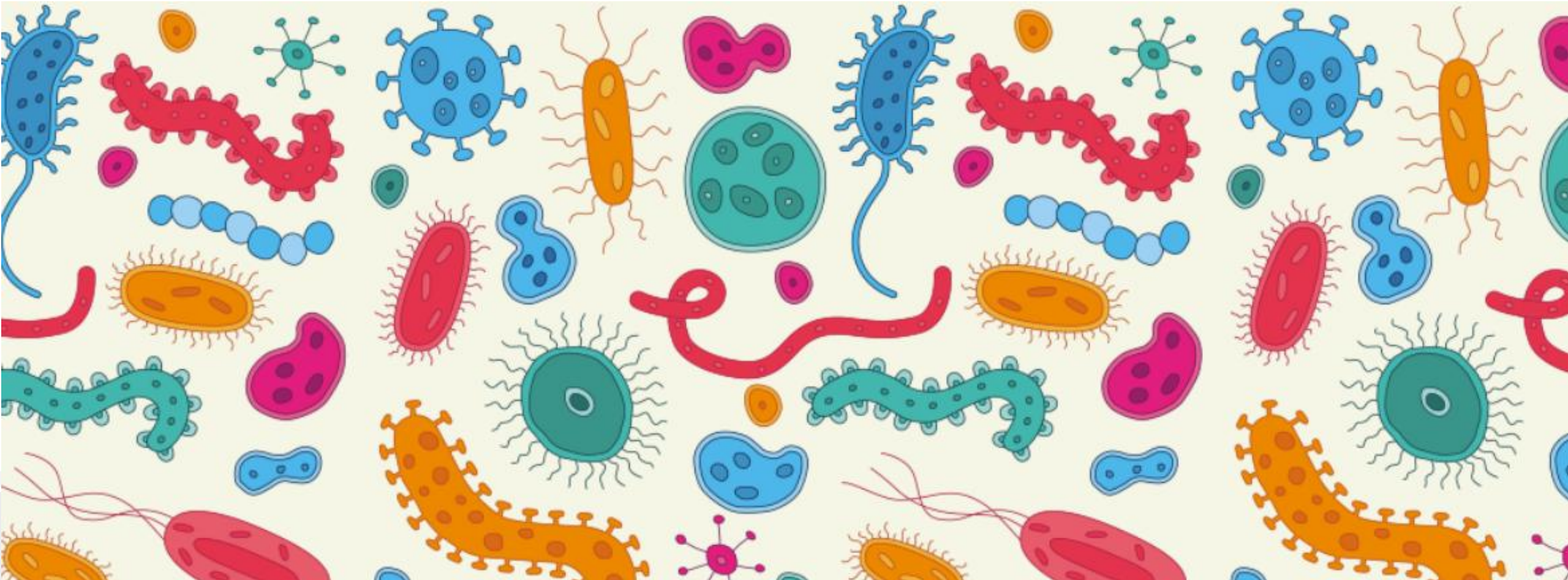
Old Threats, New Outbreaks

- A public health infectious disease update for Primary Care



Learning Objectives

By the end of this session, participants will be able to:

- 1. Utilize state resources—such as public health reports, regional health alerts, and OHA surveillance dashboards—to track active communicable disease trends in your specific county.
- 2. Apply practical, frontline strategies for diagnosing and managing infectious disease threats that are not going away.
- 3. Engage effectively in the local public health response by identifying, reporting, and containing emerging infectious disease threats early.

Infectious diseases trending today

- In the news
- In Oregon
- In our backyards

In the news

Ebola Bundibugyo 2026 outbreak

- Designated a Public Health Emergency of International Concern by WHO
  - Confirmation of outbreak May 15, 2026, CDC HAN issued May 19 2026
- Centered in Democratic Republic of Congo
  - Challenges: remote geography, population mobility, community distrust
- Active spread ongoing
  - Only 20% of cases are emerging from contact tracing lists
    - 80% of recent infections from unidentified transmission chains
  - >8,400 confirmed cases, >4,080 confirmed deaths
    - 48% case fatality rate
- Spreads through direct contact with bodily fluids
  - Ugandan outbreak over in August
  - Easy to control in countries with robust public health system
  - Infection control protocols work!

- FDA-approved Ebola vaccines and MAB treatments designed for Zaire ebolavirus and don’t work well against this strain.
- Work continues in Oregon with monitoring returning travelers (no flags yet)

Hanta Virus (zoonotic infection)

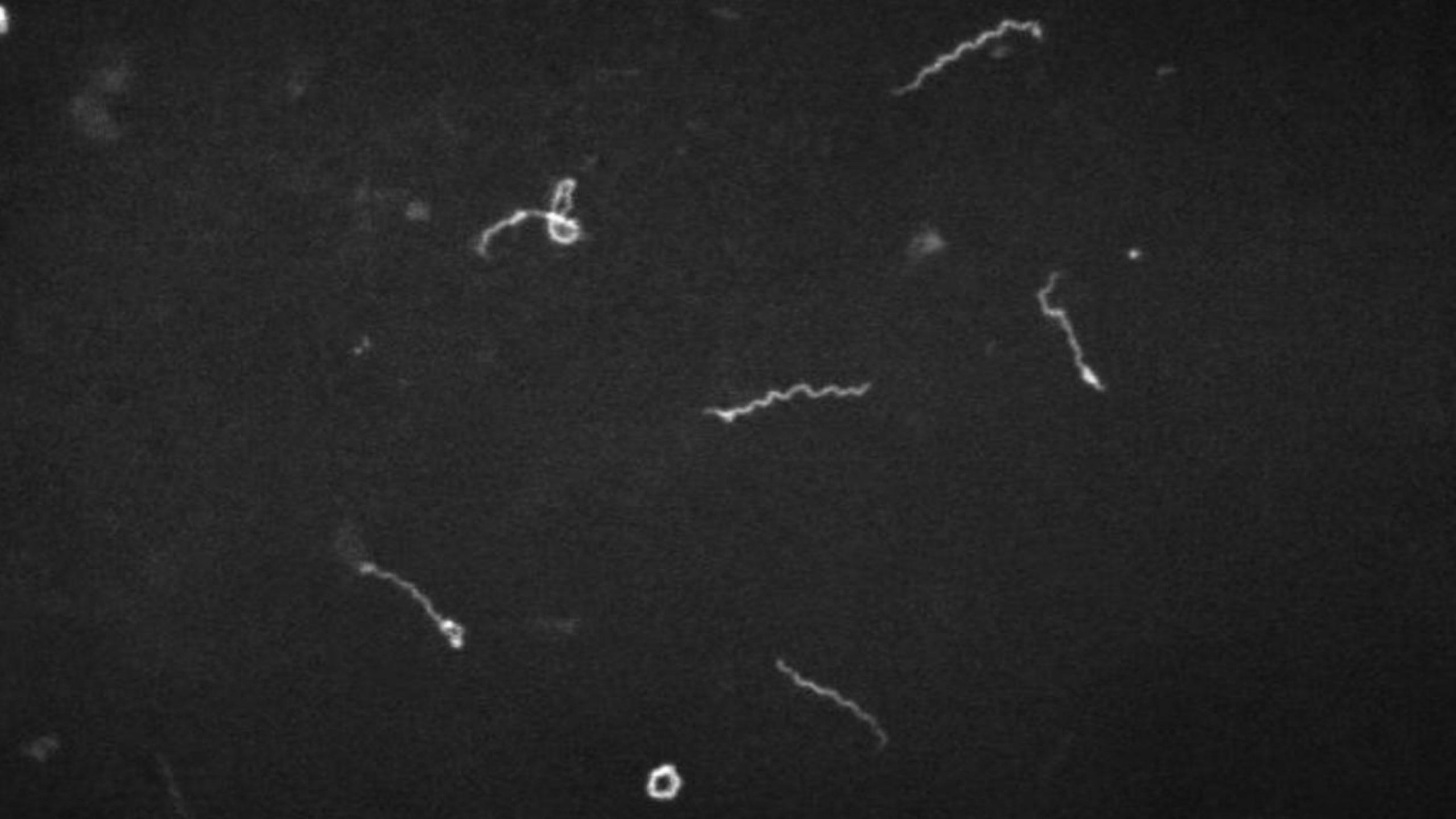
- Endemic in wild rodents (but detected in 100 species of mammals)
  - Most cases occur when humans inhale aerosolized viral particles from urine, feces or saliva of wild rodents
    - Western US has high infection rates in wild rodents
    - In 2025 hantavirus was in the news for killing Betsy Arakawa, wife of actor Gene Hackman (Santa Fe, New Mexico)
  - 10,000 – 100,000 human cases annually (isolated instances)
    - 35% mortality rate (driven by overactive immune response)
    - In the Americas can see Hantavirus Cardiopulmonary Syndrome (HCPS) with up to 50% mortality rate
    - In Asia can see Hemorrhagic Fever with Renal Syndrome (HFRS)
- 2026 Andes Virus Cluster (10 cases, 3 fatalities)
  - Only hanta virus to spread human-to-human (why it got press)
    - Linked to a cruise ship
    - Requires prolonged close contact with someone highly transmissible to pass this on
  - Contained through isolation, monitoring and contact tracing
    - First case April 6, 2026; outbreak reported to WHO May 2, 2026; CDC HAN issued May 8, 2026
    - WHO declared contained/over July 2, 2026

Cyclosporiasis

- A gastrointestinal illness (watery diarrhea, abdominal cramping, bloating, nausea, fatigue, weight loss) caused by the microscopic parasite *Cyclospora*.
- Symptoms last weeks to months if untreated.
- Outbreak started 5/1/2026, outbreak declared over 9/11/2026
- Outbreak was linked to iceberg lettuce over from Taylor Farms (Mexico) distributed to Taco Bell, Walmart
- >19k cases confirmed, >15k in the Midwest (epicenter).
- We have had cases in Oregon, but not in excess of usual prevalence
  - 15 → 23 so far in 2026; avg of 18/year over last 5 yrs (26 in 2025, 30 in 2024, 10 in 2023, 8 in 2022, 14 in 2021).
  - This is completely typical and consistent with previous years.
  - The contaminated lettuce was not distributed to retail or food services locations in Oregon.
  - The Oregon cases are non-outbreak cases, and continue to be linked to recent international travel.

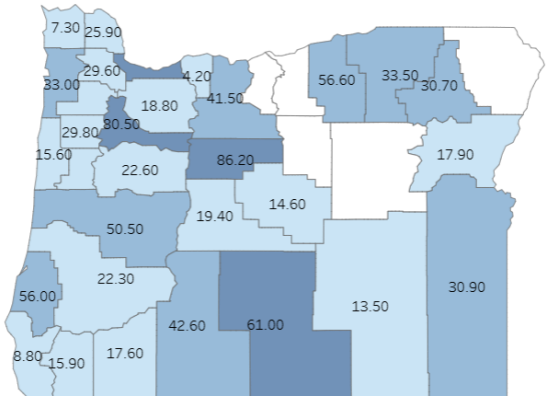
Figure A: Oocyst of *C. cayetanensis* in an unstained wet mount. Image courtesy of the Oregon State Public Health Laboratory.

In Oregon

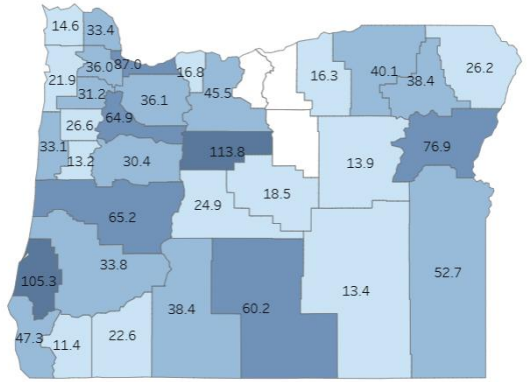


Syphilis

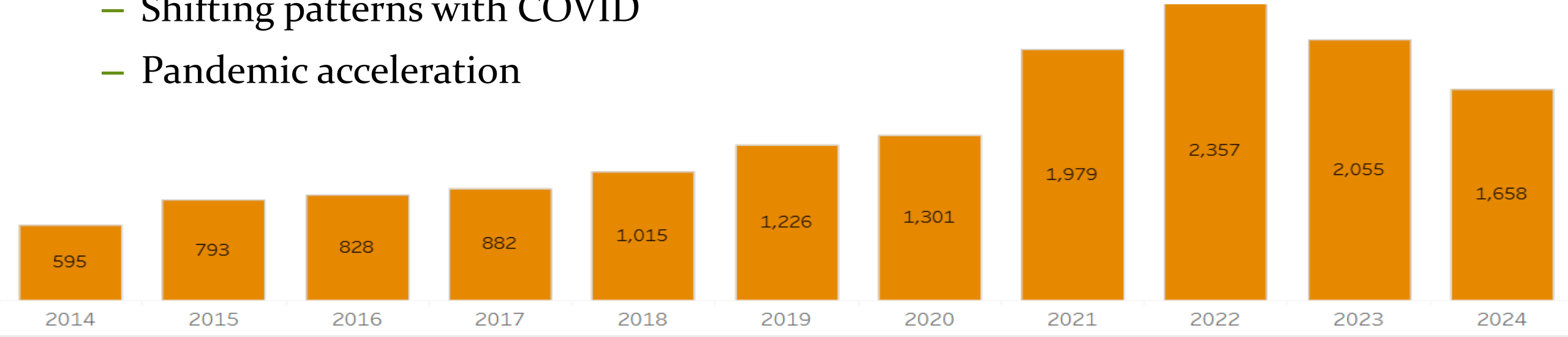
- Resurgence of old disease
- 3rd most common STI in OR
- Risk factors are changing
  - Rise started in 2008
  - Shifting patterns with COVID
  - Pandemic acceleration



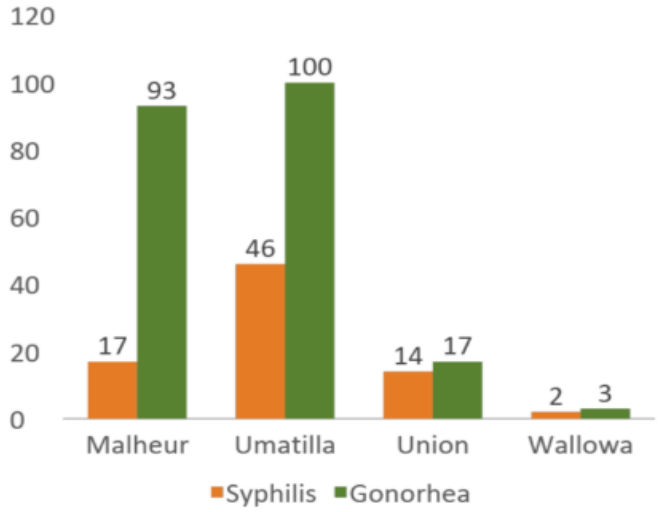
2024

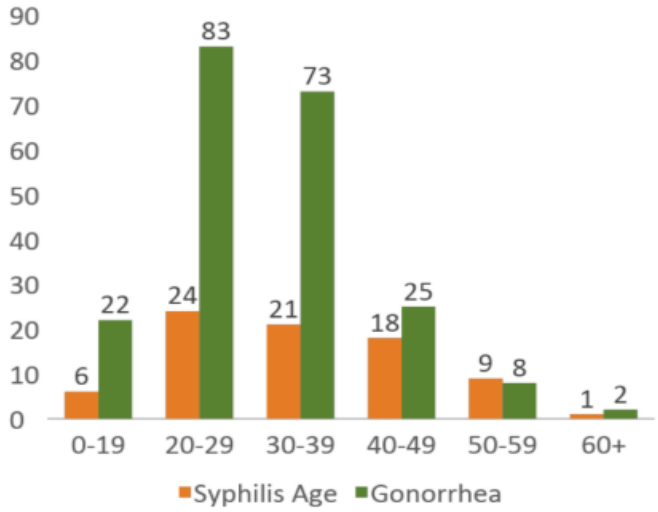


2023

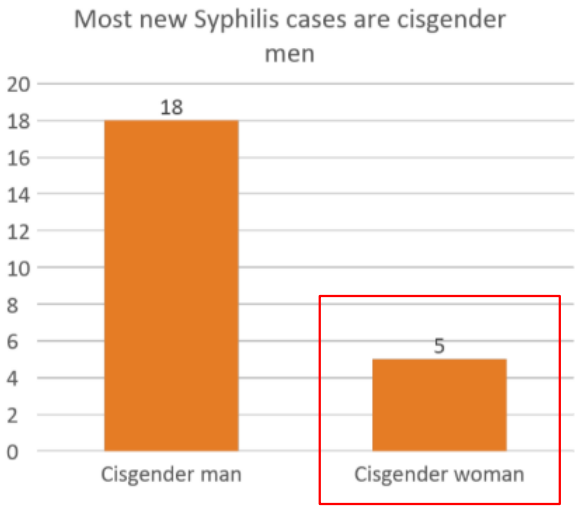


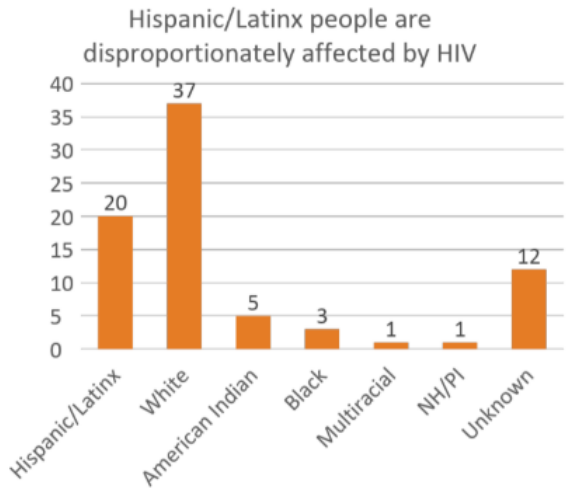
Syphilis/Gonorrhea in Malheur, Umatilla, Union and Wallowa, in 2022 and 2023



