EpiNotes

WINTER 2026

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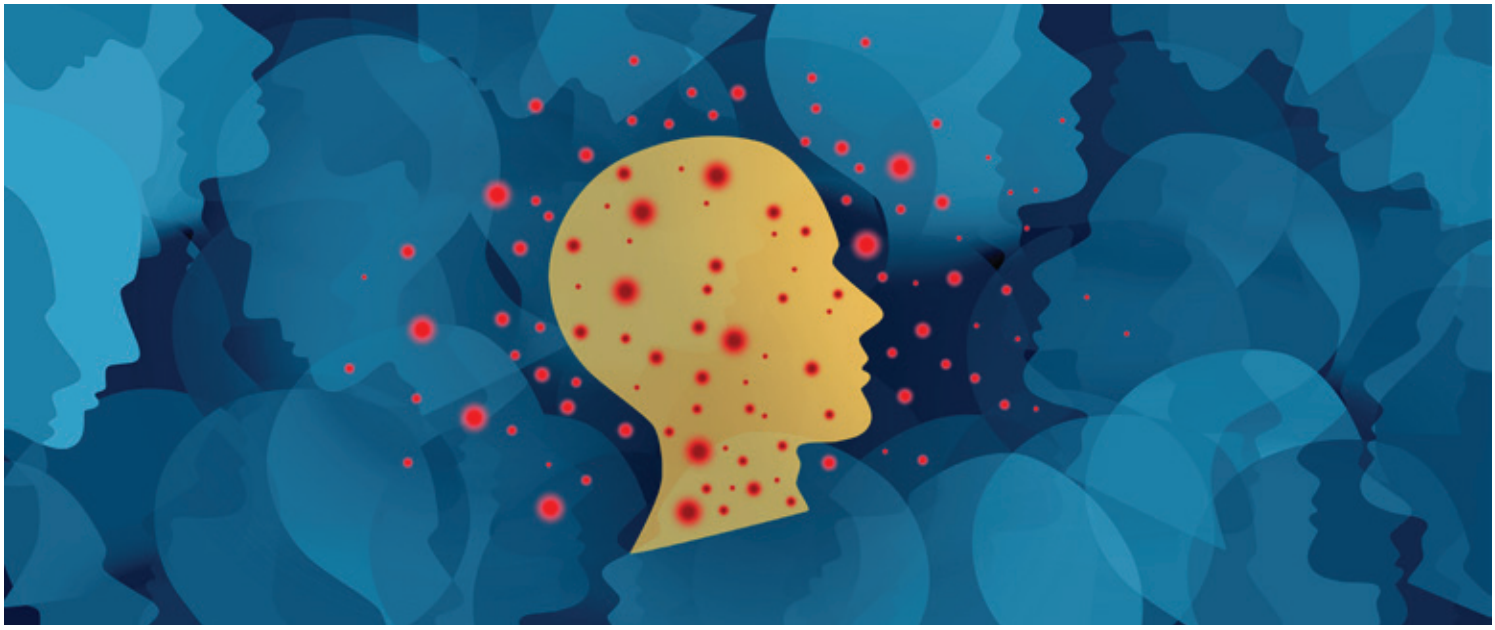

Measles Outbreak in South Carolina, 2025-2026

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As of mid-March, the measles outbreak that has been causing preventable disease among children and adults in Spartanburg County, S.C., continues but has slowed. Although not every case has occurred in Spartanburg, the close-knit community there has experienced the highest number of cases. This outbreak is among the largest in the United States in the past 35 years. The South Carolina Department of Public Health (DPH) measles response team has triaged and investigated hundreds of cases.

How do we respond? In many ways, it is basic applied epidemiology. In other ways, it has required new and adaptive strategies.

Suspected measles cases must be reported to DPH immediately. Health care providers who evaluate a patient they believe may have measles should call their regional

DPH epidemiologist and provide key clinical and exposure information. DPH offers guidance on appropriate testing and, when needed, coordinates testing through the state Public Health Laboratory. Most measles tests, however, are performed at commercial laboratories and reported electronically to DPH. The department also provides guidance on isolation for sick people and quarantine recommendations for their close contacts.

During a case investigation, a DPH epidemiologist interviews the parent of a child with measles (or the adult patient) to determine where the person may have been exposed, whether they are connected to other known cases, and where they went during their infectious period. Measles is contagious from four days before to four days after rash onset, a total of nine days. The rash onset date is one of the most important pieces of information collected during an interview. Measles is most contagious when symptoms are most severe, including high fever, cough, runny nose, red eyes, and a widespread rash.

