



Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
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Anthrax Detection Systems in Postal Facilities

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A Closer Look at Drowning in Louisiana

Mona Doshani, MD MPH

The concern of terrorist events involving infectious agents has led to the development of autonomous detection systems. One of these systems, the Biohazard Detection System (BDS) was developed under contract with the U.S. Postal Service (USPS) specifically to detect aerosolized *Bacillus anthracis*. Experts consider anthrax to be one of the simplest and most accessible bioweapon pathogens. The USPS plans to install BDS in approximately 300 mail processing and distribution centers across the United States. Five of these facilities are within Louisiana. These postal facilities have high-speed mail-handling equipment which could potentially aerosolize *B. anthracis* spores if sent through the mail (as demonstrated during the 2001 anthrax attacks). These systems will be functional in Louisiana by the end of the summer, 2005.

These BDS systems combine automated air sampling and single target real-time polymerase chain reaction (PCR) testing. An alert at a postal facility would require additional testing at the State Laboratory following the Centers for Disease Control and Prevention (CDC) guidelines. Additional testing will include multi-target PCR testing for rapid presumptive test results with final test results from culture, (culture still being considered the gold-standard). The Louisiana State Laboratory is a participant in the national Laboratory Response Network.

Response to the identification of aerosolized *B. anthracis* spores in an air sample is necessary for prompt evacuation of facilities, on-site decontamination of potentially exposed workers, timely post-exposure prophylaxis and to interrupt the flow of contaminated let-

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“Lea Owens took her eyes off from her six year old son, Harley, only briefly, but in the three minutes that she was in the bathroom of her home, Harley slipped out the back door and into the swimming pool, where he drowned.” - *USA Today*, May 3, 2004

As schools start to close for the summer and the weather warms, an increasing number of Louisiana residents begin to frequent swimming pools, beaches, boating and recreation facilities. The significant increase in drownings during the months of July and August has a direct correlation to the increase in water recreation activities.

Research produced by Dr. Frank Pia (innovator in lifeguard training and drowning prevention programs), suggests that in most cases, drowning victims cannot call out for help. The instinctive actions of flapping their arms (to get the head above water) and exhaling/inhaling quickly (to get a breath of air) are overwhelming and are sometimes seen as “playing” in the water. These actions are especially true of someone who cannot swim at all. Children thrashing in this manner may last twenty to thirty seconds before they drown, whereas adults can last up to a minute before exhaustion - without being able to call for help. A person who can swim may call out for help, as they know their circumstances better. Once the drowning reaction starts however, there is likely to be no sound uttered as the drowning person is getting just enough air to breath and cannot talk.

Each year nationwide, approximately 4000 children and adults drown, of which nearly 300 are children, (ages five and under) who drown in swimming pools. According to an extensive study in the July 2001 issue of *Pediatrics*, infants are most likely to drown inside the home (in bathtubs or buckets) and toddlers are most likely to drown in swimming pools or hot tubs. Older children and adolescents are most likely to drown in ponds, lakes and streams.

Various studies show that fifteen to forty-five percent of those who drown, do know how to swim. Understandably, swimmers increase their risk simply because they are more likely than non-swimmers to be in the water. They tend to put themselves at risk by being over-confident about their abilities and taking more chances. Many drowning tragedies can be prevented by understanding where drownings mostly occur and avoiding the situation (example: beaches in which riptides or strong surface currents are present). The American Red Cross recommends that anyone who is likely to play in or around the water should wear personal flotation devices

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Anthrax Detection Systems... (Cont. from page 1)

ters into the postal stream. Planning for evacuation from the Louisiana facilities and decontamination of potentially exposed persons has included the USPS, public safety responders and the Louisiana Department of Health and Hospitals, Office of Public Health (OPH). Post-exposure prophylaxis will be provided by OPH to potentially exposed persons. Recommended therapy for inhalational anthrax infection in the contained casualty setting remains ciprofloxacin or doxycycline. This guidance is for all exposed persons including children, pregnant women and immuno-compromised persons. This information can be found in the Morbidity and Mortality Weekly Report of June 4, 2004, *Responding to Detection of Aerosolized Bacillus anthracis by Autonomous Detection Systems in the Workplace*, available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5307a1.html>.

Recent mail-related events highlight the continued challenge of response. These events include the two Washington area Department of Defense related mail facilities which resulted in the interruption of Pentagon mail delivery and placed over 900 workers on preventive antibiotics in March 2005, a February 2004 report of the toxin ricin in a Senate office building and a November 2003 alarm at a Navy mail processing center in Anacostia Naval Station near Washington, D.C. The US Postal Service BDS system provides an approximate real-time screening tool and the opportunity for a rapid response to a possible bioterrorism threat. For more information, contact Stacy Hall (504) 568-5005 x110 sthall@dhh.la.gov.