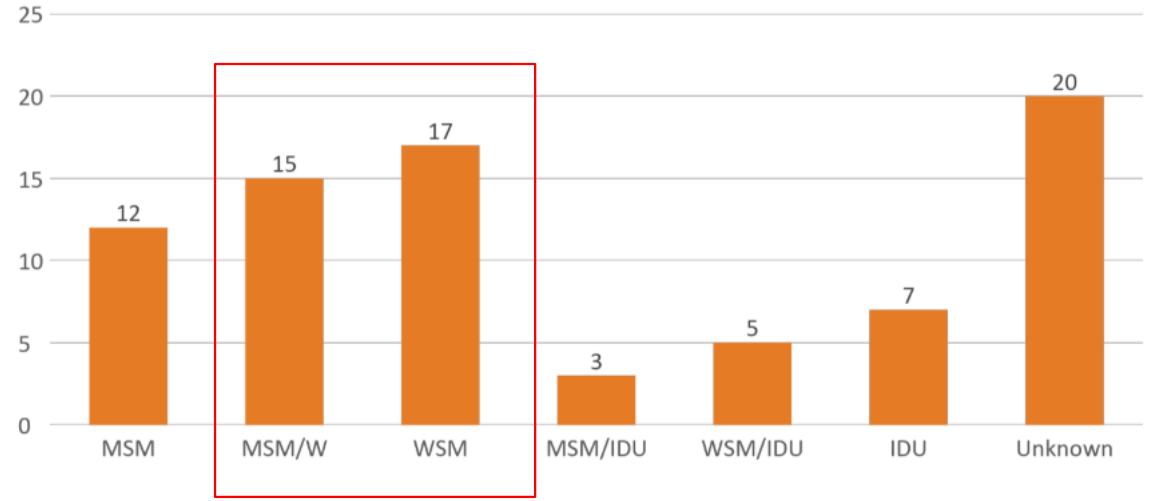


Syphilis cases by gender and race/ethnicity





MSM/W and WSM comprise most new syphilis cases

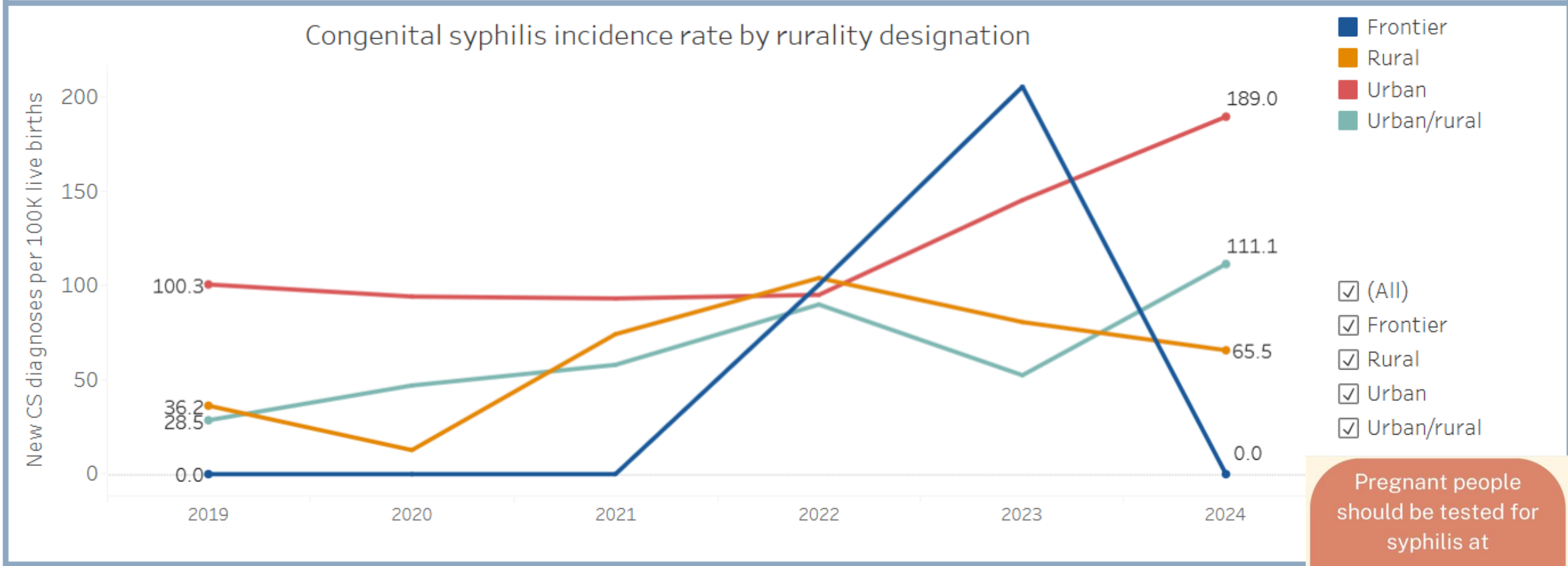


Re-emergence of Syphilis

- **Early MSM-driven resurgence (2008–2013)**
  - >10x increase from **21 cases in 2008 to 229 cases in 2013**.
  - Predominantly HIV co-infections
  - **Secondary syphilis**
- **Pandemic-era acceleration (2019–2021)**
  - **Drop in HIV/STI testing**
  - **Despite this had increase in # cases!**
  - **Accelerated with re-opening and again with availability of vaccines**
  - **Both primary and secondary syphilis**
  - **Steep rise in cases among women**
- **Rise in congenital syphilis (2019–2024)**
  - **2 cases in 2018 → 24 cases in 2024 (all vertical transmission)**

Syphilis

- How does it present? Well, it depends…… (“the great imitator”)
  - Primary = chancre (painless ulcer)
  - Secondary = symptoms of viral illness (fever, malaise, rash, LAD)
  - Tertiary = impact on organs years later (brain, heart, gummas)
  - Latent = no symptoms!
- How do you diagnose?
  - Lab tests (treponemal and non-treponemal) – NEED BOTH
- How do you cure?
  - Penicillin IM! 1 dose for acute diagnosis, 3 doses for latent syphilis
- Who do you notify ?
  - Public Health; within 24 hours
- How do you prevent?
  - 30-50% exposed to primary or secondary syphilis will be infected
  - DoxyPep in high risk populations (MSM, TGF, hx STI in last year)
  - 200 mg of doxycycline w/in 72 hours
    - Decreased **syphilis and chlamydia by >70%** and gonococcal infections by ~50%.



The location of congenital syphilis cases was assigned based on the pregnant person's county of residence

- Implementation of 3x/pregnancy screening protocols helps!
- Congenital syphilis is PREVENTABLE

Pregnant people should be tested for syphilis at

First prenatal visit

During the third trimester

And at delivery

Oregon STI Data

Oregon STD Statistics

Contact Us

You can get these materials in other languages, large print, braille or a format you prefer free of charge. Contact us at prevention.info@odhsoha.oregon.gov.

STI Dashboards

Syphilis Dashboard | Congenital Syphilis Dashboard

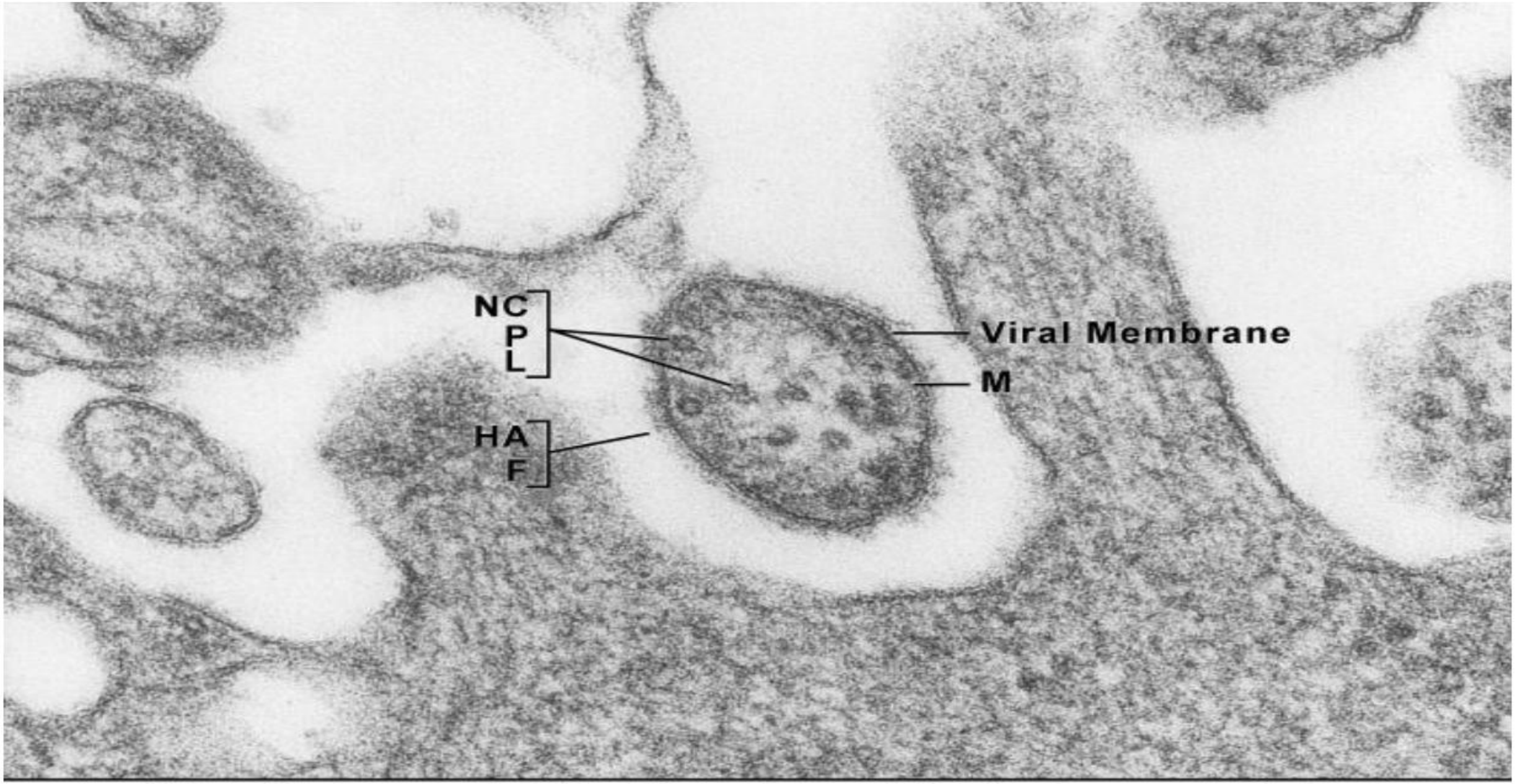
Gonorrhea Dashboard | Chlamydia Dashboard

The chlamydia, gonorrhea, and syphilis reports show the incidence rate in all Oregon counties, demographic information, treatment and the percentage of some of the factors affecting each disease. Incidence rates are shown for the last decade and treatment and factors affecting disease show only recent data.

Each disease report has tabs to navigate across the data on the top of the page and has filters to select a specific year in the top right corner.

Related Resources

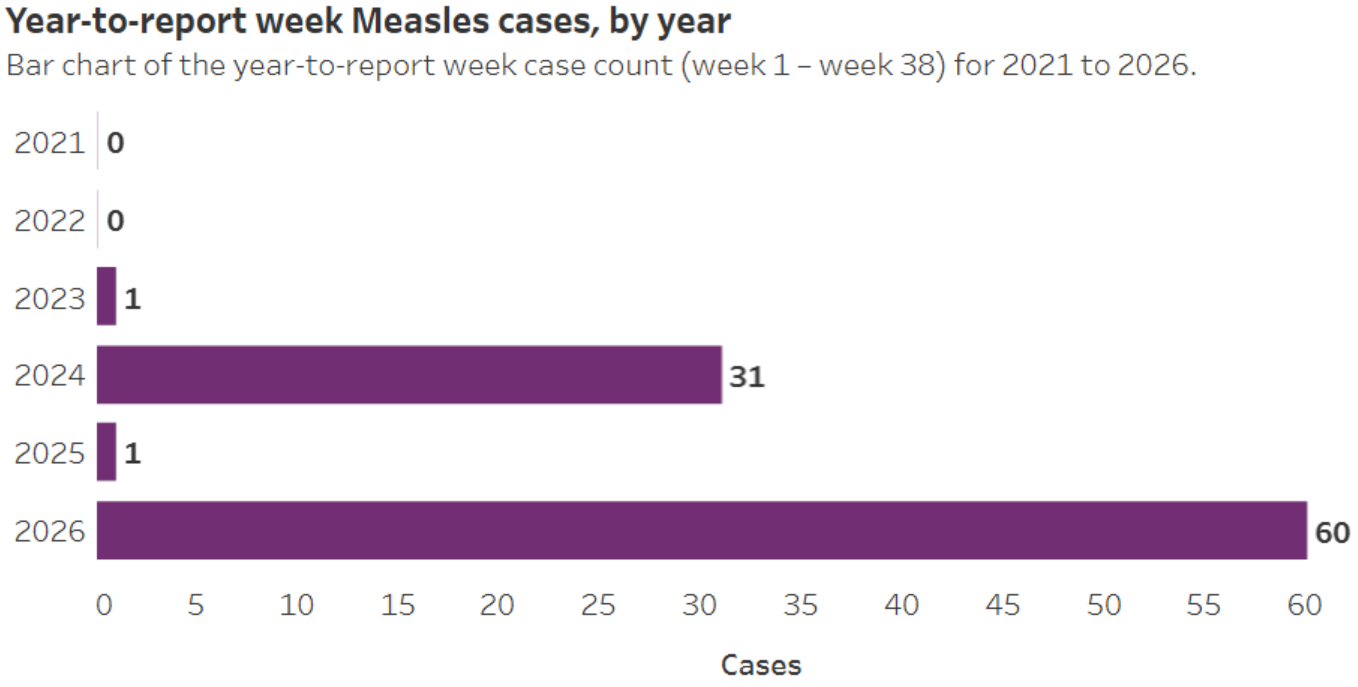
- HIV Care and Treatment
- Viral Hepatitis
- HIV Prevention
- STD Prevention



NC = Nucleocapsid; P = Phosphoprotein; L = Large protein;
HA = Hemagglutinin; F = Fusion protein; M = Matrix protein

Measles

- Resurgence of old disease
  - US currently experiencing largest outbreak in >30 years
    - >3,500 confirmed cases in 2025/2026
  - Elimination status (held since 2000) under WHO review
- Contributors
  - Vaccine hesitancy
  - Under-vaccinated community clusters



Measles Cases in Oregon (2026)

Total Cases	60
Unvaccinated or Unknown	56
1 MMR Dose	2
2 MMR Doses	2
Hospitalizations	5
Deaths	0

Data current as of October 14, 2026.

Clinical Presentation

Guidance for providers and the public

Symptoms typically begin seven to 21 days after exposure and include cough, runny nose and conjunctivitis with high fever, followed by a rash that starts on the head or neck and spreads downward. People are contagious from four days before the rash appears until four days afterward.

Health care providers should report suspected cases immediately and consider post-exposure prophylaxis for exposed patients:

- MMR vaccine, within 72 hours of exposure.
- Immunoglobulin, within six days.

For most vaccine-eligible people 6 months and older, MMR vaccination within 72 hours is recommended.

Anyone not protected against measles is at risk. OHA encourages people to check vaccination status and contact a health care provider if they have questions.

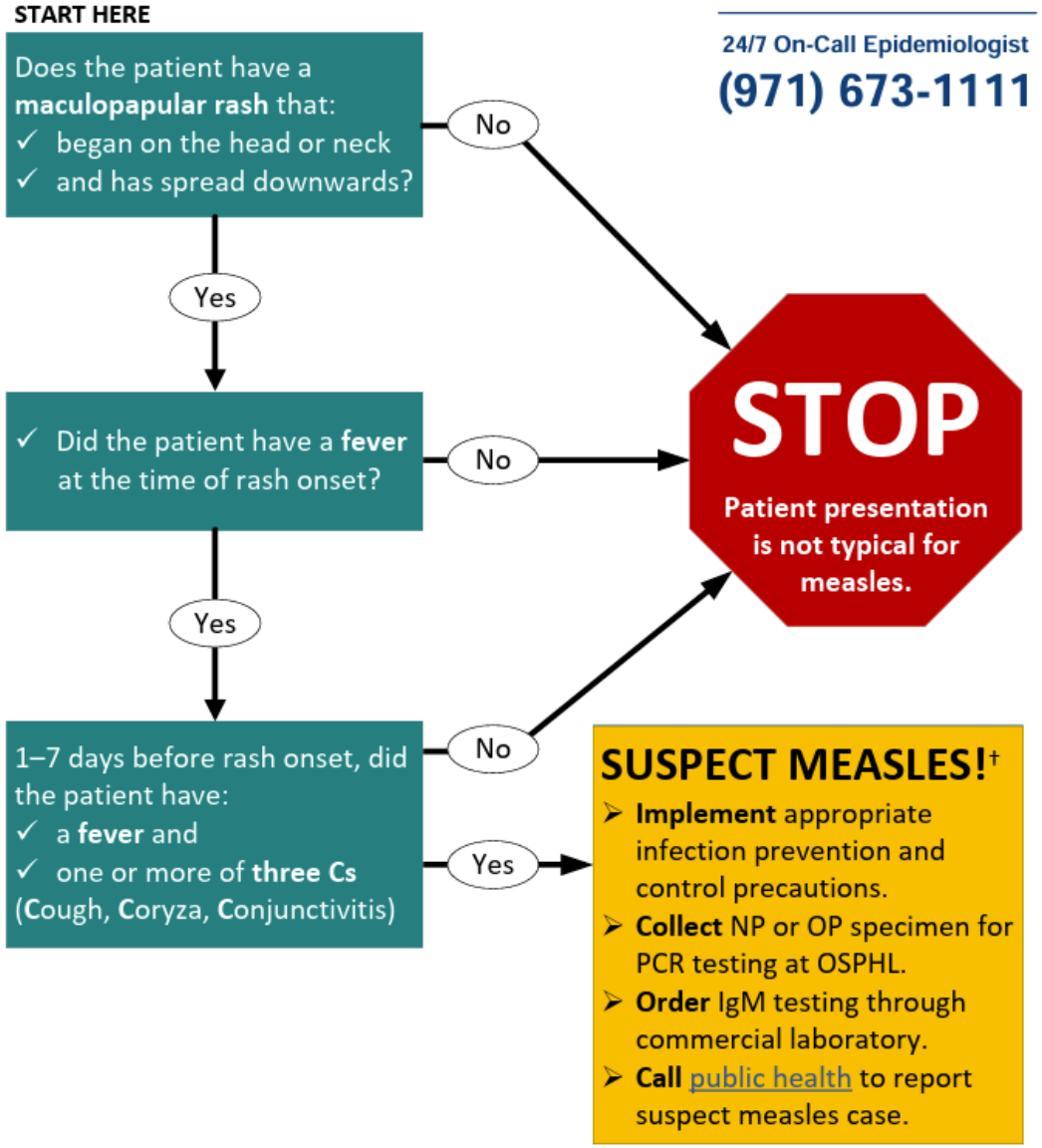
For more information on measles, visit OHA's measles page and the measles wastewater dashboard page.

###

Clinical algorithm for suspect measles cases without known exposure to measles*

OREGON HEALTH AUTHORITY

24/7 On-Call Epidemiologist
(971) 673-1111



* For patients with a known exposure to a measles case within the last 21 days, clinicians should have a high level of suspicion for measles and should call public health to report any combination of the above symptoms.

† Patients who are unvaccinated or have recent travel to an area where measles is circulating are at highest risk of developing measles.

