



Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
P.O. Box 60630, New Orleans, LA 70160 (504) 568-5005
www.oph.dhh.state.la.us/infectiousdisease/index.html



Kathleen Babin eaux Blanco
GOVERNOR

Frederick P. Cerise, M.D., M.P.H.
Secretary

May-June 2004

Volume 15 Number 3

A Case Study: Difficulties in Diagnosing Cyclosporiasis

Nevin Krishna, MPH; Jeff Davis, BS

A conference held February 6-8, 2004 in Irving, Texas was attended by approximately forty persons from fifteen states and the District of Columbia. One week after the conference, at least seventeen attendees developed gastrointestinal symptoms. On March 4th, CDC confirmed the diagnosis of *Cyclospora* infection by examining the stool specimen from the index-case patient. An epidemiologic investigation was initiated. Currently there is no more information on non-Louisiana resident cases.

February 12th, one of the conference attendees from Louisiana developed fever (102°F), nausea, vomiting and diarrhea. He was hospitalized from February 16-28, because of severe symptoms. Cyclosporiasis was considered, but rejected based on a negative laboratory test. The patient was later readmitted from February 29 - March 2, because of severe cellulitis. A stool sample was requested as part of the investigation. This late sample from March 5th was positive for *Cyclospora*.

Epidemiology

Various types of fresh produce have been implicated in investigations of previous outbreaks of cyclosporiasis. Infection occurs after the host ingests oocysts which are the result of fecal contamination. The source of oocysts may be human or animal. (The oocysts excreted by humans are not infectious. However, if food contaminated with human waste is allowed to fester, the oocysts can mature into an infectious form.) Several animals (poultry, duck, non-human primates) harbor *Cyclospora*, but their role has not yet

been determined.

Cyclospora requires time outside the host for sporulation to occur; thus human to human transmission is not likely. The time required in nature for sporulation to occur is not yet known but sporulation takes about two weeks under laboratory conditions. The average **incubation period** for cyclosporiasis is one week, however, in some outbreaks it has been as short as 24 hours. There are no community-based studies to determine the prevalence of cyclosporiasis in endemic countries. Surveys of laboratory stool specimens in the US show a low prevalence: 0.5% of specimens examined. Travelers infected with *Cyclospora* have shown untreated water to be a risk factor.

Waterborne outbreaks are frequent. *Cyclospora* are highly resistant to chlorine disinfection. The first outbreak described in the USA was linked to tap water in a physicians' dormitory in 1990. In 1992 an outbreak in a British military detachment in Nepal was recorded. *Cyclospora* oocysts were found in the water supply which was a mixture of river and municipal water that had acceptable residual concentration of chlorine.

Foodborne outbreaks in the past were linked to raspberries, mesclun lettuce and basil.

Currently, there is no information on the source of the outbreak in Irving, Texas.

Clinical picture

Cyclospora is an intracellular parasite in the enterocytes of the upper small bowel. There are some inflammatory changes, villous atrophy and crypt hyperplasia in the jejunal tissue of infected individuals. Patients have diarrhea, abdominal cramps, nausea, fatigue, loss of appetite and eventual weight loss. The diarrhea is watery without blood or inflammatory cells and often follows a cyclical pattern. Vomiting and fever are uncommon. The infection is self limited. In patients who are not treated with trimethoprim-sulfamethoxazole, illness can be protracted, lasting for a few weeks with remitting and relapsing symptoms. In some of these cases, fatigue and weight loss may occur. Some individuals have contracted the infection more than once after a few months, therefore acquired immunity is not totally protective. In immuno-compromised individuals, the infection is severe with a high recurrence rate.

Diagnosis

The diagnosis is based on the demonstration of oocysts in the stools, duodenal, jejunal aspirates, or biopsy specimens. The microorganisms are detected on the microscopic examination of a wet (Continued on next page)

Content

A Case Study: Difficulties in Diagnosing Cyclosporiasis.....	1
Antimicrobial Resistance Update & SNS Distribution Information.....	2
The Pelican Project - On the Right Track for a Right Start - HIV/AIDS Program Perinatal HIV Reduction Initiative.....	2
All Kids Need To Be Buckled-Up - Do It Right!.....	4
Cutaneous Anthrax or Orf	4
LA - One of Four States to Earn the Green Light	5
Asthma Prevalence in Louisiana.....	5
Funding	6
Hydrotherapy Pools - A Source of Infection?	6
OPH Training Offerings - Videoconference Courses	6

A Case Study: Difficulties in Diagnosing Cyclosporiasis (Cont)

mount of fresh stools. Health-care providers should consider the diagnosis of *Cyclospora* infection in persons with prolonged diarrheal illness and specifically request testing of stool specimens for this parasite.

