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Louisiana Morbidity Report

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Adequate Prenatal Weight Gain and Birth Weight

Juan M. Acuna, MD MSc; Janet Guidry, RD MPH

Background: Weight gain during pregnancy has been strongly and consistently associated with poor neonatal outcomes, especially low birth weight (LBW defined as less than 2500 grams) and very low birth weight (VLBW defined as less than 1500 grams). Low birth weight is considered the most important single cause of perinatal mortality.

Inadequate weight gain has also been associated with poor pregnancy outcomes such as pregnancy induced hypertension and diabetes. For these reasons, weight gain in pregnancy is a very important public health issue that must be addressed during prenatal care by both patients and health care providers. In addition to the total amount of weight gain, the rate of the weight gain can also affect pregnancy and infant outcomes.

Prenatal weight gain within the Institute of Medicine (IOM) recommended ranges is associated with better pregnancy outcomes (Table 1). Despite this, only 30% to 40% of women in the United States actually gain weight within the IOM recommended ranges during pregnancy.

Table 1: Institute of Medicine recommended weight gain during pregnancy

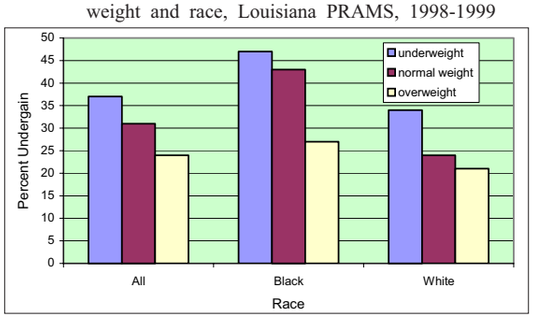
Pre-pregnancy body mass index (BMI)	Recommended Weight Gain
<19.8 (under weight)	28 – 40 lbs.
19.8 – 26 (normal weight)	25 – 35 lbs.
> 26.0 – 29 (over weight)	15 – 25 lbs.
> 29 (obese)	15 lbs.

Methods: The Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS) data, collected during 1998 and 1999, was used to look at the association of weight gain during pregnancy and pregnancy outcome. Descriptive analysis and multivariate relationships were studied. An analysis of the distribution of weight gain during pregnancy, the risk factors for inadequate weight gain and the relationship between weight gain and low birth weight was conducted.

Findings: Given that inadequate prenatal weight gain is of most concern, the rest of the document will reflect only those analyses performed on the population with inadequate prenatal weight gain.

In Louisiana the proportion of women with inadequate weight gain during pregnancy varied with pre-pregnancy status and race. The distribution is summarized in Figure 1.

Figure 1: Inadequate weight gain during pregnancy by pre-pregnancy weight and race, Louisiana PRAMS, 1998-1999



Women who were underweight during pre-pregnancy had the highest proportion of inadequate weight gain. The relationship of pre-pregnancy BMI and inadequate weight gain was greatest for Black women. Pre-pregnancy weight is associated with prenatal weight gain and thus, infant birth-weight. Although weight gain has the greatest impact on pregnancy outcome in underweight and normal-weighted women, it is also significant in women who are overweight. Black women have a tendency to have a higher proportion of inadequate weight gain during pregnancy. Women with underweight pre-pregnancy BMI have a higher proportion of inadequate weight gain. Even women with a BMI less than 29.0 should gain at least 15 pounds. Women with a BMI greater than 29.0 who lose weight or gain less than 15 pounds are more likely to deliver a small-for-gestational-age infant. As seen in Figure 2, there is a stronger relationship between the pre-pregnancy weight and the percentage of LBW in Black women, which is not seen in White women. Black women will have a higher percentage of LBW regardless of the pre-pregnancy BMI than White women.

This relationship may also be explained from the perspective of the proportion of LBW and VLBW babies born to women, according to the pregnancy weight gain, (Figures 3 and 4).

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Content

Adequate Prenatal Weight Gain and Birth Weight (Cont.)

