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Louisiana Morbidity Report

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July-August 2003 **Volume 14 Number 4**

Hazardous Substances Emergency Events Surveillance (HSEES) Related Injuries, Louisiana, 2001

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Since 1990, the Agency for Toxic Substances and Disease Registry (ATSDR) of the U.S. Department of Health and Human Services has maintained an active, state-based Hazardous Substances Emergency Events Surveillance (HSEES) system to describe the public health consequences associated with the release of hazardous substances. The Louisiana Department of Health and Hospitals (LDHH) has participated in this surveillance system since 2001 and has summarized following, the characteristics of events with injuries reported to the surveillance system by the LDHH from January 1 through December 31, 2001.

Methods

A substance is considered hazardous if it can be reasonably expected to cause injury or death to an exposed person. Releases that are eligible are eligible for inclusion in the surveillance system are the following:

A. hazardous substance releases if they are uncontrolled or illegal and require removal, cleanup, or neutralization ac cording to federal, state, or local law
B. threatened releases if they either involve actions such as evacuations which are taken to protect the public health or they would have required removal, cleanup, or neutralization according to federal, state, or local law
C. releases to air and water that could not be cleaned up if the amount released should have been cleaned up if the spill had occurred on land.

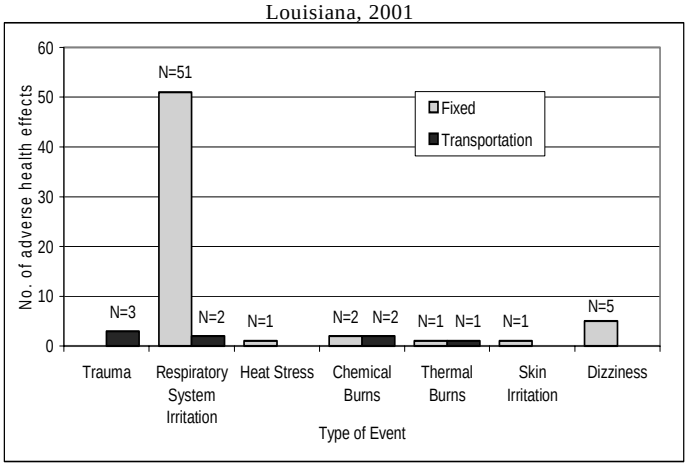
Events involving only petroleum products are excluded.

Various data sources which included, but were not limited to, the Louisiana State Police, the National Response Center, and the Louisiana Department of Environmental Quality were used to obtain information about these events. For each event, information was collected about its type (fixed-facility or transportation-related event); substance(s) released (identity, chemical form, type of release, and quantity released); victim(s) (population group, type of injury sustained, medical outcome, demographics, personnel protective equipment (PPE) worn, and distance from the event *); the type of area in which the event occurred; date and time of occurrence; numbers of persons potentially affected; evacuations; response plans; and causal factors.

Results

In 2001, 815 events qualified for surveillance. Out of 815 events, there were a total of sixty-three victims in twenty events (2.5% of all releases). Of the events with victims, 70.0% involved only one victim, and 80.0% involved either one or two victims. Of the transportation events, 5.3% involved victims, while only 1.9 % of the fixed–facility events involved victims. Approximately 13% of the victims were injured in transportation-related events and 87.3% were injured in fixed-facilities.