Measles

- How do you diagnose?
  - **Send both molecular and serologic testing** on all suspected cases
  - **Molecular**
    - **RT-PCR** for measles RNA from a **nasopharyngeal or throat swab** (preferred)
    - Adding a **urine specimen** increases sensitivity.
    - Highest yield in the first ~3 days after rash onset (sensitivity ~94%, specificity ~99%)
      - RNA detectable up to ~2 weeks.
  - Serologic
    - **Serum measles-specific IgM**
      - Detectable ~3–30 days after rash
      - Up to ~20% negative in first 72 hours — repeat if initially negative
    - **IgG** seroconversion or 4-fold rise between acute and convalescent sera also confirms
      - a single positive IgG indicates only prior immunity.
      - In recently vaccinated patients (MMR within ~6–45 days)
        - Genotyping/IgG avidity distinguishes wild-type infection from vaccine response.
- How do you treat?
  - Supportive Care
  - High dose (closely supervised) Vit A in children
  - **Post-exposure prophylaxis** for susceptible close contacts
    - Coordinate with public health
- Who do you notify?
  - PUBLIC HEALTH (immediately, upon suspicion – don't await confirmation of dx)

Wastewater monitoring

- Oregon State University (routine testing)
- CDC (interactive map)

College of Engineering » **Oregon Wastewater Surveillance**

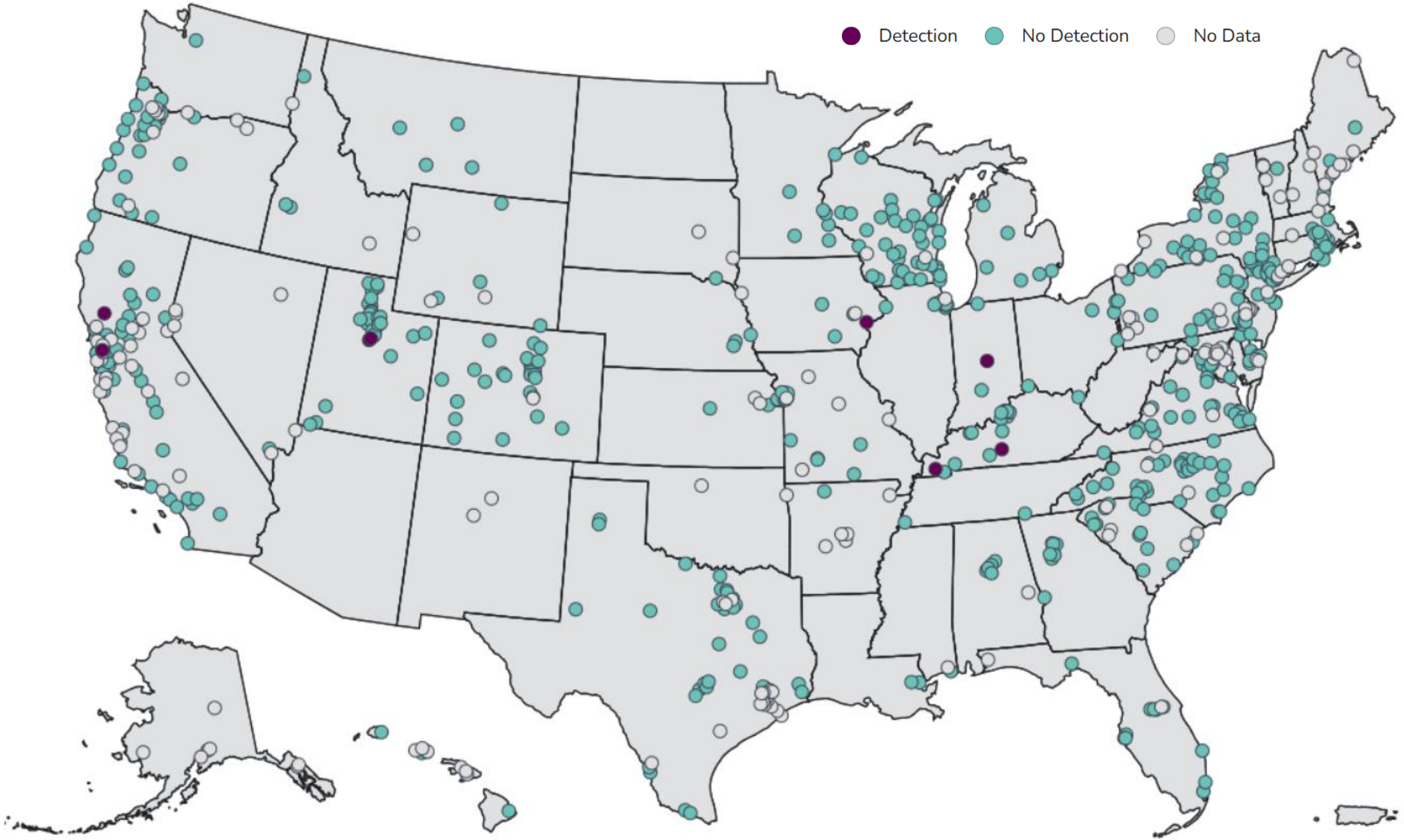
HOME PEOPLE LABORATORY PROJECTS PRESS PUBLICATIONS ABOUT UTILITY PARTICIPANTS

Home

Measles Update October 2025

The Oregon Wastewater Surveillance Program is now routinely testing for the measles virus. Weekly results are shared to the CDC NWSS Wastewater Data for Measles Dashboard (https://www.cdc.gov/nwss/rv/measles.html), which indicates if the wild-type virus has or has not been detected. Any positive results will be communicated by the Oregon Health Authority directly to that community's local public health department prior to publication on the CDC NWSS dashboard. Beginning today, Oregon data has been uploaded, however the government shutdown is affecting the frequency of dashboard updates.

For more information about the measles data displayed, please visit the CDC NWSS Measles Dashboard: https://www.cdc.gov/nwss/rv/measles.html


Detection
No Detection
No Data

Prevention

- Measles is a very contagious, airborne disease.
- Measles starts with a fever, runny nose, cough, red eyes and sore throat, and is followed by a blotchy rash that starts on the face or at the hair line and then spreads all over the body.
- Young children and adults are at risk for becoming more sick.
- The best protection against measles is the MMR (measles-mumps-rubella) vaccine.

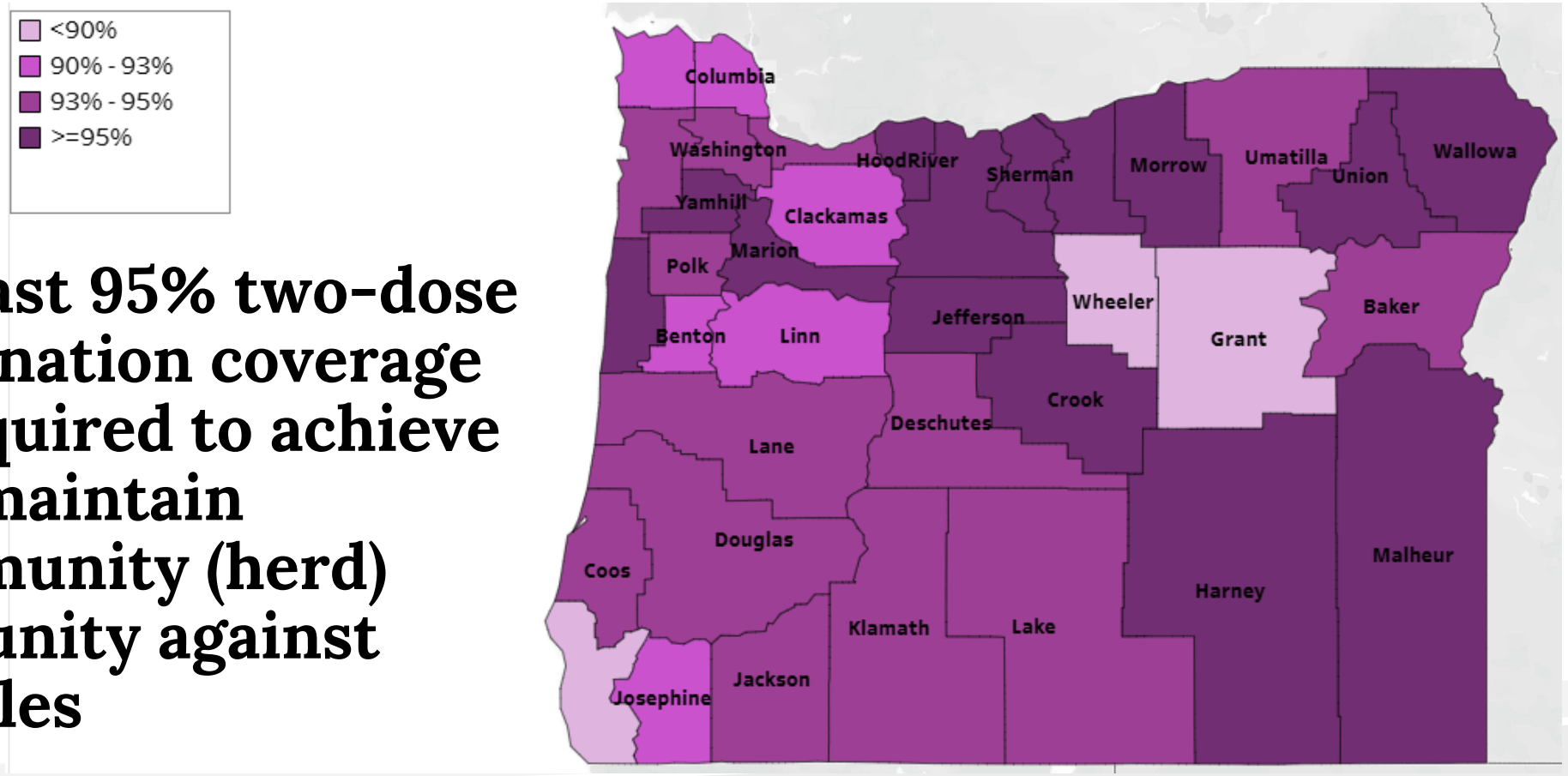
Evidence of immunity

- Birth before 1957
- Laboratory-confirmed disease
- Laboratory evidence of immunity (protective antibody titers)
- Documentation of vaccination

Vaccination considerations

- Born before 1957 – had wild-type virus (life-long immunity)
- Born between 1957 and 1968 - should get 1 or 2 shot series
  - Using less effective killed measles vaccine in that time frame
- Born between 1967 and 1989 – high risk individuals at risk
  - Using only one shot of the live attenuated vaccine
  - Healthcare workers and international travelers offered "2nd" dose
- Born after 1989 – protected! (unless declined series)
  - Using current two-shot series of live attenuated vaccine
  - 93% effective after 1 dose, 97% effective after 2 doses

Childhood Measles UTD Immunization Rates



- **At least 95% two-dose vaccination coverage is required to achieve and maintain community (herd) immunity against measles**

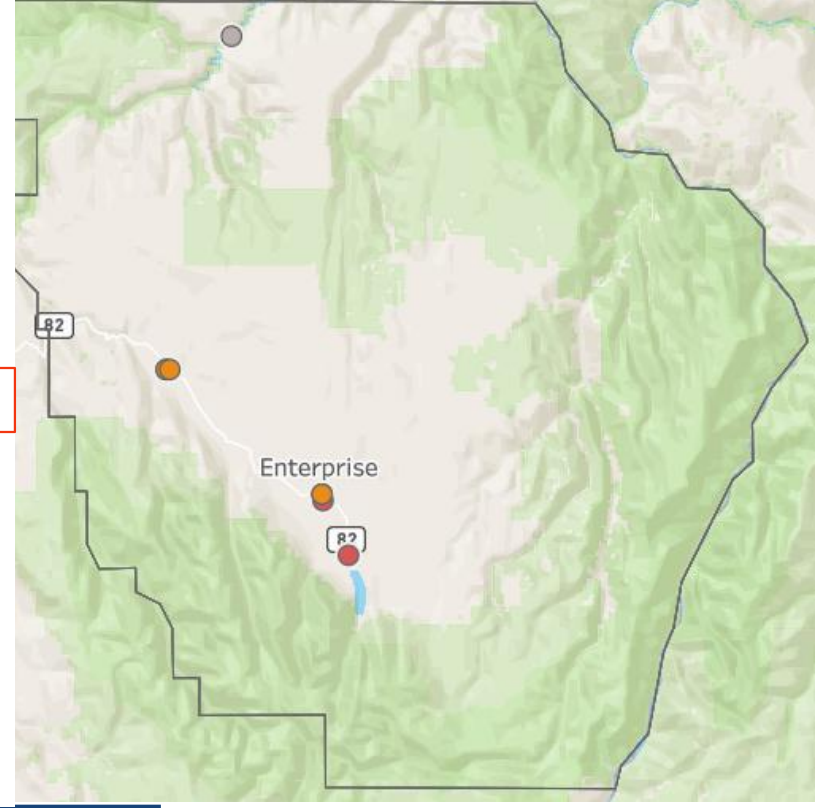
The safest schools are those with 95-100% of students fully vaccinated. The most vulnerable schools are those with less than 90% of students vaccinated. Sites with fewer than 10 children do not have data available.

- 90-94.9% vaccination for all school required vaccines
- <90% vaccination for all school-required vaccines
- <10 students

tableau public Create Learn

Oregon Measles Immunization Data by Oregon Immunization Progr

Enterprise Elementary, Wallowa	Enterprise Elementary	Wallowa
Enrollment*	236	
Not Required**	0	
% No Record***	0.0%	
% All Required Vaccines	92.4%	89.3%
% DTaP / Tdap	94.5%	91.5%
% Polio	94.1%	94.2%
% Varicella	97.5%	95.8%
% MMR1	97.5%	96.1%
% MMR2	94.1%	93.5%
% Hep B	97.5%	95.9%
% Hep A	96.2%	94.1%
% NME - Any	4.2%	7.6%
% NME - DTaP / Tdap	3.4%	6.5%
% NME - Polio	3.8%	4.4%
% NME - Varicella	1.3%	3.3%
% NME - MMR1	0.8%	2.8%
% NME - MMR2	3.4%	4.9%
% NME - HepB	0.8%	2.8%
% NME - HepA	1.3%	4.0%
% NME - All	0.8%	2.5%
% Medical Exemption	0.0%	0.2%



oregon immunization program

Oregon Childhood Measles Immunization Data

School Immunization Rates
Download the Data
Comments/Contact Us

Measles is a highly contagious, airborne disease caused by the measles virus. Symptoms include fever, runny nose, cough, red eyes, and a sore throat, followed by a rash that may begin on the face or hair line, and soon spreads to the rest of the body. The effects of measles can be significant, life-long, and potentially lethal. Approximately 1/3 of reported cases have complications, which can include: pneumonia, ear infections, diarrhea, encephalitis, hospitalization, and death.

There is a safe, effective vaccine for measles that is recommended for all children at 1 year of age. Immunizing against measles helps protect the child, but also helps to prevent the spread of measles among immunocompromised people and the youngest children.

This dashboard reports rates of vaccines given to children at the recommended age of 1. However, when interpreting these numbers, remember that there are approximately 38,000 Oregonian children vulnerable to measles who are not yet old enough to receive the vaccine.

At least 95% two-dose vaccination coverage is required to achieve and maintain community (herd) immunity against measles

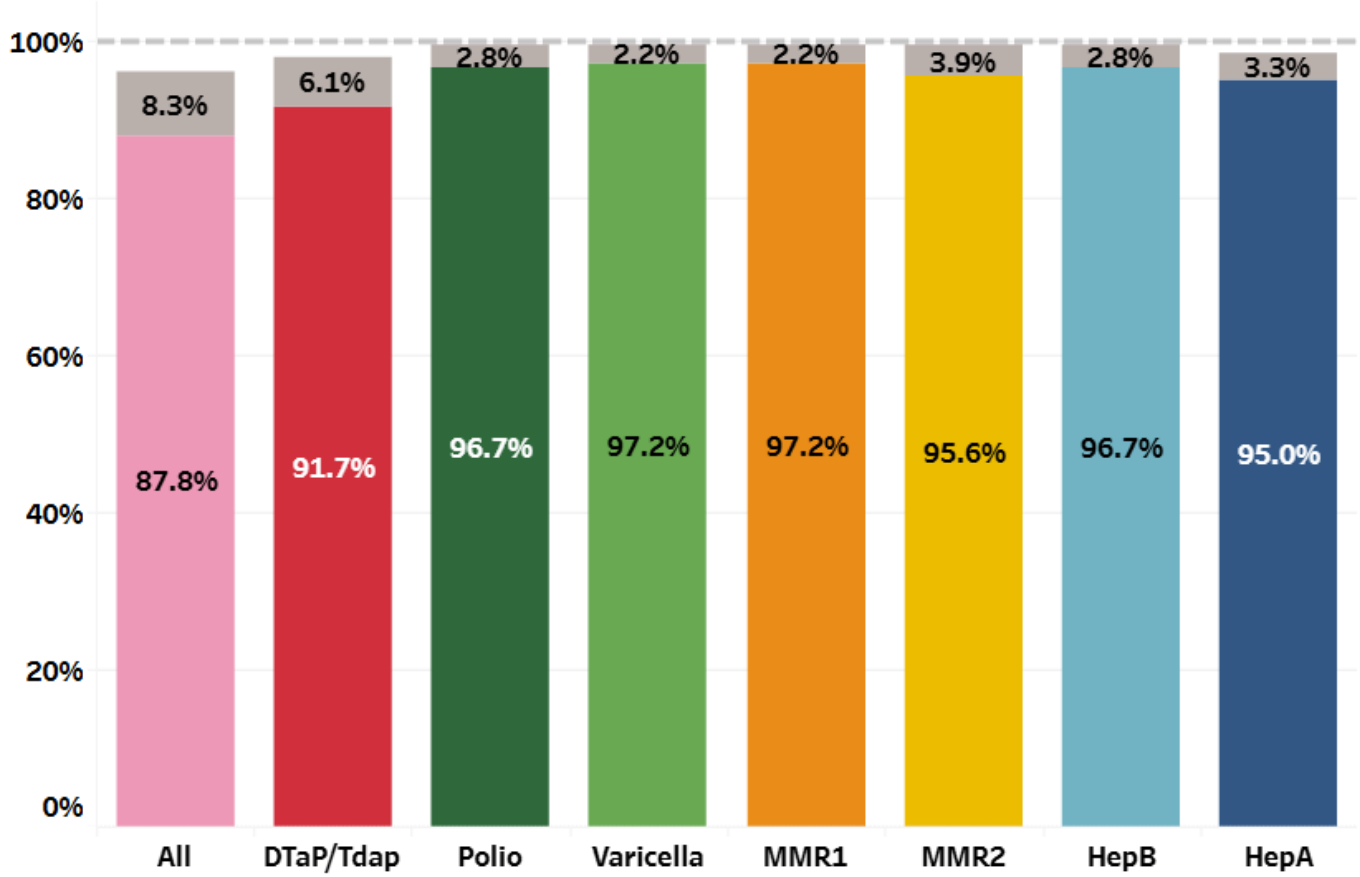
School-Level vs County Data

The tables and figures below show the immunization and exemption rates for any site with 10 or more enrolled children. **The goal is for at least 95% of children to be immunized for community protection and to reduce the chance of spreading vaccine preventable diseases.** On the drop-down menu below, select your school to show the school's immunization and exemption rates as well as the county vaccination rates. For a printer-friendly version, click on the button below.