Figure 2: Percent low birth weight newborns by pre-pregnancy weight and race, Louisiana 1998-1999

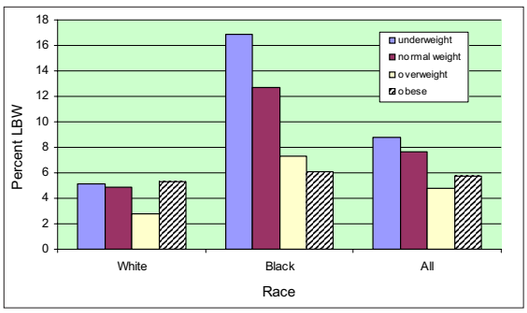


Figure 3: Percent of LBW newborns by race and weight gain in pregnancy, Louisiana PRAMS, 1998-1999

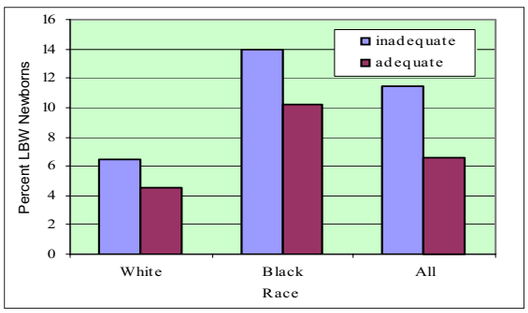
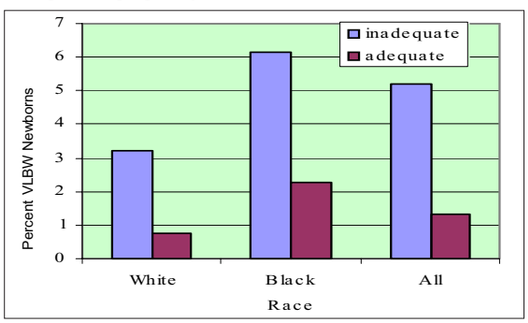


Figure 4: Percent of VLBW newborns by race and weight gain in pregnancy, Louisiana PRAMS, 1998-1999



Regardless of the race, the percentage for both LBW and VLBW is greater in the groups of women that have inadequate weight gain during pregnancy. Nevertheless, Black women have a higher proportion of LBW and VLBW then White women, regardless of whether they have adequate or inadequate weight gain during pregnancy.

To look at the effect of factors such as education, smoking, drinking, and social-economic groups on the relationship between prenatal weight gain and birth weight outcomes, a multivariate analysis was conducted. In this analysis, (after correcting for all the above-mentioned factors that may be an influence), weight gain was identified as an important risk factor for LBW in Louisiana. Those women with inadequate weight gain during pregnancy have an 80% greater chance of having a LBW baby than those with adequate weight gain. The analysis also indicated that the lack of nutritional counseling during pregnancy increases the rate of very low birth weight newborns by 47% and that Black women have a 60% higher proportion of LBW than White women. Smoking during pregnancy is the most important risk factor for LBW/VLBW as it quadruples the proportion of LBW newborns.

Risk factors for women who had inadequate weight gain during pregnancy were also analyzed. In the multivariate analysis White women were twice as likely to have inadequate weight gain during pregnancy as Black women. Other risk factors include smoking during pregnancy (three times more likely), drinking during pregnancy (twice more likely), income lower than $16,000 per year (40% increased risk) and being single (50% increased risk).

In summary, pregnancy is a critical period during which good maternal behaviors, including nutrition, are key factors influencing healthy weight gain and the rate of weight gain. Women should not smoke or drink alcohol and must seek nutritional counseling during pregnancy. If a woman does not gain enough weight, she will be more likely to have a LBW/VLBW baby. If she is White, smokes or drinks and does not get appropriate counseling during pregnancy, she will be more likely to not gain appropriate weight during her pregnancy.

Every pregnant women should consume a variety of foods according to the Dietary Guidelines by USDA: two servings from the meat group; two to three servings from the milk group; three servings from the fruit group; four servings from the vegetable group; nine servings from the breads/cereal group. The additional amount of calories during the second and third trimesters of pregnancy is approximately 300 kcal per day, however the women's pre-pregnancy weight, rate of weight gain and appetite are better indicators of adequate calories consumed. Whole grains, leafy green and yellow vegetables and fruit should be consumed daily to meet nutrient needs and provide enough fiber. Meat, poultry, seafood, legumes and nuts are important sources of protein, zinc, iron and magnesium. Women who eliminate certain foods or food groups should be encouraged to see a health professional for dietary evaluation.

To prevent low weight gain during pregnancy, LBW and VLBW infants, health care providers can support and educate patients on the right amount of weight gain, rate of weight gain and other healthy behaviors. Surveys by the Centers for Disease Control and March of Dimes indicate that women are willing to follow recommendations given by their health provider.

