

## MANDATORY REPORTING AND NOTIFICATION

*New law, new regulations, new obligations...*

### Physicians are still indispensable sentinels for public health

**Since the promulgation of the Public Health Act and its regulations, physicians are responsible not only for reporting certain diseases, infections, and intoxications but are also required to report health threats.**

#### Report as soon as you observe characteristic clinical signs

To reduce the risk of transmission, physicians must report any possibility that a patient has a reportable disease as soon as they observe clinical signs characteristic of the disease.

The earlier the Public Health Department receives a report, the faster epidemiological measures can be undertaken.

The new Public Health Act is more specific than the Public Health Protection Act, which it replaced. Previously, physicians were obliged to report cases "of which they were aware". This wording could have been interpreted to mean that physicians could wait until they were certain of the nature of a case by watching its clinical evolution before reporting it. The Act could have also been understood to mean that the laboratory would send in the report before a physician received the results confirming a diagnosis.

Article 82 of the Public Health Act now clearly enjoins physicians to report **as soon as characteristic clinical signs are observed.**

#### **Art 82.** "Persons required to report [...]"

1) any physician who diagnoses an intoxication, infection or disease included in the list or who observes the presence of clinical manifestations characteristic of any of those intoxications, infections or diseases in a living or deceased person; [...]"

#### Reporting threats to public health: legal obligations

Last year's SARS threat was a cruel reminder that agents that cause reportable diseases are not the only ones that can threaten public health.

Vigilance is vital to counter the epidemic emergence of new contagious diseases, poisonings caused by toxic chemical products, or the damaging effects of physical agents.

#### *Physicians' obligations*

Physicians are sentinels who see the very first signs of an outbreak of an infectious disease or an intoxication, whatever the cause and regardless of whether it is reportable by law or not.

When a physician notices a cluster of cases of an uncommon syndrome or an unusual number of cases of a known syndrome and he or she suspects these cases might be linked to a common source, the physician is legally bound to report this to the Public Health Department. (Art. 93)

#### *The obligations of health institutions*

Whether or not they are physicians, the people in charge of health and social services institutions have the same obligations within their facilities. (Art. 93)

#### *The legal power of institutions and all health professionals*

The directors of certain institutions as well as health professionals practising in such institutions may also report. (Art. 94)

#### *Public Health Act*

"Art. 2. [...] In this Act, a threat to the health of the population means the presence within the population of a biological, chemical or physical agent that may cause an epidemic if it is not controlled."

"Art. 93. Any physician who suspects the presence of a threat to the health of the population must notify the appropriate public health director.

Health and social services institutions must report to the appropriate public health director any situation where they believe on reasonable grounds that there exists a threat to the health of the persons who are present in their facilities."

"Art. 94. The directors of institutions or establishments constituting work environments or living environments, such as a business establishment, an educational institution, a childcare centre and other childcare facilities, a house of detention and transition housing may report to the appropriate public health director any situation which they have cause to believe constitutes a threat to the health of the persons who are present in those places. A health professional practising in such an institution or establishment may also report such a situation to the public health director."

**Rapid and complete reporting of a contagious disease or chemical contamination allows the Public Health Department to deploy the epidemiological measures needed to identify the source, break the chain of disease transmission, and perhaps even save lives. Conversely, if reports are not filed, are delayed, or do not include all the information requested, dozens of people could be infected, become contagious, asymptomatic or sick, or require treatment or hospitalisation. Some may even die. For people who were or could have been in contact with a contagious person or source of contamination, delayed reporting is risky... and eventually risky for others around them.**

## Reporting is mandatory and easy

Physicians, directors of departments of medical biology and directors of laboratories all share the duty of notifying the director of public health of certain infectious diseases and biological or chemical intoxications that must be reported, as stated in the Public Health Act (R.S.Q., chapter S-2.2) and its regulations.

### *By telephone, mail, fax and email*

Reports can be sent in by telephone, mail, fax or encrypted email. What is important is to report cases as quickly as possible. The forms of the ministère de la Santé et des Services sociaux can be used, as can other forms (photocopies of computer forms from the laboratory or clinic, etc.), as long as all the information required on the Ministère's form is included. For security reasons related to confidentiality, only members of the Réseau de telecommunications sociosanitaires (RTSS) are authorised to transmit reports by e-mail. When faxing reports, the risks of dialling a wrong number can be eliminated if the fax number is entered into the machine's memory

### *Completely*

It is important that all the information required by the Regulation be provided so that Public Health can intervene rapidly and compile valid data. If any information is missing, we have to contact the physician by telephone. When you take the time to file a complete report, you help save your time and ours.

### *Quickly*

The time limit for effective action with a patient's contacts or community is short. In fact, it is shorter than the disease's incubation period. Although intervention is usually less effective beyond this time period, it is still important that you send in the forms. It is essential to report quickly. The 48-hour grace period (except for diseases under extreme surveillance, to be reported immediately) represents the outside legal limit; it is better to report right away.

