



Kathleen Babineaux Blanco
GOVERNOR

Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
P.O. Box 60630, New Orleans, LA 70160 - Phone: (504) 219-4563
<http://www.dhh.louisiana.gov/offices/reports.asp?ID=249&Detail=306>



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

March-April 2006

Volume 17 Number 2

Neisseria meningitidis: An Organizational Meningitis Outbreak

Bruce Hurley, MPH; Juliette Stefanski, MD;
Patricia Fontenot, RN CIC

Introduction/Background:

Neisseria meningitidis, a gram-negative diplococcus, is the causative agent of invasive meningococcal diseases including meningococemia and meningitis. In Louisiana, this bacteria is responsible for approximately forty-five cases of disease per year and the sero-groups B, C, and Y each account for thirty percent of all cases.

By definition, an outbreak occurs when there are three or more confirmed or probable cases within a three-month period and the attack rate exceeds ten cases per 100,000 persons. Outbreaks may be either community or organizationally based. This criterion identifies the population at risk.

Investigation:

Between January 26, 2006 and February 14, 2006 a total of six cases of meningococcal disease, caused by *Neisseria meningitidis* sero-group C, were reported to the Office of Public Health (OPH). The case investigation identified the outbreak as an organizational outbreak linked to the local university and the population at risk was approximately 17,000 people. Additionally, the attack rate was 29.4 cases per 100,000 population at risk (5 cases/17,000 population at risk)*100,000 = 29.4/100,000). Only five of the six cases were directly linked to the university. Close personal contacts to the infected individuals were identified as persons who may have been in close prolonged contact such as household members. Antibiotic prophylaxis was recommended only for this high-risk group.

(Continued on page 3)

Contents

Neisseria Meningitidis: An Organizational Meningitis Outbreak	1
Don't Mix with Bleach!	1
Neonatal Mortality to Teen Mothers, Louisiana, 1997-2001	3
Hurricane Katrina's Impact on Tuberculosis Control in the Gulf States	5
OPH Training Offering	5
Immunizations Bulletins	5
LA Office of Public Health's Occupational Health Surveillance Program ..	6
Outlawing of Private Ownership of Non-Human Primates in Louisiana.....	6
IDE Field Epidemiology Techniques Training	6

Don't Mix with Bleach!

Harmful Exposures to Mixtures of Bleach/Ammonia-Based Products and Bleach/Acid-Based Products
Louisiana, September 2005 - February 2006

Kathleen Golden, MSPH; Michelle Lackovic, MPH;
Shannon Soileau, MS; Dianne Dugas, MPH MSW

Following Hurricanes Katrina and Rita, many residents of South Louisiana returned home to find that their water-damaged properties would require cleaning and disinfecting. Telephone calls to the Louisiana Department of Health and Hospitals/Office of Public Health/Section of Environmental Epidemiology and Toxicology's (OPH/SEET) telephone hotline, provided an indication of the number of residents involved in clean-up work. From September 1, 2005 through February 28, 2006, OPH/SEET received approximately 1,000 telephone calls from residents seeking advice on how to clean their mold-contaminated properties and belongings. These calls represent only a small portion of all the hurricane-related inquiries made by Louisiana residents to state and federal agencies.

Recommendations issued by OPH/SEET and the Centers for Disease Control and Prevention (CDC) for removing mold from hard, non-porous surfaces involve cleaning first with a detergent, followed by a solution of bleach and water. Residents are warned not to mix bleach with ammonia containing products, or any other cleaning products and to provide adequate ventilation during and after application. The mixture of household bleach (i.e., sodium hypochlorite) with ammonia-based products or acid-based cleaning agents such as toilet bowl cleaners, drain cleaners and vinegar can result in the release of toxic gases. Exposure to these gases can cause health effects ranging from mild skin irritations to respiratory failure.

Sodium hypochlorite is the active ingredient in chlorine bleach and is found in household bleach and many other disinfectants. When bleach products are mixed with ammonia or ammonia-based products, toxic gases called chloramines are formed. Exposure to chloramine gases can cause respiratory symptoms such as coughing, shortness of breath, wheezing and chest pain. Other common symptoms include irritation to the throat, nose and eyes.

When bleach is mixed with with acid-based cleaning agents, chlorine gas is produced. Chlorine gas exposure resulting from mixtures of bleach and acid-based products is irritating to the mucous membranes and can cause coughing and breathing problems, burning and watery eyes and a runny nose.

