

Poliomyelitis (Paralytic and Nonparalytic)

Disease Category: Enteric and Vaccine Preventable

Timeframe to follow-up:

See the link to the [Disease Investigation Process document](#)

Signs and Symptoms ¹	- Most people infected with poliovirus will not have any visible symptoms. About 1 in 4 will have flu_ like symptoms_such as sore throat, fever, tiredness, nausea,_headache, or_stomach pain. These symptoms usually last 2-5 days and are self-limiting. - Fewer than 1% of people will have weakness or flaccid paralysis in their arms or legs or both. The paralysis can lead to permanent disability and death.
Incubation ²	Non-paralytic: 3 to 6 days Paralytic: 7 to 21 days - Range 3 to 35 days
Case Classification ³	The following case definition for paralytic poliomyelitis and nonparalytic poliovirus infection has been approved by the Council of State and Territorial Epidemiologists (CSTE) and was published in 2023. Clinical Criteria: Acute onset of flaccid paralysis with decreased or absent tendon reflexes in the affected limbs, in the absence of a more likely alternative diagnosis. Confirmatory Laboratory Evidence: - poliovirus detected by sequencing of the capsid region of the genome by the CDC Poliovirus Laboratory, OR - poliovirus identified in an appropriate clinical specimen (e.g., stool [preferred], cerebrospinal fluid, oropharyngeal secretions) using a properly validated assay, AND - specimen is not available for sequencing by the CDC Poliovirus Laboratory. Confirmed: - Paralytic Poliomyelitis: Meets clinical criteria AND confirmatory laboratory evidence. - Nonparalytic Poliovirus Infection: Meets confirmatory laboratory evidence.
Differential Diagnosis ⁴	- Poliomyelitis should be considered when evaluating any case of acute flaccid paralysis. - It should be included alongside other potential diagnoses such as Guillain-Barré syndrome and transverse myelitis.

	Acute flaccid myelitis, mainly seen in children, is typically associated with enterovirus D68 and less commonly with enterovirus A71 or other nonpolio enteroviruses.
<u>Treatment</u> ⁴	Treatment for poliovirus infections is purely supportive.
<u>Duration</u> ⁴	- Nonparalytic: 2-5 days - Paralytic: Several weeks
<u>Exposure</u> ⁵	- Human reservoir: fecal-oral, or oral-oral. The polio virus enters the body through the mouth, usually with hands contaminated with the stool of an infected person. - Respiratory and oral-to-oral transmission through saliva may also occur. - In communities with lower vaccination rates, polio can spread more easily. - Therefore people 2 months and older should get vaccinated against the virus as soon as possible. - The polio virus typically persists in the throat for approximately 1 week and in feces for 3-6 weeks. Cases are most infectious during the days before and after the onset of symptoms. - Poliovirus can contaminate food and water.
<u>Laboratory Testing</u> ^{3,6}	Nevada OSE and/or local health authorities (LHA) arrange testing for individual cases with CDC consult. CDC does confirmation or serology. - Nevada State Public Health Laboratory (NSPHL) and Southern Nevada Public Health Lab (SNPHL) perform initial testing of swabs. - CDC's Emergency Operations Center should also be contacted at 770-488-7100. - Best specimens: 2 to 4 lesion swabs collected with synthetic swab (polyester, nylon, or Dacron, do not use cotton swabs) or scab samples from lesions. - Each swab or scab should be placed into a separate specimen container with viral transport media (VTM). - Label container with patient's first name, last name, date of birth, date and time of specimen collection, and body site specimen was collected from. <i>Specimen shipping (Section 4):</i> - Refrigerate (2-8°C) or freeze ($\leq 20^{\circ}\text{C}$) all specimens within one hour after collection. Whenever possible ship specimens on dry ice. Specimens received outside of acceptable temperature ranges will be rejected. Specimen Collection and Submission Instructions
<u>Control of Contacts</u> ²	Records case occupation(s) and any other high-risk activities with dates, descriptions, and locations: food handling, provision of childcare in any setting, daycare attendance, employment, or household contact of an attendee or

