



Malaria

Disease Plan

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Questions about this disease plan?

Contact the Utah Department of Health Bureau of Epidemiology: 801-538-6191.

✓ WHY IS MALARIA IMPORTANT TO PUBLIC HEALTH?

Malaria is endemic throughout most of the tropics. Of the approximately 3.4 billion people worldwide who are exposed annually, 1.2 billion are at high risk. The World Health Organization (WHO) states that there were 198 million cases of symptomatic malaria in 2013. About 1,500 cases of malaria are diagnosed in the United States each year. The vast majority of cases in the United States are in travelers and immigrants returning from countries where malaria transmission occurs, many from sub-Saharan Africa and South Asia.

Important components for reducing the burden of malaria morbidity and mortality include more sensitive diagnostic tools, effective use of antimalarial drugs, and improved personal and community protection and mosquito control. The approach to elimination or control of malaria includes these basics, along with improvements in tracking human illness and parasite surveillance, and effective resource delivery.

✓ DISEASE AND EPIDEMIOLOGY

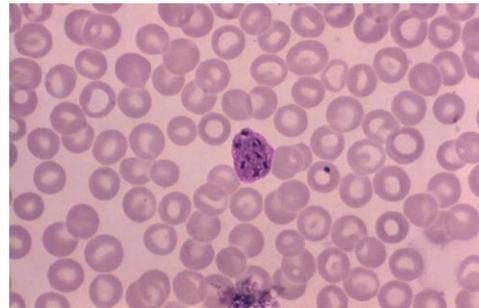
Clinical Description

The classic symptoms of malaria are high fever with chills, sweats, and headache, which may involve recurrence or intensification of symptoms, especially fever. Depending on the infecting species, fever may appear every other or every third day. Other symptoms may include malaise, nausea, vomiting, diarrhea, cough, arthralgia (joint aches), respiratory distress, and abdominal and back pain. Pallor and jaundice may also be present. Enlargement of the liver and spleen (hepatosplenomegaly) may occur and is more prominent in chronic infections.

Infection with *P. falciparum* is potentially fatal and most commonly manifests as a non-specific febrile illness. Falciparum malaria may present with coagulation defects, shock, renal and liver failure, acute encephalopathy, pulmonary and cerebral edema, and coma. The duration of an untreated primary attack can vary from a week to a month or longer. Relapses of *P. vivax* and *P. ovale* infections can occur at irregular intervals for up to five years. Malaria infections may persist for life (chronic infections), with or without recurrent episodes of fever.

Causative Agent

There are four *Plasmodium* species (sporozoan parasites) that commonly cause malaria in humans: *P. vivax*, *P. malariae*, *P. ovale*, and *P. falciparum*.



Plasmodium vivax schizonts. CDC, Dr. Mae Melvin, 1977

Differential Diagnosis

The differential diagnosis can include dengue fever, schistosomiasis, leptospirosis, tick-borne fevers, trypanosomiasis, and Yellow Fever.

Laboratory identification

Malaria is usually diagnosed through a blood smear that can be performed at most reference laboratories. Serology testing is also available, but the test may cross-react with a variety of other illnesses and reliance solely upon serological results for diagnosis may be misleading. PCR testing has limited availability.

UPHL: The Utah Public Health Laboratory (UPHL) does not perform diagnostic testing for malaria, but it will forward thick and thin blood smears to the CDC for testing. The CDC will also perform serologic testing for malaria, but only under special circumstances (e.g., serum of a blood donor suspected of being a source of transfusion-related malaria, or serum from laboratories conducting malaria-related studies). ARUP also performs diagnostic testing.

Treatment

Malaria can be a severe, potentially fatal disease (especially when caused by *Plasmodium falciparum*) and treatment should be initiated as soon as possible.

In endemic areas, WHO recommends that treatment be started within 24 hours after the first symptoms appear. Treatment of patients with uncomplicated malaria can be conducted on an ambulatory basis (without hospitalization), but patients with severe malaria should be hospitalized, if possible.

In areas where malaria is not endemic, all patients with malaria (uncomplicated or severe) should be kept under clinical observation if possible.

