Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
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www.oph.dhh.state.la.us/infectiousdisease/index.html

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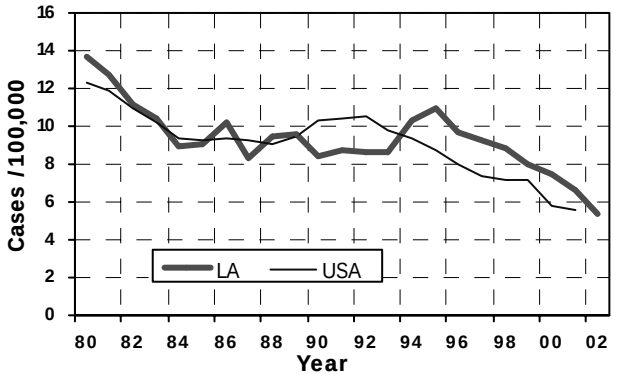
March-April 2003 **Volume 14 Number 2**

Tuberculosis in Louisiana

The incidence of tuberculosis in Louisiana is slightly lower in 2002 than the average incidence in the United States. As in the USA, incidence was decreasing progressively with a short interruption in the late 90's from 1994 to 1996.

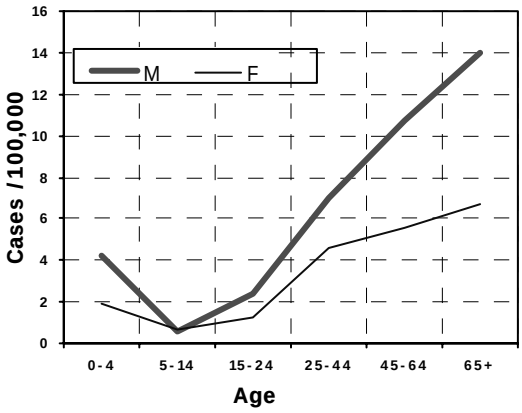
Figure 1: Incidence (new reported case rate) of tuberculosis per 100,000 by year in Louisiana and the USA, 1980-2002



The most striking feature of tuberculosis epidemiology in Louisiana is the vast disparity in tuberculosis incidence within gender, ethnic group and geography.

Gender: In the older age groups, the incidence is close to threefold higher among males than among females while throughout the world the difference is two-fold (Figure 2).

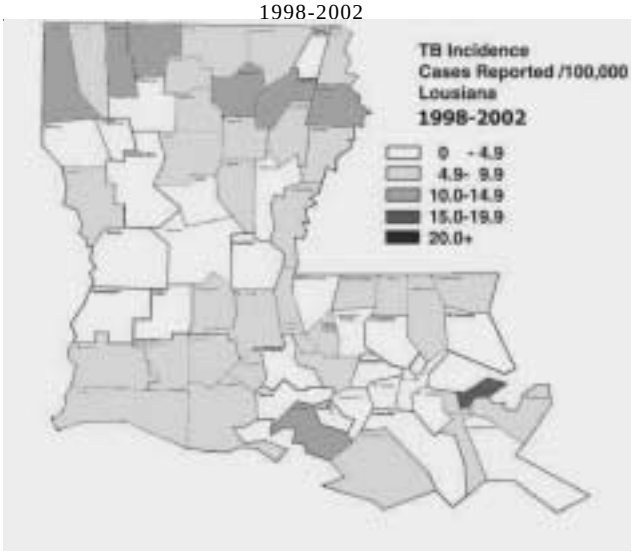
Figure 2: Incidence (new reported case rate) of tuberculosis per 100,000 for 2002 in Louisiana by age group and gender



Ethnic Group and Geography

The geographical distribution by parish (Figure 3) shows low rates throughout the state except for Orleans Parish.

Figure 3: Geographical distribution of tuberculosis per 100,000 1998-2002



Major disparities are seen among ethnic groups. Incidence among Whites has slowly decreased from 9.1 /100,000 in 1980 to 2.5/ 100,000 in 2002. Incidence among African-Americans has also decreased from 22.4 /100,000 in 1980 to 9.3/100,000 in 2002. Incidence among Asians has seen dramatic variations from year to year: highs of 46.8 /100,000 in 1980, 43.6 /100,000 in 2000 and lows of 12.3 / 100,000 in 1992. In 2002 the incidence among Asians was 27.4/100,000.

