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# Louisiana Morbidity Report

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## Summary of West Nile Virus Louisiana, 2006

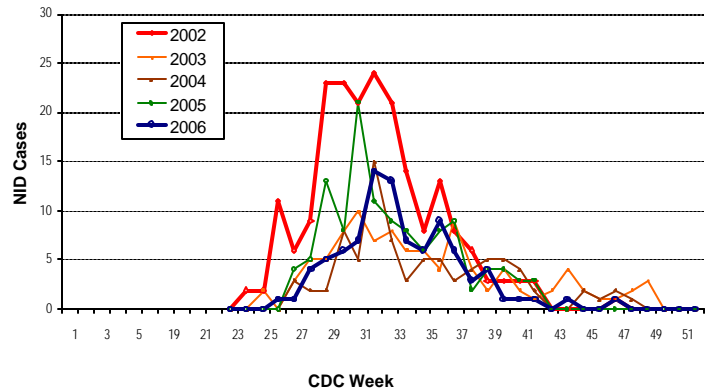
Christine M. Scott, MSPH

The total number of reported cases of West Nile Virus (WNV) neuroinvasive disease (NID), the most severe presentation of the disease, and WNV-related mild, febrile illness were ninety-one and eighty-eight respectively for the state of Louisiana in 2006. There were twenty-two asymptomatic cases identified through the screening of blood donors. The number of these asymptomatic cases is higher than previous years; however, the number of cases identified slowly increased since screening of blood donors began in 2003.

Among all WNV-related infections, sixty percent were male and seventy-eight percent were White. There were ten WNV-related deaths, with sixty percent of the fatalities being male. The average age of the fatalities was seventy-two years. Persons sixty years of age or older were twice as likely to have WNV-NID; persons forty-five years of age or older were three times as likely to have WNV fever illness. The age range for asymptomatic cases was from twenty to sixty-seven years of age, with an average age of forty-four years.

A similar seasonal pattern of WNV-NID disease cases has been observed from year to year from 2002 to 2006. (Figure 1)

Figure 1: West Nile Virus - Neuro-Invasive Disease cases  
Louisiana, 2002-2006



Each year the first cases occur in late June or early July (Centers for Diseases Control and Prevention (CDC) week 25 -26), the peak of cases occurs in mid-August (CDC week 31-33), and the last cases occur from the end of November to early December (CDC week 47-49). Although WNV-related mild, febrile illnesses are not graphed on Figure 1, a similar seasonality is exhibited by WNV fever cases.

According to most entomologists and mosquito abatement experts, the landfall of Hurricanes Katrina and Rita in 2005 seems to have increased numbers of nuisance mosquitoes in several areas of the state. Although very high levels of marsh breeding mosquitoes have been reported, the increased numbers seem to have had no effect on the seasonal pattern or number of WNV cases in Louisiana.

WNV fever cases made up nearly fifty percent of all WNV infections reported in Louisiana in 2006, a higher proportion than in any previous year. However since 2001, when the state's first case of WNV was reported, information on WNV fever cases and asymptomatic cases has been inconsistently reported. Therefore, the number of WNV-NID cases is considered the only true measure to monitor the progress of the endemic. The aforementioned inconsistency of case reporting should preclude the observer from attributing significance to this increase. As the diagnostic tests used in the laboratory become cheaper and their request by physicians increases, as a result of improved awareness of the disease across the state, an increase in the number of WNV fever cases reported is expected. The increase in the proportion of WNV fever to WNV-NID cases will likely continue since ninety-nine percent of all symptomatic infections are characterized by mild disease, not the more severe neuroinvasive form.

(Continued on page 2)