(Continued on next page)

Due to the number of residents cleaning mold-contaminated households, OPH/SEET was concerned about health effects resulting from exposure to bleach mixtures. To determine the frequency and nature of exposure to household cleaning products, OPH/SEET reviewed Louisiana Poison Control Center (PCC) data for a six-month period: September 1, 2005 through February 28, 2006. The Louisiana PCC receives calls statewide from healthcare providers and the general public. The majority of calls involve an acute exposure to a toxic substance. The PCC's primary function is to provide callers with toxicologic and treatment information. Individuals who experienced health effects related to exposure to a mixture of bleach and an ammonia-based product or a mixture of bleach and an acid-based product were included in the data review.

Sixty-five individuals statewide called the PCC during this six-month period to report health effects resulting from exposure to a bleach/ammonia or bleach/acid mixture. (Table 1)

Table 1: Exposure to household chemicals: bleach/ammonia and bleach/acid mixtures (n = 65 cases)
Louisiana, September 1, 2005 - February 28, 2006

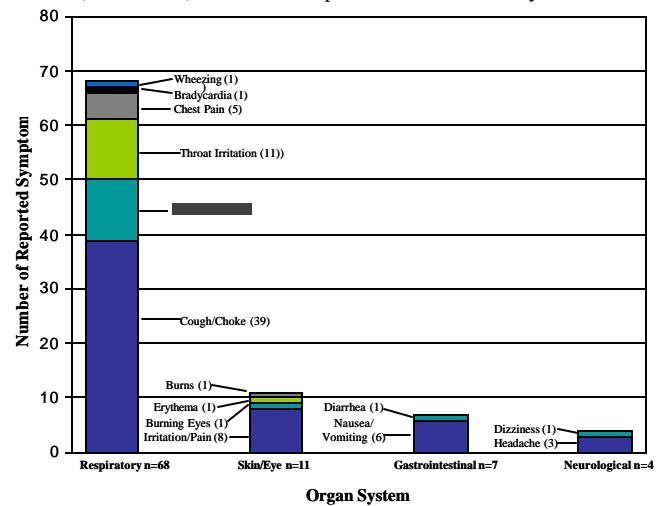
Age Group (years)*	Number	%
0 - 19	5	8
20 - 40	40	62
41 - 60	16	25
61 - 70	1	2
> 70	3	5
<i>*Total percentage is greater than 100 due to rounding.</i>		
Gender		
Male	20	31
Female	45	69
Work-Related		
Yes	6	9
No	59	91
Routes of Exposure**		
Inhalation/nasal	61	94
Ocular	3	5
Dermal	2	3
<i>**Percentages for route of exposure add up to more than 100% because several cases reported more than 1 route of exposure.</i>		

The typical exposure scenario involved an adult who was cleaning a home and mixed two cleaners or applied one cleaner after another. The majority of cases (45 or 69%) were females and 62% were between twenty and forty years of age. The average was eleven (range = 7 to 14) reported cases per month.

Twenty-six parishes reported at least one exposure. Approximately forty-five percent of the cases came from eleven hurricane-affected parishes: Jefferson (10), Calcasieu (5), Tangipahoa (3), Livingston (2), St. Tammany (2), St. Mary (2), Vermilion (2), Iberia (1), Orleans (1), St. Charles (1), Terrebonne (1). The Parish is unknown in four cases.

Of the sixty-five cases, twenty-two (34%) reported exposure to chloramine gases and forty-three (66%) were exposed to chlorine gas. Overall, ninety-four percent of the cases were exposed via inhalation. Respiratory effects were the most common. (Figure 1)

Figure 1: Reported symptoms by organ system of cases with health effects associated with exposure to bleach/ammonia or bleach/acid mixture (n=65 cases) Louisiana, September 2005-February 2006



The single most commonly reported symptom was cough/choke (n=39) followed by throat irritation (n=11) and dyspnea (n=11). Most of the reported cases (48 cases, or 74%) experienced self-limiting health effects that were managed on-site.