	employee, direct patient care, or other activities with high risk for fecal-oral or droplet transmission.
Key areas of focus during investigation ³	Travel history, communities, vaccine information
Public Health Actions	Reports of Poliomyelitis cases must be made to the Local Health Authority immediately after identifying a case having or a suspected case considered to have. Assess the likelihood of polio and AFM: confirm compatible clinical symptoms, verify vaccination and travel history, assess exposure risk (e.g., contact with a recent oral polio vaccinated recipient), obtain history of recent respiratory or GI illness, and review test findings Local Health Authority to notify Office of State Epidemiology (dpbhepi@health.nv.gov) or call 775-684-5911/775-400-0333 (after hours) if outbreak suspected. For individual confirmed or probable cases: • Confirm diagnosis, if possible • Identify potential exposures • Prepare a case report and submit to the Chief Medical Officer (through OSE) within 7 days after completing the case investigation • Identify potential outbreaks from common sources • Provide education about how to prevent transmission To the best of the local health authority's ability, each step of the investigation should be completed within one working day or in alignment with NAC 441A.
Key Partner Agencies	• CDC • Local Health Authorities • Hospitals and medical providers

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POLIOMYELITIS (PARALYTIC AND NONPARALYTIC)

I. DISEASE REPORTING

A. Legal Reporting Requirements

A report to the health authority may be made by telephone; telecopy (in the form prescribed by the health authority); or any form of electronic communication identified by the health authority, following the specified format and procedure.⁷

1. *Health Care Providers and Health Care Facilities*

Health providers and facilities must notify the health authority where provider is located immediately after identifying the case.⁷⁻⁹

2. *Laboratories*

Laboratories must notify the health authority immediately after identifying the case.⁷ If the lab is located outside of Nevada, notify the Nevada Chief Medical Officer through the Office of State Epidemiology (OSE) within the same timeframe.^{7,10}

3. *Local Health Authority (LHA)*

LHA's must notify the Office of State Epidemiology (OSE) within 7 days after completing the case investigation.¹¹

II. THE DISEASE AND ITS EPIDEMIOLOGY

A. Background

Poliomyelitis virus infects only humans and is caused by three serotypes of poliovirus. The virus enters through the mouth and multiplies in the oropharynx and gastrointestinal tract. The virus is usually present in nasopharyngeal secretions for one to two weeks and can be shed in stool for several weeks after infection. Most people infected with poliovirus will be asymptomatic. About one out of four people will have flu-like symptoms. These symptoms usually last two to five days, then go away on their own. Approximately 1-5% of persons will develop meningitis while fewer than 1% will have weakness or paralysis in their arms, legs, or both. The paralysis can lead to permanent disability and death. The risk of severe disease and death following primary infection with poliovirus increases with increasing age. Sometimes children can develop new muscle pain, weakness, or paralysis as adults, 15 to 40 years later, called post-polio syndrome. ^{4,12} There is no specific treatment or cure for paralytic polio. ⁴ There are two types of vaccines available to prevent polio: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The US has used IPV exclusively since 2000.
^{1,4}

B. Etiologic Agent

Acute paralytic disease may be caused by naturally occurring (wild) polioviruses, and rarely by oral poliovirus (OPV) vaccine viruses. Polioviruses are members of the

family Picornaviridae, genus Enterovirus, in the species enterovirus C. It includes 3 serotypes all of which can cause paralysis. OPV-associated cases of vaccine-associated paralytic poliomyelitis (VAPP) may occur in those recently vaccinated or their close contacts or may be associated with circulating vaccine-derived polioviruses (cVDPVs) that have pathogenic characteristics that are equal to naturally occurring polioviruses because of sustained person-to-person transmission in populations with inadequate immunity.⁴

There are three types of polio infections:

- 1) Subclinical: This type of polio does not affect the central nervous system – the brain and spinal cord. 95% of polio cases identified are usually subclinical.
 - If there are symptoms, they are flu-like and can cause intestinal symptoms and only lasts a few days and does not cause long lasting issues.
- 2) Non-paralytic: This type of polio affects the central nervous system but does not result in paralysis. It may cause aseptic meningitis. It causes more symptoms than subclinical polio.
- 3) Paralytic: This is the most serious and rarest form of polio as it results in full or partial paralysis in the patient. The three types of paralytic polio are –
 - a. Spinal Polio – Affects the spine.
 - b. Bulbar Polio – Affects the brainstem.
 - c. Bulbospinal Polio – Affects the spine and brainstem.
 - It can paralyze the muscles that allow you to breathe, speak, swallow and move your limbs. Depending on what parts of your body are affected, it's called spinal polio or bulbar polio. Spinal and bulbar polio can appear together (bulbospinal polio). Less than 1% of people with polio get paralytic poliomyelitis. ⁴

