Bobby Jindal
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Louisiana Morbidity Report

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P.O. Box 60630, New Orleans, LA 70160 - Phone: (504) 219-4563
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Alan Levine
SECRETARY

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Gingivo-stomatitis Outbreak in Day Care Center, Region 7* Louisiana, 2008

Keasha Henson, MPH

A child care center reported a small outbreak of gingivo-stomatitis affecting thirteen out of fifty-eight students (Attack rate 22%). The symptoms of gingivo-stomatitis can be mild or severe and may include sores on the inside of the cheeks or gums, vesicular lesions, fever, irritability, general discomfort, uneasiness, or ill feeling and a very sore mouth with no desire to eat. An examination of the mouth can show small ulcers. The sores generally resolve in two or three weeks with or without treatment. Treatment may reduce discomfort and speed healing. The goal is to reduce symptoms. Good oral hygiene should continue to be practiced. Even if there is bleeding and it is painful, a thorough but gentle brushing of the gums is important to reduce the chances of additional infection from normal mouth bacteria. Medicated mouth rinses may be recommended to reduce pain.

The most common cause of gingivo-stomatitis is Herpes Simplex Virus (HSV) type I. A coxackie virus is also responsible for herpangina that may resemble HSV gingivo-stomatitis. The incubation period varies from two days to two weeks, after which people shed the virus for at least one week, sometimes longer. People with symptomatic primary infection shed the most viruses in the saliva and those with asymptomatic infection shed the least. Transmission is extremely common in child care settings. Transmission is

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Contents

Pneumonia Among Children Five and Under Louisiana, 1999-2004

Marlow Macht, MS MD-MPH Candidate

Pneumonia is a significant cause of morbidity amongst young children. Little is known about the recent epidemiology of pneumonia among children five years of age and under in Louisiana.

Methods:

Records were abstracted from the Louisiana Hospital Inpatient Discharge Database (LAHIDD) for the years 1999 through 2004 for children aged five years and under with a main diagnosis of pneumonia.

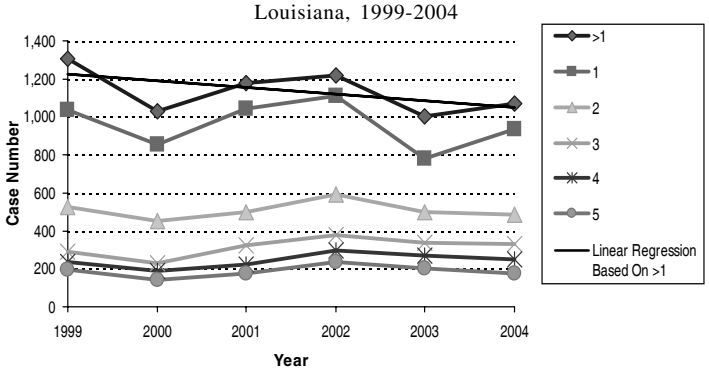
Limitations:

This data includes multiple admissions for some patients and only represents diagnoses by physicians, which may be influenced by prevalent seasonal disease. The data may also be subject to bias reflecting coder interpretation of physician notes. (The coder's primary purpose being billing, not epidemiology.)

Results:

In the five years studied, there were 20,107 admissions for pneumonia among children aged five years and under. The average age was 1.44 years with the median age being one year. Children under one year of age accounted for 33.9% of the admissions, with children at the age of one year, accounting for 28.7% and the remainder accounting for 37.5%. There was a clear decrease in the number of hospitalizations with age. (Figure 1)

Figure 1: Pneumonia in children aged five years and under Louisiana, 1999-2004



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Louisiana Fact
Louisiana and Mental Health

In the early 1800s, asylums for the mentally ill had yet to be established in Louisiana. Early drafts of the Napoleonic code of law (1800-1808) that were available to Louisiana jurists contained a legal definition of insanity, one of the earliest references to the role of medical experts and one of the first references to a judicial commitment of the mentally ill, authorizing parish judges to order confinement (homes or safe custody).

On December 14, 1816, the New Orleans city council named a committee to consider whether or not Charity hospital should accept mental patients. Although there was no record of any action taken, the hospital continued to give sanctuary to the insane, as records from 1818 indicated. Four years later, the legislature provided for a separate building to be erected in the next two to three years to receive the insane (although not exclusively), being the first effort by Louisiana to provide for mental patients.

