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Louisiana Morbidity Report

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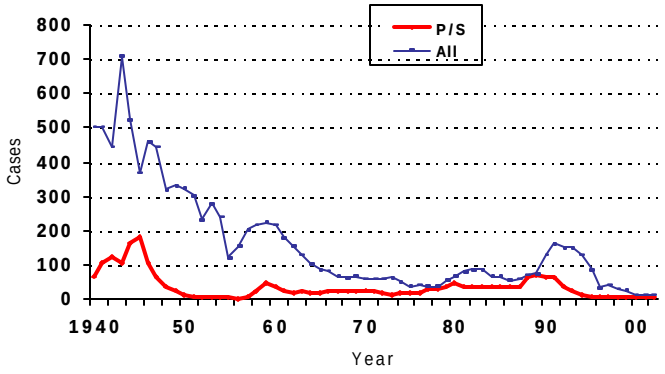
David W. Hood
SECRETARY

May-June 2003 **Volume 14 Number 3**

Primary and Secondary Syphilis in Louisiana

With the advent of penicillin, contact investigation, preventive treatment of contacts and educational interventions, cases of syphilis steadily declined in the period between 1940 and the 1980's. However, due to a combination of budget cuts and reallocation of resources to other programs, syphilis incidence steadily increased during the 1980's - with a sharp increase appearing in the early 1990s. (Figure 1)

Figure 1: Primary/ Secondary and All Syphilis Incidence Rates per 100,000 1940-2002

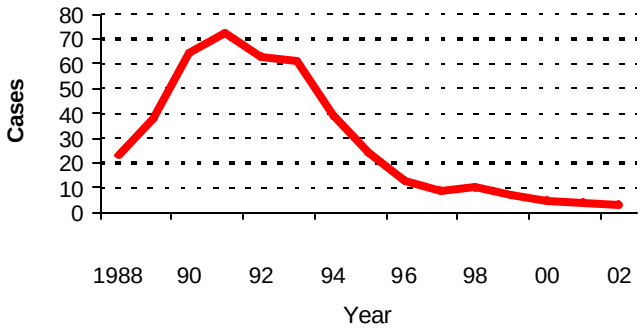


A few years of neglect have caused a huge regression. Rates of primary and secondary syphilis (reflecting the intensity of recent transmission) in the early 1990's had reverted to those of the late 1940's, **wiping out fifty years of progress**. This is a reminder that public health programs should not be neglected.

Contents

After peaking in the early 1990's, the incidence of cases of primary and secondary syphilis started to decline in 1994. The steep decline during the late 1990's slowed between the years 2000 to 2002 (Figure 2)

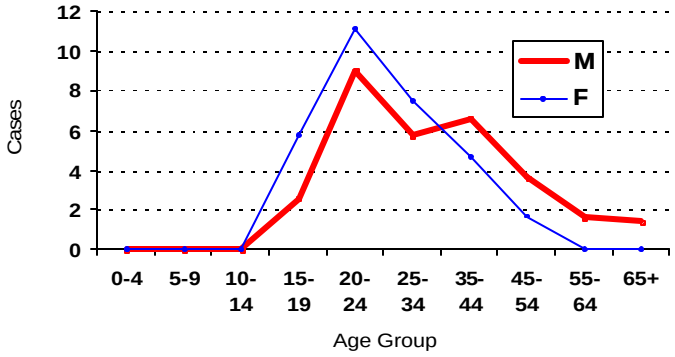
Figure 2: Primary/ Secondary Syphilis Incidence Rate per 100,000 1988-2002



Age and Gender

Age and gender distribution are typical of that of syphilis, with peaks for males in the late teens-twenties age group and a gradual decrease showing for older age groups. The increase occurs in younger age groups in females. (Figure 3)

Figure 3: Primary/ Secondary Syphilis Incidence: Age & Gender per 100,000 1988-2002



Comparing age group distribution within the last three years, it appears that decreases occur in all age groups and gender with larger decreases among males in the 25-34 age group (particularly African-Americans). There are lower decreases among females in all age groups.

