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References

- Hayes EB, Komar N, Nasci RS, Montgomery SP, O'Leary DR, Campbell GL. Epidemiology and transmission dynamics of West Nile virus disease. *Emerg Infect Dis.* 2005;11:1167–73.
- Komar N, Clark GG. West Nile virus activity in Latin America and the Caribbean. *Rev Panam Salud Publica.* 2006;19:112–7.
- Morales-Betoulle ME, Morales H, Blitvich BJ, Powers AM, Davis EA, Klein R, et al. West Nile virus in horses, Guatemala. *Emerg Infect Dis.* 2006;12:1038–9.
- Bosch I, Herrera F, Navaro JC, Lentino M, Dupuis A, Maffei J, et al. West Nile virus, Venezuela. *Emerg Infect Dis.* 2007;13:651–3.
- Morales MA, Barrandeguy M, Fabbri C, Garcia GB, Vissani A, Trono K, et al. West Nile virus isolation from equines in Argentina, 2006. *Emerg Infect Dis.* 2006;12:1559–61.
- Blitvich BJ, Bowen RA, Marlenee NL, Hall RA, Bunning ML, Beaty BJ. Epitope-blocking enzyme-linked immunosorbent assays for detection of West Nile virus antibodies in domestic mammals. *J Clin Microbiol.* 2003;41:2676–9.
- Sabattini MS, Avilés G, Monath TP. Historical, epidemiological and ecological aspects of arbovirus in Argentina: Flaviviridae, Bunyaviridae and Rhabdoviridae. In: Travassos da Rosa APA, Vasconcelos PFC, Travassos da Rosa JFS, editors. An overview of arbovirology in Brazil and neighboring countries. Belem (Brazil); Instituto Evandro Chagas; 1998. p. 113–34.

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Clostridium difficile Surveillance Trends, Saxony, Germany

To the Editor: Vonberg et al. (1) recently commented on the increase of *Clostridium difficile* seen in US hospitals by using discharge diagnoses and confirmed the observation from the United States (2) with hospital discharge data from Germany during 2000 through 2004. *C. difficile* ribotype 027 has recently been isolated in Germany (3). We further contribute to the assessment of *C. difficile* as an emerging threat by looking at population surveillance data.

C. difficile is not a federal notifiable disease in Germany, which limits our ability to analyze national surveillance trends. However, in 2002 the state of Saxony implemented additional mandatory surveillance of community- and hospital-acquired infectious enteritis caused by laboratory-confirmed *C. difficile*.

To check for an increase in notifications due to reporting bias of gastroenteric diseases, we compared the quarterly incidence data from 2002 through 2006 with data on *Salmonella* spp. infections (usually reported by local general practitioners) and rotavirus

and norovirus infections (both usually reported by clinics). The potential problem of reporting bias for gastroenteric diseases has been addressed recently (4). Information about age and sex of *C. difficile* patients was available for 2006 only.

Quarterly incidences for *C. difficile* in Saxony were from 1.7–3.8 per 100,000 population in 2002 and 2003 and continued to increase to 14.8 cases per 100,000 population in 2006 (Figure). This constitutes a 6-fold increase of the yearly average of *C. difficile* incidence rates between 2002 and 2006. The third quarter of 2005 experienced a sharp drop that could not be explained retrospectively and might have resulted from transition to new procedures for data collection and management.

Gastroenteric infections showed clear seasonality with a slightly decreasing yearly trend for *Salmonella* spp. and seasonal values from 13.8 cases per 100,000 in winter to summer peaks of 56.8. Rotavirus infections displayed an even stronger seasonality, with values from 7.0 cases per 100,000 in summer to winter peaks of 140.3. Norovirus infections peaked again during winter, at 137.2 cases per 100,000 but had as few as 11.0 cases per 100,000 during summer. Notification does not suggest reporting bias of gastroenteric infections.