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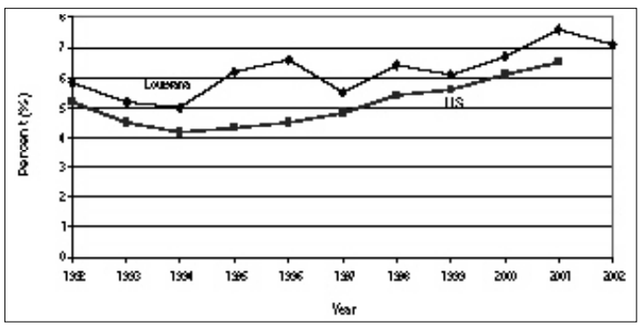
Disparities in Diabetes Prevalence, Management and Mortality

Patrice L. Rose, MPH

Diabetes is a common and costly disease. According to the 2001 Behavioral Risk Factors Surveillance System (BRFSS), the national adult diabetes prevalence rate is 6.5%. Despite the fact that diabetes can affect anyone, disparities in prevalence, self-management practices and mortality exist between Blacks and Whites and are inconsistent. While Blacks have a higher prevalence of diabetes, Blacks report better self management practices than Whites. Blacks also have a disproportionately high diabetes mortality rate.

A 10-year study of the BRFSS (1992-2002) reveals that the prevalence of diabetes has been consistently higher in Louisiana than in the United States (Figure 1). The prevalence of diabetes was on a downward trend in Louisiana and in the nation until 1994. Since that time, the proportion of adults with diabetes has increased, with Louisiana rising to approximately 7.6% in 2001 and the U.S. to 6.5%.

Figure 1: Prevalence of diabetes, BRFSS 1992-2002, Louisiana vs U.S.



In 2002, an estimated 230,000 (7%) adults in Louisiana were diabetic. An investigation of self-management practices, however, indicates that while Blacks have a higher prevalence of diabetes (9% vs 6%), Whites are more likely than Blacks to have never received self-management education (52% vs 38%).* Whites are also more likely than Blacks to not have received a podiatric exam (27% vs 20%) and to have less than the recommended number of office visits (56% vs 42%) within the last 12 months (Figure 2). Despite better self-management and educational opportunities among Black diabetics, the mortality rate remains higher than among White diabetics. In 2000, the overall age-adjusted diabetes mortality rate for Louisiana was 41 per 100,000 and ranked highest in the nation when compared to the U.S. rate of 25 per 100,000. Blacks were more than twice as likely to die of diabetes as Whites (75 per 100,000 vs 31 per 100,000) (Figure 3). Black females had the highest rates of mortality (80 per 100,000), followed by Black males (66 per 100,000), White males (35 per 100,000) and White females (29 per 100,000).

As with many chronic diseases, modification to lifestyles and behaviors are imperative for the control of diabetes. Nevertheless, inconsistent disparities between Blacks and Whites in prevalence and self-management practices indicate that there are underlying factors that contribute to the high mortality rate of Black diabetics. Further studies are needed to determine the various sources of disparity, including the cause of poor self-management among Whites and identify forms of intervention that will successfully eliminate the disparities.

Figure 2: Diabetes self-management practices by race

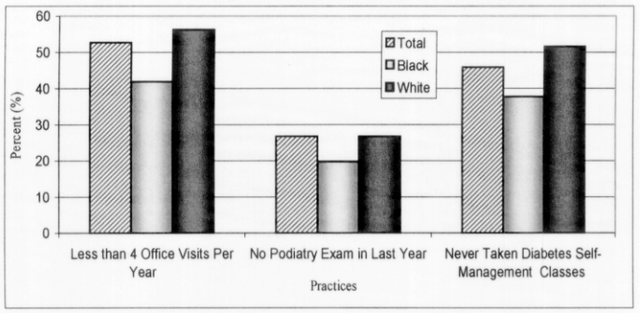
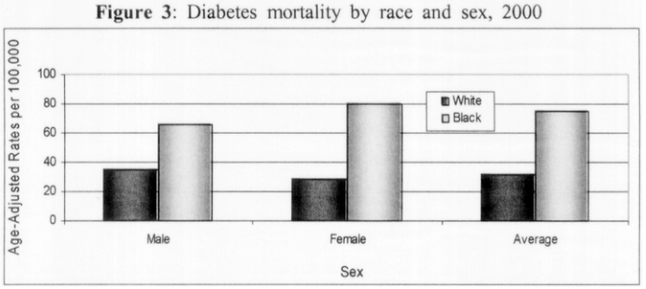


Figure 3: Diabetes mortality by race and sex, 2000



In an effort to reduce health disparities in the state, the Louisiana Office of Public Health (LA OPH) Diabetes Prevention and Control Program is currently involved in the National Health Disparities Collaborative through the U.S. Bureau of Primary Health Care at five community health centers across the state. This collaborative effort strives to increase services and education for individuals who have or are at risk for diabetes. In addition, the Chronic Disease Epidemiology Unit is in the process of designing a diabetes-specific surveillance system that will be used to identify sources of disparity for both Blacks and Whites. For more information about the LA OPH Diabetes Prevention and Control Program Louisiana, please contact Shawn Smith at 504-568-7210.

