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STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
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Infectious Disease Epidemiology Main Webpage
http://www.infectiousdisease.dhh.louisiana.gov

Alan Levine
SECRETARY

March-April 2008 **Volume 19 Number 2**

Neisseria Meningitidis Louisiana, 2008

On Friday, January 18, 2008 - a case of *Neisseria meningitidis* invasive disease was reported by phone to the Louisiana Office of Public Health (OPH) by an infection control practitioner. The patient was a twenty-two year old college student who came to a hospital's Emergency Department and died while he was being evaluated. The student had returned on the previous Wednesday (January 16), to the dormitory from a Christmas break with his family. Thursday, midday, he complained of flu-like symptoms. At 1:00 A.M. on Friday, his roommate reported that the student's condition was worsening. Later in the morning the student's condition deteriorated rapidly and the roommate called 911. At 9:20 A.M. the student was awake and alert and reported to the hospital Emergency Room. While in the ER he became increasingly obtunded and had a diffuse petechial purpuric rash all over his body. Antibiotics were started (intravenous vancomycin, ceftriaxone and steroids). Soon after, the patient expired.

The patient died before a CSF sample could be taken. The blood culture grew out *Neisseria meningitidis* which was later identified as group W 135. This is a rare serogroup in Louisiana. There had been only three cases of Group W135 in the past ten years: one case each in 1999, 2001 and 2003.

The immediate prevention was to identify close contacts (household, close friends, roommate) which was done rapidly. The Centers for Disease Control and Prevention (CDC) and Louisiana OPH recommendations did not require any further preventive measures since this was clearly not an outbreak. By CDC definition, an outbreak is 'defined by the occurrence of three or more confirmed or probable cases of identical serogroup meningococcal disease during a period of less than or equal to three months, with a resulting primary attack rate of at least ten cases per 100,000 population'. For calculation of this threshold, population-based rates are used and not age-specific attack rates.

However, experience shows that when a single case occurs in a young adult with a fatal outcome, it creates massive concerns in a community. It is imperative to address these concerns and even take the opportunity to provide education. Often a community will demand a mass prophylaxis of some sort based on the assumption that if antibiotic prophylaxis is good for close contacts, it would be good for the community at large. However, not only is antibiotic mass prophylaxis not recommended, it is certainly harmful. Mass prophylaxis 1) will promote resistance to antibiotics if there are more cases in the future e.g. resistance among strains of *N. meningitidis* and 2) would render people more susceptible to acquiring new meningococcal infection (5% of the population are carriers of meningococci; a carrier is protected; those that recently acquire new strains are those at risk of disease; overuse of antibiotics will reduce the natural colonization and put people at higher risk of acquiring new strains that may be more aggressive). It could make people more susceptible to acquiring new colonization by *N. meningitidis* by decreasing their normal flora.

After discussions with the university's staff and the Student Health Center, it was decided to hold a public meeting to provide basic facts on meningococcal invasive disease and its prevention. An immunization clinic was also planned for the following day for those students who had not been immunized. The immunization campaign, carried out by the OPH Region 1*, the Student Health Center and university's staff, was a success with several hundred students participating.

In summary: Meningococcal invasive disease (septicemia or meningitis) occurs sporadically in Louisiana (from 50 to 80 cases per year in this state). In the past twenty years, the only outbreak in Louisiana was in Lafayette in 2006. Mortality is still very high (10%) throughout the United States in spite of antibiotic treatment. The reason is the rapidly progressing disease in some individuals, leaving no time for the antibiotic to act. These rapidly progressing lethal cases provoke intense concern in the community. Prevention of sporadic cases is limited to antibiotic prophylaxis of close contacts (household members, close intimate friends, roommates, "party buddies"). Prophylaxis of classroom contacts, dormitory residents, university students or faculty is NOT recommended.

For more information, please contact the Infectious Disease Epidemiology Section at (504) 219-4563.