If DPH determines that a person with measles may have exposed others, epidemiologists contact the affected school, business, health care facility, or individuals to provide guidance. While DPH protects patient privacy and does not release personal health information, the department notifies the public of the dates and times when exposure may have occurred. School nurses work closely with DPH epidemiologists to identify exposed students who are not immune and must quarantine at home.

At the peak of the outbreak, some weeks saw hundreds of reported cases. This required DPH to rapidly collect, verify, and share information on cases, contacts, and exposure locations across multiple response teams. Data management and communication had to be carefully coordinated to ensure timely public health action, and DPH developed new tactics to meet this need. The response has required tremendous effort, but case numbers have begun to decline. That progress is a sign that the response is working.

Updates for the 2026 List of Reportable Conditions

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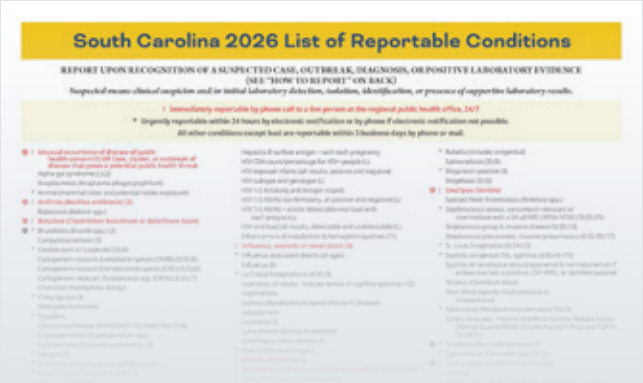
Below are the updates made to the **2026 edition of the South Carolina List of Reportable Conditions** (LORC).

This description starts at the top of the document and moves down.

1. Links that direct users to the SCION Help Desk and the 1129 Disease Reporting Form have been moved to the Reporting Mechanisms section.
2. The first item in the list of reportable conditions has been edited for clarity. It now states: Unusual occurrence of disease of public health concern (1) OR case, cluster, or outbreak of disease that poses a potential public health threat.
3. A **new condition** has been added to the list: alpha-gal syndrome. This condition is lab-only reportable. Footnote 2 accompanies it.
4. Animal (mammal) bites has been expanded to read: Animal (mammal) bites and potential rabies exposures.
5. Carbapenem-resistant Acinetobacter and Enterobacterales were reported separately for additional clarity.
6. A **new condition** has been added: Inborn errors of metabolism & hemoglobinopathies, along with accompanying footnote 11.
7. Measles now has footnote number 13, requesting that all RT-PCR specimens be submitted to the Public Health Laboratory (PHL) for additional characterization.
8. Mpox has changed slightly to: Mpox (Monkeypox) (Orthopoxvirus). Only positive results are now reportable.
9. Pertussis is now reportable within 3 days of diagnosis.
10. Varicella is now reportable within 3 days of diagnosis.

11. New footnote 2 for alpha-gal syndrome: Detection of immunoglobulin E specific to alpha-gal (sIgE) ≥ 0.1 IU/mL or ≥ 0.1 kU/L, any method.
12. Updated footnote 3 now reads: Specimen submission to the Public Health Laboratory (PHL) is required. Ship immediately; urgently reportable items within 1 business day. Ship 3-day reportables within 3 business days. Contact PHL at 803-896-0800 if assistance is needed.
13. Updated footnote 6 for carbapenem-resistant organisms: Submit isolates of carbapenem-resistant Enterobacterales and Acinetobacter species from all specimen types, incl. reporting of carbapenemase-producing organisms. Isolation submission of colonization screenings is not required.
14. Footnote 11, for Inborn Errors of metabolism & hemoglobinopathies, reads: **https://dph.sc.gov/sites/scdph/files/Library/4474-ENG-DPH.pdf**
15. Footnote 12, for lead reporting, has been updated from: "always specify site of isolate" to "Always specify venous or capillary specimen."
16. Footnote 13 for measles reads: Submit all RT-PCR-positive specimens to PHL. Ship within 1 business day. Contact PHL at 803-896-0800 if assistance is needed.
17. Updated footnote 17 for invasive Streptococcus pneumoniae to read: Submit all isolates from patients under age 5. For all other ages, submit isolates that are non-susceptible to any relevant antibiotics, as defined by the Clinical & Laboratory Standards Institute (CLSI).
18. When DHEC was split into DPH and DES, the regulation for DPH changed from §61-20 to §60-20.
19. A new section containing all available reporting mechanisms for providers has been added to the document.
20. The Social Security number has been removed from the "What to Report" section.
21. The "How to Report" sections were changed to the more appropriate "Where to Report".
22. The reporting address for HIV/STDs has been updated to reflect the agency's move to the new Health Campus. "Leave a detailed message" has been added to the telephone reporting instruction.
23. The reporting address for the Lead Program was updated to the new location.
24. For animal bites and rabies exposure reporting, a link has been added that takes the reporter directly to a secure, online reporting form.
25. For TB reporting, the Lowcountry region will use the same telephone and fax numbers throughout the region.
26. The How to Report All Other Conditions is intended to capture all conditions that are not reported to one of the other specified programs that are listed above this section.
27. The DPH Bureau of Communicable Disease Prevention and Control address has been updated to reflect the new location.