**Editor's note: Receiving self-management education does not necessarily translate into better self-management...also the reverse, better self-management does not always come from increased educational opportunities. Income level may not have a correlation with better self-management.*

Yersinia Enterocolitica

Alex Pavluck

Y. enterocolitica is a non-reportable disease and as such, may have higher numbers than listed. Foodnet 2001 data shows a sharp decline of *Y. enterocolitica* (49%) as compared to 1996-2000 data. However, the burden of this disease in the United States remains approximately 100,000 persons infected each year. Since January, 1998, the Louisiana state bacteriology lab has confirmed a total of forty-one cases. Because of *Yersinia enterocolitica's* relatively low incidence, as well as specific techniques required for identification of the organism, laboratory personnel should be notified that *Y. enterocolitica* is suspected.

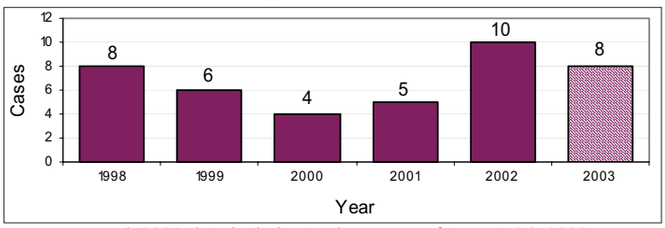
Identification: *Y. enterocolitica* is a foodborne infectious disease caused by a bacterium which comprises over fifty serotypes

(Continued on next page)

Yersenia Enterocolitica (Cont.)

and five biotypes, many of which are nonpathogenic. In Louisiana 'biotype 4' is the predominant biotype of *Y. enterocolitica* infections comprising more than 74% of all confirmed cases since 1998. Typically diagnosis is made by the examination of stool culture. However, *Y. enterocolitica* can be isolated from a number of sources including throat swabs, mesenteric lymph nodes, peritoneal fluid, blood, bile, urine, cerebrospinal fluid, sputum and wounds.

Figure 1: *Yersinia enterocolitica* Cases Confirmed by the State Bacteriology Lab, Louisiana 1998-2003*



* 2003 data includes total cases as of August 26, 2003

The resulting symptoms can vary depending upon the age of the infected individual. Common symptoms for children include fever, abdominal pain and diarrhea - which is often bloody. Symptoms generally develop fro four to six days following exposure and may last between one to three weeks or longer. Often adult infections present as right-sided abdominal pain and fever. Complications such as skin rash, joint pain, or the spread of the bacteria into the bloodstream may rarely occur. Most infections are self-limiting and will resolve completely. However, some persons may develop sequelae such as joint pain in the knees, ankles or wrists approximately one month following the initial symptoms. This joint pain will typically resolve after a duration of one to six months. Additionally a skin rash, called "erythema nodosum," may also appear on the legs and trunk, (most often occurring in women). In the majority of cases, erythema nodosum will resolve within a month.

Epidemiology: The reservoir for *Y. enterocolitica* is swine. Transmission generally occurs through the ingestion of contaminated pork products. However, contaminated water, direct or indirect contact with infected animals, blood transfusion and possible fecal-oral, person-to-person contact has also been shown to be potential routes of transmission. *Y. enterocolitica* can also be transmitted to bottle-fed infants if their caregivers have recently handled raw pork intestines (e.g. chitterlings).

The incubation period typically lasts four to six days, but it can be as short as one day or as long as fourteen days. The period of communicability is unknown although transmission is likely to occur for the duration of excretion of the organism, which averages six weeks after diagnosis.

Prevention: The following prevention methods are suggested: 1. Avoid eating raw or undercooked pork. 2. Consume only pasteurized milk or milk products. 3. Wash hands with soap and water before eating and preparing food, after contact with animals and after handling raw meat. 4. After handling raw chitterlings, clean hands and fingernails scrupulously with soap and water before touching infants or their toys, bottles, or pacifiers. (Someone other than the foodhandler should care for children while chitterlings are being prepared.) 5. Prevent cross-contamination in the kitchen: -Use separate cutting boards for meat and other foods. -Carefully clean all cutting boards, counter-tops, and utensils with soap and hot water after preparing raw meat. 6. Dispose of animal feces in a sanitary manner.