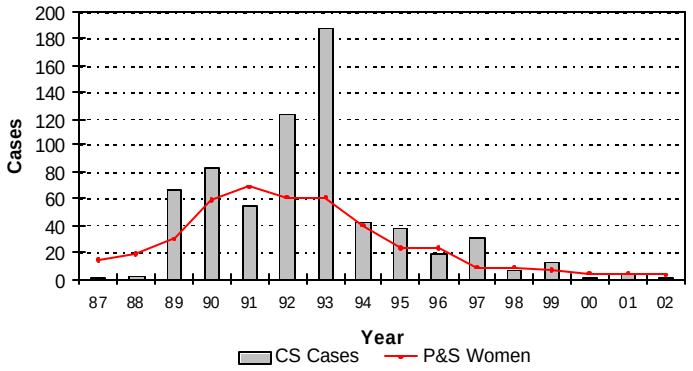
(Continued on next page)

Primary and Secondary Syphilis in Louisiana (Cont.)

Among the primary and secondary cases, females are almost all heterosexual (99%) while male cases are mostly heterosexual (79%) with a lower percentage of homosexual or bisexual men. (Orleans parish has a higher proportion of homosexual or bisexual men than other parishes.)

Congenital syphilis cases have declined as a consequence of the decrease of primary and secondary syphilis in women. (Figure 4)

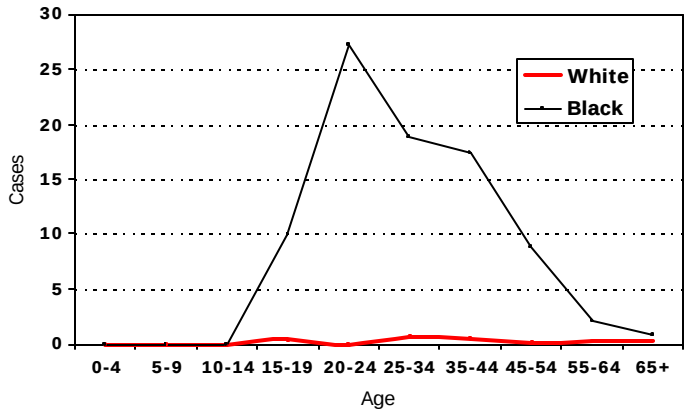
Figure 4: Congenital Syphilis vs. Primary/Secondary Syphilis per 100,000 1988-2002



Race

Race distribution shows a large difference with African-Americans reaching a peak incidence rate of 27/100,000 in the 20-24 year old age group. The highest rates among Whites remain below 5 /100,000.

Figure 5: Primary/Secondary Syphilis Incidence: Age & Race per 100,000 1988-2002

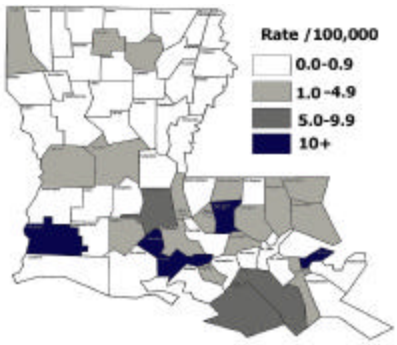


All Cases

The distribution by clinical presentation is as follows: Primary syphilis 14.2%, secondary 38.1%, early latent 47.7%. There is no significant difference by age group except among the 55-64 and older groups with 20% secondary and 80% early latent.

The following state map (Figure 6) shows a highly clustered distribution with high rates in a few parishes.

Figure 6: Average Incidence of Primary/Secondary Syphilis 1988-2002



About 90% of all cases occur in nineteen parishes (Table 1). Some of the foci are vanishing such as Region 1 (Orleans, Jefferson and St Tammany), Region 3 (Terrebonne and Lafourche, and Region 5 (Calcasieu). On the other hand some foci continue to thrive such as East Baton Rouge in Region 2 and in Region 4 with Lafayette and Iberia. In 2002 a focus appeared in Lincoln parish (Region 7).