Most drugs used in treatment are active against the parasite forms in the blood (the form that causes disease) and include:

- Chloroquine*
- Sulfadoxine-pyrimethamine (Fansidar®)
- Mefloquine (Lariam®)
- Atovaquone-proguanil (Malarone®)
- Quinine
- Doxycycline

In addition, primaquine is active against the dormant parasite liver forms (hypnozoites) and prevents relapses. Primaquine should not be taken by pregnant women or by people who are deficient in G6PD (glucose-6-phosphate dehydrogenase). Patients should not take primaquine until a screening test has excluded G6PD deficiency.

*In a region of chloroquine resistance in Malawi, return of chloroquine-susceptible *P. falciparum* malaria was demonstrated following abandonment of chloroquine use. These chloroquine-susceptible parasites likely represent a re-expansion of the susceptible parasites that survived in the population despite widespread drug pressure in the region. Despite this finding, it is not advised to use chloroquine for treatment in Malawi.

How to treat a patient with malaria depends on:

- The type (species) of the infecting parasite
- The area where the infection was acquired and its drug-resistance status
- The clinical status of the patient
- Any accompanying illness or condition
- Pregnancy
- Drug allergies, or other medications taken by the patient

Case fatality

The case fatality rate is 10–40% in the absence of prompt treatment.

Reservoir

Humans are the only important reservoir of human malaria. Non-human primates are naturally infected by many malarial species that can potentially infect humans, but natural transmission from non-human primates to humans is extremely rare and seldom results in serious disease. The vector for human malaria is the *Anopheles* mosquito, which transmits the parasite from infected human to uninfected human.

Transmission

Malaria is transmitted by the bite of an infective female *Anopheles* mosquito, which occurs mainly between dusk and dawn. Rarely, transmission can be congenital (via the placenta) or can occur through transfusions, use of contaminated needles, and organ transplantation.

Susceptibility

Susceptibility is universal except in humans with specific genetic traits. Tolerance to clinical disease is present in adults in highly endemic communities where exposure is continuous over many years. Persons with sickle cell trait show relatively low parasitemia when infected with *P. falciparum*, and, thus, are relatively protected from severe disease. Persons infected with HIV are at increased risk of symptomatic falciparum malaria and its severe manifestations.

Incubation period

The incubation period is approximately 7–14 days for *P. falciparum*; 8–14 days for *P. vivax* and *P. ovale*; and 7–30 days for *P. malariae*. With some strains of *P. vivax*, mostly from temperate areas, there may be a prolonged incubation period of 8–10 months until clinical illness; incubation periods for *P. ovale* may be even longer. With infections acquired by blood transfusion, the incubation period depends on the number of parasites infused; it is usually short, but may be up to two months.

Period of communicability

Malaria is not directly communicable from person to person, except through congenital transmission; however, during parasitemia, the disease may be transmitted to other persons through blood transfusion or through shared, contaminated needles. Infected human hosts can

be a source of infection for *Anopheles* mosquitoes for prolonged periods of time (1–3 years or longer, depending on the species of malaria) if not adequately treated.

Epidemiology

Malaria is endemic throughout the tropical areas of the world. About half of the world's population lives in areas where transmission occurs. Areas with the highest prevalence include sub-Saharan Africa, parts of Central and South America, India, and parts of Oceania and Southeast Asia. Transmission is also possible in more temperate climates, such as in the U.S., if *Anopheles* mosquitoes are present. Locally-acquired cases of malaria have been reported recently in Florida, New York, and Virginia. Mosquitoes in airplanes flying from tropical climates have been the source of occasional cases in persons working or living near international airports. However, nearly all of the malaria cases reported annually in the U.S. (~1,000) are acquired outside of the U.S. *P. vivax* and *P. falciparum* are the most common species worldwide. The worldwide spread of strains of chloroquine-resistant *P. falciparum* and *P. vivax* is of increasing importance. Resistance to other antimalarial drugs is now occurring in many areas where the drugs are widely used.

PUBLIC HEALTH CONTROL MEASURES

Public health responsibility

- Identify the source of infection and prevent further transmission.
- Investigate all reported cases; complete and submit proper investigation forms.