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Contents

A Short Birth Interval Enhances a Risk of Low Birthweight Louisiana, 2000-2004

Tri Tran, MD MPH; Lyn Kieltyka, PhD MPH; Ashley Chin, PhD MA

Objectives and methods:

Although many studies have indicated an association between a short birth interval and adverse birth outcomes, the effect of birth interval on low birthweight has not been investigated in Louisiana. The objectives of this study are to define those who are more likely to have a short birth interval (less than 12 months), and determine if there is relationship between birth interval and low birthweight (less than 2,500 grams), in Louisiana. The 2000 to 2002 birth records were linked with 2000 to 2004 linked Medicaid/birth records. Only singleton births with gestational age greater than thirty-one weeks were included in this study. Maternal social security number was used for the data linkage. Multivariable logistic regression was used to determine factors associated with a short birth interval and the effect of birth interval on low birthweight, accounting for: maternal race; education; marital status; age; smoking during pregnancy; Medicaid payment for delivery and adequacy of prenatal care; gestational age of the newborn. SAS 9.1 was used for analyses and alpha was set at 0.05 for statistical significance.

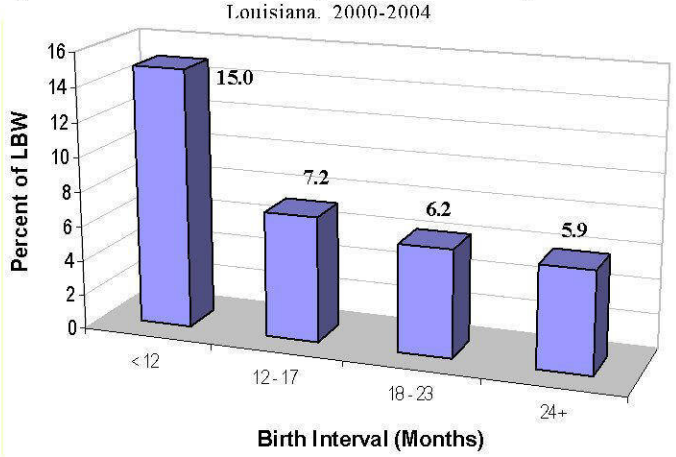
Results:

Percents of births within the following intervals are: less than twelve months, 6.4%; twelve to seventeen months, 29.6%; eighteen to twenty-three months 34.9%; greater than twenty-three months 29.1%. (Table 1, Figure 1)

Table 1: Percent of low birthweight and birth interval less than twelve months - Louisiana, 2000-2004

Maternal Characteristics		% Low Birthweight	% Birth Interval < 12 Months
Birth Interval (Months)	< 12	15.0	--
	12 - 17	7.2	--
	18 - 23	6.2	--
	24+	5.9	--
Race	White	4.5	4.6
	Afr.-Am.	9.9	8.4
	Other	4.0	5.7
Age (Years)	< 20	10.5	12.3
	20 - 24	7.7	7.3
	25 - 29	5.7	4.8
	30 - 34	5.0	3.4
	35+	5.7	2.8
Education (Years)	< 12	10.3	9.4
	12	7.1	6.6
	> 12	4.2	3.7
Medicaid-paid Delivery	No	4.4	3.9
	Yes	8.7	8.1
Gestation (Weeks)	32 - 36	42.2	13.1
	37+	2.8	5.6
PNC Adequacy (Kotelchuck Index)	Inadequate	9.0	8.2
	Intermediate	6.8	6.4
	Adequate	5.3	5.8
	Adequate +	8.0	6.4
Smoking During Pregnancy	Yes	11.7	7.7
	No	6.3	6.2
Marital Status	Married	4.6	4.4
	Other	9.6	8.6

Figure 1: Percent of low birthweight (LBW) newborns by birth interval Louisiana, 2000-2004



African-American, less educated, younger, pre-term birth and Medicaid-paid-delivery women were statistically more likely to have a birth interval less than twelve months. A birth interval less than twelve months, African-American, less educated, prenatal smoking, pre-term birth and Medicaid paid delivery women were statistically associated with low birthweight. (Table 2).

