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Louisiana Morbidity Report

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A Web Based Integrated Veterinary Surveillance System for Louisiana

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Early detection through effective surveillance and an effective response coordinated by the public health system are critical components of a successful defense against bioterrorism. The public's first line of defense against any such attack is the physician. The goal of educating and training physicians is to facilitate rapid recognition of diseases from potential bioterrorist agents. Diagnostic laboratories are another key portion of the response effort and must expeditiously provide effective services to physicians and their patients. Rapid identification of biological agents is indispensable to an effective public health response.

Just as physicians are the first line of defense in the detection of unusual biological events in humans, veterinarians are the vanguard of surveillance in the animal world. Routine disease surveillance failed in the early detection of the West Nile virus in New York City in 1999. One major reason for the failure may have been the lack of coordination between reports of human and avian encephalitis. A better, more coordinated surveillance system may have facilitated more rapid recognition. Correction of this apparent shortcoming is critical to future planning as animal outbreaks may be the first result of a bioterrorist attack. Devastating societal effects of the recent Bovine Spongiform Encephalopathy (BSE)/New Variant Creutzfeldt-Jakob (vCJD) and foot and mouth disease outbreaks in Great Britain indicate the importance of surveillance for both natu-

(Continued on page 6)

Content

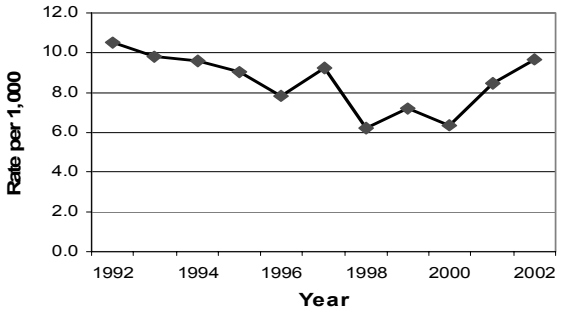
Infant Mortality Rates Suffer Rapid Increase, New Orleans, LA 2000-2002

Lyn Kieltyka, PhD, MPH; Frances Mather, PhD; Juan Acuña, MD, MSc

Each year, Louisiana ranks among the worst in the United States for infant mortality rates (IMR), calculated as the number of deaths of infants under one-year of age divided by the number of live births. Among large US cities, New Orleans had the sixteenth highest IMR from 1995 to 1998, despite considerable declines in IMR during the early and mid-1990s.

For the period of 1992-2002, the number of live births to New Orleans residents declined from approximately 9,000 to 7,000 per year. The IMR declined steadily from 10.5 per 1,000 (CI 8.8-12.5) in 1992 to a low of 6.2 per 1,000 (CI 4.6-8.3) in 1998 but climbed to 9.7 per 1,000 (CI 7.5-12.2) in 2002 (Figure 1).

Figure 1: Infant Mortality Rates* New Orleans, LA 1992-2002



* Includes live births and fetal deaths weighing 500g or more, 24+ weeks gestation.

Although the reasons for the observed increase in mortality are unclear, Louisiana vital statistics data was used to investigate characteristics of women residing in New Orleans who gave birth from 2000 to 2002.

According to the year 2000 census, out of an estimated 474,000 people residing in Orleans Parish, 53% were female. Approximately 67% of Orleans Parish residents were Black, 28% White and 5% other race/ethnicity. The results presented in this report, group race according to Black / non-Black (due to small numbers in the 'other' category and the tendency for those individuals to be more similar to Whites than Blacks).

