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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

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

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Newborn Screening for Congenital Hypothyroidism in LA 1999-2002

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Congenital Hypothyroidism (CH) is one of the most preventable causes of mental retardation with a worldwide incidence rate of approximately 1 case in 3,600 to 5,000 births. Since 1979, Louisiana's mandated newborn heel stick screening battery has included tests for detecting congenital hypothyroidism.

The Office of Public Health's (OPH) Genetic Diseases Program defines congenital hypothyroidism as any condition in an infant requiring thyroid replacement medication for adequate thyroid functioning. Table 1 shows that there were 66 infants identified with congenital hypothyroidism from January 1, 1999 through December 31, 2002. There were 265,683 live births reported during 1999-2002 which represents an incidence rate of one case per 4,026 births.

Table 1: Cases of congenital hypothyroidism, Louisiana, 1999-2002

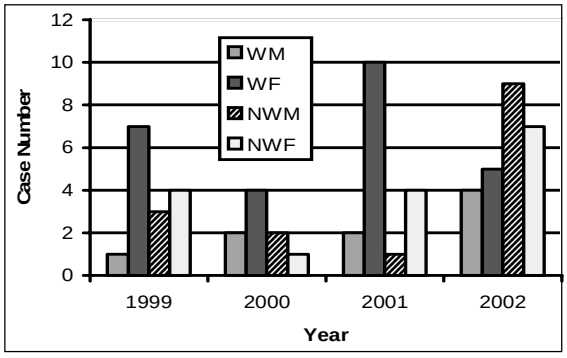
YEAR	CONGENITAL HYPOTHYROIDISM	TOTAL BIRTHS
1999		
White	8	**38,350**
Non-White	7	**28,684**
2000		
White	6	**38,467**
Non-White	3	**29,806**
2001		
White	12	**37,284**
Non-White	5	**28,337**
2002		
White	9	**36,605**
Non-White	16	**28,150**
TOTAL	66	**265,683**

This rate of incidence is similar to the reported worldwide rate, but significantly higher than the rate of one case per 6,250 births for the period from January 1988 through 1999 (LMR Volume 12, Number 3 May-June 2001). This increase in the number of infants reported to be initially placed on medication may be reflective of a more aggressive approach to diagnosis and treatment by neonatologists, pediatricians and family practice physicians.

Since follow-up ends with the verification of treatment, the number of infants taken off medication due to transient hypothyroidism is unknown. Therefore, the increases in cases reported from January 1, 1999 through December 31, 2002 may not necessarily represent an increase in infants with primary congenital hypothyroidism including thyroid dyshormonogenesis.

The graph in Figure 1 indicates that there is no statistically significant difference in the number of newborns detected with congenital hypothyroidism by race.*

Figure 1: Cases of congenital hypothyroidism by race and sex, Louisiana, 1999-2002



* The race of the infant is determined by the reported race of the mother.

The distribution by sex for nonwhites is nearly equal. In contrast, the number of white females detected with congenital hypothyroidism is significantly higher than for white males. This is consistent with the findings of previously published articles, one which reported a female preponderance of congenital hypothyroidism, and the other described gender as the most important factor with at least a 2:1 (female/male) ratio across all major ethnic groups except for blacks.

Twenty-five parishes had at least one case during 1999-2002 and these parishes are located in all nine regions of the state. (Figure 2)

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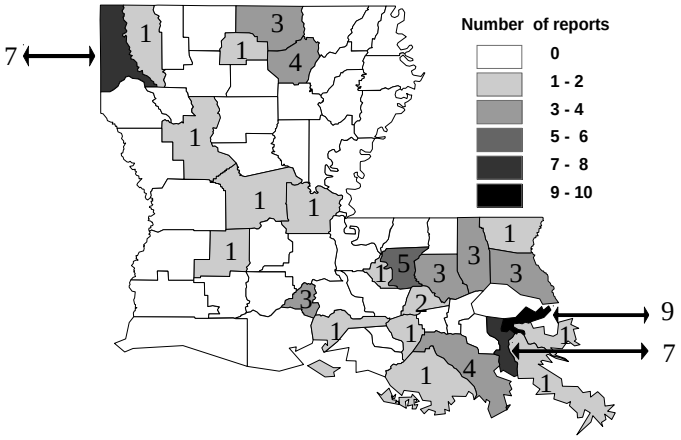
Content

Figure 2: Geographical distribution of reported cases of congenital hypothyroidism, Louisiana 1999-2002



Although the majority of infants were placed on treatment by 21 days, treatment occurred later for 38%.