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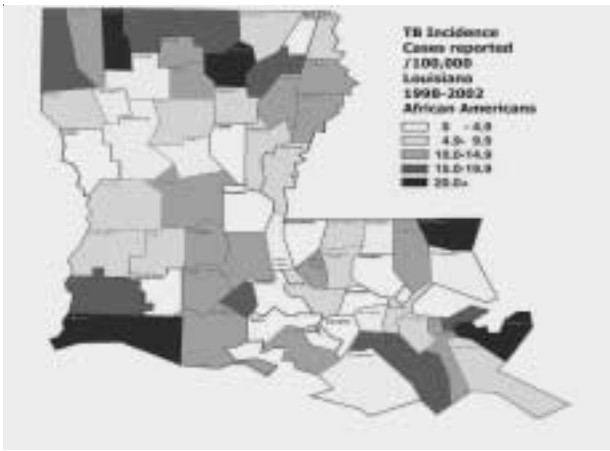
The map for the African-Americans (Figure 4) shows much higher rates in some parishes. High rates are noted in some populations such as Cameron, Ouachita, Plaquemines, Washington and Webster parishes.

Figure 4: Geographical distribution of tuberculosis in African-Americans per 100,000, 1998-2002



As expected, high caseloads are found mostly in the cities, with one-third of the cases from Orleans and Jefferson parishes.

Incidence maps do not necessarily represent the caseload, which in fact is more concentrated, since two-thirds of the cases come from six parishes (148 / 230 cases from Orleans, Caddo, Jefferson, Ouachita, East Baton Rouge and St Mary).

Foreign-born cases represent only a small fraction (approximately 10%) of the cases. (Louisiana still has relatively high rates among the indigenous population.) In 2002 there were 26 cases among foreign-borns (out of a total of 230 cases). The largest group of foreign-born remains Vietnamese (9/26 foreign-born cases in 2002), with no other group standing out (Latin America - 5 cases, other Southeast Asian countries - 7 cases). Most foreign-born cases reside in the large cities (New Orleans, Baton Rouge, Lafayette and Shreveport) and in the Lafayette area where large numbers of Vietnamese have settled. Half of the cases occurring among Vietnamese happen within 5 years of their coming to the USA. Cases occur among all age groups, particularly among young adults but not as much among older age groups.

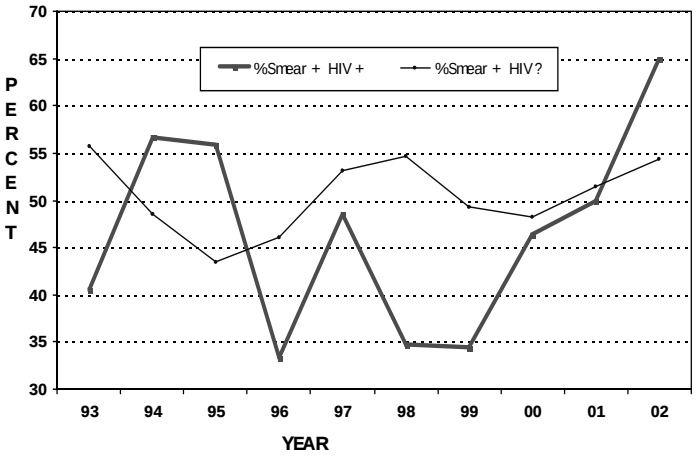
Co-Infection

HIV infection is present among 14% of new TB cases. Most co-infected cases occur among men (83% of all cases) with males 25-44 representing 56% of cases and males 45-65 representing 26% of cases. Most cases are concentrated in the New Orleans and Baton Rouge areas. A few co-infections may have been missed since testing among TB cases is not complete. HIV testing of TB cases increased from 50% of TB cases in 2000 to 72% in 2002.

The proportion of **homeless** cases ranged from 2 to 8% with a slight increasing non-significant trend (slope +1.5 cases/year, p=0.13). Most homeless cases are in Orleans parish (56% of all cases).

The sputum smear status of pulmonary cases with HIV infection was as low as 35% but since 1999, has increased steadily to reach 65% in 2002 while the proportion of smear positive among pulmonary cases hovers from 45% to 55%. **(This dispels the myth that HIV pulmonary cases are not infectious.)**

Figure 5: Sputum smear of pulmonary cases by HIV status



Clinical Picture

The majority (85%) of cases are pulmonary. Among the extrapulmonary cases, the most common are pleural (28%) and lymphatic (28%) followed by other locations (genito-urinary, bone and joint, meningeal, peritoneal and miliary) in the range of 1 to 8% .