C. Description of Illness^{2-3 12-13}

Non- Paralytic:

- The incubation period for nonparalytic poliomyelitis is 3 to 6 days. For onset of paralysis in paralytic poliomyelitis, the incubation period is usually 7 to 21 days. The risk of severe disease and death following primary infection with poliovirus increases with increasing age.
- Approximately 70% of all polio infections in children are asymptomatic. Infected individuals without symptoms shed the virus in nasopharyngeal secretions and stool for several days or weeks and can transmit the virus to others.
- Approximately 24% of polio infections in children consist of a minor, nonspecific illness without clinical or laboratory evidence of central nervous system invasion. This clinical presentation is known as abortive poliomyelitis, and is characterized by a low fever, sore throat, and complete recovery in less than a week.
- Nonparalytic aseptic meningitis occurs in 1% to 5% of polio infections in children. The clinical presentation includes stiffness of the neck, back, or legs, usually following several days of a prodrome like that of minor illness. Increased or abnormal

sensations (e.g., pain in the limbs, back, or neck), headache, and vomiting can also occur. Typically, symptoms last 2 to 10 days and are followed by complete recovery.

Paralytic:

- Less than 1% of all polio infections in children result in flaccid paralysis. The course may be biphasic in children, with initial minor illness that lasts several days, a symptom-free period of 1 to 3 days, followed by major illness with paralysis, fever and muscle pain. Paralysis usually progresses within 2 to 3 days. Among adolescents and adults, the minor illness is often absent, and they suffer more severe pain and paralysis. Paralysis is typically asymmetrical, more severe proximally, and associated with absent or reduced deep tendon reflexes and intact sensation. Patients usually do not experience changes in cognition.
- Paralysis is often permanent, although total or partial recovery can occur through compensation by muscles not affected. Weakness or paralysis present 12 months after onset, which occurs in two-thirds of patients with paralysis, is usually permanent.
- Paralytic polio is classified into three types, depending on the level of involvement. Spinal polio is most common, and during 1969–1979 accounted for 79% of paralytic cases. It is characterized by asymmetric paralysis that most often involves the legs. Bulbar polio presents with weakness of facial, oropharyngeal, and respiratory muscles innervated by cranial nerves and accounted for 2% of cases. Bulbospinal polio, a combination of bulbar and spinal paralysis, accounted for 19% of cases.
- The case fatality ratio for paralytic polio is generally 2% to 5% among children and up to 15% to 30% among adolescents and adults. Fatality rates increase 25% to 75% with Bulbospinal Polio.
- Paralytic disease with similar clinical manifestations may be caused by:
 - naturally occurring wild-type polioviruses
 - by the attenuated polioviruses contained in the oral poliovirus vaccine (Sabin strains) in extremely rare occasions, or
 - by vaccine-derived polioviruses (VDPVs), which are Sabin vaccine strains that have reverted and re-acquired the virulence and transmissibility of wild polioviruses.
- After an interval of 15 to 40 years, 25% to 40% of people who contracted paralytic poliomyelitis in childhood experience new muscle pain and exacerbation of existing weakness and may develop new weakness or paralysis. This disease entity is referred to as post-polio syndrome. Post-polio syndrome is not an infectious process, and people experiencing this syndrome do not shed poliovirus.

D. Disease Burden in Nevada

Polio is not endemic to Nevada.¹⁴

See the [Nevada Office of State Epidemiology Communicable Disease Dashboard](#) for Nevada specific data on Polio.

E. Reservoirs²

Humans are the only known reservoir, and most frequently people with inapparent infections, especially children. No long-term carriers of wild- type poliovirus have been detected. Chronic carriage of vaccine- derived poliovirus has been reported, all from high- income countries or emerging economies and all associated with primary B- cell immunodeficiency.

F. Modes of Transmission^{2,5}

Transmission is primarily spread from person- to- person, principally through fecal- oral contamination.