### *Confidentially*

The only people who know the names of the individual about whom the report is filed are the data entry clerk and the physician or nurse who is following up on the case. These people have signed oaths of confidentiality. Moreover, all data entry, computer analysis, and archiving procedures conform strictly to the rules of the Access to Information Commission (AIC) and the Public Health Act.

### *Report without disclosing confidential information*

"Art. 95. Reporting a situation [...] does not authorize the person making the report to disclose personal or confidential information unless, after evaluating the situation, the public health authority concerned requires such information in the exercise of the powers provided for [...]"

### *Collaborate with the epidemiological investigation*

The conscientious collaboration of physicians and other health professionals is vital to the epidemiological investigation conducted by public health following a report or notification.

In the past, the information you were asked to provide might have been somewhat puzzling. The new Act is very clear: "A public health director may [...] order any person [...] to immediately communicate [...] any document or any information [...], even if the information is personal information or the document or information is confidential;" (Art. 100, 8). Moreover, public health must follow the rules related to the respect individuals and of confidentiality.

### *Reporting unusual clinical manifestations following vaccination: physicians' and nurses' duty*

"(Art. 69). Any physician or nurse who observes an unusual clinical manifestation [...] in a person having received a vaccine or a contact of that person [...] must report the situation to the appropriate public health director as soon as possible." Forms for this purpose are available from public health departments and in the appendix of the Quebec Immunization Protocol, available on the Ministère's Web site at [www.msss.gouv.qc.ca](http://www.msss.gouv.qc.ca). Go to [santé publique/vaccination](http://santé publique/vaccination).

## What's new in the Regulation

### *Changes in the list of notifiable infectious diseases*

Fourteen microbial infections and diseases have been added to the list while four others have been removed. The reporting method has been altered for a number of diseases and infections that were already reportable. The Table on the following page describes these changes.

The list of diseases and chemical or physical intoxications has been completely revised. See page 4.

### *A new form*

To speed up epidemiological investigations, the patient's health insurance number, date on which a laboratory specimen was taken and the name of the laboratory where the specimen was sent are now required, in addition to the patient's name and address. Answers to questions about giving or receiving blood, blood products, organs or tissues should only be provided for cases of the bloodborne diseases identified on the list with an asterisk (\*). The form is available from public health departments and the Ministère's Web site:

<http://www.msss.gouv.qc.ca/sujets/santepub/mado.html>.

### *Diseases also reportable by laboratories*

When a disease must be reported by the physician and the laboratory, both are required to report it. The obligation of one does not preclude the duty of the other, especially since different information is requested from both.

### *Escherichia coli O157: H7 (E. coli) infections*

Not only do E. coli O157: H7 enteric infections, or infections of any verocytotoxin-producing strain, con-

tinue to be diseases that must be reported by laboratories but the complications associated with these infections (haemolytic-uremic syndrome and thrombotic thrombocytopenic purpura) now have to be reported by physicians who know of such cases.

### *Nominal reporting for STI*

All sexually transmitted infections must be reported the same way and with the same form as other reportable diseases. Although they are no longer on the list of diseases for which treatment is compulsory, the programme providing free medication for their treatment is still in force.

### *HIV and AIDS are not reportable, unless you know or learn that ...*

Physicians do not have to report HIV infection and AIDS to the Public Health Department **unless they know or learn from the patient that he or she has given or received blood or blood products, organs or tissues**. A physician should question a patient about this issue while taking the medical history when HIV is suspected or when giving a diagnosis. Physicians should not report this condition unless a patient responds positively to these questions.

In addition, epidemiological information about HIV infection is collected: a nurse assigned to this task at the Laboratoire de santé publique du Québec undertakes this process, which is done exclusively over the telephone in a conversation between the nurse and the physician who ordered the HIV test that turned out to be positive. Likewise, the physician who has diagnosed an AIDS-defining illness is required to collect epidemiological information on the AIDS case using the SP-100 form available from the Ministère at 514 873-9997 (fax) or on the Web site at:

[www.msss.gouv.qc.ca/sujets/santepub/mado.html](http://www.msss.gouv.qc.ca/sujets/santepub/mado.html)

