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Louisiana Morbidity Report

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Hansen's Disease in the United States and Louisiana, 2001

Capt. Larry Pfeifer, RPh, MApSt and Capt. Richard Truman, PhD
National Hansen's Disease Program

Background

The National Hansen's Disease Programs (NHDP) is the Health Resources and Services Administration Bureau of Primary Health Care entity primarily responsible for the care and treatment of Hansen's disease (HD or leprosy). Located in Carville, Louisiana for more than 100 years, the NHDP relocated to Baton Rouge in 1999. While a few long-term care patients continue to reside at the old Carville center, clinical, administrative, and research facilities are now located on the campuses of Summit Hospital and Louisiana State University in Baton Rouge. In addition to inpatient and outpatient clinical services, the NHDP provides physical and occupational rehabilitative care, operates a national pharmacy for no-cost delivery of anti-HD drugs, and coordinates the care of Hansen's Disease patients in nine grant funded regional clinics and private physician offices around the country.

The NHDP specializes in the care of neuropathic disorders. Program experts offer clinical consultation, diagnostic support, and professional education programs to health care workers in the U.S. and abroad. Widely known for its pioneering research efforts to improve detection and treatment of Hansen's Disease, the NHDP mission now includes research on tuberculosis, a disease caused by a closely related pathogen. While leprosy remains rare in the United States (with approximately 2,500 active cases), many patients continue to require specialized care for this disease and its complications.

Contents

The NHDP works in conjunction with the Centers for Disease Control to conduct leprosy surveillance in the United States and Puerto Rico. Notification is mandatory for leprosy in Louisiana. This data is useful for coordinating beneficiary medical services for new patients and their families, assessing epidemiological trends, and planning for future programmatic needs. Patient information is collected from health care providers using the Hansen's Disease (Leprosy) Surveillance Form, which is available for download from the NHDP website at ***http://www.bphc.hrsa.gov/nhdp/printable_forms.htm***. The information from this form is entered into a computerized database and maintained as the National Hansen's Disease Registry (NHDR). Since 1824, 11,451 cases have been entered into the NDHR (as of June 1, 2002). The following paragraphs summarize data reported to this registry in 2001 and highlights some current trends in Louisiana.

Temporal & Geographic Distribution

In 2001 a total of 110 Hansen's disease cases were reported to the NHDR, which is slightly lower than the past ten year running average of 131.6 cases annually.

Ninety-one cases (83%) were reported in the first seven months of the year. However, an investigation into the monthly case reporting from previous years showed that there is no seasonality associated with U.S. reported cases.

Geographically, new cases were reported from 28 states and Puerto Rico. The map depicts the distribution of reported cases by state (see Figures 1 & 2).

Texas and New York reported the most cases at 16 each, followed by Louisiana (15), Washington (11), and Florida and California at 10 cases each. These six states accounted for 70% of total number of leprosy cases reported in the U.S. Other than Texas and Louisiana, where larger numbers of indigenous leprosy cases are reported, the number of cases reported from other states is primarily a function of immigration patterns.

Of the U.S. cases reported in 2001, 80 (72.7%) were born in 23 foreign countries. Four of these birth countries, Mexico 20 (18.2%), India 10 (9.1%), the Philippines 9 (8.2%) and the Dominican Republic 6 (5.5%) represent just over one-half (56.3%) of the foreign-born cases. Although nearly three-fourths of the reported cases were born in foreign countries, the interpretation that most U.S. cases are being "imported" cannot be made unless consideration is given to the relationship between when these individuals entered the U.S. and when they were diagnosed.

Looking at the 30 U.S. endemic cases reported in 2001, the table and the corresponding map illustrate the distribution of these cases by state of birth. (One case from Puerto Rico is not shown.)

(Continued on next page)

Figure 1: Hansen's Disease cases by reporting state, 2001

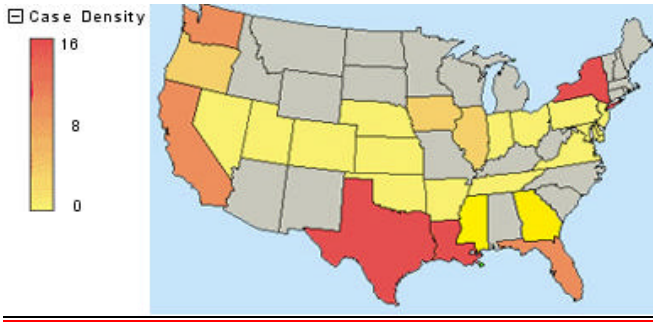
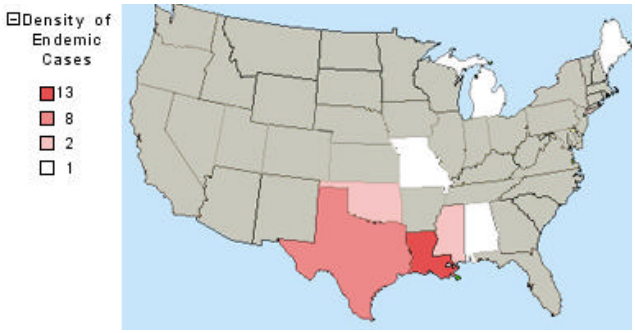