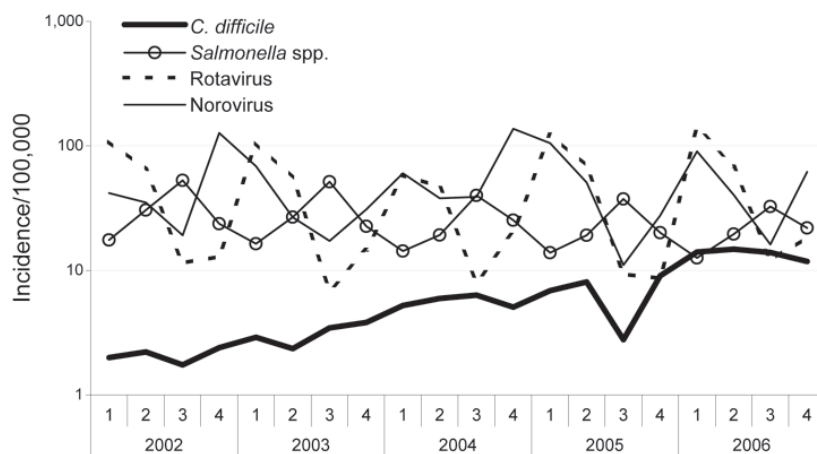


Figure. Quarterly incidence per 100,000 population of *Clostridium difficile* infections compared with gastroenteric infections caused by *Salmonella* spp., rotaviruses, and noroviruses in Saxony, Germany, 2002–2006. Note the log scale on the y axis.

Elderly persons, i.e., those ≥ 65 years of age, were affected most by *C. difficile* infections; this age group accounted for 1,506 (65%) of all cases ($n = 2,306$) in 2006. The 45- to 64-year age group had the next highest number of cases, 451 (20%). Men and women were affected equally in the different age groups; slightly more women ($n = 805$) than men ($n = 701$) with *C. difficile* infection were ≥ 65 years of age.

According to state and local health departments, there were no major health campaigns since 2004 that might have selectively increased awareness for *C. difficile* notification. Our results show a continuous increase of cases that even reaches seasonal notification levels of *Salmonella* spp. and rotavirus infections, but the increase is difficult to explain entirely by changes in reporting behavior. We emphasize

the role of individual German states in setting additional surveillance targets for public health. Given the epidemic potential and the severity of the disease, especially among the elderly, surveillance of *C. difficile* should be introduced throughout Germany along with enhanced prevention and treatment strategies (5).

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References

1. Vonberg RP, Schwab F, Gastmeier P. *Clostridium difficile* in discharged inpatients, Germany. *Emerg Infect Dis.* 2007;13:179–80.

2. McDonald LC, Owings M, Jernigan DB. *Clostridium difficile* infection in patients discharged from US short-stay hospitals, 1996–2003. *Emerg Infect Dis.* 2006;12:409–15.
3. Kleinkauf N, Weiss B, Jansen A, Eckmanns T, Bornhofen B, Kühnen E, et al. Confirmed cases and report of clusters of severe infections due to *Clostridium difficile* PCR ribotype 027 in Germany. *Euro Surveill.* 2007 Nov 15;12(11):E071115.2.
4. Wilcox M, Fawley W. Viral gastroenteritis increases the reports of *Clostridium difficile* infection. *J Hosp Infect.* 2007;66:395–6.
5. McDonald LC, Coignard B, Dubberke E, Song X, Horan T, Kuttu PK. Recommendations for surveillance of *Clostridium difficile*-associated disease. *Infect Control Hosp Epidemiol.* 2007;28:140–5.

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ANOTHER DIMENSION

The CAT Scan

Ronald O. Valdiserri

I enter your portal through a scrim of invisible rays,
beads of energy outnumbering my regrets.
Supine on a cold bed, part supplicant, part sacrifice.
Like all captives, fearing judgment.
Woosh, then comes the warm tingle of the dye,
everywhere at once.
It feels like a cleansing...
washing away debris, debt, equivocation.
“no,” silently, I correct myself,
acknowledging the iodine’s more melancholy assignment:
building a luminous marquee around 56 years of imperfection and wear.
And the lights blink yellow.

Dr Valdiserri is chief public health consultant in the Office of Public Health and Environmental Hazards at the US Department of Veterans Affairs. Prior to joining the VA in 2006, Dr. Valdiserri served as the deputy director of the National Center for HIV, STD, and TB Prevention at the US Centers for Disease Control and Prevention. He has published extensively on HIV/AIDS prevention issues, including a series of personal essays on AIDS (“Gardening in Clay,” Cornell University Press, 1994).