Download the 2026 List of Reportable Conditions



The 2026 List of Reportable Conditions is now available!

View the Poster

View the Flyer

Provide Feedback on Reporting Mechanisms

HIV Cluster Detection and Response

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Ending the HIV Epidemic (EHE) initiative, launched in the U.S. in 2019, is a federal, multi-agency plan that aims to reduce new HIV infections by 75% by 2025 and by 90% by 2030[1]. The initiative includes four pillars: Diagnose, Treat, Prevent, and Respond.

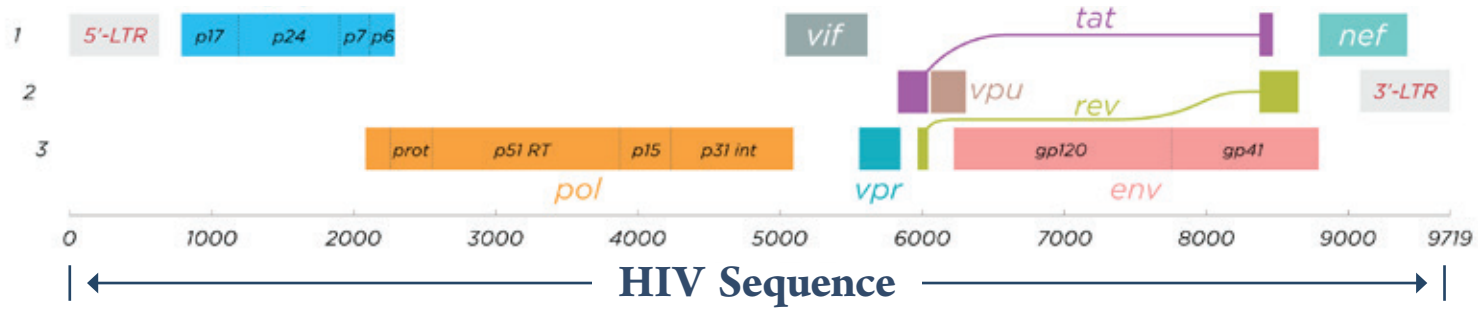
The Respond pillar of EHE is foremost in responding to cluster detection by implementing proven HIV prevention strategies where transmission is occurring rapidly. An HIV cluster indicates relatively rapid transmission.

For public health purposes, "cluster" is defined as a group of health events that are related or share characteristics. HIV clusters are cases associated with geographic areas, subpopulations, or social networks. Cluster Detection and Response (CDR) can identify gaps in prevention and care services. This has provided a foundation for improving service delivery to networks experiencing rapid HIV transmission[2].

Antiretroviral therapy (ART) is the lifelong treatment for HIV, using medications to suppress the virus, prevent disease progression, and stop transmission by achieving an undetectable viral load. HIV genotypic resistance testing is recommended for people with HIV to guide selection of an antiretroviral (ARV) regimen. This genetic sequencing is usually performed at the initiation of HIV treatment or when changing ARV regimens. The HIV genotypic resistance test results are compiled and analyzed for clusters.