Figure 2: Endemic Hansen's Disease cases by state of birth, 2001



Historically, there has always been an association between the incidence of Hansen's disease in the United States and geographic location, with a vast majority of the cases being reported from the gulf coastal states. Indeed, in 2001 Louisiana alone represented 43.3% of native-born leprosy cases followed by Texas with 26.6%. Collectively, the gulf coastal states of Louisiana, Texas and Mississippi represent 76.7% of endemic U.S. cases in 2001. On a population adjusted basis, Louisiana continues to report a disproportionately large number of cases.

Distribution of Cases by Race and Ethnicity, Age and Gender

The following table summarizes the distribution of the 2001 reported cases by race and ethnicity.

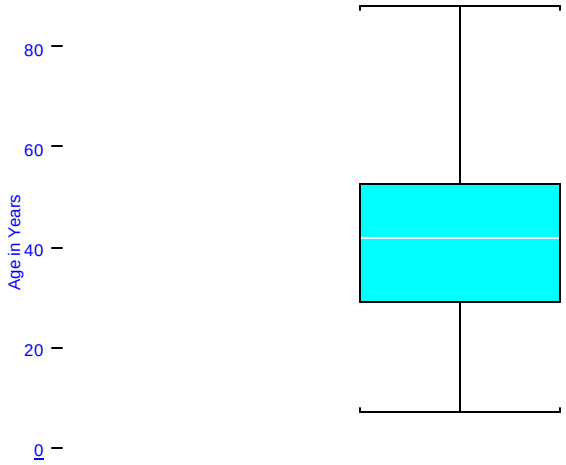
Table 1: Reported Hansen's Disease cases by race and ethnicity, 2001

American Indian or Alaska Native	1	0.9%
Asian or Pacific Islander	25	22.7%
Black, not of Hispanic Origin	8	7.3%
Hispanic, Black	7	6.4%
Hispanic, White	35	31.8%
Indian, Middle Easterner	8	7.3%
Not specified/unknown	5	4.5%
White, not of Hispanic Origin	21	19.1%
Total	110	100%

White Hispanics comprised the largest ethnic group representing 31.8% of the total cases, followed by Asian or Pacific Islander (22.7%), and White, Not of Hispanic Origin (19.1%). The group Indian, Middle Easterner was newly added to the revised surveillance form at the end of the calendar year 2000. This group was added to prevent confusion in collecting and processing surveillance information, and subdivide major populations with a substantial number of leprosy cases on the Asian continent. Since the new surveillance form was not fully implemented during 2001, the Indian, Middle Easterner ethnic group is probably under-represented, and intersects to some degree with the Asian or Pacific Islander group. Of the 110 cases reported to the registry in 2001, 70 (64%) were male and 40 (36%) were female, and this trend for gender bias is typical historically.

The age at diagnosis for the cases reported to the registry in 2001 ranged from 7.1 to 88.2 years with a median and mean age of 41.8 and 43.0 years respectively. This age distribution is graphically depicted by the following boxplot which shows a fairly symmetrical distribution about the median, and suggests that the disease is not highly associated with a particular age (Figure 3). Thus, the differential diagnosis for leprosy should not be excluded on age related grounds.

Figure 3: Reported Hansen's Disease cases by age at diagnosis, 2001



Reported Case Distribution by Disease Classification

The Hansen's disease surveillance form provides for initial classification of the disease into one of six categories which correspond to the universally used ICD-9-CM diagnosis codes for leprosy 030.0-030.3, 030.8, and 030.9. (This classification scheme is often considered an indicator of disease severity and is useful in determining

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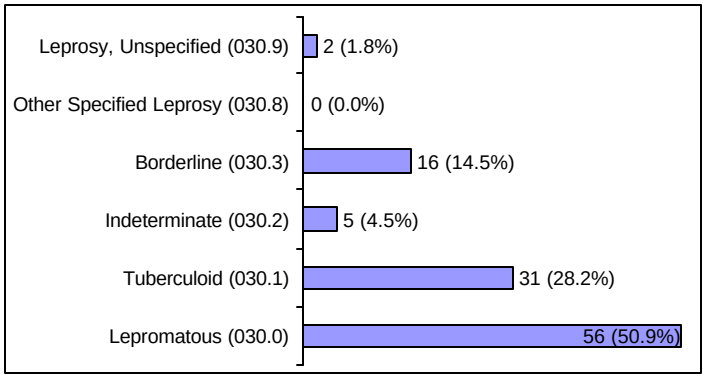
appropriate therapeutic regimens and predicting disease-related complications.) The following chart quantifies the cases reported to the registry in 2001 by disease type.

