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# Epidemiology *report*

## 2013 STD and Viral Hepatitis Summary

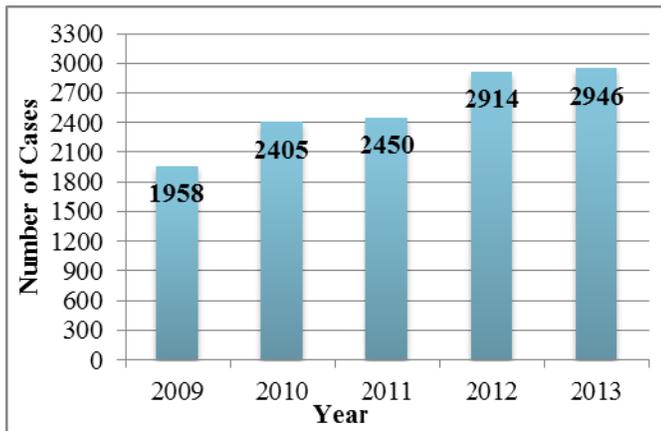
*By Sarah Weninger, STD and Viral Hepatitis Surveillance Epidemiologist*

### Chlamydia

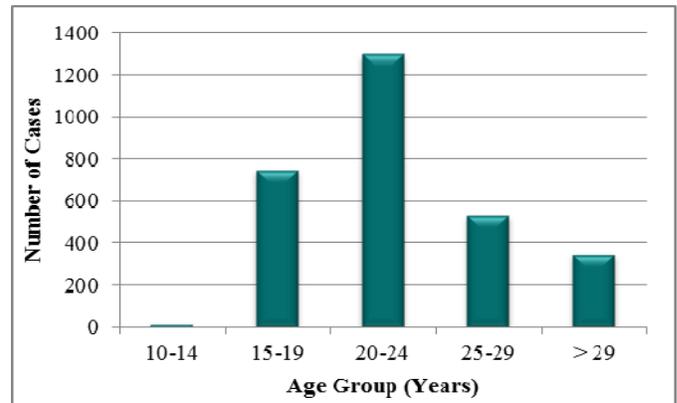
In 2013, 2,946 cases of chlamydia were reported to the North Dakota Department of Health (NDDoH), only a slight increase from the 2,914 cases reported in 2012 (Figure 1). The case count reported in 2013 corresponds to a rate of 407.2 per 100,000 which is below the national rate reported in 2012 of 456.7 cases per 100,000. Since 2009, the number of chlamydia cases reported has increased by more than 50 percent.

Of the cases reported, 1,930 (65%) were females. The majority of cases (70%) are reported in people ages 15 to 24 (Figure 2).

**Figure 1. Reported Chlamydia Cases by Year, North Dakota, 2009-2013**



**Figure 2. Reported Chlamydia Cases by Age Group, North Dakota, 2013**



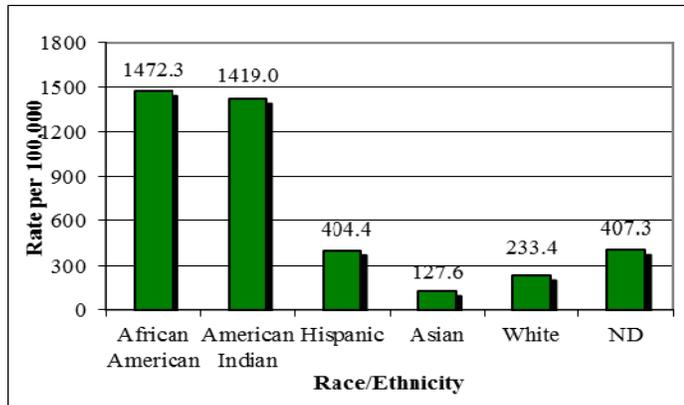
In 2013, 23 percent of chlamydia cases were reported with an unknown race. Of cases with known race, 1,513 (66%) cases were reported among Whites followed by American Indians with 559 (24%), African Americans with 193 (8%), Hispanics with 84 (4%) and Asians with 11 (0.5%). There was a 25 percent increase in the number of cases reported among African Americans in 2013 (154 cases in 2012 compared to 193 cases in 2013).

The highest chlamydia rate in North Dakota for 2013 was reported in African Americans at 1,472.3 per 100,000 (Figure 3). Among American Indians, North Dakota’s largest minority population, the rate was 1,419.0 per 100,000. In contrast, the rate among Whites in 2013 was 223.4 per 100,000.



The rate for all of North Dakota in 2013 was 407.3 per 100,000, compared to 433.25 per 100,000 in 2012. 2013 chlamydia rates indicate that minority populations continue to be disproportionately affected by STDs in North Dakota.

