

**MEDDAC/VS Regulation 40-1**

**Medical Services**

# **Animal Bite/Scratch Case Management and Rabies Prevention**

**Headquarters  
U.S. Army Medical Department Activity  
Fort George G. Meade  
2480 Llewellyn Avenue  
Fort George G. Meade, MD 20755-5800  
9 December 2002**

**Unclassified**

# ***SUMMARY of CHANGE***

MEDDAC REG 40-1

Animal Bite/Scratch Case Management and Rabies Prevention

Specifically, this revision—

- o Has been published in a new format that includes a cover and this “Summary of Change” page.
- o Reformats the title page. The Contents section now includes the page numbers that the various chapters and paragraphs begin on.
- o Makes numerous changes to the paragraph concerning the responsibilities of the Chief, Preventive Medicine Service (para 2-2); the Chief, Veterinary Services (para 2-5); the Chief, Department of Primary Care (para 2-6); and the Community Health Nurse (para 2-7).
- o Reassigns the responsibilities of the ATA physician, which no longer exists, to primary care managers (para 2-8).
- o Makes minor changes to table 2-2 (page 6) and table 2-4 (page 7).
- o Makes numerous changes throughout chapter 3 (pages 8 through 14).

## Medical Services

### Animal Bite/Scratch Case Management and Rabies Prevention

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**History.** This is the fourth known revision of the regulation. The date of the first printing of this regu-

lation is unknown; however, it was on or before 20 November 1996.

**Summary.** This regulation details the procedures for management of animal bite and scratch cases and the implementation of pre-exposure rabies prophylaxis of occupationally high risk personnel.

**Applicability.** This regulation applies to the MEDDAC headquarters, all outlying U.S. Army health clinics (USAHCs), and the Fort Meade Branch Veterinary Services (VS).

**Proponent.** The proponent of this regulation is the Chief, Preventive Medicine Service.

**Supplementation.** Supplementation of this regulation is prohibited.

**Suggested improvements.**

Users of this publication are invited to send comments and suggested improvements, by memorandum, directly to the Commander, U.S. Army Medical Department Activity, ATTN: MCXR-PM, Fort George G. Meade, MD 20755-5800, or to the MEDDAC Command Editor by fax to 301-677-8088 or e-mail to john.schneider@na.amedd.army.mil.

**Distribution.** Distribution of this publication is by electronic medium only.

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\* This publication supersedes MEDDAC/VS Reg 40-1, dated 14 July 2000.

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## **Chapter 1**

### **Introduction**

#### **1-1. Purpose**

This regulation prescribes policy, assigns responsibility and establishes procedures for the management of potential human exposure to rabies, including the handling of animal bite and scratch incidents and pre-exposure prophylaxis of personnel who are at high risk for rabies exposure as a result of their occupations.

#### **1-2. References**

Related publications, prescribed forms and referenced forms are listed in appendix A.

#### **1-3. Explanation of abbreviations and terms**

Abbreviations and special terms used in this regulation are explained in the glossary.

## **Chapter 2**

### **Responsibilities**

#### **2-1. General**

All responsibilities that pertain to the MEDDAC within this regulation are pertinent to the headquarters.

#### **2-2. The Chief, Preventive Medicine Service (PM)**

The Chief, PM will—

- a. Serve as Chairperson, Rabies Advisory Board (RAB).
- b. Be responsible for monitoring, technical guidance and overall coordination of this program.
- c. Review all animal bite and scratch cases to evaluate appropriateness and conformity of treatment and proper follow up procedures in accordance with (IAW) this regulation and report findings to the RAB at the quarterly meetings.
- d. Convene meetings of the RAB on a quarterly basis and as needed to determine the need for post-exposure rabies prophylaxis.
- e. Initiate any changes in post-exposure rabies prophylaxis that may be indicated or any actions recommended by the RAB.
- f. Ensure the monitoring of the immunization status of patients who are scheduled for rabies post-exposure prophylaxis and verify that the vaccine series has been completed.
- g. Complete Section IV of DD Form 2341 (Report of Animal Bites – Potential Rabies Exposure), which constitutes final action and disposition of all bite cases. When the Chief, PM is not a physician, the Chief, DPC will sign blocks 33, 34 and 37 as the medical authority.
- h. Provide a roster of RAB members, updated as necessary, which includes each member's duty telephone number, to all RAB members, to primary care nurse triage managers, and to each outlying MEDDAC medical treatment facility (MTF).

#### **2-3. Commanders and directors of outlying U.S. Army health clinics (USAHCs)**

Commanders and directors of outlying USAHCs will—

a. Be responsible for the implementation of the Rabies Prevention Program within their respective USAHCs IAW the provisions of this regulation.

b. Prepare a standing operating procedure detailing the specific procedures to be followed at their respective USAHCs and provide a copy to the Chief, PM, and their local senior PM (environmental health or community health) representative.

#### **2-4. The Chief, Pediatric Service**

The Chief, Pediatric Service will serve as or appoint a physician representative to serve as an ancillary member of the RAB.

#### **2-5. The Chief, VS**

The Chief, VS will—

a. Provide necessary veterinary care to animals, including vaccinations against rabies.

b. Establish liaison with military and civilian health authorities, animal control, and police agencies in order to effectively provide veterinary support to the rabies control program.

c. Provide for the examination and observation of biting animals owned by on-post residents of Fort Meade or other military installations supported by the VS.

d. Coordinate the examination and observation of biting animals owned by persons who do not reside on a military installation. Such evaluations will normally be done by city or county health departments.

e. Take all appropriate veterinary medical actions in evaluation of animals involved in bite and scratch incidents to include verification of current vaccination status, examination and quarantine of the animal involved, and submission of tissues for rabies diagnosis. Notify PM of the laboratory results.

f. Ensure DD Forms 2341 pertaining to animal bite incidents are picked up from the Kimbrough Ambulatory Care Center (KACC) White Team, Family Care Center (FCC) IAW this regulation.

g. Consult with the treating physician and RAB in determining the risk of exposure to rabies.

h. Complete Section III of the original DD Form 2341 and forward it to the Community Health Nurse for final review when quarantine or appropriate veterinary action has been completed.

i. Enter the appropriate incident information into the animal's record and the VS bite incident log.

j. Determine method and duration of quarantine and arrange for quarantine of biting animal(s) if the owner resides on post.

k. Coordinate with appropriate local civilian authorities to obtain information on animal status within 72 hours and at the end of quarantine for those animals quarantined under civilian jurisdiction.

l. Notify the Chief, PM at the time quarantine is initiated for all animals involved in biting incidents.

m. Immediately notify the Chief, PM if any animal involved in a reported bite incident cannot be located or develops signs or symptoms of rabies.

n. Advise the Chief, PM regarding local and state rabies information.

o. Coordinate with the Chief, PM and the occupational health physician concerning pre-exposure anti-rabies prophylaxis for individuals occupationally at high risk of exposure to bites from potentially rabid animals.