Figure 4: Registered leprosy cases by ICD-9-CM diagnosis code, 2001 (n=110)



A category of multibacillary cases can be created by combining the borderline and lepromatous classes. Likewise, paucibacillary cases can be identified by grouping tuberculoid and indeterminate categories. For 2001, 72 (65.4%) of the total cases reported were multibacillary and 36 (32.7%) were grouped as paucibacillary.

Endemic Leprosy in Louisiana

Of the 15 total Hansen's disease cases reported from Louisiana in 2001, 13 are identified as endemic cases. (A determination that a case is endemic is made when Louisiana is listed as the state of birth, and the individual resides in the state at the time of diagnosis.)

Four (30.8%) of the endemic cases were female and nine (69.2%) were male. Eleven (84.6%) of these case were Caucasian and two (15.4%) were black. The distribution of these cases by disease classification closely paralleled that seen for all reported cases in 2001 with seven (53.8%) lepromatous cases and two (15.4%) cases each for the tuberculoid, borderline and indeterminate categories. Thus there were nine (69.2%) multibacillary and four (30.8%) paucibacillary endemic cases. These endemic Louisiana cases tended to be older than that reported nationally with a respective mean and median diagnosis age of 52.8 and 51.9 years, and a range of 20.1 to 88.2 years. This difference in the mean age at diagnosis for the endemic Louisiana cases and the rest of the cases reported in 2001 is statistically significant ($p<0.0303$).

Geographically, these 13 endemic Louisiana cases came from 13 different parishes. The map (Figure 5) illustrates the distribution of these cases by parish. While these cases were widely distributed throughout the state, most of the cases were concentrated in the southern one-half of the state. This is consistent with the distribution of cases reported in other years with more cases being reported from southern Louisiana.

Conclusions

Although Hansen's disease remains quite rare in the United States, cases are rather widely distributed throughout the country. The majority of newly reported cases nationwide are primarily driven by immigration patterns from countries where leprosy is indigenous. However, for Louisiana and the gulf coastal region, endemic leprosy represents the bulk of the reported cases. This disease afflicts virtually all races and ethnic groups, is found in both genders, and is reported in almost all age groups.

Regardless of its origins, leprosy is a highly treatable infectious disease. With effective therapeutic regimens that are available, Hansen's disease is minimally contagious, and does not produce the many of the disfiguring disabilities that have been associated with less effective regimens in the past. However, leprosy does remain a notifiable disease to NHDP, CDC, and various state and local health agencies.

Figure 5: Cases of Hansen's Disease by parish, 2001

Louisiana Fact

From Mokdad Ah et al, 2003. "Prevalence of Obesity, Diabetes and Obesity Related Risk Factors, 2001", JAMA 289:76 (Data from BRFSS, 2001)

*In 2001, Louisiana ranked eighth in the nation for obesity * with a prevalence of 23.3% among adults. The national average was 20.9% with the highest prevalence in Mississippi (25.9%).*

*Louisiana also ranked eighth in the nation for diabetes ** with a prevalence of 8.5%. The national average is 7.9%. The highest prevalence was in Alabama (10.5%) followed by Mississippi (10.3) and Florida (10.3%)*

** Obesity is defined as a body mass index greater than 30. Body mass index (BMI) = Kilograms/Height in m2.*
*** The participant had answered 'Yes' to the question 'Have you ever been told by a doctor that you were diabetic?'*

Allergies? Asthma? ER Visits?

Titled "What You Need To Know About Pesticides & Your Health in Louisiana", an information filled, colorful new pamphlet, is now available from the Louisiana Department of Health and Hospitals Office of Public Health Section of Environmental Epidemiology & Toxicology.

This free pamphlet will be a welcome addition to waiting areas by answering common questions on insecticide, herbicide, fungicide and rodenticide use such as:

'*How does exposure happen*?' (Drift, Occupational, Household use)
'What are some of the signs and symptoms of pesticide exposure?'
'What are some common pesticides that can cause adverse effects?'
'*What should I do in case of exposure*? (First Aid instruction, call the Louisiana Poison Control Center 1-800-256-9822)

WHAT TYPES OF PESTICIDES ARE COMMONLY USED

Insecticides:

Insecticides are used to control or kill insects. Organophosphate and carbamate insecticides are the most common type of insecticide used on crops and in the home. Most pesticide poisonings result from exposure to organophosphate insecticides. Organophosphate and carbamate insecticides affect the nervous system of people. Exposure to toxic amounts can cause adverse effects ranging from shortness of breath, excessive salivation, nausea, vomiting, headache, dizziness and chest discomfort to convulsions, paralysis and even death.