PCC recommendations for inhalational exposure to chlorine or chloramine gases involve moving the patient to fresh air and monitoring for respiratory distress. Cases with ongoing cough or difficulty breathing are advised to be evaluated by a healthcare provider for respiratory tract irritation, bronchitis, or pneumonitis. Healthcare providers are recommended to administer oxygen and assist ventilation as required. A breathing treatment by hand-held nebulizer containing three milliliters of sodium bicarbonate 8.4% with two milliliters normal saline is also recommended by the PCC to relieve breathing problems associated with chlorine exposure.

Chlorine gas exposure is more toxic than chloramine exposure. Even at low levels, chlorine gas exposure is almost always irritating to the mucous membranes (eyes, throat, and nose) and causes coughing and breathing problems. The increased toxicity of chlorine gas is reflected in the rate of reported medical visits for chlorine cases versus chloramine cases: thirty-three percent of the chlorine cases were treated by a healthcare provider versus fourteen percent of chloramine exposures (Table 2).

Louisiana Morbidity Report	
Volume 17 Number 2	March-April 2006
<p>The Louisiana Morbidity Report is published bimonthly by the Infectious Disease Epidemiology Section of the Louisiana Office of Public Health to inform physicians, nurses, and public health professionals about disease trends and patterns in Louisiana. Address correspondence to Louisiana Morbidity Report, Infectious Disease Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.</p>	
Assistant Secretary, OPH	Sharon Howard, MSW
State Epidemiologist	Raoult Ratard, MD MPH
Editors	Susanne Straif-Bourgeois, PhD MPH Theresa Sokol, MPH Rosemarie Robertson, BS MT(C) CNMT
Layout & Design	Ethel Davis, CST

Table 2: Medical visits for chloramine and chlorine exposure (n=65 cases) Louisiana, September 1, 2005-February 28, 2006

Medical Visits	Chloramine (n=22)		Chlorine (n=43)		Total (n=65)	
	Number	%	Number	%	Number	%
Yes	3	14	14	33	17	26
No	19	86	29	67	48	74

The data review suggests that many Louisiana residents improperly use household cleaning chemicals resulting in exposure to toxic chloramine or chlorine gas. The number of calls to the PCC involving exposure to these products is likely an underestimate of the actual exposures. In addition, it is difficult to draw conclusions about the number of reported cases during this six-month time period due to telephone outages, disruption of medical services and the significant depopulation of Orleans, St. Bernard and Plaquemines parishes. It is likely, however, that a greater proportion of residents in the hurricane-affected parishes are using bleach in combination with other household cleaning chemicals than before the storms.

There are several important findings as a result of this review: 1) approximately twenty-six percent of the bleach mixture exposures were severe enough to require a medical visit; 2) chlorine exposures were more common than chloramine exposures; 3) chlorine gas exposures were more likely to result in a medical visit than chloramine gas exposures. These findings highlight the importance of continuing to educate the public about the dangers of mixing bleach with any household chemical. Although the warning message about mixing bleach with ammonia is well-known, this study suggests that the public is not as well informed about the dangers of mixing bleach with acid-based cleaning products.

For more information about this project or OPH/SEETS's chemical surveillance program, contact Kathleen Golden at 504-219-4575 or kmgolden@dhh.la.gov.

(*Neisseria meningitidis*: ... Continued from page 1)

In an effort to prevent the continuation of the outbreak, recommendations were issued for three groups of individuals to get vaccinated with a meningococcal vaccine. The groups identified were members of social organizations including fraternities and sororities, all persons who lived on campus at the university, students, faculty and staff at the university through twenty years of age. As vaccine became available, groups deemed at lower risk were offered vaccinations. Upon completion of the vaccination campaign, 5,000 students received vaccinations through the OPH vaccination clinics. Private providers also provided vaccine for their patients.

Discussion:

This outbreak linked cases through the local university; however, the spread of disease can occur only when individuals are in close personal contact with each other. In some instances this includes sharing items that will facilitate droplet transmission from person to person. Casual contact, such as being in the same classroom, does not put a person at elevated risk or warrant prophylaxis. The recommendation for mass vaccination is not generally considered necessary, but the specifics of the outbreak at the university

warranted the efforts used in part because the risk of having invasive meningococcal disease is highest among college aged freshman and sophomores. The targeted vaccination campaign encompassed the groups deemed at highest risk and the campaign was completed successfully. Routine surveillance throughout the region continues to detect any resurgence of cases.

For references or more information, please contact bhurley@dhh.la.gov or (337) 262-5613.