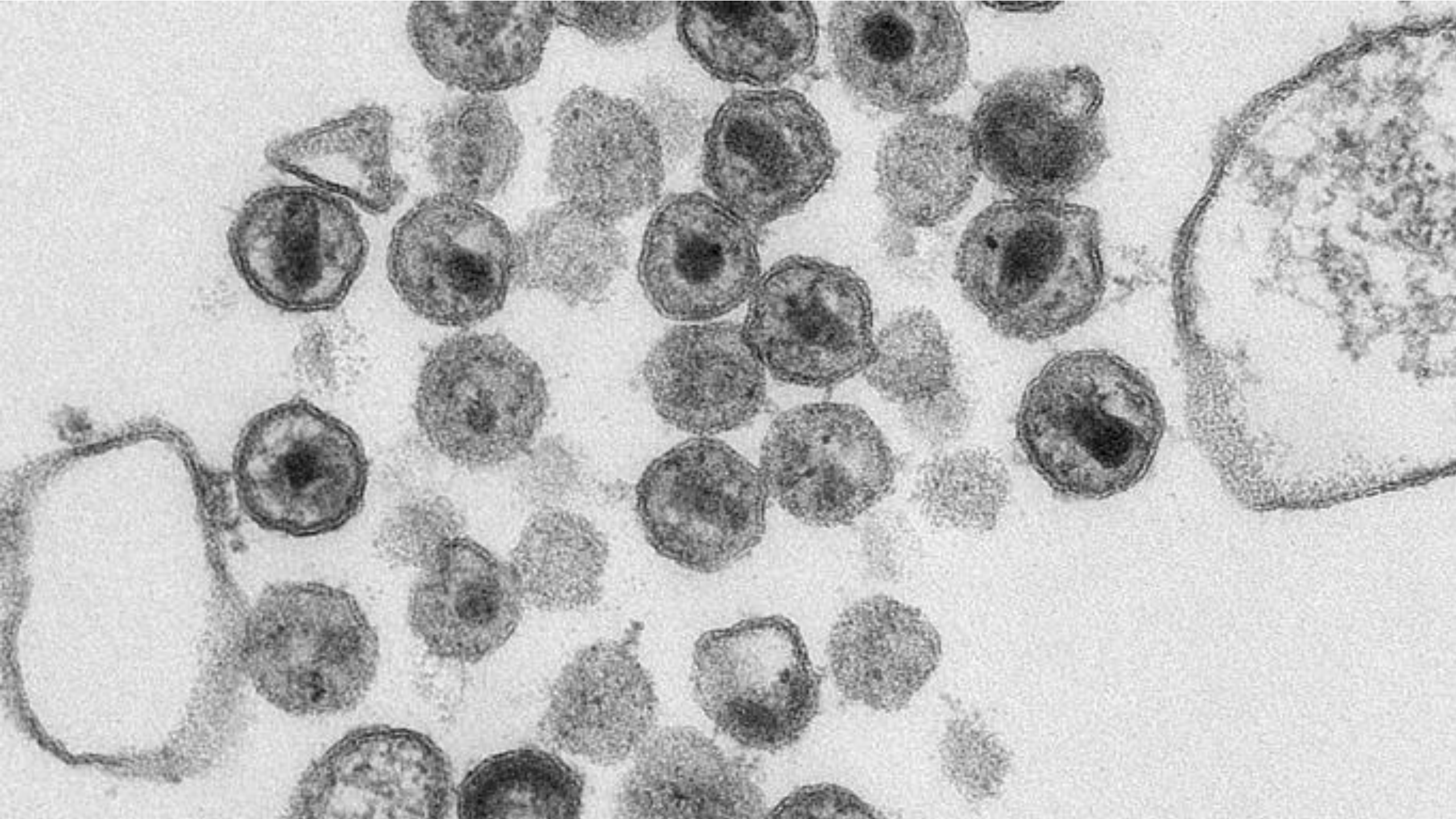
Printer friendly version

	Enterprise Jr/Sr High School	Wallowa
Enrollment*	180	
Not Required**	0	
% No Record***	0.0%	
% All Required Vaccines	87.8%	89.3%
% DTaP / Tdap	91.7%	91.5%
% Polio	96.7%	94.2%
% Varicella	97.2%	95.8%
% MMR1	97.2%	96.1%
% MMR2	95.6%	93.5%
% Hep B	96.7%	95.9%
% Hep A	95.0%	94.1%
% NME - Any	8.3%	7.6%
% NME - DTaP / Tdap	6.1%	6.5%
% NME - Polio	2.8%	4.4%
% NME - Varicella	2.2%	3.3%
% NME - MMR1	2.2%	2.8%
% NME - MMR2	3.9%	4.9%
% NME - HepB	2.8%	2.8%
% NME - HepA	3.3%	4.0%
% NME - All	2.2%	2.5%
% Medical Exemption	0.0%	0.2%

Select school: Enterprise Jr/Sr High School, Wallowa



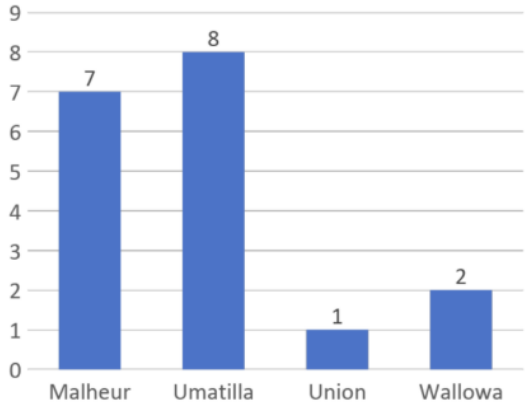
The chart shows both the vaccination rates (colored bars) and nonmedical exemption rates (grey bars) for each vaccine. These numbers may not total 100% if some children have medical exemptions, or are incomplete or in process with immunizations but do not need an exemption because they are on schedule.

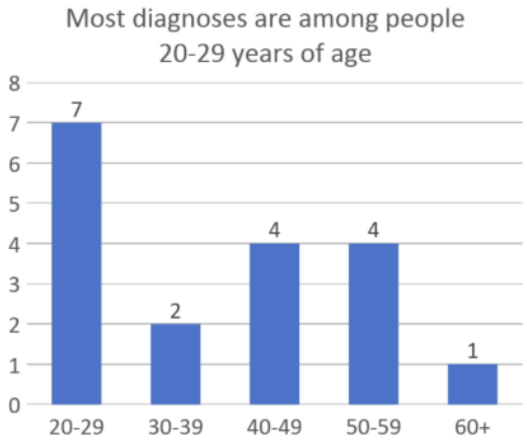


Human Immunodeficiency Virus

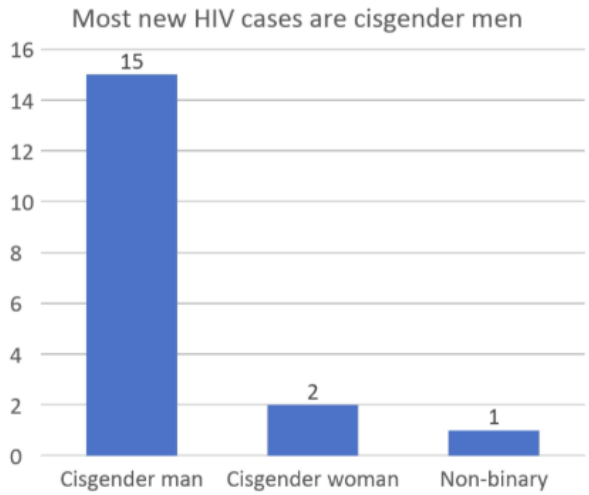
- Significant rise in cases in Eastern Oregon led to CDC/OHA response (18 cases in 4 counties in 2022-2023)
- Convened regional meeting with Public Health and Community Based Organizations in regions impacted
- Focused on provider education, access to testing, building relationships/partnerships
- OHA created End HIV Oregon Dashboard (launched 11/2022)

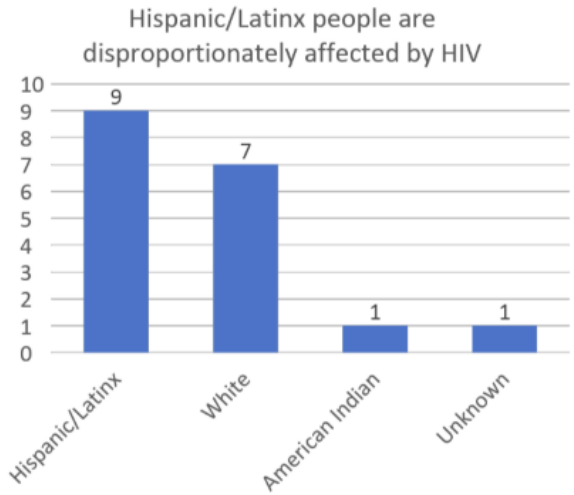
HIV in Malheur, Umatilla, Union and Wallowa, in 2022 and 2023, 18 cases



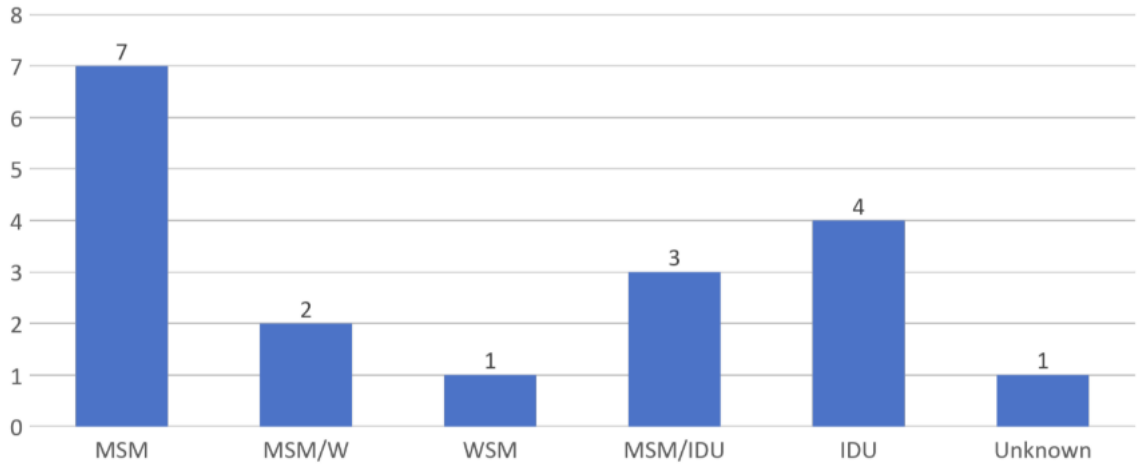


New cases by gender and race/ethnicity

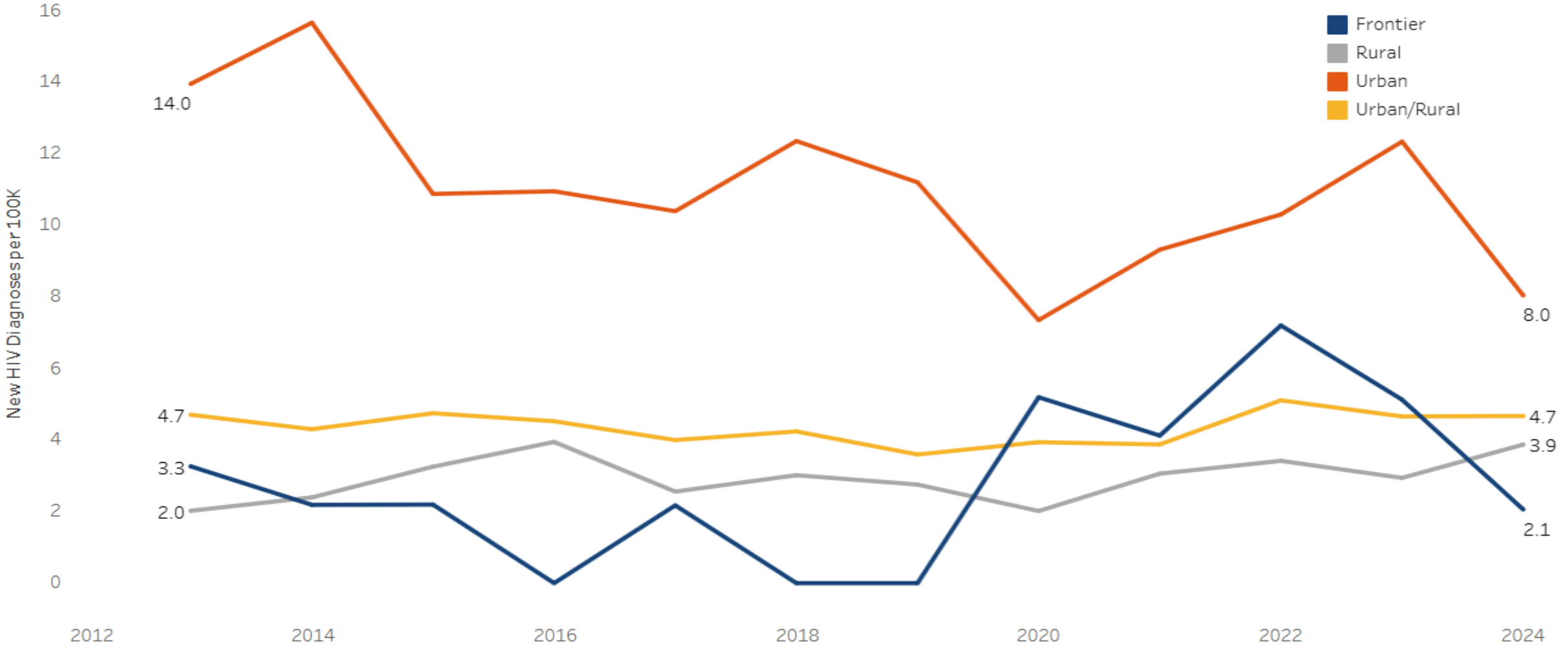




MSM and MSW/people who inject drugs comprise most new cases of HIV



In 2024, new HIV diagnoses (per 100K) decreased in urban and frontier regions, while rural regions experienced an uptick in recent years



Calculations

Definitions

Data sources

Impact of COVID-19

Contact us!

Data Sources: OHSU
Oregon Office of Rural
Health, Orpheus, BRFSS

END HIV OREGON

End HIV OR initiative strives to eliminate new HIV transmissions and improve the health of people living with HIV. The **End HIV Oregon Dashboard** tracks key metrics, using disease, survey, prescription, and social determinants of health data—across the initiative's four pillars:

Testing is easy | Prevention works | Treatment saves lives | Respond to End HIV

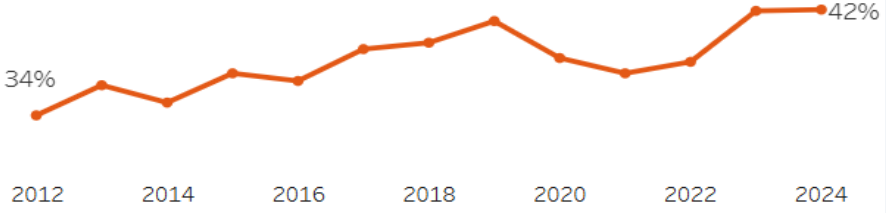
Testing

New HIV diagnoses

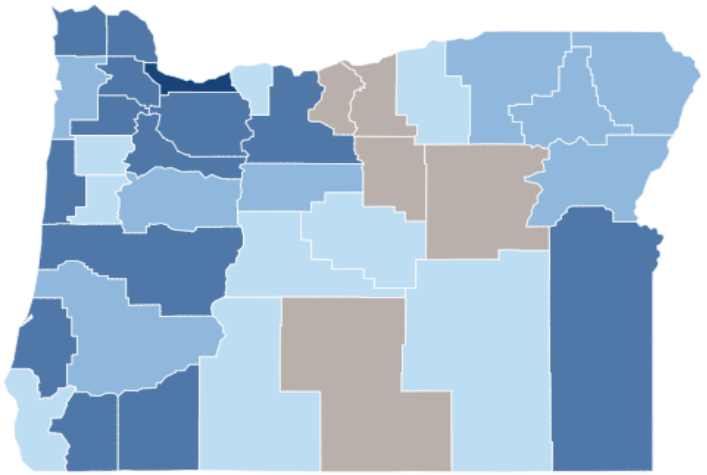
New HIV diagnoses, 2024

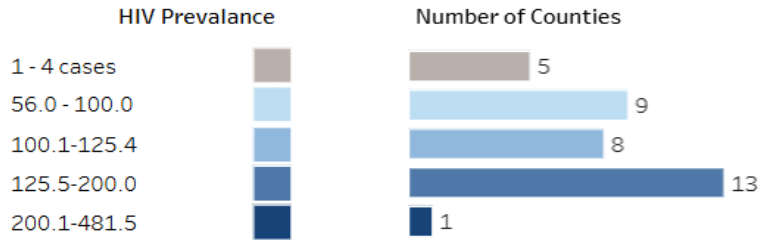
People living with HIV, 2024

Lifetime HIV screening among Oregonians



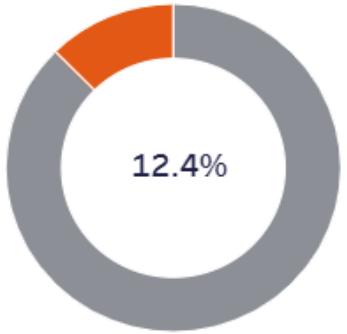
People Living with HIV in Oregon Counties: 2024