- Where sanitation levels are high, pharyngeal spread may be relatively more important.
- In rare instances, foodstuffs, and other materials contaminated with feces have been implicated as vehicles for transmission.
- Transmission is possible if the virus is excreted.
- The virus is detectable more easily and for a longer period in feces than in throat secretions. The virus typically persists in the throat for approximately 1 week and in feces for 3-6 weeks.
- Cases are most infectious during the days immediately before and after the onset of symptoms.
- Second infections of poliomyelitis are rare and result from being infected with a poliovirus of a different type.
- Type- specific immunity, apparently of lifelong duration, follows both clinically recognizable and inapparent infections.

G. Incubation Period^{2,3}

The incubation period for nonparalytic poliomyelitis is 3 to 6 days. For onset of paralysis in paralytic poliomyelitis, the incubation period is usually 7 to 14 days with a reported range of 3 to 35 days.

H. Period of Communicability^{2,4}

Transmission is possible if the virus is excreted. Poliovirus is highly infectious, with seroconversion rates among susceptible household contacts of children nearly 100%, and greater than 90% among susceptible household contacts of adults. Persons infected with poliovirus are most infectious in the days immediately before and after the onset of symptoms, but poliovirus may remain present in the stool for up to 6 weeks.

I. Testing^{6,15}

All testing must be conducted by the CDC. Collect two whole-stool and two throat specimens, taken at least 24 hours apart, within the first 14 days after paralysis begins. These should be obtained as quickly as possible, along with any additional specimens

recommended by the CDC. Refer to the [CDC's specimen collection guidance](#) for full instructions.

J. Treatment⁴

There is no treatment. Healthcare providers should consider consulting neurology and infectious disease experts to discuss possible treatments/interventions on a case-by-case basis.

Provide most current treatment guidelines from [Red Book](#) to the healthcare provider or refer case to physician for proper treatment for Polio.

III. EPIDEMIOLOGIC CASE INVESTIGATION

The public health authority should begin investigating the case of Polio, step by step, immediately of notification or in alignment with [NAC 441A](#).

A. Step 1: Review relevant information about the disease.

1. *Review scientific information in [Control of Communicable Diseases Manual](#), most recent edition.*
2. *Review [Poliomyelitis most recent case definition 2024 CDC](#).*

B. Step 2: Begin investigating the case.

1. Contact Reporting Source and/or Reported Case

Upon receiving an initial case report, review lab test results and available clinical details and epidemiologic factors. Please make three attempts to contact the case (text and phone calls) on separate days, at different times of the day (morning, afternoon, late afternoon). Document all attempts to contact a reporting source and/or reported case, preferably in the "Encounters" tab of EpiTrax. Please use case report forms (CRF) to gather accurate information about the case. Focus on the key data elements listed above. Filling out an electronic version of the CRF in EpiTrax (called a Confidential Morbidity Report (CMR) in EpiTrax) is preferred. If used, the completed PDF version should be attached to the CMR in EpiTrax. The CRF should be completed within 7 days of completing the investigation of the case.¹¹

C. Step 3: Identify potential sources of infection³

Because poliovirus detected in the United States is likely to be imported, travel history for the patient and close contacts is essential, especially travel to or contact with visitors from areas where polio risk remains elevated or OPV is used. Communities with low vaccination coverage are at increased risk if poliovirus is introduced, so suspected cases from undervaccinated populations should be prioritized for follow-up and specimen collection

D. Step 4: Initiate control measures for case and/or for contacts (see Section IV – Section VI below).

E. Step 5: Provide Education and Prevention messaging to the case and/or contacts (see Section IX below).

IV. CONTROL OF CASE³

Because poliomyelitis has been eliminated from the Americas, every suspected case must be promptly investigated by local and state health departments in collaboration with CDC. The jurisdiction where the patient resides at diagnosis is responsible for submitting the case notification, even if information is incomplete. Notifications can be updated as new details become available. Paralytic and nonparalytic poliomyelitis are classified as “Immediately notifiable, Urgent,” requiring notification to CDC within 24 hours. CDC’s Emergency Operations Center (770-488-7100) assists with specimen collection, diagnostic procedures, record compilation, and evaluation of whether infection may be due to wild or vaccine-derived poliovirus. Paralytic cases should be reported under event code 10410 in NNDSS; nonparalytic cases under event code 10405.