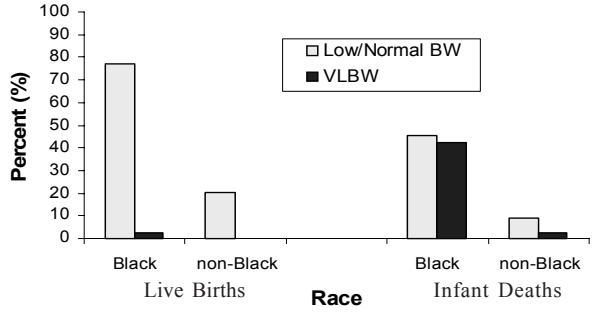
Results indicated that Orleans Parish Black women accounted for about 80% of all live births and 90% of all very low birth weight (VLBW) births each year. VLBW is defined as a birth weight less than 1,500 grams (about 3.3 lbs). Although less than 5% of infants

(Continued on page 2)

Infant Mortality Rates Suffer Rapid Increase (Cont from page 1)

born from 2000 to 2002 were VLBW, 74 out of the 164 infant deaths (nearly 50%) were VLBW babies (Figure 2).

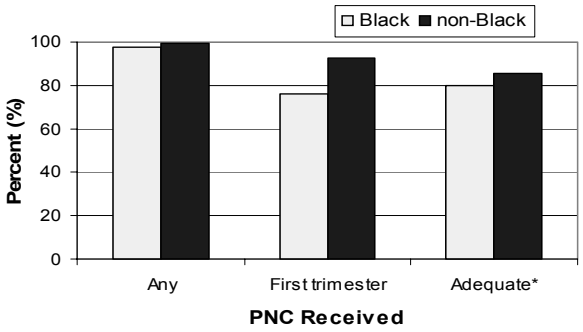
Figure 2: Distribution of race & birth weight, New Orleans, LA 2000-2002



From 2000-2002, Black mothers tended to be younger than non-Black mothers (median 24 versus 31 years of age, p<0.0001) and over 20% of births to Black women were to adolescents age 15-19 years compared to less than 5% for non-Blacks (p<0.0001). Fewer black mothers reported being married (23% versus 80%, p<0.0001) and fewer Black mothers reported having completed high school (33% versus 73%, p<0.0001).

Regardless of race, over 97% of women received some prenatal care (PNC) during their pregnancy and about 76% of Black women and 93% of non-Black women began PNC in their first trimester of pregnancy (Figure 3).

Figure 3: Percent (%) of women receiving prenatal care by race New Orleans, LA 2000-2002.



About 80% of Black women and slightly more non-Black women received adequate PNC prior to delivery (*) this calculation considers the number of prenatal visits compared to the gestational age of the unborn baby).

We analyzed the overall fetal and infant mortality rate by splitting the rate into smaller components by allocating deaths according to distribution of birth weight and age at death. Five of the 11.6 per 1,000 fetal and infant deaths were attributable to babies weighing less than 1500 grams (VLBW) at delivery, regardless of age at death (Figure 4).

Figure 4: Fetal and infant mortality rate per 1,000 by race for all mothers, New Orleans, LA 2000-2002

Birth Weight	Fetal Deaths	Neonatal	Post Neonatal
500-1499 g	5.0		
1500 + g	2.0	1.7	2.9

Compared to a referent group of Louisiana women who gave birth in 1998, were White, over 19 years old and reported attending at least some college (this group is known to have experienced very low fetal and infant mortality), New Orleans women experienced 5.4 more deaths per 1,000; in other words, there was an excess of 5.4 deaths per 1,000 that could be potentially prevented through the use of effective intervention programs. (Excess deaths were compared to the referent group of Louisiana White women who gave birth in 1998 and were twenty or more years old and had more than twelve years of education.) Of these 5.4 excess deaths, about half (2.4 per 1,000) were VLBW babies. This provides further support that VLBW babies have a higher mortality rate than low or normal birth weight babies.

Looking at the VLBW mortality rate by race, all of the excess deaths of the VLBW babies were born to Black women (3.2 excess deaths per 1,000). In contrast, White women actually experienced fewer VLBW deaths per 1,000 than was seen overall for the comparison group of Louisiana White women.

