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Louisiana Morbidity Report

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July - August 2007 **Volume 18 Number 4**

Trends in Antibiotic Sensitivity* - Louisiana, 2006

Sharmin Afroz, MPH candidate

Introduction:

Antibiotic resistance is an increasing problem. The 'Antibiotic Sensitivity Active Surveillance System' began in Louisiana with the collection of aggregate data in 2000 to track the emergence of antibiotic resistant organisms. This surveillance program, which allows the state to track and evaluate antibiotic resistance trends, monitors three pathogens: Drug resistant *Streptococcus pneumoniae* (DRSP), Methicillin resistant *Staphylococcus aureus* (MRSA) and Vancomycin resistant enterococcus (VRE). The primary goal of the Antibiotic Sensitivity Active Surveillance System is to estimate the proportion of selected bacteria in the state that are resistant to antibiotics by the reporting of laboratory aggregate data.

Methods:

Over the past seven years, forty-three hospitals have participated in the surveillance system at some point in time. Currently, twenty-seven hospitals provide information to the surveillance system each month on a brief reporting form. Each hospital reports the total number of *S. pneumoniae*, *S. aureus* and enterococcus species isolated in their lab for each month. In addition, they also report the total number of drug resistant or drug intermediate resistant isolates for each of those organisms. As duplicates are not reported, the forms contain counts on one isolate of DRSP, MRSA, or VRE per patient per hospital visit. Each report is entered into an Access database and from this database, quarterly and annual summary reports are generated for the participating hospitals.

The purpose of this analysis is to determine if there is a significant trend in the rates of antibiotic resistance for *S. pneumoniae*, *S. aureus* and enterococcus from 2000 to 2006. Since interest was in resistance as either present or not present, the resistance and intermediately resistant variables were combined to get one variable for resistance.

For each organism of interest, using the annual rates, a test for trend was conducted using the Cochran-Armitage Trend test. The analyses were conducted using SAS (Version 9.1; Cary, NC).

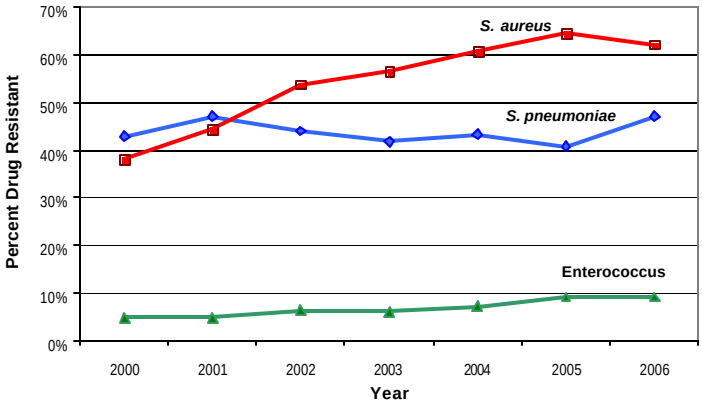
Results:

A trend analysis was conducted to determine if the rates of resistance were increasing over the past seven years (2000, 2001, 2002, 2003, 2004, 2005 and 2006). The results can be seen in Table 1 and Figure 1.

Table 1: Trend analysis of resistance for *S. pneumoniae*, *S. aureus*, Enterococcus species - Louisiana, 2000-2006

		2000	2001	2002	2003	2004	2005	2006	Z (C-A trend test)	p-value
S. Pneumoniæ	Resistant	547	662	548	432	371	250	357		
	Susceptible	729	744	696	604	485	364	402	-0.24	0.8109
	% Resistant	42.87	47.08	44.05	41.70	43.34	40.72	47.04		
S. aureus	Resistant	4560	6682	9489	9711	9514	6637	8116		
	Susceptible	7377	8347	8152	7425	6180	3632	4933	50.33	<.0001
	% Resistant	38.20	44.46	53.79	56.67	60.62	64.63	62.20		
Enterococcus	Resistant	451	496	647	288	600	486	487		
	Susceptible	8577	10013	9327	4446	7746	4796	4781	14.15	<.0001
	%Resistant	5.00	4.95	6.49	6.08	7.19	9.20	9.24		

Figure 1:Percent drug resistant *Streptococcus pneumoniae*, *Staphylococcus aureus* and Enterococcus species - Louisiana, 2000-2006



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GBS Assessment Prevention, Control Policies in Perinatal Women - Louisiana, January - May, 2007

Navya Nair, MPH

Introduction

Group B Streptococcus (GBS) is a bacterial infection that is life-threatening to newborns. It can be transmitted from mother to infant during labor. Approximately half of the cases of GBS disease occur in the first week of life (early onset cases), most of which start within a few hours of birth. Common complications for early onset disease include sepsis, pneumonia and meningitis. Premature babies are at a higher risk of becoming infected with GBS. The disease can be prevented by providing antibiotics to the mother during labor. The Centers for Disease Control and Prevention (CDC) has specific recommendations to control and prevent GBS infections.