## **2-6. The Chief, Department of Primary Care (DPC)**

The Chief, DPC will—

- a. Ensure that all providers within DPC are familiar with the provisions of the regulation.
- b. Ensure that physicians staffing the FCC comply with this regulation regarding evaluation and treatment of patients potentially exposed to rabies.
- c. Ensure proper completion and distribution of DD Form 2341 and MEDDAC Form 573 (Rabies Post Exposure Prophylaxis) by White Team personnel. (A copy of MEDDAC Form 573 is included in the –R Forms section at the back of this regulation.)
- d. Quarterly, through the Noncommissioned Officer in Charge (NCOIC), Pharmacy Service, ensure the presence of 10 doses of rabies immune globulin (RIG) and 10 doses of human diploid cell rabies vaccine (HDCV) in the pharmacy.
- e. Ensure that DD Form 2341 is initiated on all animal bite and scratch cases. The form will be completed in IAW paragraph 3-8b, below.
- f. Ensure that the patient's name and sequence number are recorded Animal Bite Log, located in the White Team.
- g. Ensure that MEDDAC Form 573 is initiated, in triplicate, for patients requiring rabies post-exposure prophylaxis and distribute the completed form IAW paragraph 3-11e, below.
- h. Ensure the patient is provided a copy of the MTF's Bite Victim Instruction Letter.
- i. Serve as a member of the RAB.
- j. Keep the following documents readily available for all primary care managers:
  - (1) Current roster of RAB members and their phone numbers.
  - (2) Current telephone numbers of the supporting veterinary services branch.
  - (3) A copy of this regulation.

## **2-7. The Community Health Nurse (CHN)**

The CHN will—

- a. Provide pre-numbered DD Forms 2341 in triplicate, MEDDAC Form 573 in triplicate, and a supply of the MTF's Bite Victim Instruction Letter to the White Team.
- b. Pick up completed DD Forms 2341 from the White Team each duty day.
- c. Call the patient to confirm the location and status of the biting animal as soon as the DD Form 2341 is received.
- d. Maintain a log of all animal bite and scratch reports which includes the status of the animals and administration of rabies post-exposure prophylaxis.
- e. Ensure the Chief, PM (or senior PM officer on duty if Chief, PM is not available) and Chief, DPC are informed the same day of high risk bite and scratch incidents, as defined in this regulation.
- f. Monitor the status of patients who are started on rabies post-exposure prophylaxis to ensure that the patients are completing the series as prescribed. Call the patient when he or she fails to report for immunization. Notify the Chief, PM if the patient again fails to report for immunization.

- g. Prepare quarterly reports of animal bite and scratch incidents for the RAB.
- h. Maintain on file completed DD Forms 2341 in PM for two years.
- i. Animal bite and scratch incidents will be provided quarterly to the Maryland Department of Health and Mental Hygiene (410-222-7256).
- j. The CHN designee will review all bite and scratch cases each normal duty day. High risk cases will be referred to the KACC Composite Health Care System Rabies Advisory Board Mail Group, or directly to the RAB, and the CHN designee will notify the patient when the RAB recommends post-exposure prophylaxis.
- k. At any outlying clinic where there is no assigned CHN, the Environmental Science Officer will be responsible for complying with paragraphs a through j.

## **2-8. Primary care managers (PCMs)**

PCMs will—

- a. Provide emergency treatment of animal bite and scratch wounds IAW appendix B. If necessary, this will include adequate cleaning and tetanus prophylaxis or antibiotics therapy and arranging for follow up wound care.
- b. Evaluate animal bite and scratch incidents to determine the need for rabies post-exposure prophylaxis. The protocol in table 2-1 (see page 5) will be used for this purpose.
- c. Contact the senior medical RAB member, the veterinarian on call, or another RAB member if questions or uncertainty arise concerning rabies prevention policies or specific rabies post-exposure treatment decisions.
- d. Provide initial rabies post-exposure prophylaxis when required IAW the schedule in table 2-2 (see page 6).
- e. Provide the patient or patient's adult sponsor with an *Animal Bite Victim* form letter.
- f. Complete part I of DD Form 2341. Completion of part I may be delegated to a member of the AHC administrative staff.
- g. Complete and sign part II of DD Form 2341.

## **2-9. The Chief, Occupational Health Clinic (OH)**

The Chief, OH will conduct a rabies pre-exposure prophylaxis program for all personnel who have a potential for occupational exposure to rabies. (See tables 2-3 and 2-4 on page 7.)

## **2-10. The NCOIC, Immunization Clinic**

The NCOIC, Immunization Clinic will—

- a. Administer rabies pre-exposure prophylaxis as noted in table 2-4 (see page 7).
- b. Administer rabies post-exposure prophylaxis as noted in table 2-2 (see page 6).
- c. Annotate MEDDAC Form 573 after each dose of HDCV. Forward the MEDDAC Form 573 to PM upon completion of the HDCV series.
- d. Serve as a non-voting member on the RAB.

## **2-11. The RAB members**

Primary and ancillary members of the RAB will—

- a. Develop, review, approve, and ensure implementation of policies and procedures relating to the prevention and treatment of animal bites and scratches, the quarantining and testing of potentially rabid animals, and the use of anti-rabies prophylaxis. (Ancillary members

are not required to participate in this process.)

b. Maintain current knowledge of the United States Public Health Service Immunization Practices Advisory Committee's recommendations and applicable Army regulations on rabies prevention.

c. Provide concurrence or nonconcurrence with recommendations on the use of rabies post-exposure prophylaxis in individual cases.

d. Meet quarterly to review pertinent information and statistical data on individual and cumulative animal bite and scratch incidents, the treatments administered, antirabies prophylaxis, and animal rabies. (Ancillary members are not required to attend the quarterly meetings.)