The single highest occurrence of excess deaths (3.2 per 1,000) was to Black mothers of VLBW babies. New Orleans community interventions should focus on Black women and address issues related to maternal health and prematurity, such as maternal smoking or alcohol use, unintended pregnancy as well as other maternal risk factors such as high blood pressure.

Black mothers also had an excess of 2.2 deaths per 1,000 for post-neonatal babies weighing 1,500 or more grams at birth. (Neonatal deaths are deaths occurring between days 1 – 28 of life. Post-neonatal deaths are deaths occurring between days 29-365 of life.) (Figure 5).

Figure 5: Fetal and infant mortality rate per 1,000 Black mothers - New Orleans, LA 2000-2002

Birth Weight	Fetal Deaths	Neonatal	Post Neonatal
500-1499 g	4.9		
1500 + g	2.2	1.7	2.6

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Potential interventions to address these deaths should focus on infant health and could include campaigns on safe sleep position or environment, injury prevention, breast feeding promotion, or access to medical homes.

In comparison to the referent group, New Orleans White women experienced the highest mortality (2.0 per 1,000) and the greatest excess mortality (0.8 excess deaths per 1,000) for babies weighing 1,500 grams or more and 1-28 days old at death (Figure 6).

Figure 6: Fetal and infant mortality rate per 1,000 White mothers New Orleans, LA 2000-2002

Birth Weight	Fetal Deaths	Neonatal	Post-Neonatal
500-1499 g	1.8		
1500 + g	1.5	2.0	1.5

Intervention programs targeting a reduction in these deaths may include advanced neonatal care, pediatric surgery and treatment of congenital anomalies.

We have shown that the greatest excess of fetal, neonatal and infant deaths in New Orleans occurred in VLBW babies born to Black mothers. It is known that infant mortality rates are higher for women who are Black, unmarried, adolescent, did not receive prenatal care, did not complete high school, and/or smoked during pregnancy. Some of these key risk factors may also be associated with an increased risk of having a VLBW baby.

There are well-designed programs already in place in New Orleans whose goals are to help pregnant women and infants receive health related care, yet our babies are still dying at an alarming rate. It is imperative that professional medical communities become more involved in order to monitor those women at highest risk and implement new programs or modify existing programs to reduce our rapidly rising infant mortality rate.

For more information, please call (504)568- 5073.

Work Sites, Health Policies and Risk Factors for Chronic Disease

Lu Ann White, PhD, DABT, Tulane University of New Orleans ,
Tara Doskey, MPH

Louisiana ranks high in all of the risk factors for chronic disease and low in healthy behaviors. These factors lead to increased absenteeism and higher medical and insurance costs for businesses and industries in Louisiana.

The Louisiana Office of Public Health (LA-OPH) and the Tulane University Prevention Research Center collaborated to conduct a statewide survey of Louisiana employers to assess the status of worksite health promotion policies. The survey gathered information on work place policies concerning health insurance coverage and inclusion of health promotion and preventive measures, nutrition and food availability at work, support of physical activity, smoking and cessation, and responding to cardiac emergencies. The survey was intended to obtain qualitative descriptive information about work place health promotion and does not provide quantitative data.

The goal was to obtain responses from small, medium and large companies in Louisiana and from the five major cities (Baton Rouge, Lake Charles, Monroe, New Orleans and Shreveport). In Louisiana, the overwhelming number of companies are small (85%) and most (60%), are not located in the five major cities. This reflects the lack of major business and industry within the state and also, the rural or small town nature of the state.

The majority (>70%) of the companies have a written policy on smoking. Many companies do not permit smoking indoors and if it is permitted, it is only allowed in a designated area. The majority (>70%) of all companies and/or their health insurance do not provide tobacco cessation or incentives for not smoking. Most companies do not sell tobacco products on site; if tobacco is sold, it is most likely to be at a large company.