Table 1: Syphilis foci 1999-2002

Parish	99	00	01	02	Total
Orleans	50	20	24	9	**103**
Jefferson	18	1	4	0	**23**
St Tammany	7	0	3	3	**13**
East Baton Rouge	27	32	55	33	**147**
Tangipahoa	9	6	3	1	**19**
Ascension	13	2	2	0	**17**
East Feliciana	0	2	4	8	**14**
Livingston	5	1	1	4	**11**
Terrebonne	7	18	15	9	**49**
Lafourche	32	5	4	1	**42**
Lafayette	31	31	15	26	**103**
Iberia	12	27	14	11	**64**
St Landry	5	14	3	5	**27**
St Martin	0	7	6	7	**20**
Acadia	9	8	0	1	**18**
Calcasieu	43	16	2	1	**62**
Caddo	8	0	0	7	**15**
Lincoln	0	0	0	10	**10**
Other Parishes	28	20	18	16	**82**
Louisiana	**304**	**210**	**173**	**152**	**839**
% in 19 Parish	**90.8**	**90.5**	**89.6**	**89.5**	**90.2**

Louisiana Morbidity Report
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Low rates of syphilis and the concentration of syphilis cases in a small number of geographic areas have set the stage for the elimination of syphilis. Despite some remaining foci of transmission, progress has been made towards elimination of this disease.

Medical Awareness Course Announced

A Medical Awareness Course has been developed for physicians, nurses, pharmacy technicians and lab technicians through a grant initiative. The Health Resources and Services Administration (HRSA) Grant is a bioterrorism planning program, with one of its goals being to increase the level of awareness for diagnosing potential terrorism agents and/or potential disease outbreaks.

Differential diagnosing and clinical symptomotology is an important aspect to these training courses. The full-day agenda includes topics such as *"Bioterrorism Agents – What do I need to know?"* by Thomas Arnold, MD from the Emergency Medicine Department at the LSU Medical Center in Shreveport; *"Chemical Agent Management: What am I likely to see?"* by Mark Ryan, PharmD from the Louisiana Drug and Poison Information Center; *"Web-based reporting and Reportable Diseases"* by Raoult Ratard, MD State Epidemiologist from the Louisiana Office of Public Health; *"Nuclear Threats: Is there anything I can do?"* by Knox Andress, RN and the *"National Pharmaceutical Stockpile in Louisiana"* by Philip McCrory, RPh from the Louisiana Office of Public Health. (Please see the article about the Strategic National Stockpile on page 5 of this issue.)

The first of these trainings is scheduled in Lafayette on June 27, 2003. For convenience, these trainings are offered throughout the state at the following locations and dates: Lake Charles - July 8, 2003; Baton Rouge - July 22, 2003; New Orleans (2 sessions are offered at this location) August 14, 2003 and September 16, 2003; Alexandria - August 22, 2003; Terrebonne - October 9, 2003; Monroe - October 22, 2003; Shreveport - November 6, 2003; St. Tammany - November 20, 2003. For more details and registration information, please call Rosanne Prats, MHA, ScD at 225-342-3417 or email rprats@dhh.state.la.us .

Trends in Antibiotic Sensitivity

Karen Lees, MPH

Introduction

Antibiotic resistance is an increasing problem. The 'Antibiotic Sensitivity Active Surveillance System' began in Louisiana with the collection of aggregate data in 2000 to track the emergence of antibiotic resistant organisms. This surveillance program, which allows the state to track and evaluate antibiotic resistance trends, monitors three pathogens: Methicillin resistant *Staphylococcus aureus* (MRSA), drug resistant *Streptococcus pneumoniae* (DRSP), and Vancomycin resistant enterococcus (VRE). The primary goal of the Antibiotic Sensitivity Active Surveillance System is to estimate the proportion of selected bacteria in the state that are resistant to antibiotics by the reporting of laboratory aggregate data.

Methods

Over the past three years, forty-three hospitals have been a part of the surveillance system at some point in time. Currently, thirty-one hospitals provide information to the surveillance system each month on a brief reporting form. Each hospital reports the total number of *S. aureus*, *S. pneumoniae*, and enterococcus species isolated in their lab for each month. In addition, they also report the total number of drug resistant or drug intermediate resistant isolates for each of those organisms. As duplicates are not reported, the forms contain counts on one isolate of MRSA, VRE, or DRSP per patient per hospital visit. Each report is entered into an Access database, and from this database quarterly and annual summary reports are generated for the participating hospitals.

The purpose of this analysis is primarily to determine if the rates of antibiotic resistance for *S. pneumoniae*, *S. aureus*, and enterococcus were significantly different over the four quarters in 2002 and secondarily to determine if there is a significant trend in the rates of antibiotic resistance for these organisms from 2000 to 2002. Since the interest was in resistance as either present or not present, the resistance and intermediately resistant variables were combined to get one variable for resistance.