Office of Public Health Sexually Transmitted Diseases and Emergency Preparedness Programs Collaborate, Baton Rouge, LA

Lisa Longfellow, MPH; Jerry T. Monier, Jr.

In 2004, over 250 volunteers and public health personnel visited 2800 households to deliver health information, offer screenings for syphilis, HIV, high blood pressure and elevated blood sugar. Of the 165 patients seen in field clinics, ten were positive for syphilis (two new cases), three had positive HIV blood tests (two new cases), eighteen had elevated blood sugar, eighty-seven had elevated blood pressure and eighteen had multiple abnormal tests. Patients were advised to be evaluated by their physicians for further follow-up and treatment. The HIV and STD cases were contacted by the health department and referred for treatment.

This project also allowed the Office of Public Health (OPH) to test its response capacity to a small scale localized emerging public health threat. With the support of the OPH Emergency Preparedness and Response Section and the staff of OPH Region 2, volunteers and public health personnel were deployed to specific locations of the Baton Rouge Area. Volunteers were teamed and were provided communications equipment and reported in progress to a Field Command Center established to coordinate the event. It is important to note that very few traditional emergency response agencies conduct exercises of this magnitude, while at the same time having a positive impact upon the community.

There are plans to hold similar events in Shreveport and New Orleans on August 19, 2005. For more information or to volunteer, call the STD Epidemiology Section (504) 568-5275.

Prevalence of Legionella Antibodies - Louisiana, 2005

Theresa Sokol, MPH

The Infectious Disease Epidemiology Section (IDES) surveillance program of the Louisiana Office of Public Health (OPH) often receives reports of legionellosis based on a single serologic test result. The Centers for Disease Control and Prevention (CDC) laboratory criteria for case confirmation are the following:

— Isolation of *Legionella* from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluids, or

— Demonstration of a fourfold or greater rise in the reciprocal immunofluorescence antibody (IFA) titer to greater than or equal to 128 against *Legionella pneumophila* serogroup 1 between paired acute and convalescent-phase serum specimens, or

— Detection of *L. pneumophila* serogroup 1 in respiratory secretions, lung tissue, or pleural fluid by direct fluorescent antibody testing, or

— Demonstration of *L. pneumophila* serogroup 1 antigens in urine by radioimmunoassay or enzyme-linked immunosorbent assay.

Because of the ubiquity of *Legionella* in closed water systems, a large proportion of the national population is thought to have elevated titers of *Legionella* antibodies. As such, the previous category of “probable” case, which was based on a single IFA titer, was determined to lack specificity for surveillance. As a result, the “probable” case classification is no longer used by CDC, and reports of legionellosis based solely on single IFA titers are not counted as cases.

In order to substantiate the discontinuation of the “probable” case classification, OPH Laboratories performed *Legionella* serologic testing on two types of asymptomatic persons: 1) young adults that submitted blood for routine screening in prenatal clinics, and 2) public health laboratory personnel who were not at increased risk for occupational exposure to respiratory pathogens. A total of sixty serologies were performed. (Table 1)

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Table 1: Legionella serologies performed - Louisiana, 2005

Result	Number	Percent
Negative	6	10.0
1/64	17	28.3
1/128	10	16.7
1/256	13	21.7
1/512	13	21.7
1/1024	1	1.7

This survey confirms that there is a high prevalence of elevated Legionella antibody titers in the Louisiana population. These results confirm the futility of case confirmation based on a single IFA titer. While a fourfold or greater rise in paired acute and convalescent-phase serum specimens is still considered confirmatory for case confirmation purposes, collection of the convalescent specimen is often impractical and rarely reported. However, isolation of Legionella from clinical specimens and demonstration of Legionella antigens in urine allow for immediate case confirmation. IDES is beginning to receive an increasing number of reports of legionellosis based on the detection of Legionella antigens in urine. In contrast to reports based on single IFA titers, the rapid case confirmation associated with urine antigen reports facilitates timely case investigation and potential cluster identification.

Has Mortality From Influenza and Pneumonia Been Rising in Louisiana?