Table 2: Adjusted odds ratio (confidence interval 95%) of birth interval less than twelve months and low birthweight - Louisiana, 2000-2004

Maternal Characteristics		Birth Interval < 12 Months	Low Birthweight	Reference
Birth Interval (Month)	< 12	NA	1.5 (1.2, 1.7)	12+
Race	Black	1.4 (1.2, 1.5)	1.9 (1.7, 2.1)	White
	Other	NS	NS	
Education (Years)	< 12	1.5 (1.3, 1.7)	1.4 (1.2, 1.6)	12+
	12	1.2 (1.1, 1.4)	1.2 (1.0, 1.3)	
Age (Years)	< 20	2.8 (2.1, 3.7)	NS	35+
	20-24	1.9 (1.4, 2.5)	NS	
	25-29	1.5 (1.1, 1.9)	NS	
	30-34	NS	NS	
Gestation (Weeks)	32-36	2.2 (2.0, 2.5)	22.9 (20.8, 25.3)	37+
Medicaid-paid Delivery	Yes	1.4 (1.2, 1.5)	1.3 (1.2, 1.5)	No
Smoking During Pregnancy	Yes	NS	2.1 (1.9, 2.5)	No

NS: Not significant; NA: Not applicable

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Conclusions:

Babies born to mothers with birth interval less than twelve months were fifty percent more likely to have low birthweight than those born to mothers with birth interval greater than or equal to twelve months. African-American, less educated, younger and poor women are a high-risk population for birth intervals less than twelve months. Similar high-risk profiles were found for low-birth weight, including women who were African-American, less educated, smoked and Medicaid-paid. Family planning interventions targeting women at risk for short birth intervals can play an important role in reducing low birthweight in Louisiana.

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

Multi-Drug Resistant Acinetobacter Louisiana, 2008

In March, 2008 an investigation was carried out at the request of 'Hospital A' which experienced an increase in Multi-Drug Resistant Acinetobacter (MDRA) in their patient population. In the past year (2007), the hospital had fifteen patients from whom MDRA was isolated. An additional ten cases occurred in the first quarter of 2008. The main sites were: tracheal aspirates (11); sputum (1); wound and decubitus ulcer (7); blood (2); catheter tip (2); urine (1). The majority of cases came from patients on ventilator (those with tracheal aspirates and sputum), or patients with decubitus ulcers.

There was no obvious pattern of transmission among the hospitalized patients, some being in intensive care units, skilled units or long term units. No common exposure was identified. The most common factor among many of these patients was previous hospitalizations and residence in long term care facilities.

The investigation was continued in one specific 'Nursing Home B' which has a ventilator care unit with eleven rooms for twenty patients. Nine of the hospital cases had been in and out of that specific nursing home. Six of these were diagnosed with MDRA while in Hospital A, one in Nursing Home B and two in other facilities during previous hospitalizations. The risk factors of these nine patients were: ventilator-assisted respiration (7); decubitus ulcers (3); diabetes (5); hemiplegia or quadriplegia (3); renal failure (2); congestive heart failure (2).

The hospital had instituted a systematic screening of high risk patients. Those found colonized or infected were placed in a modified contact precautions and cohorted. A one- time systematic screening in the nursing home did not identify more MDRA cases than those that were known already. Respiratory care procedures were reviewed and found to be adequate. Recommendations were to place the ventilator patients in modified contact precautions and to cohort them in specific rooms. Personnel were instructed to care for these patients first, thus avoiding going from an infected to a non-infected patient. Since all of these patients were bed-ridden, contact precautions were easy to institute.

Note: There are over twenty species of Acinetobacter, though the species *Acinetobacter baumannii* accounts for more than eighty percent of isolates causing human disease. Acinetobacter is becoming a more common cause of hospital-associated infections since patients with high risk conditions are being kept alive.

Reservoir: Acinetobacter is found in almost all soils and water and has been isolated in a wide variety of foods (pasteurized milk, frozen foods, chilled poultry). Enteral feedings and oral solutions can be contaminated. It can survive for weeks to months on clothing, dry surfaces as bedrails, ventilators and wet surfaces as in sinks. In some patient rooms, Acinetobacter is widely spread throughout surfaces that have been in contact with patients, hence the importance of thorough cleaning and disinfection after discharge of an infected patient.

Transmission: Acinetobacter can be spread from person to person (infected or colonized patients), or by contact with contaminated surfaces of exposure to the environment.

Acinetobacter is a healthcare-related pathogen. *Acinetobacter baumannii* is increasingly reported as the cause of outbreaks and nosocomial infections such as bloodstream infections, ventilator-associated pneumonia, urinary tract infections and wound infections and is primarily a healthcare-associated pathogen.

Colonization may occur. Acinetobacter is carried on wet skin areas and nasal cavities but also on dry skin, particularly of health care workers. It is the most common gram-negative organism persistently carried on the skin of hospital personnel. Up to twenty-five percent of healthy ambulatory adults exhibit cutaneous colonization and seven percent of adults and infants have transient pharyngeal colonization.