Examples of Organophosphates:

- Chlorpyrifos (Dursban®, Empire®, Lorsban®)
- Diazinon (Basudin®, Knox Out®, Spectracide®)
- Malathion (Dielathion®, Fyfanon®, Maltox®
- Methyl Parathion (Bladan M®, Penncap-M®)

Examples of Carbamates:

- Aldicarb (Temik®)
- Carbaryl (Sevin®)

Two other types of insecticides are pyrethrins/pyrethroids and organochlorines:

Pyrethrins/pyrethroids are not considered to be very toxic, although skin irritation and asthma have occurred following exposure.

Examples of Pyrethrins/Pyrethroids:

- Cypermethrin (Ammo®, Cybush®)
- Lambda-cyhalothrin (Karate®)
- Permethrin (Ambush®, DeLice®, Dragnet®, Pounce®)
- Pyrethrin (CheckOut®)

Organochlorine insecticides include DDT, chlordane, endosulfan and lindane. DDT and chlordane are no longer widely used because of their persistence in the environment and their toxicity to wildlife and humans. Organochlorines can accumulate in the body and remain for long periods of time. Short-term exposure can cause headache, vomiting, diarrhea, dizziness and seizures. Long-term exposure to some organochlorines has been shown to alter reproductive development in animals.

Examples of Organochlorines:

- Endosulfan (Phaser®, Thiodan®)
- Lindane (Gammasan®, Kwell®)

Herbicides:

Herbicides are used to kill weeds. Exposure to toxic amounts of an herbicide can cause eye and skin irritation, coughing, burning of the throat and lungs, dizziness, nausea and temporary incoordination.

Examples of Herbicides:

- Atrazine (AAtrex®, Atranex®, Crisazina®
- 2,4-D (Barrage®, Lawn-Keep®, Plantgard®, Weedone®)
- Glyphosate (Polado®, Rodeo®, Roundup®)
- Molinate (Arrosolo®, Ordram®)

Fungicides:

Fungicides are used to control molds, fungi and mildew. They are widely used in agriculture, industry and the home and garden for a number of purposes: protection of seed grain, berries, flowers and grasses and control of mildews and slime. Different fungicides vary in their potential for causing harm. The most common health effect is irritation to the skin, mouth and nose. Some of the more toxic fungicides can cause headaches, nausea, vomiting, dizziness and loss of consciousness.

Examples of Fungicides:

- Benomyl (Benlate®)
- Mancozeb (Green Light General Purpose Fungicide®, Dithane DF®)
- Thiophanate Methyl (Banrot®)

Rodenticides:

Rodenticides are used to kill rats, mice and other rodents. Exposure to toxic amounts of warfarin and other anticoagulant rodenticides can cause internal bleeding. Exposure to other rodenticides can cause difficulty breathing, nausea, vomiting and unconsciousness. Typically, it is necessary to consume rodenticides by mouth in order to be harmed.

Examples of Rodenticides:

- Bromadiolone (Acilone®, Bromalone®)
- Warfarin (Dicusat E®, Ramorin2®)

Whom may I contact about pesticide problems?

If you believe you have suffered health effects from a pesticides exposure, file a Health-Related Pesticide Incident Complaint as soon as possible with the Louisiana Department of Agriculture and Forestry (LDAF). Complaints are investigated by LDAF and the Department of Health and Hospitals (DHH). LDAF determines if a misapplication of violation has occurred, and DHH evaluates the health effects resulting from the pesticide exposure. A final report is provided to the complainant. To file a complaint, contact LSAF's

Pesticide Hotline: (225) 925-3763.

The pamphlet is available online at ***http://oph.dhh.state.la.us/PDF/Pesticide_2001.pdf***. For more information or to order this pamphlet, contact Michelle Lackovic at (504) 568-8027.

HIV-1 Genotyping Analysis

Terry Crockett, Gita Talati, MS

The central laboratory Virology section will be offering HIV-1 Genotyping in Spring 2003 for patients infected with HIV-1 that meet specific criteria. **(**Genotyping testing is the ability to detect resistant HIV-1 isolates in clinical samples.) This technology will aid clinicians in their ability to monitor more effectively therapy by possibly showing evidence of drug resistance in HIV patients.