Prevention

International Travel

People traveling to malaria-endemic parts of the world should be notified of their risk of contracting the disease and of control measures they can take to protect themselves from mosquitoes. Travelers can use repellents, wear protective clothing, and use mosquito nets when rooms are not screened. They have a choice of medications recommended for prophylaxis depending on circumstances.

Detailed recommendations for preventing malaria are available 24 hours a day from the CDC Malaria Hotline, which can be accessed by telephone at 770-488-7788, by fax at 888-CDC-FAXX or 888-232-3299, or on the CDC website at www.cdc.gov/travel.

Travelers and recent immigrants from malaria-endemic regions with symptoms suggestive of malaria should be referred to a health care provider for prompt testing and treatment. Failure to treat individuals with malaria could lead to transmission of the disease to mosquitoes that bite these individuals, and then to other people bitten by those mosquitoes.

Chemoprophylaxis

Non-immune individuals who will be exposed to mosquitoes in malarious areas must make use of protective measures against mosquito bites, and will benefit from the use of suppressive drugs for chemoprophylaxis. The possible side effects of long-term (up to 3-5 months) use of

the drug or drug combination recommended for use in any particular area should be weighed against the actual likelihood of being bitten by an infected mosquito.

Vaccine

No approved vaccine is available yet. Vaccine trials are underway.

Isolation and quarantine requirements:

No restrictions, except for exclusion from blood donation.

✓ CASE INVESTIGATION

Case Definition: Malaria (2014)

Reporting

- Report all suspect and confirmed cases of malaria.

Table of criteria to determine whether a case should be reported to public health authorities

Criterion	Confirmed			Suspect
	1	2	3	4
Laboratory Evidence				
Demonstration of <i>Plasmodium</i> species in blood film	S			
Demonstration of <i>Plasmodium</i> species by molecular testing (e.g., PCR)		S		
Demonstration of unspiciated malaria parasite in blood			S	
Detection of <i>Plasmodium</i> species by rapid diagnostic antigen testing				S

Notes: S = This criterion alone is Sufficient to identify a case for reporting.

*Efforts should be made to determine a species for all cases of malaria either by expert microscopists or by molecular methods such as PCR.

Laboratory criteria

- Detection of circulating malaria-specific antigens using rapid diagnostic test (RDT),
OR
- Detection of species specific parasite DNA in a sample of peripheral blood using a Polymerase Chain Reaction (PCR) test (Note: Laboratory-developed malaria PCR tests must fulfill CLIA requirements, including validation studies),
OR
- Detection of malaria parasites in thick or thin peripheral blood films, determining the species by morphologic criteria, and calculating the percentage of red blood cells infected by asexual malaria parasites (parasitemia).

Case classification

Confirmed

1. Detection and specific identification of malaria parasite species by microscopy on blood films in a laboratory with appropriate expertise in any person (symptomatic or asymptomatic) diagnosed in the U.S., regardless of whether the person experienced previous episodes of malaria while outside the country.

OR

2. Detection of *Plasmodium* species by nucleic acid test* in any person (symptomatic or asymptomatic) diagnosed in the U.S., regardless of whether the person experienced previous episodes of malaria while outside the country.

OR

3. Detection of unspiciated malaria parasite by microscopy on blood films in a laboratory with appropriate expertise in any person (symptomatic or asymptomatic) diagnosed in the U.S., regardless of whether the person experienced previous episodes of malaria while outside the country.

Suspect

1. Detection of *Plasmodium* species by rapid diagnostic antigen testing without confirmation by microscopy or nucleic acid testing in any person (symptomatic or asymptomatic) diagnosed in the U.S., regardless of whether the person experienced previous episodes of malaria while outside the country.
2. Clinical samples, including blood smears or EDTA whole blood from all cases, may be referred to the CDC Division of Parasitic Diseases and Malaria Diagnostic Laboratory for confirmation of the diagnosis and anti-malarial drug resistance testing. Any questionable cases should be referred to the CDC Division of Parasitic Diseases and Malaria Diagnostic Laboratory for confirmation of the diagnosis.

