From: Chavez, Gilbert (CDC cdph.ca.gov)
Sent: Monday, September 22, 2014 6:57 PM
To: Gould, Carolyn V. (CDC/OID/NCEZID); Bensyl, Diana M. (CDC/OPHSS/CSELS)
Cc: Rosenberg, Jon (CDPH-CHCQ-HAI); Janssen, Lynn (CDPH-CHCQ-HAI); Laufer, Alison S. (CDC/OID/NCEZID); Iacino, Jean (CDPH-CHCQ); Weiss, Edward (CDC/OPHSS/CSELS); Murray, Erin@cdph.ca.gov (CDC cdph.ca.gov); Watt, James (CDC cdph.ca.gov); Billingsley, Kathleen (CDPH-EXE-DIR)
Subject: EPI-AID Request - Pseudomonas in NICU

On September 15, 2014, the California Dept. of Public Health (CDPH) notified the Centers for Disease Control and Prevention (CDC) of 11 cases of *Pseudomonas aeruginosa* infections and colonizations among patients in a neonatal intensive care unit (NICU). These represent a recurrence of an outbreak of *Pseudomonas aeruginosa* infections and colonizations that had occurred between September 8, 2013 and January 29, 2014, with 13 cases and 2 deaths. *Pseudomonas aeruginosa* was cultured from the water from the faucets in the individual patient room sinks, and after extensive remediation efforts including changing all the faucets, hyperchlorination of water, and installation of point of use filters in each faucet in the NICU by January 29, cases did not recur and the outbreak was believed to be controlled. However, genetic analysis of the *Pseudomonas aeruginosa* from water and patients did not reveal any similarity between the two sources, raising questions about the conclusion that the water was the source of the outbreak.

Beginning June 22, 2014, cases of infection and colonization recurred. Following the notification of CDC on September 15, 2 additional cases have occurred, bringing the total to 13, including the death of an infant from a *Pseudomonas aeruginosa* bloodstream infection on September 17. Genetic typing of these recent cases showed one type present in 3 of the currently infected patients that matches 2 of the previous patients, but not any of the previous water samples, again raising concerns about a source other than water. An extensive review of patient, healthcare personnel, and environmental factors by the hospital personnel and reviewed by CDPH personnel did not result in any specific leads. Because of this outbreak women with high risk pregnancies are being diverted to other hospitals.

Because of the scope of the outbreak, the potential for ongoing cases in the NICU, the impact on high risk infants in the region, and CDC's expertise in healthcare-associated infection prevention, CDPH is requesting CDC assistance with an urgent public health investigation with the following objectives:

1) Conduct case-finding and case confirmation
2) Perform infection control assessment
3) Assess risk factors
4) Perform environmental evaluation
5) Make recommendations for control measures

Dr. Jon Rosenberg will be the California point of contact for this investigation.

We look forward to your prompt and favorable response to our request. Please let us know of your plans to proceed and next steps. Thank you for your ongoing support of our programs.

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To report a disease outbreak or public health emergency, please contact the 24/7 California Department of Public Health Duty Officer at (916) 328-3605 (Pager).


Center for Infectious Diseases
California Department of
PublicHealth