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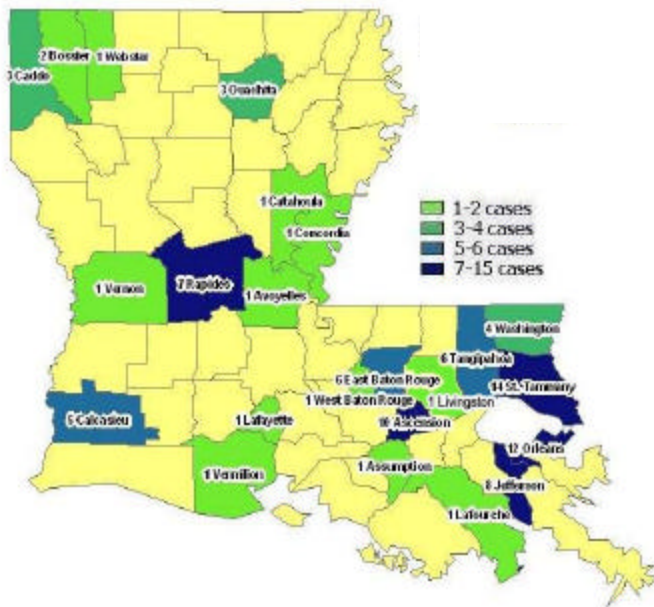
While sporadic cases have occurred throughout the state, some parishes experience large numbers of cases year after year as displayed in the below table. (Figure 2)

Figure 2: WNV-NID cases by year – Louisiana, 2002-2006

Parish	Population	2002	2003	2004	2005	2006
Washington	43,926	7	2	0	3	4
Calcasieu	183,577	8	1	3	2	5
Ascension	76,627	6	2	1	3	10
Bossier	98,310	3	8	9	6	2
Tangipahoa	100,588	11	7	1	3	6
Ouachita	147,250	6	2	5	16	3
Livingston	91,814	13	4	6	9	1
Orleans	484,674	12	2	1	6	12
Rapides	126,337	13	2	8	7	7
Jefferson	455,466	26	3	1	5	8
St. Tammany	191,268	23	4	0	3	14
Caddo	252,161	5	38	8	16	3
East Baton Rouge	412,852	37	1	22	17	6

The number of WNV-NID cases reported in Louisiana by parish in 2006 can be seen in the map. (Figure 3)

Figure 3: WNV-NID cases – Louisiana, 2006



It should be noted that three cases of California group Encephalitis, most likely LaCrosse Encephalitis, one case of Eastern Equine Encephalitis and two cases of St. Louis Encephalitis were also reported in 2006. These infections are not considered outbreaks since sporadic cases of these arboviruses often occur from year to year in the state.

For more information, please contact Christine Scott at (504) 219-4544 or email cmscott@dhh.la.gov.

## The Louisiana Animal Welfare Commission\* Pet Registry System: Benefits to Public Health

The Louisiana Animal Welfare Commission (LAWC), originally chartered during the administration of Governor Mike Foster, has been charged by the Louisiana Legislature to create a statewide pet registry. This registry will be characterized by several diverse features that will benefit the pet owning public and enhance the capabilities of the Louisiana Department of Agriculture and Forestry (LDAF), the Louisiana Department of Health and Hospitals Office of Public Health (OPH), local and parish animal control agencies, the Louisiana Veterinary Medical Association (LVMA), and other professional and animal control welfare organizations in tracking of stray animals, emergency operations, and the conduct of public health surveillance for zoonotic diseases, primarily rabies.

Communities in the United States spend millions of dollars to control the feral animal population. Animal shelters throughout the country are often filled to capacity with surplus animals. The Humane Society of the United States estimates that six to eight million dogs and cats are cared for in animal shelters around the country.<sup>2</sup> An effective statewide system of linking animals with owners may help reduce the feral animal population and assist in reuniting escaped animals with their owners.

Stray dogs and cats also contribute to the problem of animal bites and the resultant costs to health care.<sup>2</sup> Local and parish animal control jurisdictions and most veterinary clinics maintain registries of rabies vaccinations and identification tags, but often the information from one jurisdiction is not available to others. This lack of information sharing limits the possibility that an animal will be reunited with its owner, and also limits the ability of animal control and health agencies to verify rabies vaccination histories.

The LDAF and LVMA have created a system to facilitate the movement and sheltering of pets in the event of an emergency evacu-

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ation, such as the massive evacuations associated with Hurricanes Katrina and Rita. In these mass evacuations problems were experienced linking separated pets with owners and thousands of previously owned pets were never returned to rightful owners. The LAWC Pet Registry System will serve to address each of the aforementioned problems and will also provide additional benefits.

The LAWC Pet Registry System will provide an easily remembered toll-free telephone number that can be used by citizens and private and public entities to report a lost pet, find the owner of a pet, or, during emergencies, report the location of a pet in need of rescue.

The LAWC Pet Registry System will not rely on locally based systems of pet identification, although present databases, such as rabies tag registrations, may be included. This lack of reliance on locally based identification systems will permit the LAWC Registry to function in times of emergency.

