

Top 10 Communicable Diseases Report Utah, 2016



The Utah Department of Health (UDOH) monitors more than 75 communicable diseases in the state. The list below shows the 10 most common communicable diseases reported to public health authorities. Many cases of disease go undiagnosed and unreported; therefore, the numbers shown are most likely lower than what occurred in the community.

Top 10 Reported Communicable Diseases in Utah, 2016, Cases and Rates

Disease	2016 Count [*]	2015 Count [*]	2016 Rate [†]	Change in Rates	P-value [^]
Chlamydia	9,458	8,616	310.1	↑	< 0.0001
Hepatitis C, chronic	2,288	1,890	75	↑	< 0.0001
Gonorrhea	2,099	1,560	68.8	↑	< 0.0001
Influenza-associated hospitalization	1,652	588	54.2	↑	< 0.0001
Campylobacteriosis	503	437	16.5	↑	= 0.0601
Salmonellosis	333	460	10.9	↓	< 0.0001
Hepatitis B, chronic	315	307	10.3	↑	= 0.9215
Streptococcal disease, invasive, other	287	368	9.4	↓	= 0.0007
Pertussis	268	504	8.8	↓	< 0.0001
Streptococcus pneumoniae, invasive disease	243	191	8	↑	= 0.0209

Highlights

Chlamydia is a sexually transmitted infection that continued to increase in Utah in 2016 with 9,458 cases reported, compared to 8,616 in 2015. The rate increased from 287.6 cases per 100,000 person/year in 2015 to 310.1 cases per 100,000 person/year in 2016[□]. This sexually transmitted infection continues to be the most frequently reported communicable disease both nationally and in Utah. Chlamydia primarily affects younger populations, and the majority of infected individuals experience no signs or symptoms. Testing is the only way to know if a person is infected. Untreated chlamydia can lead to infertility.

Gonorrhea is a sexually transmitted infection that has increased every year in Utah since 2011. In 2016, 2,099 cases were reported, compared to 1,560 in 2015. The 2016 rate of gonorrhea increased 32.2% from 2015, resulting in a rate of 68.8 per 100,000 person/year[□]. Gonorrhea infections are commonly asymptomatic, and re-infection after treatment is possible. UDOH and Utah's local health departments (LHDs) are closely monitoring the increase. LHD Disease Intervention Specialists (DIS) investigate all reported cases of gonorrhea, ensure appropriate treatment, and provide partner services. In 2016, 92% of gonorrhea cases were appropriately treated, largely due to their efforts.

Influenza-associated Hospitalizations are reportable in Utah; a confirmed case is defined as anyone that is hospitalized, for any length of time, who has an associated positive influenza diagnostic test. Influenza hospitalization surveillance allows public health to better understand the specific population in Utah who are at increased risk for influenza, and guides prevention messages and interventions. Influenza is best assessed seasonally; a typical influenza season begins in October, and continues to the following May. Therefore, comparing the cases between MMWR year 2015 (n=588) and MMWR year 2016 (n=1,652) is not as meaningful as comparing the number of cases from the 2015-16 influenza season (n=1,193) and 2016-17 influenza season (n=1,404). Contributing factors for the severity of the influenza season are the predominant influenza strain(s) circulating, the uptake of influenza vaccines and how effective the available vaccines are against circulating strains; these factors change each year. Influenza A H3N2-predominant seasons (i.e., 2016-17 season) have been associated with more severe illness relative to influenza A H1N1-predominant seasons (i.e., 2015-16).

[□]Increases in reported cases may result from increases in testing and/or reporting as well as actual increases in rates of disease.

^{*}Utah case counts for 2016 are provisional and subject to change. Case counts are determined using print criteria outlined in the CDC National Notifiable Diseases Event Code List.

[†]Rates are calculated per 100,000 population. Population estimates can be found at: <http://quickfacts.census.gov/qfd/states/49000.html>.

[^]P-value < 0.05 is generally considered as statistically significant; it is calculated from Chi-Square test to determine whether the differences in case counts between 2015 and 2016 after adjusting for population increases are statistically significant. For example, the increase in cases for Campylobacteriosis from 2015 to 2016 (437 vs. 503) is not statistically significant after adjusting for population increase based on the Chi-square test.