- Few companies have a policy or provide labels to identify healthier food choices; those that do are more likely to be the larger companies.
- Few companies offer free or discounted memberships to off site facilities.
- Few promote the use of stairs through motivational signage (tables).
- Most small companies do not provide health risk appraisals for employees; one half of the medium and large companies surveyed offer health risk appraisals.
- Few small and medium companies have defibrillators; 60% of large companies report having defibrillators. CPR training is available at the majority (>75%) of large and medium companies and at nearly half (48%) of the small companies.

From these results, health promotion activities that could be targeted include:

- Increasing the smoking cessation activities and incentives by the companies.
- Continued activities to encourage ***No Smoking*** in buildings to increase the number of companies with smoking policies and prevent slippage.
- Promotion of healthy eating within and by companies.
- Promotion of the companies providing incentives for increasing employee physical activity; awareness of the benefits of physical activity to the company as well as to the employees.
- Encouragement of programs and partnerships to sponsor health screenings at the work place.
- Increased information on cardiac emergency preparedness by companies and employees.

The information generated by the survey will assist the Heart Disease and Stroke program in the development of a state plan. For more information, please contact Tara Doskey, Program Manager, Heart Disease and Stroke Program, (504) 568-7210.

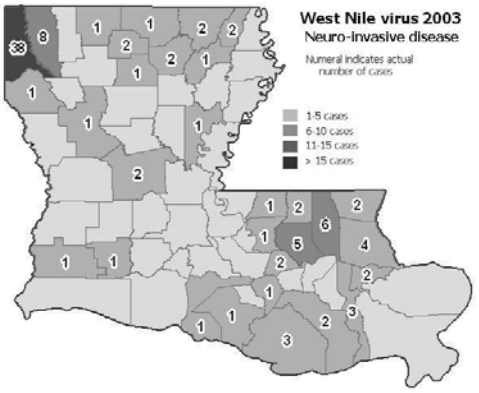
Are Hunters at Increased Risk of Contracting West Nile Virus?

Manisha Kukreja, MD, MPH Candidate; Sarah Michaels,MSPH

Background

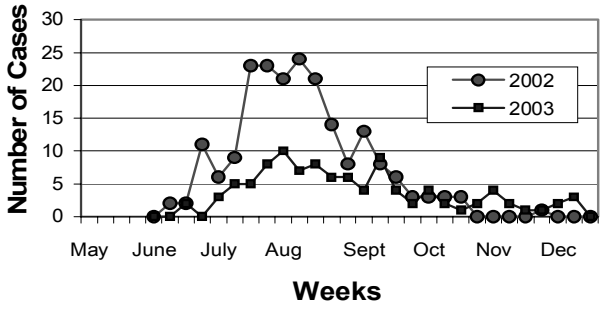
West Nile Virus (WNV) was first identified in Louisiana in 2001. In 2002, an outbreak of 329 human cases (204 neuro-invasive disease (NID) and 125 fever) with twenty-five deaths occurring in the state due to WNV infection. (Cases were classified as "fever" for a mild clinical presentation including fever, headache and muscle aches or "NID" for more severe neurologic involvement.) The following year, 2003, fewer cases were identified: 122 cases (101 NID and 21 fever) with nine deaths. Caddo and Bossier Parishes-Shreveport metropolitan area, experienced the largest focus of human cases (51 cases - 41.8%). (Figure 1)

Figure 1: West Nile neuro-invasive cases, Louisiana, 2003



Compared to 2002, a larger number of the 2003 cases were characterized by onset of symptoms late in the arboviral season (November-December) (Figure 2).

Figure 2: West Nile neuro-invasive cases, Louisiana, 2002-2003



Of the 2003 cases with onset date before November 1st, 55.5% were male while cases with later onset dates were 75.0% male. Looking at the trend towards later season cases with most of these cases being male, the question arises: are there any activities that men practice more often than women during these months and could hunting be one of these activities?