The system that is planned will be an interactive computer telephone system. Once the prototype is established and functioning, other capabilities, such as user access through a secure website, can be added.

Data will be entered into the system by two methods. The first of which will be the incorporation of existing electronic identification databases, such as parish animal control license and veterinary rabies license registrations. This database will contain tag and/or microchip number information linking the animal to the specific animal control jurisdiction or veterinary hospital.

A second method of entry will be available to individual pet owners who choose to subscribe to the registry. Data entry forms will be made available in various locations (websites, animal shelters, pet shops, veterinary hospitals, Department of Motor Vehicle and other government offices, etc.) in paper or electronic formats. The forms will be submitted by mail or electronically for inclusion in the registry. Owner specific data and animal identification numbers of all types (local pet licenses, tattoos, AKC registrations, owner telephone numbers, microchip numbers, etc.) will be stored in a secure database. The system will issue a unique coded identification number to each subscriber. This number will be provided to the pet's owner on a metal tag that will exhibit the telephone number of the LAWC Pet Registry.

If a lost animal is found at large, the LAWC Pet Registry may be contacted by telephone. The system will record the telephone number of the caller and will request that the caller enter the LAWC Pet Registry ID number or any other numbers discovered on a tag, a tattoo, or a microchip scanner. If the number is from a rabies tag, the caller will be asked to enter the tag administrator name (parish animal control, local animal control, or veterinary hospital name) and the tag number. The system will be able to locate contact information and other associated information relevant to the unique identification number entered. When the animal's owner is a subscriber to the system, the system will communicate to the caller whatever information the owner previously had authorized for release, such as a phone number, e-mail address, or physical address. When tag or microchip information is entered from a rabies vaccination database, the phone number of the original record holder, such as a local or parish animal control jurisdiction, will be provided, facilitating contact with an entity that can locate the

owner.

How would such a system benefit all Louisiana citizens? The LAWC Pet Registry will provide a central identification clearinghouse that may be used to assist local law enforcement agencies, animal control departments and public health officials in investigations of animal bite incidents. The Office of Public Health is responsible for statewide surveillance for rabies, a fatal disease most often contracted from animal bites. Many of these bites are perpetrated by feral animals. Records of vaccination on these stray animals are almost always unavailable. Easier trace-back to owners would facilitate location of vaccination records, decrease unnecessary euthanasia and testing of these animals and reduce the unnecessary administration of multiple, expensive post-exposure rabies vaccines to human victims. In disaster situations where large numbers of animals are housed in shelters, as was witnessed in the aftermath of Hurricanes Katrina and Rita, access to rabies vaccination records will allay many concerns for the safety and welfare of animal caretakers in these facilities.

In emergency evacuations the system can be used in several modes. A central secure repository of information can be maintained redundantly on servers in several areas of the state, thus protecting records and ensuring accessibility in times of natural or other disasters. In the event of large scale evacuations, trace-back of stranded animals to evacuees can be facilitated. Another benefit would be the ability of first responders to events such as fires or floods to determine if animals are registered at certain locations, thus streamlining rescue efforts.

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## Pregnancy Intention and Breastfeeding Initiation Among Women Louisiana, 2004

*Ashley Chin, PhD MPH MA; Tri Tran, MD MPH;  
Jeanette Magnus, MD PhD*

In 2004, only 53.9% of African-American women, 73.6% of White women and 70.3% of all women in the United States initiated breastfeeding, well below the goal of seventy-five percent set forth in the Surgeon General's Healthy People 2010. Breastfeeding confers myriad benefits to the child, the mother and society, thus it is vitally important that we determine what factors are associated with a woman's decision to breastfeed her infant.

*(Continued on page 4)*

*Pregnancy Intention & Breastfeeding (Cont.)*

Women with unintended pregnancies tend to be at higher risk for negative health behaviors and birth outcomes. Determining whether pregnancy intention is associated with breastfeeding initiation is particularly important in Louisiana, where approximately half of all pregnancies resulting in a live birth are unintended and breastfeeding rates remain low. If breastfeeding is associated with pregnancy intention, customizing breastfeeding education for the woman with an unintended pregnancy may help to mitigate its negative effects. This research sought to determine whether pregnancy intention is associated with breastfeeding initiation among women in Louisiana.