About 50% of pulmonary cases are confirmed by a positive sputum smear and culture. These are the most infectious cases, responsible for the majority of tuberculosis transmission. An additional 20% of pulmonary cases have a negative sputum smear but a positive culture. Finally an additional 10% do not produce sputum naturally. (However, *Mycobacterium tuberculosis* has been cultured on a specimen obtained by sputum induction or bronchial lavage.) In total, 80% of all pulmonary tuberculosis cases are bacteriologically confirmed, which meets the accepted standard.

Fifty-five percent of those confirmed by bronchial lavage had no result for natural or induced sputum. It is important to stress that the recommended approach to diagnose active pulmonary tuberculosis in a patient who does not produce natural sputum is to perform sputum induction before bronchoscopy and bronchial lavage.

Seventy percent of extra-pulmonary tuberculosis is confirmed bacteriologically.

Louisiana Morbidity Report
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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.

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Treatment Regimen, Sensitivity to Antibiotics and Response to Treatment

Almost eighty percent of cases are now started on the standard treatment regimen of INH, rifampin, PZA and ethambutol. An additional 18% are started on INH, rifampin and PZA. Most of these cases are among children. Pediatricians are often reluctant to use ethambutol among young children. Other regimen are only used when intolerance or resistance are present.

Presently, primary resistance to anti-tuberculosis agents is not a major problem but needs to be monitored carefully. Primary resistance to INH is at 4.5%, varying from year to year from 2 to 6%. (Above the 4% threshold, the use of these four drugs - INH, RIF, PZA, EMB - is preferred over the use of the first three drugs - INH, RIF, PZA.) Resistance to INH and rifampin, commonly named MDR or multi- drug resistant, is still rare (0-1 case per year).

Acquired resistance is rare: over the past eight years among patients who were sensitive to all drugs at onset of treatment, five cases acquired resistance to INH, two to rifampin, one to INH/rifampin, and one to INH/rifampin/PZA. Among those who were resistant to rifampin at onset of treatment, two developed INH resistance. This remarkably low development of resistance during treatment is probably the result of close monitoring of cases and directly observed therapy.

BRFSS: Trends in Cigarette Smoking Among Young Adults (18-24) in Louisiana

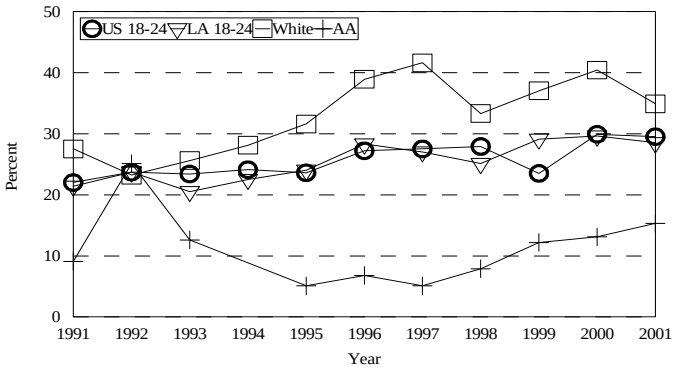
Srikant Nannapaneni, MPH

According to results from the 2001 Louisiana Behavioral Risk Factor Surveillance System (BRFSS) more than 125,000 (28.5%) young adults (18-24) in Louisiana currently smoke cigarettes. Tobacco use continues to be the single largest cause of death and disease in Louisiana with cigarette smoking responsible for an estimated 6,427 deaths and 96,085 years of potential years of life lost in 1999. Initiation of tobacco use is known to occur at a very early age with more than half of the adult current smokers in Louisiana (60.6%) reporting smoking cigarettes regularly by the age of 18.

As seen in the Figure, over the past decade (1992-2001), prevalence of cigarette smoking among young adults has increased in Louisiana (21.4% - 28.5%) mirroring similar increases nationwide (22.0% - 29.5%). Also during the same time period, prevalence of smoking increased by 68% among African-American young adults (9.1% - 15.3%) compared to 27% among Whites (27.5% - 34.9%). Furthermore, rates of smoking increased by 34% among young men (25.0% - 33.6%) compared to 30% young women (17.7% - 23.1%).