Methods

A case study was conducted to determine if there was an association of environmental and behavioral factors with WNV disease. Cases were Louisiana residents diagnosed with WNV during the 2003 transmission season. All had laboratory evidence of IgM antibodies to WNV by enzyme-linked immunosorbent assay in serum or spinal fluid. A standard questionnaire was administered by telephone (June-October 2004). Data management and analysis was performed using MS Access and SPSS Version 11.0.

Results

Contact with the families of deceased cases (n=9) was not attempted. Among the remaining 113 cases, sixty-seven completed the interview and four refused. The remaining forty-two cases were lost to follow up, mostly due to non-working telephone numbers (59% response rate). Interviewed and non-interviewed cases were comparable by age, gender, clinical presentation and onset date.

Among males, seventy-seven percent reported hunting in Louisiana during the 2003 season (October 1st - January 31st). No females reported hunting. Deer was the most common animal hunted (77%) with other animals including duck, squirrel and rabbit. The habitat used for hunting was either woods (87%) or marsh (47%). Hunters also identified the type of marsh as either salt (58.8%) or fresh water (41.2%). Caddo Parish (Northwestern Louisiana) was the most commonly reported hunting location. Of the hunters reporting, 83.3% did not use repellant during hunting.

Hunters ranged in age from nineteen to eighty-five years with the most common age group being forty-five to fifty-nine years (30%), but seventeen percent were over the age of seventy-five. One hundred percent of male non-hunters had onset date before the hunting season (Fisher's Exact Test 0.036) while forty percent of hunters had onset date during the hunting season (Table 1).

Table1: Male West Nile Virus case response to hunting by onset date Louisiana, 2003

		Onset		
		Pre-hunting	**Hunting**	**Total**
Hunter	N	9	0	9
	Y	18	12	30
Total		27	12	39

Among the twelve male cases who had an onset during the hunting season, all were hunters.

The questionnaire also examined other possible behavioral and environmental risk factors. Sixty percent of those cases listing occupations (n=58) reported working outdoors. Outdoor activities most often reported were sitting (80%), walking (82%) and gardening (58%). Environmental factors included sources of untreated standing water near the home that could serve as potential mosquito breeding sites: a canal or ditch (69%), lake (52%) and wooded area (38%). Other possible breeding sites reported around the home were flower pots (61%), bird baths (33%) and other containers that held untreated water (40%).

Discussion

While it is often assumed that WNV is contracted in or around the home, there is most likely a complex association between behavioral and environmental risk factors for acquiring WNV infection. Many properties contain breeding sites and a case-control study could determine if any of these is a significant risk factor.

In the Southern U.S. the arboviral season can coincide with the

hunting season when it is falsely assumed that the risk of acquiring WNV has passed. There is also a belief among many deer hunters that animals can detect the odor of repellants and a conscious choice is made not to use them. Fortunately, there are new types of repellants seeking FDA approval that have little or no odor and may be acceptable to the hunter population. Wearing repellant is one behavior that needs be targeted, especially for older hunters that are at greater risk for developing NID from a WNV infection. Based on the results of this study, hunting may contribute to the incidence of WNV infection in Louisiana.

Louisiana Arbovirus Surveillance History

Charlie Anderson, BS; Sarah Michaels, MSPH

Diseases caused by arthropod-borne viruses (arboviruses), especially those transmitted by mosquitoes, have been known to affect inhabitants of Louisiana at least since the 18th century. A yellow fever epidemic in New Orleans in 1855 led to the establishment of the Louisiana State Health Department. Until the end of the 19th century, the concept of diseases being transmitted by insects was not understood. Yellow fever transmission from person to person by mosquitoes was hypothesized by Dr. Carlos Finlay in 1881 in Cuba and first proven in well-known experiments by Drs. Walter Reed and Carlos Finlay in 1900.