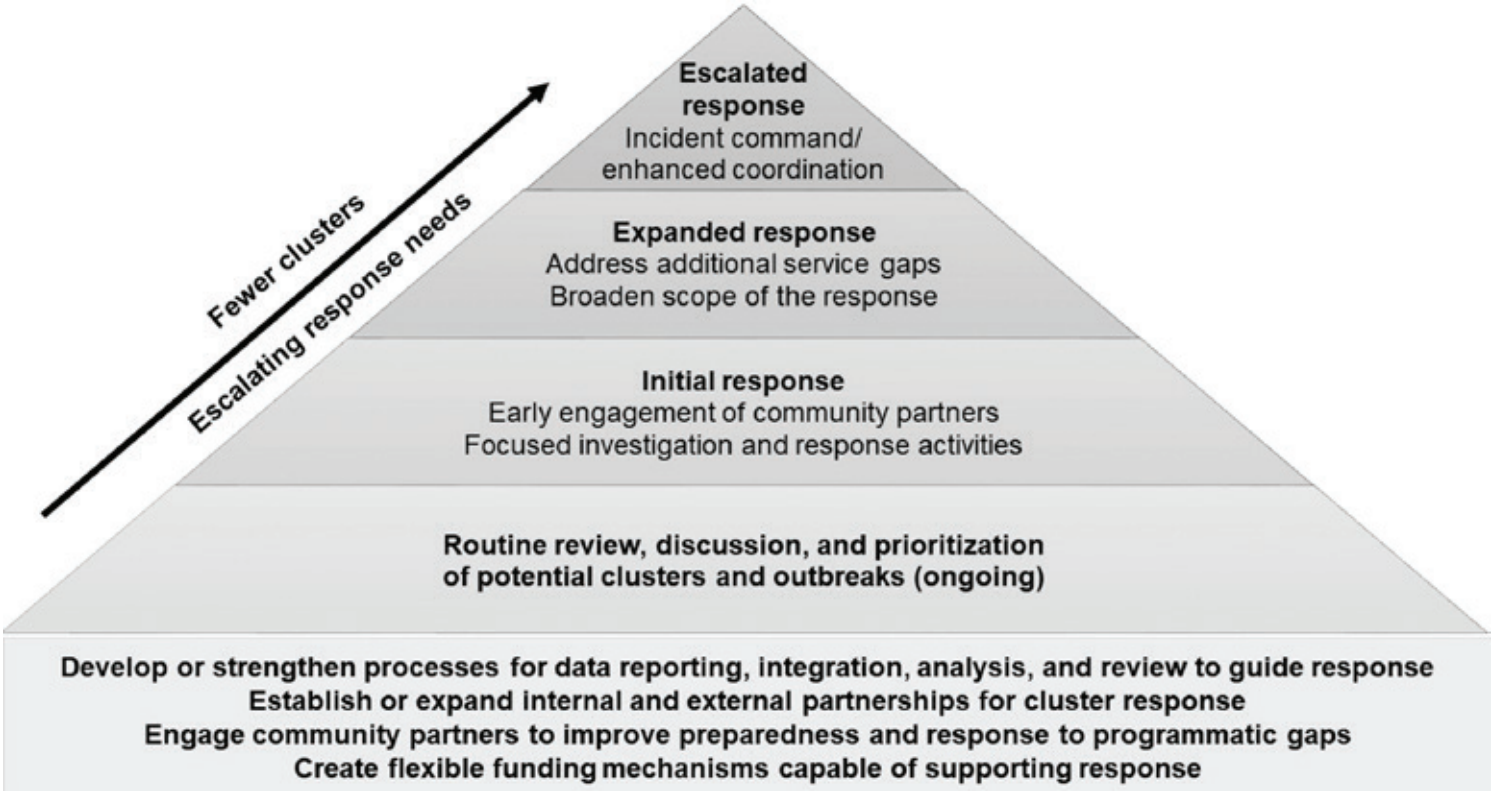
The focus of genotypic resistance testing is on the Pol region of the HIV genome.

Figure 1. The HIV Genome



An important feature of HIV transmission is the large number of mutations that occur as the virus moves from one person to the next. A cluster is indicated by the similarity of the gene sequences among infected people. A threshold of 1.5 or 0.5% is used to analyze sequences over a three-year period.

Figure 2. Scope of HIV cluster detection and response activities[3]



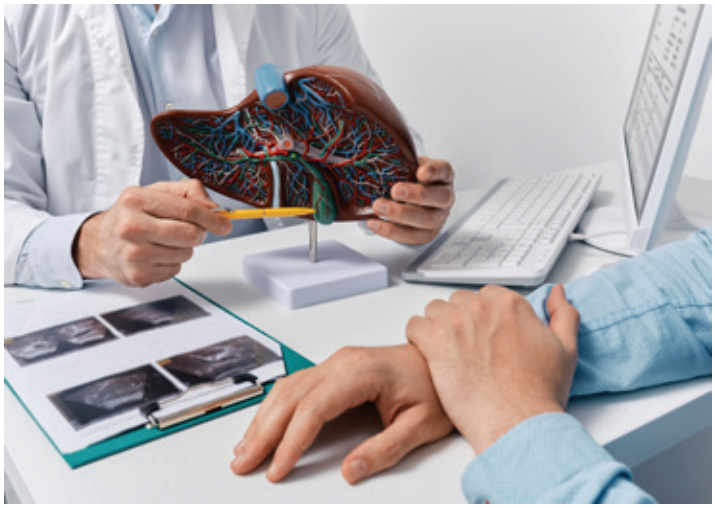
The base of the pyramid of responses in Figure 2 above illustrates the array of the initial scope. The Respond pillar of EHE is supported by the other three pillars: Diagnose, Treat, and Prevent. Linking people in the network to essential services, identifying and addressing gaps in programs and services, testing, providing HIV and other medical care, and providing pre-exposure prophylaxis are options in an effective response[3].