**Figure 3. Reported Chlamydia Rates by Race/Ethnicity, North Dakota, 2013**

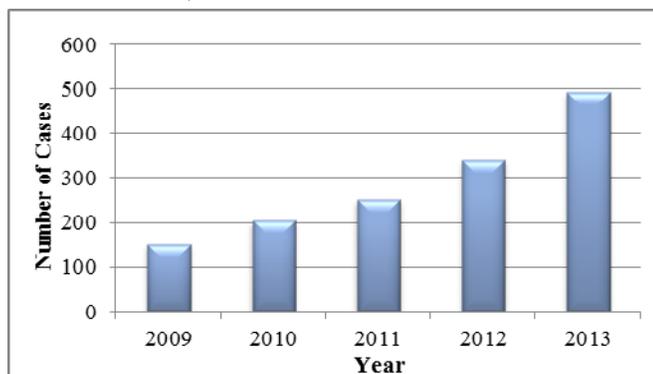


Counties reporting the highest chlamydia rates in North Dakota are: Sioux, Benson, Rolette and Mountrail counties with incidence rates of 1,534; 1,308; 1,200; and 735 per 100,000 population, respectively (**Map 1-Page 4**). These rates are higher than the rate of 407 per 100,000 for all of North Dakota.

**Gonorrhea**

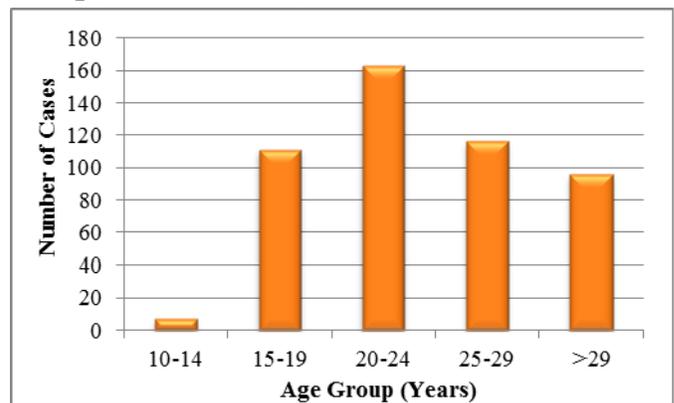
In 2013, 493 cases of gonorrhea were reported to the NDDoH, a 45 percent increase from the 340 cases reported in 2012 (**Figure 4**). Gonorrhea cases reported to the NDDoH have increased by over 340 percent over the past 10 years.

**Figure 4. Reported Gonorrhea Cases by Year, North Dakota, 2009-2013**



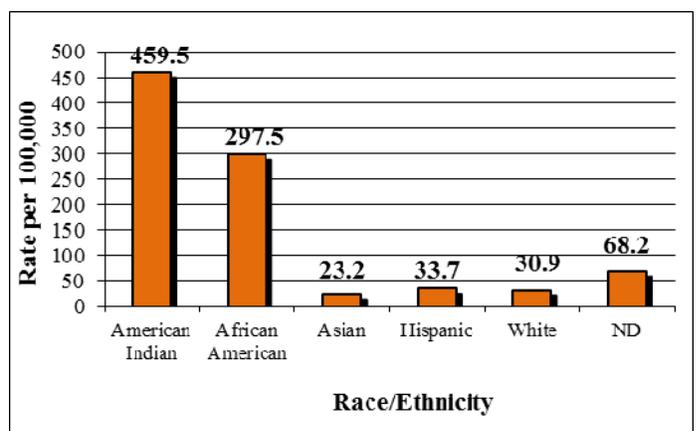
Of the reported gonorrhea cases, 301 (61%) occurred among females and 192 cases occurred among males. The majority of cases were reported among 20- to 29-year-olds. Individuals between 15 to 29 years accounted for 79 percent of gonorrhea cases reported in 2013 (**Figure 5**).

**Figure 5. Reported Gonorrhea Cases by Age Group, North Dakota, 2013**



The majority of gonorrhea cases were reported among Whites (200 cases), followed by American Indians (181 cases) and African Americans (39 cases). Fourteen percent of gonorrhea cases were reported with unknown race. As with chlamydia, gonorrhea rates continue to reflect disparity among North Dakota racial and ethnic groups. The gonorrhea rate for American Indians in 2013 was 459.5 per 100,000, and 297.5 per 100,000 for African Americans. In contrast, the rate among Whites in 2013 was 30.9 per 100,000, and the rate for all of North Dakota was 68.2 per 100,000. (**Figure 6**).

**Figure 6. Reported Gonorrhea Rates by Race Ethnicity, North Dakota, 2013**





In 2013, gonorrhea cases were reported from 32 counties compared to 30 counties in 2012 (**Map 2-Page 5**). Sioux County reported the highest gonorrhea rate, followed by Rolette and Benson counties with rates of 925.5, 473.2 and 363.2, per 100,000 populations, respectively. Five additional counties, Ramsey, Hettinger, McKenzie, Mountrail and Cass reported higher gonorrhea rates than the rate of 68.2 per 100,000 for North Dakota.

**Dual Therapy for Gonorrhea**

The Centers for Disease Control and Prevention (CDC) recommends the following treatment for gonorrhea:

- Ceftriaxone: 250 mg IM in a single dose
- AND**
- Azithromycin: 1 g orally in a single dose.