Treatment

The drug of choice is trimethoprim-sulfamethoxazole (160/800 mg) bid for seven days. In immuno-compromised patients a dose of 160/800 mg qid for ten days is recommended. Most standard treatment of gastroenteritis agents are ineffective: quinolones, quina-crine, tinidazole, metronidazole, macrolides.

Prevention

Surveillance: Cases of *Cyclospora* infection unrelated to travel outside of the United States or Canada may be associated with a new outbreak. Newly identified clusters should be investigated to identify the vehicles of infection and to identify the sources and modes of contamination of the implicated vehicles. In June 1998, the Council of State and Territorial Epidemiologists passed a resolution recommending that cyclosporiasis be made a nationally notifiable disease in the United States; cyclosporiasis is a reportable condition in Louisiana.

Avoid food contamination: Fruits and vegetables should be washed thoroughly before eaten. This practice, however, does not eliminate the risk for transmission of *Cyclospora*.

Food handlers: Food workers should be particularly meticulous about hand-washing.

Public waters: To reduce the risk for *Cyclospora* contamination of fountains and pools, the following measures may be useful: showering before entering the fountains and pools, excluding persons with diarrhea or incontinence, excluding children wearing diapers. For recreational water facilities designed for human use, improved filtration may reduce risk as well as restricting food consumption in the fountain/pool area. Exclusion of persons from decorative water displays not designed for interactive use should be instituted and enforced.

Antimicrobial Resistance Update & Strategic National Stockpile Distribution Information



Debbie Mills



Dr. B.J. Foch



Ken Boudreaux

On April 13, 2004, the Region 5 Office of Public Health (OPH) in conjunction with GlaxoSmithKlein Pharmaceuticals presented speakers Debbie Mills, RPh, Tri-Regional Pharmacist Louisiana D.H.H.OPH, Kenneth W. Boudreaux, MS, RPh, Pharmacy Clinical Manager Rapides Regional Medical Center and B.J. Foch, MD, FAAP, Medical Director and Regional Administrator Region 5 OPH to interested pharmacists and clinical personnel in the Lake Charles area.

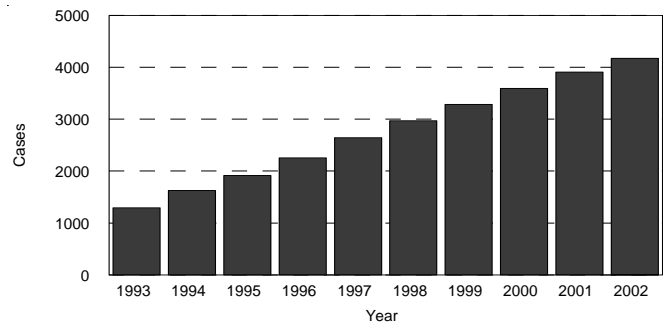
The Pelican Project-

On the Right Track for a Right Start - The HIV/AIDS Program Perinatal HIV Reduction Initiative

Cheryl Wheeler, MPH; Maya Wyche MPH; Jennifer McKeever, MSW; Tia Zeno, MPH, William Robinson, PhD.

Louisiana is experiencing a growing number of persons living with HIV, with women making up an increasing number of this population. The number of women living with HIV in this state has grown from 1295 cases in 1993 to 4190 cases in 2002. (Figure 1).

Figure 1: Proportion of HIV/AIDS Cases in Women by Year of Detection Louisiana, 1993-2002



Since perinatal HIV reporting began in Louisiana in 1993, over 1400 babies have been born to HIV infected women. It is encouraging to note that since antiretroviral (ARV) therapy was found to be highly effective in reducing mother to child HIV transmission, the rates of perinatal transmission have decreased from 26% in 1993 to approximately 5% in 2002 (Figure 2).

Much work remains, however, to achieve even lower rates of transmission that are possible when women with HIV and their infants receive optimal care. One of the goals of the HIV/AIDS Program (HAP) is to move toward complete elimination of HIV transmission from mothers to babies in Louisiana. The aim of HAP's perinatal HIV prevention efforts is to impact the chain of events that lead

Louisiana Morbidity Report

Volume 15 Number 3

May-June 2004

The Louisiana Morbidity Report is published bimonthly by the Infectious Disease Epidemiology Section of the Louisiana Office of Public Health to inform physicians, nurses, and public health professionals about disease trends and patterns in Louisiana. Address correspondence to Louisiana Morbidity Report, Infectious Disease Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.