A 1840 statute allowed parish judges to admit patients to a "lunatic asylum" that was opened in that same year at Charity Hospital in New Orleans (CHNO). During this time in history, Charity hospital was the only state institution equipped to house the mentally ill. An act by the legislature in 1847 established the first free standing state asylum in Jackson.

On November 21, 1848, the entire mentally ill population of CHNO was transported by steamboat up the Mississippi River to Bayou Sara and from there, by oxcart to the Insane Asylum of Louisiana (East Louisiana State Hospital) in Jackson, Louisiana.

Special thanks to: J Am Acad Psychiatry Law, 2003; "New Orleans' Charity Hospital"- Salvaggio; "The Rudoph Matas History of Medicine in Louisiana -Duffy; Eastern Louisiana Mental Health System Website. For full references please email rroberts@dhh.la.gov.

Whose Infants Are More Likely to Be Delivered By Primary Cesarean? Louisiana, 2005

Tri Tran MD MPH; Roshan Badakhsh MPH; Ming-Kuang Hsueh MPH; Lisa Longfellow MPH

Objectives, Data Sources, and Methods of Analysis:

Primary Cesarean (PC) rates in Louisiana have increased from 18.0% in 2000 to 25.4% in 2005. The PC rate for the United States in 2004 was 20.6%. Many epidemiological studies have indicated that risks such as cardiac arrest, hysterectomy, major puerperal infection, re-hospitalization after delivery and fetal distress are more prevalent in c-sections than vaginal deliveries. Determining factors associated with PC is helpful to define high-risk populations for PC.

The 2005 birth records, 2005 Medicaid and 2004 to 2005 sexually transmitted disease (STD) data were linked. STD data included chlamydia, gonorrhea and syphilis. Medicaid data provided information of live-birth delivery paid for by Medicaid. Only live births to women without previous cesarean were included in analysis (N = 49,679). Multivariable logistic regression was used to determine: association of PC with mother's demographic and economic characteristics; prenatal health behaviors, medical risks, labor/delivery complications, prenatal care and STD during pregnancy; Medicaid paid-for delivery; newborn's gestational age, birth weight, plurality, sex and congenital anomalies. LinkPro 3.0 and SAS 9.1 were used for data analyses and linkage. Alpha was set at .05 for statistical significance.

Results:

In 2005, the PC rate was 25.4% in Louisiana. This rate was very high in live births with multiple births (71.5%), congenital anomalies (34.8%), very low birth weight (< 1,500 grams) (53.1%), low birth weight (1,500-2,499 grams) (40.4%), high birth weight (4,000+ grams) (35.5%), preterm birth (< 37 weeks) (40.1%), labor/delivery complications (47.4%), intensive prenatal care (29.4%), age greater than thirty-five (30.0%), and first time live birth (37.1%). (Tables 1 and 2)

Table 1: Percentage of primary cesarean by maternal characteristics Louisiana, 2005

Maternal Characteristics		Percent	CI 95%
Race	White	26.3	25.7, 26.8
	African-American	24.3	23.7, 24.9
	Other	22.0	19.9, 24.1
Age (Years)	<20	26.4	25.5, 27.4
	20-34	24.6	24.2, 25.1
	35+	30.0	28.6, 31.4
Mother's Education (Years)	< 12	21.5	20.8, 22.3
	12	25.0	24.3, 25.6
	> 12	27.6	27.0, 28.2
Medical Risk	No	22.3	21.9, 22.8
	Yes	30.9	30.2, 31.5
Labor/Delivery Complications	No	15.0	14.6, 15.4
	Yes	47.4	46.6, 48.2
STDs During Pregnancy	No	25.5	25.1, 25.9
	Yes	23.0	21.6, 24.5
Medicaid-Paid Delivery	No	27.0	26.3, 27.6
	Yes	24.5	24.0, 25.0
Birth Spacing (Months)	First live birth	37.1	36.5, 37.7
	<12	11.9	9.8, 14.0
	12-23	9.6	8.8, 10.3
	24-35	10.7	9.8, 11.5
	36+	15.4	14.8, 16.0
Prenatal Care Adequacy (Kotel Chuck Index)	Inadequate	18.6	17.4, 19.8
	Intermediate	22.9	21.5, 24.3
	Adequate	22.7	22.1, 23.3
	Adequate Plus	29.4	28.8, 30.0
Smoking During Pregnancy	Yes	24.2	23.0, 25.3
	No	25.5	25.1, 25.9