Figure 1: Distribution of type of injury by event type, HSEES Louisiana, 2001



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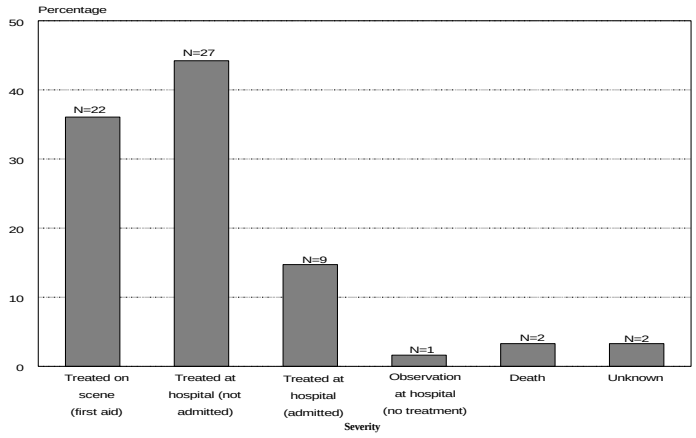
Some victims had more than one adverse health effect. The most commonly reported adverse health effect in fixed-facility events was respiratory system problems (83.6%). Trauma was reported in 37.5% of all transportation-related events, but was not reported in any fixed-facility events. (The trauma may have been caused by the sequence of events -for example, a motor vehicle accident- leading to the release of a hazardous substance and not by exposure to the hazardous substance itself.) The medical outcome of the sixty three victims is shown in Figure 2. Most victims were treated without having been admitted to a hospital.

Figure 2: Medical outcomes, HSEES Louisiana, 2001



Among the sixty three victims, sixty (95.2%) were 'Employees', one (1.6%) was a 'Responder', one (1.6%) was 'General Public' and one (1.6%) was a 'Police Officer'. Out of the sixty employees, thirty nine (65.0%) were reported as wearing PPE, nineteen (31.7%) had not worn any form of PPE and two (3.3%) were unknown. Of the thirty nine employee victims wearing PPE, thirty seven (94.9%) were wearing fire fighter turn-out gear, one (2.6%) was wearing level 'A' protection and one (2.6%) was wearing a hard hat.

Of the two persons who died as a result of hazardous substances releases, one was a driver of a truck loaded with phosphoric acid. The victim suffered from severe burns when the truck turned over and caught fire. The other fatality resulted from a Cronex release in a hospital X-ray room. The victim was an employee of the hospital and suffered from a respiratory system problem.

The number of total releases versus releases with victims by substance category is presented in Table 1.

Chlorine (13.2%) was the substance category that most likely involved victims. Per cent releases with victims were similar for Ammonia (8.8%), Mixtures (7.1%) and Acids (6.1%), with Ammonia having the higher number of releases (sixty eight).

Additional analyses were conducted involving ammonia releases because it was the second most commonly released substance and it was responsible for 26.1% of the events with victims. Of the sixty-eight releases of ammonia reported, fifty eight (92.1%) only involved ammonia. Five (8.6%) of these fifty eight events, resulted in a total of twenty one victims; nineteen (90.5%) 'Employees', one (4.8%) 'Responder Unknown Type' and one (4.8%) member of the 'General Public.'

Table 1: Number of total substance releases vs. releases with victims by substance category

	Total releases	Releases with victims	Percentage of releases with victims
Acids	66	4	6.1%
Ammonia	68	6	8.8%
Bases	29	1	3.5%
Chlorine	38	5	13.2%
Mixtures	14	1	7.1%
Other inorganic substances	376	3	0.8%
Other, not otherwise specified	207	2	1.0%
Paints and dyes	4	0	0.0%
Pesticides	30	0	0.0%
Polychlorinated biphenyls	4	0	0.0%
Volatile organic compounds	326	1	0.3%
Total	1162	23	2.0%

Conclusion

Unplanned chemical releases can affect the health of industry workers, the general public, first responders, and health care providers. Analysis of 2001 data found that even though victims were more likely to be injured in a transportation-related event, the majority of injuries were respiratory irritation associated with fixed-facility events. Many of these incidents and/or associated adverse effects may have been prevented and/or minimized if educational materials such as chemical fact sheets, HSEES' annual reports, case studies, and selected toxicological profiles were provided to industries, first responders, health care providers and members of the general public and appropriate actions were taken. There is a need for increased awareness of hazardous substance emergency events in Louisiana in order to reduce the occurrence of acute releases of hazardous substances and prevent injury and illness related to these events. The Louisiana HSEES system's ultimate goal is to use the data to target prevention activities by ATSDR and LDHH to reduce or mimimize adverse human health outcomes and diminished quality of life from exposure to hazardous substances.

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* Fixed-facility events involve hazardous substances released at industrial sites, schools, farms, or other permanent facilities; transportation-related events involve hazardous materials released during transport by surface, air, or water. Victims are defined as individuals with symptoms (including psychological stress) or injuries (including death) that result from the event. Victims who receive more than one type of injury are counted once in each applicable type of injury.

