



# Louisiana Morbidity Report

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March-April 2001

Volume 12 Number 2

## Meningococcal Meningitis Trends

In 2001, there has been 37 cases of invasive meningococcal disease reported during the first three months of the year (January to March).

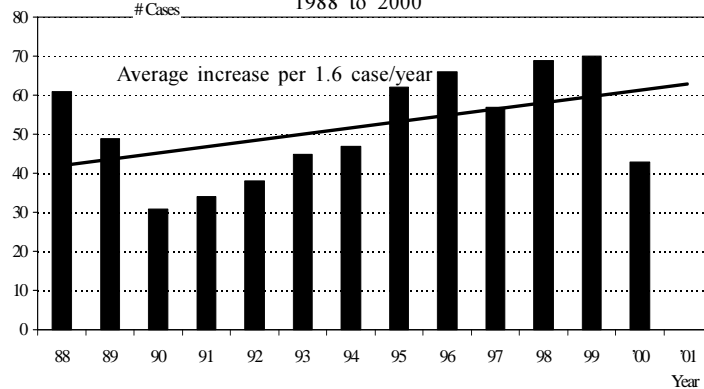
This report includes meningococcal meningitis and other invasive meningococcal diseases, septicemia being the most common one. The yearly number of cases of invasive meningococcal diseases reported ranged from 30 to 70. The years 1996, 1998 and 1999 had high number cases while 2000 was low.

The rates range from 0.5 to 1.5 reported case /100,000 /year. These rates are similar to those from other US states.

Based on capsular polysaccharide there are 5 groups of meningococci. These groups are important to consider because of their epidemiologic, clinical and preventive importance. The 3 main groups observed in Louisiana are B, C and Y. Group A and W135 are uncommon.

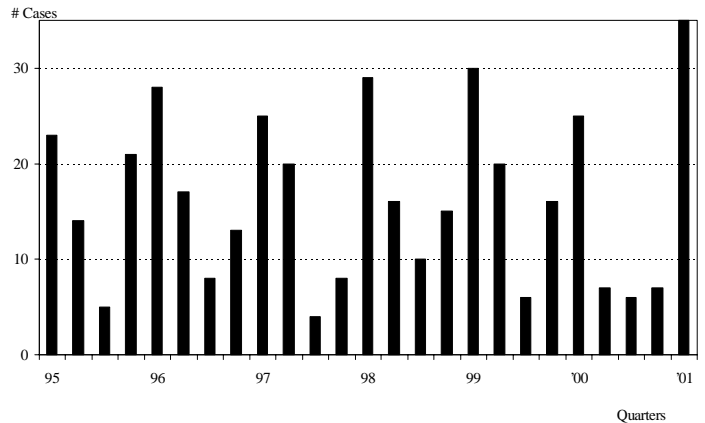
Meningococcal meningitis is highly seasonal: about 40% of all cases are reported between January, February and March. Figure 2 represents the number of cases by quarter.

Figure 1: Trend in number of cases of meningococcal meningitis from 1988 to 2000



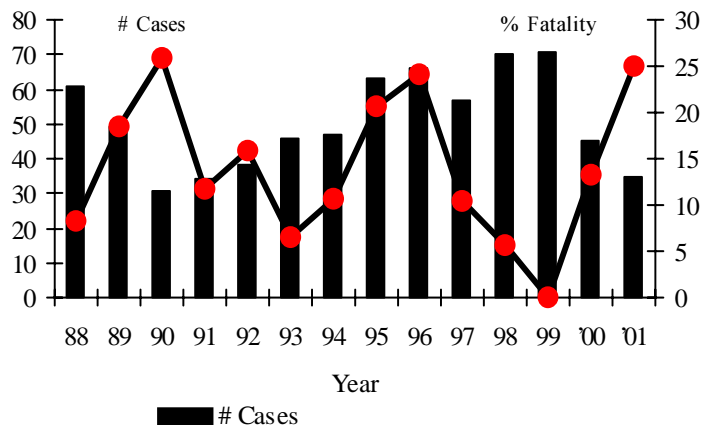
This graph shows the number of cases by year from 1988 to 2000. There is an increasing trend with a slope showing an average increase of 1.6 cases /year ( regression line formula  $y = 1.5989x + 40.5$ ) however this increase is not significant ( $p=0.108$ ; Figure 1).

Figure 2: Seasonal trend in meningococcal meningitis, 1995-2001



Mortality from meningococcal invasive disease is high although meningococci have remained sensitive to numerous antibiotics. The difficulty in making an early diagnosis and the fulminant progression of some cases are the main reasons for the fatal outcomes. The case fatality rates range from 10% to 25%. All age groups are affected.