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Assistant Secretary, OPH ***M. Rony Francois, MD MSPH PhD***

State Epidemiologist ***Raoult Ratard, MD MPH***

Editors ***Susanne Straif-Bourgeois, PhD MPH***
Theresa Sokol, MPH
Rosemarie Robertson, BS MT(C) CNMT

Layout & Design ***Ethel Davis, CST***

Table 2: Percentage of primary cesarean by newborn's characteristics Louisiana, 2005

Newborn's Characteristics		Percent	CI 95%
Sex	Male	26.1	25.6, 26.7
	Female	24.5	24.0, 25.1
Birthweight (Grams)	< 1,500	53.1	50.2, 55.9
	1,500-2,499	40.4	38.9, 41.8
	2,500-3.999	22.3	21.9, 22.7
	4,000+	35.3	33.4, 37.2
Abnormal Conditions	No	24.1	23.7, 24.5
	Yes	37.4	36.0, 38.8
Congenital Anomalies	No	25.2	24.8, 25.6
	Yes	34.8	31.4, 38.2
Plurality	Singleton	23.8	23.4, 24.2
	Twin+	71.5	69.3, 73.7
Prematurity	Preterm (<37 weeks)	40.1	39.0, 41.3
	Term (37+ weeks)	23.0	22.6, 23.4

Results of the multiple regression model showed that the PC was strongly statistically associated with multiple live births (adjusted odds ratio [OR]: 7.3, CI: 6.1, 8.7), labor/delivery complications (OR: 4.9, CI: 4.7, 5.1), and first time live birth (OR: 5.8, CI: 5.2, 6.4). Low or high birth weight, preterm delivery, older mothers, birth spacing greater than thirty-six months and intensive prenatal care were also statistically associated with PC (p values < .05). (Table 3)

Table 3: Maternal and newborn's characteristics statistically associated with primary cesarean – Louisiana, 2005

Effects		Odds Ratio	CI 95%	Reference group
Plurality	Twin+	7.3	6.1, 8.7	Singleton
Birthweight (Grams)	<1500	1.8	1.5, 2.1	2,500-3,999
	1500-2499	1.3	1.2, 1.4	
	4000+	2.1	1.9, 2.3	
Labor/delivery Complication	Yes	4.9	4.7, 5.1	No
Mother's Age (Years)	20-34	1.5	1.4, 1.6	< 20
	35+	2.5	2.3, 2.8	< 20
Birth Spacing (Months)	12--23	0.9	0.8, 1.1	24-35
	36+	1.4	1.3, 1.6	
	< 12	1.0	0.8, 1.3	
	1st time live birth	5.8	5.2, 6.4	
PNC Adequacy (Kotel Chuck Index)	Adequate plus	1.3	1.2, 1.3	Adequate
	Inadequate	0.9	0.8, 1.0	
	Intermediate	1.1	1.0, 1.2	
Prematurity	Preterm	1.2	1.1, 1.3	Term

STD during pregnancy and Medicaid-paid delivery were not seen to be associated with PC statistically.

Conclusions:

Live births with multiple births, labor/delivery complications, first-time live birth, longer birth spacing, older mothers, low or high birthweight, preterm birth and intensive prenatal care were more likely to be delivered by cesarean. This message may be useful for physicians when taking care of patients with high-risk of primary cesarean. Effective interventions executed by the Maternal and Child Health programs to decrease modifiable risk factors associated with PC will limit unnecessary primary cesarean and its complications.

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

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Epidemiology of Appendicitis Louisiana, 1999-2004

Melissa Devito, MD-MPH Candidate

Appendicitis is the most common surgical condition of the abdomen. Differing regional incidence, seasonality and male predominance have been observed in previous studies at the national and regional level of the United States and Canada. In addition, a steadily declining rate of appendicitis has been observed since the 1940s. However, none of these studies specifically observed the Louisiana population. This investigation analyzes Louisiana Hospital Inpatient Discharge Database (LAHIDD) records from the years 1999 through 2004 to characterize the epidemiology of appendicitis in Louisiana. This work has implications for health planning and treatment decisions.

