KCMS KCOA

Bulletin

THE OFFICIAL JOURNAL OF THE KENT COUNTY MEDICAL SOCIETY & THE KENT COUNTY OSTEOPATHIC ASSOCIATION SPRING 2026

– Serving Physicians in Kent, Ottawa, Barry, Ionia, and Montcalm counties –

Invasive Group A Streptococcal Infections Increase in Kent County

Kristin Oldenberg, MD, FACOG
Kent County Health Department Medical Director

Kristin Oldenberg, MD, FACOG and Julie Payne, MPH

Kent County has experienced a substantial and ongoing increase in invasive Group A Streptococcal (iGAS) infections since 2021, consistent with national trends reported by the Centers for Disease Control and Prevention (CDC) and published analyses in JAMA.[12]

Local surveillance indicates both higher case counts and a shift toward more severe disease presentations compared with national patterns.

KEY LOCAL FINDINGS

- Rapid increase in cases: Confirmed iGAS infections more than tripled in Kent County between 2020 and 2024.[1]
- Older adults disproportionately affected: Adults ≥65 years have the highest incidence locally, with rates nearly double those reported nationally.[12]
- Racial disparities: Black residents are disproportionately represented among iGAS cases relative to population size.[2]
- Greater disease severity:
  - Bloodstream infections (bacteremia) now account for approximately 60% of cases, substantially higher than national averages.[12]
  - Increases in septic shock and pneumonia have also been observed.[1]
  - ICU admissions have become more frequent, reflecting more severe clinical illness.[1]
- Common risk factors locally:
  - Acute skin breakdown and chronic wounds[3]
  - Heart disease, diabetes, obesity, and smoking[3]
  - Alcohol and other substance use[3]
  - Residence in long-term care facilities or housing instability[13]
  - Many patients have multiple overlapping risk factors[3]

CLINICAL IMPLICATIONS

Providers should be alert to the increased likelihood of rapid progression and invasive disease, particularly among adults with underlying conditions or social risk factors.[13] iGAS should be considered early in patients presenting with:

- Rapidly worsening soft-tissue infections[4]
- Severe pain disproportionate to exam findings[4]
- Fever, hypotension, or signs of sepsis[14]
- Skin breakdown, injection sites, or chronic wounds[3]
- Recent residence in congregate settings (e.g., LTCFs)[1]

RECOMMENDED ACTIONS FOR CLINICIANS

- **Early recognition and treatment**
  - Maintain a high index of suspicion for iGAS.[12]
  - Promptly obtain blood cultures and initiate empiric therapy when invasive infection is suspected.[14]
- **Patient education:** Counsel patients to seek immediate care for worsening redness, swelling, pain, fever, or systemic symptoms.[1] Discourage self-treatment of deep or infected wounds.[3]
- **Wound care and prevention:** Reinforce proper wound cleaning, covering, and monitoring—especially for patients managing wounds at home.[3]
- **Harm reduction and outreach:** Support referral to syringe-service programs, wound-care clinics, and community outreach resources for people who use drugs.[3]
- **Infection control:** Reinforce hygiene and wound-care practices in healthcare and long-term care settings.[1]

PUBLIC HEALTH MESSAGE

The rise in iGAS in Kent County reflects a convergence of post-

CONTINUED ON PAGE 23

STREPTOCOCCAL INFECTIONS CONTINUED FROM PAGE 22

pandemic immunity gaps, emerging Group A Streptoccus emm strains, substance use, socioeconomic stressors, chronic disease burden, and barriers to timely wound care.[1,2,3] Early clinical recognition and preventive counseling are critical to reducing severe outcomes and mortality.[1,4]

[1]*Centers for Disease Control and Prevention. Increase in invasive group A Streptococcal infections, United States. CDC Health Alert Network (HAN). 2023–2024.*
[2]*Lynfield R, et al. Invasive group A Streptococcal infections in the United States, 2013–2022. JAMA. 2024;331(5):430–439.*
[3]*O'Loughlin RE, et al. Risk factors for invasive group A streptococcal disease among adults—United States. Clin Infect Dis. 2021;73(11):e3718–e3726.*
[4]*Stevens DL, et al. Practice guidelines for the diagnosis and management of skin and soft tissue infections. Clin Infect Dis. 2014;59(2):e10–e52.*

Lyme Disease: Emerging Endemicity, Clinical Guidance

Kristin Oldenberg, MD, FACOG and Julie Payne, MPH

Newly reviewed data from the Kent County Health Department (2025) demonstrate a 1,857% increase in Lyme disease cases over the past 10 years in Kent County, Michigan. The first reported case occurred in 2002. This rise parallels the geographic expansion of the black-legged tick (Ixodes scapularis) across Michigan.

Black-legged ticks were first documented in Michigan in the late 1990s in Menominee County (Upper Peninsula).[1] By the early 2000s, ticks were identified in the southwestern Lower Peninsula. Spread has been attributed to deer, small mammals, domestic animals, and migratory birds transporting ticks across the Great Lakes. By 2025, Lyme disease has expanded northward from Indiana and inland from the Lake Michigan shoreline, establishing transmission risk in Kent County.

LOCAL EPIDEMIOLOGY (2025)

A total of 237 cases were reported. Age distribution included 10–19 years: 56 (23.6%); 20–49 years: 85 (35.9%); 50–79 years: 94 (39.7%); and 80+ years: 2 (0.8%). There were 145 male cases (61.2%) and 92 female cases (38.8%). Most cases (81.4%) reported exposure in Michigan, and 61.2% reported exposure in Kent County. Case geographic clustering was noted in Rockford (49341) with 31 cases, Ada (49301) with 29 cases, and Lowell (49331) with 25 cases for the top three zip codes. Cases resided there but may have acquired the disease elsewhere.