For references please contact (504)5685005 x 113 or for more information go to:
http://www.cdc.gov/ncidod/dbmd/diseaseinfo/yersinia_g.htm

Perception of West Nile Virus Activity

Sarah Michaels, MPH

With the explosion of West Nile Virus (WNV) in Colorado in August and the relatively few cases reported this year in Louisiana, one question that is being asked is "What has changed?"

Louisiana has always had a favorable climate for mosquito reproduction and a history of mosquito-borne disease. Although West Nile virus has grabbed most of the media attention in recent years, St. Louis and eastern equine viruses have long caused sporadic cases and occasional outbreaks. In 2002, Louisiana had the earliest WNV human infection in the country (6/10/02) as well as some of the latest (11/30/02). By August 29, 2002, there were 205 reported human cases and eight fatalities. In 2003 there were again human onset dates in June (6/15/03), however by August 25, 2003, the toll was only forty infected and no fatalities.

In March 2003, OPH began its earliest monitoring and testing of dead birds. West Nile is maintained in a bird-mosquito cycle where birds serve as amplifying hosts. Mosquitoes that bite both birds and humans can transmit the virus. (Humans do not produce a high enough virema to infect a mosquito.) There were many more positive birds in 2003 with some activity recorded as early as March. Only about 10% of the birds tested in the spring were positive while the number rose to about 50% or higher during the summer months. More testing has translated into finding more activity and evidence that the virus may actually be cycling almost year round.

Has the environment changed or have weather patterns had an effect on the mosquito population? With the extremely wet spring that occurred in the southern part of the state, it seems strange to some that the majority of the cases are coming from the Shreveport area. However, perhaps extensive rainfall actually "flushed" areas in the south of Louisiana while sporadic downpours followed by periods of drying out caused more standing water and therefore more breeding sites in Louisiana's north. Much more research needs to be done in this area.

Could the number of susceptible individuals be decreasing? This does not appear likely. In 2002, the Centers for Disease Control (CDC) conducted a study in Slidell and found the number of people infected with WNV to be about 2%. Are people heeding the prevention messages? The DHH/ OPH public education campaign, "Fight the Bite!" has encouraged people to eliminate mosquito breeding sites and take personal protection against mosquitoes. This campaign has been very successful, leading a number of other states to borrow from it.

Have mosquito control activities changed? This year, St.Tammany parish started very early in the season larvaciding and has experienced much lower adult and larvicide counts (trap and dip counts). However by this time last year, adult counts were similar and there were still new human infections. A number of parishes

have begun mosquito control programs and many are taking steps to access their feasibility through the LaMap project (a joint partnership with DHH and LSU).

Is there a difference in how the cases are being reported? One in five people infected with WNV develops a mild febrile illness, while one in 150 develops meningitis or encephalitis (ME). This year thirty-eight of the forty cases are ME in Louisiana (95%), while in Colorado 118 of the 546 cases are ME (21.6%). In 2002, 204 of the 329 cases reported were ME (62.0%). Perhaps because of the novelty of a new disease in an area, many residents experiencing mild symptoms get tested who may not have otherwise been diagnosed.

Another point to keep in mind is the actual rate per population. (The rate per population is much more descriptive than total numbers.) Last year, Louisiana had the highest rate, (per 100,000 people) of any state, 7.4 (329 cases). By comparison, Illinois reported many more cases (884), but had a rate of 6.2.

Lastly, the largest numbers of WNV infections occur in late August and early September with case numbers expecting to dramatically increase across the country. As the northern climates cool, Louisiana expects to continue having warm temperatures and mosquito activity. The key message is for Louisiana residents not to drop their guard as there is still a very active season to go.

OPH Epi Training Offering

The Office of Public Health Infectious Disease (ID) Epidemiology Section is offering **two**, one-day training sessions. The trainings will be targeted towards sanitarians, public health nurses, infection control professionals, disease surveillance specialists, epidemiologists, health care providers and other public health care professionals interested in epidemiological principles and outbreak investigations.

The first training to be held on December 3, 2003, Field Epidemiological Techniques I, is a repeat of the session held on August 12-13, 2003 for those individuals not on the ID- Rapid Response Team (ID-RRT). The topics will include: Epidemiology Primer, ID Outbreak Teams Roles and Responsibilities, Louisiana- Diseases and Outbreaks, Disease Modes of Transmission and a Bioterrorism Table-Top Exercise. The second training to be held on December 4, 2003, Field Epidemiological Techniques II is a new course and will focus on specific diseases. The topics will include:West Nile Virus, Norovirus, Pneumonia, Vibrio, Salmonella, Shigella, Rabies, Hepatitis, Vector Borne Disease and MRSA. This course is open for everyone, including members of the ID-RRT.