Assistant Secretary, OPH

Sharon Howard, MSW

State Epidemiologist

Raoult Ratard, MD MPH

Editors

Susanne Straif-Bourgeois, PhD MPH

Theresa Sokol, MPH

Rosemarie Robertson, BS MT(C) CNMT

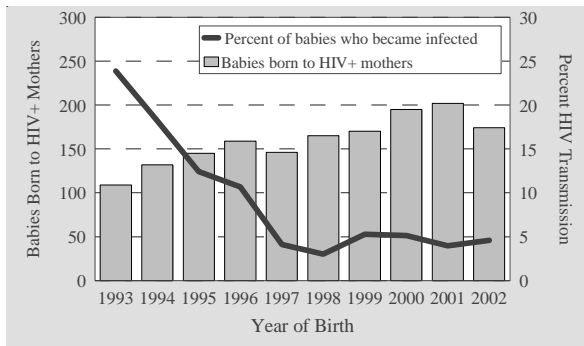
Layout & Design

Ethel Davis, CST

to an HIV-infected child. We aspire to reduce the proportion of women:

- who are HIV-infected
- who unintentionally become pregnant
- who do not seek prenatal care
- who are not offered or who refuse HIV testing
- who are not offered ARV therapy
- who refuse ARV therapy
- who do not complete ARV therapy
- whose child becomes infected despite treatment

Figure 2: Babies Born to HIV+ Mothers & Perinatal Transmission Rates, Louisiana, 1993-2002



HAP Program Efforts

In 2000, HAP began a perinatal working group designed to develop cross-collaborative efforts between the HIV/AIDS Prevention, Services and Surveillance Programs. Out of this working group and in conjunction with funding from the Centers for Disease Control and Prevention (CDC), the following initiatives were instituted: to monitor the epidemic; to promote national recommendations for counseling and testing of all pregnant women and adoption of protocols to prevent perinatal HIV transmission; to enhance linkages to services.

- Enhanced Perinatal Surveillance

In order to monitor rates and trends of mother-to-child transmission of HIV, the HIV/AIDS Surveillance program conducts an intensive review of the medical records of women with HIV delivering in Louisiana and their live born infants. Data are gathered regarding the quantity and quality of a mother's prenatal care, ARV use in pregnancy and labor and delivery, prophylactic therapies in newborns and other factors associated with transmission. Follow-up reviews of medical records of all HIV-exposed babies are conducted semi-annually until a definitive serostatus is ascertained. These data are used to analyze trends in perinatal transmission and to identify specific interventions to break the chain of events that lead to a baby being infected with HIV.

- Perinatal Fast Track

Derived from the CDC's Partner Counseling and Referral mandate, the objective of this innovative program is to quickly identify positive pregnant women who may not be receiving medical care and supportive services and promote linkages to care. Positive pregnant women are identified through routine surveillance activities, counseling and testing and case management. Once a positive pregnant woman is identified, steps are taken to determine whether she is receiving medical care or supportive services. For women not known to be in care, the Partner Counseling and Referral Program's

Disease Intervention Specialists (DIS) are promptly notified in order to locate the patient and facilitate referral to services. Since the initiative's inception in October 2002, thirty-four mothers have been identified through Fast Track, resulting in twelve who were contacted by DIS for assistance with accessing medical and support services.

- Medical Center Outreach/Rapid Testing Implementation

This program targets the major delivery centers within Louisiana to develop policies on the counseling and testing of all pregnant women and the implementation of rapid testing protocols for women who present for delivery without documented prenatal care or HIV test results during their current pregnancy. The HAP Perinatal Prevention program coordinator and medical consultant visit medical centers throughout the state to confer with medical providers and other personnel to address and help overcome barriers to effective perinatal prevention efforts.

- Clinician Education

Through mailings and encounters with HAP Surveillance and Prevention staff, educational materials are distributed to clinicians statewide to promote the national screening and treatment recommendations. Moreover, clinicians and nurses are offered the opportunity to enhance their patient care skills by participation in a HAP-sponsored clinical preceptorship offered by the Delta Region AIDS Education Training Center. Individual in-service or grand rounds are available to clinicians throughout the state through the HAP Perinatal Prevention Coordinator.