There are three types of drugs currently used in the treatment of HIV-1 infected patients: **Nucleoside Reverse Transcriptase Inhibitors**, (Epivir®, HIVID®, Retrovir®, Videx®, Zertit®, Ziagen®, Multi-NRTI(a), and Multi-NRTI(b), **Nonnucleoside Reverse Transcriptase Inhibitors**, (Rescriptor®, Sustiva®, and Viramune®), and **Protease Inhibitors –** drugs of choice, (Agenerase®, Crixivan®, Fortovase®, Kaletra®, Norvir® and Viracep®). The purpose in performing this analysis is to ascertain if there is any evidence of drug resistance to these drugs by finding mutations of the HIV-1 virus present in the patient's sample. (Evidence of viral resistance can be conferred by a single mutation or one or more mutations in tandem.) Samples analyzed will be evaluated against the current resistance mutation list (which will be updated as different viral resistance mutations are discovered).

The HIV-1 gene sequencing methodology currently targets the entire protease gene region composed of 99 amino acids. The RT is the other gene of interest in genotyping, consisting of **p66** and **p51** subunits. (The **p51** subunit is composed of the first 440 amino acids of the RT gene. The **p66** subunit is composed of all 560 amino acids of the RT gene.) A combination of seven forward and reverse primers are included in the analysis of each patient's sample. (A primer is a sequence of nucleotides that serve as a starting poing for polymerization.) The seven primers are assembled to form a sequence then evaluated against the reference sequence **HIV-1 pNL4-3 strain**.

Hepatitis B and C Surveillance Update

Theresa Sokol, MPH

Acute cases of hepatitis B & C (newly acquired symptomatic infections) have been nationally notifiable conditions since 1990. However, surveillance limited to acute disease cannot provide a clear understanding of the disease burden associated with chronic infection. According to national CDC estimates, 1.25 million persons have chronic hepatitis B and 3.9 million persons are (or have been) chronically infected with hepatitis C. These persons with active HBV or HCV infections are a major reservoir for transmission of hepatitis B and C. With screening for HBV and HCV infection as well as the advent of laboratory-based reporting of markers for hepatitis B and C, an increasing number of persons testing positive for HbsAg and anti-HCV are being reported to state health departments. State health departments can use this data to monitor the burden of disease due to chronic infection and to develop prevention programs. For this reason, beginning January 1, 2003, the CDC has designated chronic hepatitis B infection and hepatitis C infection (past or present) as nationally notifiable conditions. In accordance with this recommendation, the Louisiana Department of Health and Hospitals is now collecting information on all cases of hepatitis B and C with positive lab markers indicating active infection.

OPH VIDEOCONFERENCE COURSE OFFERINGS

Applications have been placed for Nursing Continuing Education Units for both of the course offerings listed below and they are free of charge. For more information please contact the Infectious Disease Epidemiology Section at (504) 568-5005 ext 124.

Foodborne Terrorism for Public Health Professionals

The OPH Infectious Disease Epidemiology Section is offering a videoconference focusing on enhancing the prevention, recognition, response and control of a bioterrorist attack on food. The presenters at the videoconference are the following: Dr. Gary Balsamo, State Public Health Veterinarian; Ms. Annu Thomas, Foodborne Disease Surveillance Coordinator; Mr. Wayne Dupree, Microbiology Laboratory Scientist Manager and Mr. George Borden, Retail Food Program Manager.

This videoconference is targeted towards sanitarians, public health nurses, infection control professionals, disease surveillance specialists, epidemiologists, health care providers and other public health staff. It will be accessible at nine sites throughout Louisiana on April 25 from 1:30-4:00 PM. *Registration Deadline is March 28, 2003!*

Epidemiology Methods II

The OPH Infectious Disease Epidemiology Section is offering a series of videoconferences focusing on intermediate epidemiological methods for public health practice. Dr. Susan Hassig, Clinical Associate Professor of Epidemiology at Tulane School of Public Health and Tropical Medicine, will be the main presenter. Four units will be offered: May 16 - Basic Epidemiology Methods, May 23 – Intermediate Epidemiology Methods, May 30 – Cross-Sectional Study Design and June 6 – Case-Control Study Design. The scheduled time for each unit is from 9:00-12 noon. The videoconferences are targeted to OPH nurses and other public health nurses, infection control personnel, epidemiologists and health care professionals interested in epidemiological principles and practice. The videoconferences will be accessible at eight sites throughout Louisiana. *Registration Deadline is May 2, 2003!*

Louisiana's PRAMS and Prenatal Exposure to Alcohol

Brandy K. Wallace, MPH; Juan Acuna, MD MSc; Suzanne Kim-Whitmore MPH, Dionka Pierce, MPH; Kirti Y. Patel, MPH

Introduction: Alcohol exposure during pregnancy is associated to poor pregnancy outcomes as well as a leading cause of birth defects (fetal alcohol syndrome) and developmental disorders. Recent findings from the Centers for Disease Control and Prevention (CDC) show that one in eight women (12.5%) of childbearing age (18 to 44 years old) reported "risk drinking" (drinking seven or more drinks per week, or five or more drinks on any one occasion). From the fetal perspective, prenatal alcohol consumption is most damaging to the mental development of the infant during the last three months of pregnancy.