**Table 2-1  
Protocol for determining rabies post-exposure prophylaxis**

<b>Animal species</b>	<b>Circumstances</b>	<b>Treatment of exposed person</b>
Dogs, cats, and ferrets	Animal appeared healthy at time of bite, full information about owner is expected to be available for quarantine when reported through Veterinary Services.	Rabies prophylaxis is not indicated. Inform patient about the 10-day quarantine period and record the patient's current telephone number in order to recall the patient if a problem develops relative to the animal during the quarantine. <sup>1</sup>
	Information about the animal's owner is unknown or incomplete and it is questionable whether the animal can be located. or Animal is rabid or suspected of being rabid.	Start rabies post-exposure prophylaxis (RIG and HDCV) immediately. Administer RIG and first dose of HDCV during initial visit of patient. This recommendation applies whether or not the animal has been vaccinated for rabies, whether the bite was provoked or unprovoked, and even though the animal looks healthy at the time of the bite. If prophylaxis is started and the animal is subsequently located and placed under quarantine, stop prophylaxis. In all cases, either the animal is to be under quarantine or the patient advised to take prophylaxis.
	Animal is available for quarantine but appeared ill or abnormal at the time of the bite.	During duty hours, discuss with the Rabies Advisory Board. After duty hours, start rabies post-exposure prophylaxis (RIG and HDCV). If prophylaxis is started and the animal is subsequently found to be rabies free, stop prophylaxis.
Wild animals (Racoons, bats, skunks, foxes, coyotes, and other carnivores). <sup>2</sup>	Animal should be regarded as rabid unless the animal is proven negative by laboratory tests.	Start rabies post-exposure prophylaxis (RIG and HDCV) immediately. Administer RIG and first dose of HDCV during initial visit of patient. This recommendation applies regardless of the circumstances of the bite and whether or not the animal is available for veterinary and laboratory examination. Start prophylaxis immediately even though laboratory results for the animal's brain will be available in a few hours. Stop prophylaxis if laboratory tests are negative.
Livestock, small rodents (such as mice and rats), lagomorphs (rabbits and hares), large rodents (woodchucks and beavers), and other mammals.	Consider individually.	Discuss with Rabies Advisory Board under unusual circumstances. Bites of squirrels, hamsters, guinea pigs, gerbils, chipmunks, rats, mice (and other small rodents), rabbits and hares almost never require antirabies treatment. Therefore, the Rabies Advisory Board need only be consulted under circumstances when the animal is behaving strangely. Although still an uncommon occurrence, rabies continues to be found in rodents, especially large rodents like groundhogs and woodchucks in the racoon rabies areas.

Notes:

1 During the 10-day observation period, begin post-exposure prophylaxis at the first sign of rabies in a dog, cat or ferret that has bitten someone. If the animal exhibits clinical signs of rabies, it should be euthanized immediately and tested.

2 The animal should be euthanized and tested as soon as possible. Holding for observation is not recommended. Discontinue vaccine if immunofluorescence test results of the animal are negative.

Note: In addition to this protocol, the AHC physician should contact the Rabies Advisory Board whenever he/she has a question concerning the need for rabies post-exposure prophylaxis. See list of Rabies Advisory Board members for telephone numbers.

**Table 2-2**  
**Rabies post-exposure prophylaxis schedule**

Vaccination status	Treatment	Regimen <sup>1</sup>
Not previously vaccinated.	Local wound.	All post-exposure treatment should begin with immediate, thorough cleansing of all wounds with soap and water. A viricidal agent such as povidone-iodine solution should be used to irrigate the wound.
	RIG. <sup>2</sup>	Administer 20 IU/kg body weight. If anatomically feasible, <b>the full dose</b> should be infiltrated around the wound(s) and any remaining volume should be administered at an anatomical site distant from vaccine administration. RIG should not be administered in the same syringe as the vaccine. Because RIG may partially suppress active production of antibody, no more than the recommended dose should be given.
	Vaccine.	HDCV <sup>3</sup> , Rabies Vaccine Absorbed (RVA) or Purified Chick Embryo Cell (PCEC) 1.0ml IM <sup>4</sup> (administration location per package insert). <sup>5</sup> One dose each on days 0, <sup>6</sup> 3, 7, 14, and 28.
Previously vaccinated. <sup>7</sup>	Local wound.	All post-exposure treatment should begin with immediate cleansing of all wounds with soap and water. A viricidal agent such as povidone-iodine solution should be used to irrigate the wound.
	RIG. <sup>2</sup>	RIG should <b>not</b> be administered.
	Vaccine.	HDVC <sup>3</sup> , RVA or PCEC 1.0ml IM (administration location per package insert). <sup>5</sup> One dose each on days 0 <sup>6</sup> and 3.

Notes:

1. These regimens are applicable for all age groups, including children.
2. Rabies Immune Globulin.
3. Human Diploid Cell Vaccine.
4. Intramuscular.
5. Carefully follow the package insert administration instructions.
6. Day 0 is the first day the first dose of vaccine is administered.
7. Any person with a history of pre-exposure vaccination with HDCV, Rabies Vaccine Absorbed (RVA), or Purified Chick Embryo Cell Vaccine (PCEC); prior post-exposure prophylaxis with HDCV, RVA or PCEC; or previous vaccination with any other type of rabies vaccine and a documented history of antibody response to prior vaccination.

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**Table 2-3****Rabies pre-exposure immunization and guidelines**

Risk category	Nature of risk	Typical populations	Pre-exposure recommendations
Continuous	Virus present continuously, often in high concentrations. Specific exposures may go unrecognized. Aerosol, bite or nonbite exposure.	Rabies research lab worker. <sup>1</sup> Rabies biologic production workers.	Primary course. <sup>2</sup> Serologic testing every six months; booster vaccination if antibody titer level falls below acceptable level. <sup>2</sup>
Frequent	Exposure usually episodic with source recognized, but exposure may also be unrecognized. Aerosol, bite or nonbite exposure.	Rabies diagnostic lab workers, <sup>1</sup> spelunkers, veterinarians and veterinary staff, animal control workers, military police, and wildlife workers in rabies-zoonotic areas.	Primary course. <sup>2</sup> Serologic testing every two years; booster vaccination if antibody titer is below acceptable level. <sup>3</sup>
Infrequent (Greater than population at large.)	Exposure nearly always episodic with source recognized. Bite or nonbite exposure.	Veterinarians and veterinary staff, animal control workers and wildlife workers in areas of low rabies rates. Veterinary students. Travelers visiting foreign areas where rabies is enzootic and immediate access to appropriate medical care, including biologics is limited.	Primary course. No serologic testing or booster vaccination.
Rare (Population at large.)	Exposure nearly always episodic with source recognized. Mucous membrane, bite with source unrecognized.	U.S. population at large, including persons in rabies epizootic areas.	No vaccination necessary.