Methods:

A comprehensive survey questionnaire was developed based on CDC guidelines to assess the procedures regarding GBS prevention and control policies at local OB/GYN clinics. This survey was used to determine what the policies for preventing GBS were in clinics and to evaluate their compliance with CDC recommendations.

This questionnaire was administered through direct telephone interviews and faxed surveys to physicians, nurses and technical assistants working in the clinics. The data from the thirty-nine completed surveys was compiled into a spreadsheet and subsequently analyzed using SPSS (Version 11.5) to describe each variable and assess the level of compliance with CDC guidelines.

Results:

Screening guidelines: While most respondents had a policy to prevent GBS (97.4%), only 73.5% used CDC guidelines (the rest used individually customized guidelines; 5.9% used none). The screening of all ante-natal women for GBS was done by 97.4% of respondents. The majority (70.3%) of these said that they use laboratory based screening techniques, while only 29.7% said that they use a combination of laboratory and risk-based screening approaches, which is recommended by the CDC.

Screening planned C-sections: Of those women who have planned caesarean sections, 57.1% receive treatment. The CDC recommendations state that these women are at low risk for having an infant with GBS disease and they should not routinely receive intrapartum chemoprophylaxis for perinatal GBS disease prevention.

Screening previously colonized patients: The CDC recommendations also state that all women who have previously given birth to infants with GBS disease should receive intrapartum chemoprophylaxis; culture-based screening is not required in these cases. It was found in the study that only 51.5% of respondents provide treatment to all women who have previously given birth to an infant with GBS disease.

Timing: Most (91.9%) respondents followed CDC guidelines by conducting laboratory-based screening at thirty-five to thirty-seven weeks of pregnancy.

Screening site: Most (73.0%) respondents said that both vaginal and rectal cultures were used for screening, as is recommended. Only 69.7% were compliant with the CDC recommendation in taking vaginal cultures from the lower vagina. (Respondants who reported taking cultures from the cervix, which is not recommended by the CDC - 30.3%; respondants who reported that most culture results were received before labor - 94.4%)

Risk based approach: In using the risk based approach, the following high risk determinants were used (Table 1):

Table 1: Percentage of clinics that use the following risk factors to determine a high-risk case - Louisiana, January-May 2007

Risk Factor Asked	No. of Respondents	Use Risk Factor (Valid %)
Gestation < 37 weeks	29	89.7
Duration of membrane rupture =18 hrs	29	79.3
Temperature =100.4 ° F	29	75.9
Other risk factor	29	25.0

Drugs used for prophylaxis: When asked what intrapartum treatment is used to treat a case, the respondents answered in the following manner (Table 2):

Table 2: Drugs used for treatment or prophylaxis Louisiana, January-May 2007

Drug Used	No. of Respondents	Yes (Valid %)
Penicillin G	29	65.5
Ampicillin	29	51.7
Cefazolin	29	6.9
Clindamycin	29	44.8
Erythromycin	29	13.8
Vancomycin	29	3.4
Other	29	10.3

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Prophylaxis in absence of screening: CDC recommendations state that if a screening result is not known at the time of labor, risk assessment should determine provision of chemoprophylaxis. Only 28.6% said that they proceed in this manner while 68.6% of respondents stated that they provide chemoprophylaxis for all and 2.9% stated that they proceed without chemoprophylaxis.

Treatment of infants: When asked if antimicrobial prophylaxis was given to babies of mothers who received intrapartum chemoprophylaxis, 24.0% said yes, 36.0% said no and 40.0% said sometimes. CDC does not recommend routine use of antimicrobials for these newborns, but therapeutic use is recommended with clinically suspected sepsis.

GBS in urine: If GBS is isolated from the urine, the respondents proceed in the following manner: (Table 3)

Table 3: Percentage of clinics that proceed with various actions if GBS is isolated from the urine - Louisiana, January-May 2007

Action	No. of Respondents	Yes (Valid %)
Do nothing	31	3.2%
Depends on GBS concentration in urine	31	0%
Take vaginal/rectal cultures	31	38.7%
Treat UTI	31	45.2%
Provide chemoprophylaxis at labor	31	64.5%

CDC recommendations state that if GBS is isolated from the urine, then chemoprophylaxis must be provided at labor and the urinary tract infection must be treated.