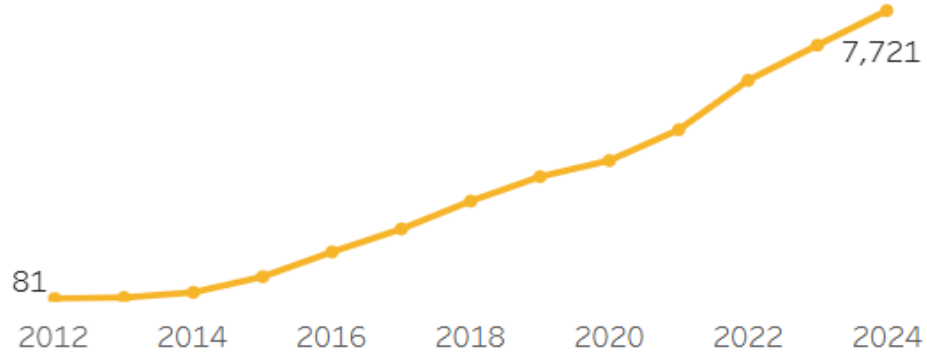


Prevention

2024 HIV diagnoses: proportion ever on PreP

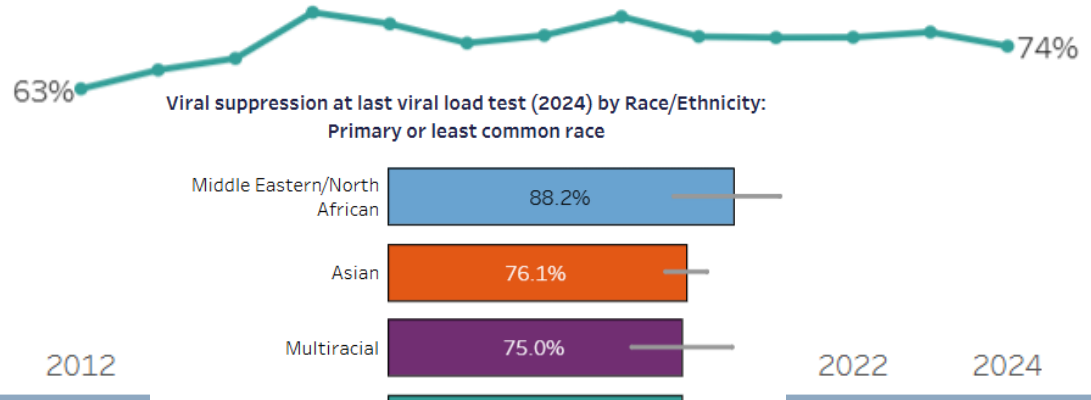


PrEP prescriptions

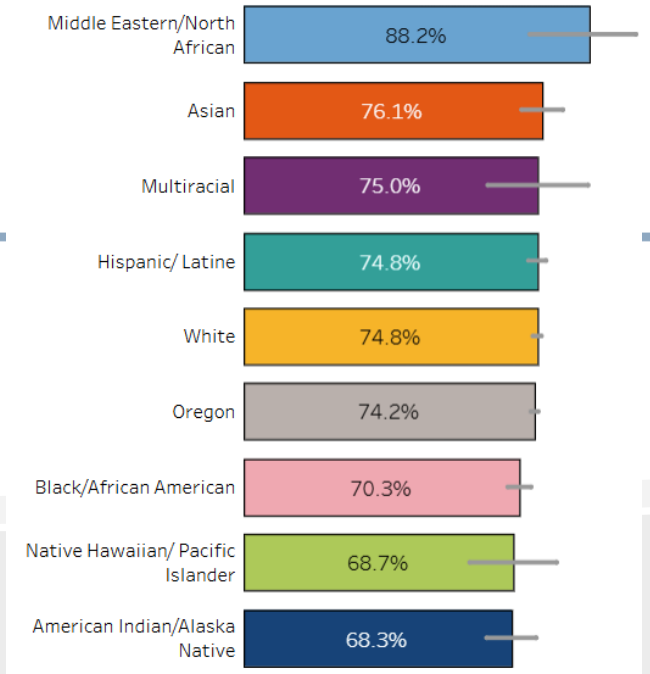


Treatment

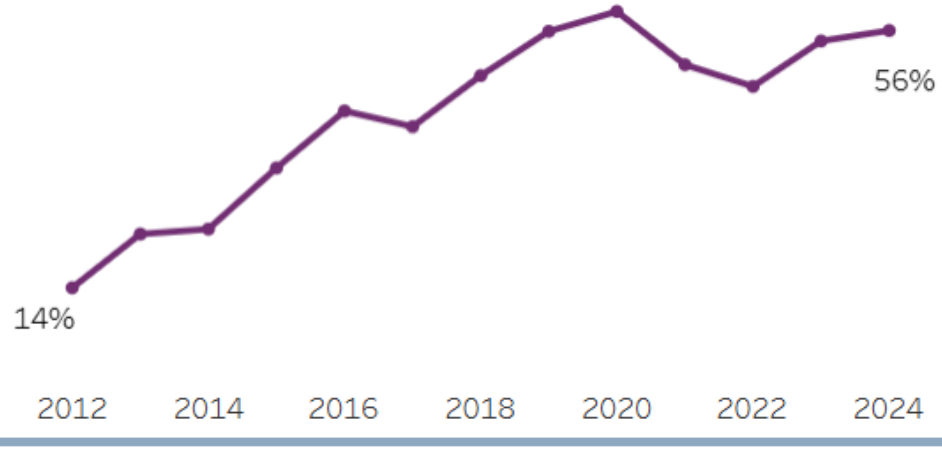
Viral suppression at last viral load test



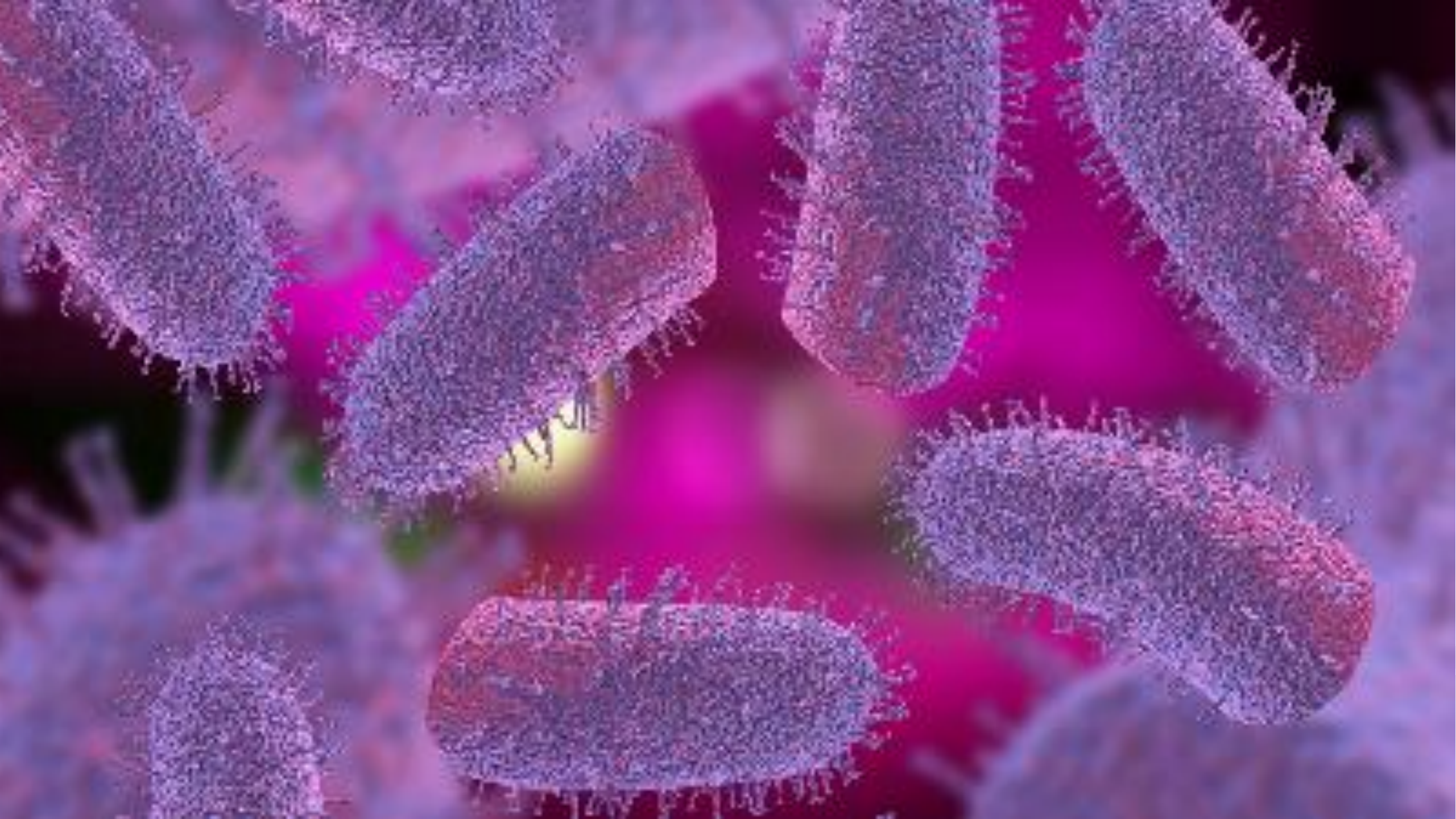
Viral suppression at last viral load test (2024) by Race/Ethnicity: Primary or least common race



Viral suppression within 3 months of diagnosis



In our backyards

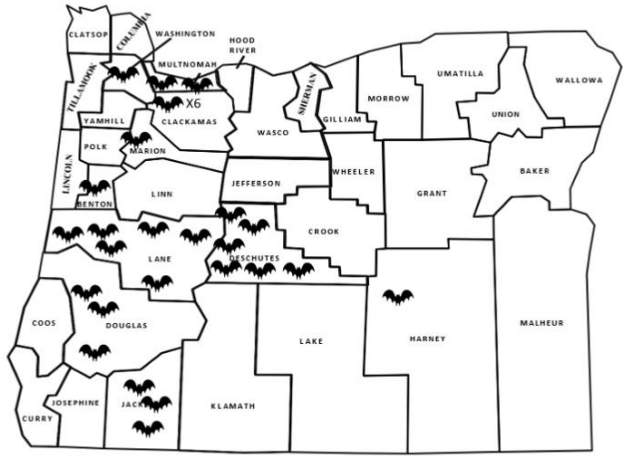


Rabies

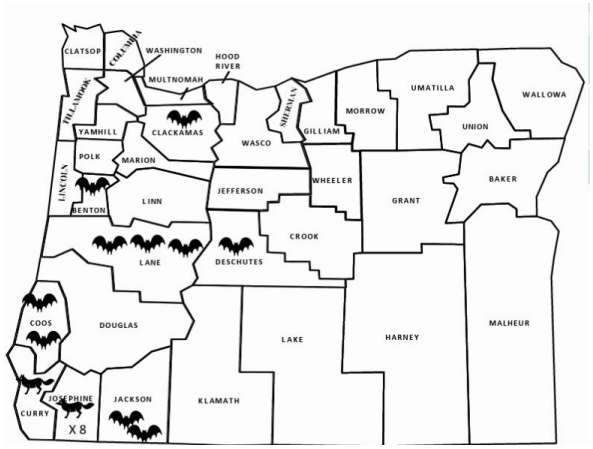
- 100% fatal to humans
- Wildlife vector risk (mostly bats, sometimes foxes/skunks)
- Zero positive dog cases for decades
- Canine variant declared eliminated in 2007 (due to widespread vaccination)
- Human death from rabies in 2021 (Boise ID)
- Last Oregon human case/death was 1989
- Vector of transmission is saliva

Rabies maps

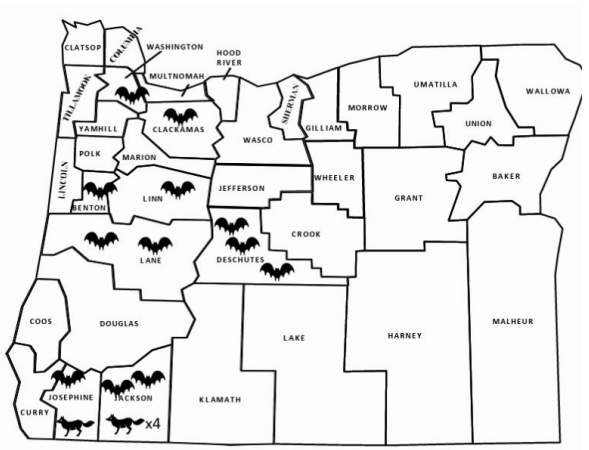
2026



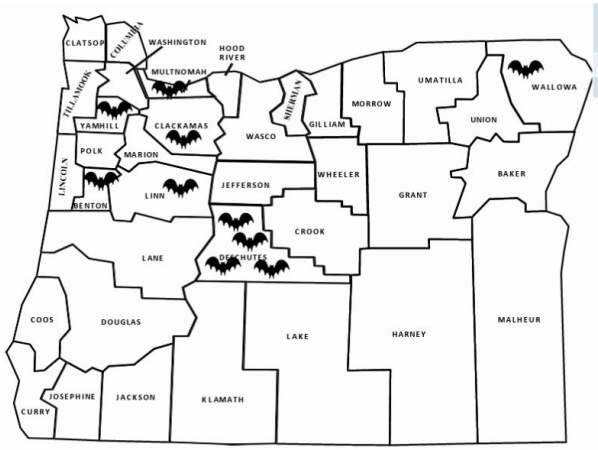
2025

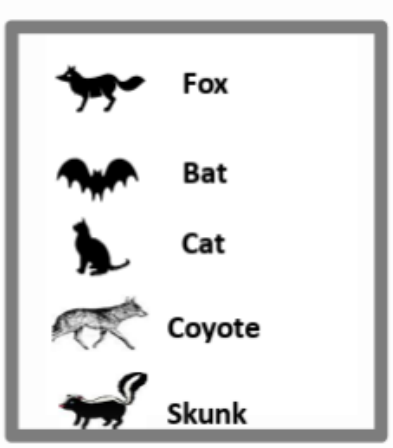


2024



2023





https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/RABIES/Pages/rabies.aspx

Health Alert Network (HAN)

EXPLORE THIS TOPIC

SEARCH

Nationwide Increase in Reported Human Rabies Exposures: Rabies Post-exposure Prophylaxis Administration

SEPT. 10, 2026

- CDC and OHA put out HAN notifications
- Can be regarding a communicable disease risk, an outbreak, or testing, treating or prevention of a communicable disease

Post-exposure prophylaxis

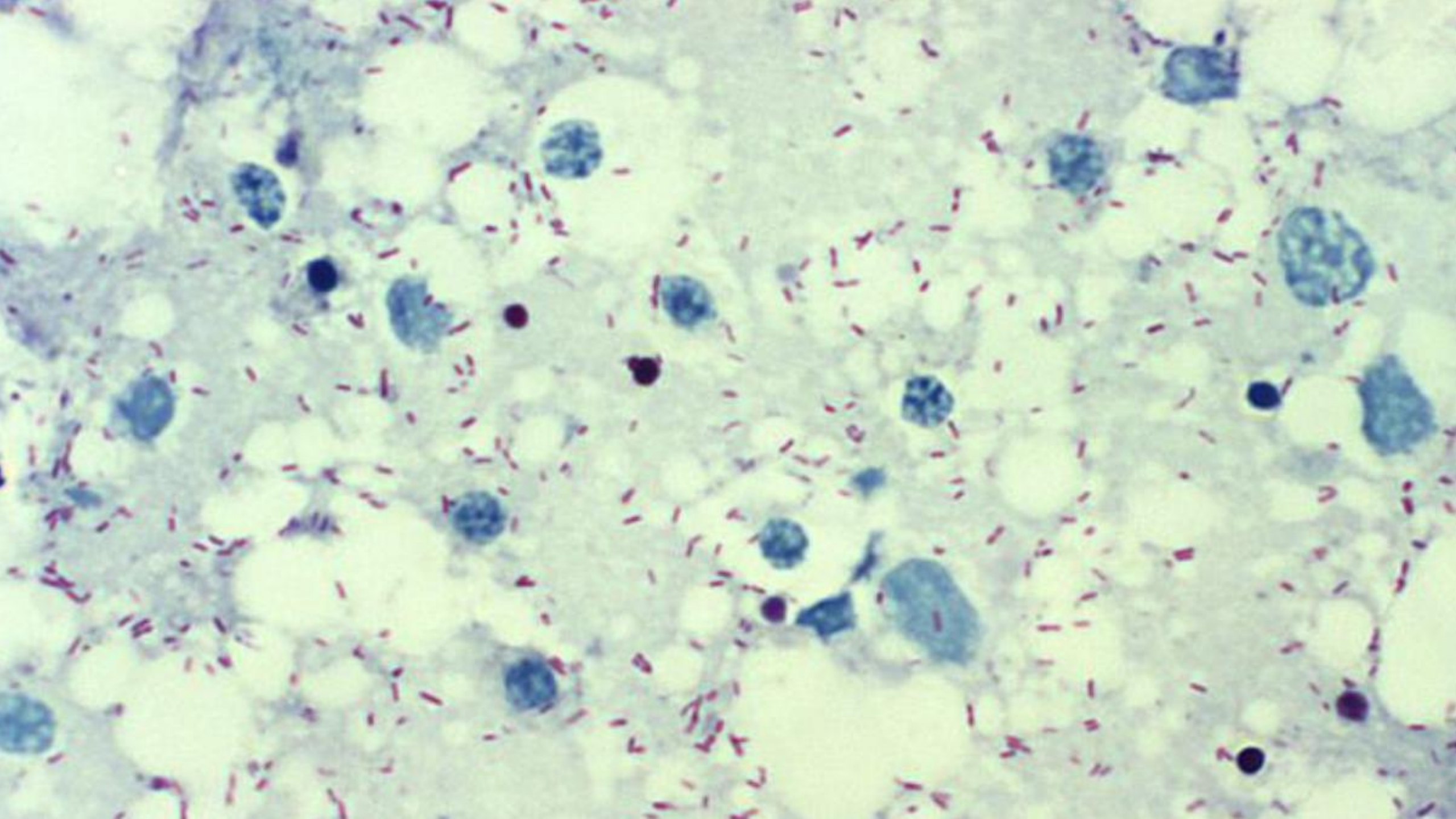
The Advisory Committee on Immunization Practices (ACIP) rabies PEP recommendations consists of:

- Wound care
- A dose of human rabies immune globulin (HRIG)
- Rabies vaccine given at the time of the first medical visit, and a dose of vaccine given again on days 3, 7, and 14 after the first dose.

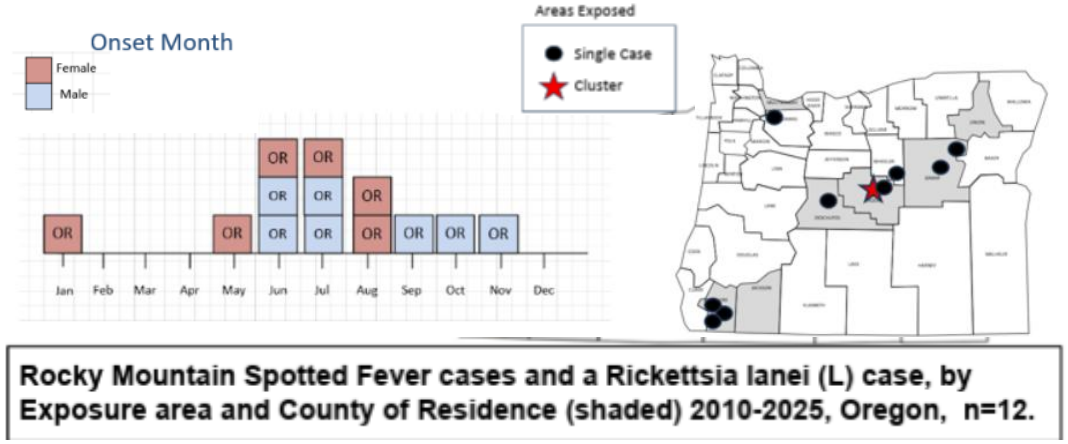
* Also review Tetanus status

Pre-exposure prophylaxis recommendations depend on risk

- Risk Category 1 = humans working with live rabies virus
  - 2 shot series (1 week apart), titers every 6 months
- Risk Category 2 = bat handlers, those doing animal necropsies
  - 2 shot series (1 week apart), titers every 2 years
- Risk Category 3 = veterinarians, veterinary technicians, animal control officers, wildlife biologists, spelunkers, and frequent travelers to regions where dog rabies is endemic
  - 2 shot series (1 week apart), one time titer check (1-3 years) or one booster
- Risk Category 4 = same as RC3, but for short term (3 years or less)
  - 2 shot series (1 week apart)
- Risk Category 5 = general population
  - None

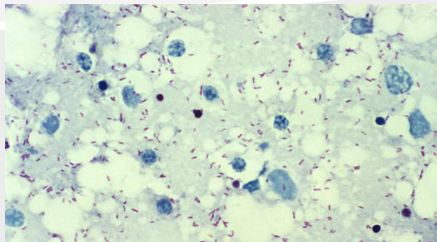


Tick-borne illness

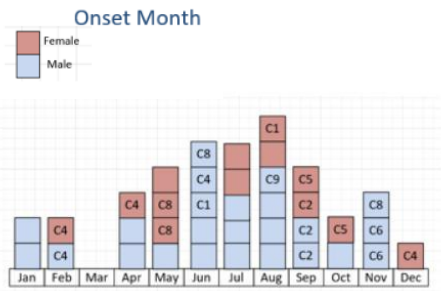


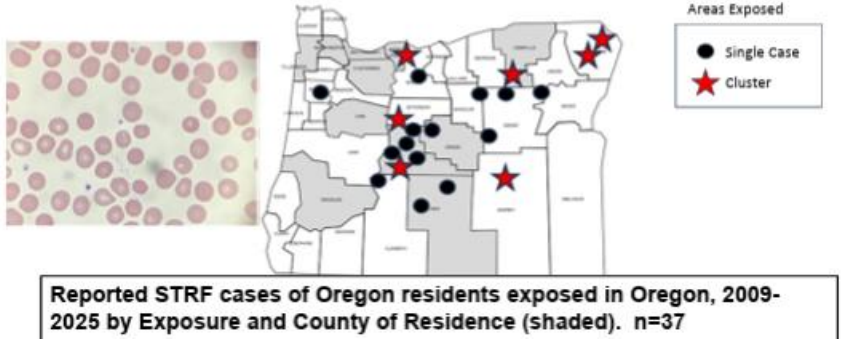
Rocky Mountain Spotted Fever cases and a Rickettsia lanei (L) case, by Exposure area and County of Residence (shaded) 2010-2025, Oregon, n=12.