Figure 3: Case fatality rate, 1988-2000



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There are wide variations in the case fatality rates by year with no correlation between high case fatality and high number of cases. **Chemoprophylaxis is the most important preventive measure in the USA**

In the United States, the primary means for prevention of sporadic meningococcal disease is antimicrobial chemoprophylaxis of **close contacts** of infected persons. Close contacts include

- household members
- frequently sleeping or eating in the same dwelling as the patient (i.e., college dormitory)
- day care center contacts
- direct exposure to the patient's oral secretions (e.g., through kissing, mouth-to-mouth resuscitation, endotracheal intubation, or endotracheal tube management).

The attack rate for household contacts exposed to patients who have sporadic meningococcal disease is an estimated four cases per 1,000 persons exposed, which is 500-800 times greater than for the total population. Because the rate of secondary disease for close contacts is highest during the first few days after onset of disease in the index patient, antimicrobial chemoprophylaxis should be administered as soon as possible (ideally within 24 hours after identification of the index patient). Conversely, chemoprophylaxis administered >14 days after onset of illness in the index patient is probably of limited or no value. Oropharyngeal or nasopharyngeal cultures are not helpful in determining the need for chemoprophylaxis and may unnecessarily delay institution of this preventive measure.

**Chemoprophylaxis is NOT recommended for casual contacts**

who have no history of prolonged contact with the patient's oral secretions (schoolmate, work), not recommended for those who are in contact with a high risk contact or medical personnel without direct exposure to the patient's secretions.

**Chemoprophylaxis Agents**

Rifampin, ciprofloxacin, and ceftriaxone are all 90%—95% effective in reducing nasopharyngeal carriage of *N. meningitidis* and are all acceptable alternatives for chemoprophylaxis. Systemic antimicrobial therapy of meningococcal disease with agents other than ceftriaxone or other third-generation cephalosporins may not reliably eradicate nasopharyngeal carriage of *N. meningitidis*. If other agents have been used for treatment, the index patient should receive chemoprophylactic antibiotics for eradication of nasopharyngeal carriage before being discharged from the hospital.

Drug	Age group	Dosage	Duration
Rifampin	Children < 1 mo	5mg/kg q 12 hr	2 days
	Children ≥ 1 mo	10 mg/kg q 12 hr	2 days
	Adults	600mg q 12 hrs	2 days
Cipro	Adults	500mg	Stat
Ceftriaxone	Children < 15 yr	125 mg	Stat IM
	Adults	250mg	Stat IM

In the USA routine vaccination with the quadrivalent meningococcal polysaccharide vaccine is not systematically recommended because:

- relative ineffectiveness in children <2 years of age (among whom risk for endemic disease is highest)
- relatively short duration of protection

However, the polysaccharide meningococcal vaccine is useful:

- for controlling serogroup C meningococcal outbreaks
- for military recruits
- for travelers to highly endemic countries

Note: **College freshmen, particularly those living in dormitories or residence halls**, are at modestly increased risk for meningococcal disease compared with persons the same age who are not attending college. Therefore, the American College Health Association (ACHA), which represents about half of colleges that have student health services, released a statement recommending that “college health services [take] a more proactive role in alerting students and their parents about the dangers of meningococcal disease,” that “college students consider vaccination against potentially fatal meningococcal disease,” and that “colleges and universities ensure all students have access to a vaccination program for those who want to be vaccinated.”

For both adults and children, vaccine is administered subcutaneously as a single, 0.5-ml dose. The vaccine can be administered at the same time as other vaccines but should be given at a different anatomic site. Protective levels of antibody are usually achieved within 7-10 days of vaccination.

## BRFSS: Cervical Cancer Screening 1991-1999

Data Analysis by Buddy R. Bates, MSPH

In 1999, 91.8% of women (aged 18 years and older with a uterine cervix) in Louisiana reported EVER receiving a Pap smear. There appears to be no racial disparities overall in ever receiving a Pap

<b>Louisiana Morbidity Report</b>	
Volume 12 Number 2	March-April 2001
<p>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.</p>	
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smear. Caucasian women (92%) reported higher overall levels of ever receiving a Pap smear than African American women (91%). However, Louisiana is approaching the goal (85%) set forth for cervical cancer screening within the last 3 years for women 18 years and older with no history of hysterectomy. For 1991-1999, an average of 83% of adult females with an intact cervix reported receiving a Papanicolaou (Pap) smear test within the last 3 years. The highest prevalence (86%) was in 1994 with the lowest prevalence (70%) occurring the following year. There is no significant difference between racial groups regarding Pap smears within the last 3 years. Over the last decade, African-American women, on average, reported higher rates of Pap smear tests (85%) than Caucasian women (83%).