The version of LAHIDD available contained demographic data, admission diagnosis, admission source and up to eight discharge diagnoses. Diagnoses were coded using the International Classification of Diseases, ninth revision. Between eighty-six and 131 hospitals contributed data each year from 1998 through 2004. Records with codes indicating appendicitis as the main or one of the first four discharge diagnoses were analyzed. Codes indicating non-perforating appendicitis are 540, 540.0 and 541. Codes indicating perforated appendix are 540.1 and 540.9 .

Demographics:

The mean age of men or women with appendicitis was respectively, thirty and thirty-three years of age (p < 0.001). (Table 1)

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Pneumonia Among Children...(Continued from page 1)

The most frequent admissions were for infants less than one year of age, with the frequency decreasing for those up to age five, who had the lowest frequencies of admissions. The frequency of admissions varied from year to year but the overall trend showed a slight decrease for those aged less than two years. The cases of pneumonia for children five and under per 1000 hospital admissions decreased, from 7.7 per 1000 in 1999 to 5.3 per 1000 in 2004.

Those admitted were 55.7% male and 44.3% female showing a proportion of males higher than expected (51% males in this age group). No ethnic group was listed for twenty percent of the patients. Among those with race listed, 49.7% were White, 35.3% were African-American and 14.9% were 'Other'. (The distribution in the Louisiana population for 2004 was 65% White, 33% African-American and 2% 'Other'.) Thirty-nine percent of admissions were classified as emergency, 36.3% urgent and 24.3% elective. Amongst all patients, 99.4% (19,985) were discharged to home.

Most of the variation in pneumonia admissions from year to year comes from unclassified pneumonias, with viral pneumonias also contributing to yearly variability. The majority are pneumonia with no further etiologic diagnosis. (Table 1)

Table 1: Most common pneumonia-related diagnoses
LAHIDD, 1999-2004

Diagnosis	Number	Percent
Pneumonia, Organism Undetermined	14,316	71.2
Respiratory Syncytial Viral Pneumonia (RSV)	1,952	9.7
Bronchopneumonia	1,887	9.4
Viral Pneumonia Unspecified	791	3.9
Influenza With Pneumonia	324	1.6
Other	319	1.6
Mycoplasmal Pneumonia	207	1.0
Pneumococcal Pneumonia	311	1.5
Total	**20,107**	

Looking more closely at the viral pneumonias, most of the variation is due to Respiratory Syncytial Virus (RSV) pneumonia. For example, in 2003, it was possible that physicians recorded more clinical diagnoses of influenza and fewer diagnoses of RSV because of knowledge about the influenza season. The data do not indicate which cases of influenza or RSV were laboratory-proven.

The trend in bacterial pneumonias is most interesting. There was a drop from ninety cases of Gram positive pneumonia (78 pneumococcal) in 1999 to forty cases (34 pneumococcal) in 2004. This was accompanied by a rise in mycoplasmal pneumonias from thirty-seven in 1999 to fifty-two in 2004. This drop coincided with the introduction of the pneumococcal vaccine. However, it is not clear if this represents an actual drop in the number of pneumonia cases or a drop in clinical suspicion for pneumococcal pneumonia. Of note, there was no increase in staphylococcal pneumonia.