- Perinatal Care Network

The network primarily consists of the Ryan White Title II agencies throughout the state that provide supportive services for people living with HIV. As a part of efforts to reduce perinatal transmission, HAP has worked to enhance HIV Case Managers' skills and abilities to facilitate access to and retention in medical and supportive services for women living with HIV. Standards of Care for the provision of case management to HIV-positive women of childbearing age, pregnant women and women with children, were developed in 2001 and are updated annually. The protocol emphasizes the vital role that case managers can play through their work with women living with HIV/AIDS, in the effort to reduce perinatal HIV transmission in Louisiana.

Case Management agencies are contractually obligated to adhere to the protocol and Case Managers are provided with two trainings annually that address issues specific to women living with HIV, including overcoming barriers to care, coordinating support services, adhering to the protocol and increasing access to retroviral therapy for women and infants.

- Future Project Goals

Although remarkable steps have been made toward the reduction of perinatal HIV transmission in Louisiana, areas for improvement persist. Efforts are underway to promote universal screening of all pregnant women as advised by the CDC. Private facilities with high rates of perinatal exposure will also be targeted for this intervention. The Pelican Project and the working group will continue to assess areas of missed opportunities for intervention with babies who do become infected to ascertain any gaps in services.

For further information regarding Perinatal HIV Prevention initiatives, please contact the HIV/AIDS Program at (504) 568-7474.

All Kids Need To Be Buckled-Up—Do It Right!

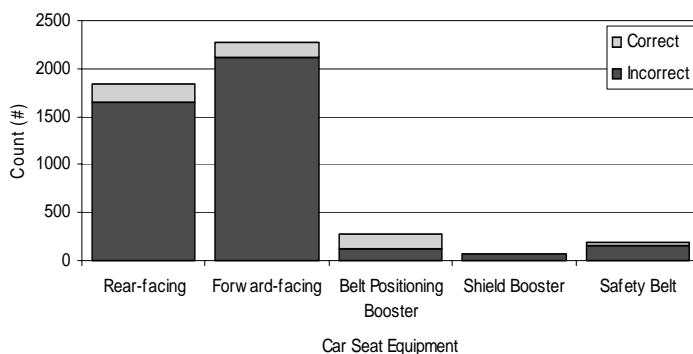
Kerry Chausmer, LCSW, MPH, CHES

Motor vehicle crashes are the leading cause of unintentional injury death for all children less than fifteen years of age in Louisiana and account for over forty percent of the total number of unintentional child injury deaths in the state. The majority of motor vehicle deaths result from fatal head injuries, especially among the youngest children. Injuries from motor vehicle crashes result in the largest number of years of life lost before age sixty-five and cost more than any other childhood injury. Severe and serious non-fatal injuries, primarily brain and spinal cord injuries and facial disfigurement, have devastating effects on the child, the family, the community and society as a whole.

Correctly installed and used child safety seats reduce the risk of death by 71% for infants, by 54% for toddlers and reduce the need for hospitalization by 69% for children ages four and under. All kids should ride properly buckled up in the back seat for every ride **without exception**.

Although non-use is a major issue, misuse is also a serious threat. Specially trained certified Child Passenger Safety Technicians across our state have participated in check-up events in the past five years and found that 92% of all rear and forward facing child safety seats checked were misused. (Figure 1).

Figure 1: Installation of Checked Child Restraint Seats Louisiana, 1998-2003, N=4658



For information on Louisiana check up events or how to properly secure your child in their safety seat and buckle it in, contact us at safekids@chnola.org or (504) 568-2508.

Cutaneous Anthrax Or Orf: The Reporting System For Bioterrorism Is Working

Stacy Hall MSN; Theresa Sokol, MPH

In early March 2004, a physician called the Louisiana Office of Public Health (LOPH) to report suspected anthrax in a male patient. The patient had developed a lesion on the fifth digit of the left hand

which had started as a papule approximately two weeks earlier. The papule became a vesicle and the center formed an eschar. The lesion measured one centimeter (cm). The patient was treated with ciprofloxacin 1000 mg. One week into the treatment, small brownish ulcers of about three to five mm appeared on the same finger. The patient felt well and was afebrile. No other family members had any other lesions or diseases.

The patient had been helping his wife take care of sheep. There was a livestock show during the first week of February in which the sheep had participated. The patient, in sheering some sheep, noticed that one sheep had a lesion on the neck. The sick sheep was taken to a veterinary clinic where the neck abscess was lanced.