Drinking alcohol at the levels reported by the CDC could pose a serious health threat to the unborn fetus and the outcome of the pregnancy. Children affected by prenatal exposure to alcohol may suffer lifelong consequences, including mental retardation, learning disabilities, and serious behavior problems. Recent reported estimates of the number of U.S. children affected by fetal alcohol exposure range widely, from 5 per 10,000 live births to 1 per 100 live births. The actual prevalence of Fetal Alcohol Syndrome (FAS) is not known, as the diagnosis of the condition is difficult, which makes it frequently under or misdiagnosed. Differential exposure to alcohol by different populations may play a role in the variability of the rates as well. Different studies show prevalence rates for the United States that range from 0.3 to 2.2 cases per 1,000 births. This means that each year in the United States, between 1,200 and 8,800 babies are born with FAS. Many more are born with alcohol-related neuro-developmental disorder.

Therefore, evaluation of the prevalence of prenatal alcohol consumption during the last three months is very important to the health and well being of Louisiana's infants.

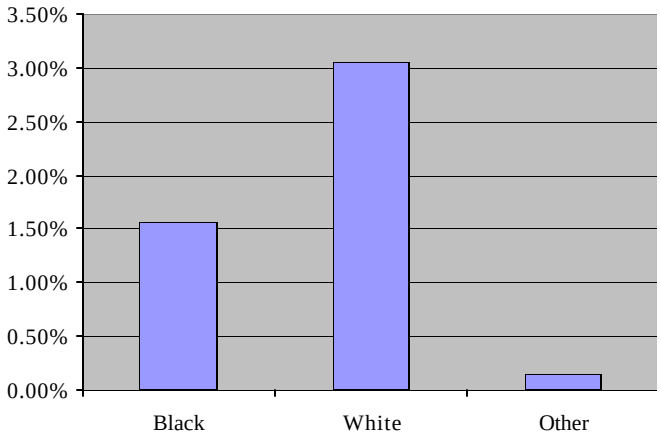
Materials and Methods: To study alcohol consumption during the last three months of pregnancy, we used the Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS), a population-based surveillance system that surveys women who have recently given birth in Louisiana to determine behaviors and risks associated with pregnancy. The LaPRAMS surveys approximately 200 women randomly selected from birth certificates, per month. Participation in LaPRAMS is voluntary and answers are kept confidential. The sample size for 1998 was 2,421 mothers and the sample size for 1999 was 2,286 mothers. This sample size was randomly chosen from 65,006 reported live births in 1998 and 65,228 reported live births in 1999 (3.7% of all live births) within Louisiana.

The LaPRAMS survey defines drinking during the last three months of the pregnancy, as the number of alcoholic drinks consumed in an average week and the number of times five alcoholic drinks or more were consumed in one sitting. Drinking before pregnancy was not analyzed.

Multivariate analysis was conducted using SAS/SUDAAN. The following risk factors were studied to determine the association with drinking during the last 3 months of pregnancy. Included were race, mother's age, mother's level of education, marital status, geographic location of residence, income level, Medicaid status, low birth weight, parity, stressors such as smoking during pregnancy, and physical abuse before pregnancy.

Results: According to 1998-1999 data, the statewide rate of drinking during the last 3 months of pregnancy is 4.75% (95% CI 4.6, 4.9) overall. Among whites 3.05% (95% CI 2.95,3.14) reported drinking during the last 3 months of pregnancy, blacks reported 1.56% (95% CI 1.49,1.63), and mothers of other races (other) reported 0.14% (95% CI 0.12, 0.17). Among those that drank during last three months of pregnancy, 4.5% (95% CI4.4, 4.6) drank one to two drinks per week, whites possessing 3% of the 4.5% total. Being of black race was found to be protective for drinking in the last three months of pregnancy (OR 0.44, 95% CI 0.35-0.55).

Figure: Drinking last 3 months of pregnancy LaPRAMS, 1998-99



Conclusions: According to LaPRAMS the prevalence drinking during pregnancy in Louisiana is lower than in the US (4.75% and 12.5% respectively), and is associated to white race, smoking, and physical abuse. (A limitation to this report is that alcohol consumption during the last three months of pregnancy is self-reported in LaPRAMS and could not be verified.) Disclosures by the women surveyed may have underreported their prenatal alcohol consumption due to increasing awareness of the dangers of drinking alcohol during pregnancy.

Public Health Implications: Understanding the prevalence of alcohol use during pregnancy helps decision-making processes in the state to optimize the efficient investment of resources. As drinking is more prevalent in the white population and associated to smoking and physical abuse, state interventions addressing this group and the associated factors may help the decrease the prevalence.

