

MINUTESof the**WILLIAMSON COUNTY COMMISSIONERS' COURT MEETING****October 29, 2002**

THE STATE OF TEXAS)(

COUNTY OF WILLIAMSON)(

BE IT REMEMBERED that at 9:35 a.m. on October 29, 2002, a SPECIAL SESSION of the Commissioners' Court of Williamson County, Texas, was held with the following being present, to-wit:

	JOHN C. DOERFLER, County Judge
	MICHAEL L. HEILIGENSTEIN, Commissioner, Precinct 1
	GREGORY W. BOATRIGHT, Commissioner, Precinct 2
ABSENT	DAVID HAYS, Commissioner, Precinct 3
	FRANKIE LIMMER, Commissioner, Precinct 4
	EUGENE D. TAYLOR, County Attorney
	NANCY E. RISTER, County Clerk

AGENDA ITEM 1

Hear any interested person and consider forming the next agenda or adding items to today's agenda.

Terry Deyoe of 1590 County Road 233 addressed the court concerning a training facility and shooting range being built near his neighborhood by the Texas Department of Public Safety. He voiced concerns about environmental, safety, noise and property value issues. Commissioner Heiligenstein and Judge Doerfler noted that the Commissioners' Court has no authority over land use by the State of Texas, and that it would best be addressed through the legislature.

Health District Director Karen Wilson introduced Jennifer Jackson, Coordinator for the Communicable Disease Control Program for the Health District, and Williamson County Health Authority Dr. Ed Sherwood. Dr. Sherwood gave the court an update on the West Nile Virus, stating that although there have been 8 cases found in horses in Williamson County, there are no documented cases in humans in Williamson County at this time.

< Attachment >

OUTLOOK

West Nile Virus Encephalitis

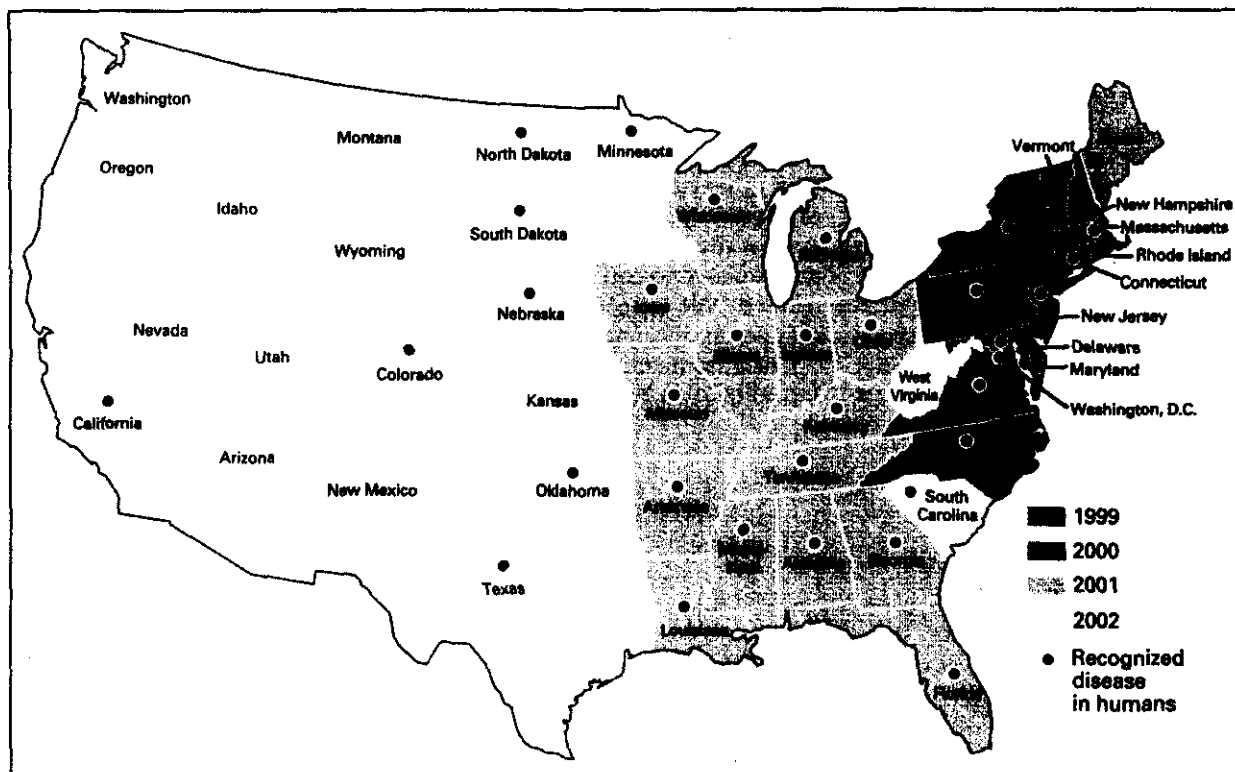
In August 1999, Dr. Deborah Asnis, an infectious-disease clinician in Queens, New York, reported two cases of encephalitis associated with muscle weakness to the New York City Department of Health. Dr. Marci Layton and her colleagues at the Department of Health rapidly mounted a collaborative investigation that ultimately identified West Nile virus as the cause of the ongoing outbreaks of disease in humans and in crows. West Nile virus, which was first identified in a patient in Uganda in 1937,

had not previously been recognized in the Western Hemisphere. The virus has now spread throughout most of the United States and has been identified in Canada and the Cayman Islands. It poses numerous challenges to clinicians, microbiologists, veterinarians, personnel of mosquito-control programs, and public health officials.