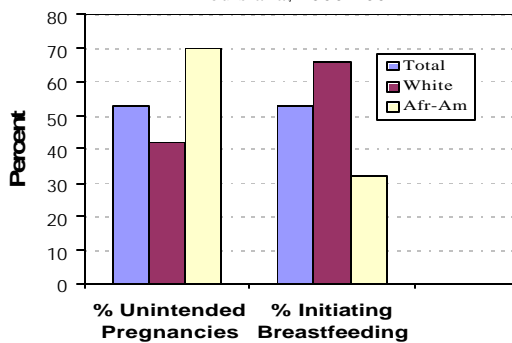
**Methods:**

Data from African-American and White primiparous mothers of singletons who participated in the 2000-2002 Louisiana Pregnancy Risk Assessment Monitoring System (La PRAMS) was used, resulting in a sample size of 2609. Logistic regression was used to determine whether pregnancy intention was associated with breastfeeding initiation among the total sample and stratified by race, adjusting for demographic, behavioral and clinical variables. Alpha was set at 0.05 for statistical significance and SAS-callable SUDAAN was used for analyses.

**Result:**

From 2000-2002, fifty-three percent of pregnancies ending in a live birth were classified as unintended and fifty-three percent of new first time mothers initiated breastfeeding. (Figure 1)

**Figure 1:** Unintended pregnancy and breastfeeding among women Louisiana, 2000-2002



In the unadjusted analysis, women with unintended pregnancies were sixty percent less likely to breastfeed compared to women with intended pregnancies (OR 0.4, 95% CI 0.3, 0.5). After control-

ling for race, education, age, work/school status, income, smoking and delivery type, pregnancy intention was not significantly associated with breastfeeding initiation (OR 0.8, 95% CI 0.6, 1.1). After stratifying by race, Whites with less than twelve years of education and an unintended pregnancy were significantly less likely to initiate breastfeeding as similarly educated White women with intended pregnancies (OR 0.5, 95% CI 0.2,0.9). (Table 1)

**Conclusions:**

Overall, pregnancy intention was not significantly associated with breastfeeding initiation among women in Louisiana after adjusting for known covariates. Among Whites with less than twelve years of education, pregnancy intention was significantly associated with breastfeeding initiation.

**Discussion:**

The results of this study must be viewed in light of several limitations. The PRAMS survey ascertains pregnancy intention at one point in time, between two and six months postpartum. This ascertainment is subject to recall bias, in that a woman's characterization of her pregnancy as intended, unintended or unwanted may have changed over the course of her pregnancy or since the birth of her child. If this were the case, it would most likely result in the misclassification of some unintended pregnancies as intended and therefore obscure any significant differences in breastfeeding initiation by pregnancy intention status.

Additionally, pregnancy intention was defined using a single PRAMS question: "Thinking back to just before you got pregnant, how did you feel about becoming pregnant?" The responses were limited to: "I wanted to become pregnant sooner", "I wanted to become pregnant then", "I wanted to get pregnant later", or "I did not want to get pregnant then or at any time in the future". Previous research has shown that pregnancy intention is a complex construct, which may not be adequately captured in the current question format. Pulley et al found that by defining the extent to which a pregnancy was mistimed (rather than just intended vs. unintended) women with intended and only moderately mistimed were similar to each other and both were significantly different than women with seriously mistimed or unwanted pregnancies. Researcher Marjorie Sable goes so far as to recommend that pregnancy intention no longer be used as a variable in public health research. She suggests that factors related to a woman's feelings about pregnancy, such as unhappiness, denial and ambivalence, would be more appropriate

**Table 1:** Odds ratio of breastfeeding initiation by pregnancy intention and education among women - Louisiana, 2000-2002

	Total Unadjusted	Total Adjusted <sup>1</sup>	White Unadjusted	White Adjusted <sup>2</sup>	AA Unadjusted	AA Adjusted <sup>3</sup>
<b>Pregnancy Intention</b>						
Intended	1.0	NA	1.0	NA	1.0	1.0
Unintended	0.4 (0.3,0.5)	NA	0.6 (0.4,0.7)	NA	0.5 (0.4,0.8)	0.8 (0.6,1.3)
<b>Education and Pregnancy Intention</b>						
<12, Intended	1.0	1.0	1.0	1.0	NA	NA
<12, Unintended	0.4 (0.2,0.6)	0.7 (0.3,1.0)	0.4 (0.2,0.7)	0.5 (0.2,0.9)	NA	NA

NA = Not Applicable

1. Adjusted for race, maternal education, age, income, work/school status, delivery type, and smoking status.

2. Adjusted for maternal education, age, work/school status, smoking status, and delivery type.

3. Adjusted for maternal education and marital status.

for this very complicated construct.