Both trainings will be held at the Louisiana State Office building in New Orleans and are free of charge but seating is limited. The *Registration Deadline is November 3rd.* For a registration form, please email Rosemarie Robertson at rroberts@dhh.state.la.us or call (504) 568-5005 x124.

Field Epidemiology Training, August 12-13, 2003

Influenza Vaccination: Focus on Diabetics and Older Populations

Patrice L. Rose, MPH

In Louisiana, the flu season lasts from late November to spring each year. In 2000, there were 25 deaths attributable to influenza reported in Louisiana and 1765 deaths reported in the United States with most of these deaths occurring in the senior population.

With over 1,546 of the deaths occurring among adults over the age of 65, older Americans are at a greater risk of influenza related morbidity and mortality. Many of these deaths could be preventable by taking a safe and effective vaccine. The U.S. Preventive Services Task Force recommends that people over the age of 65 and those with chronic conditions, such as diabetes, have an annual flu vaccination.* In the April 25, 2003 issue of the *MMWR* report, Prevention and Control of Influenza, the CDC reports that the influenza vaccination has been shown to be 30%-70% effective in preventing hospitalization for pneumonia and influenza among elderly persons living outside of chronic-care facilities and the vaccine can be up to 80% effective in preventing death among elderly persons residing in nursing homes. The Healthy People 2010 goal is to increase the percentage of people over the age of 65 who receive an annual flu shot to 90% and those with chronic conditions, such as diabetes, to 60%.

According to the CDC National Immunization Program, the Food and Drug Administration (FDA) has "approved an intranasal, trivalent, cold-adapted, live, attenuated influenza vaccine for use in healthy persons aged 5 to 49 years to prevent influenza A and B." However, at this time this intervention has not been approved for at-risk groups (such as older populations and those with chronic conditions such as diabetes).

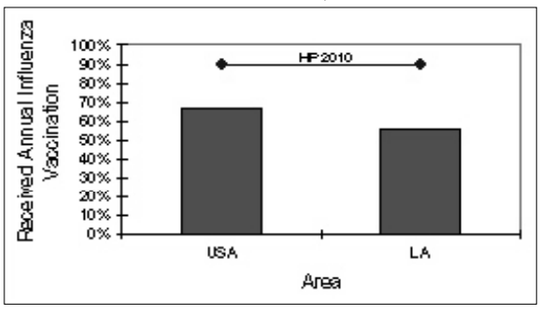
Prevalence data for flu vaccination is collected by the Behavioral Risk Factor Surveillance System (BRFSS), an annual telephone survey administered to non-institutionalized adults over the age of 18. This survey includes the question asked in both 2001 and 2002

"During the past 12 months, have you had a flu shot?" Although the 2001 data is available for both the U.S. and Louisiana, the U.S. data for 2002 is not available.

According to the 2001 BRFSS, adults in Louisiana over the age of 65 were less likely to have received a flu shot compared to those in the U.S. (56% vs 67%). (Figure 1).

Analysis of the 2002 BRFSS indicates that a similar proportion of adults over the age of 65 (57%) received a flu shot in the twelve months preceding the survey. Of these, Blacks are less likely than Whites to have had an annual flu shot (47% vs. 61%) while males and females responded similarly (56% vs 58%).

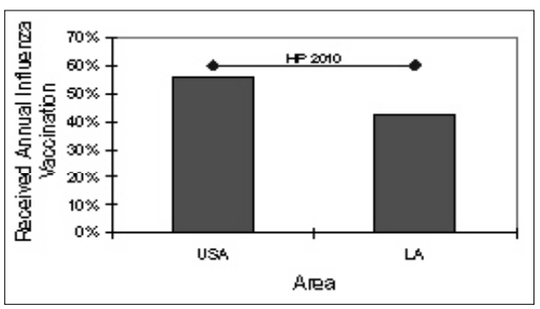
Figure 1: Influenza vaccinations among those 65+ years, Louisiana vs U.S.A, 2001



Chronic Conditions: Diabetes

Because populations with chronic conditions such as diabetes are at a greater risk of morbidity and mortality from complications of influenza, the U.S. Preventive Services Task Force recommends annual influenza vaccination. Nationally, 57% of adult diabetics received an annual flu vaccination in 2001, while the percentage of adult diabetics in Louisiana was 42%. (Figure 2).

Figure 2: Influenza vaccinations among diabetics (18 years and older), Louisiana vs USA, 2001



In 2002, Black diabetics were less likely than White diabetics (45% vs 54%) to have received an annual flu shot. In addition, female diabetics were less likely than male diabetics (45% vs 52%) to have received an annual flu shot. (Table 1).