Acinetobacter is also a common colonizer of tracheostomy sites and open wounds. Risk factors for colonization or infection include length of hospital stay, surgery, wounds, treatment with broad-spectrum antibiotics, parenteral nutrition, indwelling catheters, mechanical ventilation and admission to an intensive care unit.

Risk factors associated with:

- community-acquired Acinetobacter infection include alcoholism, cigarette smoking, chronic lung disease, diabetes mellitus
- nosocomial infection include length of hospital stay, surgery, wounds, previous infection (independent of previous antibiotic use), fecal colonization with Acinetobacter, treatment with broad-spectrum antibiotics, indwelling central intravenous or urinary catheters, admission to a burn unit or intensive care unit (ICU), parenteral nutrition and mechanical ventilation.

Health care workers are not at risk of disease. Acinetobacter rarely causes serious infection in otherwise healthy people and therefore poses minimal threat to healthcare workers or patients' family members. Pregnant healthcare workers are not at increased risk from this organism and can therefore care for patients infected or colonized with the organism.

Outbreaks are frequently located in intensive care units and burn units involving patients on mechanical ventilation. Sources of transmission identified in the outbreak setting include predominately respiratory equipment such as resuscitator bags, valves, ventilator circuits, spirometers, peak flow meters, suction catheters,

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Multi Drug Resistant Acinetobacter...(Continued from page 3)

etc. Other sources include humidifiers, warming baths, multidose vials, distilled water, pillows, mattresses, bedpans, showers and water faucet aerators. No source was identified in approximately fifty percent of reported outbreaks. The costs associated with control of an outbreak can be staggering and some institutions have been forced to close entire units in order to interrupt the transmission of Acinetobacter.

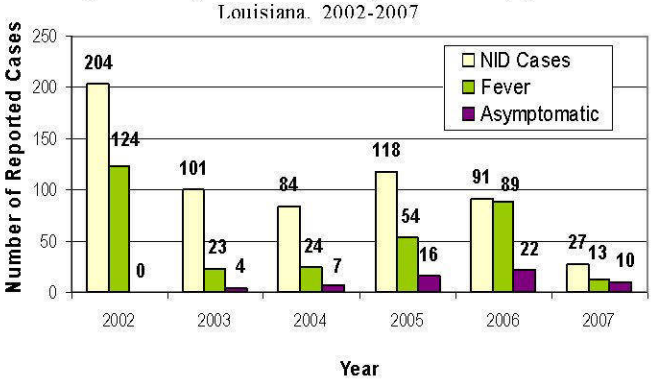
For more information, please contact the Infectious Disease Epidemiology Section at (504) 219-4563.

Summary of Human West Nile Virus - Louisiana, 2007

Christine M. Scott, MSPH

The total number of reported cases of West Nile Virus (WNV), neuroinvasive disease (NID), and WNV-related mild, febrile illness were twenty-seven and thirteen cases, respectively. Ten cases of asymptomatic West Nile infection were identified through the screening of blood donors. There were two WNV-related deaths reported with the average age of the fatalities being seventy-four years. A significantly lower number of cases were reported in 2007 compared to previous years. (Figure 1)

Figure 1: Proportion of clinical presentation by year Louisiana, 2002-2007



Among all WNV-related infections, fifty-two percent were male and two-thirds were White. It appears as if males were just as likely to develop WNV-NID as females, as fifty-five percent of all WNV-NID cases were male. (Table 1)

Table 1: WNV-related infections by sex – Louisiana, 2002-2007

Age Group	Neuroinvasive Disease Cases by Gender			
	Male	Male Incidence	Female	Female Incidence
0-14	1	0.2	0	0.0
15-29	3	0.6	0	0.0
30-44	2	0.4	1	0.2
45-59	4	1.0	2	0.5
60-75	4	2.0	5	2.0
75+	1	1.2	4	2.7
Undetermined				
Total	15	0.7	12	0.5