Stayin' Afloat 2003

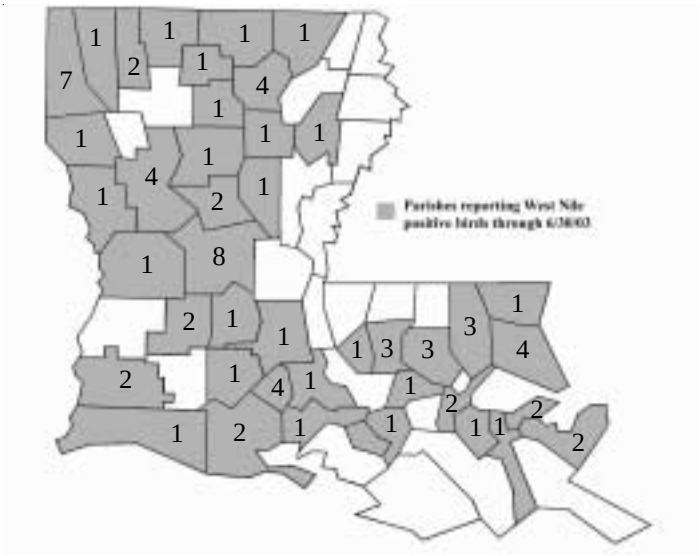
Miriam Nkemnji, MPH; Erika Murray, BA

A drowning prevention awareness campaign was conducted for Lake Charles and throughout Region 5 after five drowning deaths occurred at the I-10 Beach location in Lake Charles during the 2001-

(Continued on next page)

Dead Birds Positive for West Nile Virus in Louisiana as of June 30, 2003

(81 positive of 1,427 tested; 10,937 dead birds reported)



Carville: The Gillis W. Long Hansen's Disease Center

The last hospital in the industrialized world for the treatment of Hansen's Disease, (leprosy) was in Carville, Louisiana located near Baton Rouge. In 1894, the first patients were brought by barge from New Orleans to an abandoned plantation for treatment. The Catholic Daughters of Charity of St. Vincent de Paul arrived in 1896 to provide care for the patients at the Louisiana home and the order continued to manage and care for patients with this disease for the next hundred years.

In 1992 the Center's Laboratory Research Branch moved to the Louisiana State University (LSU) School of Veterinary Medicine in Baton Rouge. With the passing of a bill in the U.S. Congress in 1998, the Gillis W. Long Hansen's Disease Center was relocated to Baton Rouge, Louisiana as the coordinating center for outpatient care for the National Hansen's Disease Programs *(NHDP).* The NHDP conducts professional education programs for U.S. and international health care workers, providing basic information which is not provided in standard medical curricula. The NHDP also operates state of the art, world renowned laboratory research programs dedicated to improved detection, treatment and prevention of Hansen's disease and its associated effects.

The Carville facility closed its doors in June 1999. A few patients, life-long residents remain on site. Currently, the site is being used by the military for National Guard groups as well as educational programs such as the "Youth ChalleNGe Program," supervised by the Louisiana National Guard for at-risk youths.

Mardi Gras at Carville, 1957

2002 swimming season. The event "Stayin' Afloat 2003", which took place in Lake Charles, LA on May 31, 2003 was a collaboration between various groups such as the Children's Miracle Network, the City of Lake Charles and the Lake Charles Child Death Review Panel.

A total of thirteen sponsors and seventeen agencies provided support for the 2003 Stayin' Afloat event. More than forty volunteers were on hand to make sure that the 200 children who attended the event had a safe and fun time. The mayor of Lake Charles, Randy Roach, showed support by attending the event as well. Media coverage had representation from five sources (B104-radio remote, Cable Channels, KPLC TV (NBC), KVHP TV (Fox), and Lake Charles American Press).