Overall compliance: Of the questions asked, thirteen that directly related to CDC recommendations were used to measure the level of compliance with the CDC. (Table 4)

Table 4: Level of CDC compliance of the clinics as a measure of accordance with CDC recommendations - Louisiana, January-May 2007

Level of Compliance	No. of Respondents	Valid Percent
Low (0-5 of 13 recommendations met)	39	28.2
Medium (6-10 of 13 recommendations met)	39	53.8
High (>10 of 13 recommendations met)	39	17.9

Conclusion:

The CDC has issued recommendations for the prevention of GBS infections among newborns. These guidelines have proven effective in reducing GBS infections and should be followed by healthcare providers.

For more information, please call (504) 219-4563

Cities Readiness Initiative

Stacy Hall, RN MSN; LaMiesa Bonton, MPA

Two Louisiana "cities", Baton Rouge and New Orleans/ Metairie/Kenner, have been designated by the Department of Homeland Security (DHS) and the Department of Health and Human Services (DHHS) to participate in the Cities Readiness Initiative (CRI) Program. CRI will enhance preparedness at all levels of government and will provide a consistent nationwide approach to prepare for, respond to and recover from a large-scale public health emergency. CRI provides an opportunity for DHS and DHHS to work closely with state and local partners to prepare for possible large-scale catastrophic events. A common resource for both departments, the Strategic National Stockpile (SNS), is a key participant in this initiative.

The CRI program began in May 2004 with twenty-one pilot cities and then added fifteen more metropolitan statistical areas in May 2005. There are now seventy-two "cities" with at least one CRI in each state. The Cities Readiness Initiative will help save lives through the delivery of medicines and medical supplies within a timeframe that will make an appreciable health difference in the event of a bioterrorism attack.

The CRI guidance outlines "Of foremost concern is the ability to respond in a timely manner to a bioterrorism attack over a large geographic area with an agent such as *Bacillus anthracis*, the organism that causes anthrax. In this care, antibiotics must reach the entire population within twenty-four to forty-eight hours to have the greatest life-saving effect."

Prompt administration of antibiotic chemoprophylaxis to a population exposed to aerosolized anthrax spores has the potential to save many lives. Preparedness for such an anthrax attack translates well to readiness for intentional and natural outbreaks involving other organisms for which antibiotics are an appropriate medical countermeasure, for example, plague or tularemia. This readiness for intentional and natural outbreaks will strengthen the public health response infrastructure for mass immunoprophylaxis. (Immunoprophylaxis is defined as using vaccines to counter outbreaks involving viruses for which vaccines are an appropriate medical countermeasure, for example, smallpox or pandemic influenza.)

The US Public Health Service, the Centers for Disease Control and Prevention (CDC) and US Marshall Service staff provided an Executive Brief for the Cities Readiness Initiative in Baton Rouge on February 15th and New Orleans/Metairie/Kenner on February 16, 2007 for local and state response personnel. An initial planning session for future activities was completed for Baton Rouge on February 27th and New Orleans/Metairie/Kenner on February 28, 2007. The Baton Rouge CRI already has participation of most essential response partners. Innovative options are expected from the New Orleans/Metairie/ Kenner CRI.

For more information, please contact Ms. Hall at (504) 568-5022 or email shall@dhh.la.gov or LaMiesa Bonton at (225) 763-3535 or email lbonton@dhh.la.gov.

Trends in Antibiotic Sensitivity (Continued from page 1)

The rates of drug resistant *S. pneumoniae* have not been increasing over the past seven years (Z for trend =-0.2392, p=0.8109). The rates of methicillin-resistant *S. aureus* have increased from 2000 to 2006. These increases were highly significant (Z for trend =50.33, p<0.0001). Rates of Vancomycin resistant Enterococcus also appeared to be significantly different over the past seven years (Z trend =14.15, p<0.0001).

* Based on the May-June 2003 Louisiana Morbidity Report

Maternal Mortality Review Louisiana, 2000-2004

Folorunso Akintan, MD MPH; Nicole Richmond, MPH; Tri Tran, MD MPH

Introduction:

A review of maternal mortality serves as a strong indicator of the state of health among women of reproductive age. Louisiana remains one of the states with the highest maternal mortality. As stated in a previous article**, "…there has not been a statistically significant change in the trend of maternal mortality in Louisiana in the past nine years". (See definitions for terms on page 5)

Objective of the Review:

1) Determine if there are racial disparities associated with the causes of maternal mortality in Louisiana.