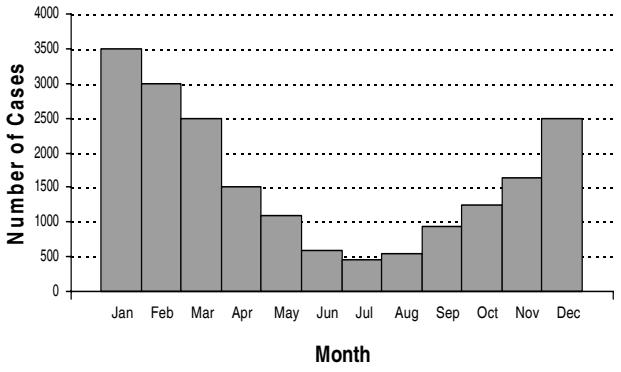
There was a fifty-six percent decrease in pneumococcal pneumonia admissions and a forty percent increase in mycoplasmal pneumonia admissions. Gram negative and RSV pneumonias were more common in children under one year of age than in older children. Viral pneumonias account for a larger proportion of all pneumonias in younger children. In children under one year, viral pneumonias accounted for 24.1%, as contrasted with 14.1% for children age one, 12.0% for age two, 7.7% for age three, 5.9% for age four and 6.0% for age five. RSV represented a steadily declining portion of all viral pneumonias, from 72.9% at for those under age one to 14.1% of five year olds. Bacterial pneumonias showed a peak of Gram-negative infection among children under one (representing 33.3% of bacterial pneumonias). Mycoplasma infections steadily increased from 6.2% to 51.9% of all bacterial infections from newborns to age five.

Among children admitted with a primary diagnosis of pneumonia, 5,322 (26.5%) had a secondary diagnosis of asthma, 3,393 (16.9%) had a secondary diagnosis of suppurative or unclassified otitis media and 1,817 (0.9%) had a diagnosis of acute bronchitis. The main diagnoses of those with secondary diagnoses of asthma, otitis media and bronchitis did not differ markedly from the main diagnoses of the entire cohort.

Only eight patients (0.04%) died. Of those who died, two had a secondary diagnosis of asthma, one had a secondary diagnosis of tetralogy of Fallot, one had a diagnosis of *Staphylococcus aureus* septicemia, one had a diagnosis of septicemia NOS, one had a diagnosis of primary cardiomyopathy and one had a diagnosis of cerebral palsy and developmental delays. Only one death did not have a complicating chronic disease listed.

More admissions occurred during the winter months (December 12.6%, January 17.1% and February 15.1%). RSV was responsible for most of the seasonal variation. (Figure 2)

Figure 2: Pneumonia cases by month of year
LAHIDD, 1999-2004



Conclusions:

Pneumonia amongst children five years old and under is prevalent.

Males were admitted at a higher rate than their proportion in the general population. Pneumococcal pneumonia admissions decreased in the period studied and mycoplasmal pneumonia increased.

For references or more information, please call (504) 219-4563 or email *rratard@dhh.la.gov* .

Epidemiology of Appendicitis...(Continued from page 3)

Table 1: Appendicitis by sex and race distribution LAHIDD, 1999-2004

Variable	Number	Percent
Male	8,583	57.2
Female	6,434	42.8
Total	**15,017**	
African-American	2,117	14.1
Asian	182	1.2
White	8,377	55.8
Native American	144	1.0
Other	917	6.1
Missing	3,280	21.8

Incidence:

The crude incidence of appendicitis was 56.1 per 100,000 population per year. The crude incidence for males was 32.1 per 100,000 population per year and 24.1 per 100,000 population per year for females. The male to female incidence ratio was 1.3:1. Yearly incidence did not significantly increase over the study period (R2 = 0.52, P = 0.12). (Figures 1 and 2)

Figure 1: Annual incidence of appendicitis – LAHIDD, 1999-2004

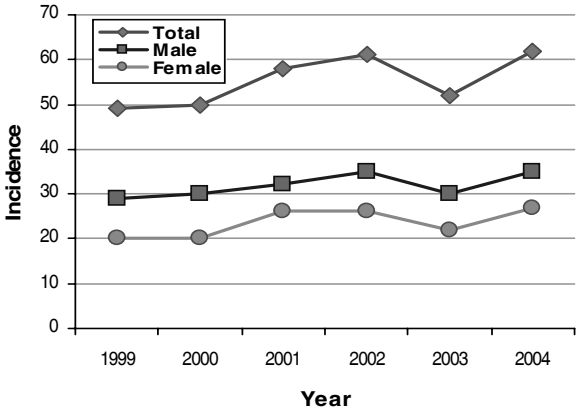
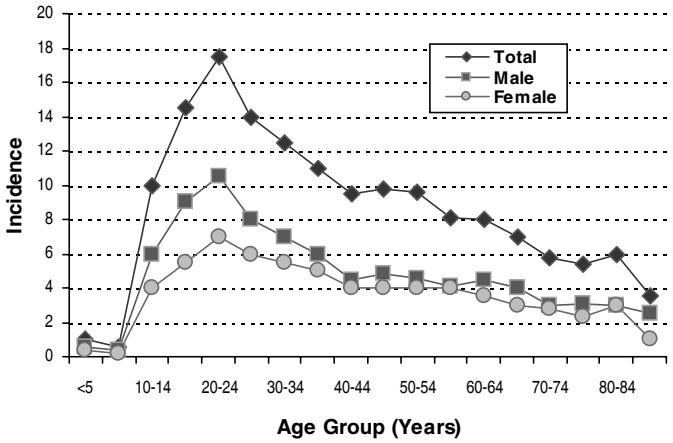