West Nile virus is primarily an infection of birds and culicine mosquitoes, with humans and horses serving as incidental hosts. Amplification of virus in this bird-mosquito-bird cycle begins when adult mosquitoes emerge in early spring and continues until fall. Among humans, the incidence of disease peaks in late summer and early fall. Birds provide an efficient means of geographic spread of the virus, and within four years, the virus has spread throughout much of the

United States (see Figure). West Nile virus and the closely related St. Louis encephalitis virus appear to have a similar ecology and epidemiology. This year, the large outbreak of West Nile virus throughout the midwestern United States is strikingly similar to the outbreak of St. Louis encephalitis in 1975, which involved nearly 2000 cases in humans. In addition to transmission from mosquitoes, transmission has been linked to the transplantation of four organs from a single donor. Investigations are under way to assess the risk of transmission by transfusion of blood or blood products.

For every five humans infected with West Nile virus, one has a mild, febrile illness usually lasting three to six days; meningitis or encephalitis develops in approximately 1 in 150 infected persons. The incubation period typically ranges from



Spread of West Nile Virus, in Birds, Horses, Mosquitoes, Other Animals, and Humans in the United States, 1999-2002.

2 to 14 days. Symptoms of the mild illness include malaise, headache, eye pain, gastrointestinal problems, and rash. Meningoencephalitis is rare in young persons, but its incidence is markedly higher among persons older than 50 years of age. Anecdotal data suggest that immunosuppression may increase the risk of severe disease. Severe muscle weakness is a common symptom and may provide a diagnostic clue. Reports of acute flaccid paralysis have suggested Guillain-Barré syndrome; however, reports in this issue of the *Journal* (pages 1279-1281) describe a poliomyelitis-like syndrome affecting anterior horn cells, for which standard treatments for Guillain-Barré syndrome would be inappropriate.

Demonstration of the presence of West Nile virus or virus-derived RNA in serum, cerebrospinal fluid, or other tissue confirms the diagnosis of a current infection. RNA of West Nile virus can be identified by qualitative reverse-transcriptase polymerase chain reaction (PCR) and by quantitative real-time PCR. However, the use of RNA-detection assays alone is not an appropriate diagnostic approach, because of their lower sensitivity. West Nile virus antigen can be identified rapidly in postmortem brain specimens with the use of immunohistochemical staining. Isolation of the virus by growth in cell culture is insensitive, especially if specimens have not been fresh-frozen. Isolation of West

Nile virus can take three to seven days, depending on the amount of virus present.

Because of the limitations of virus-detection assays, West Nile virus infections in humans are most frequently diagnosed by assessment of the antibody response in an IgM antibody-capture enzyme-linked immunosorbent assay, which can be performed in state public health laboratories in 24 to 36 hours. Approximately 75 percent of patients with flavivirus encephalitis have detectable IgM in serum or cerebrospinal fluid during the first four days of illness, and nearly all test positive by seven to eight days after the onset of illness. IgM antibodies may persist for a year or more after infection. Although identification of West Nile virus-specific IgM in cerebrospinal fluid confirms the presence of a current West Nile virus infection, identification of virus-specific IgM in serum indicates only a probable infection and necessitates further testing, including the use of serum specimens from the acute and convalescent phases of illness to identify a change by a factor of four or more in the antibody titer. Because of serologic cross-reactions with other closely related flaviviruses (e.g., St. Louis encephalitis and dengue viruses), virus-neutralization tests are used to confirm a diagnosis of West Nile virus infection when only serum specimens are available.

The introduction and subsequent spread of West Nile virus highlight

the critical importance of strengthening the linkages between health care providers and public health officials and between human and veterinary medicine and public health. Clinicians will continue to play a critical role in the initial recognition of and response to any unexpected occurrence of disease, which will also depend heavily on strengthened local, state, and national public health capacities.

Among the many questions resulting from the emergence of West Nile virus are the extent of its geographic spread, the epidemiology of the virus in different geographic areas, and the magnitude of the risk of transmission associated with organ transplantation and blood transfusion. Research priorities also include better definition of the clinical spectrum and course of the illness, assessment of candidate treatments, development of diagnostic tests that could be used to assess blood donors, if indicated, and development of a safe, effective vaccine.

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This article was published at www.nejm.org on September 23, 2002.

AGENDA ITEM 2

Read and approve the minutes of the last meeting.

Moved: **Commissioner Boatright**

Seconded: **Judge Doerfler**

Motion: To approve the minutes of the October 22, 2002 meeting.

Vote: 4 - 0

AGENDA ITEM 3

Hear County Auditor concerning invoices and bills submitted for payment and take appropriate action including, but not limited to approval for payment provided said items are found by the County Auditor to be legal obligations of the county.

Moved: **Commissioner Limmer**

Seconded: **Judge Doerfler**

Motion: To authorize the payment of bills totaling \$1,734,278.17 in computer printout from the proper line items, if found by the County Auditor to be legal expenses as appropriated in the 2001/2002 County Budget.

Vote: 4 - 0

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