Finally, PRAMS only surveys women whose pregnancies have resulted in a live birth. It is reasonable to speculate that women who choose to carry an unintended pregnancy to term are very different in many aspects, including the propensity to choose to breastfeed, than women who choose to terminate an unintended pregnancy.

#### Public Health Implications:

Although pregnancy intention was not found to be significantly associated with breastfeeding initiation, it is still a very important indicator of prenatal health behaviors, birth outcomes and subsequent well baby care. Efforts to increase breastfeeding should target all women, not only those with unintended pregnancies.

For references or more information, please contact Dr. Chin at (504) 219-4567 or email [acchin@dhh.la.gov](mailto:acchin@dhh.la.gov).

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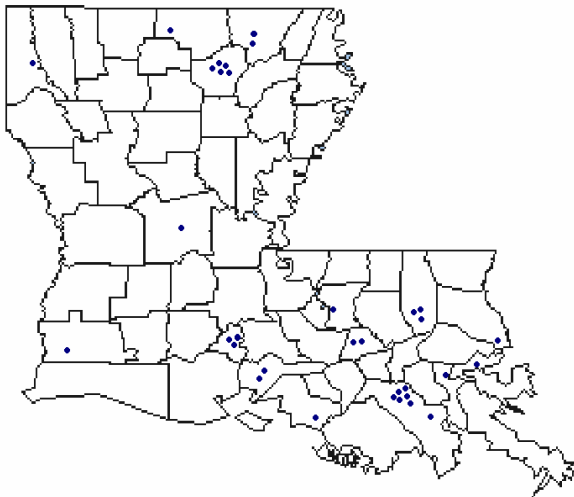


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## Sentinel Surveillance for Influenza

The Infectious Disease Epidemiology section of the Office of Public Health (OPH) is recruiting family practice physicians and pediatricians for its Influenza Sentinel Surveillance Program. This program, comprised of a network of physicians, hospitals, schools and nursing homes, is part of a larger, national surveillance system for influenza-like illness (ILI). (Figure 1)

**Figure 1:** Participating sentinel surveillance physicians, seasonal influenza Louisiana, 2006-2007



Surveillance is conducted year-round and data are collected weekly by OPH and the Centers for Disease Control and Prevention (CDC).

Participating physicians and clinics are asked to submit the number of influenza-like illnesses and total patients seen for any reason to OPH on a weekly basis. A summary report of influenza activity in Louisiana is issued each week and participants receive a certificate of participation at the end of each influenza season. For more information about this program, please contact the Joanna Eavey, the Influenza Surveillance Coordinator at 504-219-4546 or email [JJEavey@dhh.la.gov](mailto:JJEavey@dhh.la.gov).

## Pandemic Influenza External Tabletop Exercise Region 8 - Monroe, Louisiana January 17, 2007




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## Announcements

### Field Epidemiology Training

The Infectious Disease Epidemiology Section will hold a one and a half day training for non-ID-RRT (Infectious Disease Rapid Response Team) members. The session is free of charge but attendees must register. This training is targeted towards sanitarians, however, other public health care professionals interested in epidemiological principles and outbreak investigations are welcomed to attend. The training workshop will take place in the Community Room at the Community Health Care Center, Ouachita Parish Health Unit-1650 Desiard Street, Monroe, Louisiana. Ten CEU credits will be awarded to attending sanitarians. Please contact Greg Hill at [ghill@dhh.la.gov](mailto:ghill@dhh.la.gov) for more information.