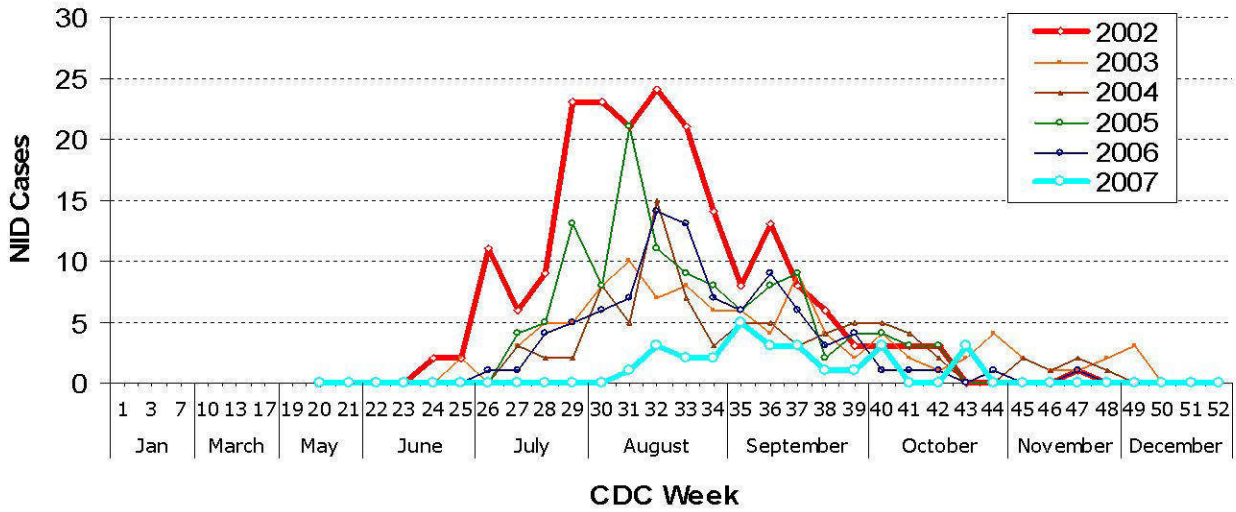
Persons sixty years of age or over were twice as likely to have WNV-NID. The age range for asymptomatic cases was from eighteen to sixty-seven years of age, with an average age of forty-four years. (Table 2)

Table 2: WNV-related infections by age groups - Louisiana, 2002-2007

Age Group (Years)	Clinical Classification			
	NID Cases	Incidence	Fever Cases	Incidence
0-14	1	0.1	1	0.1
15-29	3	0.3	1	0.1
30-44	3	0.3	1	0.1
45-59	6	0.8	7	0.9
60-75	9	2.0	2	0.4
75+	5	2.1	1	0.4
Undetermined				
Total	27	0.6	13	0.3

A similar seasonal pattern of WNV-NID disease cases in Louisiana has been observed year to year from 2002 to 2006 (Figure 2).

Figure 2: WNV - Neuroinvasive disease cases by CDC week - Louisiana, 2002-2007



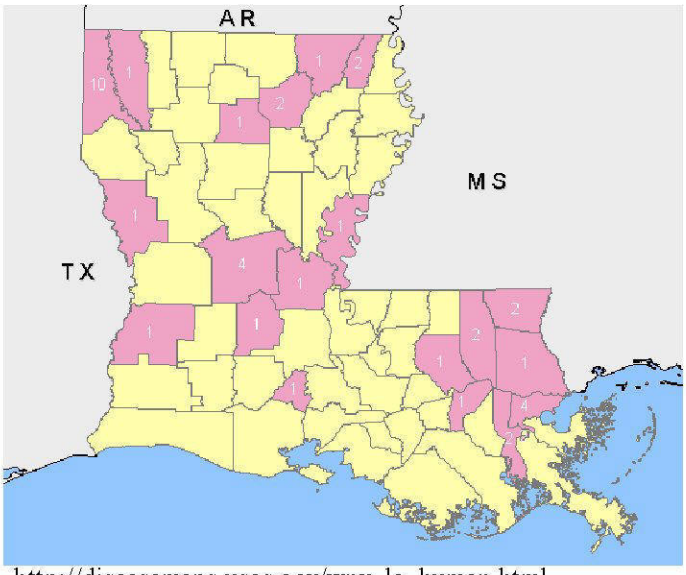
Typically, each year the first West Nile cases occur in late June or early July (CDC week 25-26). West Nile activity peaks in mid-August (CDC week 31-33), and the last cases occur from the end of November to early December (CDC week 47-49). In contrast to previous years, the first case in 2007 did not occur until the beginning of August (CDC week 31), with a peak in early September (CDC week 35), and the last cases in late October (CDC week 43). Although WNV-related mild, febrile illnesses were not graphed in Figure 2, a similar seasonality is exhibited by WNV fever cases.