The statewide influenza immunization program for high risk individuals is scheduled to begin the week of October 27, 2003. Persons in high risk groups such as those over the age of 65 and those who have chronic conditions should receive an influenza vaccination prior to the beginning of the flu season each year to avoid infection and complications that may result.

Table 1: Flu shot coverage among high risk groups in Louisiana, 2002

	% Received Influenza Vaccination in Last Year	
	65+ AGE GROUP	DIABETICS
Total	57.3%	48.0%
White	60.9%	53.6%
Black	46.9%	44.8%
Male	56.4%	51.6%
Female	57.9%	44.7%

** The State of Louisiana Influenza Protocol 2003-2004, dated September 9, 2003, recommends that people over the age of 50 and those with chronic conditions have an annual flu vaccination.*

Influenza, Pneumonia and Tetanus Immunization

Ruben Tapia

The Office of Public Health (OPH) will begin its influenza campaign on October 27, 2003. In keeping with the recommendations of the Advisory Committee on Immunization Practices (ACIP), the OPH Immunization Program recommends immunization of the elderly and those individuals who are at high risk of serious illness or death from influenza. Influenza strains anticipated to be prevalent this flu season should be closely related to A/Moscow/10/99 (H3N2), A/New Caledonia/20/99 (H1N1), and B/Hong Kong/33072001- like antigens. For the Moscow/10/99 [H3N2]-like antigen manufacturers will use the antigenically equivalent A/Panama/2007/99 [H3N2] virus and for the B/Hong Kong/33072001- like antigen, manufacturers will use either B/Hong Kong/33072001or the antigenically equivalent B/Hong Kong/143472002. These strains are included in this year's vaccine.

A limited amount of thimerosal free influenza vaccine will be made available for children 6 to 35 months of age.

Please remember that the influenza virus often changes from year to year and because of this, it is very important to get vaccinated against influenza on a yearly basis. Last year less than 25% of the State population at high risk received the much needed influenza vaccination. Among African-Americans, less than 17 % of those in need received it.

As part of an adult immunization program, each person who comes to a medical provider to receive an influenza vaccination should also be offered the tetanus-diphtheria (Td vaccine), if he or she needs it, (according to OPH recommendations, i.e. "routine" booster dose for adults every ten years). Also recommended is checking the vaccine history status for Pneumococcal Polysaccharide Vaccine – 23 valent (PPV-23). Immunization with Pneumococcal vaccine is highly recommended for anyone aged 65 or older, as well as for people of any age who have a chronic illness. Individuals that received the 14-valent polysaccharide vaccine licensed in 1974 need to be revaccinated with PPV-23. Also, a second dose is recommended for those people aged 65 and older who got their first dose (whether 14-valent polysaccharide vaccine or 23-valent polysaccharide vaccine) when they were under 65 years of age (and if at least five or more years have past since the first dose).

For information on clinic times and days, please contact your local parish health unit or your private provider.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
Jul-Aug 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 Jul-Aug 2003	Jul-Aug 2002	Jan-Aug Cum 2003	Jan-Aug Cum 2002	% Chg
Vaccine-preventable															
H. influenzae (type B)		0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Hepatitis B	Cases	2	3	0	1	0	0	0	2	0	8	14	92	95	-3.2
	Rate[1]	0.2	0.5	0.0	0.2	0.0	0.0	0.0	0.6	0.0	0.2	0.3	2.1	2.2	na
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Mumps		0	0	0	0	0	0	0	0	0	0	0	0	1	-100.0
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	1	-100.0
Pertussis		0	0	0	0	0	0	0	0	0	0	1	6	8	-25.0
Sexually-transmitted															
HIV/AIDS	Cases[2]	12	12	1	2	2	0	2	0	1	32	231	336	840	-60.0
	Rate[1]	1.2	2.1	0.3	0.4	0.7	0.0	0.4	0.0	0.2	0.7	5.3	7.7	19.2	na
Gonorrhea	Cases	794	210	74	155	50	61	268	82	87	1781	2331	7791	8104	-3.9
	Rate[1]	76.8	34.8	19.3	28.3	17.7	20.3	51.2	23.2	19.9	39.9	55.2	174.3	192.0	na
Syphilis (P&S)	Cases	5	7	0	8	1	2	1	1	3	28	33	83	98	-15.3
	Rate[1]	0.5	1.2	0.0	1.5	0.4	0.7	0.2	0.3	0.7	0.6	0.8	1.9	2.3	na
Enteric															
Campylobacter		3	3	1	3	3	2	0	5	3	23	32	65	92	-29.3
Hepatitis A	Cases	1	0	0	0	0	0	0	0	0	1	14	49	61	-19.7
	Rate[1]	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	1.1	1.4	na
Salmonella	Cases	11	19	7	19	6	11	3	12	19	107	208	339	571	-40.6
	Rate[1]	1.1	3.3	1.9	3.7	2.2	3.6	0.6	3.4	4.9	2.5	4.9	7.9	13.2	na
Shigella	Cases	0	4	1	5	0	6	0	1	5	22	31	207	370	-44.1
	Rate[1]	0.0	0.7	0.3	1.0	0.0	2.0	0.0	0.3	1.3	0.5	0.7	4.8	8.6	na
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Vibrio, other		1	0	0	1	1	0	0	0	0	3	6	12	30	-60.0
Other															
H. influenzae (other)		0	1	0	0	0	0	0	0	0	1	0	12	7	71.4
N. Meningitidis		0	0	0	0	1	0	0	0	1	2	5	32	33	-3.0
Tuberculosis		na	na	na	na	na	na	na	na	na	na	52	na	137	na