## Changes to the list of reportable infectious diseases

Diseases	Comments	Reported by
<ul style="list-style-type: none"> <li>Babesiosis</li> <li>Chagas disease</li> </ul>	<ul style="list-style-type: none"> <li>- Added because of potential transmission through blood and its derivatives.</li> <li>- Extremely rare parasitosis.</li> </ul>	Physicians and laboratories
<ul style="list-style-type: none"> <li>Creutzfeldt-Jakob disease and its variants</li> </ul>	<ul style="list-style-type: none"> <li>- Prion disease.</li> <li>- Added because of potential transmission through blood and its derivatives.</li> </ul>	Physicians
<ul style="list-style-type: none"> <li>Type I or II HTLV infection</li> </ul>	<ul style="list-style-type: none"> <li>- Viral infection.</li> <li>- Added because of potential transmission through blood and its derivatives.</li> </ul>	Laboratories
<ul style="list-style-type: none"> <li>West Nile Virus (WNV)</li> <li>Hantavirus infection</li> <li>Lyme disease</li> </ul>	<ul style="list-style-type: none"> <li>- Vector-borne zoonoses and infections.</li> <li>- Additions.</li> </ul>	Physicians and laboratories
<ul style="list-style-type: none"> <li>Leptospirosis</li> </ul>	<ul style="list-style-type: none"> <li>- Vector-borne zoonoses</li> <li>- Addition.</li> </ul>	Laboratories
<ul style="list-style-type: none"> <li>Cryptosporidiosis</li> <li>Cyclosporiasis</li> <li>Listeriosis</li> </ul>	<ul style="list-style-type: none"> <li>- Infections and food poisonings transmitted through water and food.</li> <li>- Additions.</li> </ul>	Laboratories
<ul style="list-style-type: none"> <li>Acute flaccid paralysis</li> </ul>	<ul style="list-style-type: none"> <li>- Disease of multiple aetiology (Guillain-Barré, transverse myelitis, WNV infection).</li> <li>- Addition required by WHO for poliomyelitis surveillance.</li> </ul>	Physicians
<ul style="list-style-type: none"> <li>Vancomycin-resistant enterococcus (VRE) outbreak</li> <li>Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) outbreak</li> </ul>	<ul style="list-style-type: none"> <li>- Emerging infections</li> <li>- Additions.</li> </ul>	Physicians
<ul style="list-style-type: none"> <li>Severe acute respiratory syndrome (SARS)</li> </ul>	<ul style="list-style-type: none"> <li>- Emerging viral disease.</li> <li>- Addition</li> </ul>	Physicians and laboratories
<ul style="list-style-type: none"> <li>Vancomycin-resistant <i>Staphylococcus aureus</i> (VRSA)</li> </ul>	<ul style="list-style-type: none"> <li>- Emerging infection.</li> <li>- Addition.</li> </ul>	Laboratories
<ul style="list-style-type: none"> <li>Verocytotoxin-producing <i>Escherichia coli</i> infection</li> </ul>	<ul style="list-style-type: none"> <li>- Modified nosological definition.</li> <li>- Enteric infections caused by <i>E. coli</i> O157: H7 or any other verocytotoxin-producing strain.</li> </ul>	Laboratories
<ul style="list-style-type: none"> <li><i>Escherichia coli</i> invasive infection</li> </ul>	<ul style="list-style-type: none"> <li>- Modified nosological definition.</li> <li>- Only reports of invasive enteric infections complicated by hemolytic uremic syndrome or thrombotic thrombocytopenic purpura are appropriate according to nosological definitions.</li> </ul>	Physicians and laboratories
<ul style="list-style-type: none"> <li><i>Chlamydia trachomatis</i> infection</li> <li>Syphilis</li> <li>Gonococcal infection</li> <li>Lymphogranuloma venereum</li> <li>Chancroid</li> <li>Granuloma inguinale</li> </ul>	<ul style="list-style-type: none"> <li>- Wording modified.</li> <li>- From now on, all STI are reported nominally.</li> <li>- Patients still eligible for the free medications programme.</li> </ul>	Physicians and laboratories
<ul style="list-style-type: none"> <li>HIV infection</li> <li>AIDS</li> </ul>	<ul style="list-style-type: none"> <li>- Wording modified.</li> <li>- Not diseases that must be reported to public health by the physician unless the patient has given or received blood or blood products, organs or tissues</li> <li>- Epidemiological information must be collected as per statutory regulations.</li> </ul>	
<ul style="list-style-type: none"> <li>Scarlet fever</li> <li>Neonatal herpes</li> <li>Group B streptococcal infection</li> <li>Enterovirus meningitis</li> </ul>	<ul style="list-style-type: none"> <li>- Removed.</li> <li>- Did not meet the criteria for inclusion on the list.</li> </ul>	

## Do it yourself ... or ask someone else

You don't have the time to fill in the form? Then get someone else to do it.

Some of your colleagues have tried this approach and found that it works well. They ask their secretary or laboratory technician to fill in the form or to call, if it is urgent.

The form must be signed by the physician.

## Your reports are available internationally



When you report an infectious disease you are also contributing information to an international infectious disease monitoring network that provides information not only to your colleagues on the Island of Montréal, but also to those in the rest of the province, in Canada, and around the world. Information on the incidence of infectious diseases or on the characteristics of cases (age, sex, health and social service region, and sometimes source of contamination or specific risk factor) can result in all our colleagues paying particular attention to their patients who have similar characteristics. Consequently, the international network can send out a call for vigilance and find sources of contamination.

Data from which personal information has been removed are forwarded daily to a provincial register, allowing constant provincial monitoring. Some data are also communicated to federal authorities, who then transmit them to international bodies.

## Legal obligations, civil and professional responsibilities

Reporting notifiable diseases (Art. 82, PHA) and unusual clinical manifestations (Art. 69, PHA) are part of the medical act and legal obligations, not just other annoying administrative tasks.