Table 2: Cases of congenital hypothyroidism from birth to initial treatment, 1999-2002

Age In Days	1-7	8-21	>21	**Total**
Cases	7	34	25	66

OPH is anticipating an increase in the proportion treated by 21 days for the next reporting period as a new policy was disseminated to hospitals that recommends an earlier repeat screening after a blood transfusion.

Laboratory results indicating congenital hypothyroidism of newborns are required to be reported by the laboratory performing the testing to the Genetic Diseases Program via fax (504)568-7722, in accordance with the Newborn Screening Rule (LAC 48: V., 6303). Staff with the Genetics Program track and assist in providing follow-up to ensure affected infants are detected and treated early. When necessary, local assistance may be provided by parish health unit nurses. Closure occurs once treatment has been reported and verified. Consultation is available from the Genetic Disease Program by calling (504)568-7723 or (504)568-5070. Please contact this department for more information or references for this article.

CORONER SURVEILLANCE

Dielda Robertson, BS

Establishing effective surveillance systems, training local first responders and developing electronic communication systems were identified as key areas imperative to the success of the Anti-Bioterrorism Initiative.

The Centers for Disease Control and Prevention (CDC) recognized early that the records of medical examiners/coroners may provide vital information about the patterns and trends of mortality in the United States. These records are also an excellent source of public health surveillance data. Medical examiners/coroners are skilled in preserving medico-legal evidence that may be important for subsequent criminal proceedings and in handling situations that involve mass deaths.

These investigators have state statutory authority to investigate violent, suspicious, sudden, or unexplained deaths, including those due to homicide, trauma and unapparent or poorly explained causes, such as drugs, toxins and infectious agents. Autopsies are an effective way of obtaining an accurate diagnosis for deaths from infectious diseases and toxic exposures.

In 1979, autopsy pathologists played a critical role in recognizing inhalational anthrax cases caused by an accidental discharge from a former Soviet bioweapons laboratory. In 1985, Illinois medical examiners identified the cause of death of persons who ingested acetaminophen that had been intentionally contaminated with cyanide. In the 1993 outbreak of Hantavirus Pulmonary Syndrome in the southwestern United States, medical examiners played an important role in recognizing the novel, rapidly fatal infectious syndrome.

Louisiana has a highly decentralized coroner system for death investigations. Coroners are elected positions provided for by the Louisiana constitution but supported financially by each individual parish. Coroners must be licensed physicians unless none will accept office, in which case coroners may be lay persons. There are sixty-four parish coroners in the state of Louisiana of whom fifty-five are licensed physicians. The Louisiana constitution further mandates the conditions under which deaths must be investigated which includes those stated above. In practice, coroners have a significant amount of leeway to determine which cases to refer for autopsy. Coroners and medical examiners are also required by the Louisiana Sanitary Code to report cases of suspected or confirmed communicable diseases to the State Health Officer.

To be fully integrated into the medical, law enforcement and public health plans for detecting and responding to bioterrorism, medical examiners and coroners need information about the biological and chemical agents likely to be used. Access to laboratories capable of identifying these agents, adequate data management systems for mortality surveillance and improved autopsy facilities and procedures to ensure that prosectors are protected from infectious and chemical agents, are recommended.

OPH has in place a comprehensive surveillance system for reportable diseases and syndromes suspected of being the result of

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bioterrorism. One of the objectives is to include coroner-generated death investigation data in the disease surveillance system.

Coroner Education Program Overview

The Coroner Education Program is in the development phase and will be targeting all Louisiana coroners. The initial coroner education session was conducted by medical and bioterrorism professionals from OPH. Future sessions will cover bioterrorism, the OPH public health surveillance system and reporting methods.