## Notes:

- Judgment of relative risk and extra monitoring of immunization status of laboratory workers is the responsibility of the laboratory supervisor. (See U.S. Department of Health and Human Services' Biosafety in Microbiological and Biochemical Laboratories, 1993.)
- Primary vaccination course consists of HDCV 1.0ml IM (administration location per package instructions), one each on days 0, 7, and 21 or 28, or HDCV 0.1ml intradermal (ID), one each on days 0, 7 and 21 or 28.
- Booster immunization when required consists of one dose of HDCV, 1.0ml does IM (administration location per package instructions), or 0.1ml dose ID. Because allergic hypersensitivity reactions to booster doses of HDCV have been reported in the literature, personnel requiring booster doses should have their rabies antibody level measured and only be given the vaccine if the antibody has fallen below an acceptable level. Acceptable antibody level is complete virus neutralization at 1.5 serum dilution by the rapid fluorescent focus inhibition test (RFFIT).

**Table 2-4****Rabies pre-exposure prophylaxis schedule**

Type of vaccination	Route	Regimen
Primary	Intramuscular	HDCV <sup>1</sup> or PCEP <sup>2</sup> 1.0 mL (administration location per package instructions), one each on days 0, <sup>3</sup> 7 and 21 or 28
	Intradermal	HDCV, <sup>1</sup> 0.1 mL, one each on days 0, <sup>2</sup> 7 and 21 or 28
Booster	Intramuscular	HDCV <sup>1</sup> or PCEP <sup>2</sup> 1.0 mL (administration location per package instructions), one each on day 0, <sup>3</sup> only
	Intradermal	HDCV, <sup>1</sup> 0.1 mL, day 0, <sup>3</sup> only

- Human diploid cell vaccine.
- Purified chick embryo cell vaccine.
- Day 0 is the day the first dose of vaccine is administered.

Note: When chloroquine phosphate was used routinely for malaria prophylaxis, investigators discovered that the drug decreased the antibody response to concomitantly administered HDCV. Although interference with the immune response to rabies vaccine by other antimalarials structurally related to chloroquine (e.g., mefloquine) has not been evaluated, precautions for persons receiving these drugs should be followed. Accordingly, HDCV should not be administered intradermally to a person traveling to malaria-endemic countries while the person is receiving one of these antimalarials. The intramuscular administration of three doses of 1.0 mL of vaccine for preexposure prophylaxis provides a sufficient margin of safety in this situation. For persons who will be receiving both rabies preexposure prophylaxis and antimalarial chemoprophylaxis in preparation for travel to a rabies-zoonotic area, the intradermal regimen should be initiated at least one month before travel to allow for completion of the full 3-dose vaccine series before antimalarial prophylaxis begins. If this schedule is not possible, the intramuscular regimen should be used.

## **Chapter 3 Policies and Procedures of the MEDDAC Rabies Prevention Program**

### **Section I Policies**

#### **3-1. Rabies**

a. Rabies is an almost invariably fatal acute viral infection of the central nervous system which is usually transmitted to humans through saliva contaminated bites or scratches of rabies infected animals. Wild animals constitute the most important source of rabies exposure for humans. Skunks, raccoons, and bats account for more than 85% of reported cases of animal rabies each year. Dog and cat bites continue to be the principal reason for giving antirabies treatments; however, the risk of exposure from dogs and cats has decreased greatly over the past decade. Bites of rabbits, squirrels, chipmunks, rats and mice rarely warrant postexposure rabies prophylaxis.

b. The prevention of rabies is dependent upon an active surveillance program of animal life in the area; a rabies vaccination program for domestic animals; an effective stray animal control program; and prompt and adequate evaluation for groups at increased risk of exposure to rabies virus. Since rabies is normally transmitted by the inoculation of infectious saliva through the skin, the likelihood of infection is reduced by careful and thorough cleansing of all animal bite wounds and administration of HDCV and RIG when indicated.

c. Animal bite and scratch incidents treated at the MEDDAC's outlying clinics will be managed by their identified personnel IAW this regulation.

#### **3-2. The RAB**

a. The RAB consists of the following members:

(1) Chief, PM (chairperson and proponent).

(2) Chief, DPC.

(3) Chief, Fort Meade Branch Veterinary Services.

(4) Nursing representative, Immunization Clinic.

(5) Nursing representative, CHN

(6) Physician representative, Pediatric Clinic (only for decisions on post-exposure prophylaxis, as required).

b. The above membership is subject to change. The most current listing of the board's membership can be found in MEDDAC/DENTAC/VS Reg 15-1.

#### **3-3. Management of animal bite and scratch incidents at KACC**

a. All animal bites and scratches will be evaluated and initially treated by the PCMs.

b. All animal bites and scratches will be reported to the proper authorities IAW paragraph 2-8c above.

c. The second through fifth doses of the rabies postexposure prophylaxis series will be administered by the Immunization Clinic on regular duty days and by the After Hours Clinic (AHC) on weekends and holidays.

### **3-4. Management of animal bite and scratch incidents at outlying clinics**

a. Animal bite and scratch incidents treated at the outlying clinics will be managed IAW this regulation.

b. Kirk, Dunham, and Barquist USAHCs. Due to their relative size and staffing, these outlying clinics are authorized to maintain their own official RAB and process and maintain final copies of their animal bite and scratch reports through their local Preventive Medicine sections. Their RABs will meet quarterly and provide the minutes of their meetings to their respective process improvement committees.

c. All other outlying clinics will utilize the RAB at Dunham, and will send their DD Forms 2341 to the RAB at Dunham. It is recommended that these clinics send any patients requiring post-exposure rabies prophylaxis to a local civilian source of care in lieu of maintaining the required immunization material at their clinics.

## **Section II**

### **Animal Bite/Scratch Case Management and Rabies Prevention Program at the MEDDAC headquarters**

#### **3-5. Initial procedures for animal bite and scratch incident management**

a. All persons who sustain an animal bite or scratch will be referred to their PCMs for treatment.

b. The PCM will initiate DD Form 2341 in triplicate, by completing part I of the form and placing the patient identification information, including home telephone number, in the lower left hand corner. Part I contains data on the history of the animal bite or scratch and must be thoroughly completed in order to enable the apprehension of the suspected animal.

c. Community Health Nursing (CHN) will provide the White Team with pre-numbered DD Forms 2341 in triplicate. The White Team will maintain an animal bite log that contains the patient's name, the sequence number of the DD Form 2341 and the patient's disposition.

d. The PCM will review part I of DD Form 2341 and ensure all items are completed. The PCM will evaluate and treat the patient IAW the following procedures and complete part II of DD Form 2341 documenting the treatment.

e. The PCM will administer the initial treatment of the animal bite or scratch wound IAW the guidelines contained in appendix B and, if required, arrange for wound care follow up in the appropriate clinic.

f. The PCM will give a copy of the MTF's Bite Victim Instruction Letter to the patient.