Cervical cancer screening is positively associated with education. Those with less education are less likely to receive the recommended cervical cancer screening. Cervical cancer screening is also associated with age. A comparison of age groups to pap smear tests shows women 65 years and older have a significantly lower probability of not receiving a Pap smear within the last three years though there is an increasing trend in Pap smear testing from 1995 (Table). Women, 45-64 years of age, reported lower rates of screening as

**Table:** Pap smear screening within three years for female respondents with a cervix, Louisiana, 1998 (N=680)

Groups	Total Respondents		Weighted (adjusted) Rate
	Total	#	%
<b>TOTAL</b>	680	567.0	83.6
<b>Age</b>			
18-24	88	77	87.6
25-44	361	331	91.3
45-64	135	101	72.6
65+	86	51	64.6
<b>Education</b>			
Less than high school	107	67	65.0
High school graduate	236	205	86.6
Some college	171	148	86.4
College graduate	165	147	88.8
<b>Income</b>			
<\$15,000	101	67	65.0
\$15,000-\$24,999	128	105	81.6
\$25,000-\$49,000	198	173	87.7
≥\$50,000	141	134	94.1
<b>Race</b>			
Caucasian	417	355	86.2
African American	208	174	82.8

well.

The National Center for Health Statistics has set a Healthy People 2000 goal of 95% for women aged 18 years and older with a uterine cervix who have EVER received a Papanicolaou (Pap) Smear test and a goal of 85% for women aged 18 years and older with a uterine cervix who have received a Pap smear test within the preceding 1-3 years.

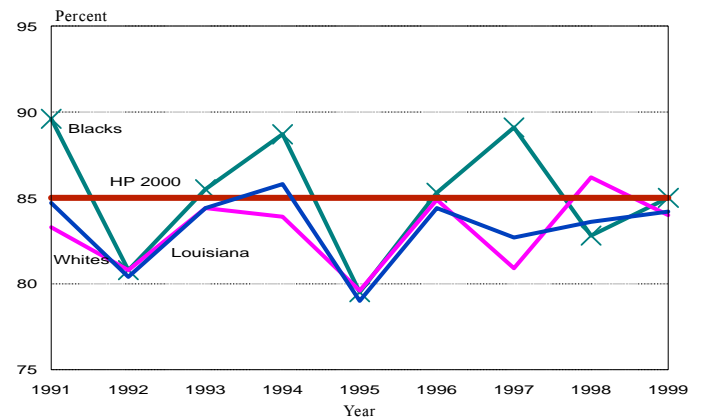
While the proportion of women having had a Pap smear test within the past 3 years decreases markedly with age, the incidence of cervical cancer increases with age. The U.S. Preventive Services

Task Force in it's Guide to Clinical Preventive Services gives the following recommendations: 1) Pap smear testing for all women who are or have been sexually active and who have a cervix, 2) Pap smears should begin with the onset of sexual activity and should be repeated at least every 3 years, after three negative annual Pap smears. The test may be done more frequently on physician recommendations.

The Pap smear test is the most effective method for discovering precancerous changes or cancers on the cervix. Cervical cancer is rare and is almost completely curable when diagnosed. Since this is a preventable disease, no woman should die from cervical cancer. Regrettably, nearly 4,800 women die from this disease annually.

The Louisiana Department of Health and Hospitals, Office of Public Health is a grantee of the National Breast and Cervical Cancer Early Detection Program. Through the Louisiana Women's Preventive Health Program, underinsured women may receive Pap testing at no cost.

**Figure 1:** Response rate trends of Louisiana women ≥18 years of age by race who reported having a pap smear within 3 years, 1991-1999



The results of pap smear screening from the Louisiana Women's Preventive Health Program are presented below.

Abnormal pap results (Bethesda System)	No. Women	Percent
ASCUS <sup>1</sup>	73	57.0%*
High grade SIL <sup>2</sup> (HGSIL)	9	7.0%*
Low grade SIL (LGSIL)	12	14.7%*
Squamous cell carcinoma	3	2.3%
Unsatisfactory	24	18.6%

\* Require follow-up, repeat pap at 3 or 6 months or colposcopy or colposcopy with biopsy.

<sup>1</sup>ASCUS = Atypical squamous cells of undetermined significance

<sup>2</sup>SIL = Squamous intra-epithelial lesion

The program outreach activities target women that are rarely or never screened. Program participants are able to establish a medical home that provides follow-up, health education and medical referrals. For information on service providers or general program information call 1-888-599-1073.