Nathan Weed, MPH

Pneumonia is a disease that results from a wide number of infections - viral, bacterial and fungal. Viral agents that commonly cause pneumonia include adenoviruses, respiratory syncytial virus, parainfluenza viruses and of course, influenza viruses. Bacteria that cause pneumonia include *Haemophilus influenzae* type B (Hib), *Staphylococcus aureus*, *Klebsiella pneumoniae*, *Streptococcus pyogenes*, *Neisseria meningitidis* and other organisms that are less commonly considered as causes of pneumonia such as *Escherichia coli*. Additionally, individuals with immune systems impaired by immunosuppressants or diseases of the immune system are at high risk of Pneumocystis pneumonia, caused by a fungus (*Pneumocystis carini* or PCP). Broadly, many of the microbial agents that cause upper respiratory tract infections can lead to the development of pneumonia.

This past year, there has been increased national attention directed at the influenza vaccine shortage. The associated concern among both health care professionals and the public resulted in greater scrutiny of the distribution of deaths associated with influenza and related illnesses. Louisiana's Office of Public Health - Infectious Disease Epidemiology Section, monitors trends in mortality from infectious diseases and continually seeks opportunities to share this information. A regularly asked question has been, "Did pneumonia and influenza cause more deaths this year in our state than last year?"

In order to better respond to public queries regarding pneumonia and influenza mortality, all of the death certificates issued

between 1999 and 2003 in Louisiana were sorted by cause of death, listed and analyzed using Microsoft Access. Causes of death are coded according to the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10). Specifically ICD-10 provides coding for pneumonias that present in a clinically distinct way such as bronchopneumonia, pneumonias caused by specific bacteria or viruses (for example *Haemophilus influenzae* and varicella) as well as pneumonias that are caused by an unspecified agent. The crude numbers of mortality resulting from these causes of death are presented in Table 1. Additionally, the cause of death "influenza with pneumonia" was added to the table.

Table 1: Number of deaths caused by Pneumonia and Influenza Louisiana, 1999-2003

Specific Cause of Death	1999	2000	2001	2002	2003
Bacterial pneumonia, unspecified	9	9	9	16	10
Bronchopneumonia, unspecified	34	34	27	24	13
Hypostatic pneumonia, unspecified	2	2	1	3	3
Influenza with pneumonia, influenza virus identified	0	0	0	0	4
Influenza with pneumonia, virus not identified	7	12	0	2	8
Lobar pneumonia, unspecified	17	11	7	3	13
Other bacterial pneumonia	2	0	1	1	0
Other pneumonia, organism unspecified	2	1	1	0	2
Pneumocystosis	4	2	2	3	3
Pneumonia due to <i>Escherichia coli</i>	2	0	0	0	0
Pneumonia due to <i>Haemophilus influenzae</i>	0	0	1	0	0
Pneumonia due to <i>Klebsiella pneumoniae</i>	2	2	1	1	3
Pneumonia due to <i>Mycoplasma pneumoniae</i>	0	2	4	0	0
Pneumonia due to <i>Neisseria meningitidis</i>	0	0	0	0	0
Pneumonia due to other specified infectious organisms	1	0	0	0	0
Pneumonia due to other streptococci	4	3	5	1	4
Pneumonia due to <i>Pseudomonas</i>	2	4	1	5	3
Pneumonia due to <i>Staphylococcus</i>	21	18	12	8	13
Pneumonia due to <i>Streptococcus pneumoniae</i>	8	3	9	2	4
Pneumonia due to <i>Streptococcus</i> , group B	0	0	1	0	0
Pneumonia, unspecified	890	876	893	897	839
Respiratory syncytial virus pneumonia	0	0	0	1	1
Varicella pneumonia	0	0	1	1	0
Viral pneumonia, unspecified	4	8	2	2	1

The data provided by death certificates issued in Louisiana between 1999 and 2003 provide evidence that the number of deaths associated with pneumonia and influenza have been fairly consistent with the possibility that there is a minor decrease in the number of cases each year. Although the mortality has remained about the same for these past five years, the Infectious Disease Epidemiology Section will continue monitoring the causes of death attributable to pneumonia and influenza in order to detect changes in this trend.

ERRATUM

May-June 2005 issue, page 2 *Region IX Childhood Obesity Study*: First row percentages for White Normal and White Overweight.

Table 2b: Study Population Descriptives - Race -Louisiana, 2003

	Normal	Overweight	Obese	Total
White	238 (40.2%)	119 (20.1%)	235 (39.7%)	592 (100%)
Black	163 (37.9%)	101 (23.5%)	166 (38.6%)	430 (100%)
Hispanic	10 (40%)	4 (16%)	11 (44%)	25 (100%)
Asian	2 (50%)	2 (50%)	-	4 (100%)
Total	413 (39.3%)	226 (21.5%)	412 (39.2%)	1051(100%)

OPH Training Offerings

Video Conferencing

This videoconference is 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.