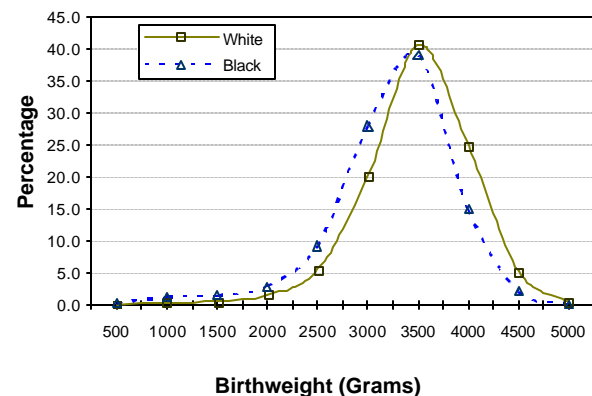
Neonatal Mortality to Teen Mothers Louisiana, 1997-2001

Tri Tran, MD MPH; Genet Burka, MD MPH;
Frances Mather, PhD; Juan Acuna, MD MSc

This study analyzes neonatal mortality to Louisiana resident teen births where the mother is thirteen to nineteen years of age during the period 1997 – 2002. The source of data is a cohort birth-infant death linked file, with information from the death certificate linked to information from the birth certificate for each neonate less than twenty-eight days of age who died in or out of Louisiana. The data excludes births less than 400 grams of birthweight and less than twenty weeks of gestational age. Only singleton and twin births to Black and White teens are included in the study.

Cox regression was used to identify risk factors with adjustment for the factors together in the multivariable regression model. As the birthweight distribution of White births (mean: 3228 g, standard deviation: 564 g) and Black births (mean: 3002 g, standard deviation: 617 g) are different, birthweight was standardized to a Z score for analysis. (Figure 1)

Figure 1: Birthweight distribution of black and white live births to teen mothers - Louisiana, 1997-2002

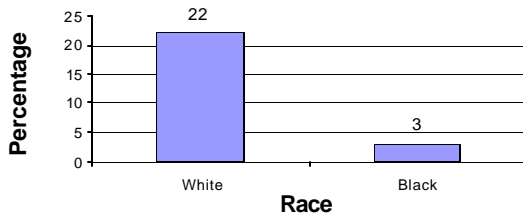


During the period 1997-2002, eighteen percent of all live births were to teens thirteen to nineteen years of age, twenty-six percent among Black births and eighteen percent among White births. Unadjusted neonatal mortality rate (NMR per 1,000 live births) was higher among White teen births (4.4 per 1,000 live births) compared to all White births (3.4 per 1,000 live births) and similar among Black teen births (6.0 per 1,000 live births) and all Black births (6.2 per 1,000 live births).

(Continued on next page)

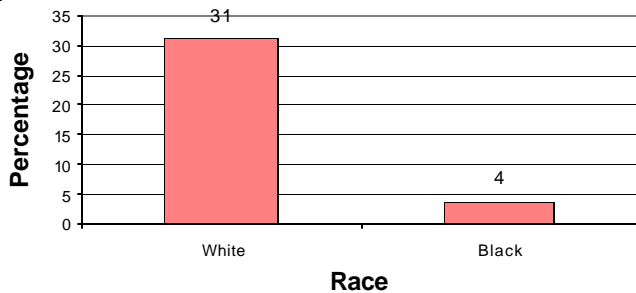
The majority of the mothers were eighteen to nineteen years old (Whites: 70 %, Blacks: 59%) and had nine to twelve years of education (Whites: 83%, Blacks: 85%). Adequate prenatal care (Kotelchuck index) was low in both White (76%) and Black (63%) births. Self-reported smoking during pregnancy was higher among White (22%) births compared to Black (3%) births. (Figure 2)

Figure 2: Percentage of teen mothers who self-reported smoking during pregnancy by race - Louisiana, 1997-2002



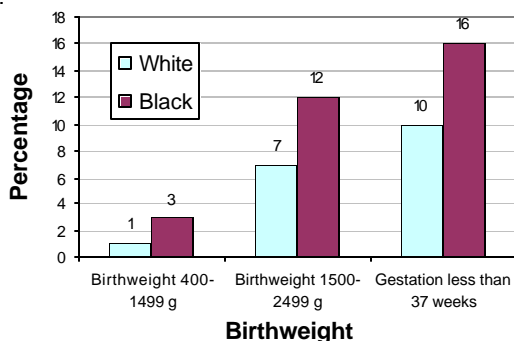
Newborn complications and mother’s medical risk were somewhat lower among White births (26%, 19%) compared to Black births (27%, 25%). The percentage of married women is very low within the Black population (4%) and approximately eight times less than within the White population (31%). (Figure 3)