The reporting physician was advised by the LOPH Infectious Disease Epidemiology Section (IDES) to: 1) collect a punch biopsy at the active border of the lesion(s) - at least one on the main lesion and one on the smaller lesions, 2) request a culture for anthrax and a pathologic exam and 3) take contact precautions and recommend them to the patient and his family. The specimens were sent to the LOPH laboratory, which was alerted to carry out anthrax and orthopox testing on the samples.

The IDES immediately contacted the Department of Agriculture State Veterinarian to report the suspected case and to request help in examining the sheep. CDC and Homeland Security became involved as sheep pox is on the list of possible Bioterrorism agents. The Department of Agriculture sent a foreign animal disease veterinarian to examine the sheep which appeared to be normal. The specimens were negative for anthrax and orthopox by PCR at the LOPH Laboratory. The negative results were confirmed by the Poxvirus Branch at CDC. Staff from the IDES, the State Veterinarian's office and the foreign animal disease veterinarian visited the farm where the sheep were kept and bled them for serologic testing for Orf.

Currently the patient has a healed one cm primary lesion on the little finger and numerous smaller healed lesions. The physical appearance of the primary healed lesion is consistent with the appearance of an orf lesion.

Orf (or CONTAGIOUS ECTHYMA or Sore Mouth)

Contagious ecthyma (CE), also known as sore mouth or Orf, is an acute infectious disease in sheep. It occurs worldwide, wherever sheep are raised. In 1932, Orf was first reported as an infectious disease in humans, both in the United States and in Europe.

Contagious ecthyma is caused by parapoxvirus, a member of the poxvirus group. Parapoxvirus is a member of the family Poxviridae, which contains double-stranded DNA viruses known to be the largest viruses. Although immunologically distinct from vaccinia, the virus is antigenically similar to goat pox virus and pseudo-cowpox virus, but not to sheep pox virus. The virus can survive for very long periods in scabs of infected sheep. Live virus has been found in dried scabs up to twelve years after they have been shed. These shed scabs drop into the sheep bedding and the environment. This may become a source of infection for sheep many months later.

About two to three days after exposure to the virus, the lesions progress from vesicles to pustules and finally, thick scabs on

the lips, nostrils, face, eyelids, teats, udders, feet and occasionally inside the mouth. The scabs last from one to two weeks. Most animals will have only a mild weight loss because of unwillingness to eat from the painful condition of their mouths. Young lambs and kids are more at risk to serious consequences.

The disease can look like sheep-pox or *Staphylococcus* dermatitis. There is no effective treatment that would kill the virus. The disease will clear up in one to four weeks without treatment if the infected animals are kept clean. There is a live vaccine that causes the disease in a location on the body where little or no damage is done.

In humans, the virus is spread by direct contact with mucus membranes of infected animals or material contaminated by infected animals including shears, feeding areas, trucks, or clothing.

After an incubation period of five to six days, a small, firm, red or reddish-blue lump enlarges to form a flat-topped, blood-tinged pustule or blister. The fully developed lesion is usually two to five cm in diameter. Characteristically, although there appears to be pus under the white skin, incising this will reveal firm, red tissue underneath. The Orf lesion is sometimes irritable during the early stages and is often tender. Orf lesions are generally solitary or few in number. They occur most commonly on the fingers, hands or forearms but can appear on the face. Red streaks up the lymph channels with enlargement of the lymph glands on the inner side of the elbow and/or under the arm may be seen. There may be a mild fever. In most cases, no specific treatment is necessary. The lesion may be covered to prevent contaminating the environment or other people, although person-to-person spread is very uncommon. Large lesions can be removed by shave excision.

The infective virus enters through small cuts or abrasions. People handling infected sheep should wear rubber or plastic gloves. Thoroughly wash exposed skin areas and then apply a skin antiseptic such as 70% isopropyl alcohol.

Asthma Prevalence in Louisiana

The Centers of Disease Control and Prevention (CDC) analyzed data for 2002 from the Behavioral Risk Factor Surveillance System (BRFSS) concerning self-reported prevalence of asthma by race/ethnicity for the fifty states, the District of Columbia and three territories (Guam, Puerto Rico and the U.S. Virgin Islands). Among the estimated sixteen million (7.5%) U.S. adults with asthma, prevalence among minority populations ranged from 3.1% to 14.5% compared with 7.6% among whites. This survey did not measure asthma prevalence among institutionalized adults, military personnel, persons under the age of eighteen years or residents without telephones.

