

tered. The logical organization of the chapter and the arrangement of the myriad of epidemiological and serological data from numerous publications collected worldwide into one very readable account are breathtaking. The citation of many references from pre-PubMed days and of more recent ones not indexed in common databases complements the authors' profound knowledge of this virus, which luckily they share with the reader.

In my opinion, this chapter alone would have been worth spending the money for the book, but the reader gets even more: a nice overview of Dengue viruses by Ching-Juh Lai and Robert Putnak and a superb description of the history and current status of Crimean-Congo hemorrhagic fever virus research by Pierre Nabeth. Na-

both even procured English translations of hardly available Russian literature, thereby emphasizing the Soviet and Russian contributions to the field. The book ends with David Buckeridge and Geneviève Cadieux's description of current surveillance principles and strategies, numerous color pictures, and an unfortunately short index.

In summary, this book is a must for researchers and other professionals with an interest in emerging infectious diseases. Of course, some viruses, such as Chikungunya virus, have not been addressed in this volume; but for those viruses that are included, I cannot imagine a better introduction than this book. Edward Tabor and Elsevier will hopefully produce many more compendia along the lines of this volume.

Capsule

Ed Krisiunas

WNWN International, Burlington, Connecticut

What's new? What's hot? What's timely? If you don't have time to search the Internet for the latest developments that might impact your work environment, you just might find some of this information in the "Capsule" column. Please e-mail any comments or suggestions to ekrisiunas@aol.com or to Co-Editor Barbara Johnson at barbara_johnson@verizon.net or Co-Editor Karen B. Byers at karen_byers@dfci.harvard.edu.

Notice to Readers: New Public Health Emergency Law and Forensic Epidemiology Training Materials Released

CDC's Public Health Law Program has released version 3.0 of its Public Health Emergency Law and Forensic Epidemiology training materials on CD-ROM. These self-contained training packages were developed for use by instructors to provide public health preparedness training to front-line practitioners in any jurisdiction in the U.S.

Public Health Emergency Law is designed to help public health practitioners and emergency management professionals improve their understanding of how to use the law as a public health tool. Forensic Epidemiology is designed to help public health and law enforcement agencies strengthen coordination of responses to pandemic influenza and similar threats. Materials include a new CDC-developed case study on pandemic influenza.

Information on how to order a free CD-Rom with the two sets of training materials is available at www2.cdc.gov/phlp/phel.asp. Additional information is available via e-mail at fe-phel@mcking.com. For more information, visit: www.cdc.gov/mmwr/preview/mmwrhtml/mm5713a7.htm

Notice to Readers: Newly Licensed Smallpox Vaccine to Replace Old Smallpox Vaccine

CDC has begun distribution of a new-generation smallpox vaccine, ACAM2000™ (Acambis, Inc., Cambridge, Massachusetts), to civilian laboratory personnel, the military, and state public health preparedness programs. ACAM2000 is a live, vaccinia virus smallpox vaccine that was licensed for use in the U.S. by the Food and Drug Administration in August 2007. ACAM2000 will replace Dryvax® smallpox vaccine (Wyeth Pharmaceuticals, Inc., Marietta, Pennsylvania) because of withdrawal of the Dryvax license. ACAM2000 is a live vaccinia virus derived from plaque purification cloning from Dryvax. The safety data available from the ACAM2000 clinical trials indicate a similar safety profile to Dryvax. For more information, visit:

www.cdc.gov/mmwr/preview/mmwrhtml/mm5708a6.htm

Surveillance for Acute Viral Hepatitis—U.S., 2006

MMWR Surveillance Summaries, March 21, 2008/57(SS02), 1-24. Problem/Condition: In the U.S., acute viral hepatitis most frequently is caused by infection with three viruses: hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus (HCV). These unrelated viruses are transmitted through different routes and have different epidemiologic profiles. Safe and effective vaccines have been available for hepatitis B since 1981 and for hepatitis A since 1995. No vaccine exists against hepatitis C.