The Model Medical Examiner Surveillance for Bioterrorism Mortality (Med-X) is a project funded by Health and Human Services and CDC to recognize bioterrorism mortality and also to capture deaths caused by infectious agents of public health importance. In order for coroners to quickly identify possible bioterrorism events, the Coroners Education Program adopted with minor modifications*, the Med-X criteria for medical investigators and renamed it as the Louisiana Coroner Criteria (LACC).

Future programs will cover the LACC, the Coroner Education and Reporting Tool (CERT) form and a general question and answer session. Any coroners not attending the program will receive the presentation materials and an educational brochure by mail following the conference.

The Louisiana Coroners Criteria (LACC)
Antecedent Death Symptom Criteria to Notify OPH

- Fever greater than or equal to 101° within 3 days of death
- New rash within 3 days of death
- Encephalopathy **or** meningitis **or** new-onset seizures
- Paralysis
- Acute bloody diarrhea
- Unexpected death case in a person less than 50 years of age

* The symptoms of fever and new rash prior to death are the most specific indicators of an infectious etiology of death. Modifications were based on this unpublished data.

To recognize bioterrorism mortality and capture deaths of public health importance, ante mortem symptoms and pathologic syndromes are used for reporting cases to the Louisiana OPH which has developed an array of clinical symptoms and tied the symptoms to potential autopsy-based pathologic syndromes. All infectious disease and toxin related deaths are evaluated to identify the specific causative agent. The Louisiana OPH has established a bioterrorism reporting hotline for the public, 1-800-256-2748 whenever bioterrorism is suspected or a disease of public health importance appears.

For more information or references, please call (504) 5685005 x 110.

The Effects of Mold Exposure on Health

Katherine Mortland, MPH

While molds and humans have co-existed for thousands of years, recent concerns have developed in Louisiana regarding the effects of mold exposure on health. Lawsuits, media coverage and insurance issues have brought the problem into the public eye and created a growing demand for information. Building practices developed in the 1970's have created more airtight building structures which can lack proper ventilation and be conductive to the growth of mold. While the problem is present everywhere, Louisiana faces greater concerns due to its humid climate, which promotes quick mold growth after water damage.

As molds grow, spores are released into the air where they can be easily inhaled, exposing people to both indoor and outdoor molds daily. Approximately five per cent of the population is predicted to have some allergic airway symptoms from molds over their lifetime. Reactions to mold and the severity of symptoms depend on the types of mold present, the extent of exposure, the age of the individual, the individual's immune system and existing sensitivities or allergies.

The most common allergic reactions to mold include runny nose, sneezing, nasal congestion, watery eyes, skin rash and itching. In more serious cases, sinusitis may occur secondary to nasal obstruction. Molds can also trigger asthma attacks resulting in wheezing, chest tightness and shortness of breath. Opportunistic infections that can affect the skin, eyes, lungs or other organs may occur following exposure to mold in people with weakened immune systems, (e.g. those who are immune-compromised through disease or immune-suppressed from drug treatment).

Microbial volatile organic compounds (mVOC's) are compounds produced through fungal metabolism and are released directly into the air, often giving off strong or unpleasant odors. Exposure to mVOC's from mold can irritate the eyes and respiratory system and are linked to symptoms such as headaches, dizziness, fatigue, nasal irritation and nausea. The effects of mVOC's on human health are not completely understood and research is still in the early stages. Some research links mVOC's to "sick building syndrome" which is characterized as an excess of non-specific complaints and syndromes occurring in occupants of specified buildings.

Mycotoxins, which are naturally occurring substances produced by some fungi as secondary metabolites, are another mechanism by which molds can affect health. Molds produce mycotoxins as a defense mechanism to discourage other molds or bacteria from growing in the same area. Unfortunately, humans who inhale, ingest, or touch mycotoxins may experience toxic effects. Not all molds produce mycotoxins and those that do, may not produce them in every situation. The Environmental Protection Agency (EPA) cautions that finding mold in a building does not necessarily mean that there are also mycotoxins in the building and even when mycotoxins are present, the quantities may be low and human exposure may not occur.