For each organism of interest, a chi-square statistic was calculated to determine if the percent of resistant isolates was different from quarter to quarter in 2002. Using the annual rates, a test for trend was conducted using the Mantel-Haensel Chi Square statistic. Both of these analyses were conducted using SAS (Version 8.02; Cary, NC).

Results

The results of the analysis of 2002 quarterly counts of antibiotic susceptible and resistant isolates can be seen in Table 1.

Table 1: Analysis of Antibiotic Resistance by Quarter for 2002 for *S. pneumoniae*, *S. aureus*, and *Enterococcus* species from the Louisiana Antibiotic Sensitivity Active Surveillance System

		First Quarter	Second Quarter	Third Quarter	Fourth Quarter	$?^2$	p-value
S. pneumoniae							
	Resistant	221	124	70	133	0.0141	0.9996
	Susceptible	279	157	90	170		
S. aureus							
	Resistant	2076	2296	2527	2590	57.7417	<0.0001
	Susceptible	2136	1901	2182	1933		
Enterococcus							
	Resistant	140	151	113	142	1.5974	0.6600
	Susceptible	2394	2503	2133	2297		

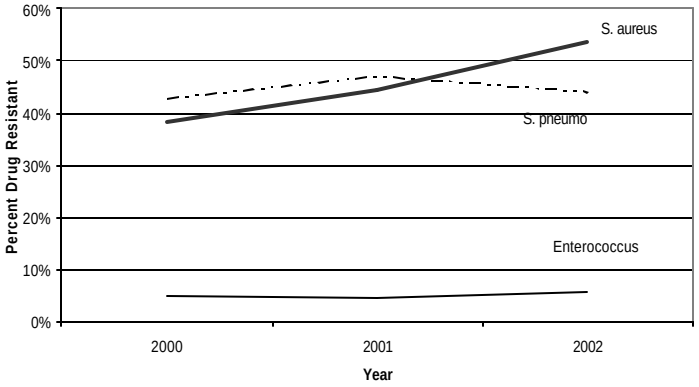
The percentages of drug resistant *S. pneumoniae* were not significantly different from each other ($\times^2$=0.0141, p=0.9996), ranging from 43.8% to 44.2% in 2002. The rates for methicillin resistant *S. aureus* **were** significantly different throughout the year ($\times^2$=57.7417, p<0.0001), ranging from 49.3% in the first quarter to 57.3% in the fourth quarter. In addition, there was a significant increasing trend throughout the year ($\times^2$ for trend =45.6359, p<0.0001); the rates of resistance in the fourth quarter were 16% higher than those in the first quarter. The percentages of vancomycin resistant enterococcus (VRE) ranged from 5.3% to 6.2% in 2002, but these rates were not significantly different from each other ($\times^2$=1.5974, p=0.6600).

A trend analysis was conducted to determine if the rates of resistance were increasing over the past three years (2000, 2001, and 2002). The results can be seen in Table 2 and Figure 1.

Table 2: Trend Analysis of Resistance for 2000-2002 for *S. pneumoniae*, *S. aureus*, and *Enterococcus* species

		2000	2001	2002	$?^2$ (for trend)	p-value
S.pneumoniae						
	Resistant	547	662	548	0.3767	0.5394
	Susceptible	729	744	696		
S.aureus						
	Resistant	4660	6682	9489	723.1479	<0.0001
	Susceptible	7377	8347	8152		
Enterococcus						
	Resistant	451	496	547	3.0889	0.0788
	Susceptible	8577	10,013	9827		

Figure 1: Percent drug resistant *Streptococcus pneumoniae*, *Staphylococcus aureus*, and *Enterococcus* species, 2000-2002