Investigations should collect key demographic, clinical, laboratory, vaccination, and epidemiologic information to determine whether the case meets criteria for paralytic poliomyelitis and whether wild or vaccine-derived virus may be involved. Important details include patient identifiers, symptom onset, hospitalization information, test results, vaccination history, and exposure risks. Because poliovirus detected in the United States is likely to be imported, travel history for the patient and close contacts is essential, especially travel to or contact with visitors from areas where polio risk remains elevated or OPV is used.

Communities with low vaccination coverage are at increased risk if poliovirus is introduced, so suspected cases from undervaccinated populations should be prioritized for follow-up and specimen collection. For detailed information on polio vaccination and immunization practices, providers should refer to The Pink Book.

V. CONTROL OF CONTACTS²

Inquire about case activities and occupations during the communicable period 10 days prior to and after onset of symptoms. Record case occupation(s) and any other high-risk activities with dates, descriptions, and locations: food handling, provision of childcare in any setting, daycare attendance, employment, or household contact of an attendee or employee, direct patient care, or other activities with high risk for fecal-oral or droplet transmission. Investigate symptomatic contacts in the same manner as a case.

Immunization of family and other close contacts is recommended but may not contribute to immediate control as the virus has often infected susceptible close contacts by the time initial case is recognized. Occurrence of a single case of poliomyelitis due to wild poliomyelitis virus or a cVDPV in a country that has interrupted transmission is a public health emergency prompting immediate investigation and planning for a large-scale response. A thorough search for additional cases of AFP in the area around the case and

enhancing AFP surveillance across the country assure early detection, facilitate control, and identify unrecognized and unreported cases.

VI. CONTROL OF CARRIERS

Persons can be *asymptomatic* carriers of Poliomyelitis. Carriers may be identified through outbreak investigation, or healthcare provider testing. Investigate carriers in the same manner as a case.

VII. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL^{2,16}

Coordinate with senior epidemiology staff to determine if an outbreak is occurring. If so, notify DPBH Environmental Health, local health authorities, or infection control, as appropriate.

- Poliomyelitis is a disease under surveillance by WHO and targeted for eradication. Countries party to IHR (International Health Regulations) which the United States of America is) are required to inform WHO immediately of any individual cases of paralytic poliomyelitis due to wild virus or cVDPV and to report the details and extent of virus transmission. Countries should also report wild poliovirus and cVDPV isolated from other sources (e.g., environmental sampling).
- Non- paralytic poliovirus infections, if detected, should also be reported to local health authorities.
- In any country that has previously interrupted transmission of poliovirus, a single case of poliomyelitis due to wild poliovirus or cVDPV must now be considered a public health emergency requiring an extensive supplementary immunization response over a large geographic area. Responses should be initiated within 4 weeks of confirmation of the index case and should usually consist of a minimum of 5 mass immunization rounds (fewer for cVDPV type 2 outbreaks) spaced as closely as 2-3 weeks apart, if possible (with greater than or equal to 2 rounds after the last detected case for wild poliovirus and cVDPV type 1 or 3 outbreaks), using bivalent OPV, covering a minimum of 2- million children and achieving at least 95% coverage in each administrative area.
- Response to any type 2 cVDPVs requires an authorized release of monovalent or new more stable type 2 OPV by WHO.
- Cases must be reported to WHO under the IHR- and the planning of a large-scale immunization response must begin immediately, be completed within 72 hours, and if appropriate, be coordinated with bordering countries,
- Primary isolation of the virus should be in a designated Global Polio Eradication Laboratory under standard procedures to allow prompt referral for genomic sequencing and analysis. Once a wild polio is isolated, molecular epidemiology can help trace the source. For vaccine- derived poliovirus molecular epidemiology can determine the approximate time of circulation after emergence.

VIII. PREVENTION

The investigator should reference the most recent disease specific public educational materials from the CDC. The [Nevada OSE website](#) also provides information about Poliomyelitis.

Prevention Tips for the General Public: ¹

- The best way to prevent polio is to vaccinate against this preventable disease.
- The investigator should search for the most recent online public educational materials about the disease from the CDC.
- Polio vaccination helps children build immunity so they can fight poliovirus.
- Children receive the best protection when they get all four recommended doses of inactivated polio vaccine (IPV).
- More than 99% of children who complete the full IPV series are protected.
- Anyone who is unvaccinated or only partially vaccinated should receive polio vaccination.
- Wash hands frequently with soap and water to help reduce the spread of poliovirus.
- Alcohol-based hand sanitizers do not kill poliovirus.