The 18-24 year age group is considered especially important because this group constitutes the highest cigarette user group among all adults and studies show an increasing trend in smoking prevalence in this age group. Furthermore, research suggests that this age group is being targeted aggressively by the tobacco industry. Data on cigarette smoking among the 18-24 year olds is gathered through the Louisiana BRFSS and is available from 1991. The Louisiana BRFSS is an ongoing Random Digit Dialed (RDD) telephone survey of adults 18 years and older living in Louisiana households.

Figure: Trends in cigarette smoking among young adults (18-24) 1991-2001



Source: Louisiana Behavioral Risk Factor Surveillance System (1991-2001)

The Louisiana Office of Public Health Tobacco Control Program (OPH-TCP) is implementing programs to decrease the prevalence of smoking among Louisiana residents of all age groups and also awards grants to community based organizations working in the area of tobacco use prevention. Current strategies of the OPH-TCP include bringing about policy and environmental changes such as; making all schools in Louisiana completely tobacco free, restoring local control to communities to implement stricter smoke-free indoor air laws, and insurance coverage for smoking cessation services. For further information on the activities of the OPH-TCP please contact Ms. Diane Hargrove-Roberson, Program Administrator, OPH-TCP at (504) 568-359

OPH EPI TRAINING OFFERINGS

Field Epidemiological Techniques

The OPH Infectious Disease Epidemiology Section is offering a two-day training session for non-ID-RRT members (Infectious Disease Rapid Response Team). This training is targeted towards sanitarians, public health nurses, infection control professionals, disease surveillance specialists, epidemiologists, health care providers and other public health care professionals interested in epidemiological principles and outbreak investigations. The training will be held at the State Office building in New Orleans July 30-31, 2003 and is free of charge. The Registration Deadline is June 3rd. For more information please contact the Infectious Disease Epidemiology Section at (504) 568-5005 x 124.

Available Presentations on Antibiotic Sensitivity

The OPH Infectious Disease Epidemiology Section has the following presenters available for scheduling at health-related facilities. Each presentation is free of charge and can be tailored to the audience (physician, nursing groups) and time available (usually between 30 –60 min). Please call (504) 568-5005 ext. 127 or ext. 124 to schedule.

Raoult Ratard, MD, MPH, State Epidemiologist
Catrin Jones-Nazar, MD, MPH

Antibiotic Use; Antibiotic Sensitivity; Antibiotic Sensitivity: "The Louisiana Program"; MRSA; MRSA, VRE, and DRSP Epidemiology and Control; Louisiana Antibiogram; Prevent Antimicrobial Resistance: "A Campaign for Clinicians"

Update: West Nile Virus

Surveillance

Surveillance programs in place last summer detected West Nile virus in birds from a particular parish before the disease appeared in residents of that parish nearly 90 percent of the time. Therefore, surveillance is a crucial part of predicting when and where the virus will strike in humans.

The health department will test blue jays, crows, grackles, house sparrows and birds of prey, as well as sentinel chickens, for West Nile virus this year. All testing will take place at Louisiana State University's Veterinary Medical Diagnostic Lab. Citizens are asked to call the public health unit in their parish to report the dead birds that they find. (To find a listing of contact information for each parish health unit, please go to http://oph.dhh.state.la.us/ophregions/index.html.) Citizens reporting a dead bird will be asked to give the time, date and address of the bird's recovery. Although it is very unlikely to contract West Nile virus by touching dead birds, people are advised to take precautions when handling them. People who find a dead bird are advised against handling the bird with bare hands and should double bag the bird using Ziploc®-like bags. If the bird is not too badly decomposed, the person reporting should take it to the nearest public health unit. In limited cases, public health officials will retrieve the bird. As of mid-April 2003, there has been lab confirmation of twenty-two birds positive for West Nile virus. These twenty-two birds came from different parishes – East Baton Rouge, West Baton Rouge, Rapides, Ouachita, Lafayette, Calcasieu, Tangipahoa, De Soto, Caddo, Jefferson, Lincoln, Livingston, Orleans, St.Martin, St.Tammany, Vernon and Washington.

Horses infected with West Nile Virus may also be valuable sentinels for human disease. Although OPH has no direct role in surveillance of disease in horses, the agency requests that veterinarians promptly report all cases to the State Veterinarian, Dr. Maxwell Lea. Veterinarians should also report the precise location of the horse as well as date of onset of clinical signs of West Nile virus. For more information on West Nile Virus, please visit DHH's Web site, www.fightthebitelouisiana.com/ (http://oph.dhh.state.la.us/infectiousdisease/westnile/).