Infectious Diseases Surveillance and Investigation in Health Care Facilities

The OPH Infectious Disease Epidemiology Section is offering the fourth and final section of the videoconference series focusing on infection control. The title of Part IV is 'Outbreak Investigation'. 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 9:00 a.m. - Noon, September 14, 2005.

Applications have been placed for Nursing and Physician Continuing Education Units. *Registration Deadline is August 31st!*

In-House Training

Basic Life Support (CPR)

Every month the EMS/Injury Research and Prevention Program hosts a "Basic Life Support for Healthcare Providers" course for all Office of Public Health employees. This training includes adult and pediatric Cardiopulmonary resuscitation (CPR), foreign-body airway obstruction and one/two-rescuer CPR. For this one-day course, classes are scheduled to begin at 9:00 a.m., break at noon, resume at 1:00 p.m. and end by 4:00 p.m. The next available CPR classes will be held in New Orleans on August 12, September 9, October 14, November 18 and December 17, 2005. Participants are limited to twenty per class. To sign up for the class, please contact Patricia Jones at the Injury Prevention Program at (504) 568-2509 or email pjones@dhh.la.gov.

FET I & II

The Infectious Disease Epidemiology Section will repeat the Field Epidemiological Techniques I and II classes on October 18–19, 2005. 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 September 12, 2005.*

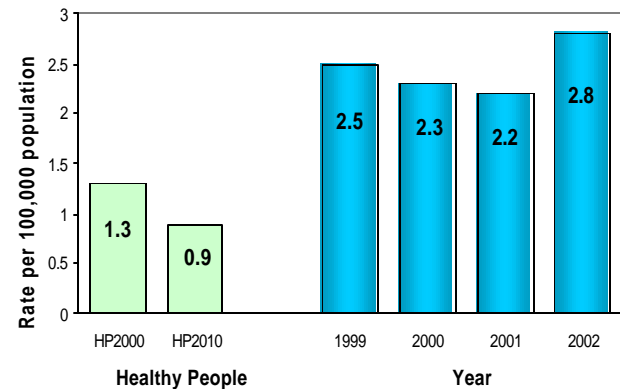
A Closer Look at Drowning in Louisiana (Cont. from page 1)

(PFD's), and receive water safety training which includes swimming lessons as well as rescue techniques (CPR). In addition, children must be supervised at all times.

Louisiana

Louisiana has approximately 8277 square miles of water, abundant marshland and water recreational sites. The National Healthy People 2010 (HP) objectives proposed 0.9 drownings per 100,000 population as an achievable target. To compare Louisiana to the rest of the nation, data was extracted (using the ICD-9 code for drowning) from death certificates and analyzed (using SPSS version 11.0). In 1999, the rate was 2.5 drownings per 100,000 population. A steady decline appeared in 2000 and 2001 followed by a slight increase in drownings in 2002. (Figure 1)

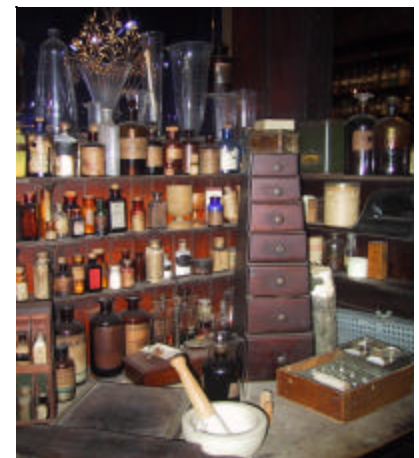
Figure 1: Drowning rate, National Healthy Peoples Objectives 2000 and 2010 versus Louisiana, 1999-2002



The discrepancy between the HP objective and Louisiana's rates led to the suggestion of conducting intervention studies in order for the state to achieve the desired objective. Many interventions have been initiated. However, without the intensive efforts from the community, it may not be possible for Louisiana to achieve the HP 2010 objective.

LOUISIANA FACT

The first licensed pharmacy in the United States was opened in the French Quarter in New Orleans by Louis Dufilho, the first officially licensed pharmacist to practice in the United States. Louis Dufilho was licensed in 1816 and opened his pharmacy at 514 Chartres in 1823. The site is now the New Orleans Pharmacy Museum.



Source: New Orleans Pharmacy Museum

From a period of 1999 to 2002, there were 435 drownings in Louisiana, (Table 1) of which the majority (381) were unintentional/chance happenings.