Two questions were asked concerning 'Lifetime' and 'Current' asthma. The first question 'Have you ever been told by a doctor, nurse or other health professional that you have asthma?' - 'lifetime' had a total of 240,422 responding within the states/territories. The percentage answering 'yes' in the fifty states/territories was 11.8% (11.6-12.0 95% CI). The number responding from Louisiana was 5,030 with a percentage answering 'yes' at 10.4% (9.4-11.5). Only five states had a lower percentage. The highest state/territory was Puerto Rico (19.6%) and the lowest was South Dakota (8.6%).

The second question, 'Do you still have asthma?' - 'current asthma' was asked to 239,779 respondents in the states/territories. The overall percentage answering 'yes' from these was 7.5% (7.3-7.7 95% CI). Louisiana had 5,015 respondents with 6% of these answering 'yes' (5.3-6.8). Only four states/territories reported a lower percentage. The highest being Puerto Rico (11.5%) and the lowest was The U.S. Virgin Islands (4.7%).

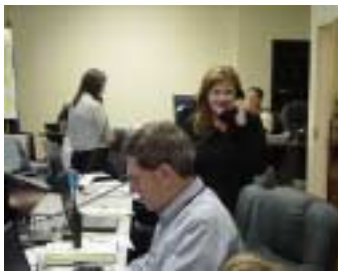
LA - One of Four States to Earn the Green Light

On March 15-19, 2004, the Shreveport area hosted a Bioterrorism Training Exercise and Demonstration Drill (TED) to ascertain readiness to receive supplies from the Strategic National Stockpile (SNS). One of the duties of the SNS is to deliver critically needed drugs and medical material in case of an emergency such as bioterrorism, an industrial accident or natural disaster. (See LMR May-June 2003).

Three color levels (yellow, red and green) were created to give feedback to the states undergoing the training. The duties rated include response time for identifying clinical symptoms in hospital Emergency Rooms, providing potential treatment and deploying pharmaceuticals quickly to distribution points for the state. Louisiana qualified for the green level indicating that the state is ready to respond to emergencies including a case of Infectious Disease Bioterrorism.



Dr. Marilyn Reynaud (2nd from L) acting as a patient waiting to receive medication



Dr. Martha Whyte and Knox Andress, RN working at the Bossier EOC



Medication supplies at one dispensing clinic



Patients outside the dispensing clinic

Funding

Julyana Cheng, MHA

The Infectious Disease Epidemiology (IDES) Section receives two federal grant funds and four state funds to staff epidemiologists and support staff in both the central office and in the nine regions of Louisiana for the state fiscal year 04 (July 1, 2003 – June 30, 2004).

Two federal grant funds were awarded by Centers for Disease Control and Prevention (CDC). The Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) grant was awarded to assist the State of Louisiana to improve surveillance for, as well as to respond to, infectious disease controls. It funds one Epidemiologist Manager, six Epidemiologists, two Lab Scientists, four students and three Information Technology positions for seven components: Emerging Pathogens, Antimicrobial Resistance, Foodborne Diseases, Hepatitis C Prevention and Control, Influenza Surveillance and Response, West Nile Virus, and National Electronic Diseases Surveillance System (NEDDS).

The second federal grant fund is the Public Health Preparedness and Response for Bioterrorism (BT): Surveillance and Epidemiology Capacity. This grant provides funding for personnel which includes nine regional Disease Surveillance Specialists, nine regional Hospital Nurse Coordinators, one BT Coordinator, one Epidemiologist and two support positions. As for state funds, the Epidemiology Surveillance and Laboratory Service fund supports our State Epidemiologist, Public Health Veterinarian and one support position for infectious diseases surveillance. The Rabies Control fund supports testing in the Office of Public Health Laboratory. The Bioterrorism Response Fund provides three support positions for state BT events preparedness.

The Infectious Disease Epidemiology Fund supports one program manager, two Epidemiologist Supervisors, one Public Health Nurse, one Educational Training Specialist and one support position for studying the distribution and determinants of infectious diseases in the community, conducting infectious disease outbreak investigations, instituting disease control measures and coordinating programs that prevent the spread of communicable diseases.

CDC Site Visit for Bioterrorism Grant on April 8th in Baton Rouge



From left to right: Sabrina Perkins, Dr. Stephen Martin, Kathleen Golden, Lee Smith, Melissa Walker, Phil McCrory, Jerry Monier, Dr. Gary Peck, Dr. Henry Bradford, Melanie King w/CDC, Stacy Hall, Sherrie Bruce w/ CDC, Janet Merritt, Locke Thompson w/ CDC, Nancy Bourgeois, Charles Mayeux

Hydrotherapy Pools -A Source of Infection?

