

# Legionellosis

## 1. DISEASE REPORTING

### A. Purpose of Reporting and Surveillance

1. To identify outbreaks and potential sources of transmission, in order to prevent further exposure.
2. To educate potentially exposed persons about signs and symptoms of disease, thereby facilitating early diagnosis and treatment.
3. To identify populations at high-risk of complications from infection.
4. To identify additional cases.

### B. Laboratory and Physician Reporting Requirements

Physicians are required to report a case or suspected case within one working day of identification/diagnosis. Laboratories are to report all test results indicative of and specific for legionellosis within one working day.

### C. Local Health Department Reporting and Follow-Up Responsibilities

1. Report all confirmed and presumptive (but not suspect) cases to OHS (see case definitions below) by the end of the calendar week of initial report, using the legionellosis case investigation form (07-03).
2. Begin follow-up investigation within one working day. Send a copy of the completed case investigation form to OHS by end of the calendar week in which the investigation is completed.

## 2. THE DISEASE AND ITS EPIDEMIOLOGY

### A. Etiologic Agent

*Legionellae* are Gram-negative bacilli. In all, 48 species with at least 70 serogroups are recognized; *L. pneumophila* is responsible for >90% of infections. Eighteen serogroups of *L. pneumophila* are currently recognized; serogroup 1 causes the majority of the disease reported in the US. *Legionellae* thrive in warm, aquatic environments and are relatively resistant to the effects of chlorine and heat. They do not colonize the human respiratory tract.

### B. Description of Illness

Legionellosis is a bacterial infection more common in adults >50 years of age and very unusual in persons <20, most of those being immunosuppressed. It was first recognized following a 1976 outbreak of pneumonia involving American Legion convention delegates, named by the press "Legionnaires' disease" (LD). There are no reliable distinguishing clinical characteristics other than that the illness is primarily respiratory; diagnosis must come from the lab. Illness is usually associated with two clinically and epidemiologically distinct syndromes: Legionnaires' disease, a potentially fatal form of pneumonia, and Pontiac fever, a self-limited "flu-like" illness without pneumonia. Persons with Legionnaires' disease may present early in the illness with nonspecific symptoms including fever, malaise, myalgia, anorexia, and headache. Cough may be only slightly productive, and chest pain, occasionally pleuritic, can be prominent. GI symptoms, especially diarrhea, occurs in 20 to 40 percent of cases. Chest x-rays usually show a pneumonia. Pontiac fever is a milder, self-limited illness. Extrapulmonary legionellosis is rare.

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Persons at increased risk for infection include the elderly, smokers, those with chronic diseases such as COPD or diabetes, and the immunosuppressed.

### C. Reservoirs

Water is the primary reservoir. *Legionellae* can survive for months in tap and distilled water. A variety of natural and man-made aqueous sources have been implicated, including warm, stagnant water such as that found in, or aerosolized from:

- plumbing systems and hot water tanks;
- shower heads and faucets;
- cooling towers;
- evaporative condensers of large air-conditioning systems;
- whirlpool spas;
- respiratory therapy equipment;
- ultrasonic misters;
- humidifiers; and,
- decorative fountains.

Potting soil has been associated with *L. longbeachae*, a serogroup uncommon in the US. Foreign travel may be associated with acquisition of infection.

### D. Modes of Transmission

*Legionellae* are generally spread through the air by aerosolized water which is then inhaled or microaspirated. Infection has also occurred by contamination of surgical wounds with potable water. It is not transmitted from person to person.

### E. Incubation Period

For Legionnaires' disease, 2–10 days (range 5–6 days); for Pontiac fever, 5–66 hours (range 24–48 hours).

### F. Period of Communicability

Person to person transmission has not been documented. It can survive for months in tap and distilled water.

### G. Treatment

For Legionnaires' disease, erythromycin has historically been the drug of choice. Newer fluoroquinolones, ciprofloxacin, levofloxacin, and ofloxacin, azithromycin, doxycycline or rifampin (used only in combination with other antibiotics, primarily erythromycin) are also used. Sanford's Guide suggested duration of therapy should be 14–21 days. Delay in treatment is associated with increased mortality rates.

Pontiac fever requires no specific treatment.

## 3. CASE DEFINITIONS, DIAGNOSIS, AND LABORATORY SERVICES

"Legionnaires disease is more accurately described as an elusive diagnosis rather than an exotic disease." David R. Murdock, 2003 (CID 2003:36 [1 January] ). Because of variable presentations, clinical diagnosis is often difficult. A dearth of sensitive and specific serologic tests makes laboratory confirmation problematic as well. The best diagnostic combination is the urine antigen test and culture of lower respiratory secretions (e.g., sputum or bronchial washing). Urine antigen screen is the most sensitive diagnostic test available; it detects only *L. pneumophila*, serogroup 1, the most common detected cause of legionellosis. Under optimal conditions, about 80% of cases can be confirmed by nasopharyngeal culture. Under the usual conditions encountered in outbreak investigations, only 25-50% of cases are confirmed. PCR testing has become available, but is best confirmed by culture and/or urine antigen screen.

### A. Confirmed Case Definition (Reportable to DHS)

A clinically compatible case with at least 1 of the following positive "diagnostic" tests:

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- positive culture from sputum, blood, lung tissue, pleural fluid, or other normally sterile site;
- urine antigen positive (remember: urine antigen detects only Serogroup 1; good news is that >70% of cases *are* Serogroup 1); this relatively rapid test remains positive for up to 60 days after onset despite antibiotic therapy;
- PCR-positive urine, bronchoalveolar-lavage fluid, or serum; or
- a four-fold rise in antibody titer ( $\geq 128$ ) in acute and convalescent serum tested 1-3 months after illness onset

### B. Presumptive Case Definition (Reportable to DHS)

Anyone with an undiagnosed compatible illness or single serum antibody titre ( $\geq 128$ ) and with epi-linkage to a confirmed case or outbreak.

### C. Suspect Case Definition (Not Reportable to DHS)

Anyone with an undiagnosed compatible illness and a single antibody titer ( $\geq 128$ ) who lacks epi-linkage to a confirmed case or outbreak.

### D. Services Available at the Oregon State Public Health Laboratory

None.

## 4. ROUTINE CASE INVESTIGATION

As most cases of legionellosis present as sporadic disease, routine case investigation is limited to collecting basic demographics, information about the basis of diagnosis, and risk factors which may shed light on susceptibility to disease (in other words, fill out the case investigation report form). Unless circumstances indicate that an outbreak may be occurring (§ 5 and 6), further investigation is not indicated.

Identification of a nosocomial (hospital/institution-acquired) case warrants additional case-finding at the implicated institution as clusters/outbreaks have been reported having such common environmental sources of exposure (§6).

## 5. CONTROLLING FURTHER SPREAD

No prophylaxis is indicated for household/contacts; person-to-person transmission has not yet been demonstrated.

**Environmental investigation**—An environmental investigation would only be undertaken in the course of an outbreak investigation (§ 6).

## 6. MANAGING SPECIAL SITUATIONS-INVESTIGATING A POSSIBLE OUTBREAK

Many outbreaks, community and nosocomial, have been attributed to *Legionella spp.* in the decades since the 1976 American Legion Convention in Philadelphia. Actually, several have been described retrospectively. If a cluster of legionellosis is suspected, confirmation and investigation are warranted, as morbidity may be significant and mortality high (up to 30%), and reservoirs may be found and eliminated. Contact ACDP epidemiologists to discuss possible outbreaks. Such investigations may involve complex questionnaires and detailed environmental evaluations.