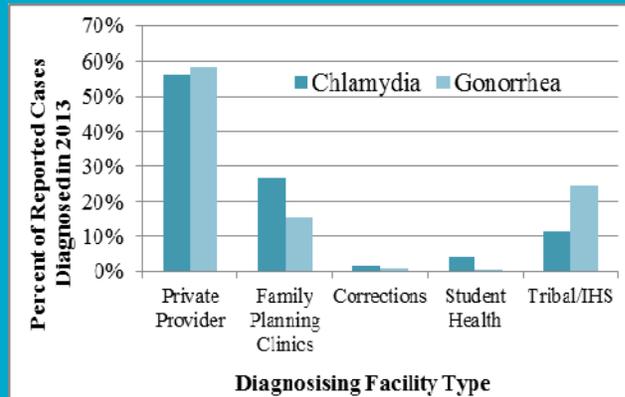
These two antibiotics are recommended to be given simultaneously or at a minimum on the same day. It is recommended to administer the injection of ceftriaxone and oral azithromycin to the patient in the clinic setting ensuring the proper administration of both antibiotics and compliance with the recommended regimen. If a written prescription is provided for azithromycin, please counsel the patient on the importance of taking the azithromycin as part of the treatment plan and educate the patient on taking the antibiotic as soon as possible.

The simultaneous treatment of gonorrhea with the two recommended antibiotics is important for ensuring patients are being treated appropriately. There is no guidance on the acceptable interval between administration of azithromycin 1 g and ceftriaxone 250mg. If there is not sufficient evidence that treatment with both medications have occurred within a 24 hour period, re-treatment should be considered. If re-treatment with the correct regimen in an appropriate timeframe does not occur, a test-of-cure can be performed 3 to 4 weeks after completing therapy.

**Facts About STDs in North Dakota**

The majority of chlamydia and gonorrhea infections are diagnosed at a private healthcare facility. (**Figure 7**).

**Figure 7. Diagnosing Facility Type of Chlamydia and Gonorrhea Cases in ND, 2013.**



Of those cases who were interviewed and responded to risk factor questions, 52 percent reported never or rarely using condoms, 30 percent report having sex while high or intoxicated and 23 percent reported having anonymous sex partners.

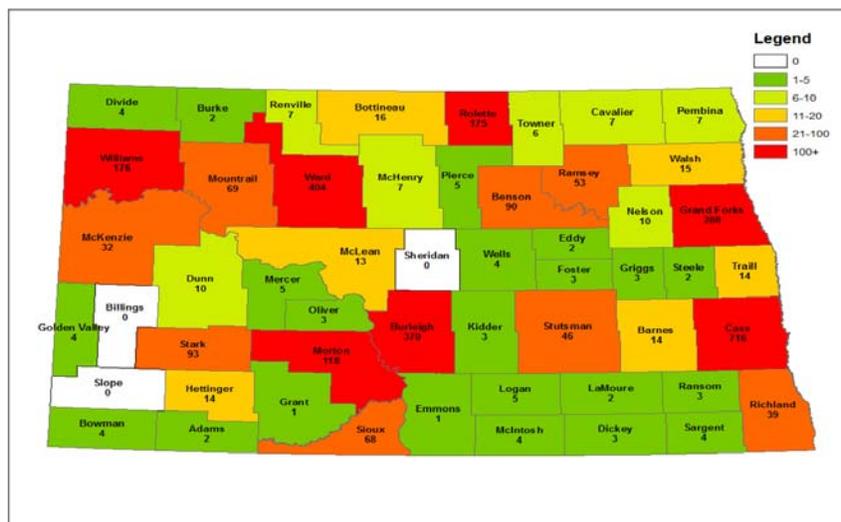
For cases with a known HIV testing status at time of chlamydia or gonorrhea diagnosis, only 70 and 80 percent of chlamydia and gonorrhea cases, respectively, were tested for HIV at time of diagnosis. It is recommended that all individuals testing positive for a STD are also tested for HIV.

Although the majority of chlamydia and gonorrhea cases are treated appropriately in North Dakota, 4 percent of chlamydia and 8 percent of gonorrhea cases were not treated or not treated appropriately in 2013.



<u>County</u>	<u>Chlamydia Cases, 2013</u>	<u>Chlamydia Rates, 2013</u>	<u>County</u>	<u>Chlamydia Cases, 2013</u>	<u>Chlamydia Rates, 2013</u>
Adams	1	42.68	McLean	15	167.37
Barnes	18	162.66	Mercer	12	142.45
Benson	82	1231.23	Morton	125	455.03
Billings	1	127.71	Mountrail	60	781.96
Bottineau	11	171.10	Nelson	6	191.94
Bowman	6	190.42	<b>North Dakota</b>	<b>2,914</b>	<b>433.25</b>
Burke	2	101.63	Oliver	3	162.51
Burleigh	382	469.82	Pembina	4	53.96
Cass	697	465.36	Pierce	5	114.76
Cavalier	0	0.00	Ramsey	43	375.51
Dickey	2	37.81	Ransom	6	109.95
Divide	7	338.00	Renville	8	323.89
Dunn	9	254.52	Richland	51	312.48
Eddy	3	125.79	Rolette	215	1542.66
Emmons	6	169.01	Sargent	5	130.58
Foster	1	29.91	Sheridan	2	151.40
Golden Valley	8	476.19	Sioux	55	1324.34
Grand Forks	294	439.72	Slope	0	0.00
Grant	1	41.77	Stark	79	326.46
Griggs	1	41.32	Steele	1	50.63
Hettinger	9	363.34	Stutsman	71	336.49
Kidder	3	123.20	Towner	2	89.05
LaMoure	4	96.64	Traill	13	160.08
Logan	3	150.75	Walsh	11	98.93
McHenry	20	370.71	Ward	358	580.46
McIntosh	2	71.20	Wells	5	118.85
McKenzie	31	487.42	Williams	155	692.03

