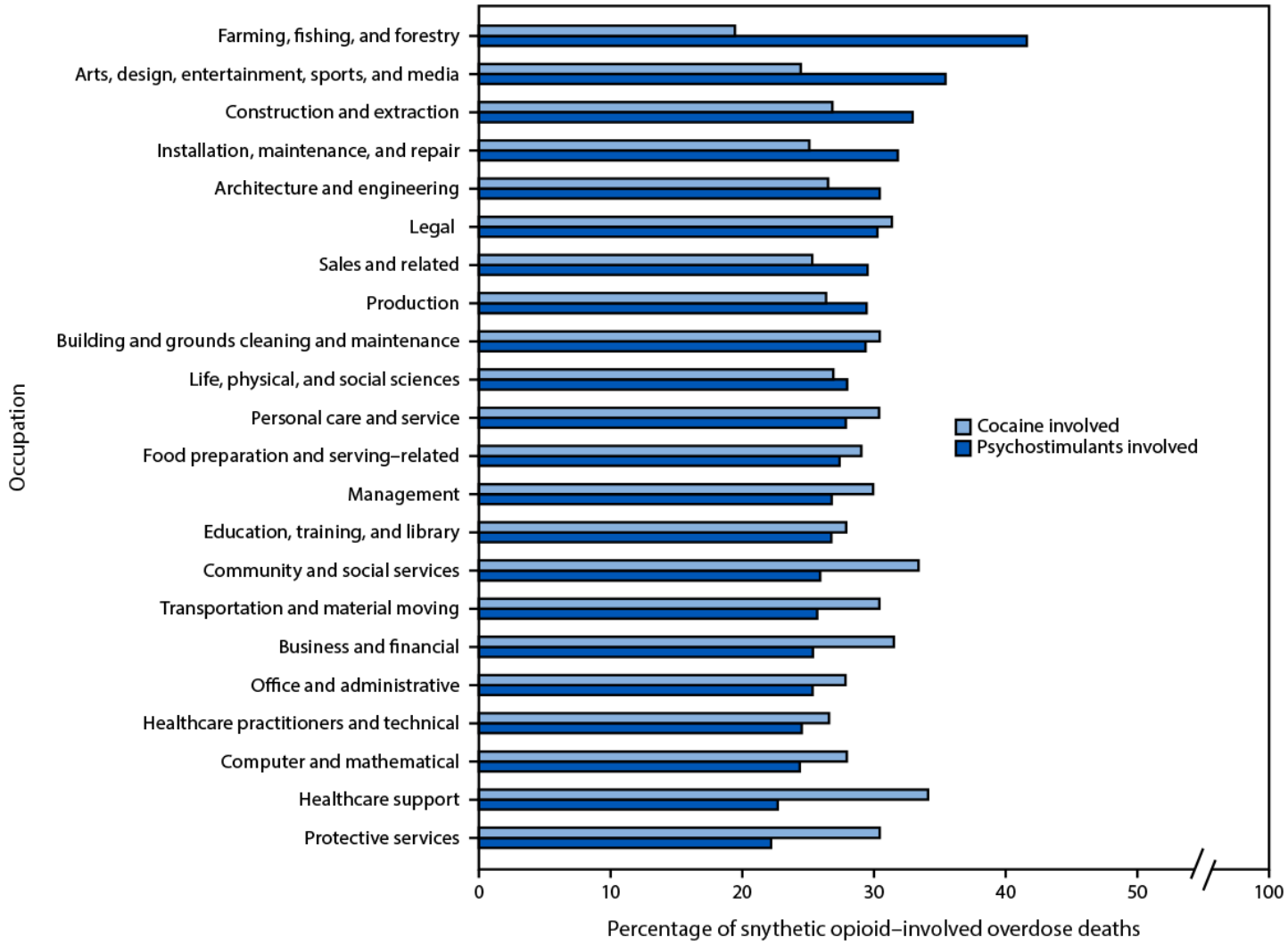
Raw oysters are a continuing source of enteric illness. Producers and distributors should be aware of and prevent shellfish contamination in wet storage. Consumers should cook oysters to 145°F (62.8°C) before consumption. Concurrent outbreaks of foodborne illness with similar modes of transmission can be unrelated and should be confirmed by product traceback.

Oyster Norovirus MMWR

Other Public Health Updates

Indiana Department of Health

FIGURE 1. Percentage of fatal synthetic opioid–involved overdoses* co-involving psychostimulants† or cocaine§ for 22 major occupation groups¶ — National Vital Statistics System, United States, 2022**



***Reminder from last webinar**

Indiana Department of Health

https://www.cdc.gov/mmwr/volumes/74/wr/mm7410a3.htm?s_cid=mm7410a3_w#T1_down

Controlled Substance Prescribing Patterns Among Fatal Overdose Decedents, PA 2017-2022

- Psychostimulant (stimulant)-related overdose death rates have increased sharply in the United States since 2010, and in 2022, **32%** of all U.S. overdose deaths involved stimulants.
- The Pennsylvania Department of Health's Office of Drug Surveillance and Misuse Prevention analyzed controlled substance dispensation patterns during the 3 years preceding death among overdose decedents
- Opioid prescribing, rather than stimulant prescribing, might be an important potential risk factor for stimulant-related overdose death.

Controlled Substance Prescribing Patterns Among Fatal Overdose Decedents, PA 2017-2022

Comparing overdose deaths in 2022 with those in 2017

- Deaths involving opioids ***without*** stimulants **decreased** from 2,974 to 1,995
- Deaths involving stimulants ***without*** opioids **increased** from 300 to 549
- Deaths involving ***both*** opioids and stimulants **increased** from 1,703 to 2,346.
- Irrespective of whether an opioid, stimulant, or both contributed to death, decedents filled more opioid (67.7%, 74.1%, and 63.9%, respectively) than stimulant (10.6%, 11.6%, and 13.4%, respectively) prescriptions preceding death.
- A higher proportion of stimulant overdose decedents without an opioid contributing to death (74.1%) filled opioid prescriptions compared with decedents whose deaths involved opioids without stimulants or both opioids and stimulants (67.7% and 63.9%, respectively).

Ways to connect with us

- Access our webpage with resources for clinicians
- Please let us know what topics you'd like us to cover: Email Gcrowder@health.in.gov or Ehawkins@health.in.gov
- Sign up for IHAN– Indiana Health Alert Network https://ihan-in.org

Questions?

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