A physician is also obliged to report to the local public health department any person who has tuberculosis (the only disease in Quebec for which treatment is mandatory) and who is not collaborating in or refusing medical treatment (Art. 86, PHA).

A health professional who fails to make a report is liable to a fine of \$600 or \$1200 (Art. 138, PHA). In the case of a second or subsequent offence, the minimum and maximum fines are doubled (Art. 142, PHA).

Such an infraction may lead to civil action.

Moreover, the duty to report is also included in article 40 of the Quebec Code of Ethics of Physicians:

"A physician who has reason to believe that the health of the population or of a group of individuals is threatened must notify the appropriate public health authorities."

# Reportable diseases and intoxications caused by chemical agents

The ministerial Regulation under the Public Health Act adopted in November 2003 sets out a new list of reportable diseases and chemical intoxications (MADO). While in the previous Regulation under the Public Health Protection Act chemical agents causing intoxications were reportable, the new Regulation now identifies pathologies: reportable diseases and intoxications caused by chemical agents.

## Diseases related to exposure to a chemical substance

There are 10 reportable diseases on the new list: cancers, pneumoconioses and other pneumopathies. Most are pulmonary diseases but angiosarcoma of the liver and certain mesotheliomas are also included. They can be caused by occupational or environmental exposure and can be prevented. These diseases meet the criteria for inclusion on the list of reportable diseases despite the long latency period between exposure and appearance of some of these diseases.

## Intoxications related to exposure to a chemical substance

Also on the new list are intoxications caused by 12 families of contaminants, including plants and mushrooms. A diagnosis of chemical poisoning is not always easy to make. Symptoms may vary greatly depending on whether intoxication with an agent is acute or chronic. Acute poisonings generally appear following short-term exposure, with symptoms developing quickly. Chronic intoxications usually result from repeated exposures over a long period of time. Symptoms are linked either to an accumulation of the poison in the body (e.g. lead), or to an accumulation of the effect generated by repeated exposures without accumulation of the toxic substance in the body (e.g. certain solvents).

## Intoxications that must be reported by laboratories

Laboratoires are required to report results of biological indicator measurements that exceed the thresholds established by public health. Biological indicators are

## Reportable diseases and intoxications caused by chemical agents

### ► By physicians

- Asbestosis
  - Angiosarcoma of the liver
  - Asthma whose occupational origin has been confirmed by a special committee on occupational lung diseases
  - Acute broncho-pulmonary injury of chemical origin (bronchiolitis, pneumonitis, alveolitis, bronchitis, bronchial irritation syndrome, or pulmonary oedema)
  - Berylliosis
  - Byssinosis
  - Lung cancer linked to asbestos and whose occupational origin has been confirmed by a special committee on occupational lung diseases
  - Mesothelioma
  - Silicosis
- Injury of the cardiac, gastro-intestinal, hemato-poietic, renal, pulmonary or neurological systems where the physician has serious reason to believe that the injury is the result of a chemical exposure of environmental or occupational origin through:
    - Alcohols (e.g. methanol)
    - Aldehydes (e.g. formaldehyde)
    - Ketones (e.g. methylethyl ketone)
    - Mushrooms (e.g. amanitas, clitocybes)
    - Corrosives (e.g. hydrofluoric acid)
    - Esters (e.g. methyl acetate)
    - Gases and asphyxiants (e.g. CO)
    - Glycols (e.g. ethylene glycol)
    - Hydrocarbons and other volatile organic compounds
    - Metals and metalloids (e.g. lead)
    - Pesticides (e.g. insecticides, herbicides)
    - Plants (e.g. datura, foxglove, jimson weed)

### ► By laboratories

- Intoxications caused by chemicals in the following classes, when biological indicator results are abnormally high and exceed thresholds recognised by public health: alcohols, ketones, esters, gases and asphyxiants, glycols, hydrocarbons, and other volatile organic compounds, metals and metalloids, pesticides.

not available for all chemical substances and the dose-response relationship is well documented only for a few chemical substances. Thresholds defined for laboratory reporting are determined with a view to protecting population health and can differ from toxicity thresholds for individuals. The quantity of contaminant that has penetrated into the body or the effects of this contaminant on the body can be evaluated through biological indicators. It can involve the chemical substance itself (e.g. lead, mercury, etc.), a chemical substance metabolite (e.g. styrene: urinary mandelic acid) or an indicator of the chemical substance's biological effect (e.g. organophosphorus insecticides: cholinesterase inhibitors).

## Prévention en pratique médicale

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# REPORTABLE DISEASES, INFECTIONS AND INTOXICATIONS

As per the Public Health Act (R.S.Q., c. S-2.2) and its regulations - November 2003

**By the physician (P) • By the laboratory (L) • By both the physician and the laboratory (P+L)**

**Under extreme surveillance** - Report immediately by telephone or fax to both the National Director of Public Health and the Director of Public Health in your region simultaneously, and confirm in writing within 48 hours.