Figure 3: Percentage of marital status of teen mothers within race - Louisiana, 1997-2002



Plurality was slightly different between White (singleton: 99% twin: 1%) and Black (singleton: 98% twin: 2%) births. Deliveries in level III hospitals are higher among White (41%) than Black (33%) births. Very low (400-1499 grams) or low birthweight (1500-2499 grams) and preterm (less than 37 weeks of gestational age) births are lower among White (very low birth weight (VLBW): 1%, low birth weight (LBW): 7%, and preterm: 10%) than among Black births (VLBW: 3%, LBW: 12%, and preterm: 16%). (Figure 4)

Figure 4: Percent of VLBW (400-1499 grams), LBW (1500-2499 grams) and normal (2500 grams or more) by race.



Unadjusted neonatal mortality was 4.4 per 1,000 live births (95% Confidence Interval (CI): 3.5, 5.2) for Whites and 6.0 per 1,000 live births (CI: 5.1, 6.8) for Blacks. Neonatal mortality rates are lower in births with no maternal medical risk, adequate prenatal care, singleton, no newborn complications, level III hospitals, term and normal birthweight than in births with maternal medical risk, inadequate prenatal care, twin, newborn complications, level I-II hospitals, preterm and VLBW or LBW, respectively.

A multivariable Cox regression model including the newborn’s and mother’s characteristics as risk factors shows that Black neonates were more likely to die than White infants, with adjusted hazard ratio (HR) of 1.5 (CI: 1.2, 2.8). Lower birthweight, newborn complication and lower maternal education are statistically significant for increased hazard of neonatal deaths. (Table 1)

Table 1: Factors statistically associated with hazard rates of neonatal mortality for teen mothers in a multivariate Cox regression model Louisiana, 1997-2002

Variables	HR*	95% CI**	P value	
Race	Black	1.5	1.2, 2.8	0.002
	White	1.0	-	
Newborn complication	Yes	1.7	1.3, 2.1	0.000
	No	1.0	-	
Education (grades)	< 9	1.4	1.0, 2.0	0.009
	9+	1.0	-	
Z score of birthweight	0.233	0.214, 0.254	0.000	

*HR: Hazard Ratio, **CI: Confidence Interval

The five leading causes of neonatal deaths are listed in Table 2.

Table 2: Percents of leading causes of neonatal deaths to teen mothers Louisiana, 1997-2002

Cause of neonatal deaths	White	Black
Congenital malformations, deformations, and chromosomal abnormalities	34.7	17.8
Disorders related to short gestation and low birth weight	22.8	20.8
Respiratory distress of newborn	3.0	9.6
Newborn affected by maternal complications of pregnancy	3.0	5.6
Atelectasis	3.0	5.6
All Others	33.7	40.6

Together, the two leading causes accounted for fifty-eight percent of all White neonatal deaths while all five leading causes accounted for fifty-nine percent of all Black neonatal deaths.

Attempts to reduce newborn complications among live births to teens should receive high priority. Assisting adolescent mothers to bear infants with birth weights and gestational age in the normal range is an appropriate goal to reduce neonatal mortality.

For references or more information, email Dr. Tri Tran at ttran@dhh.la.gov or call(504)219-4450.

Hurricane Katrina's Impact on Tuberculosis Control in the Gulf States

Highlights from State and Local Programs

Charles Wallace, Ph D MPH; Phyllis Cruise, CDC Public Health Advisor, Texas Department of State Health Services

On August 29, 2005, Hurricane Katrina slammed into the Northern Gulf of Mexico, causing devastation and destruction that severely crippled social and medical institutions in Louisiana, Mississippi and Alabama. At the urgent request of Louisiana Governor, Kathleen Babineaux Blanco, Texas Governor, Rick Perry agreed to allow hurricane victims taking shelter in the New Orleans Superdome to be moved to the Houston Astrodome (Harris County, Texas).