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

**ANNUAL REPORT/INFECTIOUS DISEASE SURVEILLANCE REPORTS:** *Angiostrongylus cantonensis*, Chagas Disease; Chlamydia, *Clostridium difficile* Infections, Disease Rate Comparison-Southern States, Gonorrhea, RSV-Pneumonia, TB Incidence by Parish

**ANTIBIOTIC SENSITIVITY:** Louisiana Antibiogram Questions & Answers; Louisiana State Antibiotic Sensitivity Active Surveillance System

**EPIDEMOLOGY MANUAL:** Foodborne Outbreak; MRSA Public Information and for Health Professionals; Norovirus-Nursing Home; Rotavirus Public Information, Streptococcal Infections Group B

**FOODBORNE:** Surveillance of Foodborne Illness in Louisiana: Overview and Analysis of All Reported Outbreaks from 1980-2006; Foodborne Disease Outbreak Surveillance in Louisiana: A Look at General Trends and Salmonella, 1980-2006

**HEPATITIS:** Support Group Contact Information

**LOUISIANA MORBIDITY REPORT:** 1976 through 1983

**PUBLIC INFORMATION:** Norovirus

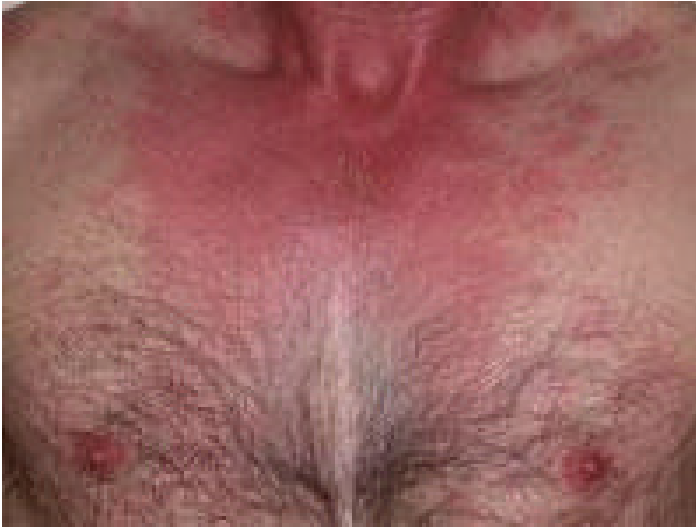
**WEST NILE VIRUS:** West Nile in Louisiana, 2006

# Scombroid Fish Poisoning Louisiana - December, 2006

Joan Brunkard, PhD; Stephen Henry, MPH; Jeff Davis, RS

Scombroid fish poisoning is a histamine reaction in response to the breakdown of histidine by bacteria when fish are not properly refrigerated. Tuna, mahi mahi, amberjack, bluefish and mackerel are the most commonly implicated vehicles. During the years 1998 through 2002, 118 scombrototoxin outbreaks involving 463 people were reported to the Centers for Disease Control and Prevention (CDC) from State Health Departments. However, most cases are unreported because symptoms resolve quickly and may be difficult to distinguish from other illnesses. Scombroid symptoms include flushing, diarrhea, rash, itching and a burning or peppery taste in the mouth; symptoms are generally self-limiting and usually resolve within several hours. (Figure 1)

**Figure 1:** Flushing and rash due to scombroid



More severe symptoms include respiratory distress, swelling of the tongue and blurred vision. In some cases, particularly in people with underlying medical conditions, antihistamines may be required to resolve symptoms. Proper temperature regulation (keeping fish refrigerated at 41° F or below) is essential to avoid episodes of scombroid poisoning.

## Scombroid Outbreak

On December 14, 2006, six workers who ate at an oil refinery cafeteria in Louisiana became ill with an allergic, histamine-like reaction within two hours of eating tuna steaks. The median onset time was one hour (range: 15 min.–2 hrs.). One person was transported to a local Emergency Department (ED) and diagnosed with scombroid fish poisoning based on clinical symptoms and exposure. The refinery infirmary nurse notified the Louisiana Office of Public Health

and an epidemiologic investigation was initiated to identify the source of the outbreak, determine the extent of illness and implement control measures.

The infirmary nurse indicated that approximately four of the refinery staff presented with a “flushing,” pruritic rash on the face, neck and waist, heart palpitations and diarrhea. The rash was compared to a niacin reaction. She also noted that a “sick call”/“all call” was announced between 3:00 PM and 4:00 PM that afternoon on the refinery premises, which resulted in only two or three additional persons reporting illness related to their consumption of tuna steak. Case-patients were treated with Benadryl® (Diphenhydramine) and Imodium® (Loperamide), onsite at the refinery infirmary on December 14th. One individual experienced symptoms severe enough to prompt his EMS transport to the ED. All reported case-patients had a self-limited illness with symptoms that resolved between hours or up to a day after the exposure.