For further information, please contact: Dionka Pierce, 504-568-7726, La PRAMS, Maternal and Child Health, Epidemiology, Assessment, and Evaluation Section, Office of Public Health, Department of Health and Hospitals, 325 Loyola Ave, Room 504, New Orleans, LA.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
Nov- Dec 2002
PROVISIONAL DATA
Table 1. Disease Incidence by Region and Time Period

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Nov-Dec 2002	Nov-Dec 2001	Jan-Dec Cum 2002	Jan-Dec Cum 2001	% Chg
Vaccine-preventable															
H. influenzae (type B)		0	0	0	0	0	0	0	0	0	0	1	0	1	-100.0
Hepatitis B	Cases	4	1	2	0	1	0	2	1	0	11	6	135	115	14.8
	Rate[1]	0.4	0.2	0.5	0.0	0.4	0.0	0.4	0.3	0.0	0.3	0.1	3.1	2.7	
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mumps		0	0	0	0	0	0	0	0	0	0	1	1	2	-100.0
Rubella		0	0	1	0	0	0	0	0	0	1	0	2	0	200.0
Pertussis		0	0	0	0	0	0	0	0	0	0	2	8	11	-37.5
Sexually-transmitted															
HIV/AIDS	Cases[2]	53	30	6	13	8	8	3	7	4	132	173	1112	1167	-5.0
	Rate[1]	5.3	5.2	1.6	2.4	2.9	2.7	0.6	2.0	0.9	3.0	4	25.4	26.7	
Gonorrhea	Cases	525	122	71	154	58	69	289	116	84	1488	1818	11386	12288	-7.3
	Rate[1]	50.5	21.5	18.8	29.8	21.6	22.6	57.1	33	21.8	35.3	43.1	269.8	291.2	
Syphilis (P&S)	Cases	0	6	0	7	0	2	4	4	0	23	31	152	173	-12.1
	Rate[1]	0	1.1	0	1.4	0	0.7	0.8	1.1	0	0.5	0.7	3.6	4.1	
Enteric						.									
Campylobacter		3	1	2	1	1	0	2	3	4	17	11	122	129	-5.0
Hepatitis A	Cases	4	0	1.0	0	0	0	0	0	1	6	28	84	85	-1.2
	Rate[1]	0.4	0	0.3	0	0	0	0	0	0.3	0.1	0.6	2.0	2.7	
Salmonella	Cases	14	8	22	5	11	21	0	10	11	102	62	902	868	3.8
	Rate[1]	1.4	1.4	5.8	1.0	4.1	6.9	0	2.9	2.9	2.4	1.4	20.9	20.1	
Shigella	Cases	31	35	3	0	0	2	1	0	9	81	33	564	250	55.7
	Rate[1]	3.0	6.2	0.8	0	0	0.7	0.2	0	2.3	1.9	0.8	13.1	5.8	
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	1	0	100.0
Vibrio, other		3	0	1	0	0	0	0	0	0	4	1	43	27	37.2
Other															
H. influenzae (other)		0	2	0	0	2	0	0	0	0	4	0	12	11	8.3
N. Meningitidis		4	3	0	2	0	1	0	0	0	10	4	49	79	-61.2
Tuberculosis		0	0	0	2	1	1	3	1	0	8	130	174	281	-61.5

1 = Cases Per 100,000

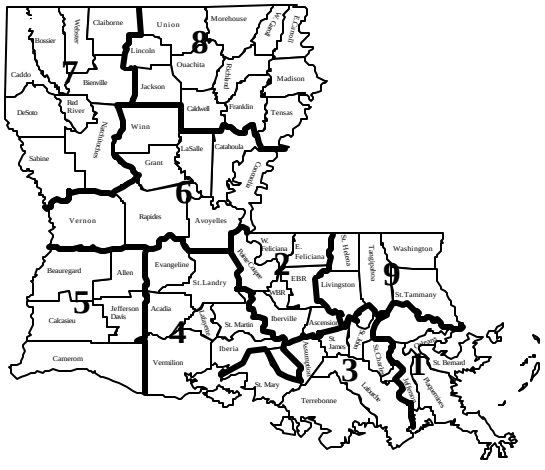
2=These totals reflect persons with HIV infection whose status was first detected during the specified time period. This includes persons who were diagnosed with AIDS at time HIV was first detected.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Legionellosis	5
Lyme Disease	5
Malaria	4
Rabies, animal	6
Varicella	29

Table 3. Animal rabies (Sep-Oct)

Parish	No. Cases	Species
Calcasieu	4	3 bats, 1 horse
Acadia	1	skunk
Lafayette	1	skunk