The Reliant Park complex, which includes the Astrodome, the Reliant Arena and the Reliant Center, housed approximately 25,000 displaced evacuees of which 23,000 were in the Astrodome. Also, 2,800 evacuees were housed in the George R. Brown Center in downtown Houston. In addition, 120,000 evacuees were housed in ninety-seven shelters in Dallas, San Antonio and dozens of smaller cities across the state as far north as Midland and as far west as El Paso. Another 100,000 persons were housed in hotels and motels around the state. It is estimated that a total of 250,000 displaced residents from Louisiana evacuated to Texas.

On August 31, 2005, Mr. Charles DeGraw, Louisiana State Tuberculosis (TB) Controller, called the Texas Department of State Health Services TB Program to inform them that approximately one hundred TB patients could be among the displaced residents as the Louisiana TB Program had been significantly impacted by the flood waters. Working with Mr. DeGraw, the Texas TB Program immediately began putting support systems in place for those areas in the state receiving displaced residents from Louisiana.

Local and regional health departments in Texas were notified to be on the lookout for persons with TB and were told to "Think TB" at all times because many of the persons diagnosed in Louisiana might not communicate their condition to the medical teams working in the shelters. Shelter workers were told to be alert to the signs and symptoms of TB and take any shelter resident identified as having TB to the shelter medical triage stations for evaluation and isolation, if indicated.

Mr. DeGraw asked the State of Texas to "loan" the Louisiana TB Program the necessary TB drugs to continue providing treatment to persons staying in Louisiana since his medication supply was under water. Texas agreed to provide the necessary medications for Louisiana as well as working with VersaPharm Inc. to arrange for medications to be sent to Louisiana. Mr. Joe Ware, President of VersaPharm, responded by shipping all the needed medications to the Louisiana TB Program at no cost to the State of Louisiana.

On September 7, 2006, Ms. Phyllis Cruise, Senior CDC Public Health Advisor assigned to Texas, was deployed to work at the Incident Command Center at the Houston Astrodome. She assisted in the medical follow-up of persons residing in the shelters and worked primarily in the three large shelters located in Reliant Park. The Texas Department of State Health Service TB Program orga-

nized a team comprised of staff from public health regions, local health departments, the data analysis unit at the Texas Department of State Health Services and the Louisiana State Health Department TB Program to address the issues surrounding the management of persons in shelters who are found to have TB.

The Texas TB program also arranged for the Texas State Laboratory to provide laboratory assistance after Mr. DeGraw requested laboratory support. The Texas State Laboratory agreed to receive and process TB specimens submitted by the State of Louisiana for evaluation and provided the Louisiana TB Program with the containers needed to ship specimens to the Texas State Laboratory. As of October 31, there had been 307 specimens submitted to the Texas State Laboratory for processing.

In an effort to determine if any of the displaced Louisiana residents living in the shelters had been diagnosed, the Texas TB Program worked with the Texas Emergency Command Center, the Incident Command Center in Houston, the City of Houston and Harris County government officials, the Texas State Health Service Regions, local health departments throughout the state of Texas, local hospitals, the American Red Cross and countless shelters across the state to match known tuberculosis patients with the listing of shelter residents. TB program staff confidentially worked with shelter administrators to match the lists. Persons identified were then evaluated and placed on medication and in some cases hospitalized for treatment. The Texas Tuberculosis Program worked with the Texas State Pharmacy to ensure tuberculosis medications were stocked on the mobile pharmacies deployed to shelters. By mid-October, TB control officials were very happy to report that all TB patients who had been evacuated from the affected areas as a result of hurricane had been accounted for.

OPH Training Offering

The Hepatitis C Support Project (HCSP) Train the Trainer Program Program will be held at the WK Career Institute, 2401 Bessie Street, Shreveport, Louisiana 71103, May 18, 2006 from 9:00 am to 5:00 pm.

This workshop is targeted to health educators, HIV/STD counselors & testers, medical providers, substance abuse counselors, case managers, support group leaders, patients and other health professionals who will provide education, support and advocacy for people and populations affected by hepatitis C. Registrants that complete and successfully pass this program will be certified as HCV Basic Educators by the Hepatitis C Support Project. Registration deadline is April 27, 2006. For a registration form and agenda, please go to:

<http://www.dhh.louisiana.gov/offices/publications.asp?ID=249&Detail=1124>

Immunization Bulletins

In the Fall of 2006 PCV7 (Seven Pneumococcal Conjugate Vaccine) will be required for childcare and pre-school entry.