Parish sanitarian services conducted an environmental inspection of the kitchen/cafeteria area where the implicated meal was prepared on December 14th. No critical violations were cited. An epidemiologic investigation was conducted on December 20th with eight persons being interviewed. Of the twenty-three tuna steaks served, six people (5 males, 1 female) became ill with symptoms including diarrhea (6 out of 6), facial flushing (5 out of 6), rapid heartbeat (5 out of 6), headache (4 out of 6), rash (3 out of 6), and shortness of breath (3 out of 6). Symptoms experienced less frequently included nausea (1 out of 6), vomiting (1 out of 6), sweating (1 out of 6), burning of throat (1 out of 6), swelling of throat (1 out of 6), peppery taste in mouth (1 out of 6), and abdominal cramps (1 out of 6).

The Food and Drug Administration (FDA) collected two tuna steak samples at the refinery cafeteria from the same shipment/cases as the implicated steaks. No elevated levels of histamines were detected in the two collected samples; however, a supplier traceback investigation revealed elevated histamine levels in three of five cases of tuna steak held at a fish wholesaler in Louisiana. The implicated tuna steak served in the plant cafeteria came from inventory that originated from a retailer in the North-eastern section of the U.S. Of the five case inventory of tuna steaks, only two cases were distributed to the refinery cafeteria. The remaining three cases were voluntarily destroyed by the Louisiana wholesaler, per FDA protocol. A further traceback investigation is being conducted by FDA.

## Lessons Learned

The most effective prevention for scombroid poisoning is proper refrigeration from the time fish are caught until the time they are served. Visual inspection alone cannot identify contaminated fish, although some people report a honey-combed appearance to scombrototoxic fish. Scombroid is not destroyed when food is cooked, unlike other foodborne bacteria such as salmonella. This outbreak demonstrates the importance of prompt removal of implicated fish, the benefit of FDA involvement in histamine testing and traceback and the potential for future illnesses to be avoided when public health response is rapid and collaborative.

For references or more information, please call Dr. Brunkard at (504) 219-4559 or email [jbrunkard@dhh.la.gov](mailto:jbrunkard@dhh.la.gov).

## LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

## January - February, 2007

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 2007	Jan-Feb 2006	Jan-Feb Cum 2007	Jan-Feb Cum 2006	% Chg*	
<b>Vaccine-Preventable</b>															
Hepatitis B	Cases	1	1	3	2	0	0	0	1	1	9	13	9	13	NA*
	Rate <sup>1</sup>	0.1	0.2	0.8	0.4	0	0	0	0.3	0.3	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	0	0	0	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		0	0	0	1	0	0	0	0	0	1	6	1	6	-83.3
<b>Sexually-Transmitted</b>															
HIV/AIDS	Cases <sup>2</sup>	14	14	2	5	3	0	2	2	2	44	147	44	147	-70.1
	Rate <sup>1</sup>	1.4	2.4	0.5	0.9	1.1	0.0	0.4	0.6	0.5	1.0	3.4	1.0	3.4	NA
Gonorrhea	Cases	264	175	73	170	62	62	194	89	77	1166	1484	1101	1484	-25.8
	Rate <sup>1</sup>	25.5	29.0	19.0	31.0	21.9	20.6	37.1	25.2	17.6	26.1	33.2	24.6	33.2	NA
Syphilis (P&S)	Cases	11	17	2	7	0	0	4	1	7	49	23	49	23	113.0
	Rate <sup>1</sup>	1.06	2.82	0.52	1.28	0.00	0.00	0.77	0.28	1.60	1.10	0.51	1.10	0.51	NA
<b>Enteric</b>															
Campylobacter		0	0	1	1	0	0	0	3	2	7	14	7	14	-50.0
Hepatitis A	Cases	0	0	0	4	0	0	0	0	0	4	3	4	3	NA*
	Rate <sup>1</sup>	0.0	0.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	NA*
Salmonella	Cases	1	8	3	14	3	8	1	8	5	51	66	51	66	-22.7
	Rate <sup>1</sup>	0.1	1.4	0.8	2.7	1.1	2.6	0.2	2.3	1.3	1.2	1.5	1.2	1.5	NA*
Shigella	Cases	2	1	4	8	1	1	0	2	0	19	22	19	22	NA*
	Rate <sup>1</sup>	0.2	0.2	1.1	1.6	0.4	0.3	0.0	0.6	0.0	0.4	0.5	0.4	0.5	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*
<b>Other</b>															
<i>H. influenzae (other)</i>		0	0	1	0	0	0	1	0	0	2	3	2	3	NA*
<i>N. Meningitidis</i>		1	0	0	0	0	0	0	0	1	2	17	2	17	-88.2

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.