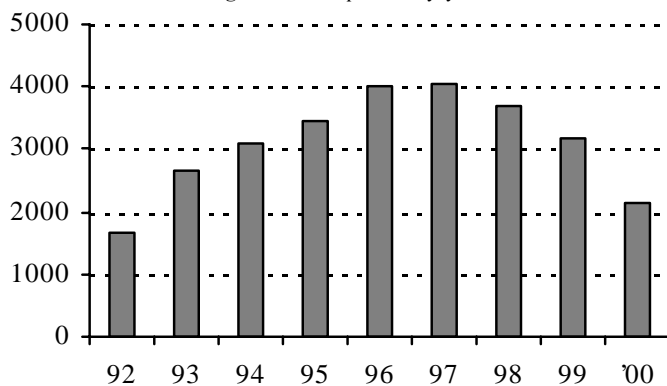
# Food Complaints

The Office of Public Health (OPH) Environmental Health Services is responsible for the inspection of food service establishments. Besides routinely scheduled inspections, OPH sanitarians investigate food complaints received.

The following is a statistical analysis of the database maintained since 1992.

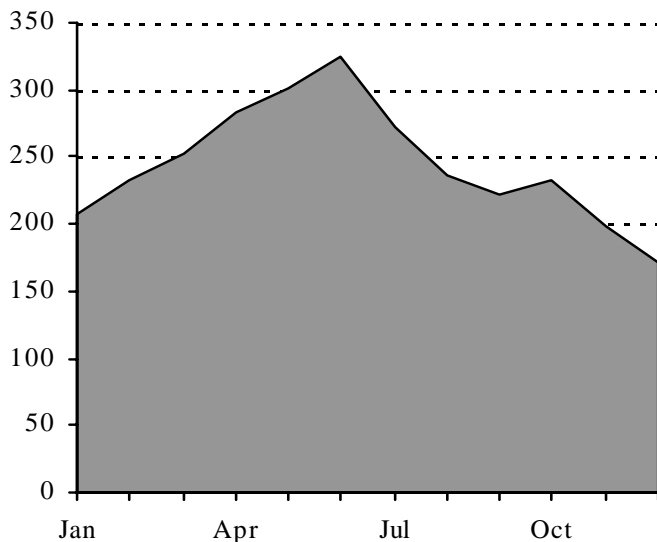
The number of complaints ranges from 2000 to 4000 per year. The numbers increased from 1992 to peak in 1997 then slowly decrease. It is important to note that a large proportion of food complaints are not reported and that sanitarian staffing patterns may also influence the number of investigations that could be carried out.

Figure 1: Complaints by year



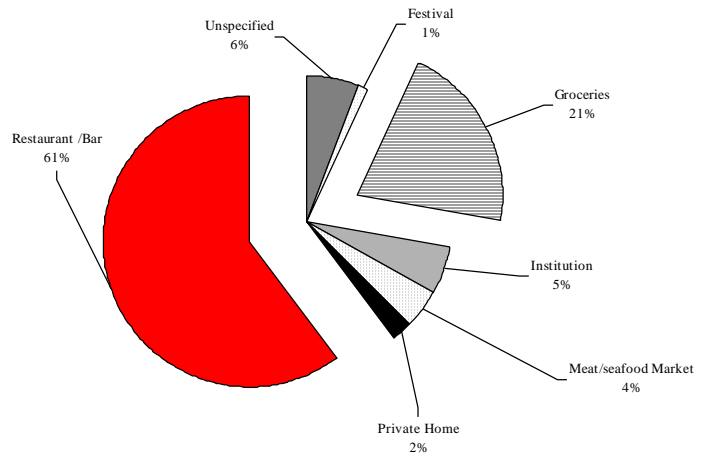
There is a definite seasonal pattern with a peak in the number of complaints in June and a low in December. This would correspond with a seasonal distribution pattern of foodborne illnesses with estival peak during the year. Contamination and proliferation of food contaminants is more likely to occur during the summer months with warmer temperatures.

Figure 2: Complaints by month



Most of the complaints are about unsanitary conditions 53%, followed by food contamination 27%, illnesses 13%, and 7% unspecified. Most complaints are associated with restaurants (61%).

Figure 3: Distribution of complaint by type of establishment



The types of food involved were chicken (1083), other poultry (62), beef (684), hamburger (639), vegetables (517), shrimps (330), fish (280), oyster (114), other seafood (334), water/Ice (268), pizza (197), Mexican food (193), sausages and cold cuts (209), breads (142), pork (136), pastry (120), egg (104), milk (83), Chinese food (57), fruits (51), and ice cream (46). Other complaints relate to bugs in the food (68), rats or mice on the premises (8), toilets poorly maintained (46), dirty conditions (68), hair in the food (32), and employee unsanitary behavior. Finally, band aids were found in the food on 2 occasions and nasal discharge in pizza twice also.

Report health related complaints about food service establishments to your local parish health unit or the Office of Public Health Environmental Health Services at 225-763-5553.

**NOTICE TO READERS**  
 The *Infectious Disease Epidemiology Annual Report 1999* has been published and is available at [www.dhh.state.la.us/oph/infectepi/default.htm](http://www.dhh.state.la.us/oph/infectepi/default.htm).