Sanitary Code - State of Louisiana
Chapter II - The Control of Disease

"It is hereby made the duty of every physician practicing medicine in the State of Louisiana to report to the State Health Officer, through the Health Unit of the parish or municipality wherein such physician practices, any case of suspected case of reportable disease which he is attending, or has examined, or for which such physician as prescribed. The report shall be made promptly at the time the physician first visits, examines or prescribes for the patient, and such report shall state the name, age, sex, race, usual residence, place where the patient is to be found, the nature of the disease and the date of onset." In addition to physician reporting, laboratories are required to report the results of tests which either confirm or suggest the occurrence of reportable diseases as specified by law. Additionally, Section 2:006 states "It shall be the duty of every osteopath, coroner, medical examiner, dentist, homeopath, infection control practitioner, medical records director, nurse, nurse midwife, nurse practitioner, pharmacist, physician assistant, podiatrist, social worker, veterinarian, and any other health care professional to report a confirmed case of reportable disease as specified in Section 2:003 in which he or she has examined or evaulated, or for which he or she is attending or has knowledge."

2:003 The following diseases are hereby declared reportable with reporting requirements by Class:

Class A Diseases/Conditions - Reporting Required Within 24 Hours:

Diseases of major public health concern because of the severity of disease and potential for epidemic spread—report by telephone immediately upon recognition that a case, a suspected case, or a positive laboratory result is known; [in addition, all cases of rare or exotic communicable diseases, unexplained death, unusual cluster of disease and all outbreaks shall be reported.]

- Anthrax
- Botulism
- Brucellosis
- Cholera
- Diphtheria
- Haemophilus influenzae (invasive infection)
- Measles (rubeola)
- Neisseria meningitidis (invasive infection)
- Plague
- Rabies (animal & man)
- Rubella (German measles)
- Rubella (congenital syndrome)
- Smallpox
- Tularemia
- Viral Hemorrhagic Fever

Class B Diseases/Conditions - Reporting Required Within 1 Business Day:

Diseases of public health concern needing timely response because of potential of epidemic spread—report by the end of the next business day after the existence of a case, a suspected case, or a positive laboratory result is known.

- Arthropod-borne encephalitis
- Aseptic meningitis
- Chancroid[1]
- E. Coli 0157:H7
- Hantavirus Pulmonary Syndrome
- Hemolytic-Uremic Syndrome
- Hepatitis A (acute illness)
- Hepatitis B (carriage in pregnancy)
- Herpes (neonatal)
- Legionellosis
- Malaria
- Mumps
- Pertussis
- Salmonellosis
- Shigellosis
- Syphilis[1]
- Tetanus
- Tuberculosis[2]
- Typhoid Fever

Class C Diseases/Conditions - Reporting Required Within 5 Business Days:

Diseases of significant public health concern—report by the end of the work week after the existence of a case, suspected case, or a positive laboratory result is known.

- Acquired Immune Deficiency Syndrome (AIDS)
- Blastomycosis
- Campylobacteriosis
- Chlamydial infection[1]
- Cryptococcosis
- Cryptosporidiosis
- Cyclosporiasis
- Dengue
- EHEC serogroup non 0157
- EHEC + shiga toxin not serogrouped
- Enterococcus, Vancomycin Resistant; (VRE)
- Giardia
- Gonorrhea[1]
- Hansen Disease (leprosy)
- Hepatitis B (acute)
- Hepatitis C (acute)
- Human Immunodeficiency Virus (HIV)
- Listeria
- Lyme Disease
- Lymphogranuloma venereum[1]
- Psittacosis
- Rocky Mountain Spotted Fever (RMSF)
- Staphylococcus aureus, Methicillin/ oxacillin or vancomycin resistant (MRSA)
- Streptococcus pneumoniae (invasive infection; penicillin resistant (DRSP)
- Streptococcus pneumoniae (invasive infection in children < 5 years of age)
- Varicella (chickenpox)
- Vibrio infections (except cholera)

Other Reportable Conditions:

- Cancer
- Complications of abortion
- Congenital hypothyroidism*
- Galactosemia*
- Hemophilia*
- Lead Poisoning*
- Phenylketonuria*
- Reye's Syndrome
- Severe traumatic head injury**
- Severe undernutrition (severe anemia, failure to thrive)
- Sickle cell disease (newborns)*
- Spinal cord injury**
- Sudden infant death syndrome (SIDS)

Case reports not requiring special reporting instructrions can be reported by Confidential Disease Case Report forms EPI-2430, facsimile (504-568-5006), phone reports (504-568-5005 or 1-800-256-2748), or electronic transmission.

[1]Report on STD-43 form. Report cases of syphilis with active lesions by telephone.

[2]Report on CDC72.5 (f.5.2431) card.

*Report to the Louisiana Genetic Diseases Program Office by telephone (505) 568-5070 or FAX (504) 568-7722.

**Report on DDP-3 form; preliminary phone report from ER encouraged (504) 568-2509. Information contained in reports required under this section shall remain confidential in accordance with the law.

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