2) Determine the risk factors associated with maternal mortality by race in Louisiana.

Method:

Our study population includes all pregnant women who had live births or fetal death and women who died during pregnancy. Birth/death data for the years 2000 through 2004 was used to determine the frequency distribution, odds ratios and cause of maternal death by race. SAS (Version 9.0) was used for the analysis and statistical significance alpha value was set at 0.05.

Results:

Fifty-nine percent of maternal (*pregnancy associated*) deaths occurred among African-American women, while forty percent occurred among White women. *Pregnancy unrelated* causes of death among White women included motor vehicle accidents and poisoning (from noxious substances, narcotics, hallucinogens and other medications or biological substances) while among African-American women, deaths were mainly due to diseases of the circulatory system and violent assault/homicide. (Table 1)

Table 1: Number of maternal deaths by race- Louisiana, 2000-2004

Race Specific Causes of Maternal Mortality				
	Whites	Afr-Am	Other	Total
Pregnancy Related Causes	15	37	1	53
Pregnancy Unrelated Causes	124	167	2	293
Pregnancy Associated Causes (Total)	**139**	**204**	**3**	**346**
Race Specific Top Five Causes of Maternal Mortality- Pregnancy Related				
	Whites	Afr-Am	Other	Total
Pregnancy Related Causes	**15**	**37**	**1**	**53**
Top 5 Pregnancy Related Causes				
All other direct obstetric causes	4	10	0	14
Eclampsia and pre-eclampsia	2	10	0	12
Indirect obstetric causes	6	4	0	10
Obstetrical embolism	1	6	1	8
Hemorrhage of pregnancy and childbirth and placenta previa	0	3	0	3
	Whites	Afr-Am	Other	Total
Pregnancy Unrelated Causes	**124**	**167**	**2**	**293**
Top 5 Pregnancy Unrelated Causes				
Motor vehicle accidents	36	21	0	57
Disease of the circulatory system	10	33	1	44
Assault (homicide) by discharge of firearm	8	29	0	37
Accident poisoning and exposure to noxious substances	19	5	0	24
Neoplasm	8	15	0	23

There is a statistically significant difference in maternal deaths when African-American women were compared to White women. African-American women were twice as likely to die. There is no statistically significant difference among women of other races when compared to Whites. A higher education was protective against maternal death among all races, while being married was only protective among Whites. Overall, women older than thirty-five years of age were twice as likely to die when compared to women twenty to thirty-five years of age. However among African-American women, those less than twenty years of age were sixty-six percent less likely to experience maternal mortality compared to those twenty to thirty-five years of age. (Table 2a)

Table 2a: Demographics - unadjusted odds ratio of maternal mortality Louisiana, 2000-2004

MATERNAL DEMOGRAPHICS vs. REFERENCE	ALL RACES Odds Ratio	WHITES Odds Ratio	BLACKS Odds Ratio
	OR (95% CI)	OR (95% CI)	OR (95% CI)
Maternal Race			
Afr-Am vs. White	1.98 (1.61, 2.44)		
Other vs. White	*1.20 (0.56, 2.57)*		
Maternal Education			
<12th vs. >12th Grade	3.77 (2.97, 4.79)	1.95 (1.29, 2.96)	1.69 (1.16, 2.45)
12th vs. >12th Grade	1.77(1.37, 2.27)	1.07 (1.12, 2.32)	1.58 (1.10, 2.27)
Marital Status			
Unmarried vs. Married	2.22 (1.79, 2.74)	2.52 (1.84, 3.47)	*1.21 (0.88, 1.67)*
Urban/ Rural			
Rural vs. Urban	0.72 (0.6, 0.86)	*1.00 (0.73, 1.38)*	*1.03 (0.78, 1.36)*
Maternal Age			
<20years vs. 20-35years	*1.01 (0.75, 1.34)*	*1.43 (0.90, 2.26)*	0.66 (0.45, 0.97)
>35years vs. 20-35years	1.91 (1.44, 2.53)	1.74 (1.13, 2.69)	2.42 (1.66, 3.51)
<20years vs. 20-35 years	1.67 (0.93, 3.01)	*1.23 (0.45, 3.77)*	0.26 (0.12, 0.56)

*These are not statistically significant. Sample size among maternal deaths accounts for most of the lack of significance in the odds ratio.