Some of the activities that were conducted at the beach included but were not limited to:

- Personal Floatation Device (PFD) fittings
- Assembling and distributing bracelets
- Face painting
- Mock station for rescuing a drowning victim
- Water safety trivia game

An interesting invention, known as 'UV beads', caught the attention of both children and adults. These beads would intensify in color if left in the sun too long and the brightness in color was an indication that the person wearing the beads needed to apply sunscreen. During the event, the beads were assembled into a bracelet and tied around the wrist. Additionally, summer safety/drowning informational brochures were handed out to every child, along with packets of samples.

Representatives from Wildlife and Fisheries fitted more than sixty PFD's on children who weighed up to ninety pounds. The remaining 400 PFD's will be available on a rental checkout system for those who come to the I-10 beach area during the summer months. Since the event, KVHP – TV (FOX) featured a story to make parents aware of the availability of the PFDs on the beach this summer and a part-time person will be employed to facilitate the rental process.

Special thanks goes to Erika Murray, Region 5 Injury Prevention Coordinator, who was instrumental in coordinating the event as well as all the sponsors and participants for their time and commitment.

Unusual Cases, 2003

The Dead Parakeet

Gary Balsamo, DVM MPH

A fifty year old woman possessed an eight year old parakeet that died suddenly, without any history of respiratory signs. Around the time of the bird's death, the woman began having respiratory symptoms, fever and cough. The history of exposure to the bird related during consultation, caused her to be tested for psittacosis. She was positive on a screening test for Chlamydia respiratory disease. A therapeutic regiment of tetracycline was recommended to be continued until ten to fourteen days from resolution of the symptoms.

The only other co-exposure was a household member who had also exhibited a cough recently. The woman was advised that her housemate should see a physician with blood work to be submitted to the OPH (Office of Public Health) lab.

Exposure to the bird seemed to be confined to close contact with bird feathers and cage dander associated with daily care and husbandry of the bird. There was no history of mouth to beak contact and no history of bite or exposure to tissues. No other birds were kept in the house. Since this parakeet had been in this owner's possession for eight years, no trace back to origin of the bird was deemed necessary.

The woman was advised to disinfect the cage using a Lysol ® solution, or a 5% bleach solution, and then aerate outdoors for two to three days. The area around the cage would have to be vacuumed and cleaned thoroughly and any objects that could have contacted the bird would have to be disinfected or discarded.

Since the woman was working, some concerns arose as to any problems associated with her continuation of work. She was not being urged to discontinue work since respiratory droplet transmission from person to person is extremely rare with this organism.

Note: Psittacosis (ornithosis) is an acute febrile respiratory tract infection with systemic symptoms and signs that often include fever, a nonproductive cough, headache, and malaise. Extensive interstitial pneumonia can occur with radiographic changes characteristically more severe than what would be expected from physical examination findings.

The usual method of diagnosis is serologic, based on a fourfold increase in complement fixation (CF) antibody titer between acute and convalescent specimens collected two to three weeks apart. In the presence of a compatible clinical illness, a single CF titer of 1:32 or greater is considered *presumptive* evidence of infection. Treatment may suppress the antibody response. The CF test does not distinguish among infections caused by *C psittaci, C pneumoniae, C trachomatis, or C pecorum*. A microimmunofluorescence assay that is more specific for *C psittaci* has been developed but is not widely available. Isolation of the agent from the respiratory tract should be attempted only by experience personnel in laboratories in which strict measures to prevent spread of the organism are used during collection and handling for culture of all specimens.

An Interesting and Deadly Malaria Case

Nevin Krishna, MPH

In late April, 2003, an elderly person presented at a hospital emergency department complaining of having chills and fever for three days. Thirteen days earlier the patient had returned from a two week trip to Zimbabwe. The attending physician suspected that malaria may have been responsible for causing the illness. While in Zimbabwe, the patient had taken a full course of chloroquine as prophylaxis for malaria. A blood smear revealed that the patient had in fact, been infected with *Plasmodium falciparum* and at the time of the blood smear approximately 5-10% of his red blood cells harbored parasites. The patient was admitted to the hospital and placed on oral quinine and intravenous doxycycline.