The Shots for Tots conference will be held at the Astor Crown Plaza in New Orleans, Louisiana, December 7-8, 2006.

For more information contact Ruben Tapia at 504-838-5300 or rtapia@dhh.la.gov.

Louisiana Office of Public Health's Occupational Health Surveillance Program

The Office of Public Health/Section of Environmental Epidemiology & Toxicology was awarded a three-year grant (7/2005 through 7/2008) from the Centers for Disease Control and Prevention (CDC) to develop a statewide Occupational Health Surveillance Program. The grant's purpose is to strengthen the Office of Public Health's capacity to conduct population-based surveillance of specified occupational health indicators using existing data systems. The thirteen occupational health conditions for study (Table 1) were identified by the CDC in collaboration with the Council of State and Territorial Epidemiologists. Conditions were selected based on the availability of data, their public health importance, and the opinion that they could be prevented.

Table 1: Occupational health conditions for study

Data Source:	Condition:
Hospital Discharge Database:	Work-related hospitalizations
	Hospitalizations from work-related burns
	Hospitalizations from Pneumoconiosis
Vital Records:	Mortality from Pneumoconiosis
Laboratories:	Elevated blood lead levels
Poison Control Center:	Pesticide Poisoning
Worker's Compensation:	Amputations
	Carpal Tunnel Syndrome
Tumor Registry:	Mesothelioma
Bureau of Labor Statistics:	Non fatal work-related injuries and illnesses
	Work-related fatal injuries
	Work-related amputations
	Musculoskeletal disorders

For more information on this program, contact Michelle Lackovic at mlackovi@dhh.la.gov or at (504) 219-4518.

Outlawing of Private Ownership of Non-Human Primates in Louisiana

Gary Balsamo, DVM MPH&TM

Louisiana will join nineteen other states that outlaw private ownership of primates. The public health implications of primate ownership are disease transmission and bites. The bites, often severe, are over three times more common in children than adults. Prior to this change, there was no licensed rabies vaccination, no recognized quarantine period and often no cooperation from primate owners in carrying out the stipulations of the sanitary code. Pursuant to this new rule, Wildlife and Fisheries may be requested to seize the animal in question, if it is determined that rabies testing is in order. The rule allows for exceptions, such as in the case of service animals or privately owned licensed sanctuaries. To view the rule go to: <http://www.wlf.state.la.us/news/?id=213>

Scenes from Infectious Disease Epidemiology Field Epidemiology Techniques I & II March 28-29, 2006 New Orleans, Louisiana



Attendees for FET I & II



*Stacy Hall, RNC MSN
"Bioterrorism 101"*



*Peter Vranken, RN DPH MBA
EIS Officer
"Epidemiology Primer"*

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

January-February, 2006

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION										TIME PERIOD				
	1	2	3	4	5	6	7	8	9	Jan-Feb 2006	Jan-Feb 2005	Jan-Feb Cum 2006	Jan-Feb Cum 2005	% Chg	
Vaccine-preventable															
Hepatitis B											7	12	7	12	-41.7
Cases	0	0	1	1	0	2	1	0	2	7	12	7	12	-41.7	
Rate ¹	0.0	0.0	0.3	0.2	0.0	0.7	0.2	0.0	0.5	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	0	0	0	0	0	0	0	4	0	4	-100.0	
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*	
Pertussis	0	2	0	0	0	0	0	0	0	2	5	2	5	-60.0	
Sexually-transmitted															
HIV/AIDS											36	181	36	181	-0.8
Cases ²	3	13	2	2	3	4	4	3	2	36	181	36	181	-0.8	
Rate ¹	0.3	2.3	0.5	0.4	1.1	1.3	0.8	0.9	0.5	0.8	4.1	0.8	4.1	NA	
Gonorrhea											1101	1229	1101	1229	-10.4
Cases	118	275	79	146	57	75	210	91	50	1101	1229	1101	1229	-10.4	
Rate ¹	11.4	45.6	20.6	26.6	20.1	24.9	40.2	25.7	11.4	24.6	27.5	24.6	27.5	NA	
Syphilis (P&S)											17	27	17	27	-37.0
Cases	4	9	1	3	0	0	0	0	0	17	27	17	27	-37.0	
Rate ¹	0.4	1.5	0.3	0.5	0.0	0.0	0.0	0.0	0.0	0.4	0.6	0.4	0.6	NA	
Enteric															
Campylobacter	2	5	0	0	0	1	1	2	0	11	17	11	17	-35.3	
Hepatitis A											1	13	1	13	-92.3
Cases	0	0	0	0	0	1	0	0	0	1	13	1	13	-92.3	
Rate ¹	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.3	0.0	0.3	NA	
Salmonella											39	70	39	70	-44.3
Cases	2	9	4	9	3	3	3	3	3	39	70	39	70	-44.3	
Rate ¹	0.2	1.5	1.0	1.6	1.1	1.0	0.6	0.8	0.7	0.9	1.6	0.9	1.6	NA	
Shigella											15	29	15	29	-48.3
Cases	0	0	0	11	1	0	1	1	1	15	29	15	29	-48.3	
Rate ¹	0.0	0.0	0.0	2.0	0.4	0.0	0.2	0.3	0.2	0.3	0.7	0.3	0.7	NA	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*	
Vibrio, other	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*	
Other															
<i>H. influenzae (other)</i>	0	1	0	0	0	0	1	0	1	3	14	3	14	-78.6	
<i>N. Meningitidis</i>	4	3	1	6	0	0	0	1	0	15	9	15	9	+66.7	