African-American women who died were two and a half times as likely to have had a *preterm birth* than *term birth*. A *risky method of delivery* was significantly associated with a two-fold increase in maternal death among White women. (Table 2b)

Table 2b: Perinatal characteristics at birth - unadjusted odds ratio of maternal mortality - Louisiana, 2000-2004

MATERNAL AND CHILD PERINATAL CHARACTERISTICS vs. REFERENCE	ALL RACES Odds Ratio	WHITES Odds Ratio	BLACKS Odds Ratio
	OR (95% CI)	OR (95% CI)	OR (95% CI)
Method of Delivery			
C/S vs. Vaginal	1.38 (1.11, 1.7)	*1.21 (0.86, 1.7)	1.48 (1.12, 1.97)
Risky Method of Delivery			
Risky vs. Non-risky	1.46 (1.12, 1.89)	1.71 (1.15, 2.52)	*1.21 (0.84, 1.75)
Preterm			
Preterm vs. term	4.46 (3.71, 5.37)	1.57 (1.02, 2.43)	2.51 (1.89, 3.32)
Low Birth Weight			
LBW vs. Normal	5.34 (4.44, 6.42)	2.83 (1.91, 4.2)	2.35 (1.76, 3.14)
Small/Big Baby			
Small Baby vs. Normal	2.52 (1.69, 3.76)	*0.37 (0.05, 2.61)	2.86 (1.89, 4.35)
Big Baby vs. Normal	0.55 (0.32, 0.96)	*0.61 (0.3, 1.25)	*0.64 (0.26, 1.55)

*These are not statistically significant. Sample size among maternal deaths accounts for most of the lack of significance in the odds ratio.

Maternal medical risk was significantly associated with a two-fold increase in maternal death among African-American women.White women with inadequate prenatal care (PNC) were five times more likely to die than those with adequate PNC while African-American women were only twice as likely to die. White women who smoked during pregnancy had a four-fold increase in maternal death while African-American women had a two-fold increase. African-American women who consumed alcohol during pregnancy had a four-fold increase risk of maternal death. (Table 2c).

Table 2c: Prenatal Characteristics - unadjusted odds ratio of maternal mortality - Louisiana, 2000-2004

MATERNAL PRENATAL CHARACTERISTICS vs. REFERENCE	ALL RACES Odds Ratio	WHITES Odds Ratio	BLACKS Odds Ratio
	OR (95% CI)	OR (95% CI)	OR (95% CI)
Maternal Smoking			
Smoker vs. non-Smoker	2.39 (1.86, 3.07)	3.58 (2.57, 4.99)	2.02 (1.30, 3.14)
Maternal Alcohol Consumption			
Drinks vs. non-Drinker	4.18 (1.98, 8.83)	*3.45 (0.85, 13.93)	4.23 (1.74, 10.3)
Maternal Medical Risk			
Medical Risk vs. No Medical Risk	1.57 (1.27, 1.94)	*1.16 (0.8, 1.68)	1.64 (1.25, 2.15)
Adequacy of Prenatal Care (PNC)			
Inadequate PNC vs. Adequate PNC	3.046 (2.274, 4.081)	5.04 (3.13, 8.11)	1.82 (1.25, 2.65)
Adequate Plus PNC vs. Adequate PNC	1.48 (1.15, 1.9)	1.55 (1.05, 2.28)	*1.32 (0.94, 1.84)
Grandmultip			
Grandmultip vs. Non-Grandmultip	3.94 (2.22, 7.01)	*1.92 (0.27, 13.71)	3.46 (1.89, 6.36)

*These are not statistically significant. Sample size among maternal deaths accounts for most of the lack of significance in the odds ratio.

Conclusions:

In Louisiana**,** racial disparity exists among maternal deaths. Causes of death and risk factors among White women are quite different from those among African-American women.

Public Health Implications:

It is important to circumvent the salient factors that enable racial disparities to exist among maternal deaths. There is a need for race-specific strategic planning in order to reduce maternal mortality in Louisiana.

Limitations:

Birth and death certificates have always had questionable data quality, having missed data and misclassifications. The data reported in this article is therefore just a tip of the iceburg and a starting point in the reduction of maternal mortality in Louisiana.

For reference or more information, please contact Dr. Akintan at Fakintan@dhh.la.gov or (504) 219-4574.