On the second day of hospitalization, the patient's parasitemia level had dropped to 1%. Despite this reduction, the patient suf-

fered a focal seizure, became obtunded and was intubated and placed on a respirator. Dialysis was initiated due to decreasing renal function. The treatment was then changed to intravenous quinidine and doxycycline. However, when EKG abnormalities were discovered on day three, quinidine was discontinued and quinine was given via nasogastric tube. The patient became hemodynamically unstable.

On day five of hospitalization, the patient exhibited marked liver enzyme level increases, fixed and dilated pupils and an EEG revealed minimal activity. Although treatment for parasitemia had cleared the infection, the patient expired on the fifth day, due to a cardiac arrest.

Note: This case underscores two important points.

The first point is the importance of seeking travel health advice prior to visiting foreign countries. Malaria has a wide geographic distribution with many different species of parasites. Plasmodium falciparum is the most severe and deadly of all four human species of malaria. Moreover, falciparum malaria is resistant to chloroquine in much of the world and all of Africa. In this case the patient had taken what he thought was a full course of prophylaxis for malaria when in fact the recommendations for prophylaxis had changed. The recommendations for that region now include atovaquone/ proguanil, doxycycline, mefloquine, or primaquine for the prevention of falciparum malaria. For travel heath information please consult the Centers for Disease Control and Prevention, Travelers Health website http://www.cdc.gov/travel/ .

The second point is for physicians to remind their traveling patients to report symptoms of sickness immediately as rapid initiation of treatment following onset of illness is needed. When the patient was first diagnosed on the first day of his visit to the hospital, his erythrocyte parasitemia was already at a level of 5-10%. Typically cases of falciparum malaria may be severe once a threshold of 2% parasitemia is achieved in a non-immune individual and 10% in others (Taylor TE, Strickland GT 2000. "Malaria in Hunter's Tropical Medicine", WB Saunders, Philadelphia).

Varicella Vaccination Update: New 2003 School and Day Care Entry Requirements

Ann M. Buff, MD MPH, Frank J. Welch, MD MSPH
Ruben A.Tapia, MPH

Vaccination Recommendations

Beginning in 2003, varicella vaccination or a documented history of varicella is required by law for entry to school and day care in Louisiana. The Louisiana Department of Health and Hospitals, Office of Public Health Immunization Schedule recommends that unvaccinated children without a reliable history of chickenpox be vaccinated. All children should be given varicella vaccine at age twelve to fifteen months as part of the routine immunization schedule. Susceptible children over age twelve should be given two doses of vaccine at least one month apart. All children should be screened for varicella vaccination at their initial visit to a health care provider, prior to day care entry and prior to school entry. *Every visit to a health care provider is an opportunity to provide immunizations.*

Varicella vaccination can and should be given to children with the following conditions (1) minor acute illnesses (i.e. diarrhea, upper respiratory tract illness including otitis media with or without fever), (2) mild to moderate local reaction to a previous dose of vaccine, (3) current antibiotic therapy and (4) the convalescent phase of an acute illness. Failure to vaccinate children with minor illnesses can substantially limit vaccination efforts and negatively impact vaccination coverage rates. There are only three absolute contraindications to varicella vaccination and two precaution conditions that may limit vaccine effectiveness or increase the risk for a serious adverse reaction (Table 1). Health care providers should therefore use every opportunity to provide appropriate vaccinations to all susceptible children and adults to help decrease morbidity and mortality from vaccine-preventable diseases.

Table 1. Advisory Committee on Immunization Practices Guide to Contraindications and Precautions for Varicella Vaccine*

Contraindications	Precautions	Administer Vaccine
1. Severe allergic reaction after a previous dose or to a vaccine component	1. Recent receipt (≤ 11 months) of antibody-containing blood products	1. Pregnancy of recipient's mother or other close household contact
2. Substantial suppression of cellular immunity	2. Moderate to severe acute illness with or without fever	2. Immunodeficient family member or household contact
3. Pregnancy		3. Asymptomatic or mildly symptomatic HIV infection**
		4. Humoral immunodeficiency (e.g. agammaglobinemia)

*Adapted from CDC
**If a vaccinee develops a presumed vaccine-related rash 7-25 days after vaccination, avoid direct contact with immunocompromised persons for duration of the rash.