Human Case Reporting

Patients exhibiting the following symptoms should be reported to the OPH Infectious Epidemiology Section. Suspect patients with any of the following clinical syndromes:

1. Viral encephalitis, characterized by fever 38°C or 100°F, and CNS involvement, including altered mental status (altered level of consciousness, confusion, agitation, or lethargy) or other cortical signs (cranial nerve palsies, paresis or paralysis, parkinsonian signs, tremors, ataxia or convulsions), and an abnormal CSF profile suggesting a viral etiology (a negative bacterial stain and culture with pleocytosis [WBC between 5 and 1500 cells/mm3] and/or elevated protein level [40 mg/dl]).
2. Aseptic meningitis (among persons aged 12 years and up), characterized by fever 38°C or 100°F, and headache, stiff neck and/or other meningeal signs, and an abnormal CSF profile suggesting a viral etiology (a negative bacterial stain and culture with pleocytosis [WBC between 5 and 1500 cells/mm3] and/or elevated protein level [40 mg/dl]).
3. Acute cases of Guillain-Barré syndrome, especially if associated with atypical features, such as fever, altered mental status and/or a pleocytosis
4. Acute flaccid paralysis
5. Rhabdomyolysis

To report, mail a completed form - the Louisiana Office of Public Health's "Lab submission form for Arboviral Testing in Humans," (available at website: http://oph.dhh.state.la.us/infectiousdisease/westnile/pagea3f2.html?page=274) with the specimen. If the specimen was sent to a diagnostic lab, please fax the same form to (504) 568-5006. If you have any questions or need a form, call the Infectious Disease Epidemiology Section at 504-568-5005.

Testing for WNV at the State Public Health Laboratory is being prioritized for hospitalized patients with viral encephalitis, aseptic meningitis, Guillain-Barré syndrome, acute flaccid paralysis or rhabdomyolysis. In order to keep the number of lab tests manageable, avoid testing asymptomatic patients bitten by mosquitoes, the worried well, those who have a viral infection, and those who are suspected of West Nile Fever (fever and headache without any cerebral or meningeal involvement).

Obtain the following specimens:

Acute phase (collected within 8 days of illness onset)
2 ml serum in labeled red top tube
and CSF (if collected): 2 ml without preservatives
Convalescent phase (collected within 14-21 days of illness onset)
At least 2 ml serum in labeled red top tube

For CSF, please keep specimens refrigerated. Do not send or store at room temperature.

For sera, centrifuge, separate from clots, dispense into two sterile tubes (at least 2 cc each) for transport, and refrigerate. Package CSF and sera in separate bags for transport to OPH. Pack blue ice or other coolants along with serum sample. Do not freeze or use dry ice. Label the specimen with the patient's name, date of birth, medical record number, and date of specimen collection. All specimens should be accompanied by the appropriate form: "Lab submission form for Arboviral Testing in Humans."

Ship to the following address:
Office of Public Health Virology Laboratory
325 Loyola Avenue, Room 709
New Orleans, LA 70112

NOTE: There is no charge for arboviral encephalitis testing. Negative test results of WNV testing will be mailed to hospital laboratories by OPH. Positive test results will be faxed as soon as they are made available. Unless there is an emergency, avoid sending samples over the weekend or on holidays. Hold the samples for delivery until the next business day. In case of emergency, make prior arrangements with the laboratory (Infectious Disease Epidemiology Section, 504-568-5005 or Laboratory - Virology Section, 504-568-4039).

BRFSS: The Effect of Diabetes on Stroke Disparities

By Patrice L. Rose, MPH
Chronic Disease Epidemiologist

According to results from the 2000 Louisiana Behavioral Risk Factor Surveillance System (BRFSS), approximately 9% of adults, 35 years and older reported having diabetes. Because diabetes causes damage to the blood vessels over time, diabetics are more at risk for stroke and stroke mortality than people without diabetes. This is evidenced by further results from the Louisiana BRFSS which estimates that 9.8% of diabetic adults over 35 years of age reported having previously had a stroke, compared to only 4.1% of adults in the same age group without diabetes.

The relationship between diabetes and stroke is further complicated by the fact that race is a risk factor for both outcomes. As shown in the Table, analysis of 2000 BRFSS data shows that 12.0% of black adults aged 35 years and older in Louisiana reported having been told by a doctor that they have diabetes, as opposed to 7.7% of white adults aged 35 years and older. In the same year, Blacks were more than twice as likely to report having previously had a stroke as Whites (8.1% vs. 3.5%).