(Continued on next page)

(The Effects of Mold Exposure on Health (Cont)

"Black mold" or "toxic mold" has been the focus of much media attention in recent years. These terms have no scientific basis, but usually refer to a specific type of mold known as *Stachybotrys chartarum* (also known as *Stachybotrys atra*). Not all black molds are in fact, *S. chartarum*. This mold requires constant moisture and usually grows on extremely wet cellulose-based materials. It is normally found as a result of long-term water problems (excessive humidity, water leaks, condensation, water infiltration, or flooding). *S. chartarum* is capable of producing mycotoxins and has the potential to cause health effects. It has caused the greatest public concern due to extensive media coverage. However, all types of molds should be treated the same with respect to potential health risks and removal.

When a person believes he or she has been exposed to mold and has suffered subsequent health effects, some physicians test for mold-specific antibodies. The presence of antibodies indicates that an individual has been exposed to a particular substance in the past, but does not provide information on when the individual was exposed, where the exposure took place, or the amount of substance the person was exposed to. Having a positive test for mold-specific antibodies alone is generally considered insufficient to show that health effects reported by individuals in moisture-damaged buildings were caused by exposure to mold. If an individual has symptoms year-round as opposed to seasonal symptoms, it may indicate an indoor air allergy and skin testing may be recommended.

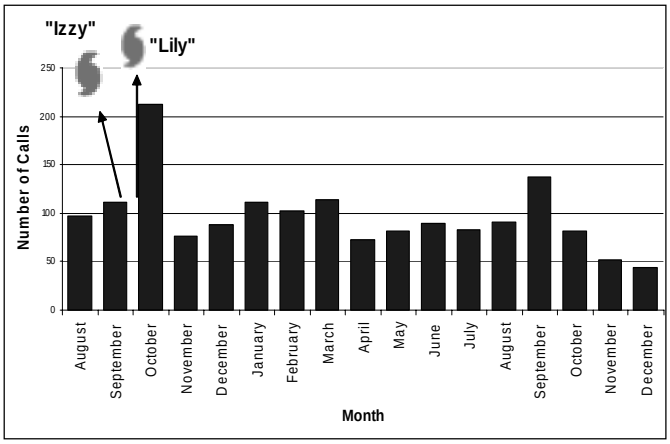
Because exposure standards for mold do not exist, it is important to know the relationship between exposure and health effects associated with mold in the indoor environment. To reduce the risk of developing or exacerbating allergies in sensitive populations, mold should not be allowed to grow unchecked indoors. Indoor mold growth is often visible or produces a detectable odor. Other clues include signs of excess moisture damage or the worsening of allergy-like symptoms. Visible mold should be eradicated and moldy odors investigated.

Although environmental mold sampling is available professionally, it can be difficult, expensive and is generally not necessary if mold is visible. However, when sampling is appropriate, samples should be collected by a professional, e.g. an environmental consultant or industrial hgienist and sent to an accredited laboratory for analysis. Even if sampling is conducted, there are no standards that determine acceptable versus non-acceptable amounts of indoor mold or predict whether or not health effects will occur from any mold present. The most important step in solving a mold problem is to identify and correct the moisture problems that allowed the growth to occur. If the mold problem is confined to an area of less than ten square feet, it is usually possible for one to conduct mold remediation, provided that the appropriate personal protective equipment is worn and that the remediator doesn't have health problems that could be exacerbated by the mold. If the problem area is large or there is possible mold growth in ductwork, walls, or carpeting, it may be necessary to hire a professional mold remediation service or an environmental consultant. Louisiana recently passed legislation (Act No. 880, Regular Session, 2003) requiring licensing by the State Licensing Board for Contractors of persons who conduct mold remediation.

People performing mold remediation, especially those with health concerns or questions, may wish to check with a physician or other health care professional before removing mold or investigating potentially moldy areas. Anyone attempting mold remediation work must wear proper personal protective equipment that prevents the inhalation and ingestion of mold spores and fragments and contact with the eyes and skin. Removing people from the work area during mold remediation is important and recommended for infants (less than 12 months old), persons recovering from recent surgery, immune-suppressed people, or people with chronic inflammatory lung diseases such as asthma, hypersensitivity pneumonitis and severe allergies.