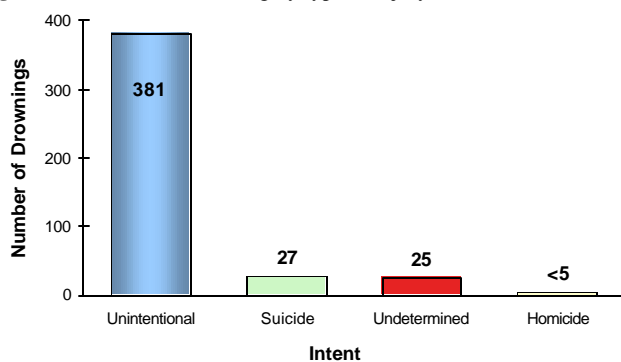
Table 1: Number and Rate of Drownings - Louisiana, 1999-2002

Demographics of Drowning	n (435)	n(%)	Rate*
Age			
0-4	57	13.1	4.4
5-14	44	10.1	1.6
15-24	74	17.0	2.6
25-34	57	13.1	2.4
35-44	86	19.8	3.2
45-54	50	11.5	2.1
55-64	27	6.2	1.7
65-74	23	5.3	2.0
75+	17	3.9	2.9
Race			
Black	256	58.9	2.9
White	169	38.9	2.2
Gender			
Male	358	82.3	4.1
Female	77	17.7	0.8
Region			
Region 1	90	21.7	2.2
Region 2	44	10.6	1.8
Region 3	51	12.3	3.3
Region 4	38	9.2	1.7
Region 5	40	9.7	3.5
Region 6	31	7.5	2.6
Region 7	47	11.4	2.3
Region 8	27	6.5	1.9
Region 9	46	11.1	2.6
Parish Unknown	21		

*Rates per 100,000 population calculated using 1999-2002 Population Estimates (US Census Bureau)

There were also twenty-seven cases due to suicides, twenty-five cases were undetermined and less than five cases were homicidal. (Figure 2).

Figure 2: Number of Drowning by type of injury, Louisiana 1999-2002



Strategies and Opportunities for Preventing Drowning:

(Adapted from the 'Saving Children' book by Susan P. Baker)

Changing the environment

- Surround all sides of home swimming pools with child-proof fencing.
- Place approved PFDs on all boats.
- Design spa and pool drains that will not suck in hair or otherwise cause children to be trapped underwater.
- Water safety signage plays an important role in the prevention of recreational water-related injuries. Signs are designed to inform the public of dangers and appropriate safety practices.

Instructing children water safety

- Teach children never to go into water alone.
- Teach the identification of hazardous situations
- Teach how to stay afloat.
- Increase knowledge on how to use PFD's.
- Training rescue techniques that do not endanger the rescuer.

Changing adult behavior

- Require all pool owners to receive training in cardiopulmonary resuscitation (CPR)
- Enforce the use of PFD's by everyone in boats or being towed by boats.
- Teach caretakers never to leave a young child unattended in the bathtub, within reach of a bucket of liquid, or near any body of water deep enough to cover the nose and mouth
- Encourage use of shallow water for infant baths.
- Empty pools when they will not be used for an extended period.

A Comparison of Asthmatics in LA vs US Using the BRFSS Survey, 2002

Daniel F. Soteris, MD, MPH; Allison L. Sabel, MD, PhD, MPH

Background

Asthma, a chronic illness in the U.S., has been increasing in prevalence since the 1980's. According to a self-reported study, the prevalence of asthma from 1980 to 1994 increased seventy-five percent among all groups, i.e. race, sex, and age in every region of the United States. Prevalence rate is the most widely used measure of disease occurrence primarily because it can be assessed using survey methods. The purpose of the report is to compare asthmatic patients in Louisiana and the U.S. with respect to demographics, medical care utilization, participation in daily living activities and asthma severity.

Methods

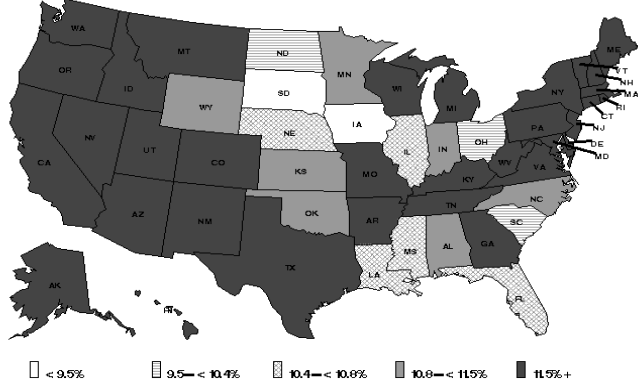
The Centers for Disease Control and Prevention (CDC) sponsors a state-based, random-digit-dialed survey of non-institutionalized civilian United States populations aged greater than eighteen years called the Behavioral Risk Factor Surveillance System (BRFSS). The survey collects self reported information about modifiable risk factors for chronic diseases. Two asthma questions concerning lifetime and current asthma were used as part of the core survey in all fifty states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands. Lifetime asthma was defined as answering yes to the question, "Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" Current asthma was defined as answering yes to the lifetime question and to the question, "Do you still have asthma?"