## Stuffed Bell Peppers and Salmonella Don't Mix Well

Iris Merlos, MPH

In this outbreak investigation the prompt collection of stools and food samples and the epidemiologic data allowed rapid confirmation of the etiologic agent and draw some conclusions for immediate and long term prevention.

In March, 2001 the Infectious Disease Epidemiology Section began an investigation of a possible outbreak of diarrheal diseases in St. Bernard Parish. Most reports involved a single restaurant in

which several persons had become ill. While some ill individuals did eat at other restaurants, no other restaurant was associated with an increased risk of illness.

Cases and controls were questioned. Persons who had diarrhea were asked to submit a stool sample. Food handlers were also interviewed and were required to submit a stool culture.

#### Results:

A total of 88 questionnaires were obtained. Sixty patients met the case definition. All case-patients had diarrhea. Twenty-five specimens tested positive for *Salmonella, serotype heidelberg*. No secondary cases occurred in the household of case-patients.

One death occurred prior to confirmatory testing and is epidemiologically related to a sibling who also tested positive for *Salmonella heidelberg*. These siblings had split the same meal served for dinner.

There was a strong and significant association between consumption of stuffed bell peppers and disease. The association with consumption of macaroni and cheese was weaker but also significant.

Food samples of ground beef, bread crumbs, eggs, cheese and sliced roast beef and environmental swabs submitted for laboratory testing were negative for salmonella. One sample of bell peppers and macaroni/cheese provided by one case-patient yielded *Salmonella, serotype heidelberg*, identical to the case-patient. Among the isolates confirmed by pulse-field gel electrophoresis, all of the isolates (both stool and food samples) were genetically identical suggesting a common source of one *Salmonella heidelberg* strain. All stool specimens submitted by the foodhandlers were negative for Salmonella, Shigella, Vibrio and Campylobacter.

Several problems were identified in the kitchen related to cooling, storing and serving foods. While the investigation did not implicate a specific ingredient of the stuffed bell peppers, the investigation did identify lapses in food handling practices that would have allowed for multiplication of the bacteria in the stuffed pepper dish. In general, salmonella food outbreaks are caused by food contaminated by salmonella and then left at improper temperatures for extended periods allowing the bacteria to grow to high enough levels to cause infections.

Outbreaks of *Salmonella heidelberg* have been associated with contaminated meat, poultry and poultry products, or improperly cooked foods. Ingestion of the organism in food derived from infected food-animals or by feces of an infected person or animal may cause salmonella.

Outbreaks of salmonella may be prevented, however, even if food is initially contaminated. Proper thorough cooking to 165°F and holding temperature of not less than 140°F will kill bacteria even if incidentally contaminated. Rapid cooling will prevent multiplication of the bacteria. Safe food handling, preparation and storage will help prevent further illness caused by salmonella, and other bacteria and viruses.



## First Pneumococcal Vaccine Approved for Infants and Toddlers

Ruben A. Tapia, MPH

The recently approved vaccine for prevention of pneumococcal diseases in infants and toddlers has become part of the Office of Public Health Immunization Schedule. The name of the vaccine is Seven-Valent Pneumococcal Conjugate Vaccine (PCV-7). The vaccine prevents invasive diseases caused by the organism *Streptococcus pneumoniae* (also known as pneumococcus) including bacteremia (an infection of the bloodstream) and meningitis, an infection of the lining of the brain or spinal cord. These diseases can cause brain damage and, in rare cases, even death.

The vaccine, Pneumococcal 7-valent Conjugate Vaccine (Diphtheria CRM197Protein) is marketed as Prevnar by a unit of Wyeth-Ayerst Laboratories, a Division of American Home Products Corporation in Philadelphia, PA.

Infants can receive the vaccine as a series of four inoculations administered at 2, 4, 6, and 12-15 months of age. Children who are unvaccinated and are age 7 to 11 months of age should be given a total of 3 doses, two months apart, and children age 12 to 23 months should be given a total of 2 doses at least two months apart. Most children who are 24 months of age or older only need one dose of the vaccine. Children age 24 to 59 months at higher risk of infection, including those with certain illness (sickle cell anemia, HIV infection, chronic lung or heart disease) and those who are Alaska Natives, American Indians, or African Americans are recommended to receive the vaccine. The vaccine should also be considered for other children age 24 to 59 months who are at increased risk for pneumococcal infections: children who are in group day care, those who have had frequent or complicated episodes of acute otitis media during the past year, or children who are socially or economically disadvantaged. This vaccine is not indicated for use in adults or as a substitute for other approved pneumococcal polysaccharide vaccines approved for high risk children over the age of two.

On the clinical trial prior to FDA approval, the vaccine was 100% effective in preventing invasive pneumococcal disease caused by the seven strains of pneumococcus in the vaccine. The vaccine was approximately 90% effective in preventing invasive disease for illnesses caused by all pneumococcal subtypes.