Disease Epidemiology

Varicella is a highly infectious disease caused by a member of the herpes virus family, varicella zoster virus (VZV). Varicella is spread primarily through the respiratory route and patients are contagious prior to the onset of rash until the first few days following rash appearance. Although commonly considered a mild childhood disease, varicella can cause serious complications including death. Varicella remains the leading cause of vaccine-preventable deaths in children in the U.S. today. The most common complications include secondary bacterial infection, pneumonia, cerebellar ataxia and encephalitis. In Louisiana, thirty-seven deaths were reported from varicella between 1980-2001 with twelve of those deaths occurring after the introduction of the varicella vaccine (Louisiana State Center for Health Statistics, unpublished data, 2002). In Louisiana, varicella vaccine coverage levels have increased from approximately 5% in 1996 to 73% in 2001. Comparatively, national coverage rates have increased from 26% in 1997 to 76% in 2001.

Vaccine Efficacy and Safety

In March 1995, the Food and Drug Administration (FDA) approved a live, attenuated varicella virus vaccine (Varivax; Merck & Co., Inc.) for use in the United States. The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) published varicella vaccination recommendations in July 1996. In order to increase coverage rates nationally and decrease the burden of disease, the ACIP recommended in May 1999 that all states institute requirements for varicella vaccine or

(Continued on next page)

(Varicella Vaccination Update Cont.)

documented evidence of natural disease for all children entering elementary school and day care facilities.

Vaccination has ranged from 71 to 100 percent effective in preventing disease of any severity and from 95 to 100 percent effective in preventing moderate-to-severe disease. Although the vaccine is highly effective, a modified form of varicella can develop in vaccinated persons following exposure. Breakthrough cases of varicella are generally mild compared to natural varicella infections. Breakthrough cases typically have far fewer lesions (usually less than fifty), fewer systemic symptoms, shorter duration of illness and fewer complications.

The most commonly reported adverse events following varicella vaccination include local injection site reactions and rash. Minor injection site reactions such as pain, redness and swelling occur in approximately twenty percent of those immunized. Approximately three to five percent of vaccinated children will develop a localized rash and another three to five percent will develop a generalized varicella-like rash. These rashes generally consist of less than ten maculopapular lesions and occur within seven to twenty-one days of vaccination. Children who develop more than fifty lesions (particularly vesicular lesions) or a rash within fourteen days of vaccination are likely to have been harboring wild-type VZV prior to immunization. Serious adverse events related to the varicella vaccine are rare.

(Adapted from an article submitted for publication in the September issue - *Medical Society Journal*.)

For more information contact the Immunization Section of the Office of Public Health at 504-483-1900.

Atlanta Conference on *Antibiotic Use*

Louisiana was well-represented at the CDC (Centers for Disease Control) sponsored "Expanding Our Vision: CDC and Partners' National Conference on Appropriate Antibiotic Use in the Community" held in Atlanta, June 5-6, 2003. This conference is a precursor to the national kick-off "Get Smart – Know When Antibiotics Work" campaign scheduled for September, 2003 in Chicago.

Dr. Catrin Jones-Nazar and Rosemarie Robertson from the Infectious Disease Epidemiology Department of the Office of Public Health (OPH), Department of Health and Human Resources (DHH), headed a booth displaying information both on the Louisiana Antibiogram* and on the State's Antibiotic Resistance Program .

The display and poster presentation also highlighted a local antibiotic resistance program created by Mr. Kenneth Boudreaux,

RPH and Dr. Francis Brian, Jr. from the Rapides Regional Medical Center in Alexandria, Louisiana. With the initiative of these two concerned healthcare professionals, their worry about local antimicrobial resistance trends and their hospital's antibiotic use patterns, became a program. Information from their program was included in the Louisiana Antibiotic Resistance Program Abstract poster presentation during the conference as an important lesson learned: **Individual hospitals and staff members can make large contributions to the appropriate antibiotic use campaign.**

The Rapides work will be showcased at the Antibiotic Resistance Workshop Pilot Program planned for the month of September, taking place at Public Health Region 6 of the State of Louisiana. The campaign will include physician as well as community education.