While sporadic cases have occurred throughout Louisiana, some parishes experience large numbers of cases year after year as displayed in the following table (Figure 3) and map (Figure 4).

Figure 3: WNV-NID cases by year - top thirteen parishes Louisiana, 2002-2007

Parish	2002	2003	2004	2005	2006	2007
Washington	7	2	0	3	4	2
Calcasieu	8	1	3	2	5	0
Ascension	6	2	1	3	10	0
Bossier	3	8	9	6	2	0
Tangipahoa	11	7	1	3	6	1
Ouachita	6	2	5	16	3	1
Livingston	13	4	6	9	1	1
Orleans	12	2	1	6	12	2
Rapides	13	2	8	7	7	2
Jefferson	26	3	1	5	8	2
St. Tammany	23	4	0	3	14	0
Caddo	5	38	8	16	3	7
East Baton Rouge	37	1	22	17	6	0

Figure 4: The number of WNV-NID cases reported by parish Louisiana, 2007



http://diseasemaps.usgs.gov/wnv_la_human.html

It should be noted that zero cases of California group Encephalitis and Eastern Equine Encephalitis were reported in Louisiana in 2007. There were two cases of St. Louis Encephalitis reported within the state; these infections are not considered outbreaks since sporadic cases of these arboviruses often occur from year to year in Louisiana.

For more information, please contact Theresa Sokol at (504) 219-4539 or tsokol@dhh.la.gov.

Norovirus - Region IV* Louisiana, 2008

April Bernard, BSBE; Karen Buroker, RN; Pam Kreyling, RN MPH; Juliet Stefanski, MD

Background:

A dinner party was held at a local restaurant on February 27, 2008 with nineteen people in attendance. On February 29, one dinner party attendee realized that she and approximately seven other attendees were all experiencing vomiting and diarrhea. An elderly attendee was hospitalized for dehydration coinciding with the symptoms. On March 3, 2008 the former attendee made the initial complaint to the local parish Sanitarian Department. The sanitarians conducted a retail food inspection of the restaurant on the same day as the complaint and notified the Region IV Disease Surveillance Specialist and Regional Epidemiologist of the results.

On the March 3, 2008 inspection, a few minor violations were noted but most importantly, the restaurant was in violation for employees not following proper hand washing guidelines. During this inspection, the owner stated that two of his kitchen staff employees were experiencing a "virus type" illness while working the night of the dinner party. On a routine retail food inspection conducted eighteen days prior to the dinner party, (February 11), the restaurant was cited for the same problem of poor employee hand washing.

Investigation:

Questionnaires regarding food intake and symptoms were administered by phone to all nineteen dinner party diners and the two restaurant workers who were ill. One restaurant worker worked as a dishwasher and doing food preparations. He stated that he worked until 7:30 P.M. the night of the dinner (the meal was served between 8 P.M. and 8:30 P.M.), and developed nausea, vomiting and diarrhea at about 8:30 P.M. The other ill worker, a sibling of the first, was a cook who developed the same symptoms around 6:30 A.M. the next day. The mother of the workers, living in the same household with the second worker, was ill with similar symptoms at about the same time in the morning.

A case was defined as a person with abdominal cramping with vomiting and/or diarrhea. Twelve persons (2 food workers and 10 diners) met the case criteria. The attack rate for the diners was 52.6% (10 out of 19). Symptoms of these ten cases were as follows: ten (100%) had abdominal cramps; ten (100%) had diarrhea; ten (100%) had nausea; six (60%) had vomiting. The mean incubation period was 35.3 hours (range 11.5 to 53.5 hours). (Figure 1)