Humans spend the majority of their time indoors and risk exposure through chronically damaged building infrastructure or acute water damage from flooding or leaking pipes. The Louisiana Office of Public Health (OPH), Section of Environmental Epidemiology & Toxicology (SEET) indoor air quality consultation program provides verbal and written information on mold testing, remediation and health effects. The OPH/SEET fields approximately twenty to thirty phone calls a week from Louisiana residents who have questions and concerns about mold growth, health effects and mold remediation. Figure 1 shows a spike in phone calls due to extensive water damage and mold problems from hurricanes.

Figure 1: Monthly Indoor Air Quality calls made to OPH/SEET: Louisiana, August 2002-December 2003



Written information is often mailed to the caller, along with verbal consultations.

For references or more information please contact Katherine Mortland, Office of Public Health, Section of Environmental Epidemiology & Toxicology at 504-568-8537.

Birds and West Nile Virus

Charles Anderson, BS

The Infectious Disease Epidemiology Section has received many citizen inquiries on the role of birds in the transmission cycle of West Nile Virus (WNV) to humans and other mammals.

The virus is transmitted from bird-to-bird and from birds to

mammals by mosquitoes. No transmission from mammal-to-mammal by mosquitoes is known to occur. When some birds become infected by a bite from an infected mosquito, they develop a blood level of the virus (viremia) sufficiently high to infect any mosquitoes that subsequently bite them. However, infected humans and other mammals, even those who become ill, do not develop a high enough viremia to infect mosquitoes.

Bird species and even individual birds within species, respond differently to WNV infection. Many birds develop a high viremia which lasts about a week, but are otherwise seemingly unaffected. Others, besides becoming viremic, also develop a generalized infection which causes them to become very ill and die in a short time. Still others never become viremic enough to infect mosquitoes nor do they develop illness. All birds which become infected produce antibodies which persist in the blood of those which survive the infection.

Experience in Louisiana and the rest of the United States has shown that WNV usually builds up in the bird population well in advance of the occurrence of cases of human infection. Thus, it is possible to get early warning of threat to the human population by conducting surveillance on the bird population. (Figures 1 & 2)

Although it is possible that any bird may die from WNV infection, it has been found that certain species are much more likely to do so. Crows, blue jays, grackles, cardinals, sparrows and birds of prey have been found to be more susceptible than most other species. These birds usually die within three or four days of being infected. Citizens are urged to collect freshly dead birds of these species and submit them to local health units. The birds are tested for the presence of WNV by a laboratory at the LSU School of Veterinary Medicine. In 2001 when the first positives were received in Louisiana, every bird was tested from Jefferson and Orleans parishes. The most frequent submissions, besides crows and jays, were doves and pigeons. Subsequently, ducks and starlings from mass die-offs have also been tested. Ducks, starlings, doves and pigeons all tested negative.

Chickens infected with WNV do not become ill nor do they produce a high enough viremia to infect mosquitoes. However, chickens do produce antibodies which can be detected by blood tests. For these reasons, caged chickens can be maintained and bled periodically (usually weekly) to indicate the presence of WNV in an area without posing a threat to the human population. Previously uninfected (naive) chickens are placed in cages and any that test positive, are removed and replaced with other naive individuals.

Another less widely employed method of surveillance is to trap and bleed live wild birds for detection of antibodies. A disadvantage of this method is that, without knowing an individual bird's history, it is not possible to know how far in the past the bird was infected. As of December 31, 2003, the number of birds positive for WNV was 391 and the number of humans positive was 120. For more information please call 568-5005 ext 125 or 140.