**P+L** • Botulism  
**P+L** • Cholera  
**P+L** • Yellow fever

**P+L** • Viral haemorrhagic fevers\*  
(e.g. Ebola fever, Marburg fever,  
Crimea-Congo fever, Lassa fever)

**P+L** • Anthrax  
**P+L** • Plague  
**P+L** • Smallpox

## Report to the Director of Public Health in your region within 48 hours

**L** • Amebiasis  
**P** • Asbestosis  
**P** • Angiosarcoma of the liver  
**P** • Asthma whose occupational origin has been confirmed by a special committee on occupational lung diseases  
**P** • Acute broncho-pulmonary injury of chemical origin (bronchiolitis, pneumonitis, alveolitis, bronchitis, bronchial irritation syndrome or pulmonary oedema)  
**P** • Injury of the cardiac, gastro-intestinal, haematopoietic, renal, pulmonary or neurological systems where the physician has serious reason to believe that the injury is the result of a chemical exposure of environmental or occupational origin through:  
- Alcohols (e.g. isopropyl alcohol, methanol)  
- Aldehydes (e.g. formaldehyde)  
- Ketones (e.g. acetone, methylethyl ketone)  
- Mushrooms (e.g. amanitas, clitocybes)  
- Corrosives (e.g. hydrofluoric acid, sodium hydroxide)  
- Esters (e.g. ethoxylate fatty acid esters)  
- Gases and asphyxiants (e.g. carbon monoxide, hydrogen sulphide, acetylene)  
- Glycols (e.g. ethylene glycol)  
- Hydrocarbons and other volatile organic compounds (e.g. aliphatic, aromatic, halogenated, polycyclic)  
- Metals and metalloids (e.g. lead, mercury)  
- Pesticides (e.g. organophosphate insecticides and carbamates)  
- Plants (e.g. datura, jimson weed, foxglove)  
**P+L** • Babesiosis\*  
**P** • Berylliosis  
**P+L** • Brucellosis\*  
**P** • Byssinosis  
**P** • Lung cancer linked to asbestos and whose occupational origin has been confirmed by a special committee on occupational lung diseases  
**P+L** • Chancroid

**P+L** • Whooping cough  
**L** • Cryptosporidiosis  
**L** • Cyclosporiasis  
**P+L** • Diphtheria  
**P** • Vancomycin-resistant enterococcus (VRE) outbreak  
**P** • Methicillin-resistant *Staphylococcus aureus* (MRSA) outbreak  
**P+L** • Viral encephalitis transmitted by arthropods\* (e.g. WNV, dengue)  
**P+L** • Q fever\*  
**P+L** • Typhoid or paratyphoid fever  
**L** • *Yersinia enterocolitica* gastroenteritis  
**P** • Epidemic gastroenteritis of unspecified origin  
**L** • Giardiasis  
**P+L** • Granuloma inguinale  
**P+L** • Viral hepatitis\* (e.g. HAV, HBV, HCV)  
**L** • Campylobacter infection  
**P+L** • *Chlamydia trachomatis* infection  
**L** • Verocytotoxin-producing *Escherichia coli* infection  
**P+L** • Hantavirus infection  
**L** • Type I or II HTLV  
**P+L** • Plasmodium infection (malaria)\*  
**L** • Vancomycin-resistant *Staphylococcus aureus* (VRSA)  
**P+L** • Gonococcal infection  
**P+L** • Invasive *Escherichia coli* infection  
**P+L** • Invasive *Haemophilus influenzae* infection  
**P+L** • Invasive meningococcal infection  
**P+L** • Invasive streptococcal infection, group A  
**P+L** • Invasive *Streptococcus pneumoniae* infection (pneumococcus)  
**P** • HIV infection only if the infected person has given or received blood, blood products, organs or tissues\*  
**P+L** • West Nile virus infection\*  
**L** • Intoxications caused by chemical substances in the following classes, when biological indicators are abnormally high and exceed thresholds recognized by public health:  
- Alcohols (e.g. isopropyl alcohol, methanol)

- Ketones (e.g. acetone, methylethyl ketone)  
- Esters (e.g. ethoxylate fatty acid esters)  
- Gases and asphyxiants (e.g. carbon monoxide, hydrogen sulphide, acetylene)  
- Glycols (e.g. ethylene glycol)  
- Hydrocarbons and other volatile organic compounds (e.g. aliphatic, aromatic, halogenated, polycyclic)  
- Metals and metalloids (e.g. lead, mercury)  
- Pesticides (e.g. organophosphate insecticides and carbamates)  
**P+L** • Legionnaire's disease  
**P+L** • Leprosy  
**L** • Leptospirosis  
**L** • Listeriosis  
**P+L** • Lymphogranuloma venereum  
**P+L** • Chagas disease\*  
**P** • Creutzfeldt-Jakob disease and its variants\*  
**P+L** • Lyme disease\*  
**P** • Mesothelioma  
**P+L** • Mumps  
**P** • Acute flaccid paralysis  
**P+L** • Poliomyelitis  
**P+L** • Psittacosis  
**P+L** • Rabies\*  
**P+L** • Measles  
**P+L** • Rubella  
**P** • Congenital rubella  
**L** • Salmonellosis  
**L** • Shigellosis  
**P** • AIDS: only if the infected person has given or received blood, blood products, organs or tissues\*  
**P** • Silicosis  
**P+L** • Severe acute respiratory syndrome (SARS)  
**P+L** • Syphilis\*  
**P+L** • Tetanus  
**P** • Food and water poisoning  
**P+L** • Trichinosis  
**P+L** • Tuberculosis\* ♦  
**P+L** • Tularaemia  
**P+L** • Typhus