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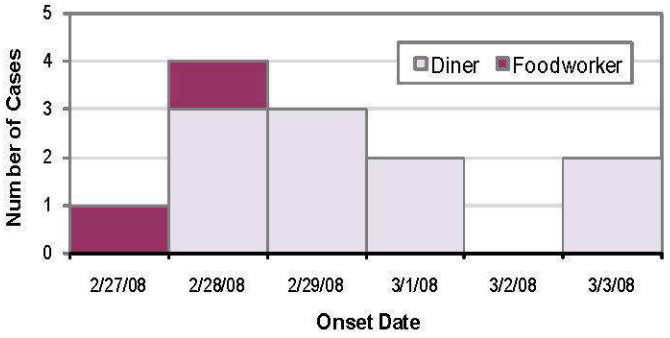
Norovirus... (Continued from page 5)

Figure 1: Number of cases by onset of symptoms, Region IV restaurant Louisiana. 2008



The dinner party had individually selected items from the full menu. Analysis of the foods eaten was done by ingredients rather than dishes. No single food item was suspicious for being the cause of illness with statistical significance, which makes food contamination prior to preparation highly unlikely.

Lab Results:

Four stool samples were submitted. Stool from one ill employee and two of the ill attendees tested positive for Norovirus Group II. One stool sample collected from an ill diner did not test positive for Norovirus Group II.

Conclusion:

Norovirus is a single stranded RNA virus in the family of Caliciviridae. Norovirus, along with other genera in the Caliciviridae family, cause gastroenteritis among both adults and children. Characterized by an acute onset of nausea, vomiting, abdominal cramps and diarrhea, Norovirus can last from twelve to sixty hours. The incubation period is twelve to forty-eight hours and is communicable from infected persons fifteen to seventy-two hours after viral absorption. Norovirus has three distinct genogroups GI, GII and GIII. Groups I and II infect humans and Group III infects pigs and cows.

Fecal-oral distribution is the primary mode of transmission. Commonly occurring in an outbreak, primary cases result from exposure to a fecally contaminated vector (food, water, etc.). Data analyzed by the Centers of Disease Control and Prevention (CDC) in 2000 demonstrates that thirty-nine percent of Norovirus outbreaks occur via food-borne settings, twelve percent via person-to-person settings and three percent via waterborne settings. Ill food handlers easily transmit Norovirus because of the large concentrations of virus excreted in their stool and low dose at which the virus can cause infection. Ready-to-eat food items (salads, dinner rolls, etc.) are at most risk of being contaminated because the items are not cooked after handling.

The restaurant owner was advised on hygiene and sanitary precautions he should practice in order to prevent a similar future outbreak. Parish sanitarians have been conducting repeat inspections since the incident and will continue to monitor closely. Strict personal hygiene is the best mode of prevention of Norovirus outbreaks. Restaurant employees should follow the Louisiana Sanitary Code, which states that employees shall wash hands and exposed portions of their arms before work and after smoking, eating, drinking, coughing, sneezing, handling raw food and using the toilet. Restaurants should also follow CDC recommendations that food handlers should be excluded from food preparation forty-eight to seventy-two hours after the subsiding of the illness.

For references or more information, please contact Pam Kreyling at (337) 262-5322 or email pkreyling@dhh.la.gov.

* *See map on page 7*

Statewide Education

In the past six months, the Infectious Disease Epidemiology Section - Office of Public Health has completed various trainings throughout Louisiana which included **Avian Influenza Rapid Response Training**, Shreveport (September 18-19), (Figure 1) and **Epidemiology Field Training Techniques**, Lafayette (December 13-14), Hammond (January 10-11) and New Orleans (February 19-20).

Information on upcoming Infectious Disease trainings are listed on the department's webpage http://www.infectiousdisease.dhh.louisiana.gov

Figure 1: Avian Influenza Rapid Response Training Shreveport, Louisiana - September 18 & 19, 2007

Announcements

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

ANNUAL REPORTS: Rocky Mountain Spotted Fever
EPIDEMIOLOGY MANUAL: Camphylobacter; Flood Waters, Foodborne Outbreak; Group A Streptococcal Infection (GAS); Legionella Form; Listeriosis Form; Meningoccal Meningitis; Meningoccal Meningitis Summary; Pertussis; Varicella Zoster; Viral Hemorrhagic Fever (VHF)
FIELD EPIDEMIOLOGY TRAINING: Cryptosporidiosis Geographic Distribution; Hepatitis; Mosquito Zapper
HEPATITIS: World Hepatitis Day
LOUISIANA MORBIDITY REPORT: 1968; 1967; Index 67-75
VETERINARY INFORMATION: Equine and Ruminant Antimicrobial Sensitivity Profiles and Trends
WEST NILE VIRUS: West Nile in Louisiana, 2007