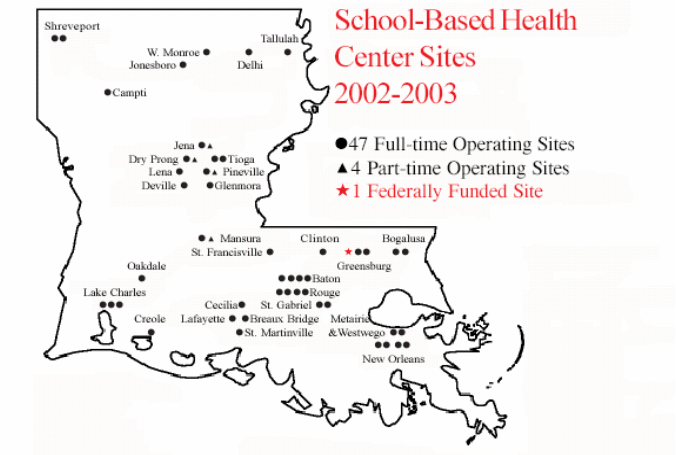
A Mantel-Haensel chi-square statistic was calculated for each organism. The rates of drug resistant *S. pneumoniae* have not been increasing over the past three years ($\times^2$ for trend =0.3767, p=0.5394). As was seen in the year 2002 data, the rates of methicillin-resistant *S. aureus* were increasing from 2000 to 2002. In 2000, the rate of resistance in *S. aureus* was 38.2%, in 2001 it was up to 44.5%, and in 2002 it was up to 53.8%. These increases were highly significant ($\times^2$ for trend =723.1479, p<0.0001). Rates of vancomycin resistant *Enterococcus* did not significantly increase over the past three years ($\times^2$ for trend =3.0889, p=0.0788).

Improved Health Outcomes - LA Adolescent School Health Initiative

Cheryll S. Sheard, MBA

The Adolescent School Health Initiative (ASHI) was enacted by the Louisiana Legislature in 1991, authorizing the Office of Public Health to facilitate and encourage development of comprehensive health centers in public schools in Louisiana which provide preventive and acute health services, counseling and appropriate referral. Currently there are 51 state funded School-Based Health Centers (SBHCs) statewide (Figure 1). The purpose of a school health center is to eliminate barriers to learning in two ways; first by providing convenient access to primary and preventive health services for students who might otherwise have limited or no access to health care and second, by meeting the physical and emotional health needs of adolescents at their school sites.

Figure 1: ***Louisiana Adolescent School Health Initiative***



To assure that quality medical, psychosocial, and educational health services are delivered in accordance with current best practices to children seen at Louisiana SBHCs, the ASHI Continuous Quality Improvement (CQI) Program was implemented. The CQI Program consists of four steps: Self-Evaluation; On-Site Review; Quality Improvement Recommendations; Ongoing Monitoring.

As part of the ASHI CQI Program, the *Best Practices for Prevention in SBHCs*, Louisiana's Preventive Services Improvement Initiative, was launched in 2001-02. The *Best Practices* are a set of clinical guidelines for SBHC preventive services based on national recommendations. SBHC staff participates in ongoing educational workshops where guidelines are highlighted. As the SBHCs implement the best practices, they also are measuring their success by collecting outcome data.

In 2001-02, SBHCs embarked upon improving the medical management of students with asthma with the goals of improving the quality of life, improving school attendance, and reducing emergency room visits and hospitalizations for students with asthma. In August of 2001, ASHI conducted an asthma workshop for SBHC medical staff. Participants learned the latest in asthma diagnosis and management and were provided program steps to implement asthma case management in their SBHC.

Data was collected on 53 students with asthma who were followed for one school year at two of the SBHCs. The students self-reported school absences as well as emergency room visits and hospital admissions due to asthma for the previous year. Next, information was collected on those same indicators for the current year after the implementation of nurse asthma case management. As a result there were 101 fewer absences, 23 fewer ER visits, and 4 fewer hospitalizations. Many children reported less symptoms of asthma while performing routine activities and felt less frightened during asthma attacks. The improvement was felt not only by the children, but also their parents. In addition, a large number of parents reported that they missed less work than they had the previous year.

In 2001-02, as part of ASHI's CQI program, SBHCs began looking at specific outcomes. ASHI has documented specific areas of improvement of the SBHCs by using outcome measures in two key areas: up-to-date documentation of immunization status and health insurance enrollment.

Random chart audits were performed at the SBHCs in order to determine documentation of immunization status of students based on the OPH Immunization Program schedule. The first audit was done in the fall, prior to initiation of outreach efforts to immunize children and update records. The second audit was performed at the end of the school year.

The results from the first audit showed an overall up-to-date documented immunization rate of 42%. However, due to the efforts of the SBHC staff, the second audit showed an overall increase to 80%. While to-date the results have been impressive, over the next year, ASHI's goal will be to improve the up-to-date immunization rate to over 90%.