#### **3-6. Rabies post-exposure prophylaxis**

a. The PCM will determine the rabies risk using the protocol in table 2-1. This protocol provides the recommendations of the RAB regarding certain situations. Therefore, in these circumstances it is not necessary for the PCM to call the RAB prior to initiating rabies post-exposure prophylaxis. The PCM will consult with the RAB if questions or uncertainties arise when contemplating administration of rabies post-exposure prophylaxis and in cases not covered by standing recommendations. Consultation is intended to provide assistance in making treatment decisions. The treating physician will retain full responsibility for the collection of relevant information, decisions concerning rabies prophylaxis and initiation of appropriate treatment.

b. In cases requiring consultation with the RAB, the PCM will call the designated RAB medical member or, if this member is unavailable, another physician member of the RAB. The medical RAB member will consult with the veterinary officer and with another RAB member and inform the PCM of the RAB's decision. The PCM will document the consultation in the patient's medical record and on DD Form 2341. A current roster of RAB members will be maintained in the Animal Bite Book.

c. The RAB chairperson will monitor the status of the biting or scratching animal. In cases where the decision to initiate rabies post-exposure prophylaxis is made after the patient has been released from the FCC, the RAB chairperson will notify the patient of the necessity for rabies post-exposure prophylaxis, advise him or her to report to the FCC for treatment, and notify the PCM that the patient will require treatment.

d. Rabies post-exposure prophylaxis will be administered IAW table 2-2. For patients who start rabies post-exposure prophylaxis in the FCC, the PCM will arrange for administration of the remaining four doses of HDCV by—

(1) Referring the patient to the Immunization Clinic or, if that is closed, to the AHC.

(2) Instructing the patient to return to the AHC if the Immunization Clinic is closed (holiday or weekend) at the specified interval. (Follow up appointments will be made for the patient prior to his or her departure.)

(3) Instructing non-beneficiaries, such as visitors to the installation to contact—

(a) Their physicians immediately.

(b) The local health department as soon as possible.

(c) KACC's CHN, at 301-677-8424, on the same or next duty day. Provide the name, phone number and address of the non-beneficiary and information related to the animal bite or scratch incident.

(4) Instructing beneficiaries who are on temporary duty (TDY), or departing on TDY or leave, to ensure that they receive the remaining doses at a military MTF at their place of TDY or leave. Instruct the patient to contact the KACC CHN at 301-677-8424 to ensure an appropriate referral is completed.

e. MEDDAC Form 573 will be prepared in triplicate by the servicing FCC team for all patients who will be completing the rabies post-exposure prophylaxis series at KACC. The form will be annotated with the dates and locations for obtaining the remaining four doses. The Immunization Clinic will administer the vaccine on regular duty days. The AHC will administer the vaccine on dates that fall on weekends and holidays. The PCM will instruct the patient on where and when to obtain follow up. The PCM will place a copy in the Animal Bite Book and forward the original to the Immunization Clinic. When the patient reports for the follow up doses, the location administering the vaccine will annotate the patient's copy and their copy of MEDDAC Form 573. If the series is completed in the AHC, the AHC will send their completed copy to the Immunization Clinic which will in turn annotate the original MEDDAC Form 573 with the dates and forward the original thru the CHN to the Chief, PM.

f. In cases where the patient does not return on the date scheduled for his or her next dose, the AHC or Immunization Clinic will contact the CHN designee. The CHN designee will also monitor MEDDAC Form 573 in the AHC and Immunization Clinic to identify any patient who misses a dose. The CHN designee will contact the patient, encourage him or her to complete the series and document the notification on the DD Form 2341. The RAB will be notified of

patients refusing to complete ordered post-exposure treatment.

### **3-7. Disposition of biting animals**

a. FCC personnel (which includes AHC personnel), will notify the Military Police to request impoundment of all stray domestic animals and capture of wild animals involved in bite incidents on Fort Meade.

b. FCC personnel will provide the bite victim with an instruction letter from the Chief, PM regarding procedures that the bite victim must take to ensure that the biting animal is appropriately located and quarantined. If the animal's owner is known (for example, the animal belongs to the victim's family or a neighbor), FCC personnel will instruct the victim or the victim's family to have the owner contact the VS Treatment Facility on the next duty day to arrange to examine and quarantine the animal. (*The telephone number for the VS Treatment Facility is (301) 677-1300.*) Small caged pets (for example, hamsters, mice and gerbils) need not be impounded. These housebound animals are not considered to be of significance in rabies transmission and post-exposure prophylaxis is usually not recommended. If the incident occurred off post, FCC personnel will instruct the patient or patient's family to contact the local health department to search for the animal.

c. The Chief, Fort Meade Branch Veterinary Services, hereafter referred to as "the veterinarian," will attempt to determine the identity of the biting animal's owner and the animal's rabies immunization status. For any animal being maintained on post, or owned by a military member who resides off post, that has been involved in a bite incident, the veterinarian will perform the necessary examination and quarantine as required. In animal bite cases where the animal is civilian-owned and maintained off post, the installation veterinarian will notify the appropriate local health department to determine animal identity, vaccination status and quarantine status within 72 hours after the bite incident and again ten days later to confirm that the animal remained healthy. In cases occurring on post where an animal's owner cannot be identified or where the owner does not comply with the request for examination and/or quarantine, the veterinarian will request assistance from the Military Police to apprehend and impound the animal in the Veterinary Quarantine Facility. The veterinarian will remove, and submit to the State of Maryland Laboratory, the head or brain of any dead animal known to be a potential carrier of rabies involved in a biting incident or subsequently dying within the ten days quarantine period. Any wild animal involved in a biting incident will be sacrificed immediately and the head submitted to the State of Maryland Laboratory. The veterinarian will notify the CHN designee after initiating quarantine of animals involved in biting incidents. The veterinarian will notify the RAB designated physician or Chief, DPC in those cases where all attempts at identifying biting animals are unsuccessful and immediately if a suspect animal shows signs of illness or dies during the quarantine period.