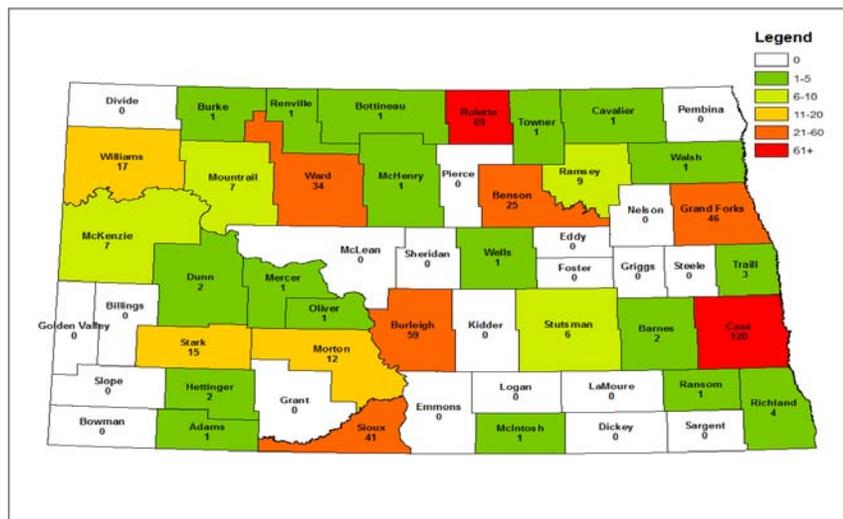
Map 1. North Dakota Chlamydia Cases by County, 2013





<u>County</u>	<u>Gonorrhea Cases, 2013</u>	<u>Gonorrhea Rates, 2013</u>	<u>County</u>	<u>Gonorrhea Cases, 2013</u>	<u>Gonorrhea Rates, 2013</u>
Adams	1	42.37	McLean	0	0.00
Barnes	2	17.87	Mercer	1	11.64
Benson	25	363.53	Morton	12	41.39
Billings	0	0.00	Mountrail	7	74.66
Bottineau	1	14.85	Nelson	0	0.00
Bowman	0	0.00	<b>North Dakota</b>	<b>493</b>	<b>68.15</b>
Burke	1	43.37	Oliver	1	53.36
Burleigh	59	66.70	Pembina	0	0.00
Cass	120	73.70	Pierce	0	0.00
Cavalier	1	25.67	Ramsey	9	77.90
Dickey	0	0.00	Ransom	1	18.13
Divide	0	0.00	Renville	1	38.34
Dunn	2	48.05	Richland	4	24.48
Eddy	0	0.00	Rolette	69	473.19
Emmons	0	0.00	Sargent	0	0.00
Foster	0	0.00	Sheridan	0	0.00
Golden Valley	0	0.00	Sioux	41	925.51
Grand Forks	46	66.49	Slope	0	0.00
Grant	0	0.00	Stark	15	53.17
Griggs	0	0.00	Steele	0	0.00
Hettinger	2	75.19	Stutsman	6	28.41
Kidder	0	0.00	Towner	1	43.16
LaMoure	0	0.00	Traill	3	36.39
Logan	0	0.00	Walsh	1	9.01
McHenry	1	16.89	Ward	34	50.01
McIntosh	1	36.31	Wells	1	23.78
McKenzie	7	75.16	Williams	17	57.44

Map 2. North Dakota Gonorrhea Cases by County, 2013

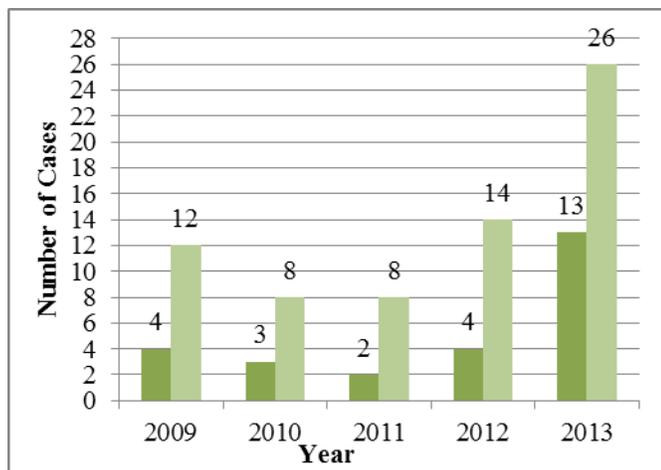




## Syphilis

In 2013, there was a significant increase in the number of syphilis cases reported in North Dakota (**Figure 10**). In 2013, 13 cases of primary or secondary (P/S) syphilis were reported to the NDDoH compared to four cases reported in 2012. Of the primary and secondary cases reported in North Dakota, 92 percent (12 cases) were reported in males. The median age was 27 years, age ranged from 19 to 53 years old. Of the male cases, 42 percent were reported in men who have sex with men. Most male cases who reported having sex with males also reported meeting partners on the internet or having anonymous sex partners.