Large numbers of seasonal viral encephalitis cases were common in the U. S. in the 20th and 21st centuries, but were not proven to be transmitted by mosquitoes until the 1930's when western equine encephalitis (WEE) was identified. Prior to that time, surveillance for the threat of the disease was not possible and sporadic outbreaks occurred without warning. Discovery of the mosquito link made it possible to monitor for the presence of virus in nature. However, testing large numbers of mosquitoes was not practical because the virus could only be detected through complicated and expensive laboratory techniques.

As late as 1960, it was suspected that most encephalitis viruses were transmitted by mosquitoes from birds to mammals and not from mammal to mammal. The birds seemed to have no observable effects from the virus and through capturing wild birds and testing their blood for the presence of viral antibodies, one could demonstrate recent infection. Once this was established, it became feasible to monitor for arboviral activity. Captive chickens, referred to as sentinels, could also be maintained in and around populated areas and tested periodically. Advances in laboratory techniques also made testing for virus in mosquitoes cheaper and faster.

Virtually all surveillance for the commonly occurring arboviral encephalitides - eastern equine (EEE), western equine (WEE), St. Louis (SLE) and Lacrosse (LAC) - was conducted by local mosquito abatement districts (MAD) ,which began in California in 1915. The first MAD in Louisiana was established in Plaquemines Parish in 1964. However, arbovirus monitoring was limited to large areas with MADs that had the resources to devote to labor-intensive surveillance activities. The number of MADs continued to expand to cover the large urban centers around the state.

When West Nile virus (WNV) was first discovered in the U.S. in 1999, it was observed that WNV-infected birds, especially crows and blue jays, died in great numbers in a very short time (as high as 80% within seven days of infection). This presented public health with a surveillance tool previously unavailable: the sudden die-off of conspicuous birds that could indicate the presence of WNV in an area. This also allowed public participation to supplement the activities of the MADs.

Dead birds can be reported to local parish health units during regular business hours. If the dead bird is in good condition and is a blue jay, crow or bird of prey, it can be submitted for testing. The bird should be double-bagged and kept cold, either in a freezer or cooler with ice. Samples not approved for testing can be disposed of in the regular household trash. There is no risk for contracting the virus when handing a dead bird, however, care should be taken when handling any dead animal.

Pertussis: Hidden in Louisiana?

Louisiana rates for Pertussis are lower than in the rest of the United States. Surveillance data indicates that pertussis infection tends to be under-diagnosed and underreported. In the recent past, pertussis infections have been overlooked due to preliminary diagnosis of influenza, bronchylitis, Respiratory Syncital Virus and West Nile Virus.

For more information read "Pertussis in Louisiana" by Theresa M. Sokol MPH, Mona Mehta MPH, Stacy Hall, MSN, and Raoult C. Ratard, MD MPH & TM, published in the Journal of the Louisiana State Medical Society Vol 156, No 6, November-December 2004.

OPH Training Offering

Infectious Diseases Surveillance and Investigation in Health Care Facilities

The OPH Infectious Disease Epidemiology Section is offering a series of four videoconferences focusing on infection control. This series is targeted towards public health nurses, physicians, infection control professionals and health care providers. It will be accessible at nine sites throughout Louisiana from 9:00AM - Noon for each session

Session 1: Hospital Acquired Infections - April 27, 2005
Session 2: Infection Control in Specific Settings: Day Care, Long Term Care, Hospitals, Correctional Facilities, Developing Countries - May 4, 2005
Session 3: Common Nosocomial Infections - May 11, 2005
Session 4: Outbreak Investigation - September 14, 2005

These videoconferences are free of charge but must be registered for as seating is limited. For site information, a registration form and agenda please email Ethel Davis at edavis@dhh.la.gov or call (504) 568-5005 x126. Applications have been placed for Nursing and Physician Continuing Education Units. *Registration Deadline is April 13th!*

A Web-based Integrated Veterinary Surveillance ...(Cont. from page 1)

ral and bioterrorist events in animals, even those not apparently affecting human health.