Figure 2: Incidence by age category – LAHIDD, 1999-2004



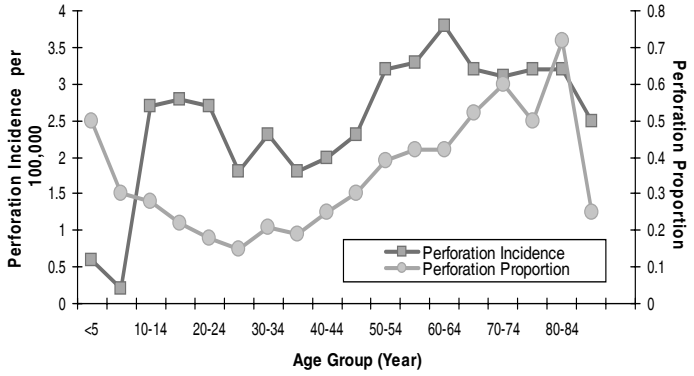
The incidence ratio between Whites and African-Americans was 4 : 1.

Admission and Discharge Status:

The majority of patients were admitted to the hospital from the emergency room (66.2%). Thirty percent of patients were referred by a physician for admission. African-Americans were 1.2 times more likely to be referred from the ER as Whites (95% CI: 1.11, 1.78; p < 0.0001). The mortality rate was 0.25%. The vast majority (95.5%) of patients were discharged to home. Patients sent to other facilities upon discharge comprised 3.7% of all discharges.

Perforations over the study period were twenty-six percent. (Figure 3)

Figure 3: Annual rate and proportion of perforated appendix by age group LAHIDD, 1999-2004



The increase in perforation was not statistically significant (R2 = 0.23,p = 0.31.) The relative risk of perforation in males was 1.08 (95% CI: 1.02, 1.14;p = 0.01).

The relative risk of perforation in African-Americans vs. Whites was 1.20 (95% CI: 1.11, 1.30; p < 0.0001). The incidence of perforation in African-Americans and Whites was 293 per 1000 cases (1999-2004 average),and 244 per 1000 cases (1999-2004 average), respectively. The relative risk of death with perforation was 32.32 (95% CI: 9.93, 105.18; p < 0.0004).

Seasonality:

Analyses of variance test and Tukey multiple comparison test were conducted on the monthly incidence rates from 1999 to 2004. No statistically significant differences in incidence were found between months in Louisiana.

Urban vs. Rural:

The risk of perforation was slightly higher in urban versus rural parishes: 1.15 (95% CI: 1.04, 1.26; p = 0.01). The risk of death did not differ between urban and rural parishes: 1.20 (95% CI: 0.41, 3.51; p = 0.74).

Discussion:

All incidence rates calculated in this study were about half of those previously reported. Addiss** reports a crude incidence of 124 per 100,000 population in the South-Central-West region of the

(Continued on page 6)

Epidemiology of Appendicitis...(Continued from page 5)

United States in 1990. Luckmann* * reported an incidence of ninety-six per 100,000 population in California in 1989. In contrast, this study yielded a crude incidence of fifty-six per 100,000 population. While the incidence of appendicitis has declined over the past decades, it is unlikely that it has decreased by half in the past fifteen years. The most likely explanation for the reduced incidence observed here is underreporting to LAHIDD. As noted previously, varying numbers of hospitals contribute and not all discharges from contributing hospitals are recorded. Any reports of incidence calculated from LAHIDD should be interpreted with caution.