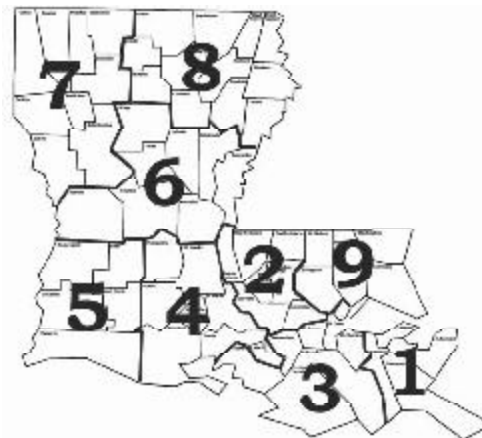
\* Percent Change not calculated for rates or count differences less than 5

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

Disease	Total to Date
Legionellosis	0
Lyme Disease	0
Malaria	1
Rabies, animal	0
Varicella	22

Table 3. Animal rabies (January-February, 2007)

There were no animal rabies reported for January-February, 2007



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	Measles (rubeola)	Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)
Avian Influenza	Neisseria meningitidis (invasive disease)	Smallpox
Botulism	Plague	<i>Staphylococcus Aureus</i> , Vancomycin Intermediate or Resistant (VISA/VRSA)
Brucellosis	Poliomyelitis, paralytic	Tularemia
Cholera	Q Fever ( <i>Coxiella burnetii</i> )	Viral Hemorrhagic Fever
Diphtheria	Rabies (animal and human)	Yellow Fever
<i>Haemophilus influenzae</i> (invasive disease)	Rubella (congenital syndrome)	
Influenza-associated Mortality	Rubella (German measles)	

**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)	Hemolytic-Uremic Syndrome	Pertussis
Aseptic meningitis	Hepatitis A (acute disease)	Salmonellosis
Chancroid <sup>1</sup>	Hepatitis B (acute illness & carriage in pregnancy)	Shigellosis
<i>Escherichia coli</i> , Shig-toxin producing (STEC), including <i>E. coli</i> 0157:H7	Hepatitis B (perinatal infection)	Syphilis <sup>1</sup>
Hantavirus Pulmonary Syndrome	Hepatitis E	Tetanus
	Herpes (neonatal)	Tuberculosis <sup>2</sup>
	Legionellosis (acute disease)	Typhoid Fever
	Malaria	
	Mumps	

**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)	Gonorrhea <sup>1</sup>	Staphylococcal Toxic Shock Syndrome
Blastomycosis	Hansen Disease (leprosy)	Streptococcal disease, Group A (invasive disease)
Campylobacteriosis	Hepatitis B (carriage, other than in pregnancy)	Streptococcal disease, Group B (invasive disease)
Chlamydial infection <sup>1</sup>	Hepatitis C (acute illness)	Streptococcal Toxic Shock Syndrome
Coccidioidomycosis	Hepatitis C (past or present infection)	<i>Streptococcus pneumoniae</i> , penicillin resistant [DRSP], invasive infection
Cryptococcosis	Human Immunodeficiency Virus (HIV Syndrome infection)	<i>Streptococcus pneumoniae</i> (invasive infection in children < 5 years of age)
Cryptosporidiosis	Listeria	Transmissible Spongiform Encephalopathies
Cyclosporiasis	Lyme Disease	Trichinosis
Dengue	Lymphogranuloma Venereum <sup>1</sup>	Varicella (chickenpox)
Ehrlichiosis	Psittacosis	Vibrio Infections (other than cholera)
Enterococcus, Vancomycin Resistant [(VRE), invasive disease]	Rocky Mountain Spotted Fever (RMSF)	
Giardia	<i>Staphylococcus Aureus</i> , Methicillin/Oxacillin Resistant[ (MRSA), invasive infection]	

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

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

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

<sup>2</sup>Report on CDC72.5 (f.5.2431) card.

<sup>3</sup>Report to the Louisiana Genetic Diseases Program Office by telephone at (504) 219-4413 or facsimile at (504) 219-4452.

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