**Figure 10. Reported Syphilis Case in North Dakota, 2013**



Thirteen additional cases of syphilis were reported to the NDDoH in 2013. Ten cases were diagnosed as late latent syphilis and three cases were diagnosed with early latent syphilis. The majority (54%) of the latent cases of syphilis were reported in females. Ages ranged from 20 to 55 with a median of 30 years. Of the six male latent cases, 3 (50%) reported having sex with men.

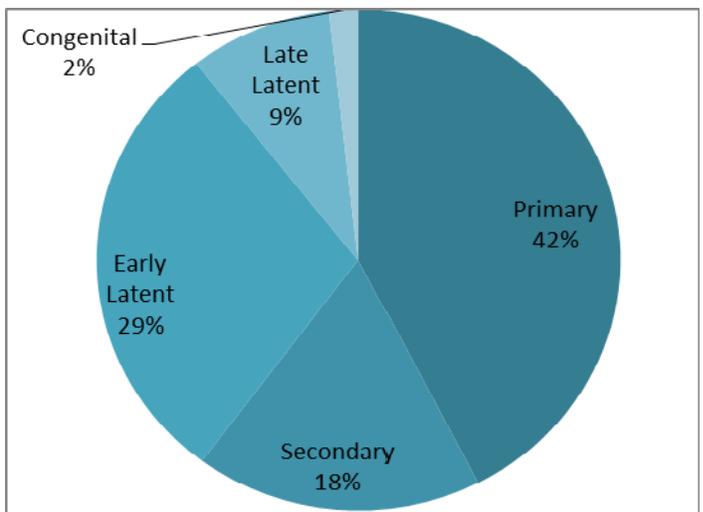
For all stages of syphilis reported in 2013, four were co-infected with HIV. In all stages of syphilis, 44 percent (8 cases) of males reported having sex with men. In the U.S., 75 percent of early syphilis cases are reported in men who have sex with men. Thirty percent of the syphilis cases in 2013 had a known history of chlamydia or gonorrhea infection.

Most commonly reported risk factors included having anonymous partners and having sex while high or intoxicated.

### **Multi-State Outbreak of Syphilis in 2013 and 2014**

North and South Dakota experienced a syphilis outbreak in 2013 that is still ongoing. The majority of cases in this outbreak occurred in the spring of 2014, peaking at 21 cases being reported in April 2014. A total of 113 cases have been reported in this outbreak since January 1, 2013. The majority of cases reported in this outbreak were diagnosed as the most infectious stages, primary and secondary syphilis (**Figure 11**).

**Figure 11. Multi-State Outbreak of Syphilis, Case by Stage; January 1, 2013 – December 10, 2014**



Traditionally, syphilis is more often seen in men who have sex with men. In this outbreak, 58 percent of cases were reported in females and none of the male cases reported having sex with males. Having sex with Multiple partners and while high or intoxicated were frequently reported risk factors in this outbreak investigation. Due to the increased number of syphilis cases seen among women and two congenital syphilis cases (both reported in South Dakota) occurring during this outbreak, the NDDoH reminds healthcare providers to screen high risk patients three times during pregnancy. Screening should occur at the first prenatal visit and during the third trimester (ideally at 28-32 weeks' gestation) and at delivery.



## **Viral Hepatitis Program Update**

Activities of the viral hepatitis program include testing at-risk individuals for hepatitis C (HCV), vaccinating at-risk individuals for hepatitis A (HAV)/hepatitis B (HBV), providing educational materials for the general public and for health-care providers, organizing and hosting an HIV/hepatitis conference for health-care providers, developing and implementing a statewide media campaign to increase awareness about viral hepatitis; and contracting with local public health units (LPHUs) to provide the above-mentioned viral hepatitis services. Currently the NDDoH has contracted with 11 HCV counseling, testing and referral (CTR) sites to implement HCV testing and HBV/HAV vaccination using state funds. CTR sites offering HCV testing and HBV/HAV vaccination are included in Box 1.

**Box 1. Hepatitis C Testing Sites,  
North Dakota**

Bismarck/Burleigh Public Health  
 Central Valley Health Unit  
 Community Action - Dickinson  
 Custer Family Planning  
 Custer Health  
 Fargo Cass Public Health  
 First District Health Unit  
 Grand Forks Public Health Dept.  
 Richland County Health Dept.  
 Southwestern District Health Unit  
 Upper Missouri District Health

Due to the availability of rapid hepatitis C CTR sites in 2013, there was a significant increase in the number of individuals tested at CTRs in 2013. Between Jan. 1 and September 30, 2013, 365 individuals were screened and 26 (7%) were positive, compared to 960 individuals screened and 72 (7%) testing positive during the same time period last year. From 2013 to 2014, there was a 163 percent increase in the number of individuals screened for hepatitis C at CTR sites. The increase in testing was due to the availability of rapid testing at all CTR sites in 2014.