1 = Cases Per 100,000

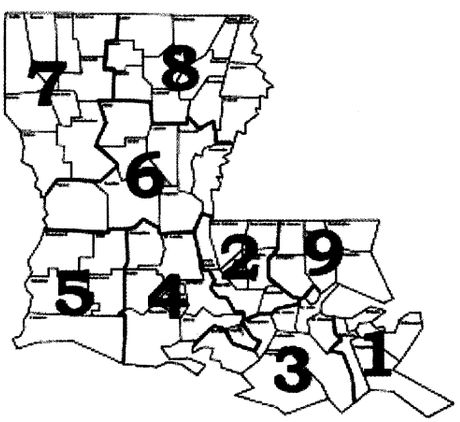
2=These totals reflect persons with HIV infection whose status was first detected during the specified time period. This includes persons who were diagnosed with AIDS at time HIV was first detected.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Legionellosis	1
Lyme Disease	6
Malaria	3
Rabies, animal	3
Varicella	11

Table 3. Animal rabies (Jan-Aug)

Parish	No. Cases	Species
Avoyelles	1	Skunk
St. Tammany	1	Bat
Unknown	1	Skunk



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
- Botulism
- Brucellosis
- Cholera
- Diphtheria
- Haemophilus influenzae (invasive disease)
- Neisseria meningitidis (invasive disease)
- Plague
- Poliomyelitis, paralytic
- Q Fever
- Rabies (animal & man)
- Rubella (German measles)
- Smallpox
- Staphylococcus Aureus, Vancomycin Resistant
- Tularemia
- Viral Hemorrhagic Fever
- 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
- Chancroid[1]
- E. Coli 0157:H7
- E. Coli Enterohemorrhagic (other)
- Encephalitis, Arthropod borne
- Hantavirus Pulmonary Syndrome
- Hemolytic-Uremic Syndrome
- Hepatitis A (acute disease)
- Hepatitis B (carriage)
- Hepatitis B (perinatal infection)
- Hepatitis E
- Herpes (neonatal)
- Legionellosis (acute disease)
- 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 workweek 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]
- Coccidioidomycosis
- Cryptosporidiosis
- Cyclosporiasis
- Dengue
- Ehrlichiosis Hansen's Disease (leprosy)
- Enterococcus, Vancomycin Resistant (VRE) (invasive disease)
- Giardia
- Gonorrhea[1]
- Hansen's Disease (leprosy)
- Hepatitis B (acute)
- Hepatitis C (acute and infection)
- Human Immunodeficiency Virus (HIV infection)
- Listeria
- Lyme Disease
- Lymphogranuloma Venereum[1]
- Psittacosis
- Rocky Mountain Spotted Fever (RMSF)
- Staphylococcus Aureus, Methicillin/ Oxacillin Resistant (MRSA) (invasive disease)
- Staphylococcal Toxic Shock Syndrome
- Streptococcal disease, Group A disease)
- Streptococcal disease, Group B (invasive disease)
- Streptococcal Toxic Shock Syndrome
- Streptococcus Pneumoniae (invasive infection, penicillin resistant (DRSP))
- Streptococcus Pneumoniae (invasive infection in children < 5 years of age)
- Trichinosis
- Varicella (chickenpox)
- Vibrio Infections (other than cholera
- West Nile Fever
- West Nile Infection (past or present)

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 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*.

[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 (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.

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