\* The physician must provide information on blood, blood products, tissues or organs donated or received.

♦ Disease for which treatment is compulsory (MATO)

**Notification of a reportable disease / infection / intoxication (MADO) according to the Public Health Act by the physician**

❖ **Monday to Friday, 8:30 a.m. to 4:30 p.m.**

- **BY CONFIDENTIAL FAX\***  
 - Confidential fax number: **(514) 528-2461**
- **BY TELEPHONE, if urgent: (514) 528-2400**  
 - Ask for the physician on-call in infectious diseases or in environmental and occupational health.

❖ **Outside these hours, for immediate epidemiological help, call (514) 528-2400 and follow the instructions.**

- **BY MAIL† :**  
 Archives, Direction de santé publique de Montréal,  
 1301 Sherbrooke Street East, Montréal, Quebec H2L 1M3

Last name and first name of patient \_\_\_\_\_

Health insurance number \_\_\_\_\_ Date of birth \_\_\_\_\_  
Year Month Day

Address (No., Street) \_\_\_\_\_

City \_\_\_\_\_

Postal code \_\_\_\_\_ Area code \_\_\_\_\_ Telephone \_\_\_\_\_ Sex M  F

Patient's occupation: \_\_\_\_\_

Business, school, day care: \_\_\_\_\_  
 City: \_\_\_\_\_

**Identification of the reportable disease, infection or intoxication**

Name of the MADO \_\_\_\_\_ Date of onset of the MADO \_\_\_\_\_  
Year Month Day

**Samples sent to laboratories**

No  Yes If yes: specify \_\_\_\_\_

Year Month Day Name of the laboratory \_\_\_\_\_ Year Month Day Name of the laboratory \_\_\_\_\_

**When reporting a MADO that spreads through blood, blood products, organs or tissues:**

For the following diseases, check the appropriate answers, complete the rest of the questionnaire and send in the report.

• Viral haemorrhagic fevers	• Q fever	• Chagas disease	• Syphilis
• Babesiosis	• Viral hepatitis (e.g. HAV, HBV, HCV)	• Creutzfeldt-Jakob disease and its variants	• Tuberculosis
• Brucellosis	• Plasmodium infection (malaria)	• Lyme disease	
• Viral encephalitis transmitted by arthropods	• West Nile virus infection	• Rabies	

For HIV infection and AIDS, only report if the patient answers 'yes' to at least one of the following questions.

Did the patient give blood?  Yes  No  Don't know

Did the patient receive blood or blood products?  Yes  No  Don't know

Did the patient give organs or tissues?  Yes  No  Don't know

Did the patient receive organs or tissues?  Yes  No  Don't know

**When reporting a case of syphilis:**

Primary  Latent (less than 1 year)  Tertiary  Other forms (specify): \_\_\_\_\_

Secondary  Latent (more than 1 year)  Congenital \_\_\_\_\_

**Essential information about the reporting physician: (if unclear, may delay the intervention)**

Name of the physician (in block letters) \_\_\_\_\_ Permit no. \_\_\_\_\_ Telephone numbers \_\_\_\_\_  
Area code No. Area code No.

Address (No., street) \_\_\_\_\_ City \_\_\_\_\_ Postal code \_\_\_\_\_

♦ To obtain forms and pre-stamped envelopes: (514) 528-2400

Year Month Day \_\_\_\_\_  
Date

Signature of the reporting physician \_\_\_\_\_ M.D.

**\*Note to the recipient**  
 The information in this message is confidential and is strictly for the use of the person to whom it is addressed. If you are not this person, please note that using, disclosing, distributing or copying this message is strictly forbidden. Moreover, if you have mistakenly received this message, please call the Archives at the Direction de santé publique de Montréal (514-528-2400, extension 3586) immediately and send this fax back to them by mail (see address at the top of the page) or special delivery. Thank you!

- Please photocopy this form -

# Epidemiological profile of notifiable diseases reported in 2002 and 2003\*

## Montréal region

### Infectious diseases

#### Hepatitis

- Hepatitis A, acute hepatitis B
  - Lowest ever annual number of cases reported: 36 cases of hepatitis A, 33 of hepatitis B.
  - Vaccination programmes continue to bear fruit.
- Hepatitis C
  - Officially a reportable disease since April 2002.
  - Almost all of the 1 204 reported cases had acquired the infection in the past.
  - Since 2000, the number of reported cases has decreased every year. (Perhaps due to under-reporting?)
  - About 65% of cases are men aged 30 to 59 years.