Hepatitis A and B vaccine is offered at many CTR sites to individuals at-risk for hepatitis C.

Many individuals seeking services at CTR sites have already been vaccinated for hepatitis A or B and thus do not need to be vaccinated. For those who are unvaccinated single hepatitis B vaccine and combination vaccine, Twinrix® may be available. Between Jan. 1 and September 30, 2014, a total of 54 doses of hepatitis A and B vaccine were administered at the CTRs, compared to 44 doses administered during the same time period in 2013.

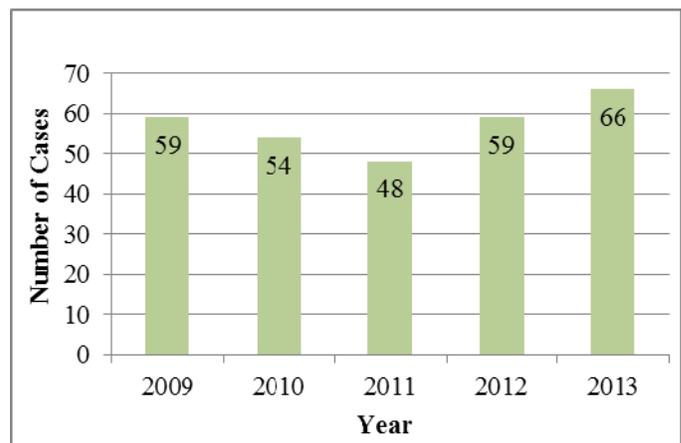
### **Hepatitis A Virus (HAV)**

Historically, North Dakota has had relatively low rates of HAV infection. From 2009 to 2013, 17 cases of acute HAV infection were reported to the NDDoH.

### **Hepatitis B Virus (HBV)**

In 2013, 66 cases of chronic HBV infection a 12 percent increase from the 59 cases reported in 2012 (**Figure 12**). There have been no reported acute hepatitis B cases reported in North Dakota in the past five years. Morbidity is based on reported positive laboratory results meeting the CDC case definition of “hepatitis B virus infection, chronic.” Numbers include both confirmed and probable cases.

**Figure 12. Reported Chronic HBV Cases by Year, North Dakota, 2009-2013.**

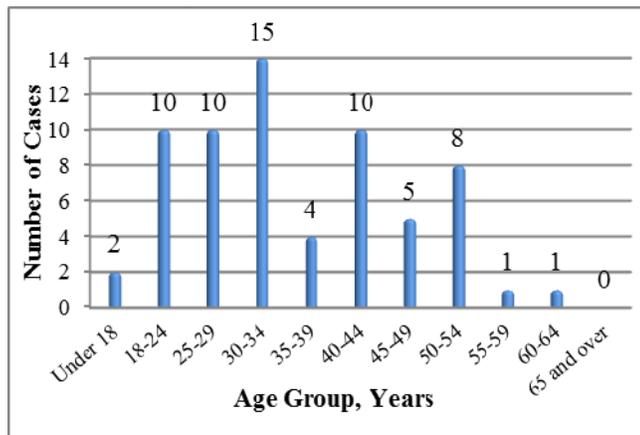


Of the 66 HBV-positive people reported to the NDDoH, 62 percent were female. Fifty-nine percent of reported cases occurred among people between the ages of 20 and 39, and the median age was 33 (range: 11 to 60 years) (**Figure 13-Page 8**).



Race information was reported for only 50 percent of cases. Among those reporting race, 52 percent were African American, 18 percent were White and 18 percent were Asian. Thirty-two percent of hepatitis B cases reported in North Dakota are refugees or individuals born in countries outside the United States that have intermediate or high rates of endemic hepatitis B infection.

**Figure 13. Reported HBV Cases by Age Group, North Dakota, 2013**



**Perinatal Hepatitis B**

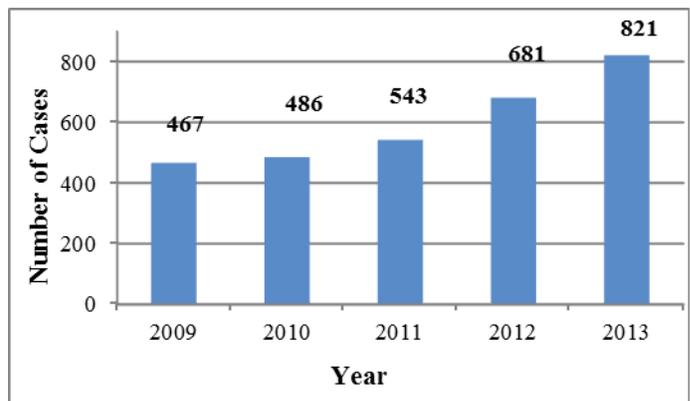
Perinatal hepatitis B surveillance and reporting are vital to the health of North Dakota infants. Screening all pregnant women for the presence of hepatitis B surface antigen (HBsAg) is a crucial step in controlling and preventing the spread of hepatitis B from mother to infant. However, documented HBsAg-positive mothers often are not screened, especially during later pregnancies, and are therefore not reported to the NDDoH. As a result, many at-risk infants may be missed. Prior to birth, the NDDoH ensures that the delivery hospital has both vaccine and hepatitis B immune globulin (HBIG) on hand, as both should be administered within 12 hours of birth. Infants born to HBsAg-positive mothers are provided both vaccine and HBIG at no charge. In 2008, the NDDoH added pregnancy in women with HBV infection to the mandatory reportable conditions list in order to ensure that all HBV-positive pregnant women are reported to the NDDoH regardless if they were tested during current pregnancy.