One of the goals of the SBHCs is to ensure that all eligible students are insured through Medicaid or Louisiana's Children's Health Insurance Program (LaCHIP). Data was retrieved both at the beginning and end of the school year to ascertain the change in the insurance status of SBHC enrollees. As a result of the hard work of the SBHC staff over the course of the year, there were 326 fewer uninsured children enrolled in the SBHCs. Efforts to enroll eligible students in LaCHIP and Medicaid will be ongoing. Plans are underway to conduct a refresher course on LaCHIP enrollment for SBHC staff.

ASHI and the SBHCs are in the process of developing *Best Practices* for:

- Type 2 Diabetes Screening and Management for Students at risk
- Hypertension Screening
- Oral Health
- Obesity Evaluation and Management

For further information on the program, please contact Maureen Daly, MD, MPH, Medical and Program Director for the Louisiana Adolescent School Health Initiative Program at (504) 568-6068.

Strategic National Stockpile Preparedness in Louisiana

The Strategic National Stockpile Program (or SNS, formerly known as the National Pharmaceutical Stockpile or NPS) was funded by Congress in 1999 to create a system to deliver pharmaceuticals and other medical material to the site of a national emergency. Originally managed by the Centers of Disease Control and Prevention (CDC), this program was renamed and moved to the Office of Homeland Security in March, 2003 where both agencies now have administrative oversight.

In addition to supplying pharmaceuticals for varied programs such as TB, STD, Family Planning, Children's Special Health Services, Genetics and Hemophilia Programs, the Pharmacy for the Office of Public Health (OPH) is involved in the state's planning for delivering critically needed drugs and medical material in case of an emergency. Even though bioterrorism comes to mind first, this fast delivery system may also be utilized in the case of an industrial accident or a natural disaster.

The OPH Pharmacy has assembled a list of more than **eight hundred** pharmacists and pharmacy technicians throughout the State who have volunteered to help dispense medications or assist in a mass vaccination effort should the need arise.

There have been different delivery methods devised among the states. In a one-point method of delivery, a single city would be the recipient of any incoming medications and dispersal would take place from that point. Louisiana currently has a three-point delivery system. Dependent upon the location and size of the event, Louisiana has the capability to receive the Strategic National Stockpile in any of the nine OPH regions within the state. The surrounding regions would receive their portion of material at their designated Regional Point of Distribution. . The material would then be further distributed to local dispensing sites and treatment facilities (e.g. hospitals, clinics). These dispensing sites are located in each parish based on population density and demographics.

The Office of Public Health is currently exercising this delivery system and its overall response to a disaster through a series of tabletop exercises and full scale drills across the state. These exercises are being done in partnership with other emergency preparedness agencies and are designed to foster partnership and increase awareness. There will be more information about the Strategic National Stockpile and other Medical Awareness Courses available at the Regional HSRA meetings (See the article on 'Medical Awareness Announced' on page 3 of this issue.)

Difficulties in the Interpretation of West Nile Virus Test Results

Early warnings are best provided by birds, mosquitoes and horses. Human tests are not a very good early warning system. Already for this season, there has been several patients for whom West Nile Virus (WNV) tests were requested which yielded inconclusive results.

This year there are added expectations of difficulties with human testing for the following reasons:

- In Louisiana there are estimates of between 30,000-60,000 people positive for WNV from last year. Since 40% are still IgM positive in serologically from one year to the next, this will have to be taken into consideration when interpreting results for 2003.

- Physicians may request more WNV testing in their patients, even among those with unrelated clinical findings. Patients with upper respiratory tract infections or problems may exhibit similar symptoms e.g. fever. (When expanding testing to "low yield" patient groups, the predictive value of a positive test decreases tremendously.) More time and effort will need to be taken in interpreting tests results among atypical clinical patients during off season and otherwise low yield population. Convalescent serum may be requested.

- There may be discordant results between EIA (Enzyme Immuno Assay) and IFA (Indirect Fluorescent Antibody) tests. IFA in being a less specific test may contribute to the number of false negatives.