The racial disparity in diabetes prevalence and stroke prevalence has a synergistic effect on the racial disparity in stroke mortality rates. In 2000, the age-adjusted stroke death rate for Blacks was 84.6 per 100,000 and 56.1 for Whites. This disparity remains constant, even when adjusting for sex (See the Figure).

Stroke prevalence estimated through the BRFSS is underestimated in that it only represents stroke survivors, stroke survivors who are not institutionalized, and stroke survivors who are functional enough to respond to a telephone survey.

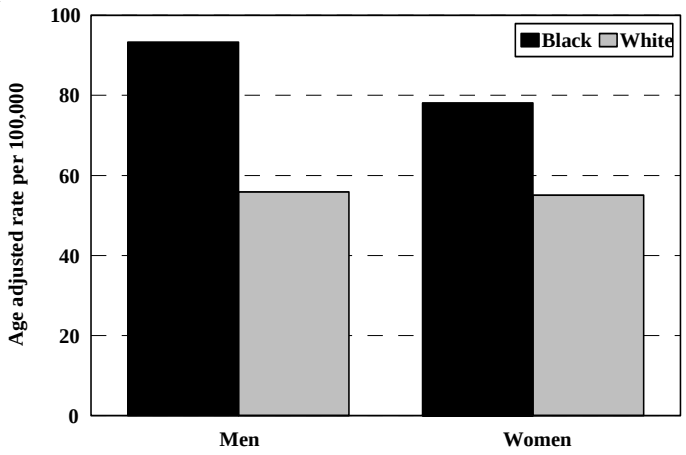
The Diabetes Control Program, in collaboration with the Cardiovascular Health Program has developed interventions targeting at-risk populations. These interventions include faith based initiatives which addresses the underlying risk factors (weight control, physical activity, hypertension, nutrition, and regular check ups) of diabetes and cardiovascular disease. The programs also collaborate with the City Of New Orleans – assisting with strengthening a local surveillance system as well as an educational component targeting at-risk populations in the City of New Orleans. For more information on these programs, please contact the Chronic Disease Control Section at 504-568-7210.

Table: Diabetes and stroke prevalence, Louisiana adults 35 years or age & older

Race	Stroke	Diabetes
Black	8.1%	12.0%
White	3.5%	7.7%
Total	4.7%	8.9%

Source: Louisiana BRFSS 2000

Figure: Stroke mortality rates by race and sex, Louisiana 2000



Source: Louisiana State Center for Health Statistics

Announcements

Now Available: Maternal and Child Health Data Book 1990-2000

The Maternal and Child Health (MCH) Section of the Louisiana Office of Public Health (LAOPH) has been concerned with the limited availability of basic MCH data for individuals, programs, and institutions throughout the state. To rectify this problem, the MCH group has compiled the most important and useful indicators reflecting data related to the health status of Louisiana's mothers and children. This MCH data should be useful in evidence-based driven programs and processes. The MCH Data Book can be found at http://www.oph.dhh.state.la.us/maternalchild/pagecd2b.html?page=487.

Video Conference Note

William M. Cassidy MD, Associate Professor of Medicine at the Earl K Long Medical Center appeared as a panel member for a videoconference aired on March 11, 2003 "Hepatitis B&C with HIV Co-Infection: A Diagnostic & Treatment Update". (The teleconference was produced by Albany Medical College, Albany, N.Y.) Dr. Cassidy spoke on the topics of Hepatitis C treatment in correctional settings, dosage for HIV non-responders and HCV progression. For more information on this conference connect to http://www.amc.edu/Patient/hiv/hivconf/index.htm

Lectures

Andrea S. Vicari, DVM, PhD, CDC's Epidemic Intelligence Service (EIS) officer assigned to the Infectious Disease Epidemiology Section, was a presenter at the 52nd EIS Conference (March 31 to April 4, 2003) in Atlanta. His presentation was "Household-Based Seroepidemiologic Survey of West Nile Virus Infection-Slidell, Louisiana, 2002."

From May through August 2003, he will be part of a STOP team to Madagascar. STOP is the program of the World Health Organization to eradicate polio world-wide. For questions on the above, please contact Dr. Vicari, Louisiana Office of Public Health, P.O. Box 60630, New Orleans, LA 70160, 504/568-5005 ext. 123.