- *Rickettsia rickettsii* bacteria cause Rocky Mountain spotted fever (RMSF)
  - How does it present – fever (all patients), headache (severe), rash (80-90%, but lags)
    - Classic triad present in 3% of patients in the first 72 hours, 70% by 2 weeks
      - Rash with acral → central progression. Maculopapular with central petechiae
    - May see leukopenia, thrombocytopenia, hyponatremia, transaminitis
  - How do you diagnose
    - Clinical diagnosis (appropriate exposure/season)
    - Serology is retrospective and can result in false-negative (even on convalescent serology)
      - (skin biopsy is more sensitive)
  - How do you treat – Doxycycline
  - Who do you notify – local Public Health within 1 working day



Tick-borne illness

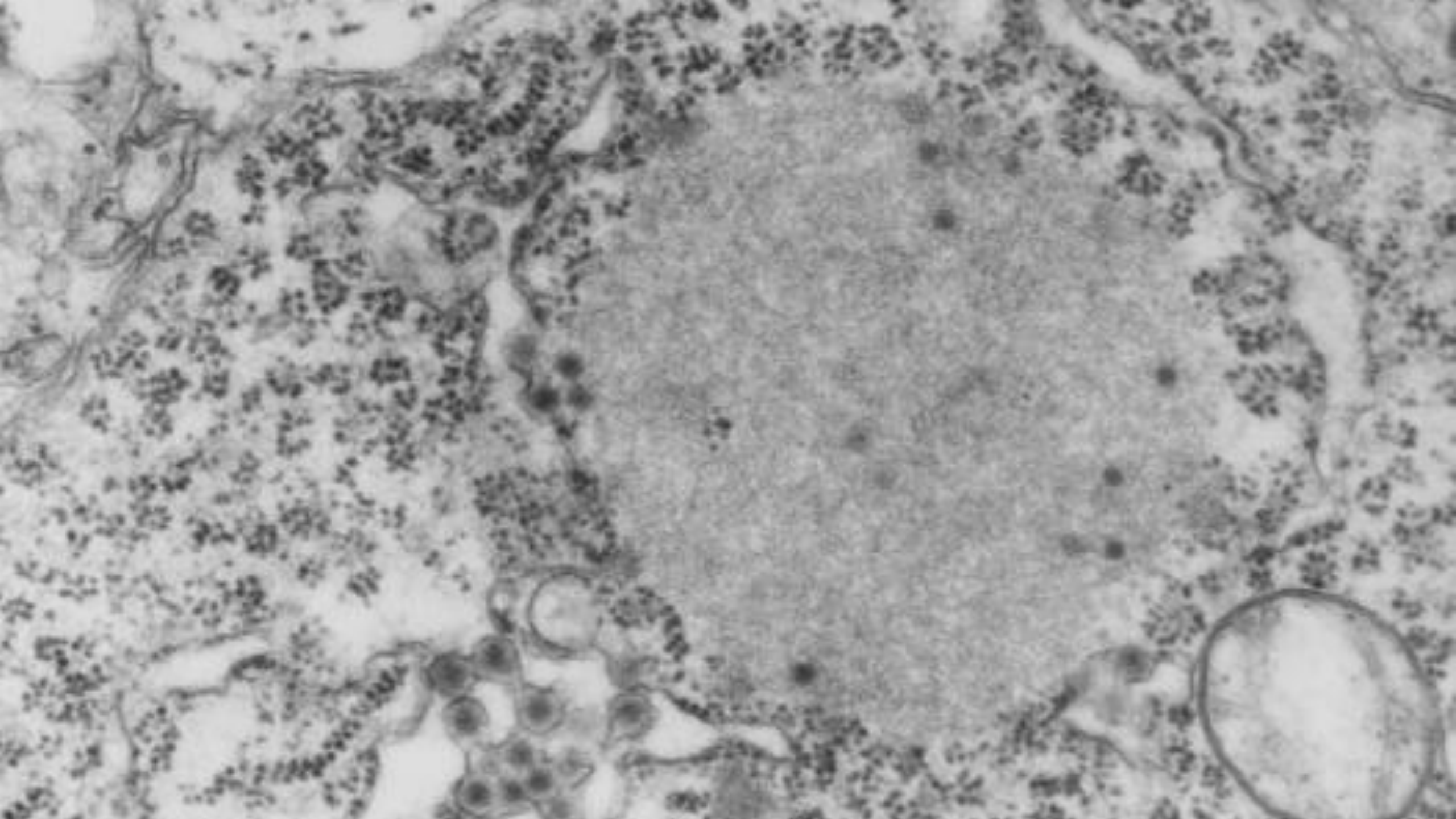




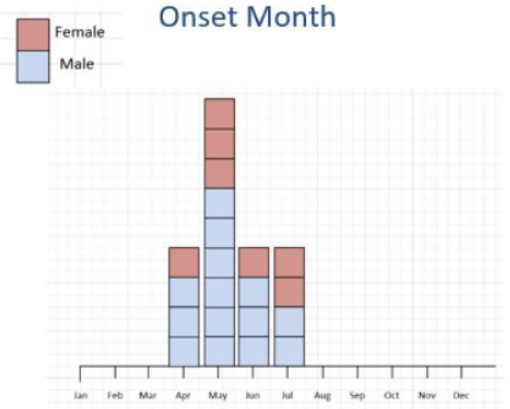
Reported STRF cases of Oregon residents exposed in Oregon, 2009-2025 by Exposure and County of Residence (shaded). n=37

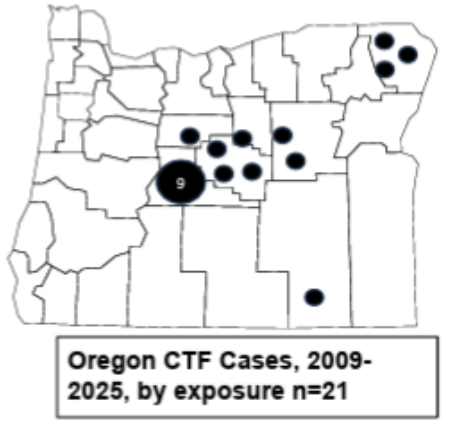
- Borrelia species (spirochete) bacteria cause tick-borne relapsing fever
  - How does it present – fever, headache, myalgias, neurologic symptoms, rash (30%)
    - High fever for 2-7 days, then fever free 4-14 days, can have up to 30 relapses
    - Can have splenomegaly, lymphadenopathy
    - Thrombocytopenia is common
  - How do you diagnose
    - Clinical diagnosis (appropriate exposure = sleeping in rustic cabin, lean-to, cave with rodents in proximity)
    - Check peripheral smear during febrile episode
  - How do you treat – Doxycycline 100 mg BID for 10 days (hospitalize to initiate)
    - Jarisch-Herxheimer Reaction occurs in first few hours after initiation of treatment 20-30%
  - Who do you notify – local Public Health within 1 working day

* Half of cases are associated with clusters (>1)
* Half the clusters are associated with hunting cabins.



Tick-borne illness



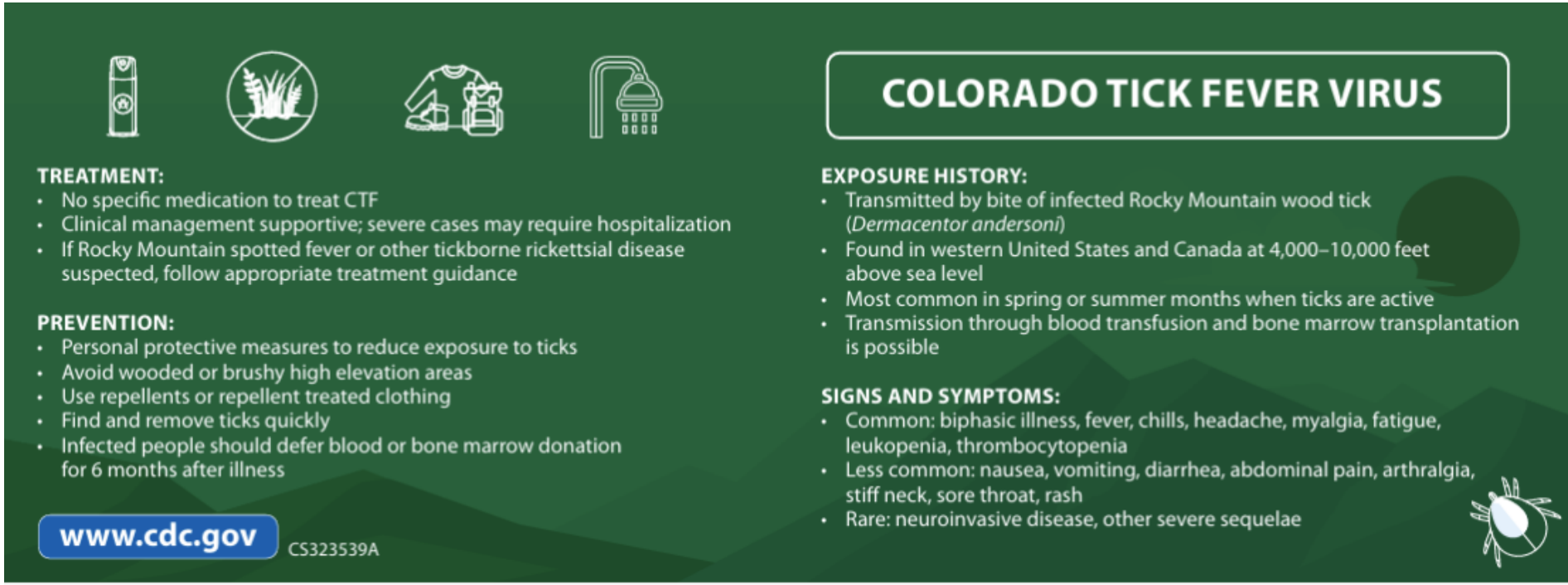


Oregon CTF Cases, 2009-2025, by exposure n=21

- Colorado tick fever virus
- How does it present – fever (high), headache, myalgias (severe)
  - 50% have biphasic illness (fever resolves after 2-4 days, then recurs 1-3 days later)
  - Can have conjunctivitis, pharyngitis, lymphadenopathy. Rash <20% (non-specific, transient, maculopapular)
  - Can have leukopenia, thrombocytopenia
  - Prolonged weakness/fatigue in convalescence
- How do you diagnose
  - Clinical diagnosis (appropriate exposure, season)
  - RT-PCR is confirmatory (antibody production delayed 14-21 days after onset): acute and convalescent sera samples
    - Quest is the only commercial lab in the country to test for this
- How do you treat
  - Supportive care
  - Rare complications of encephalitis, DIC, pericarditis, hepatitis. Children are at higher risk for severe disease.
- Who do you notify – local Public Health within 1 working day

CDC

- Pocket Guides



COLORADO TICK FEVER VIRUS

TREATMENT:
- No specific medication to treat CTF
- Clinical management supportive; severe cases may require hospitalization
- If Rocky Mountain spotted fever or other tickborne rickettsial disease suspected, follow appropriate treatment guidance

PREVENTION:
- Personal protective measures to reduce exposure to ticks
- Avoid wooded or brushy high elevation areas
- Use repellents or repellent treated clothing
- Find and remove ticks quickly
- Infected people should defer blood or bone marrow donation for 6 months after illness

www.cdc.gov CS323539A

EXPOSURE HISTORY:
- Transmitted by bite of infected Rocky Mountain wood tick (*Dermacentor andersoni*)
- Found in western United States and Canada at 4,000–10,000 feet above sea level
- Most common in spring or summer months when ticks are active
- Transmission through blood transfusion and bone marrow transplantation is possible

SIGNS AND SYMPTOMS:
- Common: biphasic illness, fever, chills, headache, myalgia, fatigue, leukopenia, thrombocytopenia
- Less common: nausea, vomiting, diarrhea, abdominal pain, arthralgia, stiff neck, sore throat, rash
- Rare: neuroinvasive disease, other severe sequelae

Diagnostic Testing

Preliminary diagnosis of Colorado tick fever (CTF) is based on signs and symptoms, places and dates of travel, activities, and history of potential tick exposure. Acute samples should be tested by reverse-transcriptase polymerase chain reaction (RT-PCR) to detect viral RNA as antibody production is delayed until 14–21 days after onset of symptoms.

Timing of specimen collection	Specimens	Preferred Test
<14 days after symptom onset	Serum (CSF if suspected CNS involvement)	RT-PCR for viral RNA
≥14 days after symptom onset	Serum (CSF if suspected CNS involvement)	Antibody testing*; consider RT-PCR for samples from days 14-21

CSF, cerebrospinal fluid; CNS, central nervous system

*If possible, acute and convalescent samples, collected at least 2 weeks apart, with the convalescent sample collected at least 3 weeks after symptom onset, should be obtained to look for seroconversion or a 4-fold rise in antibody titers typically using a plaque reduction neutralization test (PRNT).

CTF testing is available at some commercial and state health department laboratories and at CDC. Contact your state or local health department for assistance with diagnostic testing. CTF cases are reportable to local public health authorities in certain states.

For more information, www.cdc.gov/coloradotickfever

Disease-transmitting Ticks of Northeast Oregon

- *Rocky Mountain Wood Tick*
  - *Hard ticks: bite and hold on*
  - *Found in woods/grasslands/sagebrush*
  - *Can transmit:*
    - *RMSF (bacteria), CTF (virus), Tick Paralysis, Hard Tick Relapsing Fever (bacteria)*

- Ornithodoros Ticks
  - Soft ticks: feed for 30 minutes, then let go (usually during sleep)
  - Found in cabins
  - Can transmit:
    - Soft Tick Relapsing Fever (bacterial)

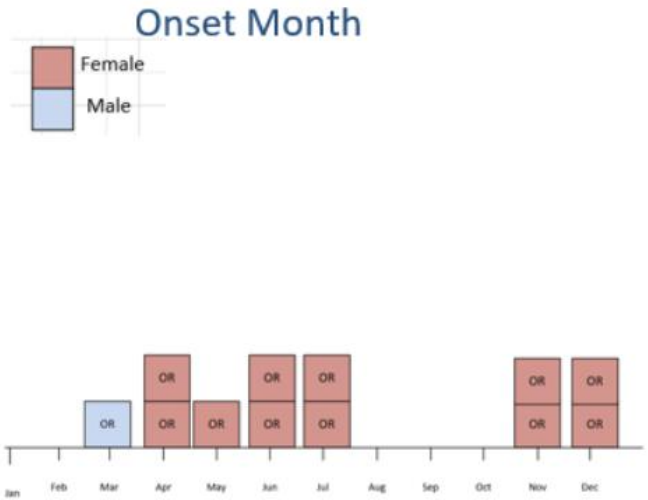
Tick-borne illness east of the Cascades

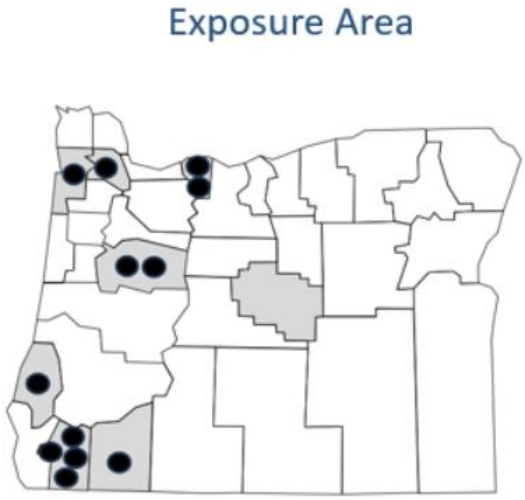
- Oregon is a very low incidence tickborne disease state with <1/million population/year/tickborne disease.
- Two most likely (endemic to east side of Cascades)
  - Soft tick relapsing fever
  - Colorado tick fever

Most commercial labs, e.g., ARUP, LabCorp, Mayo, and Quest don't include testing CTF or STRF in their "tickborne disease panels."