#### Vaccine-preventable diseases

- Despite a few reports, there were no confirmed cases of measles, rubella or type B *Haemophilus influenzae* among children, and only one confirmed case of mumps.
- Among individuals under 20 years of age, there were four cases of meningococcal infection but none was vaccine-preventable since they were caused by a serogroup not included in the vaccine.
- Whooping cough is the only vaccine-preventable disease that continues to be prevalent among children and adolescents.

#### Sexually transmitted infections

- There has been an exponential growth in the number of reported cases of contagious syphilis since 1998, at which time only 1 case had been reported; there were 3 reported cases in 1999, 6 in 2000, 11 in 2001, and 37 in 2002.
- All cases but one occurred among men who have sex with men; among the latter, two thirds had had sexual relations in gay saunas.
- Since 1998, there has been a constant increase in the number of reported cases of *Chlamydia trachomatis* infections. This infection continues to be the most frequently reported disease, with 3 274 cases (37.5%) of all notifiable diseases reported.
- Most cases were among women (70% of all cases), particularly among those aged 15 to 24 years.
- Slight decrease in the number of reported cases of gonococcal infections, whereas we had observed continuous increases since 1999.
- Men accounted for more than 80% of the 523 cases.

#### Tuberculosis

- 171 cases of tuberculosis (9.4 cas per 100 000).
- Incidence rate for the province of Quebec: 3.8/100 000.
- Incidence rate for the province of Quebec not including Montréal: 1.6 cases per 100 000.

#### Enteric diseases

- Campylobacteriosis is still the most common bacterial enteric infection with 480 cases and an incidence of 26.3 cases per 100 000.
- Salmonellosis and shigellosis are the other two most common bacterial diseases, with 246 and 102 cases respectively.
- No major outbreaks this year.

#### ... and in 2003

- Preliminary analyses show no surprises.
- The spectacular growth in the number of cases of contagious syphilis continues: over 100 cases reported in 2003.
- The number of cases of chlamydiosis continues to grow.
- Cases of vaccine-preventable diseases among adults or children returning from a trip abroad are very rare.
- Similar profile for hepatitis and tuberculosis.

### Chemical intoxications

#### REPORTABLE CHEMICAL INTOXICATIONS

NUMBER OF CASES, MONTRÉAL REGION, 1998-2003

	1998	1999	2000	2001	2002	2003 ♦
Arsenic	2	1	1	0	1	0
Beryllium	0	0	0	12	5	1
Cadmium	0	1	2	2	3	1
Carbon monoxide	14	12	25	23	3	17
Chlorine	0	0	10	0	0	0
Chrome	32	17	7	5	2	1
Chlorinated hydrocarbon	0	3	0	1	0	0
Hydrogen sulfide	0	1	4	0	1	0
Lead	156	147	105	81	71	408
Manganese	10	1	0	1	0	0
Mercury	4	1	0	4	4	7
Multiple solvents	0	0	0	0	0	2
Nickel	1	4	0	0	0	1
Phenol	0	0	0	0	0	1
Styrene	4	1	3	3	14	3
Sulfur and its compounds	1	0	0	0	0	1
Toluene	31	33	17	8	1	0
Xylene	27	15	30	13	3	5
<b>TOTAL</b>	<b>282</b>	<b>237</b>	<b>204</b>	<b>153</b>	<b>108</b>	<b>448</b>

♦ Provisional data

#### Origins of the intoxications

For every year from 1998 to 2003 in Montréal, over 90% of reports originated from occupational settings and affected mostly adult men (average age: 38 to 42 years). Environmental cases mainly affected children (average age: 9 to 35 years).

#### Lead

Lead is the chemical agent most often involved in chronic intoxications reported in Montréal. Most reports issue from the surveillance of workers exposed to lead. The principal source of exposure among children is the ingestion of lead-contaminated paint flakes. The high number of cases reported in 2003 is due to a change that lowered the reporting limit for laboratories.

#### Carbon monoxide

Carbon monoxide is the chemical agent most often involved in acute intoxications. In all, 67 cases attributed to occupation and 26 cases of environmental origin were reported from 1998 to 2003. Investigations were unable to identify work environments that are at higher risk since occupational intoxications were associated with the use of poorly maintained or defective motor vehicles and propane equipment (lift truck, floor polisher, concrete saw) sometimes used in poorly ventilated areas, and with defective furnaces and stoves. Environmental intoxications were linked to using charcoal inside the house, a slow-burning stove, defective furnaces and hot water heaters (natural gas and other fuel), an obstructed chimney, snow-covered cars and fires.