In last year's epidemic, the Office of Public Health (OPH) came forward with accounting of all the cases. In 2002, three cases were reported to the press which had inconclusive results. Follow up tests proved to be negative with explanations forthcoming as to the discrepancies. OPH will do the same this year. No information will ever be withheld BUT no inaccurate and unverified information will be relayed.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
Mar-Apr 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 Mar-Apr 2003	Mar-Apr 2002	Jan-Apr Cum 2003	Jan-Apr 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	1	1	1	1	1	2	2	0	4	13	20	33	36	-9.1
	Rate[1]	0.1	0.2	0.3	0.2	0.4	0.7	0.4	0.0	1.0	0.3	0.5	0.8	0.8	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	1	0	1	-100.0
Pertussis		0	0	0	0	0	0	0	0	0	0	3	4	4	0
Sexually-transmitted															
HIV/AIDS	Cases[2]	21	6	4	5	2	2	1	1	1	43	227	159	411	-158.5
	Rate[1]	2.1	1.0	1.0	0.9	0.7	0.7	0.2	0.3	0.2	1.0	5.2	3.6	9.4	na
Gonorrhea	Cases	375	272	64	159	63	72	345	132	78	1560	1871	3232	3697	-14.4
	Rate[1]	36.3	45	16.7	29	22.3	23.9	66	37.3	17.8	35	44.3	72.3	87.6	na
Syphilis (P&S)	Cases	1	7	0	3	2	0	5	0	2	20	23	32	44	-37.5
	Rate[1]	0.1	1.2	0.0	0.5	0.7	0.0	1.0	0.0	0.5	0.4	0.5	0.7	1.0	na
Enteric															
Campylobacter		2	0	1	1	0	1	0	2	0	7	12	22	29	-31.8
Hepatitis A	Cases	4	1	0	3	0	0	1	0	0	9	20	15	30	-100.0
	Rate[1]	0.4	0.2	0.0	0.6	0.0	0.0	0.2	0.0	0.0	0.2	0.5	0.3	0.7	na
Salmonella	Cases	3	8	3	10	1	2	0	1	6	34	106	84	171	-100.4
	Rate[1]	0.3	1.4	0.8	2.0	0.4	0.7	0.0	0.3	1.6	0.8	2.5	1.9	4.0	na
Shigella	Cases	20	7	1	8	0	5	1	0	1	43	59	101	111	-9.9
	Rate[1]	1.9	1.2	0.3	1.6	0.0	1.6	0.2	0.0	0.3	1.0	1.4	2.3	2.6	na
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vibrio, other		1	0	1	1	0	0	0	0	0	3	2	3	4	-33.4
Other															
H. influenzae (other)		0	3	0	0	1	0	0	0	0	4	1	8	2	400.0
N. Meningitidis		6	3	0	0	1	0	0	0	0	10	8	23	17	26.1
Tuberculosis		1	0	3	0	0	1	0	0	1	6	44	16	78	-387.5

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.

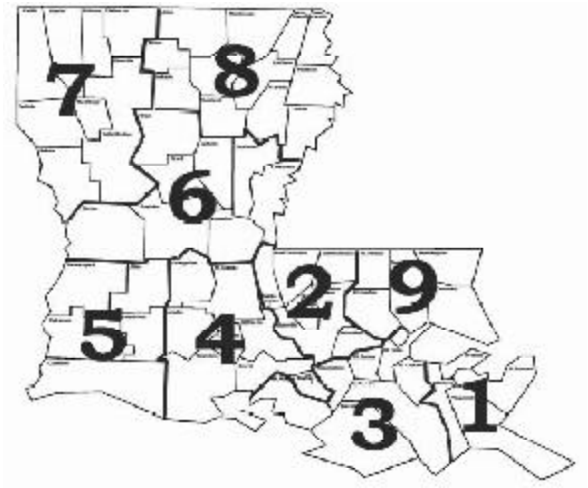
Table 2. Diseases of Low Frequency

Disease	Total to Date
Legionellosis	0
Lyme Disease	3
Malaria	1
Rabies, animal	0
SARS	0
Varicella	7

Table 3. Animal rabies (Mar-Apr)

Parish	No. Cases	Species

No rabies reported for this period



Videoconference Follow-up: Foodborne Terrorism

Annu Thomas, MSc MPH

Several questions were asked on Norwalk-type virus outbreaks during the well-attended "Foodborne Terrorism – The Role of OPH" videoconference of April 25, 2003. Noroviruses produce an estimated 30% to 40% of the cases of infectious diarrhea in the United States * where people gather in social, health-related, or recreational circumstances. Recent literature highlight the potential of Norovirus to cause large outbreaks in institutional settings through non-foodborne modes of transmission.** Outbreaks can result from the ingestion of contaminated drinking or swimming water, poorly cooked clams and oysters from contaminated waters and contaminated foods such as salads and cake frosting. These viruses cause explosive epidemics of diarrhea that can sweep through a community with a high attack rate, affecting all age groups. In the case of foodborne illness/ outbreaks, Norwalk-like virus (Norovirus) is taken into consideration when the predominant symptoms are most often **vomiting** with **acute diarrhea** (defined as an illness of less than two weeks in duration).