The median age for men and women was fairly similar to previous reports. Addiss, et. al., report a median age of twenty-one years for both men and women. Al-Omran et.al.**, found the median age to be twenty-six years. The male-female ratio of 1.3:1 in this study was similar to that of 1.4:1 reported by Addiss and Al-Omran.

The data also showed an increased incidence in appendicitis in Whites versus African-Americans at a ratio of 4:1. Luckmann reported a ratio of 2:1 and Addiss reported a ratio of 1.5:1. No single explanation has accounted for the reduced incidence in African-Americans. Underreporting of cases, dietary differences and genetic causes have been proposed as possible explanations.

Of particular interest in this study is the examination of perforation. The proportion of perforated cases peaked in early childhood, decreased to a low in the twenty-five to twenty-nine year age group and then steadily increased with age. It has been hypothesized that the increased incidence of perforation at the extremes of age is due to communication problems in the very young who cannot describe the early pain of appendicitis and the high numbers of co-morbid conditions in the elderly which confound early diagnosis. It should be noted that the percentage of perforated cases was twenty-six percent, similar to the 2.1 % found by Hale, et.al**. Hale notes that the percentage of cases of appendicitis with perforation has changed very little over the past seventy years.

Perforation is considered an avoidable admission by the Agency for Healthcare Research and Quality, which publishes the National Healthcare Disparities Report (NHDR). The NHDR compares incidence of perforation between different races and ethnicities to evaluate disparities in outpatient care. The rationale is that early appendicitis will be detected in outpatient care before perforation develops.

The 2006 NHDR showed the incidence of appendiceal perforation in African-Americans to be about 300 per 1000 cases of appendicitis compared to about 250 per 1000 cases in Whites. This study showed a similar disparity with incidence of perforation in African-Americans and Whites (293 per 1000 cases and 244 per 1000 cases, respectively). While the overall incidence rate of perforation for both races were lower than those reported in the NHDR, the likelihood of perforation was still greater in African-Americans. The LAHIDD data also show that African-Americans are more likely to be admitted from the ER. This suggests that outpatient care might not be as available for African-Americans as it is for Whites, resulting in appendicitis not being recognized in its early stages.

Interestingly, Hale, et.al report no disparity in perforation rate between African-Americans and Whites. The population in the Hale study was military and visited Department of Defense Hospitals. Possible reasons for the lack of disparity in the Hale study include the relative youth and health of the military population and the equal access to similar outpatient care available to military personnel.

This study highlighted the shortcomings of LAHIDD. Future versions of LAHIDD should strive for more hospital participation which would help alleviate concerns about underreporting of various conditions, especially in minority populations. Better technical documentation with each LAHIDD report would also enhance the value of the publication. Of particular import would be a breakdown of the types of hospitals contributing and the percentage of discharges reported by contributing hospitals. Currently, only the number of contributing hospitals is consistently listed in the yearly report.

The main weakness of this study is that the reliability of the data is not certain. No information validating the LAHIDD data has been published. In addition, not all the hospitals in the state are reporting to the database. The version of LAHIDD available for study also did not include information about Hispanic ethnicity, so trends in this population could not be examined.

This study illustrates that Louisiana has largely similar trends in the epidemiology of appendicitis as previously reported for the nation and various other regions. Importantly, these trends include an increased likelihood of perforation in African-Americans as opposed to Whites. African-Americans were also more likely to be admitted from the ER than outpatient care. Future care design should focus on the availability of outpatient care for minorities in order to resolve this disparity.

** For references or more information, please email *rratard@dhh.la.gov* or call (504) 219-4563.

Gingivo-stomatitis.....(Continued from page 1)

by direct contact with oral secretions (saliva), sharing food and drinks and putting saliva laden objects in the mouth as toddlers often do. The prevalence of HSV-1 past infection (as diagnosed by presence of antibodies to HSV-1), vary among populations. In the U.S., prevalence rates range from fifty percent to eighty percent with an overall average of sixty percent. Most of the infections are acquired at a young age.

No exclusion is recommended except for children who cannot control drooling and have ulcers and blisters. Measures that will reduce transmission are:

- Careful handwashing and hand sanitizing
- Avoid sharing food, eating from same plate or drinking from the same glass
- Avoid touching the mouth
- Avoid kissing or nuzzling symptomatic children
- Wash and sanitize mouthed toys, bottle nipples and utensils that have come in contact with saliva or have been touched by children who are drooling or putting their fingers in their mouths.