Hydrotherapy has become popular with many hospitals leading to the installation of pools as part of the physiotherapy facilities. The terms spa pool, spa bath, whirlpool and hot tub are sometimes used in connection with hydrotherapy. New worries concerning MRSA and VRE have prompted questions to the Infectious Disease Epidemiology Section of the State of Louisiana.

Despite careful control of water quality, users of hydrotherapy pools sometimes suffer from pool-related skin, ear, chest and gastrointestinal infections. The microorganisms implicated include *Pseudomonas aeruginosa*, *Stenotrophomonas*, atypical mycobacterias, *Legionella* spp., adenoviruses, enteroviruses and fungi. Legionnaires' disease has been associated with whirlpool spas, where agitation and aeration of the water enable bacteria to be inhaled.

Water is not sterile. (This includes drinking water.) With the immersion of hospitalized patients comes the chance for contamination of the tub environment, including the tub water, drains, agitators, floors and walls. Pools should be cleaned, disinfected and have some water replaced regularly. Recommendations for chemical treatment and water temperatures can be found in 'Guidelines for Environmental Infection Control in Health-Care Facilities' <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm>

OPH Training Offerings -

The course offerings listed are free of charge but must be registered for as seating is limited in some locations. For site information, a registration form and agenda please email Louise Bellazer at lbellaz@dhh.la.gov or call (504) 568-5005 x102.

VIDEOCONFERENCE COURSE

"Bugs Are Us" –An Update on Vectorborne Disease Epidemiology in Louisiana

The OPH Infectious Disease Epidemiology Section is offering a videoconference focusing on Vectorborne Diseases. This videoconference is targeted towards public health nurses, physicians, veterinarians, infection control professionals, disease surveillance specialists, epidemiologists, sanitarians, health care providers and other public health staff. It will be accessible at nine sites throughout Louisiana on June 24, 2004 from 9:00 A.M. to Noon. Applications have been entered for Veterinary, Laboratory, Sanitarian, Nursing and Medical Continuing Education Units.

NOTE THESE DATES:

September 22, 2004 9AM-Noon "Is It Safe to Breathe?" Airborne Disease Epidemiology Videoconference

October 12, 2004 Field Epidemiology Techniques I – Full Day In House Training

October 13, 2004 Field Epidemiology Techniques II – Full Day In House Training

November 10, 2004 9AM-Noon Antibiotic Resistance Update Videoconference

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

MARCH - APRIL 2004

PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD					
	1	2	3	4	5	6	7	8	9	Mar-Apr 2004	Mar-Apr 2003	Jan-Apr Cum 2004	Jan-Apr Cum 2003	% Chg	
Vaccine-preventable															
Hepatitis B	Cases	1.0	3	0	1	1	0	1	0	1.0	8	31	24	52	-53.8%
	Rate ¹	0.1	0.5	0.0	0.2	0.4	0.0	0.2	0.0	0.2	0.2	0.7	0.6	1.2	na
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	na
Mumps		0	0	0	0	0	0	0	0	0	0	3	0	0	na
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	na
Pertussis		0	0	0	0	0	0	0	0	0	0	2	4	0	na
Sexually-transmitted															
HIV/AIDS	Cases ²	41	18	5	8	10	5	12	5	3	107	189	233	368	-36.7%
	Rate ¹	4.1	3.1	1.3	1.5	3.6	1.7	2.4	1.4	0.7	2.4	4.3	5.3	8.4	na
Gonorrhea	Cases ³	609	539	117	215	46	74	339	148	76	2163	1560	3754	3697	1.5%
	Rate ¹	58.9	89.3	30.5	39.2	16.2	24.5	64.9	41.8	17.3	50.1	35.0	84	87.6	na
Syphilis (P&S)	Cases ³	11	10	3	11	1	1	2	2	5	46	20	75	44	70.5%
	Rate ¹	1.1	1.6	0.7	0	0.3	0.3	0.4	0.5	1.1	1.1	0.4	1.7	1.0	na
Enteric															
Campylobacter		6	4	0	0	1	1	0	3	4	19	18	29	35	-17.10%
Hepatitis A	Cases	1	0	0	0	0	0	2	0	0	3	14	9	18	na
	Rate ¹	0.1	0.0	0.0	0.0	0.0	0.0	0.4	0.0	0.0	1.4	2.0	2.4	3.5	na
Salmonella	Cases	13	14	4	13	0	5	3	5	5	62	86	104	153	-32.0%
	Rate ¹	1.3	2.3	1.0	2.4	0.0	1.7	0.6	1.4	1.1	1.4	2.0	2.4	3.5	na
Shigella	Cases	4	0	0	4	0	20	12	4	0	44	79	81	172	-53.0%
	Rate ¹	0.4	0.0	0.0	0.7	0.0	6.6	2.3	1.1	0.0	1.0	1.8	1.9	4.0	na
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	na
Vibrio, other		0	0	1	1	0	0	0	0	2	4	6	4	7	na
Other															
<i>H. influenzae (other)</i>		0	1	0	0	1	0	0	0	0	2	5	6	11	na
<i>N. Meningitidis</i>		1	2	0	0	0	1	0	0	1	5	11	15	27	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.