Nine questions were used as part of an optional asthma module, in which seventeen states plus the District of Columbia were included in the 2002 survey. These questions include subjective criteria allowing the categorization of asthmatics according to National Heart, Lung, and Blood Institute (NHLBI) 2002 Asthma severity guidelines. The categories are mild intermittent, mild persistent, moderate persistent and severe persistent. This study analyzed data from the 2002 BRFSS survey using SAS 8.2 software.

Results

The lifetime prevalence of asthma ranged from 8.6% in South Dakota to 14.5% in Montana (Figure 1).

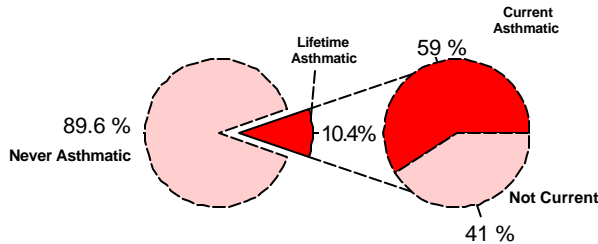
Figure 1: Lifetime prevalence of asthma, 2002



Note: Ranges are based on quantities of the overall prevalence estimates from year 2000 data. Air Pollution and Respiratory Health Branch, National Center for Environmental Health, CDC.

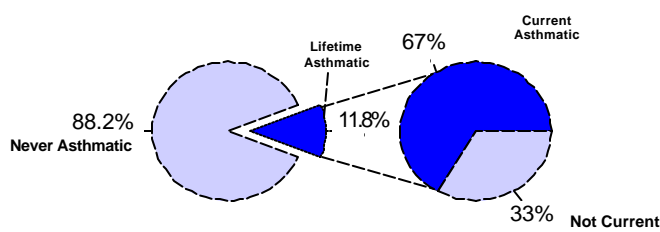
In Louisiana, 10.4% of the population was diagnosed with asthma by a health professional compared to 11.8% nationally (Figure 2).

Figure 2: Lifetime and current asthmatics - Louisiana, 2002



Current disease was diagnosed for 59% of the asthmatics in Louisiana compared to 67% nationally (Figure 3).

Figure 3: Lifetime and current asthmatics - United States, 2002

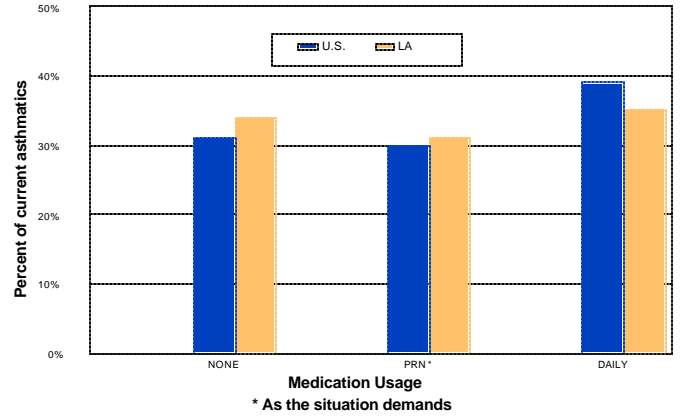


The gender distribution of asthmatics in Louisiana and the U.S. was equal: 37% female and 63% male. The racial distribution of asthmatics was 67% White and 33% Black in this state. Nationally, 87% of current asthmatics were White and 13% were Black. Louisiana is approximately one-third Black whereas the U.S. is 12% Black.

The mean age of adult asthmatics was 42.8 years in Louisiana versus 44.5 years in the United States. Annually, the mean number of asthma attacks was 1.5 in both locations. Emergency room (ER) visits for asthma was 0.5 per year, both in Louisiana and in the U.S. Non-ER urgent treatments for asthma were 0.8 in Louisiana and 0.9 nationally. The mean number of routine asthma checkups per year was 1.4 in Louisiana and 1.7 in the United States.