### **3-8. Sources, completion and disposition of required forms**

a. The CHN designee will provide pre-numbered DD Forms 2341 (in triplicate sets) and MEDDAC Forms 573 (in triplicate sets) to the White Team.

b. The PCM will complete parts I and II of DD Form 2341. The original will be faxed to VS (7-1310), one copy will be placed in the CHN Animal Bite Book, and the other copy will be retained by the clinic.

c. In cases in which rabies post-exposure prophylaxis is given, the AHC and the Immunization Clinic will document the administration of each dose IAW paragraph 3-6e above.

d. VS will obtain all original DD Forms 2341 from the Animal Bite Book in the White Team. If any patient data blocks on a DD Form 2341 are incomplete, the VS representative will refer the form to the clinic NCOIC for completion.

e. Each duty day, a representative from the CHN designee will obtain copies of DD Form 2341 from the Animal Bite Book in the White Team. Data from each form will be recorded in an Animal Bite/Scratch Log. CHN will monitor the status of biting animals and prophylaxis of bite victims and will notify the Chief, PM of the following high risk bite scratch incidents:

- (1) Wild animal bite or scratch.
- (2) Biting animal has died or been sacrificed for testing.
- (3) Biting animal has not been located and is not likely to be found.
- (4) Bite victim has been started on rabies post-exposure prophylaxis.
- (5) Bite victim on post-exposure prophylaxis has missed a dose.

g. The Chief, VS will complete part III of DD Form 2341 and after completion of the exposure incident, will forward the form to the CHN designee who will provide the form to the Chief, PM and the designated medical RAB member.

h. The completed MEDDAC Form 573 will be forwarded to the CHN designee by the Immunization Clinic or AHC.

i. The Chief, PM will review all DD Forms 2341 and complete part IV, blocks 35 and 36. The senior medical member of the RAB will complete Paragraph IV, blocks 33, 34 and 37. The completed DD Form 2341 and the white copy of MEDDAC Form 573 will be maintained by the PM or CHN under file number 40-400z and the disposition instructions provided by the U.S. Army Records Management and Declassification Agency's (USARMDA's) web site ([www.rmda.belvoir.army.mil/](http://www.rmda.belvoir.army.mil/)). The Chief, PM or the CHN will annotate the Animal Bite/Scratch Log with the final disposition of the case. The pink copy of MEDDAC Form 573 will be filed in the patient's medical record.

### **3-9. Procedure for pre-exposure rabies prophylaxis**

The OH supervisor will—

a. Identify all activities having personnel who have potential for exposure to rabies as part of their job function IAW table 2-3 (see page 7).

b. Maintain the names of the individuals as part of the Medical Surveillance Program, to include arrangement for for initial pre-exposure rabies prophylaxis by the Immunization Clinic and notification of personnel when serologic screening is due IAW table 2-4 (see page 7).

## **Section III**

### **Animal Bite/Scratch Case Management and Rabies Prevention Program at MEDDAC Locations Other Than Fort Meade**

#### **3-10. Initial procedures for animal bite and scratch incident management**

a. All persons who sustain an animal bite or scratch during duty hours will be referred to their PCMs for treatment. Each MEDDAC MTF is also responsible for developing a plan of care during non-duty hours.

b. The PCM will initiate DD Form 2341 in triplicate, by completing part I of the form and

placing the patient identification information, including home telephone number, in the lower left hand corner. Part I contains data on the history of the animal bite or scratch and must be thoroughly completed in order to enable the apprehension of the suspected animal.

c. The PCM will review part I of DD Form 2341 and ensure all items are completed. The PCM will evaluate and treat the patient IAW the following procedures and complete part II of DD Form 2341 documenting the treatment.

d. The PCM will administer the initial treatment of the animal bite or scratch wound IAW the guidelines contained in appendix B and, if required, arrange for wound care follow up in the appropriate clinic.

e. The PCM will give a copy of the MTF's Bite Victim Instruction Letter to the patient.

### **3-11. Rabies post-exposure prophylaxis**

a. The treating physician will determine the rabies risk using the protocol in table 2-1 (see page 5). The physician will consult with the Fort Meade RAB (*Kirk, Dunham, and Fort Detrick USAHCs will consult with their respective RABs*) if questions or uncertainty arise when contemplating administration of rabies post-exposure prophylaxis and in cases not covered by standing recommendations. Consultation is intended to provide assistance in making treatment decisions. The treating physician will retain full responsibility for the collection of relevant information, decisions about rabies prophylaxis and initiation of appropriate treatment.

b. In cases requiring consultation with the RAB, the treating physician will call the RAB chairperson (or another physician member of the RAB if the senior medical member is not available). The senior medical RAB member will consult with the Veterinary Officer and/or with another member of the RAB and inform the treating physician of the decision of the RAB. The physician will document the consultation in the patient's medical record and on the DD Form 2341. A current roster of RAB members will be maintained in the clinic's Animal Bite Book.

c. Each clinic will designate a point of contact (POC) to monitor the status of the biting animal. In cases where the decision to initiate rabies post-exposure prophylaxis is made after the patient has been released from the clinic, the clinic POC will notify the patient of the necessity for rabies post-exposure prophylaxis and advise the patient to report to the clinic for treatment.

d. Rabies post-exposure prophylaxis will be administered IAW table 2-2 (see page 6). For patients who start rabies post-exposure prophylaxis in the clinic, the treating physician will arrange for administration of the remaining four doses of HDCV by—

(1) Instructing the patient to return to the clinic at the specified interval and making arrangements for the immunization to be given if the clinic is not open on the days the immunization is due.

(2) Referring non-beneficiaries (for example, visitors to the installation) to health care sources in surrounding civilian communities, or to their established civilian primary care providers.

(3) Instructing beneficiaries who are in TDY status or departing on TDY or leave to ensure that they receive the remaining doses at a military MTF at their place of TDY or leave.

e. MEDDAC Form 573 will be prepared in triplicate by the clinic for all patients who will be completing the rabies post-exposure prophylaxis series at the clinic. The form will be annotated with the dates and locations for obtaining the remaining four doses. When the patient reports for the follow up doses, the clinic will annotate the patient's copy and their copy of

MEDDAC Form 573. In cases where the patient does not return on the date scheduled, the clinic POC will contact the patient and encourage him or her to complete the series and document the notification.

### **3-12. Disposition of the biting animal**

The clinic will coordinate with the servicing Veterinary Command Branch Veterinary Service (VCBVS) to ensure that the biting animal is appropriately monitored.