Figure 1: Birds Positive for WNV in Louisiana, as of 11/7/2003

Figure 2: Humans Positive for WNV in Louisiana, as of 11/7/2003

Community-Acquired MRSA

The following is an exerpt from the "Resistant Staphylococcus Aureus Management Guidelines Methicillin Resistant (MRSA)" newly published by the Louisiana Statewide Antibiotic Sensitivity Advisory Committee. This version, in final draft, can be found on the web at *http://www.oph.dhh.state.la.us/infectiousdisease/antibiosensitivity/docs/MRSAGuidelines2003.pdf*. Any suggestions for changes can be sent to rratard@dhh.la.gov.

1.1.4 MRSA as a Community Associated Organism (CA-MRSA)

MRSA has spread in the community and is now also a community-associated organism. These community-associated strains have been isolated from people without risk factors (Redbook 2003). Community associated MRSA infections are commonly reported in miscellaneous groups: patients with cystic fibrosis, day-care centers, wrestling teams and prisons (Estrada, 2001).

- CA-MRSA infections appear to be an emerging phenomenon worldwide. The genetic background of CA-MRSA organisms is different in three continents. The suggestion is that dissemination of a single CA-MRSA clone did not occur around the world but

(Continued on next page)

(Community-Acquired MRSA (Cont)

rather suggests the possibility of simultaneous co-evolution of CA-MRSA organisms in different locations (Vandenesch 2003).

- Unique clones of MRSA are increasingly responsible for community-acquired infections.
- The antimicrobial patterns of these strains are unique and differ from HA-MRSA, because they are resistant to methicillin but are not multi-drug resistant. Many are sensitive to trimethoprim-sulfamethoxazole, clindamycin, aminoglycosides and quinolones. European isolates appear more resistant (i.e., to kanamycin, tetracycline and fusidic acid) than U.S. and Oceanian isolates (Vandenesch, 2003).
- The actual prevalence of CA-MRSA cannot be accurately determined but it is estimated that 40% of adult cases may be associated with acquisition outside the hospital (Chambers, 2001). The prevalence of CA-MRSA infection was estimated at 208/100,000 in Chicago (Hussain, 2000). The prevalence seems to have increased from 10/100,000 in 1988-90 to 259/100,000 in 1993-95.
- CA-MRSA strains may be more virulent than HA-MRSA: In 1999, CDC reported four cases of lethal MRSA infections among children (twelve months to thirteen years from Minnesota and N. Dakota) who clearly had community-associated infections (hepatic abscess, brain abscess and necrotizing pneumonia) (Stratton, 2001). Unlike HA-MRSA strains, CA-MRSA stains produce superantigens (SEB and SEC, but not TSST-1).
- Superantigen production is a recently described virulence factor of both staphylococci and streptococci and is important because superantigen production by these microbes in immunologically naïve persons can cause toxic shock syndrome.
- Only two genes were unique to CA-MRSA isolates and shared by isolates from three continents: a type IV SCC*mec* cassette and the PVL locus (Panton-Valentine Leukocidin - the PVL locus that is carried on a bacteriophage. PVL represents a stable genetic marker of these CA-MRSA strains, which explains the frequency of primary skin infections and occasionally necrotizing pneumonia associated with these strains. PVL and SCC*mec* type IV may confer a selective advantage for community-based MRSA pathogens.
- Multi Locus Sequence Typing (MLST) and PFGE (Pulse Field Gel Electrophoresis) analysis showed that within a continent, the genetic background of CA-MRSA strains did not correspond to that of HA-MRSA in the same continent, suggesting that CA-MRSA did not emerge from local HA-MRSA.
- In light of these findings it appears that attempting to reduce CA-MRSA by strict infection control is a futile exercise. Control of MRSA in hospital and other health care facility is, of course, a very useful measure that certainly will limit the number of HA-MRSA but is not expected to have a significant impact on CA-MRSA.