To be placed in a molecular cluster requires an HIV diagnosis, with the patient having entered care and received a drug resistance test. The resulting sequence must also be reported to the health department Typically, only 50-60% of new HIV diagnoses have genetic sequences from drug resistance testing that meet the criteria for cluster detection analysis. Consequently, the number of cases detected in any molecular cluster is likely underrepresented.

1. Ending the HIV epidemic. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview. Updated June 2, 2021. Accessed June 24, 2020.

2. Anne Marie France, Camden J Hallmark, et al; Nationwide Implementation of HIV Molecular Cluster Detection by Centers for Disease Control and Prevention and State and Local Health Departments, United States. Emerg Infect Dis 2025

3. Alexandra M Oster, Sheryl B Lyss, R Paul McClung, et al; HIV Cluster and Outbreak Detection and Response: The Science and Experience. Am J Prev Med 2021



Why Reflex Testing for Hepatitis C Matters

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Hepatitis C virus (HCV) screening requires two steps: an initial antibody test, followed by an HCV RNA test to confirm active infection. Reflex testing automatically performs the RNA test on the same specimen when antibodies are detected, eliminating the need for a second visit.

Benefits of Reflex Testing:

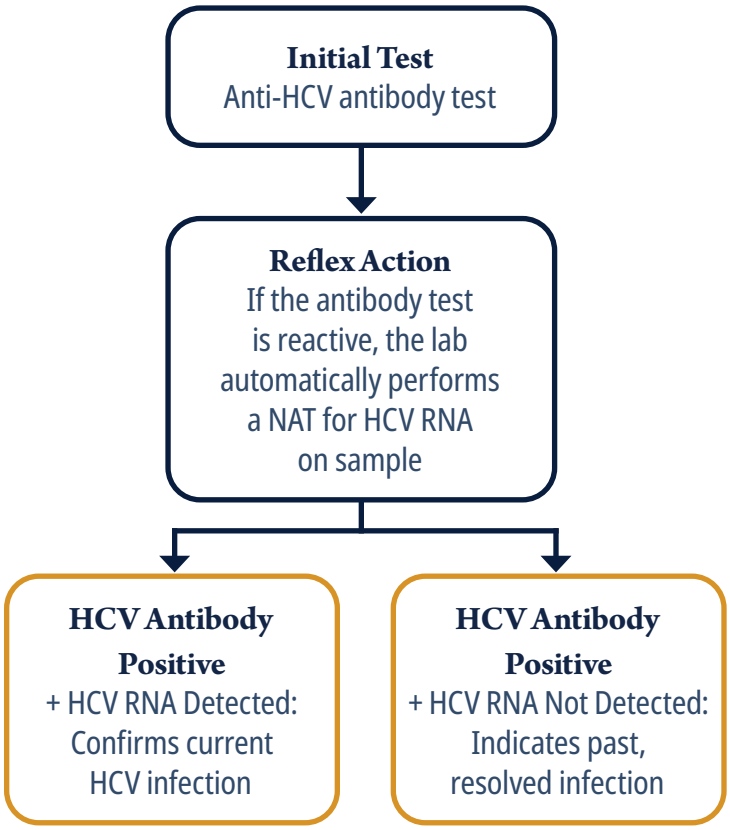
- **Faster Diagnosis:** Reduces delays by completing testing in one visit.
- **Improved Follow-Up:** Ensures confirmation for nearly all patients, preventing missed diagnoses.
- **Better Outcomes:** Speeds linkage to curative treatment and reduces transmission risk.
- **Supports Elimination Goals:** Streamlines care and aligns with public health strategies.

Reflex testing simplifies workflows, improves patient care, and strengthens our efforts to eliminate HCV.

Key Recommendations for HCV Screening with Reflex

Universal Screening: One-time, routine screening for all adults (18+) and during every pregnancy.

Targeted Screening: Periodic screening for those with ongoing risk factors *(e.g., injection drug use.)*



Benefits: This Centers for Disease Control and Prevention (CDC)-recommended approach minimizes incomplete testing (which occurs when only the antibody test is done) and reduces the need for patient follow-up visits.

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