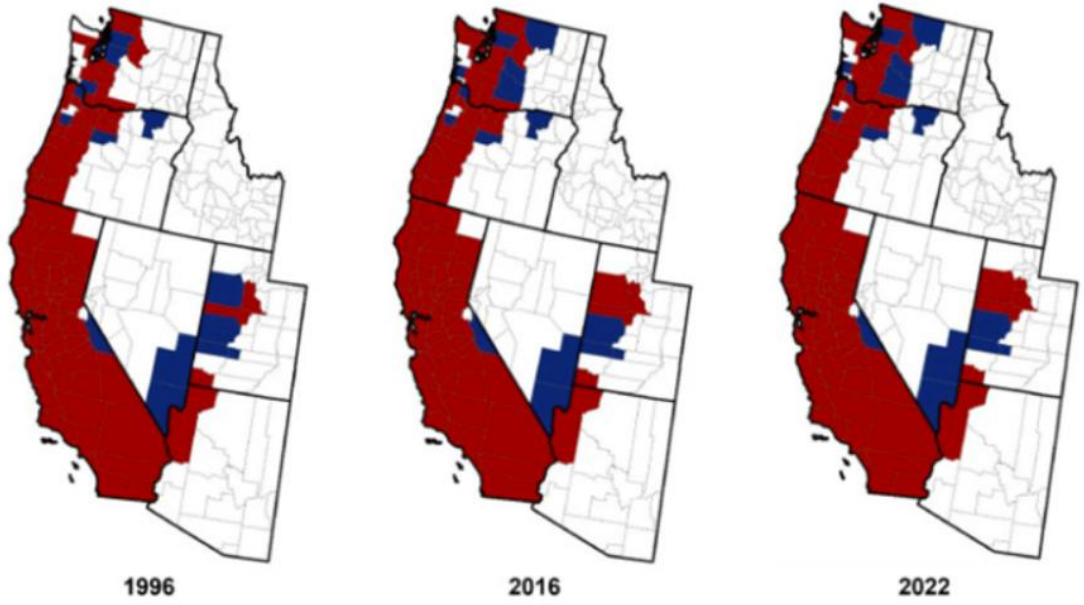
Lyme Disease

- Not present east of the Cascades by OHA (top) or CDC (bottom) data



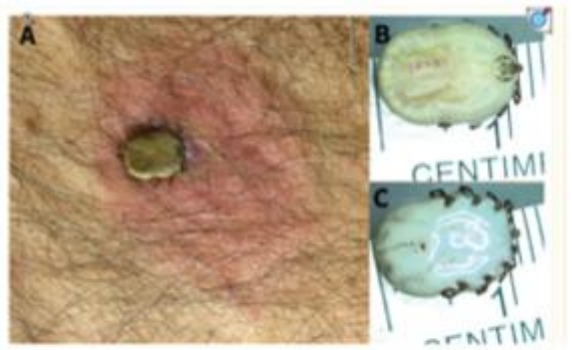


Ixodes pacificus distribution between 1990 and 2022



TIA vs Tick Paralysis

- Female in 80s presented May 2026 to Wallowa Memorial Hospital
- Presenting symptoms were dysarthria and diplopia
- Symptoms resolved within 24 hours of presentation (and initiation of doxycycline)



https://pmc.ncbi.nlm.nih.gov/articles/PMC5662451/

Tick paralysis is a potentially fatal condition caused by neurotoxins secreted by the salivary glands of Rocky Mountain wood ticks. Symptoms begin around 4 to 7 days after tick attachment with malaise and weakness, followed by progressive neurologic deficits, including blurred or double vision, difficulty swallowing, difficulty speaking, and difficulty walking. Symptoms usually resolve within a day after tick removal. Of the 5 Oregon cases of tick paralysis since 2003, onsets of disease were in April and May, when the Rocky Mountain wood tick is active.

Ounce of prevention

- Tick checks (seasons are changing with the weather)
- Remove hard ticks when you see them
- Soft ticks bite and move on (usually while you are sleeping)

- [Photo of Stephen with tick booth at STEAM night]

Algae bloom

- Hells Canyon

HAN Alerts

http://www.han.oregon.gov/

State of Oregon
Health Alert Network

Health Alert Network (HAN)

Oregon's Health Alert Network (HAN) connects hospitals, clinics, laboratories, public safety, EMS and many other public health partners via secure web applications that facilitate information sharing throughout Oregon and SW Washington. The system is managed by the Oregon Health Authority - Public Health Division - Health Security, Preparedness and Response Program.

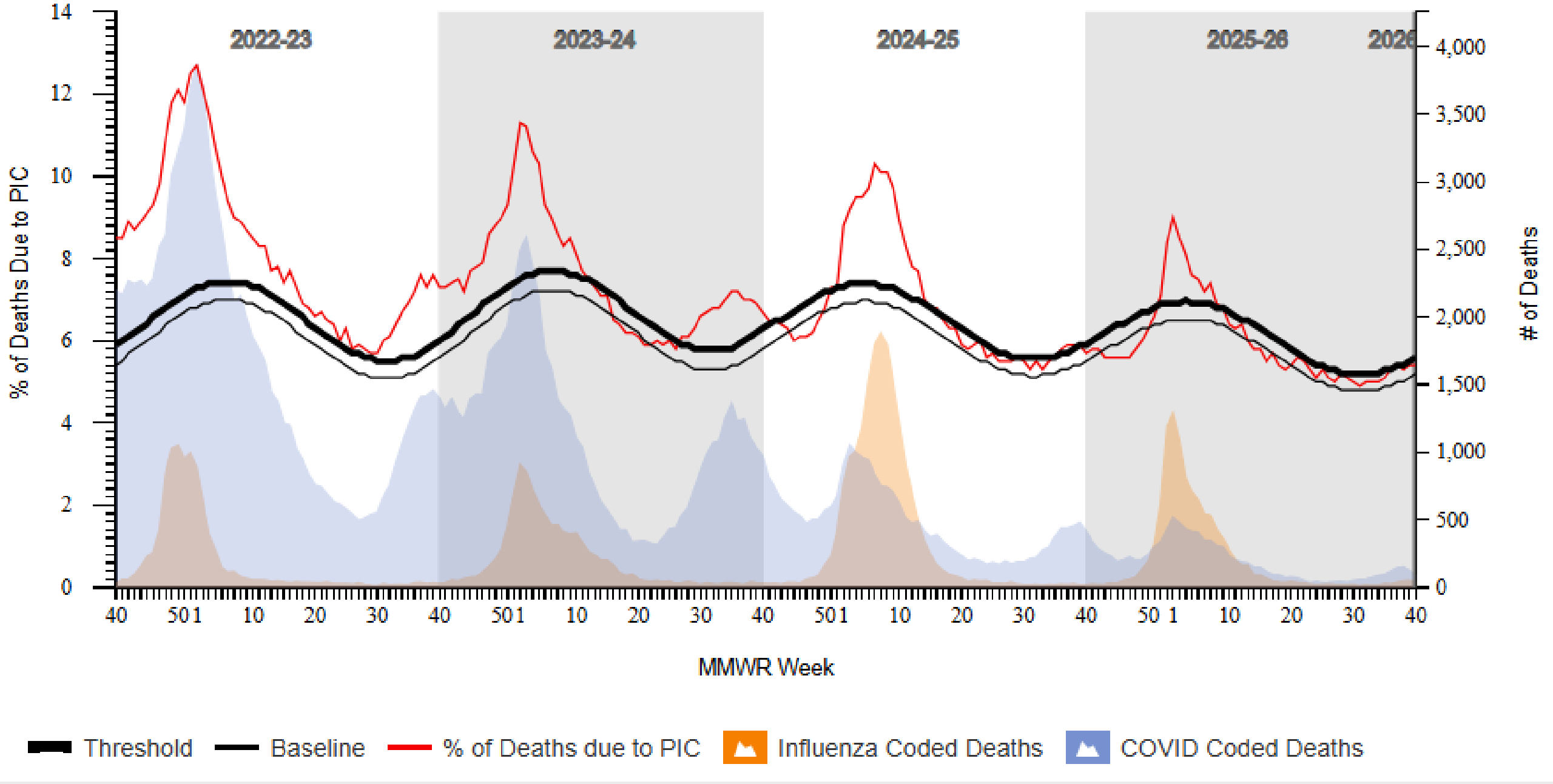
If you are a member of the Oregon Healthcare Community and would like to receive HAN Alerts, please email: HAN.Oregon@odhsoha.oregon.gov

CYANOBACTERIA ADVISORIES and PRECAUTIONS:

The Oregon Recreational CyanoHAB Program sampling season began on May 4th. Below is a list of advisories and precautions:

- Hells Canyon Reservoir – Advisory issued 7/20/2026
- Brownlee Reservoir – Advisory issued 7/20/2026
- Dexter Reservoir – Precaution issued 7/20/2026
- Wapato Marsh and Oaks Bottom Wildlife Refuge – Precaution issued 7/14/2026
- Brownlee Reservoir, Powder Arm precaution issued 7/14/2026
- Timothy Lake – Second precaution lifted 7/21/2026 (second precaution issued 7/14/2026; previous precaution 6/16/2026-7/1/2026)

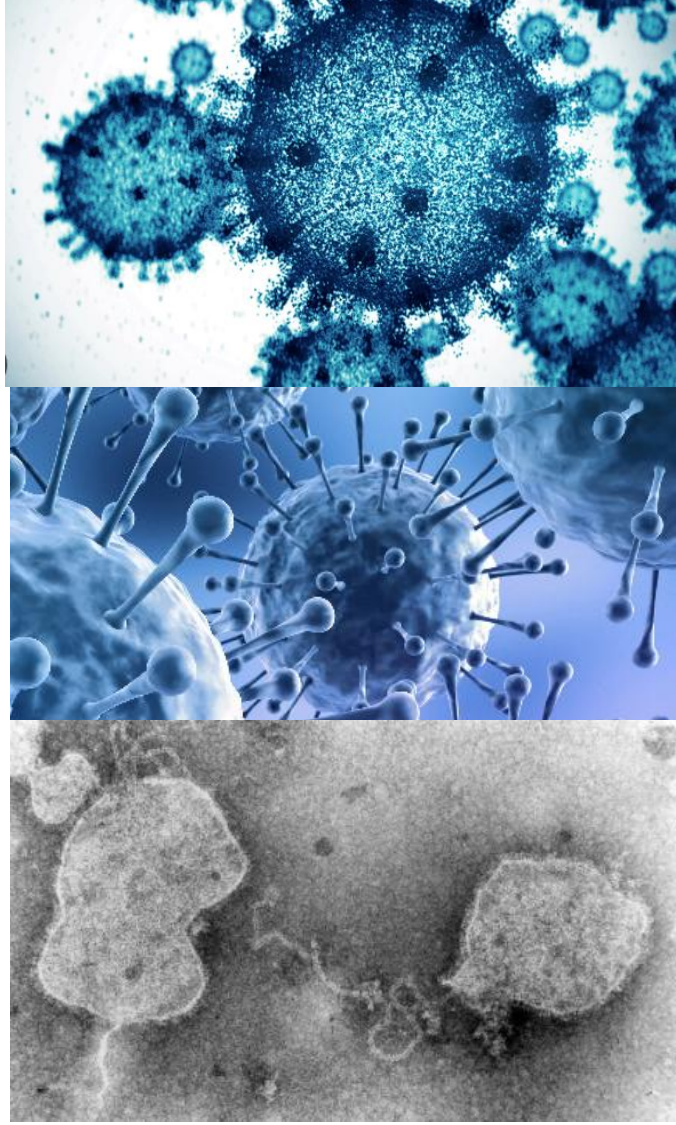
Largest current threat


2022-23
2023-24
2024-25
2025-26
% of Deaths Due to PIC
# of Deaths
MMWR Week
Threshold
Baseline
% of Deaths due to PIC
Influenza Coded Deaths
COVID Coded Deaths

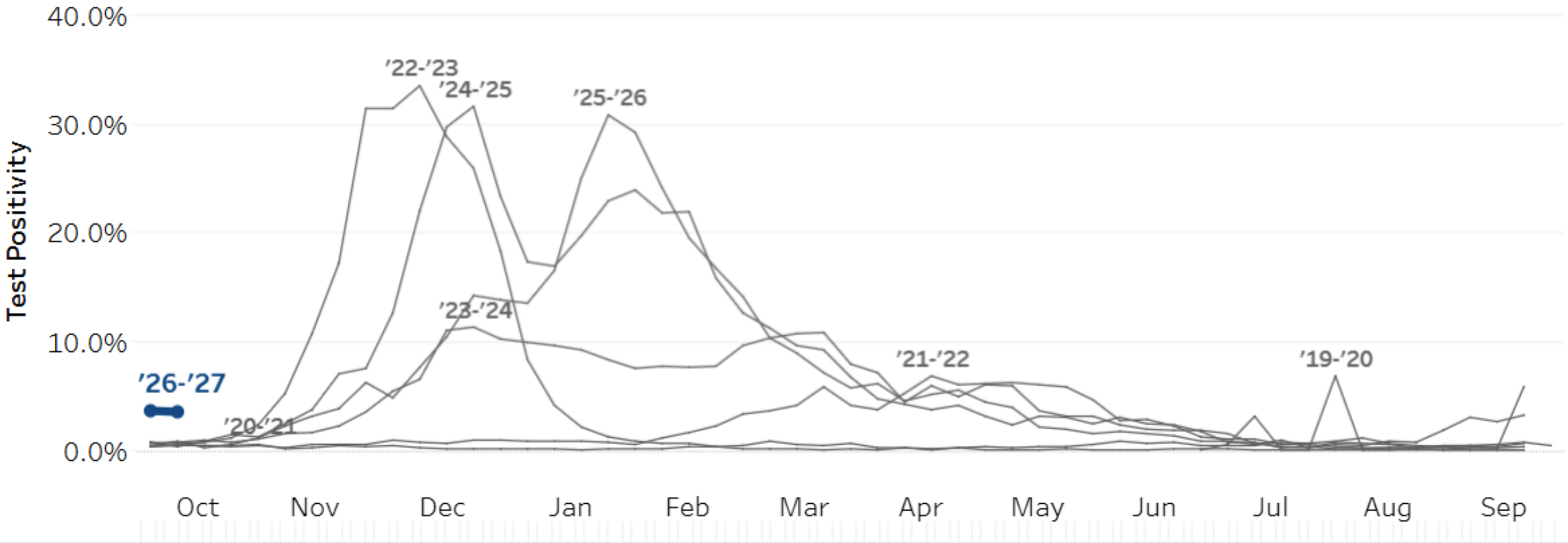
Oregon's Respiratory Virus Data

- COVID, Influenza, RSV
  - Community transmission
    - Wastewater monitoring, % positivity, outbreaks
  - Hospitalizations/ED visits/Deaths
  - Vaccination rates
  - Weekly surveillance data: Flu bites, RSV report

https://public.tableau.com/app/profile/oregon.public.health.division.acute.and.communicable.disease.pre/viz/OregonsRespiratoryVirusData/TableofContents



Flu season has started!



Select a respiratory virus

Influenza

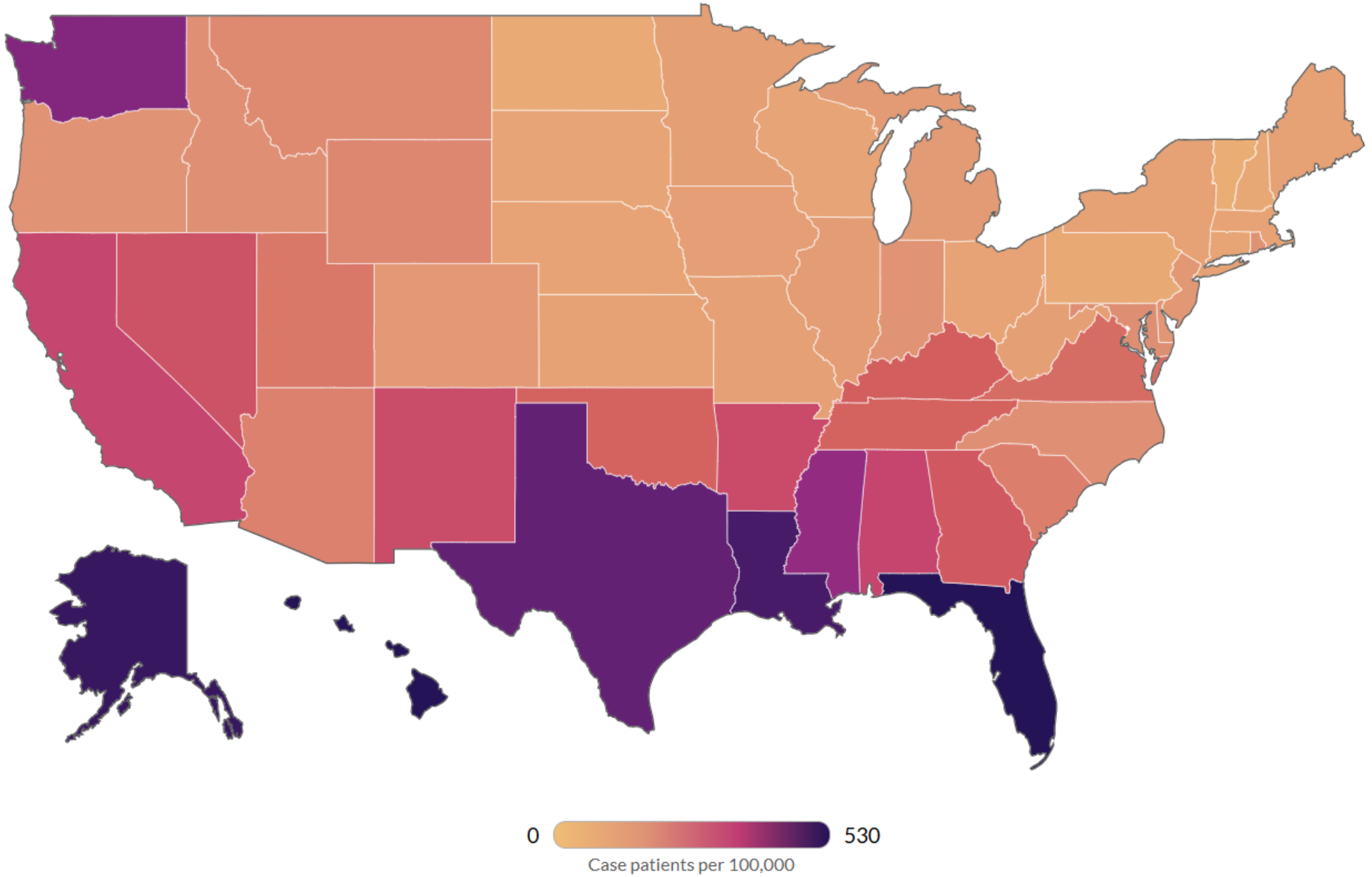
Highlight a respiratory season

2026 - 2027

Show respiratory seasons

(All)

COVID | HFM | **Flu** | Mono | Norovirus | Rotavirus | RSV | Strep | Pertussis | Measles



Positivity Rate for Communicable Disease Tests

During Week of 9/13

6.23%

COVID-19

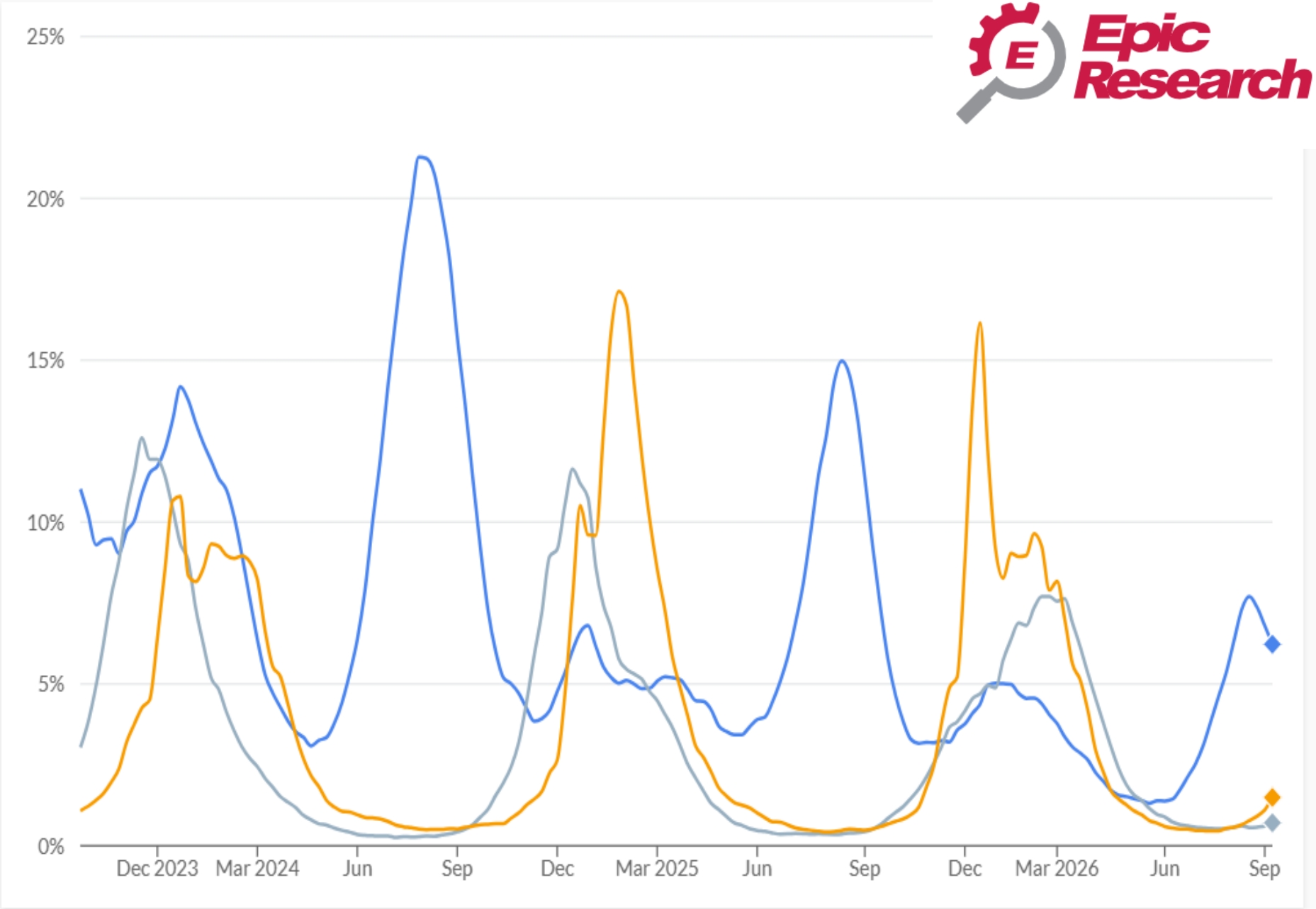
1.49%

Influenza

0.71%

RSV

Weekly percentage of communicable disease tests with a positive result.