“This new vaccine is great news for parents and their children because now, for the first time, we have a highly effective way to prevent a major cause of meningitis and serious blood infections in the most susceptible children, those under two years of age.” Said Dr. Jane Henney, Commissioner of the Food and Drug Administration (FDA). “When we prevent these infections, we are also preventing brain damage and mortality from pneumococcal diseases.” It is estimated that each year in the U.S. there are about 16,000 cases of pneumococcal bacteremia and 1400 cases of pneumococcal meningitis among children under age five. Children under the age of two are at highest risk for infection. In up to half the cases of meningitis, brain damage and hearing loss occur, and about 10% die.

For further information, call our office at (504) 483-1900.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE  
January - February, 2001  
**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	Jan-Feb 2001	Jan-Feb 2000	Jan-Feb Cum 2001	Jan-Feb Cum 2000	% Chg
<b>Vaccine-preventable</b>														
<i>H. influenzae (type B)</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	6	0	1	2	0	0	2	0	2	13	21	13	21	-38.1
Rate <sup>1</sup>	0.6	-	0.3	0.4	-	-	0.4	-	0.5	0.3	0.4	0.3	0.4	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	0	0	0	0	0	0	2	0	2	-
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	0	0	0	0	0	0	0	0	0	0	0	0	0	-
<b>Sexually-transmitted</b>														
HIV/AIDS Cases <sup>2</sup>	38	19	4	9	7	8	10	3	3	101	199	101	199	-50
Rate <sup>1</sup>	3.8	3.3	1.0	1.7	2.5	2.7	2.0	0.9	0.7	2.3	4.6	2.3	4.6	
Gonorrhea Cases	601	305	75	135	93	74	355	192	62	1892	2130	1892	2130	-11.2
Rate <sup>1</sup>	57.8	53.7	19.9	26.2	34.7	24.3	70.2	54.7	16.1	44.8	50.5	44.8	50.5	
Syphilis (P&S) Cases	1	7	2	5	1	0	0	0	1	17	36	17	36	-52.8
Rate <sup>1</sup>	0.1	1.2	0.5	1.0	0.4	-	-	-	0.3	0.4	0.9	0.4	0.9	
<b>Enteric</b>														
Campylobacter	2	1	1	2	0	0	1	0	4	15	12	15	12	+25
Hepatitis A Cases	11	0	0	1	0	0	1	2	0	15	13	15	13	+15
Rate <sup>1</sup>	1.1	-	-	0.2	-	-	0.2	0.6	-	0.6	0.2	0.6	0.2	
Salmonella Cases	8	7	2	5	6	4	3	2	5	67	33	67	33	+103
Rate <sup>1</sup>	0.8	1.2	0.5	1	2.2	1.3	0.6	0.6	1.3	1.6	0.7	1.6	0.7	
Shigella Cases	7	4	1	6	0	0	1	0	4	33	27	33	27	+22.2
Rate <sup>1</sup>	0.7	0.7	0.3	1.2	-	-	0.2	-	1.0	0.7	0.6	0.7	0.6	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Vibrio, other	0	0	0	0	0	0	0	0	0	0	0	0	0	-
<b>Other</b>														
<i>H. influenzae (other)</i>	0	0	0	0	0	0	0	0	1	1	3	1	3	-66.7
<i>N. Meningitidis</i>	9	2	1	6	0	3	0	1	0	22	16	22	16	+37.5
Tuberculosis	-	-	2	-	-	-	-	-	-	2	19	2	19	-89.5

1 = Cases Per 100,000

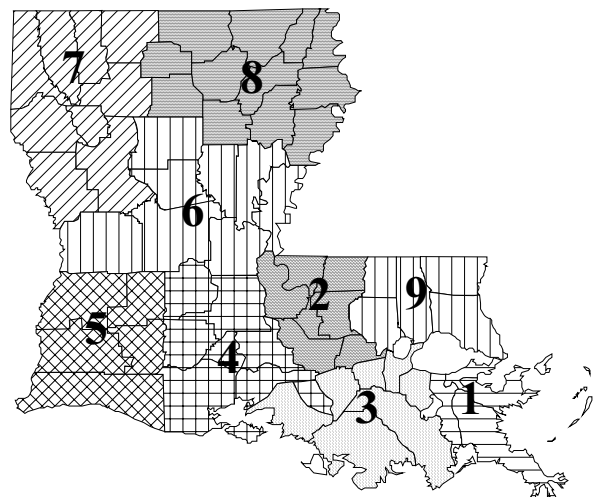
2=These totals reflect persons with HIV infection whose status was first detected during the specified time period. This includes persons who were diagnosed with AIDS at time HIV was first detected.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	2
Legionellosis	1
Malaria	1
Rabies, animal	2
Varicella	18