1 = Cases Per 100,000

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

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

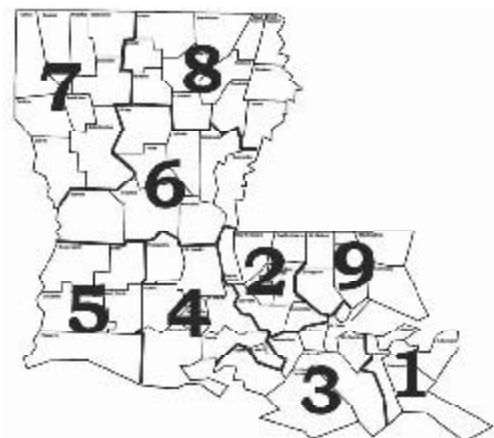
* Percentages not calculated for numbers less than 10

Table 2. Diseases of Low Frequency (January-February, 2006)

Disease	Total to Date
Legionellosis	2
Lyme Disease	0
Malaria	0
Rabies, animal	0
Varicella	49

Table 3. Animal rabies (January-February, 2006)

Parish	No. Cases	Species
	0	



**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 (other than cholera)
Cyclosporiasis	Rocky Mountain Spotted Fever (RMSF)	West Nile Fever
Dengue	Staphylococcus Aureus, Methicillin/Oxacillin Resistant (MRSA) (invasive disease)	West Nile Infection (past or present)
Ehrlichiosis	Staphylococcal Toxic Shock Syndrome	
Enterococcus, Vancomycin Resistant (VRE) (invasive disease)	Streptococcal disease, Group A (disease)	
Giardia	Streptococcal disease, Group B (invasive disease)	
Gonorrhea ¹		
Hansen's Disease (leprosy)		
Hepatitis B (acute)		

Other Reportable Conditions

Cancer	Phenylketonuria ³	Spinal Cord Injury
Complications of Abortion	Reye's Syndrome	Sudden Infant Death Syndrome (SIDS)
Congenital Hypothyroidism ³	Severe Traumatic Head Injury	
Galactosemia ³	Severe Undernutrition (severe anemia, failure to thrive)	
Hemophilia ³	Sickle Cell Disease (newborns) ³	
Lead Poisoning		

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (EPI-2430), facsimile (504-219-4522), phone reports (504-219-4563 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.

³Report to the Louisiana Genetic Diseases Program Office by telephone (504) 219-4413 or FAX (504) 219-4452.

This public health document was published at a total cost of \$990.00. Seven thousand (7,000) copies of this public document were published in this first printing at a cost of \$990.00. The total cost of all printings of this document, including reprints is \$990.00. This document was published by Moran Printing, Inc., 5425 Florida Blvd., Baton Rouge, LA 70806 to inform physicians, hospitals, and the public of current Louisiana morbidity status under authority of R.S. 40:36. This material was printed in accordance with the standards for printing for state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with the provisions of Title 43 of Louisiana Revised Statutes.

**DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
P.O. BOX 60630 NEW ORLEANS LA 70160**

PRSR STD
U.S. POSTAGE
PAID
Baton Rouge, LA
Permit No. 1032