Reporting Period Covered: Cases in 2006, the most recent year for which data are available, are compared with those from previous years. For more information, visit: www.cdc.gov/mmwr/preview/mmwrhtml/ss5702a1.htm

Human *Mycobacterium bovis* Infection and Bovine Tuberculosis Outbreak, Michigan, 1994-2007

Wilkins, M. J., Meyerson, J., Bartlett, P. C., Spieldenner, S. L., Berry, D. E., Mosher, L. B., et al. (April 2008 [date cited]). Human *Mycobacterium bovis* infection and bovine tuberculosis outbreak, Michigan, 1994-2007. *Emerging Infectious Diseases* (serial on the Internet).

Mycobacterium bovis is endemic in Michigan's white-tailed deer and has been circulating since 1994. The strain circulating in deer has remained genotypically consistent and was recently detected in two humans. We summarize the investigation of these cases and confirm that recreational exposure to deer is a risk for infection in humans. Visit the following link for more information:

www.cdc.gov/EID/content/14/4/657.htm

Conference Report on Public Health and Clinical Guidelines for Anthrax

Stern, E. J., Uhde, K. B., Shadomy, S. V., Messonnier, N. (April 2008 [date cited]). Conference report on public health and clinical guidelines for anthrax (conference summary). *Emerging Infectious Diseases* (serial on the Internet).

On March 13-14, 2006, a meeting on anthrax was held at Emory University in Atlanta, Georgia, sponsored by the Centers for Disease Control and Prevention (CDC) in collaboration with the Southeastern Center for Emerging Biologic Threats. The meeting's agenda included discussion of postexposure prophylaxis (PEP), screening and evaluation, and treatment of the various manifestations of human anthrax. The goal was to convene subject matter experts for a review of research developments and clinical experiences with anthrax prophylaxis and treatment and to make consensus recommendations for updating guidelines for PEP, treatment, and clinical evaluation of patients with anthrax. A 2001 conference on guidelines for anthrax has previously been summarized in this journal. This article summarizes the meeting's presentations and discussion. Consensus recommendations are summarized in the Table. Updated CDC guidelines for treatment and prophylaxis of anthrax will be published in detail in other CDC publications and are available on CDC's web site at www.bt.cdc.gov/agent/anthrax/index.asp.

www.cdc.gov/eid/content/14/4/e1.htm

Ask the Experts

John H. Keene

Global Biohazard Technologies, Inc., Midlothian, Virginia

Do you have a biosafety question and you're not sure who to ask? Send your questions to the "Ask the Experts" column and I'll get them answered for you. Drawing from my own experience or that of other experts in the field, we'll try to compile a thorough and comprehensive answer to your question. Please e-mail your questions to jkeene@biohaztec.com or Co-Editor Barbara Johnson at barbara_johnson@verizon.net or Co-Editor Karen B. Byers at karen_byers@dfci.harvard.edu.

Serum—To Store or Not to Store?

Should we bank serum samples from all personnel assigned to our BSL-3 laboratory?

The fifth edition of the CDC/NIH's *Biosafety in Biomedical and Microbiological Laboratories* (Biosafety Level 3, Special Practices Section B-3) states that "Each institution must establish policies and procedures describing the collection and storage of serum samples from at-risk personnel." This does not require the collection and storage of serum samples, but rather requires that the institution/facility establish policies and procedures regarding the collection and storage. Are we splitting hairs here?

NO, these guidelines do not require a serum bank, but essentially require a review of the need to bank serum—something we all have heard before, a risk assessment.

What things should be considered when determining whether to set up a serum bank? What benefit will the banking of serum provide and to whom?

It is assumed that personnel would be able to prove that banked serum specimens would provide information on exposure status and could be used to confirm that an infection had resulted from an agent with which they were working. On the other hand, the institution might also benefit from the possibility of demonstrating that the employee already had antibody to the agent prior to working in the facility.

The fact is that most of the organisms we work with in BSL-3 laboratories are present in the general community and personnel could be exposed outside of work. Proof of laboratory-acquired infection would depend on demonstrating that the organisms in the patient and the laboratory are the same. This can be done without looking at a pre-work serum sample. In addition, if the employee already had antibody, then they have been exposed