Prevention Tips for Healthcare Providers:¹⁶

- Make every effort to ensure all eligible people in at-risk communities receive recommended vaccinations.
- During every primary care visit—whether for adults or children—take time to confirm they are up to date with age-appropriate vaccines.

IX. REFERENCES

1. CDC. About Polio in the United States. Polio. May 13, 2024. Accessed June 4, 2024. <https://www.cdc.gov/polio/about/index.html>
2. Heyman DL. *Control of Communicable Diseases Manual 21st Edition*. 21st Edition. APHA Press; 2022. Accessed February 27, 2024. <https://www.zotero.org/>
3. CDC. Chapter 12: Poliomyelitis. Manual for the Surveillance of Vaccine-Preventable Diseases. April 13, 2026. Accessed August 7, 2026. <https://www.cdc.gov/surv-manual/php/table-of-contents/chapter-12-poliomyelitis.html>
4. Kimberlin DW, Barnett ED, Lynfield R, Sawyer MH, eds. Poliovirus Infections. In: *Red Book (2021): Report of the Committee on Infectious Diseases*. American Academy of Pediatrics; 2021:0. doi:10.1542/9781610025225-part03-ch107
5. Pinkbook: Poliomyelitis | CDC. April 26, 2023. Accessed June 4, 2024. <https://www.cdc.gov/vaccines/pubs/pinkbook/polio.html>

6. CDC. Laboratory Testing for Poliovirus. Polio. May 10, 2024. Accessed August 7, 2026. <https://www.cdc.gov/polio/php/laboratories/index.html>
7. *REPORTING OF COMMUNICABLE DISEASES - 441A.225*. 441A.225. 2021:Section 225. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec225>
8. *REPORTING OF COMMUNICABLE DISEASES - 441A.230*. 441A.230. 2021:Section 230. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec230>
9. *REPORTING OF COMMUNICABLE DISEASES - 441A.240*. 441A.240. 2021:Section 240. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec240>
10. *REPORTING OF COMMUNICABLE DISEASES - 441A.235*. 441A.235. 2021:Section 235. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec235>
11. *DUTIES AND POWERS RELATING TO THE PRESENCE OF COMMUNICABLE DISEASES - 441A.290*. 441A.290. 2021:Section 290. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec290>
12. Poliomyelitis | CDC Yellow Book 2024. Accessed June 4, 2024. <https://wwwnc.cdc.gov/travel/yellowbook/2024/infections-diseases/poliomyelitis#agent>
13. Polio Disease and Poliovirus | CDC. Accessed June 4, 2024. <https://www.cdc.gov/orr/polioviruscontainment/diseaseandvirus.htm>
14. CDC. Clinical Overview of Poliomyelitis. Polio. May 10, 2024. Accessed June 4, 2024. <https://www.cdc.gov/polio/hcp/clinical-overview/index.html>
15. Laboratory Support for Surveillance of Vaccine-Preventable Diseases | CDC. May 1, 2024. Accessed June 4, 2024. <https://www.cdc.gov/vaccines/pubs/surv-manual/chpt22-lab-support.html>
16. CDC. Reporting Suspected Cases. Polio. May 21, 2025. Accessed August 7, 2026. <https://www.cdc.gov/polio/php/case-reporting/index.html>

X. ACKNOWLEDGEMENTS

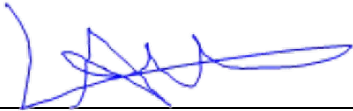
This document was developed based on the content and format of the disease investigation guidelines of several state and local health jurisdictions:

- Oregon Health Authority Investigative Guidelines
- Washington State Department of Health Reporting and Surveillance Guidelines

- Northern Nevada Public Health (formerly known as Washoe County Health District) Epidemiology and Communicable Disease Program Investigation of Communicable Disease Manual

The Nevada Office of State Epidemiology would like to acknowledge the work of these great partners.

XI. UPDATE LOG



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10/7/26

Chief Medical Officer Approval Date