Table 3. Animal Rabies (Jan-Feb, 2001)

Parish	No. Cases	Species
Acadia	1	Skunk
Lafayette	1	Skunk

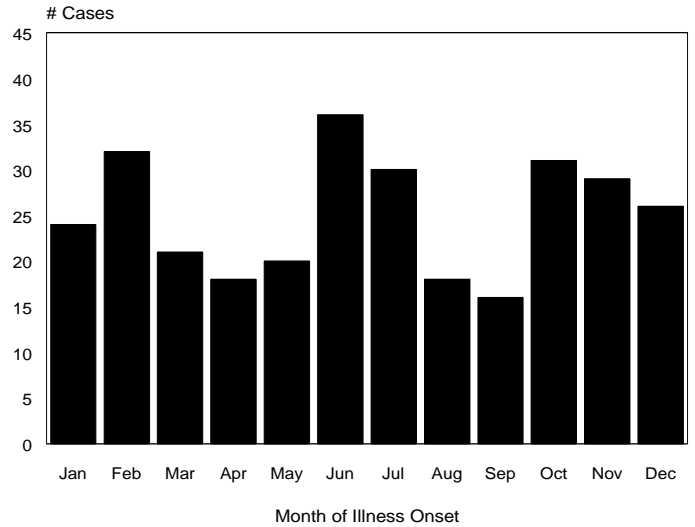


## ANNUAL SUMMARY

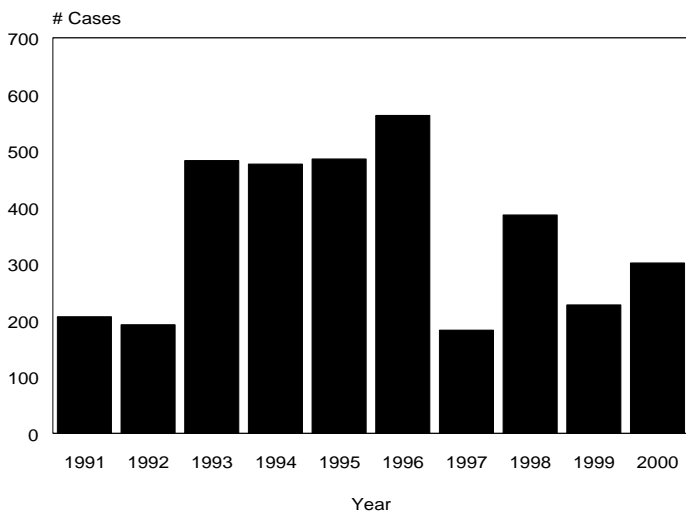
### Shigellosis - 2000

There were 301 shigellosis cases reported in year 2000 which is an increase of 33% from the last year total of 227 (Figure 1). The overall state case rate is 7.0 per 100,000. Reported cases by sex per 100,000 were equal among males (6.8) and females (6.7). Sex-race specific rates were highest among African American males and females (6.9 vs 6.0 per 100,000, respectively) compared to Caucasian males (2.0) and females (2.9). Children under the age of ten accounted for 59% of the cases while the 20 to 34 year age groups accounted for 18% (Figure 2). Of the total cases with reported risk information, seven (2%) cases were associated with a daycare while only one case was identified as a food handler. No community-wide outbreaks were reported. Reported onsets of illness for cases occurred in all months of the year with peak onsets reported in June and July (Figure 3). Of 224 (74%) isolates serotyped, *Shigella sonnei* was identified in 97% of the isolates. Parishes reporting the highest case rates per 100,000 include De Soto (16), St. Tammany (15), and Ouachita [13; Figure 4].

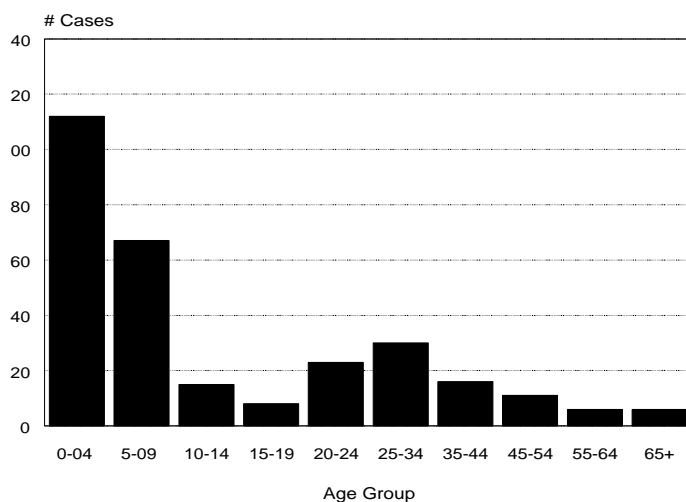
**Figure 3:** Cases of shigellosis in Louisiana by month of onset, 2000