Subject Index for the Louisiana Morbidity Report, 2000 – 2002

Note: Year and Number are listed after the comma on each line - 02/06 = Issue Number 6 for the Year 2002.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
Jan-Feb 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 Jan-Feb 2003	Jan-Feb 2002	Jan-Feb Cum 2003	Jan-Feb 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	4	1	1	1	3	9	0	1	21	15	21	15	40.0
Rate[1]	0.1	0.7	0.3	0.2	0.4	1.0	1.8	0.0	0.3	0.5	0.3	0.5	0.3	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	1	0	1	-100.0
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pertussis	2	0	1	0	0	0	0	0	0	3	0	3	0	300
Sexually-transmitted														
HIV/AIDS Cases[2]	17	2	1	4	1	0	2	1	0	28	150	28	150	-435.0
Rate[1]	1.7	0.3	0.3	0.7	0.4	0.0	0.4	0.3	0.0	0.6	3.4	0.6	3.4	na
Gonorrhea Cases	508	262	62	146	58	68	356	108	100	1668	1826	1668	1826	-9.5
Rate[1]	49.1	43.4	16.2	26.6	20.5	22.6	68.1	30.5	22.8	37.3	40.9	37.3	40.9	na
Syphilis (P&S) Cases	2	7	0	1	1	0	1	0	0	12	21	12	21	-42.9
Rate[1]	0.2	1.2	0.0	0.2	0.4	0.0	0.2	0.0	0.0	0.3	0.5	0.3	0.5	na
Enteric														
Campylobacter	1	4	0	3	0	3	0	2	2	15	7	15	7	114.3
Hepatitis A Cases	1	0	0	1	0	0	1	1	0	4	11	4	11	-125.0
Rate[1]	0.1	0.0	0.0	0.2	0.0	0.0	0.2	0.3	0.0	0.1	0.3	0.1	0.3	na
Salmonella Cases	5	21	4	4	4	3	3	4	3	51	32	51	32	59.3
Rate[1]	0.5	3.7	1.1	0.8	1.5	1.0	0.6	1.1	0.8	1.2	0.7	1.2	0.7	na
Shigella Cases	15	21	6	3	2	1	0	1	6	55	19	55	19	189.0
Rate[1]	1.4	3.7	1.6	0.6	0.7	0.3	0.0	0.3	1.6	1.3	0.4	1.3	0.4	na
Vibrio cholera	0	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	1	0	1	-100.0
Other														
H. influenzae (other)	0	0	0	0	0	2	0	1	1	4	1	4	1	300.0
N. Meningitidis	5	0	1	3	3	0	0	1	0	13	9	13	9	44.4
Tuberculosis	1	0	0	0	0	1	0	1	0	3	2	3	2	66.7

1 = Cases Per 100,000

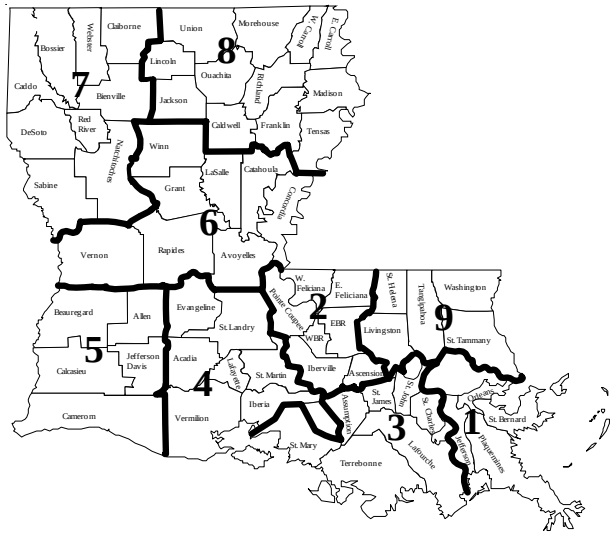
2=These totals reflect persons with HIV infection whose status was first detected during the specified time period. This includes persons who were diagnosed with AIDS at time HIV was first detected.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Legionellosis	0
Lyme Disease	2
Malaria	1
Rabies, animal	0
Varicella	4

Table 3. Animal rabies (Jan-Feb)

Parish	No. Cases	Species
No Rabies Reports for This Period		



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

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

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

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

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

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

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

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

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

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

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

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

Other Reportable Conditions:

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

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

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

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

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

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

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