OPH TRAINING OFFERINGS

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

VIDEOCONFERENCE COURSES

ARE WE MAKING A DIFFERENCE? An Epidemiological Approach to Program Evaluation - The OPH Infectious Disease Epidemiology Section is offering a series of videoconferences focusing on program evaluation principles. Dr. Susan Hassig, Clinical Associate Professor of Epidemiology at Tulane School of Public Health and Tropical Medicine, will be the main presenter. Four units will be offered: April 14, 21 and May 5, 11, 2004 from 9:00 AM – Noon. The videoconferences are targeted to OPH nurses and other public health nurses, infection control personnel, epidemiologists, health care professionals and administrators. The videoconferences are offered free of charge with Nursing and Medical Continuing Education Units applied for. The videoconferences will be accessible at nine sites throughout Louisiana. *Registration Deadline is March 16!*

Foodborne Disease Epidemiology

The OPH Infectious Disease Epidemiology Section is offering a videoconference focusing on foodborne diseases. This videoconference is targeted towards public health nurses, infection control professionals, disease surveillance specialists, epidemiologists, sanitarians, health care providers and other public health staff. It will be accessible at nine sites throughout Louisiana on April 20, 2004 from 9:00 AM – Noon. *Registration Deadline is March 30th!*

IN-HOUSE TRAINING

FET I & II

The Infectious Disease Epidemiology Section will repeat the Field Epidemiological Techniques I and II classes on March 9 – 10, 2004. This training 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. This workshop will take place at the State Office Building in New Orleans. There is a separate registration form for each day. *Registration Deadline is February 9th!*

(NOTE: The March 10th class is full. FET I and II will be repeated on October 12-13, 2004)

A Full House for Dr. Susanne Straif-Bourgeois, FET I, December 2003

Post class discussion with Dr. Raoult Ratard, FET II, December 4, 2002

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
Nov - Dec 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 Nov-Dec 2003	Nov-Dec 2002	Jan-Dec Cum 2003	Jan-Dec 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	0	0	0	1	0	0	0	0	0	1	11	125	135	-7.4
Rate[1]	0	0	0	0.1	0	0	0	0	0	0.2	0.3	2.9	3.1	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	1	1	0.0
Rubella	0	0	0	0	0	0	0	0	0	0	1	0	2	-200.0
Pertussis	0	0	0	0	0	0	0	0	0	0	0	8	8	0.0
Sexually-transmitted														
HIV/AIDS Cases[2]	4	2	2	4	2	1	3	2	0	20	178	777	1223	-36.5
Rate[1]	0.4	0.3	0.5	0.7	0.7	0.3	0.6	0.6	0	0.5	4.1	17.8	28	na
Gonorrhea Cases	422	326	171	238	78	120	440	204	88	2096	1489	11568	11386	+1.6
Rate[1]	40.8	54	44.6	43.4	27.5	39.8	84.2	57.6	20.1	46.9	35.3	258.9	254.8	na
Syphilis (P&S) Cases	9	18	1	3	0	0	1	1	8	41	23	178	152	+17.1
Rate[1]	0.9	3	0.3	0.5	0	0.0	0.2	0.3	1.8	0.9	0.5	4.0	3.4	na
Enteric					.									
Campylobacter	1	1	0	1	0	0	0	0	3	6	17	90	122	-10.0
Hepatitis A Cases	2	1	0	0	0	0	1	0	0	4	6	73	84	-27.0
Rate[1]	0.2	0.2	0	0	0	0	0.2	0	0	0.1	0.1	1.7	2.0	na
Salmonella Cases	4	6	3	4	2	3	2	6	3	33	102	598	902	-33.7
Rate[1]	0.4	1.1	0.8	0.8	0.7	1.0	0.4	1.7	0.8	0.8	2.4	13.9	20.9	na
Shigella Cases	4	1	0	4	0	2	0	4	0	15	81	327	564	-42.0
Rate[1]	0.4	0.2	0	0.8	0	0.7	0	1.1	0	0.3	1.9	7.6	13.1	na
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	1	-100.0
Vibrio, other	0	0	0	0	0	0	0	0	0	0	4	20	43	-53.5
Other														
H. influenzae (other)	0	0	0	0	0	0	0	0	0	0	0	10	12	-16.7
N. Meningitidis	1	1	0	0	0	1	0	0	0	3	4	35	49	-28.6
Tuberculosis	na	na	na	na	na	na	na	na	na	na	na	na	na	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	4
Rabies, animal	na
Varicella	18

Table 3. Animal rabies (Jan-Dec)

Parish	No. Cases	Species
	na	na

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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