Clinical manifestations included Lyme arthritis in 187 cases (78.9%), erythema migrans in 107 cases (45.2%), Bell's Palsy in 12 cases (5.06 %), and atrioventricular block in 4 cases (1.7%). Thirteen Lyme cases (5.5%) required hospitalization, ranging from 1 to 9 days, with an average stay of 4 days. No cases of meningitis, encephalitis, or Radiculoneuropathy were reported.

CLINICAL GUIDANCE FOR PROVIDERS (CDC-ALIGNED FOR ENDEMIC AREAS)[2]

- **Endemic definition:** A disease that is consistently present in a certain region. Michigan is now considered an endemic state. Incidence of cases and tick distribution are considered, and then clinicians are advised to follow endemic area diagnostic treatment approaches.
- **When to treat:** Patients with erythema migrans should be treated immediately without laboratory testing. Patients with compatible symptoms such as fever, fatigue, headache, or chills and a history of tick exposure should be treated with a low threshold.
- **First-line treatment:** Recommended antibiotics include doxycycline (preferred), amoxicillin, or cefuroxime axetil. Duration for early localized disease is 10–14 days.
- **When to test:** Testing is not recommended for patients with classic erythema migrans or low-risk patients without exposure. Testing should be considered for patients with atypical symptoms and likely exposure risk.
- **Post–tick bite prophylaxis:** A single dose of doxycycline (200 mg for adults) is recommended only if all of the following criteria are met: Ixodes tick identified, attachment for 36 hours or more, removal within 72 hours, exposure in an endemic area, and no contraindications.
- **Recognizing disseminated disease:** Clinicians should consider Lyme disease in patients presenting with facial palsy, meningitis symptoms, carditis, or large joint arthritis. Treatment duration is 14–21 days, with intravenous therapy reserved for severe cases.
- **Avoid over-treatment:** Standard antibiotic courses are effective. Prolonged or repeated antibiotic therapy is not recommended.

[1]*Lantos PM, Tsao J, Nigrovic LE, Auwaerter PG, Fowler VG, Ruffin F, Foster E, Hickling G. Geographic Expansion of Lyme Disease in Michigan, 2000-2014. Open Forum Infect Dis. 2017 Jan 9;4(1):ofw269. doi: 10.1093/ofid/ofw269. PMID: 28480261; PMCID: MC5412582.*
[2]*https://www.cdc.gov/lyme/hcp/clinical-care/index.html*

KENT COUNTY Health Department

Notifiable Disease Report

Kent County Health Department
700 Fuller N.E.
Grand Rapids, Michigan 49503

Communicable Disease Section
Phone (616) 632-7228
Fax (616) 632-7085

December 2025

DISEASE	C=Confirmed P=Probable S=Suspect U=Unknown	This Month	December Cumulative YTD 2025	2020-2024 5-Year Median December
CAMPYLOBACTER	C,P	10	152	114
CANDIDA AURIS	C	1	8	1
CARBAPENEMASE PRODUCING ORGANISM	C	2	12	3
CHICKEN POX[a]	C,P	0	16	17
CHLAMYDIA	C,P,S,U	250	2929	3646
COVID-19	C,P,S	1131	9168	44484
CRYPTOSPORIDIOSIS	C,P	2	24	24
GIARDIASIS	C,P	1	35	38
GONORRHEA	C,P,S,U	73	871	1348
H. INFLUENZAE DISEASE, INV	C,P	0	13	9
HEPATITIS A	C	0	0	2
HEPATITIS B (Acute)	C	0	2	1
HEPATITIS C (Acute)	C	0	0	2
HEPATITIS C (Chronic/Unknown)	C	9	54	116
HISTOPLASMOSIS	C,P	2	50	47
HIV	C	4	41	43
INFLUENZA-LIKE ILLNESS[b]	C,P,S	3946	44635	16629
LEGIONELLOSIS	C	2	20	18
LYME DISEASE	C,P,S	5	238	64
MEASLES	C,P	0	4	0
MENINGITIS, ASEPTIC	C	2	12	11
MENINGITIS, BACTERIAL, OTHER[c]	C	2	9	12
MENINGOCOCCAL DISEASE, INV	C,P,S	0	3	0
MUMPS	C,P,S	0	1	1
PERTUSSIS	C,P	3	63	1
SALMONELLOSIS	C,P	7	78	70
SHIGELLOSIS	C,P	1	25	20
SHIGA TOXIN PRODUCING E. COLI	C,P,S	1	30	29
STREP, GRP A, INV	C	6	52	43
STREPTOCOCCAL TOXIC SHOCK	C,P	0	0	0
STREP PNEUMO, INV	C,P	5	57	45
SYPHILIS (Congenital)	C,P,S	0	4	2
SYPHILIS (Primary & Secondary)	C,P,S	4	59	57
TOXIC SHOCK	C,P	0	0	0
TUBERCULOSIS	C	1	12	12
WEST NILE VIRUS	C,P	0	12	1
YERSINIA ENTERITIS	C,P	0	13	12

a. Chickenpox cases are reported primarily from schools. Confirmed and probable cases are included. b. Includes "Influenza-Like Illness (ILI)"and lab-confirmed influenza. ILI cases have flu-like symptoms and are reported primarily by schools. c. "Meningitis, Bacterial, Other" includes meningitis and bacteremia caused by bacteria OTHER THAN H. influenzae, N. meningitidis, or S. pneumoniae. based on CDC surveillance case definitions.