Prior to the beginning of this millennium, academia, local government and federal officials focused little attention on the threat of biological terrorism in the continental United States. Now, the attention of these entities is equivalent to those concentrated on the nuclear arms race during the Cold War years. In the year 2000 alone, the U. S. government earmarked one billion dollars to domestic preparedness for projects concerned with biological terror. Although the "Anthrax letters" of 2001 caused little morbidity or mortality, the economic and psychological effects were noteworthy. Many informed members of the medical community believe that use of biological agents for nefarious purposes will occur again.

Early detection and early defense capabilities, however, must be coordinated. Illness from a bioterrorist event or a naturally occurring emerging infection will likely be characterized by delayed onset, insidious nature and geographical diversity. The lack of uniformity of disease presentation demands a system that is able to receive and transmit information instantaneously: a real-time computerized system. Veterinarians should be a part of the system, or should utilize a system that communicates efficiently with other medical surveillance systems.

The Louisiana Office of Public Health (OPH), Infectious Disease Epidemiology Section (IDES) is charged with surveillance of reportable infectious diseases and infectious disease outbreaks. The State Veterinarian of the Louisiana Department of Agriculture and Forestry (LDAF) bears a similar responsibility regarding animal diseases. Since often no clear delineation exists between responsibilities, one conclusion may be that a joint reporting system would eliminate redundancy and would eliminate loss of time from duplication of effort.

As mentioned previously, diagnostic laboratories play a major role both in surveillance of and response to any type of outbreak. Veterinarians generally utilize a different population of laboratories than those employed by physicians. For this reason another link in the chain of cooperation must be forged. The Louisiana Veterinary Medical Diagnostic Laboratory (LVMDL) is the major state veterinary laboratory asset. Along with functioning as the clinical laboratory of the state's only veterinary school, the LVMDL is also the primary diagnostic reference laboratory for veterinarians around the state and is tasked to serve as the chief diagnostic laboratory for bioterrorist events that might involve animals. Any successful system will have to include this veterinary diagnostic laboratory.

Recent activities such as surveillance and response to the encroachment of West Nile virus, prevention of importation of Monkey Pox and routine Rabies virus surveillance have engendered a cooperative spirit between the two agencies and the diagnostic laboratory. Within the past several months, a joint initiative of these three partners has been the development of a rapid web-based disease reporting system available to veterinarians to report suspected diseases of possible bioterrorist, public health, or agricultural importance.

The heart of the system would be disease reporting. Reports of suspect, non-laboratory confirmed cases would be requested. These reports would be accessible in real-time to the State Veterinarian and OPH-IDES. Appropriate authorities would then be responsible for tracking the cases. Interaction with the laboratory would assure that results indicating the possible occurrence of agents of concern would also be transmitted in real time to authorities to foster a more efficient response.

An early version of this web-based reporting system, referred to as the Veterinary Surveillance System (VSS), is already being tested by veterinarians around the state. The website is part of the OPH's *Information Portal.* The VSS portion is a shared enterprise of OPH and LDAF. This early version features several of the concepts discussed above. VSS is co-administered by the State Veterinarian, IDES and the diagnostic laboratory. A "links" page features quick connections to sites sponsored by the Louisiana Board of Veterinary Medicine, the Louisiana Veterinary Medical Association and other veterinary organizations and agencies. A "news" page features veterinary news articles of interest and up-to-date statistics on veterinary diseases in Louisiana. The "advisory" page features lists of reportable diseases, lists of voluntarily reportable diseases and time requirements for reporting. The "VSS cases" page is the actual disease reporting instrument. Comprehensive information on reported cases is immediately available to public health and animal health authorities. Each veterinary hospital's reports are only visible to its own staff and other veterinarians are restricted from accessing other veterinary facilities' records. Security for the system meets the same requirements of other OPH databases containing human individual patient identifiers. An additional feature is an interactive "poll" question that can be posted by any of the administrators. Although results are unscientific in nature, the poll question is a method for agricultural and public health authorities to determine veterinarians' viewpoints on issues of importance.