Follow-up of HBsAg-positive mothers, infants and other susceptible sexual or household contacts is done to ensure that the infant and contacts receive three doses of the vaccine, that the vaccine is administered appropriately and that the infant receives follow-up testing for hepatitis B antibody levels. Susceptible contacts are screened and offered vaccine at no charge. Between Jan.1 and Sept. 30, 2014, 16 births to HBsAg-positive pregnant women were reported to the NDDoH; 14 births were reported during the same time frame in 2013.

**Hepatitis C Virus (HCV)**

In 2012, the NDDoH received 824 reports of people newly identified as having a positive laboratory result that indicates past or present hepatitis C virus (HCV) infection, a 21 percent increase from the 681 cases reported in 2012 (Figure 14). Of the 824 cases reported in 2013, three were reported as acute hepatitis C infections.

**Figure 14. Reported HCV Cases by Year, North Dakota, 2009-2013**



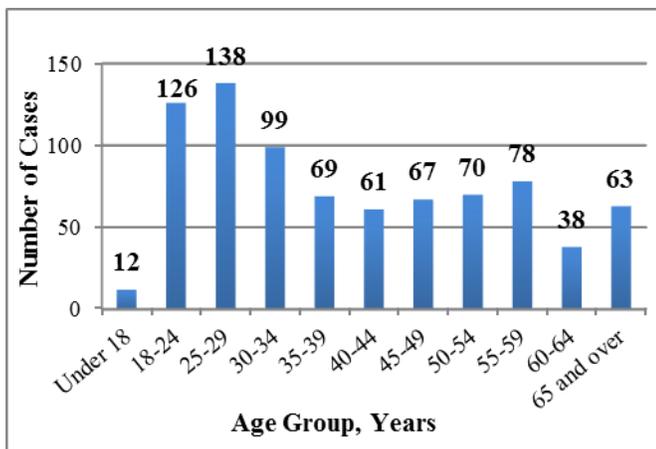
HCV morbidity primarily is based on positive lab results received from laboratories that meet the CDC case definition of “hepatitis C virus infection, past or present.” Numbers do not distinguish between resolved versus active infections. Hepatitis C infections in North Dakota are predominantly being diagnosed in young individuals (Figure15-Page 9). Among 50 percent of cases reported in 2013 were among individuals less than 35 years of age. Nationally, acute hepatitis C outbreaks are being reported across the country in persons aged 20 -29 years. These outbreaks of acute hepatitis C are primarily being seen in persons who inject drugs.



This emerging U.S. Epidemic of hepatitis C infections is mostly occurring among young nonurban person of predominantly white race. In North Dakota, risk factors are not reported on identified cases, but injection drug use is likely a risk factor for acquiring hepatitis C in North Dakota. More information on the emerging epidemic of HCV infection among young persons who inject drugs can be found at: [www.cdc.gov/hepatitis/Outbreaks/YoungPWID.htm](http://www.cdc.gov/hepatitis/Outbreaks/YoungPWID.htm).

141 per 100,000, respectively. Rates in Hettinger and Burleigh counties reflect high proportion of cases diagnosed at the correctional facilities in those counties.

**Figure 15. Reported HCV by Age Group, North Dakota, 2013**



Of the 821 HCV-positive reports, 54 percent were male. Due to limited follow-up conducted on hepatitis C cases in North Dakota, 64 percent of cases were reported with an unknown race in 2013. Among cases with a reported race, 60 percent were White and 36 percent were American Indian and 3 percent were African American.

The majority, 50 percent, of all hepatitis C cases are diagnosed in clinic or hospital settings. Other settings in which hepatitis C cases were diagnosed in for 2013 include correctional facilities (16%), tribal or Indian Health Service facilities (16%) and hepatitis counseling, testing and referral sites (6%).

Twelve counties in 2013 reported higher rates of hepatitis C infection compared to the overall rate reported for North Dakota (122 per 100,000). These counties include Hettinger, Benson, Mountrail, Rolette, Sioux, McKenzie, Mercer, Burleigh, Williams, Ward, Ramsey and Dunn with rates of 888, 601, 573, 495, 385, 299, 226, 202, 183, 172, 149, and

**NEW! - Hepatitis C RNA Testing at North Dakota Public Health Laboratory**

Qualitative Hepatitis C RNA testing is now being offered at the North Dakota Public Health Laboratory. Qualitative hepatitis C RNA testing aids in determining if the patient has a current or past hepatitis C infection.

This qualitative test will be performed on all specimens that test positive for hepatitis C antibody. At this time, there will be no additional charge for the hepatitis C RNA Test.