Definitions:

Maternal Mortality - Death of a woman, from any cause, while pregnant or within one calendar year of live birth or fetal death, regardless of the duration and the site of pregnancy per 100,000 live births.

Pregnancy Associated Death - All deaths that occurred during pregnancy or within one year of delivery or pregnancy termination regardless of cause. This can be classified into two groups; pregnancy-related and non pregnancy-related deaths.

Pregnancy Related - Complications of pregnancy; Chain of events initiated by the pregnancy or aggravation of an unrelated condition or event by the physiologic effects of pregnancy.

Pregnancy Unrelated - Any cause of death among pregnant women or those in the puerperal period other than pregnancy related deaths. It includes external cause of death, for instance, accidents, homicide, suicide and other medical conditions not aggravated by pregnancy.

Preterm - Births at a gestational age less than 37 completed weeks

Term - Birth at a gestational age of 37 completed weeks

LBW - Low Birth Weight - Weight less than 2500 grams

Normal Birth Weight - Greater than or equal to 2500 grams but less than 4000 grams

Small Baby - Birth weight less than or equal to 1400 grams

Big Baby - Birth weight greater than or equal to 4000 grams

Grandmultip - A woman who has had five previous births (live or stillbirth) and is pregnant for, or just had, the sixth one

Maternal Medical Risk - Includes preconception, prenatal and perinatal maternal medical diseases

Risky Method of Delivery (MOD):

- Low Risk = Vaginal delivery or first instrumentation or first caesarian section (C/S)
- High Risk = Repeat C/S; Repeat instrumentation; Instrumentation or Vaginal delivery after C/S

Adequacy of Preterm Birth - Calculated using Kotelchuck Index

** This article is a follow-up to "MATERNAL MORTALITY REVIEW-LOUISIANA, 1996-2004" printed in Vol. 18 No.1, *Louisiana Morbidity Report* January/February, 2007

Announcements

Updates: Infectious Disease Epidemiology Webpage
http://www.infectiousdisease.dhh.louisiana.gov

ANNUAL REPORT/ INFECTIOUS DISEASE SURVEILLANCE REPORTS: Amebiasis; Anthrax; Aseptic Meningitis; Blastomycosis; Botulism; Campylobacter; *Clostridium difficile*; Creutzfeldt Jacob; Cryptococcosis; Cryptosporidiosis; Cyclosporiasis; Diptheria; *E. coli* O157:H7; Giardiasis; *Haemophilus influenzae*; Hepatitis A; Hepatitis D; Histoplasmosis; Influenza; Legionella; Measles (Rubeola); Mumps; Pneumonia; Pneumococcal Infection; Poliomyelitis; Respiratory Syncytial Virus; Rubella; Salmonella; Shigella; Vibrio

EPIDEMIOLOGY MANUAL: *Mycobacterium bovis*; Spider Bites

FEATURED SERVICES: Mortality in the Greater New Orleans Area, Louisiana - Post Katrina

FOODBORNE: Ground Meat Recalls, Recreational Water Activities, Contact Information

INFECTION CONTROL: Infection Control Manual; Policy Memo 205-Managing Unintentional Exposures

LOUISIANA MORBIDITY REPORT: 1973, 1974, 1975; Addition of Missing Issues - 1976, 1977, 1978, 1983, 1984

Changes in USDA Food Pyramid

Leslie H. Lewis, MPH LDN RD

In 2005, the United States Department of Agriculture (USDA) released the 'MyPyramid Food Guidance System', replacing the original Food Guide Pyramid which had been used as the symbol of good nutrition since 1992. Although the pyramid symbol is still utilized, MyPyramid exhibits a new look and offers options and guidance to both healthy nutrition and physical activity. Specifically, the MyPyramid symbol illustrates the following messages: physical activity, variety, proportionality, moderation, gradual improvement and personalization. (Figure 1)

Figure 1: Steps to A Healthier You

Physical activity is symbolized by an individual climbing steps, illustrating the importance of daily physical activity. Variety is illustrated by six color bands, in which each color represents one of the five food groups (fruits, vegetables, grains, meat/milk and fats/oils. The varying width of the bands represents proportionality, where the width depicts how much from each food group an individual should eat. For example, the width of the green band representing grains is much larger than the width of the yellow band, which represents fats and oils.

In addition to the varying band width, the food group bands also get smaller from bottom to top illustrating moderation. Foods containing little fat or sugar are represented by the wide base and should be eaten most often; foods high in fat and sugar are illustrated by the narrow sections of the food groups and should be eaten in moderation. The different colors of the bands illustrate variety and the importance of eating a variety of food from each food group each day.