3 = Data should be considered provisional due to minimum delays in the reporting process.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Legionellosis	1
Lyme Disease	0
Malaria	2
Rabies, animal	1
Varicella	32

Table 3. Animal rabies (Jan-Apr)

Parish	No. Cases	Species
Caldcasieu	1	Dog



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

2:003 The following diseases/conditions 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	Neisseria meningitidis (invasive disease)	Smallpox
Botulism	Plague	Staphylococcus Aureus,
Brucellosis	Poliomyelitis, paralytic	Vancomycin Resistant
Cholera	Q Fever	Tularemia
Diphtheria	Rabies (animal & man)	Viral Hemorrhagic Fever
Haemophilus influenzae (invasive disease)	Rubella (German measles)	Yellow 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.

Aseptic meningitis	Hepatitis B (carriage)	Salmonellosis
Chancroid ¹	Hepatitis B (perinatal infection)	Shigellosis
E. Coli 0157:H7	Hepatitis E	Syphilis ¹
E. Coli Enterohemorrhagic (other)	Herpes (neonatal)	Tetanus
Encephalitis, Arthropod borne	Legionellosis (acute disease)	Tuberculosis ²
Hantavirus Pulmonary Syndrome	Malaria	Typhoid Fever
Hemolytic-Uremic Syndrome	Mumps	
Hepatitis A (acute disease)	Pertussis	

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

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

Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis C (acute and infection)	Streptococcal Toxic Shock Syndrome
Blastomycosis	Human Immunodeficiency Virus (HIV infection)	Streptococcus Pneumoniae (invasive infection, penicillin resistant (DRSP))
Campylobacteriosis	Listeria	Streptococcus Pneumoniae (invasive infection in children < 5 years of age)
Chlamydial infection ¹	Lyme Disease	Trichinosis
Coccidioidomycosis	Lymphogranuloma Venereum ¹	Varicella (chickenpox)
Cryptosporidiosis	Psittacosis	Vibrio Infections (other than cholera)
Cyclosporiasis	Rocky Mountain Spotted Fever (RMSF)	West Nile Fever
Dengue	Staphylococcus Aureus, Methicillin/Oxacillin Resistant (MRSA) (invasive disease)	West Nile Infection (past or present)
Ehrlichiosis Hansen's Disease (leprosy)	Staphylococcal Toxic Shock Syndrome	
Enterococcus, Vancomycin Resistant (VRE) (invasive disease)	Streptococcal disease, Group A disease)	
Giardia	Streptococcal disease, Group B (invasive disease)	
Gonorrhea ¹		
Hansen's Disease (leprosy)		
Hepatitis B (acute)		

Other Reportable Conditions

Cancer	Phenylketonuria*	Spinal Cord Injury**
Complications of Abortion	Reye's Syndrome	Sudden Infant Death Syndrome (SIDS)
Congenital Hypothyroidism*	Severe Traumatic Head Injury**	
Galactosemia*	Severe Undernutrition (severe anemia, failure to thrive)	
Hemophilia*	Sickle Cell Disease (newborns)*	
Lead Poisoning		

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, phone reports, or web base at <https://ophrdd.dhh.state.la.us>.

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

²Report on CDC72.5 (f.5.2431) card.

*Report to the Louisiana Genetic Diseases Program Office by telephone (504) 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.

This public health document was published at a total cost of . Seven thousand copies of this public document were published in this first printing at a cost of . The total cost of all printings of this document, including reprints is . This document was published by to inform physicians, hospitals, and the public of current Louisiana morbidity status under authority of R.S. 40:36. This material was printed in accordance with the standards for printing for state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with the provisions of Title 43 of Louisiana Revised Statutes.

**DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
P.O. BOX 60630 NEW ORLEANS LA 70160**

**PRSRSTD
U.S. POSTAGE
PAID
Baton Rouge, LA
Permit No. 1032**