For more information, please contact Ms. Henson at (318) 676-7499 or email *khenson@dhh.la.gov*

* Map of regions on page 7

March-April, 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	Mar-Apr 2007	Jan-Dec Cum 2008	Jan-Dec Cum 2007	Jan-Dec % Chg*
Vaccine-preventable															
Hepatitis B	Cases	0	0	0	0	0	0	1	0	5	6	12	19	27	-29.6
	Rate1	0	0	0	0	0	0	0.2	0	1.3	0.1	0.3	0.4	0.6	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	1	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		0	0	2	0	0	0	1	0	0	3	5	4	7	NA*
Sexually-transmitted															
HIV/AIDS	Cases[2]	21	7	1	4	4	4	6	3	3	53	215	180	397	-54.7
	Rate[1]	2.1	1.2	0.3	0.7	1.4	1.3	1.2	0.9	0.7	1.2	4.9	4.1	9.1	NA*
Gonorrhea	Cases	274	195	104	141	34	93	181	160	72	1254	2120	1741	3830	-54.5
	Rate[1]	26.5	32.3	27.1	25.7	12.0	30.9	34.6	45.2	16.4	28.1	47.4	39.0	85.7	0.0
Syphilis (P&S)	Cases	18	11	5	26	4	1	11	1	10	87	69	161	121	33.1
	Rate[1]	1.7	1.8	1.3	4.7	1.4	0.3	2.1	0.3	2.3	1.9	1.5	3.6	2.7	0.3
Enteric															
Campylobacter		0	0	0	1	1	0	0	1	2	5	19	20	32	-37.5
Hepatitis A	Cases	0	0	1	3	0	0	0	0	1	5	4	6	8	NA*
	Rate[1]	0	0	0.3	0.6	0	0	0	0	0.3	0.1	0.1	0.1	0.2	NA*
Salmonella	Cases	9	8	4	6	6	5	2	11	3	54	81	113	148	-23.6
	Rate[1]	0.9	1.4	1.1	1.2	2.2	1.6	0.4	3.1	0.8	1.3	1.9	2.6	3.4	NA*
Shigella	Cases	3	9	7	35	5	2	7	0	4	72	82	117	119	NA*
	Rate[1]	0.3	1.6	1.9	6.8	1.9	0.7	1.4	0	1.0	1.7	1.9	2.7	2.8	NA*
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other		1	0	0	1	0	0	0	1	0	3	2	4	5	NA*
Other															
H. influenzae (other)		0	0	0	1	0	0	0	0	0	1	3	3	5	NA*
N. Meningitidis		1	0	1	1	1	0	0	0	0	4	5	12	13	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.

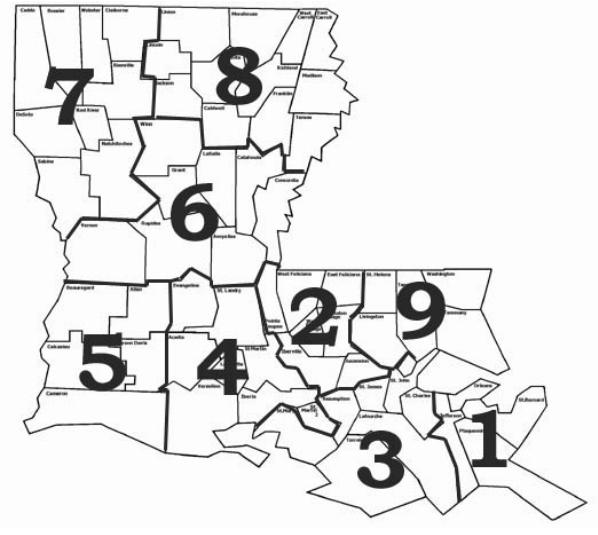
* Percent Change not calculated for rates or count differences less than 5

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

Disease	Total to Date
Legionellosis	0
Lyme Disease	0
Malaria	0
Rabies, animal	1
Varicella	6

Table 3. Animal rabies (March-April, 2008)

Parish	No. Cases	Species
	0	



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