Characteristics of Norovirus include a low infectious dose, relative stability in the environment, and spreading through multiple modes of transmission, which make Norovirus outbreaks difficult to control. Measures to prevent spread should include emphasizing basic food and water sanitation measures and encouraging good hygiene, particularly appropriate hand washing techniques, disposal of waste and soiled materials, and dis-infection.

CaliciNet is a database system under development by the CDC that collects molecular and epidemiologic data from outbreaks of norovirus throughout the United States.*** This improved surveillance system is needed to understand modes of transmission and identify more specific control measures and will be employed within the state to monitor endemic and epidemic norovirus disease.

Norovirus cannot be cultivated in the laboratory. The diagnosis can be established only by identifying viral antigen in the stool by immune electron microscopy. A monoclonal antibody-based enzyme linked immunoabsorbent assay (ELISA) and a real time polymerase chain reaction (PCR) assay has been developed that can detect Norwalk virus in stool specimens, but these are not yet commercially available. The Louisiana State Central Laboratory is looking forward to commencing norovirus testing, engaging the PCR assay by the beginning of the next fiscal year (July 2003).

For additional information please refer to the following:

CDC. Outbreaks of gastroenteritis associated with noroviruses on cruise ships-United States, 2002. MMWR 2002;51:1112—5.

CDC. Guideline for hand hygiene in health-care settings: recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16).

Centers for Disease Control and Prevention. www.cdc.gov

Center for Food Safety and Applied Nutrition. www.cfsan.fda.gov

*Centers for Disease Control and Prevention (CDC)

** J Infect Dis 1998;178:1571—8

*** CDC, unpublished data, 2002

Bioterrorism Surveillance

"Syndromic Surveillance in Louisiana" was presented by Gary Balsemo, DVM, MPH & TM and Stacy Hall, RNC MSN at a three day workshop in Miami, Florida April 28-30, 2003. The workshop, "Advancements in Surveillance and Epidemiology for Bioterrorism" sponsored by the Centers for Disease Control (CDC), provided states with the opportunity to discuss epidemiologic, surveillance and response activities. Our attendees were able to present an overview of Louisiana's telephone-based sentinel physician/facility surveillance, the coroner and dermatologic outreach activities and the web-based emergency medical services, emergency department and veterinary syndromic surveillance systems to other states and territories represented at the workshop.

Some points from this session:

· There is essentially no impact of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule on the workings of the Office of Public Health. OPH directives would supercede any federal or regulation for privacy as a delivery of service for the public good.

· The CDC is stressing the development of surveillance analysis for data coming in from the states and territories. CDC's "Early Aberration Reporting System" (EARS) was demonstrated and may positively impact programs related to Louisiana's current data-collection systems, the "Reportable Disease Database" (RDD) and Emergency Medical Services (EMS). Use of the CDC's "Advanced Laboratory-Epidemiology Response and Tracking" (ALERT) system, a hand-held, web-based portable application for the immediate implementation of syndromic surveillance and enhanced tracking of cases, will be investigated in the near future.

· There may be further examination into the advantages that having a State Medical Examiner affords for the coordination of Coroner surveillance outside of Louisiana. (Louisiana currently operates by 64 independent coroner offices.) In addition there was a discussion of the enhancement of a laboratory information and services network for coroner use.

For more information on the above topics call (504) 568-5005 x 110 or 128.

Louisiana Fact

Coincidental with the conclusion of World War I was the great influenza epidemic during the autumn of 1918……The number of influenza cases reported in Louisiana between September 29, 1918 and March 1, 1919 reached 244,857 with a mortality rate of 2.2 %. In New Orleans 11% of the population was stricken, and in the state, 10%…… The State Board of Health acted shortly after the epidemic became serious by banning public meetings…..Restrictions on public gatherings were ended in November, although cases of influenza reported in Louisiana averaged several thousand per week during the next three months.Source:

Source: The Progressive Years, by Gordon E. Gillson p264

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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