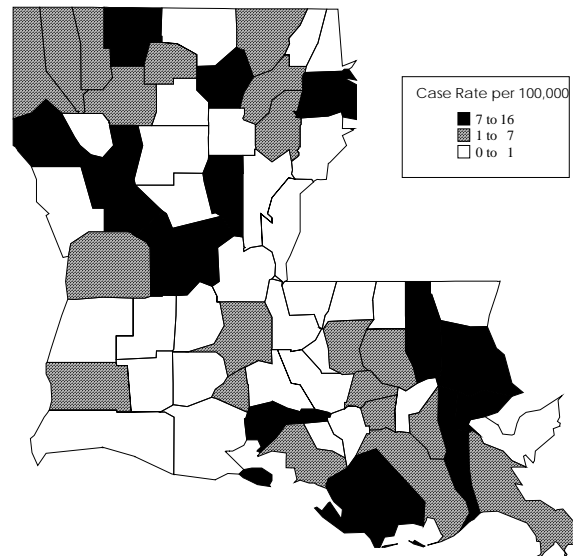
**Figure 1:** Cases of shigellosis in Louisiana by year, 1991-2000



**Figure 2:** Cases of shigellosis in Louisiana by age group, 2000



**Figure 4:** Rates of Shigellosis in Louisiana by parish, 2000



*Louisiana Fact*

*The Sisters of Charity arrived in Louisiana in 1834. The Sisters were requested by the Board of Administrators of Charity Hospital "to supervise the sick wards, and to manage the interior economy and household concerns of the Institute." Throughout the numerous epidemics of yellow fever, malaria, cholera, typhus and typhoid fever, the sisters not only nursed all patients but also converted their living quarters into wards to house additional patients. Because of the inadequate financial support of Charity Hospital during the Reconstruction period from 1865 to 1876, the very existence of the hospital depended almost entirely on the devoted services of the Sisters of Charity.*

# LIST OF REPORTABLE DISEASES/CONDITIONS

## REPORTABLE DISEASES

## OTHER REPORTABLE CONDITIONS

Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis, Acute (A, B, C, Other)	Rubella (German measles)	Cancer
Amebiasis	Hepatitis B carriage in pregnancy	Rubella (congenital syndrome)	Complications of abortion
Arthropod-borne encephalitis (Specify type)	Herpes (neonatal)	Salmonellosis	Congenital hypothyroidism*
Blastomycosis	Human Immunodeficiency Virus (HIV) infection <sup>3</sup>	Shigellosis	Severe traumatic head injury**
Botulism <sup>1</sup>	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Galactosemia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Hemophilia*
Chancroid <sup>2</sup>	Lymphogranuloma venereum <sup>2</sup>	Syphilis <sup>2</sup>	Lead Poisoning
Chlamydial infection <sup>2</sup>	Malaria	Tetanus	Phenylketonuria*
Cholera <sup>1</sup>	Measles (rubeola) <sup>1</sup>	Tuberculosis <sup>4</sup>	Reye's Syndrome
Cryptosporidiosis	Meningitis, other bacterial or fungal	Typhoid fever	Severe under nutrition (severe anemia, failure to thrive)
Diphtheria	Mumps	Varicella (chickenpox)	Sickle cell disease (newborns)*
Enterococcus (infection; resistant to vancomycin)	Mycobacteriosis, atypical <sup>4</sup>	Vibrio infections (excluding cholera) <sup>1</sup>	Spinal cord injury**
Escherichia coli 0157:H7 infection	Neisseria meningitidis infection <sup>1</sup>		Sudden infant death syndrome (SIDS)
Gonorrhea <sup>2</sup>	Pertussis		Traumatic Brain Injury
Haemophilus influenzae infection <sup>1</sup>	Rabies (animal & man)		
Hemolytic-Uremic Syndrome	Rocky Mountain Spotted Fever (RMSF)		

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, phone reports, or electronic transmission.

<sup>1</sup> Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.

<sup>2</sup> Report on STD-43 form. Report cases of syphilis with active lesions by telephone.

<sup>3</sup> Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.

<sup>4</sup> Report on CDC 72.5 (f. 5.2431) card.

All reportable diseases and conditions other than the venereal diseases, tuberculosis and those conditions with \*'s should be reported on an EPI-2430 card and forwarded to the local parish health unit or the Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160, Phone: 504-568-5005 or 1-800-256-2748 or FAX: 504-568-5006.

\* 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.

### Numbers for reporting communicable diseases

**1-800-256-2748**

**Local # 568-5005**

**FAX # 504-568-5006**

**Web site: <http://www.dhh.state.la.us/oph/infectepi/default.htm>**

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.

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