Gradual improvement is depicted by the campaign slogan "MyPyramid: Steps to A Healthier You". This slogan implies that we should all take small steps to becoming a healthier person. Finally, personalization is represented by the steps, the slogan and the MyPyramid website.

Individuals can go to the MyPyramid website at http://www.mypyramid.gov and enter their height, weight, sex, age and level of physical activity to receive a personal eating plan. Individuals can also take advantage of the MyPyramid tracker to get a detailed assessment and analysis of their current eating and physical activity habits in comparison to the 2005 Dietary Guidelines. This tool also allows individuals to track their progress over time. There is also a MyPyramid for kids, which contains a blast-off game and age-appropriate nutrition and physical activity education materials. For more information call Ms. Lewis at (504) 219-4791 or email llewis3@dhh.la.gov.

Louisiana Public Health Association Conference

April, 2007

***Left to Right**: Susan Indest - Region 2 Pandemic Flu Program Monitor,; Dr. Catrin Jones-Nazar - State Antibiotic Resistance Program Coordinator; Jeff Davis - Region 2 Disease Surveillance Specialist; Deborah Guidry - Region 2 Public Health Emergency Response Coordinator; Cheryl Ewing-2007 LPHA President, Nurse supervisor - West Feliciana Health Unit; Stephen Henry - Region 2 Epidemiologist; Cara Browning - Region 2 Injury Prevention Coordinator; Dr. Marilyn Reynard - Region 2 Medical Director*

Several of the participating regional committee members coordinating the implementation of the Region 2 'Get Smart' campaign were at hand during the Louisiana Public Health Association (LPHA) Conference Exhibits Session in Baton Rouge April 11, 2007. The 'Get Smart' campaign, funded by the Centers for Disease Control and Prevention (CDC), educates medical professionals as well as the public on methods to lessen the chance of antibiotic resistance in our environment.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

May - June, 2007

Table 1. Disease Incidence by Region and Time Period

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD May-June 2007	May-June 2006	Jan-Jun Cum 2007	Jan-Jun Cum 2006	Jan-Jun % Chg*
Vaccine-preventable															
Hepatitis B	Cases	1	2	5	0	0	2	0	0	3	13	15	39	34	14.7
	Rate1	0.1	0.4	1.3	0.0	0.0	0.7	0.0	0.0	0.8	0.3	0.3	0.9	0.8	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	2	1	2	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		1	0	0	1	0	0	0	0	0	2	5	9	16	-43.8
Sexually-transmitted															
HIV/AIDS	Cases2	24	17	0	2	3	1	8	5	2	62	189	400	516	-22.5
	Rate1	2.4	2.9	0.0	0.4	1.1	0.3	1.6	1.4	0.5	1.4	4.3	9.1	11.8	NA*
Gonorrhea	Cases	316	184	86	227	45	61	301	112	93	1425	1832	5252	5179	1.4
	Rate1	30.6	30.5	22.4	41.4	15.9	20.2	57.6	31.7	21.2	31.9	41.0	117.5	115.9	NA*
Syphilis (P&S)	Cases	20	8	3	20	2	1	4	1	17	76	38	190	103	84.5
	Rate1	1.9	1.3	0.8	3.7	0.71	0.33	0.77	0.28	3.9	1.7	0.9	4.3	2.3	NA*
Enteric															
Campylobacter		1	0	1	1	0	1	2	1	2	9	23	38	54	-29.6
Hepatitis A	Cases	0	2	2	0	0	0	1	0	2	7	4	19	9	111.1
	Rate1	0.0	0.4	0.5	0.0	0.0	0.0	0.2	0.0	0.5	0.2	0.1	0.4	0.2	NA*
Salmonella	Cases	5	13	12	26	8	6	8	4	39	121	195	268	356	-24.7
	Rate1	0.5	2.3	3.2	5.0	3.0	2.0	1.6	1.1	10.1	2.8	4.5	6.2	8.3	NA*
Shigella	Cases	13	6	3	11	1	8	1	0	50	93	15	192	69	178.3
	Rate1	1.3	1.1	0.8	2.1	0.4	2.6	0.2	0.0	13.0	2.2	0.3	4.4	1.6	NA*
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	3	0	3	NA*
Vibrio, other		0	0	2	0	0	0	0	0	0	2	9	6	17	-64.7
Other															
H. influenzae (other)		0	0	0	0	0	0	0	0	0	0	3	5	11	-54.5
N. Meningitidis		3	0	2	1	0	0	0	1	1	8	3	21	28	-25.0

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.