Communicable Disease Admissions

During Week of 9/13

691

COVID-19

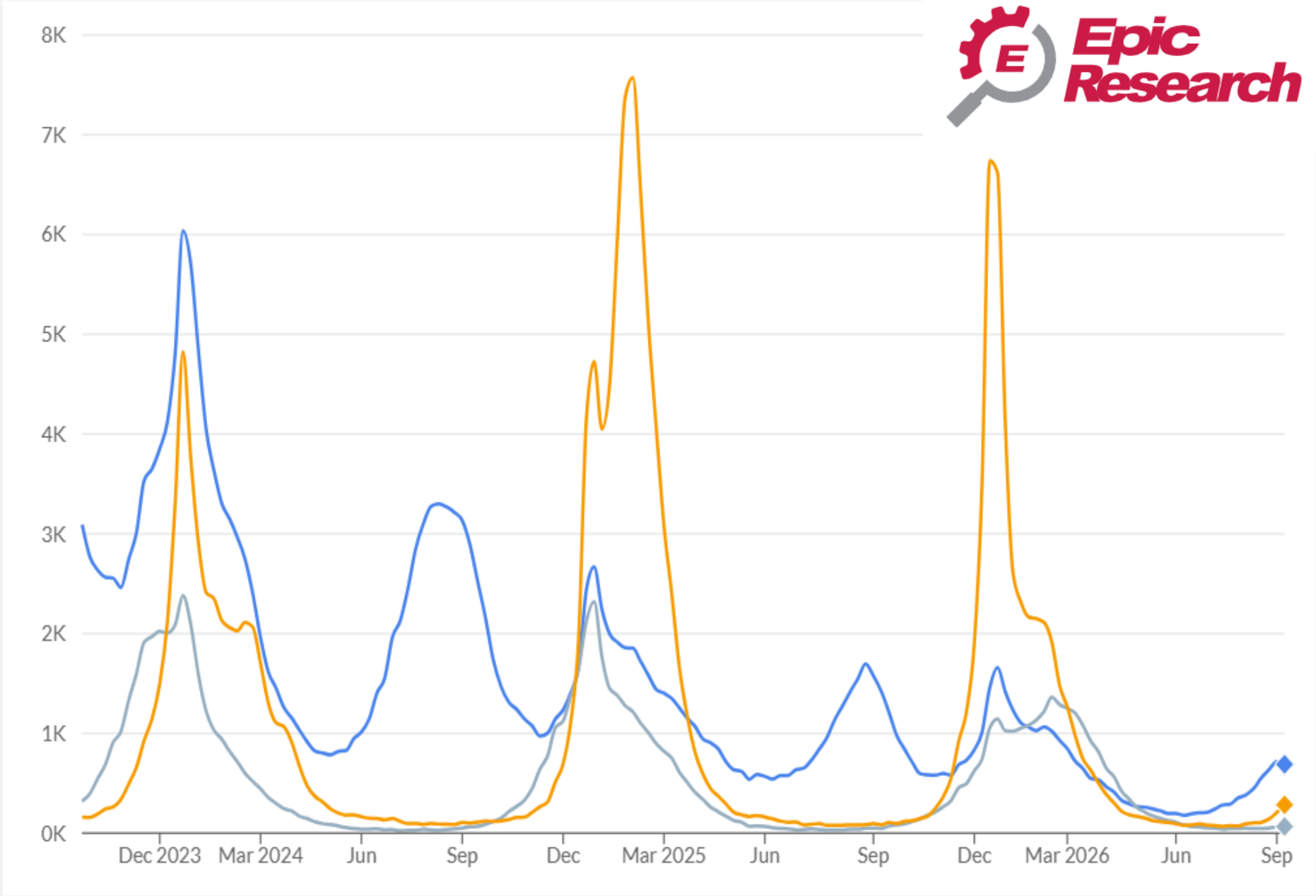
284

Influenza

66.1

RSV

Weekly rates of communicable disease diagnoses or positive labs per 100,000 patients with admissions.



Epic Research

Viral vaccines

- XFG-Adapted (JN.1-lineage) COVID-19 mRNA vaccine (26/27 season)
  - Moderna mRNA vaccine (Spikevax = 6+ months; Mnexspike = 12+ years)
  - Pfizer mRNA vaccine (Comirnaty = 5+ years)
  - Novavax protein+adjuvant vaccine (Nuvaxovid = 12+ years)
- Influenza vaccine (26/27 season = tri-valent formula [A/A/B])
  - Standard dose inactivated virus (Fluzone, Fluarix, FluLaval = 6+ months) egg-based
  - Egg-free vaccines
    - Cell based (Flucelvax = 6+ mo)
    - Recombinant (Flublok = 9+ years)
    - mRNA (mFlusiva = 50+ years)
  - High-dose vaccines
    - Fluzone High-dose (4x antigen of standard, 65+ years)
    - Fluad (standard vaccine with adjuvant, 65+ years)
  - Live attenuated (Flumist, 2-49 years)
- RSV (75+ years, 50-74 years with increased risk)
  - Arexvy (protein subunit vaccine with adjuvant)
  - Abrysvo (protein subunit vaccine, only one approved for pregnant women)
  - mRESVIA (mRNA vaccine)

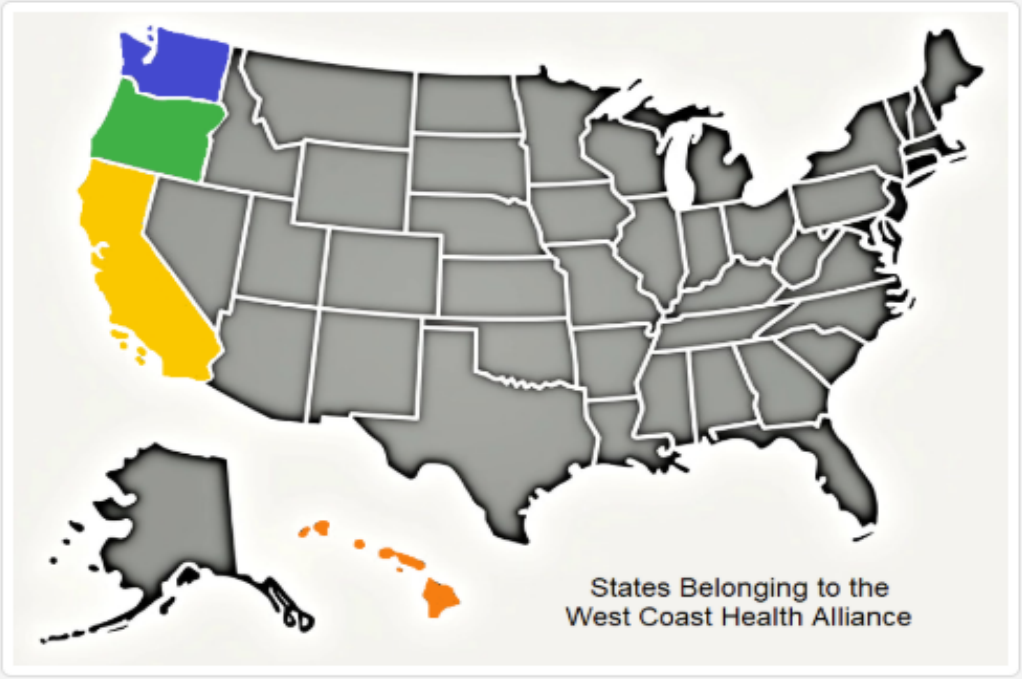
MAB (Beyfortus) for infants <8 months entering 1st viral respiratory season
(high risk infants should also receive up to 19 months ie protected for a 2nd year)

West Coast Health Alliance

The West Coast Health Alliance (WCHA) is a partnership between California, Hawaii, Oregon, and Washington to ensure that public health recommendations are guided by safety, efficacy, transparency, access, and trust.

WCHA will:

- Work together to ensure the public has access to credible information
- Coordinate to reduce confusion and increase trust in public health
- Provide evidence-based position statements, guidance, and policy recommendations
- Seek alignment with respected national professional organizations
- Share tools and best practices



States that belong to the West Coast Health Alliance

West Coast Health Alliance 2026–2027 respiratory virus season immunization recommendations

Age/Condition	COVID-19	Influenza	RSV
Children	• All 6–23 months • All 2–18 years with risk factors or never vaccinated against COVID-19 • All who are in close contact with others with risk factors[1] • All who choose to reduce risk of severe illness	• All 6 months and older[2]	• All younger than 8 months[3] • All 8–19 months with risk factors
Pregnancy	• All who are planning pregnancy, pregnant or postpartum	• All who are planning pregnancy, pregnant or postpartum	• All who are 32–36 weeks gestational age[3, 4]
Adults	• All 65 years and older • All 19–64 years with risk factors • All who are in close contact with others with risk factors[1] • All who choose to reduce risk of severe illness	• All	• All 75 years and older[4] • All 50–74 years with risk factors[4]
Healthcare Workers	• All	• All	• All who meet criteria above

1. COVID-19 vaccine is available for persons 6 months and older.
2. Two doses given at least 4 weeks apart are recommended for ages 6 months–8 years who are getting flu vaccine for the first time.
3. Protect infants with either prenatal RSV vaccine or infant dose of nirsevimab or clesrovimab.
4. RSV vaccination during pregnancy or for adults is currently recommended once rather than annually.

Other vaccine resources

- American Academy of Family Physicians
  - Adults ≥ 19
- American Academy of Pediatricians
  - Birth to 18 years
- American College of Obstetricians and Gynecologists
  - Pregnant Individuals
- American Medical Association
  - Link to printable consolidated guide
- Infectious Disease Society of America
  - Immunocompromised individuals
- Vaccine Integrity Project

Bird flu?

- If showing up with viral symptoms
  - Ask about sick birds
  - May have conjunctivitis (unique to bird flu)
  - Test with nasal and conjunctival swabs
  - Treat with Oseltamivir

Highly Pathogenic Avian Influenza Confirmed in Wallowa County

On October 6, 2025, the U.S. Department of Agriculture's (USDA) National Veterinary Services Laboratory (NVSL) confirmed Highly Pathogenic Avian Influenza (HPAI) in a backyard flock of ducks and chickens in Wallowa County. This is the first confirmed case of HPAI in Wallowa County. Samples from the flock were first taken to the Oregon Veterinary Diagnostic Laboratory (OVDL) at Oregon State University (OSU) for testing. OSU confirmed the presence of HPAI on October 3, 2025, and NVSL confirmed the results three days later. Additional cases are currently being investigated, and more information will be made available as results are confirmed.

The Oregon Department of Agriculture's (ODA) State Veterinarian, Dr. Ryan Scholz, placed the Wallowa County farm under quarantine and a team from ODA humanely euthanized all poultry on the property. None of the animals on the farm entered the food supply chain, nor were they intended for the commercial food market. It's important to note that when properly prepared and cooked, HPAI does not affect meat or egg products, and these food items remain safe. The U.S. Centers for Disease Control (CDC) also recommends choosing pasteurized milk and dairy products to protect your health.

HPAI detections are higher in the fall and spring because wild waterfowl spreading the virus are migrating to their seasonal homes. Since May 2022, three commercial poultry flocks and 47 backyard flocks have been affected in Oregon.

Death or illness among domestic birds should be reported immediately to ODA. Please report by calling 503-986-4711.

Impact of weather trends on health

- Drought, fire, warming climate =
  - Changing patterns of communicable disease
  - Worsening health outcomes, especially cardiopulmonary disease

- **Studies Highlight Health Risks From Wildfire Smoke**: A study published on September 15 in **The Lancet Oncology** found that PM2.5 particles (particles measuring 2.5 microns or less in diameter) from wildfire smoke increased lung cancer deaths in people 65 and older more than non-wildfire PM2.5. A September 17 study in **Nature Communications** also found that long-term exposure to wildfire-specific PM2.5 posted greater cardiopulmonary hospitalization risks than non-wildfire PM2.5. According to the **Oregon Department of Forestry (ODF)**, the 2026 wildfire season was the most destructive in Oregon's history, burning over 2.5 million acres.

SITSTAT

HAN.OREGON@ODHS
OHA.OREGON.GOV

OREGON HEALTH AUTHORITY

Oregon Health Authority – Public Health Division
Health Security, Preparedness and Response (HSPR)
ESF-8 Situation Status Report 037: 9/22/2026, 1400

HSPR

ENVIRONMENTAL PUBLIC HEALTH

AIR QUALITY:

- There are 40 active wildfires in Oregon. For more information, see OEM's State of Oregon Fire and Hotspots Dashboard.
- Air quality is currently **Good** or **Moderate** across most of Oregon.
- Check current air quality conditions with DEQ's Air Quality Index and Air Pollution Advisories, the US EPA Fire and Smoke Map, or by downloading the free OregonAIR app on your smartphone. Check with OR Department of Forestry for fire danger levels and public use restrictions. For Smoke Outlooks and Advisories, check with the Interagency Wildland Fire Air Quality Response Program (IWFAQRP).

WEATHER:

- There is a **Small Craft Advisory** along the southern Oregon coast due to strong winds and high seas. This advisory is in effect until 5pm Wednesday 10/7.
- For active watches and warnings visit the Nation Weather Service (NWS) Active Alerts webpage.
- For NWS Seven Day HeatRisk Forecast visit the NWS HeatRisk webpage.
- For briefings, briefing videos and additional information on current weather hazards and impacts visit the NWS Briefings and Information site.
- Watch, Warning and Advisory definitions can be found at https://www.weather.gov/sjt/WatchWarningAdvisoryExplained
- Extreme heat warning, extreme heat watch, and heat advisory definitions can be found at https://www.weather.gov/safety/heat-ww
- For hot weather safety tips and resources visit https://www.heat.gov/

DROUGHT:

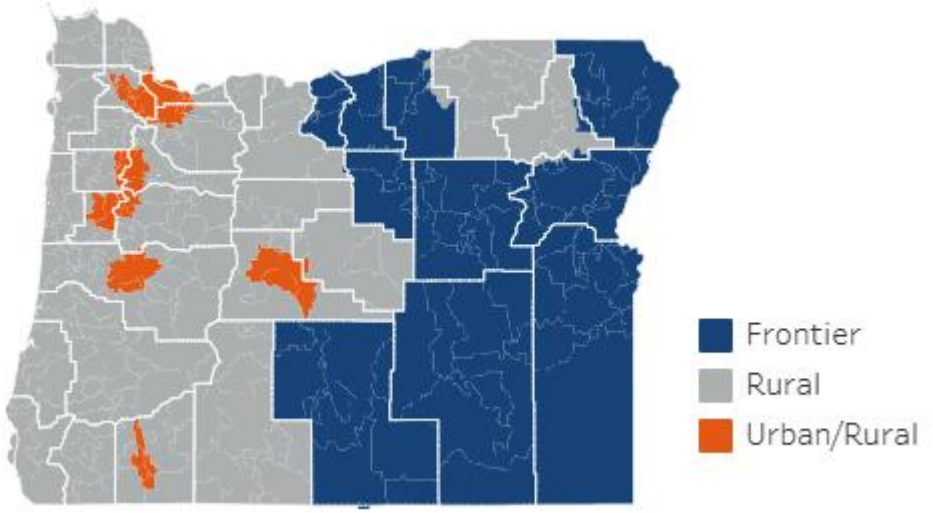
- The U.S. Drought Monitor estimates approximately 2.4 million Oregon residents are in areas of drought. https://www.drought.gov/states/oregon
- As of July 13, 2026, 21 Oregon counties are under Governor-declared drought emergency status: Baker, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wasco and Wheeler. Seasonal outlooks indicate drought conditions are likely to persist through 2026. https://apps.oregon.gov/oregon-newsroom/OR/GOV/Posts/Post/governor-kotek-declares-drought-emergency-in-curry-and-union-counties

FLOOD:

- No significant flood-related updates.

Dashboards and Reports

- CDC dashboards
- OHA Tableau
- Epic dashboards
- Orpheus



- Oregon 24/7 disease reporting: 971-673-1111

Special thanks to:

- My fellow health officers
- Staff at the OHA (especially Tim Menza, Stephen Ladd-Wilson and Melissa Sutton)
- Oregon ATEC (especially Christopher Evans and Dayna Morrison)
- CDC and OHA Tableau (data and photo sources)

References/Resources

- Weekly Communicable Disease Dashboard: https://public.tableau.com/app/profile/oregon.public.health.division.acute.and.communicable.disease.pre/viz/WeeklyCommunicableDiseaseReport/ACDPWeeklyReport
- Syphilis: https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/viz/STI_17068215959980/200HomePage
- Measles: https://www.oregon.gov/oha/ph/diseasesconditions/diseasesaz/pages/measles.aspx
- HIV: https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/viz/EndHIVOregon/EndHIVORHome
- Rabies: https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/RABIES/Pages/rabies.aspx
- Tick Borne Illness: https://www.oregon.gov/oha/ph/diseasesconditions/communicabledisease/pages/ticks.aspx
- Viral Respiratory Data: https://public.tableau.com/app/profile/oregon.public.health.division.acute.and.communicable.disease.pre/viz/OregonsRespiratoryVirusData/TableofContents
- EPIC Communicable Disease Tracker: https://www.epicresearch.org/data-tracker/communicable-diseases/