

From: Chavez, Gilbert (CDC cdph.ca.gov)

Sent: Thursday, September 11, 2014 6:02 PM

To: Patel, Priti (CDC/OID/NCEZID); Bensyl, Diana M. (CDC/OPHSS/CSELS)

Cc: Watt, James (CDC cdph.ca.gov); Epton, Erin (CDPH-CHCQ-HAI); Iacino, Jean (CDPH-CHCQ); Janssen, Lynn (CDPH-CHCQ-HAI); Epton, Erin (CDPH-CHCQ-HAI); Rosenberg, Jon (CDPH-CHCQ-HAI); Wong, Jacklyn (CDPH-CID-DCDC-TCB); King, Michael (CDC/OPHSS/CSELS); Billingsley, Kathleen (CDPH-EXE-DIR)

Subject: EPI-AID Request - Infections in an outpatient dialysis center

Dear Dr. Patel:

On May 9, 2014, the California Dept. of Public Health (CDPH) notified CDC of 6 cases of *Burholderia cepacia* bloodstream infections (BSIs) among hemodialysis patients in a single outpatient dialysis center in 2014. Additional case finding conducted by CDPH revealed 2 cases of *Stenotrophomonas maltophilia* BSIs among patients at the center in late 2013. CDC was subsequently notified of 2 cases of *S. maltophilia* and 1 case of *B. cepacia* BSIs at another dialysis center belonging to the same company. All 11 cases appeared to be in patients whose dialyzers were reused and reprocessed. Environmental cultures performed in the facility with the index cluster identified *B. cepacia* from a dialyzer preprocessing machine. At the second facility, *S. maltophilia* was recovered from a culture taken from the sink used to rinse dialyzers prior to reprocessing. In response, these two facilities temporarily halted dialyzer reuse, and then resumed reuse after some modifications to their reprocessing practices.

A broader search of BSIs caused by similar waterborne organisms that could be introduced during dialyzer reprocessing (*B. cepacia*, *Pseudomonas*, *Stenotrophomonas*, *Proteus*, *Morganella*, *Serratia*) during January to August 2014 revealed 18 potential cases across multiple facilities within the same company. Due to the urgent nature of this problem and the potential threat to patients, the California Department of Public Health would like to request epidemiologic assistance from the Centers for Disease Control and Prevention to conduct an investigation with the following objectives:

- 1) Conduct case-finding and case confirmation
- 2) Assess dialyzer reuse and reprocessing practices
- 3) Assess risk factors
- 4) Perform environmental evaluation
- 5) Make recommendations for control measures

Please note that Jackie Wong, a first year EIS Officer assigned to CDPH is willing to assist in this investigation. Drs. Jon Rosenberg and Erin Epton will be the California points 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.

Gil F. Chavez, MD, MPH
State Epidemiologist
Chief, Center for Infectious Diseases
Deputy Director, California Department of Public Health
E-mail address: Gil.Chavez@cdph.ca.gov
Website: <http://www.cdph.ca.gov/programs/cid/Pages/>
Phone: 916.445.0062
Fax: 916.445.0274

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).