January - February, 2008

Table 1. Disease Incidence by Region and Time Period

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Jan-Feb 2008	Jan-Feb 2007	Jan-Dec Cum 2008	Jan-Dec Cum 2007	Jan-Dec % Chg*
Vaccine-preventable															
Hepatitis B	Cases	4	0	1	0	2	0	1	0	4	12	19	12	19	-36.8
	Rate1	0.4	0	0.3	0	0.7	0	0.2	0	1.0	0.3	0.4	0.3	0.4	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	1	0	1	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		0	0	0	0	0	0	0	0	0	0	3	0	3	NA*
Sexually-transmitted															
HIV/AIDS	Cases2	25	14	1	7	9	2	6	4	2	70	182	70	182	-61.5
	Rate1	2.5	2.4	0.3	1.3	3.2	0.7	1.2	1.1	0.5	1.6	4.2	1.6	4.2	NA*
Gonorrhea	Cases	235	170	73	185	49	79	240	145	70	1246	1710	1246	1710	-27.1
	Rate1	22.7	28.2	19.0	33.7	17.3	26.2	45.9	41.0	16.0	27.9	38.3	27.9	38.3	NA*
Syphilis (P&S)	Cases	13	8	0	18	0	1	12	4	11	67	52	67	52	28.8
	Rate1	1.3	1.3	0.0	3.3	0.0	0.3	2.3	1.1	2.5	1.5	1.2	1.5	1.2	NA*
Enteric															
Campylobacter		1	0	1	0	0	2	3	1	4	12	13	12	13	NA*
Hepatitis A	Cases	0	0	0	1	0	0	0	0	0	1	6	1	6	-83.3
	Rate1	0	0	0	0.2	0	0	0	0	0	0	0.1	0	0.1	NA*
Salmonella	Cases	6	2	5	7	5	3	3	5	10	46	67	46	67	-31.3
	Rate1	0.6	0.4	1.3	1.4	1.9	1.0	0.6	1.4	2.6	1.1	1.6	1.1	1.6	NA*
Shigella	Cases	1	3	3	1	8	2	2	0	5	25	37	25	37	-32.4
	Rate1	0.1	0.5	0.8	0.2	3.0	0.7	0.4	0	1.3	0.6	0.9	0.6	0.9	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	3	0	3	NA*
Other															
H. influenzae (other)		0	0	0	0	0	0	1	0	0	1	2	1	2	NA*
N. Meningitidis		4	0	1	1	0	0	0	1	0	7	8	7	9	NA*

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.

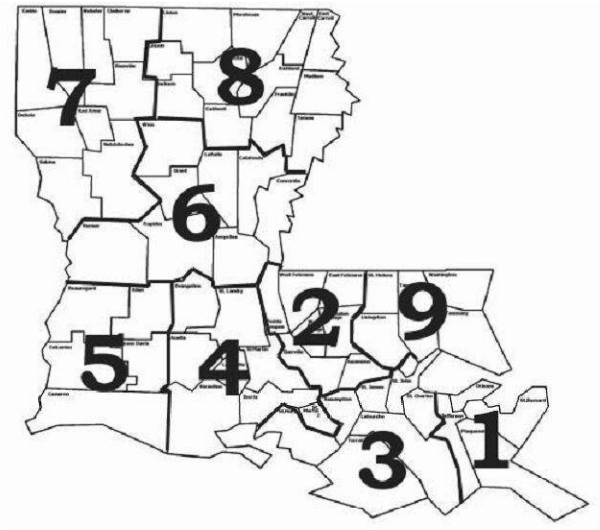
* Percent Change not calculated for rates or count differences less than 5

Table 2. Diseases of Low Frequency (January-December, 2008)

Disease	Total to Date
Legionellosis	0
Lyme Disease	0
Malaria	0
Rabies, animal	1
Varicella	19

Table 3. Animal rabies (January-February, 2008)

Parish	No. Cases	Species
Jefferson Davis	1	Skunk



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

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; fin 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 1-800-256-2748) or web base at *https://ophrdd.dhh.state.la.us*.

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

[2]Report on CDC72.5 (f.5.2431) card.

[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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