Within this state, 34% of current asthmatics utilized no asthma medication, 31% used medicines on an "as needed" basis and 35% required daily meds. Nationally, asthmatics reported medication use as 31%, 30% and 39% respectively (Figure 4).

Figure 4: Medication usage, 2002



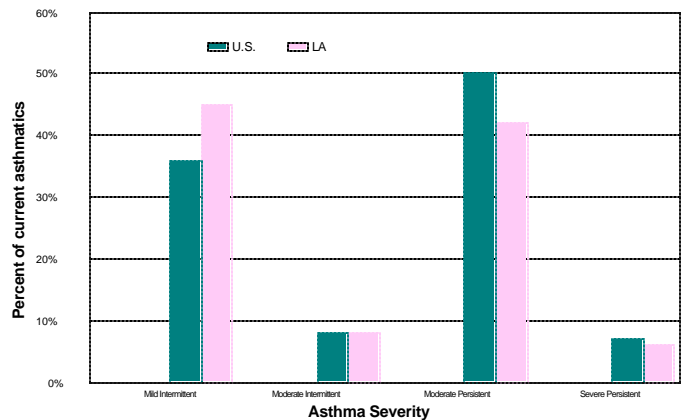
Daily living activities were limited 3.6 days per year in Louisiana and 11.6 days per year nationally (Table 1).

Table 1: Demographics and clinical factors, 2002

	Louisiana	United States
Gender	63% male 37% female	63% male 37% female
Prevalence by race	10.5% White 10.7% Black	11.9% White 12.8% Black
Mean age	42.8	44.5
Mean asthma attacks	1.5	1.5
Mean ED visits for asthma	0.5	0.5
Mean non-ED urgent visits	0.8	0.9
Mean routine asthma checkups	1.4	1.7
Mean days limited by asthma	3.6	11.6

In Louisiana, the majority of asthmatics met criteria for NHLBI categorization as 'mild intermittent asthmatics' while nationally the majority were 'moderate persistent' (Figure 5).

Figure 5: Asthma severity, 2002



Conclusions

Louisiana had a lower prevalence of lifetime and current asthmatics as compared to the national average. Asthmatics in Louisiana versus the United States had similar medical care utilization, even though disease categorization was less severe in Louisiana. Fewer asthmatics were White in Louisiana. The apparent difference in the prevalence of asthma between races reflects the greater percentage of Blacks in Louisiana. Louisianians use less medication and have less activity limitations.

For references or more information, call the Chronic Disease Epidemiology Section (504) 568-7210.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

MAY - JUNE, 2005

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD					
	1	2	3	4	5	6	7	8	9	May-Jun 2005	May-Jun 2004	Jan-Jun Cum 2005	Jan-Jun Cum 2004	% Chg	
Vaccine-preventable															
Hepatitis B	Cases	1	0	0	0	2	0	0	4	1	8	8	25	30	-16.7
	Rate ¹	0.1	0.0	0.0	0.0	0.7	0.0	0.0	1.1	0.2	0.2	0.2	0.6	0.7	NA
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Mumps		0	0	0	0	0	0	0	0	0	2	4	6	-33.3	
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	NA	
Pertussis		1	1	0	1	0	3	2	0	1	9	7	22	10	120
Sexually-transmitted															
HIV/AIDS	Cases ²	33	19	5	3	0	3	4	3	1	71	177	377	559	-33.0
	Rate ¹	3.3	3.3	1.3	0.6	0.0	1.0	0.8	0.9	0.2	1.6	4.0	8.6	12.8	NA
Gonorrhea	Cases	651	246	76	167	62	87	423	185	98	1995	2087	5189	5818	-10.8
	Rate ¹	63.0	40.8	19.8	30.5	21.9	28.9	81.0	52.3	22.4	44.6	46.7	116.1	130.2	NA
Syphilis (P&S)	Cases	16	35	1	2	1	0	0	0	3	58	51	132	132	0
	Rate ¹	1.55	5.80	0.26	0.36	0.35	0.00	0.00	0.00	0.68	1.30	1.14	2.95	2.95	NA
Enteric															
Campylobacter		2	6	2	1	0	1	1	2	6	21	37	60	72	-16.7
Hepatitis A	Cases	4	1	0	2	0	0	0	1	3	11	11	37	19	94.7
	Rate ¹	0.4	0.2	0.0	0.4	0.0	0.0	0.0	0.3	0.7	0.3	0.3	0.9	0.4	NA
Salmonella	Cases	18	23	17	32	7	9	2	7	22	137	185	306	309	-1.0
	Rate ¹	1.7	3.8	4.4	5.8	2.5	3.0	0.4	2.0	5.0	3.2	4.3	7.1	7.2	NA
Shigella	Cases	2	10	1	0	2	0	0	1	0	16	80	55	182	-69.8
	Rate ¹	0.2	1.7	0.3	0.0	0.7	0.0	0.0	0.3	0.0	0.4	1.9	1.3	4.2	NA
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Vibrio, other		3	2	2	0	1	0	1	0	1	10	14	14	21	-33.3
Other															
<i>H. influenzae (other)</i>		1	1	0	0	0	0	1	0	0	3	0	26	9	188.9
<i>N. Meningitidis</i>		0	1	0	0	2	0	1	0	2	6	8	27	26	3.8