Also at the Atlanta conference, in an 'Antibiotic Quiz Bowl' game involving regional teams, the Southeast team with star members Dr. Brian and Mr. Boudreaux claimed first place, answering questions such as "How long should children with strep throat who are not penicillin allergic be treated with antibiotics?" and "What is HEDIS ?". **

Special thanks to Rapides Regional Medical Center's, Dr. Brian and Mr. Boudreaux for their great contribution to the conference!

*Antimicrobial Susceptibilities of Selected Pathogens – information available LMR Issue 5, 2002.

** Answers: 10 days; Health Plan Employer Data and Information Set

Announcement of Training Date Change

The Field Epidemiological Techniques class, originally scheduled for July 30-31, 2003 will be rescheduled to August 12-13, 2003. The Infectious Disease Epidemiology Section is holding this two-day training for non-ID-RRT members (Infectious Disease Rapid Response Team). The training will be targeted towards sanitarians, public health nurses, infection control professionals, disease surveillance specialists, epidemiologists, health care providers and other public health care professionals interested in epidemiological principles and outbreak investigations. This workshop, taking place at the State Office Building in New Orleans, is free of charge but seating is limited. For a registration form, please email Louise Bellazer at lbellaz@dhh.state.la.us or call (504) 568-5005 x102.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
May-June 2003
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 May-Jun 2003	May-Jun 2002	Jan-Jun Cum 2003	Jan-Jun Cum 2002	% Chg
Vaccine-preventable														
H. influenzae (type B)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hepatitis B Cases	6	4	3	0	1	3	1	0	1	19	26	76	62	+22.6
Rate[1]	0.6	0.7	0.8	0.0	0.4	1.0	0.2	0.0	0.3	0.4	0.6	1.8	1.4	na
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	0	0	1	-100.0
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	1	-100.0
Pertussis	0	0	0	0	0	1	1	0	0	2	1	6	5	+20.0
Sexually-transmitted														
HIV/AIDS Cases[2]	11	7	0	4	0	2	0	2	3	29	198	265	609	-56.5
Rate[1]	1.1	1.2	0.0	0.7	0.0	0.7	0.0	0.6	0.7	0.7	4.5	6.1	13.9	na
Gonorrhea Cases	819	258	90	186	79	81	465	147	111	2239	2076	5470	5773	-5.2
Rate[1]	78.2	42.7	23.4	33.9	27.5	26.9	88.9	41.5	25.3	50.1	49.2	122.4	136.8	na
Syphilis (P&S) Cases	3	4	1	4	1	0	4	4	2	23	21	55	45	+22.2
Rate[1]	0.3	0.7	0.3	0.7	0.4	0.0	0.8	1.1	0.5	0.5	0.5	1.2	1.1	na
Enteric														
Campylobacter	3	2	1	1	0	0	0	3	2	12	30	40	59	-32.2
Hepatitis A Cases	8	1	0	0	1	0	0	0	2	12	16	38	46	-17.4
Rate[1]	0.8	0.2	0.0	0.0	0.4	0.0	0.0	0.0	0.5	0.3	0.4	0.9	1.1	na
Salmonella Cases	10	27	11	12	2	3	2	7	12	86	158	202	329	-38.6
Rate[1]	1.0	4.8	2.9	2.3	0.7	1.0	0.4	2.0	3.1	2.0	3.7	4.7	7.7	na
Shigella Cases	7	18	3	13	0	9	0	1	1	52	143	168	254	-33.9
Rate[1]	0.7	3.2	0.8	2.5	0.0	3.0	0.0	0.3	0.3	1.2	3.3	3.9	5.9	na
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vibrio, other	2	0	0	0	0	0	0	0	0	2	15	9	18	-50.0
Other														
H. influenzae (other)	0	3	0	0	0	0	0	0	0	3	2	11	4	+175.0
N. Meningitidis	0	0	0	0	0	0	0	0	4	4	8	30	25	+20.0
Tuberculosis	na	na	na	na	na	na	na	na	na	na	na	na	na	na

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	1
Lyme Disease	7
Malaria	2
Rabies, animal	0
Varicella	10

Table 3. Animal rabies (Jan-Jun)

Parish	No. Cases	Species

No rabies reported for this period

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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