### **3-13. Completion and disposition of required forms**

a. The treating physician will complete parts I and II of DD Form 2341 in duplicate. The original will be sent to the servicing VCBVS. The clinic will maintain the copy until the VCBVS returns the original DD Form 2341 to the clinic.

b. The servicing VCBVS will complete part III of DD Form 2341, then return the form to the clinic. The clinic will forward the form to the Chief, PM, KACC for completion of part IV. *(At Kirk USAHC, the Chief, PM or designated physician will complete part IV; at Dunham and Barquist USAHCs, the RAB chairperson and the Environmental Science Officer will complete part IV.)* The clinic PM representative will maintain the completed DD Form 2341 on file using file number 40-400z and the disposition instructions provided by the USARMDA's web site ([www.rmda.belvoir.army.mil/](http://www.rmda.belvoir.army.mil/)).

c. A copy of the completed MEDDAC Form 573 for patients completing the rabies post-exposure prophylaxis series will be attached to a copy of the DD Form 2341 and forwarded to the Chief, PM, KACC. The clinic will place the original MEDDAC Form 573 in the patient's medical record.

### **3-14. Procedure for pre-exposure rabies prophylaxis**

All outlying clinic OH sections will identify personnel who have the potential for exposure to rabies due to the nature of their jobs, IAW table 2-3 (see page 7), and will ensure appropriate pre-exposure and booster regime adherence IAW tables 2-3 and 2-4 (see page 7).

**Appendix A** □  
**References** □

**Section I**  
**Required Publications**

**MEDDAC Reg 15-1**

U.S. Army Medical Department Activity, Fort George G. Meade (MEDDAC) Boards, Committees, Councils, Meetings, and Teams. (Cited in para 3-2.)

**Section II**  
**Related Publications**

A related publication is merely a source of additional information. The user does not have to read it in order to understand this regulation.

**AR 40-5**  
Preventive Medicine

**AR 40-905**  
Veterinary Health Services

**AR 310-25**  
Dictionary of Army Terms

**AR 310-50**  
Authorized Abbreviations, Brevity Codes, and Acronyms

Brackenbury PH, Muwanga C. A Comparative Double Blind Study of Amoxicillin/Clavulanate vs. Placebo in the Prevention of Infection after Animal Bites. *Arch Emerg Med.* 1989; 6:251-6.

Brook I. Microbiology of Human and Animal Bite Wounds in Children. *Pediatr Infect Dis J.* 1987; 6:29-32.

Centers for Disease Control Morbidity and Mortality Weekly Report, VOL 40, No.

RR:3, Rabies Prevention – United States 1991, dated 22 March 1991

Compendium of Animal Rabies Control, 1999, American Veterinary Medical Association

Compendium of Animal Rabies Prevention and Control, 2000

Centers for Disease Control Morbidity and Mortality Weekly Report, VOL 48, No. RR:1, Human Rabies Prevention – United States, 1999

Douglas LG. Bite Wounds. *Am Fam Phys.* 1975 11:93-9.

Goldstein EJC. Bites. Principles and Practice of Infectious Diseases, 4th ed. (Mandell G, Bennet J, Dolin R. eds.) New York: Churchill Livingstone, 1995.

Goldstein EJC. Bite Wounds and Infection. *Clinical Infect Dis.* 1992; 14:633-40.

Goldstein EJC, Ctiron DM, Finegold SM. Dog Bite Wounds and Infection: A Prospective Clinical Study. *Ann Emerg Med.* 1980; 9:508-12.

Feder HM, Shanley JD, Barbera JA. Review of 59 Patients Hospitalized with Animal Bites. *Pediatr Infect Dis J.* 1987; 6:24-8.

Recommendations of the Advisory Committee on Immunization Practices (ACIP), dated 8 January 1999.

Standing Operating Procedure for Animal Bite/Scratch Case Management and Rabies

Prevention Program, HQ, Walter Reed Army Medical Center, MCHL-HE, 6 July 1999

Zook EG, Miller M, Van Beek AL, et al. Successful Treatment Protocol of Canine Fang Injuries. J. Trauma. 1980; 20:243-7.

**Section III  
Prescribed Forms**

**MEDDAC Form 573**

Rabies Post Exposure Prophylaxis.  
(Prescribed in paras 2-6, 2-7, 2-10, 3-6, 3-8, 3-11 and 3-13.)

**Section IV  
Referenced Forms**

**DD Form 2341**

Report of Animal Bites – Potential Rabies Exposure

## **Appendix B Management of Animal Bite Wounds**

### **B-1. History**

Obtain the following history:

- a. *Animal bite.* Ascertain the type of animal, whether the bite was provoked or unprovoked, and the situation and environment when the bite occurred. If the species can be rabid, locate the animal for 10 days' observation period.
- b. *Patient.* Obtain information on antimicrobial allergies, current medications, splenectomy, mastectomy, liver disease and immunosuppression.

### **B-2. Physical examination**

Record diagram of wound with location, type, depth of injury, range of motion, possibility of joint penetration, presence of edema or crush injury, nerve and tendon function, signs of infection, and odor of exudate.

### **B-3. Cultures**

Infected wound should be cultured and a Gram stain performed. Anaerobic cultures should be obtained with abscesses, septic patients, serious cellulitis, devitalized tissue, or if there is a foul odor to the exudate. Small tears and infected punctures should be cultured with a mini-tipped (nasopharyngeal) swab.

### **B-4. Irrigation**

Copious amounts of normal saline should be used for irrigation. Puncture wounds should be irrigated with a "high pressure jet" using a 20cc syringe and a 18 gauge needle or catheter tip.

### **B-5. Debridement**

Devitalized or necrotic tissue should be cautiously debrided. Debris and foreign bodies should be removed.

### **B-6. Radiographs**

Radiographs should be obtained if fracture or bone penetration is possible. They may also serve as a baseline to judge future osteomyelitis.

### **B-7. Wound closure**

Wound closure may be necessary for selected, fresh uninfected wounds, especially facial, but primary wound closure is usually not indicated. Wound edges should be approximated with adhesive strips in selected cases.

### **B-8. Antimicrobial therapy**

- a. Consider antibiotic prophylaxis to cover *Pasteurella multocida*, *Staphylococcus aureus*, and anaerobes.
  - (1) For moderate to severe injury less than eight hours old, especially if edema or crush injury is present.
  - (2) If there is possible bone or joint penetration.