\* Based on the list in effect before November 2003

# REPORTABLE DISEASES <sup>(1)</sup>

NUMBER OF CASES, MONTRÉAL REGION, 1994-2003

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003*
AIDS	303	618	600	264	158	146	141	91	62	<b>101</b>
Amebiasis	123	99	150	146	101	136	128	132	134	<b>145</b>
Botulism	0	0	1	0	0	0	0	0	0	0
Brucellosis	0	2	1	0	0	1	1	2	0	1
Campylobacter infection	443	455	489	596	624	547	484	401	<b>480</b>	369
Chancroid	0	1	0	0	0	0	0	2	0	0
<i>Chlamydia trachomatis</i> infections	1812	1784	1718	1832	2066	2495	2597	3101	3274	<b>3396</b>
Cholera	1	0	0	0	0	0	0	0	0	0
Encephalitis transmitted by arthropods	0	0	0	0	0	0	0	1	<b>10</b>	5
Enteritis due to <i>E. coli</i> O157:H7	46	56	31	46	64	59	74	52	37	14
Enterovirus meningitis	44	17	24	61	29	67	29	31	<b>50</b>	29
Epidemic diarrhoea	8	6	27	53	87	5	24	5	29	<b>39</b>
Food poisoning	46	29	59	73	56	25	32	17	<b>19</b>	16
Giardiasis	218	229	291	285	280	359	316	252	<b>288</b>	266
Gonococcal infection	439	394	306	350	308	381	443	568	523	513
<i>H. influenzae</i> , bacteremia	2	4	1	0	1	0	0	0	0	0
<i>H. influenzae</i> , meningitis	1	1	1	0	0	0	1	0	0	0
<i>H. influenzae</i> , other invasive forms	3	0	2	0	2	0	0	1	1	0
Hepatitis A	91	231	360	265	73	77	52	56	36	<b>52</b>
Hepatitis B, acute	148	101	116	84	71	58	88	52	33	29
Hepatitis B carrier	802	712	700	619	550	604	567	687	616	510
Hepatitis B, unspecified status	160	127	102	137	109	119	113	95	126	<b>210</b>
Hepatitis C, acute	0	0	0	0	1	0	0	0	0	0
Hepatitis C, unspecified status	202	357	386	490	1302	1473	2077	1438	1204	981
Hepatitis, viral, unspecified status	5	8	5	1	0	0	0	0	0	1
Invasive streptococcal infection, Group A	0	19	31	60	50	45	58	45	58	<b>71</b>
Invasive streptococcal infection, Group B	0	0	0	21	13	33	18	20	31	<b>34</b>
Invasive <i>Streptococcus pneumoniae</i>	0	0	1	286	327	266	281	256	241	<b>263</b>
Legionnaire's disease	3	3	6	4	6	6	4	7	6	3
Leprosy	1	4	3	0	0	0	1	0	1	0
Malaria	30	75	82	110	73	62	91	67	64	51
Measles	43	11	12	2	2	2	1	0	1	<b>3</b>
Meningococcal infections	26	28	10	13	10	11	8	21	13	9
Mumps	19	12	16	2	19	1	14	13	2	4
Neonatal herpes	0	0	1	0	0	0	1	2	0	0
Paratyphoid fever	3	2	3	2	4	7	3	8	4	<b>6</b>
Psittacosis	0	0	1	0	0	1	0	0	0	0
Q fever	0	0	2	0	0	0	1	1	1	0
Rabies	0	0	0	0	0	0	1	0	0	0
Rubella	7	12	5	3	1	0	2	0	1	0
Salmonellosis	274	353	295	265	289	280	302	251	<b>256</b>	233
Scarlet fever	86	23	20	21	78	28	58	5	12	<b>14</b>
Shigellosis	139	178	137	268	135	97	151	144	102	<b>132</b>
Syphilis	58	56	41	28	25	19	22	42	64	<b>152</b>
Tuberculosis	209	207	188	188	157	169	200	155	<b>171</b>	148
Tularaemia	0	1	0	0	0	0	0	0	0	0
Typhoid fever	24	21	7	9	12	7	10	9	<b>12</b>	12
Whooping cough	540	339	141	97	630	256	158	211	140	45
<i>Yersinia enterocolitica</i> gastroenteritis	75	64	60	42	41	43	25	30	<b>36</b>	27
<b>TOTAL</b>	<b>6433</b>	<b>6639</b>	<b>6432</b>	<b>6723</b>	<b>7754</b>	<b>7885</b>	<b>8576</b>	<b>8271</b>	<b>8452</b>	<b>8104</b>

(1) In accordance with the list in effect before November 2003

\* Provisional data

The following notifiable diseases were not reported from 1991 to 2003: African haemorrhagic fever (Ebola), anthrax, diphtheria, Lassa fever, granuloma inguinale, lymphogranuloma venereum, Marburg disease, plague, poliomyelitis, smallpox, tetanus, trichinosis, typhus, Yellow fever.

Note: This chart corrects the number of cases over several years presented in tables produced previously. New information emerged as a result of verification of regional origin of cases and date of onset of illness.