For instructions on proper specimen collection and storage, please contact the Division of Laboratory Services at 701.328.6272.

**HIV/STD/TB/Hepatitis Programs**

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# HIV Biannual Update

By Dee Pritchet, Surveillance Epidemiologist

Table 1 summarizes newly diagnosed HIV/AIDS cases reported from Jan. 1 through June 30, 2013, and compares the data to the same period in 2012.

The table also provides a summary about residents of North Dakota diagnosed with HIV or AIDS and known to be living as of October 31, 2013.

**Table 1. New HIV/AIDS Diagnoses and Total HIV/AIDS Cases Living in North Dakota**

Diagnosis	New HIV/AIDS cases <sup>1</sup>				Total HIV/AIDS Cases Living in N.D. <sup>2</sup>	
	Jan. - June 2014		Jan. - June 2013		Number	Percent*
	Number	Percent*	Number	Percent*		
<b>AIDS</b>	3	20%	7	44%	135	37%
<b>HIV</b>	12	80%	9	56%	228	63%
<b>Race/Ethnicity</b>						
American Indian	0	0%	1	6%	25	7%
African American	10	67%	7	44%	107	29%
Hispanic (all races)	0	0%	1	6%	22	6%
Asian/Pacific Islander	0	0%	2	13%	7	2%
White	5	33%	5	31%	198	54%
More than one	0	0%	0	0%	5	1%
<b>Gender</b>						
Male	12	80%	11	69%	270	74%
Female	3	20%	5	31%	94	26%
<b>Risk</b>						
Heterosexual contact	5	33%	8	50%	127	35%
Injecting drug use (IDU)	0	0%	0	0%	22	6%
Male-to-male sexual contact (MSM)	8	53%	7	44%	162	45%
MSM/IDU	0	0%	1	6%	19	5%
Perinatal transmission	0	0%	0	0%	1	0%
Adult Hemophilia/coagulation disorder	0	0%	0	0%	0	0%
Other	0	0%	0	0%	8	2%
Risk not specified	2	13%	0	0%	25	7%
<b>Age Group</b>						
≤15	1	7%	1	6%	7	2%
15-24	4	27%	4	25%	36	10%
25-34	2	13%	7	44%	106	29%
35-44	4	27%	4	25%	123	34%
45-54	4	27%	0	0%	70	19%
55-64	0	0%	0	0%	21	6%
65+	0	0%	0	0%	1	0%
<b>Total</b>	<b>15</b>		<b>16</b>		<b>364</b>	

\*Due to rounding, totals may not equal 100%.

<sup>1</sup>New HIV/AIDS cases reflects HIV cases that were newly diagnosed in North Dakota during the listed time period. These cases include those which are classified as AIDS cases at initial diagnosis.

<sup>2</sup>Total HIV/AIDS cases living in ND reflect HIV/AIDS cases which were alive and residing in North Dakota as of October 31, 2014.



Summary of Selected Reportable Conditions				
North Dakota, 2013-2014				
Reportable Condition	July-Sept. 2014*	January -Sept. 2014*	July-Sept. 2013	January -Sept. 2013
Campylobacteriosis	43	102	39	108
Chickenpox	5	14	8	24
Chlamydia	902	2593	805	2190
Cryptosporidiosis	75	91	39	61
E. coli, shiga toxin positive (non-O157)	1	8	11	24
E. coli O157:H7	2	8	6	12
Enterococcus, Vancomycin-resistant (VRE)	32	101	80	357
Giardiasis	11	32	19	35
Gonorrhea	167	484	137	362
Haemophilus influenzae (invasive)	2	6	2	7
Acute Hepatitis A	2	5	4	6
Acute Hepatitis B	0	0	0	0
Acute Hepatitis C	0	0	1	3
HIV/AIDS <sup>1</sup>	20	60	15	41
Influenza	15	2161	1	3213
Legionellosis	1	4	2	2
Listeria	1	1	0	0
Lyme Disease	6	12	24	27
Malaria	3	6	1	3
Meningococcal disease <sup>2</sup>	1	2	1	3
Mumps	0	0	0	3
Pertussis	10	31	29	67
Q fever	0	2	0	0
Rabies (animal)	5	15	9	34
Rocky Mountain spotted fever	1	3	0	2
Salmonellosis	30	70	36	88
Shigellosis	4	18	4	13
Staphylococcus aureus, Methicillin-resistant (MRSA)	29	93	30	84
Streptococcal pneumoniae <sup>3</sup> , (invasive, children < 5 years of age)	17	63	15	83
Syphilis, Primary and Secondary	1	10	2	12
Trichinosis	0	0	0	0
Tuberculosis	6	8	3	10
Tularemia	0	3	0	0
Typhoid fever	0	0	0	0
West Nile Virus Infection	24	24	125	125

\*Provisional data

<sup>1</sup> Includes newly diagnosed cases and cases diagnosed previously in other states that moved to North Dakota.

<sup>2</sup> Includes confirmed, probable and suspect meningococcal meningitis cases.

<sup>3</sup> Includes invasive infections caused by streptococcal disease not including those classified as meningitis.