Criteria to distinguish a new case of this disease or condition from reports or notifications which should not be enumerated as a new case for surveillance:

A subsequent attack experienced by the same person, but caused by a different *Plasmodium* species, is counted as an additional case. A subsequent attack experienced by the same person and caused by the same species in the U.S. may indicate a relapsing infection or treatment failure caused by drug resistance, or a separate attack.

Cases also are classified according to the following WHO categories:

- **Autochthonous:**
 - *Indigenous:* malaria acquired by mosquito transmission in an area where malaria is a regular occurrence.
 - *Introduced:* malaria acquired by mosquito transmission from an imported case in an area where malaria is not a regular occurrence.
- *Imported:* malaria acquired outside a specific area (e.g., the U.S. and its territories).

- *Induced:* malaria acquired through artificial means (e.g., blood transfusion, common syringes, or malariotherapy).
- *Relapsing:* Recurrence of disease after it has been apparently cured. In malaria, true relapses are caused by reactivation of dormant liverstage parasites (hypnozoites) of *P. vivax* and *P. ovale*.
- *Cryptic:* an isolated case of malaria that cannot be epidemiologically linked to additional cases.

Case Classification Table

Criterion	Case Definition	
	Confirmed	Suspected
Laboratory Evidence		
Demonstration of <i>Plasmodium</i> species in blood film	S	
Demonstration of <i>Plasmodium</i> species by molecular testing (e.g., PCR)	S	
Demonstration of malaria parasite in blood films*	S	
Detection of <i>Plasmodium</i> species by rapid diagnostic antigen testing without confirmation by microscopy or nucleic acid testing in any person (symptomatic or asymptomatic)		S

Case Investigation Process

- Complete morbidity form.
- Verify case status.
- Complete disease investigation form.
- Determine whether patient had travel/exposure history consistent with acquisition of disease in Utah or elsewhere.
- If patient acquired disease in Utah, identify the source of transmission and eliminate it.

Outbreaks

One or more non-imported cases of malaria would constitute an outbreak.

Identification of case contacts

Determine history of previous infection or of possible exposure. If a history of sharing needles is obtained from the patient, investigate and treat all persons who shared the equipment. In transfusion-induced malaria, all donors must be located and their blood examined for malaria parasites and for antimalarial antibodies; parasite-positive donors must receive treatment.

Case contact management

None.

✓ REFERENCES

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3. Control of Communicable Diseases Manual (20th Edition), Heymann, D.L., Ed; 2015.
4. Council for State and Territorial Epidemiologists (CSTE) Position statements. Available from URL: <http://www.cste.org/default.asp?page=PositionStatements>.
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✓ VERSION CONTROL

Updated July 2015: "Why is Malaria Important to Public Health" section added. Additional information added to "Treatment" section. "Version Control," and "Minimum Data Set" sections added.

✓ UT-NEDSS Minimum/Required Fields by Tab

Demographic

- County
- State
- Street
- City
- Zip Code
- Date of Birth
- Birth Gender
- Ethnicity
- Race
- Last Name
- First Name

Clinical

- Date Diagnosed
- Died
- Date of Death
- Disease
- Onset Date
- Hospitalized
- Was malaria chemoprophylaxis taken?
- Were all pills taken as prescribed?
- History of Malaria in the last 12 months (prior to this report)?
- Was it vivax?
- Was it falciparum?
- Was it Malariae?
- Was it Ovale?
- Was it not determined?
- Back pain
- Chills
- Diarrhea
- Fever
- Headache
- Myalgia
- Sweats
- Weakness

Laboratory

- Organism
- Specimen Source
- Test Result
- Test Type

Epidemiological

- Imported From
- Date of Exposure

Investigation

- Has patient traveled or lived outside the United States during the past 4 years?
- Please specify countries, dates arrived in the U.S. and duration of stay
- Blood transfusion/transplant within the past 12 months?
- Date of transfusion/transplant
- Did patient receive a blood donation from a donor with malaria
- Was patient recently born to a mother with malaria
- Did the patient travel to a malaria endemic area within the previous 3 months

Reporting

- Date First Reported to Public Health

Administrative

- Outbreak Name
- Outbreak Associated
- State Case Status