- (3) For hand wounds.
  - (4) For immunocompromised patients (including those with mastectomy, splenectomy, liver disease, or steroid therapy).
  - (5) If wound is adjacent to a prosthetic joint.
  - (6) If wound is in the genital area.
- b. Treatment. Coverage directed at same pathogens listed above. If seen early after bite and only mild to moderate signs of infection are present, oral antibiotics may be used. Amoxicillin/Clavulanic Acid, 250 to 500 mg po tid with food, covers most bites, may be used in selected cases. If hospitalized, parenteral agents such as Ampicillin/Sulbactam or Cefoxitin, should be used. If patient is penicillin-allergic, Doxycycline or Tetracycline should be used, but with caution. Tetracycline should not be used in children under seven years of age.

### **B-9. Hospitalization**

Indications include fever, signs of sepsis, spread of cellulitis, significant cellulitis, significant edema or crush injury, loss of function, compromised host or patient noncompliance.

### **B-10. Immunizations**

- a. *Tetanus*. Give tetanus booster if original three-dose series has been given, but none in the past five years. Give a primary series and tetanus immunoglobulin if patient was never immunized.
- b. *Rabies*. Rabies vaccine (day 0, 3, 7, 14, and 28) with hyperimmune globulin (RIG, 20 IU/kg body weight) MAY BE required, depending on the type of animal, the ability to observe the animal, locality and circumstances of the bite.

### **B-11. Elevation**

Elevation is strongly advised if any edema is present. Lack of elevation is a common cause of therapeutic failure.

### **B-12. Immobilization**

If bitten in an extremity, especially a hand, immobilize the extremity with a splint.

### **B-13. Follow up**

Follow up at 24 hours, and perhaps at 48 hours, is very important for outpatients.

### **B-14. Most common reasons for treatment failure**

- a. Failure to stress the importance of, or for the patient to ignore, ELEVATION of an edematous wound. If the wound is on a hand, a sling must be recommended because compliance is unlikely unless passively accomplished.
- b. Selection of the INCORRECT ANTIBIOTIC. Most fastidious animal pathogens are susceptible to penicillin and amoxicillin. Because of resistance of certain bacteria, including *P. multocida*, first generation cephalosporins, dicloxacillin, and erythromycin should be avoided or used cautiously. Although *in vitro* data suggest that some fluoroquinolones (ciprofloxacin, ofloxacin, and sparfloxacin), trimethoprim-sulfamethoxazole, and second generation oral cephalosporins (cefuroxime) are active against many bite isolates, proof of clinical efficacy is sparse.

c. Failure to recognize JOINT PENETRATION. Pain, diminished range of motion, local edema, and proximity to the joint of a puncture wound should alert one to the possibility of septic arthritis.

**B-15. Consultation advice**

Consultation advice for management of infections related to animal bites/scratches can be obtained from the Infectious Disease Service, Walter Reed Army Medical Center by calling (202) 782-1663, or fax to (202) 782-3765.

## Glossary

### Section I

#### Abbreviations

**AHC**

After Hours Clinic

**CHN**

Community Health Nurse;  
Community Health Nursing

**DPC**

Department of Primary Care

**EH**

Environmental Health Section

**FCC**

Family Care Center

**HDCV**

human diploid cell vaccine

**IAW**

in accordance with

**KACC**

Kimbrough Ambulatory Care  
Center

**MEDDAC**

U.S. Army Medical Department Activity, Fort George G. Meade

**MTF**

medical treatment facility

**NCOIC**

noncommissioned officer in  
charge

**OH**

Occupational Health Clinic

**POC**

point of contact

**PM**

Preventive Medicine Service

**RAB**

Rabies Advisory Board

**RFFIT**

rapid fluorescent focus inhibition test

**RIG**

rabies immune globulin

**RVA**

rabies vaccine absorbed

**TDY**

temporary duty

**USAHC**

U.S. Army health clinic

**USARMDA**

U.S. Army Records Management and Declassification Agency

**VCBVS**

Veterinary Command Branch  
Veterinary Service

**VS**

Fort Meade Branch Veterinary Services

### Section II

#### Terms

**Rabies exposure**

A person who has been bitten or scratched by a warm-blooded animal, or who has had contact with the saliva of a known or suspected rabid animal.

**Suspected animal**

An animal which has been involved in, or suspected to have been involved in, a biting or scratching incident.

**U.S. ARMY MEDICAL DEPARTMENT ACTIVITY, FORT GEORGE G. MEADE  
RABIES POST-EXPOSURE PROPHYLAXIS**

Date of Bite: \_\_\_\_\_

\* Previously Vaccinated?  Yes  No

DAY DUE	DATE DUE	CLINIC	INJECTION NUMBER	DATE GIVEN	DOSE	SITE OF INJECTION	SIGNATURE OF PROVIDER
0			† RIG				
0			‡ HDCV / PCEC #1				
3			‡ HDCV / PCEC #2				
7			‡ HDCV / PCEC #3				
14			‡ HDCV / PCEC #4				
28			‡ HDCV / PCEC #5				

**MTF initiating this record:**

- Kimbrough Ambulatory Care Center  Dunham USAHC  Kirk USAHC  Barquist USAHC  Fort Indiantown Gap USAHC  
 Defense Distribution Center USAHC  Letterkenny USAHC  Tobyhanna USAHC

Enter dates vaccinations will be due and the location at which each vaccination will be given. Administer and document initial dose as follows:

† RIG (Rabies Immune Globulin): 20 IU/kg body weight. If anatomically feasible, the FULL DOSE should be infiltrated around the wound(s) and any remaining volume should be administered IM at an anatomical site distant from the vaccine administration.

‡ Rabies Vaccine -- HDCV (Human Diploid Cell Vaccine) or PCEC (Purified Chick Embryo Cell Vaccine): 1.0 ml IM (per package insert). Circle which vaccine (HDCV or PCEC) was given to the patient.

\* Previously vaccinated patients only require HDCV or PCEC on Days 0 and 3 and do not require RIG.

**PATIENT INSTRUCTIONS FOR RABIES POST-EXPOSURE FOLLOW UP**

- If antibiotics are prescribed, take them.
- Seek medical attention if any of the following signs of infection are noticed:
  - Redness.
  - Increased pain.
  - Drainage from the wound.
  - Red streaks on the skin leading from the wound toward the body.
  - Enlarged or tender lymph nodes in the arm pits or groin area.
  - Elevated temperature over 100 degrees.
- Return to complete all anti-rabies vaccinations ON scheduled dates and at scheduled locations.
- Referred for completion of rabies post-exposure prophylaxis to  Tricare Prime site  Other: \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ ; DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ ; DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

**MEDDAC (Ft Meade) Form 573, 1 Dec 02**

Previous editions are obsolete and will not be used.