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

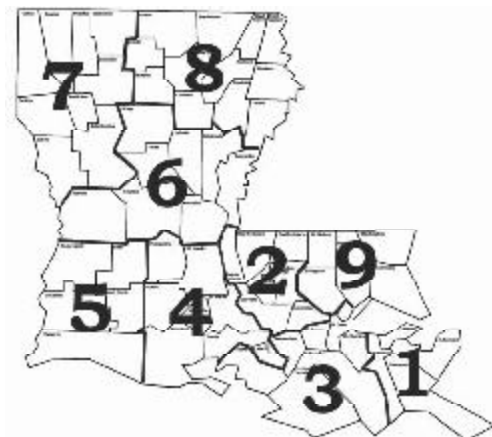
(January-June, 2005)

Disease	Total to Date
Legionellosis	0
Lyme Disease	3
Malaria	2
Rabies, animal	6
Varicella	105

Table 3. Animal rabies

(May-June, 2005)

Parish	No. Cases	Species
Caddo	1	bat
Vernon	1	bat



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	Neisseria meningitidis (invasive disease)	Smallpox
Botulism	Plague	Staphylococcus Aureus,
Brucellosis	Poliomyelitis, paralytic	Vancomycin Resistant
Cholera	Q Fever	Tularemia
Diphtheria	Rabies (animal & man)	Viral Hemorrhagic Fever
Haemophilus influenzae (invasive disease)	Rubella (German measles)	Yellow Fever
Measles (rubeola)	Rubella (congenital syndrome)	

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	Hepatitis B (carriage)	Salmonellosis
Chancroid ¹	Hepatitis B (perinatal infection)	Shigellosis
E. Coli 0157:H7	Hepatitis E	Syphilis ¹
E. Coli Enterohemorrhagic (other)	Herpes (neonatal)	Tetanus
Encephalitis, Arthropod borne	Legionellosis (acute disease)	Tuberculosis ²
Hantavirus Pulmonary Syndrome	Malaria	Typhoid Fever
Hemolytic-Uremic Syndrome	Mumps	
Hepatitis A (acute disease)	Pertussis	

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)	Hepatitis C (acute and infection)	Streptococcal Toxic Shock Syndrome
Blastomycosis	Human Immunodeficiency Virus (HIV infection)	Streptococcus Pneumoniae (invasive infection, penicillin resistant (DRSP))
Campylobacteriosis	Listeria	Streptococcus Pneumoniae (invasive infection in children < 5 years of age)
Chlamydial infection ¹	Lyme Disease	Trichinosis
Coccidioidomycosis	Lymphogranuloma Venereum ¹	Varicella (chickenpox)
Cryptosporidiosis	Psittacosis	Vibrio Infections
Cyclosporiasis	Rocky Mountain Spotted Fever (RMSF)	(other than cholera)
Dengue	Staphylococcus Aureus, Methicillin/Oxacillin Resistant (MRSA) (invasive disease)	West Nile Fever
Ehrlichiosis Hansen's Disease (leprosy)	Staphylococcal Toxic Shock Syndrome	West Nile Infection (past or present)
Enterococcus, Vancomycin Resistant (VRE) (invasive disease)	Streptococcal disease, Group A disease)	
Giardia	Streptococcal disease, Group B (invasive disease)	
Gonorrhoea ¹		
Hansen's Disease (leprosy)		
Hepatitis B (acute)		

Other Reportable Conditions

Cancer	Phenylketonuria*	Spinal Cord Injury**
Complications of Abortion	Reye's Syndrome	Sudden Infant Death Syndrome (SIDS)
Congenital Hypothyroidism*	Severe Traumatic Head Injury**	
Galactosemia*	Severe Undernutrition (severe anemia, failure to thrive)	
Hemophilia*	Sickle Cell Disease (newborns)*	
Lead Poisoning		

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>.¹Report on STD-43 form. Report cases of syphilis with active lesions by telephone.²Report 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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