Plans for future development include electronic submission of laboratory requests and electronic transmission of laboratory results between LVMDL and participating veterinarians. This component is in a conceptual stage and is characterized by several hurdles yet to be conquered.

The system's direct link to IDES and LDAF ensures a continuous stream of information between animal and human health authorities on a scale never before realized in Louisiana, a system that will hopefully characterize the rapid interagency communication necessary for effective mitigation of the risk of bioterrorism.

This web-based reportable disease system should be fully implemented by January 2006. After implementation, the system could be one of the most unique veterinary disease reporting systems in the United States as well as an example of interagency cooperation and prudent use of funding, eliminating redundancy by foregoing the creation of independent systems in each respective agency.

For references or more information, contact Gary Balsamo (504) 568-5005 x 128 or gbalsamo@dhh.la.gov.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

January - February, 2005

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 2005	Jan-Feb 2004	Jan-Feb Cum 2005	Jan-Feb Cum 2004	% Chg
Vaccine-preventable															
Hepatitis B	Cases	0	1	1	2	0	0	2	1	1	8	15	8	15	-46.7
	Rate[1]	0.0	0.2	0.3	0.4	0.0	0.0	0.4	0.3	0.2	0.2	0.3	0.2	0.3	NA
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Mumps		0	0	0	2	0	0	0	0	1	3	4	3	4	-25.0
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Pertussis		0	0	0	1	0	0	0	1	0	2	2	2	2	0
Sexually-transmitted															
HIV/AIDS	Cases[2]	36	14	2	9	5	4	0	3	10	83	166	83	166	-50.0
	Rate[1]	3.6	2.4	0.5	1.7	1.8	1.3	n/a	0.9	2.3	1.9	3.8	1.9	3.8	NA
Gonorrhea	Cases	402	126	62	125	65	49	229	114	57	1229	1903	1229	1903	-674
	Rate[1]	38.9	20.9	16.2	22.8	22.9	16.3	43.8	32.2	13.0	27.5	42.6	27.5	42.6	-0.4
Syphilis (P&S)	Cases	14	8	0	2	0	0	2	0	1	27	35	27	35	-8
	Rate[1]	1.35	1.33	0.00	0.36	0.00	0.00	0.38	0.00	0.23	0.60	0.78	0.60	0.78	-0.23
Enteric															
Campylobacter		2	5	1	1	1	1	1	1	2	15	9	15	9	66.7
Hepatitis A	Cases	11	0	0	0	0	0	0	0	1	12	4	12	4	200.0
	Rate[1]	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3	0.1	0.3	0.1	NA
Salmonella	Cases	15	8	7	6	0	6	7	5	6	60	41	60	41	+46.3
	Rate[1]	1.5	1.3	1.8	1.1	0.0	2.0	1.3	1.4	1.4	1.4	1.0	1.4	1.0	NA
Shigella	Cases	5	1	0	2	4	9	0	3	0	24	36	24	36	-33.3
	Rate[1]	0.5	0.2	0.0	0.4	1.4	3.0	0.0	0.8	0.0	0.6	0.8	0.6	0.8	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	0	0	0	0
Other															
H. influenzae (other)		0	3	0	0	0	2	2	1	2	10	5	10	5	100.0
N. Meningitidis		4	1	1	0	0	0	0	0	2	8	11	8	11	-27.3

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. Due to delays in reporting of HIV/AIDS cases, the number of persons reported is a minimal estimate. Data should be considered provisional.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Legionellosis	2
Lyme Disease	0
Malaria	0
Varicella	6

Table 3. Animal rabies (Jan-Feb)

Parish	No. Cases	Species
Lafayette	1	Skunk

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

LAC 51:II.105: 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 (EPI-2430), facsimile (504-568-5006), phone reports (504-568-5005 or 1-800-256-2748), 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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