* Percent Change not calculated for rates or count differences less than 5

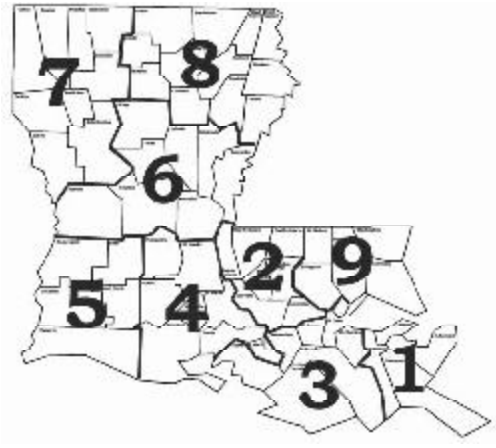

Table 2. Diseases of Low Frequency (January - June, 2007)

Disease	Total to Date
Legionellosis	1
Lyme Disease	2
Malaria	13
Rabies, animal	3
Varicella	87

Table 3. Animal rabies (May - June, 2007)

Parish	No. Cases	Species
Bossier	1	Bat
Calcasieu	1	Skunk
Jefferson	1	Bat

Sanitary Code - State of Louisiana
Chapter 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
Avian Influenza
Botulism
Brucellosis
Cholera
Diphtheria
Haemophilus influenzae (invasive disease)
Influenza-associated Mortality
Measles (rubeola)
Neisseria meningitidis (invasive disease)
Plague
Poliomyelitis, paralytic
Q Fever (*Coxiella burnetii)*
Rabies (animal and human)
Rubella (congenital syndrome)
Rubella (German measles)
Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)
Smallpox
Staphylococcus Aureus, Vancomycin Intermediate or Resistant (VISA/VRSA)
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.

Arthropod-Borne Neuroinvasive Disease and other infections (including West Nile, St. Louis, California, Eastern Equine, Western Equine and others)
Aseptic meningitis
Chancroid[1]
Escherichia coli, Shig-toxin producing (STEC), including *E. coli* 0157:H7
Hantavirus Pulmonary Syndrome
Hemolytic-Uremic Syndrome
Hepatitis A (acute disease)
Hepatitis B (acute illness & carriage in pregnancy)
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
Cryptococcosis
Cryptosporidiosis
Cyclosporiasis
Dengue
Ehrlichiosis
Enterococcus, Vancomycin Resistant [(VRE), invasive disease]
Giardia
Gonorrhea[1]
Hansen Disease (leprosy)
Hepatitis B (carriage, other than in pregnancy)
Hepatitis C (acute illness)
Hepatitis C (past or present infection)
Human Immunodeficiency Virus (HIV Syndrome infection)
Listeria
Lyme Disease
Lymphogranuloma Venereum[1]
Psittacosis
Rocky Mountain Spotted Fever (RMSF)
Staphylococcus Aureus, Methicillin/Oxacillin Resistant[(MRSA), invasive infection]
Staphylococcal Toxic Shock Syndrome
Streptococcal disease, Group A (invasive disease)
Streptococcal disease, Group B (invasive disease)
Streptococcal Toxic Shock Syndrome
Streptococcus pneumoniae, penicillin resistant [DRSP]), invasive infection]
Streptococcus pneumoniae (invasive infection in children < 5 years of age)
Transmissible Spongiform Encephalopathies
Trichinosis
Varicella (chickenpox)
Vibrio Infections (other than cholera)

Class D Diseases/Conditions - Reporting Required Within 5 Business Days

Cancer
Complications of Abortion
Congenital Hypothyroidism[3]
Galactosemia[3]
Hemophilia[3]
Heavy Metal (Arsenic, Cadmium, Mercury) Exposure and/or Poisoning (All ages)
Lead Exposure and/or Poisoning (All ages)
Pesticide-Related Illness or Injury (All ages)
Phenylketonuria[3]
Reye's Syndrome
Severe Traumatic Head Injury
Severe Undernutrition (severe anemia, failure to thrive)
Sickle Cell Disease (newborns)[3]
Spinal Cord Injury
Sudden Infant Death Syndrome (SIDS)

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, (504) 219-4522, telephone, (504) 219-4563, 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.
[3]Report to the Louisiana Genetic Diseases Program Office by telephone at (504) 219-4413 or facsimile at (504) 219-4452.

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