STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
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http://www.dhh.louisiana.gov/offices/reports.asp?ID=249&Detail=7428
Infectious Disease Epidemiology Main Webpage
http://www.infectiousdisease.dhh.louisiana.gov

January-February 2009 **Volume 20 Number 1**

Postal Plan – Louisiana, 2009

Stacy Hall, RN MSN

Past events have taught us that the risk of bioterrorism in America is real. The ability to quickly deliver medications to a large population is a central component in public health preparedness and the goal of the Strategic National Stockpile (SNS). The City Readiness Initiative (CRI) program is a federally funded effort to prepare major U.S. metropolitan areas to effectively respond to a large scale bioterrorist event by dispensing oral antibiotics to their entire population within forty-eight hours of the decision to do so. This program enhances preparedness at all levels of government and provides a consistent nationwide approach to prepare for, respond to and recover from a public health emergency.

In September 2006, the two metropolitan areas of Baton Rouge and New Orleans/Metairie/Kenner were identified by the federal government for inclusion in the national CRI Program. Office of Public Health (OPH) Regions 1, 2, 3 and 9 (see page 7 for map of regions), are actively involved in CRI planning, but all OPH regions have the goal of rapid prophylaxis of their entire population. The planning and lessons learned through the CRI Program will benefit all citizens of the State.

Point of Dispensing (POD) sites is the traditional method

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Summary of Vibrio Surveillance Louisiana, 2008

Annu Thomas MPH MSc

Vibrio bacteria are gram-negative bacteria which can be found in surface waters, both halophilic (marine), and non-halophilic (estuarine) environment. About twenty species are pathogenic with *Vibrio vulnificus*, *Vibrio cholerae* serogroups O1 and O139 and *Vibrio parahemolyticus* being the most clinically significant. Vibrio infections are defined by the Infectious Disease Epidemiology Section (IDES) as the isolation of Vibrio bacteria from humans. In Louisiana, systematic reporting of Vibrio infections started in the early 80's. Vibriosis has been a nationally reportable disease since January, 2007.

Cholera is a Class A disease and should be reported within twenty-four hours, while all other Vibrio infections are Class C diseases and should be reported within five business days. To report a Vibrio illness, call (504) 219-4563 or (800) 256-2748.

2008 Case Reports

In 2008, preliminary data revealed that forty-five Vibrio cases have been reported to IDES (Table 1).

Table 1: Vibrio case number by species – Louisiana, 2008

Species	Number	Percent
V. vulnificus	10	22.2
V. parahaemolyticus	11	24.2
V. mimicus	14	31.4
V. fluvialis	2	4.4
V. cholerae nonO1 nonO139	3	6.7
V. cholerae O141	1	2.2
V. cholerae O1toxigenic	1	2.2
V. cholerae O1 non-toxigenic	1	2.2
V. alginolyticus	2	4.4
Total	**45**	**100.0**

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Emergency Department Surveillance During Disasters Louisiana, 2002-2008

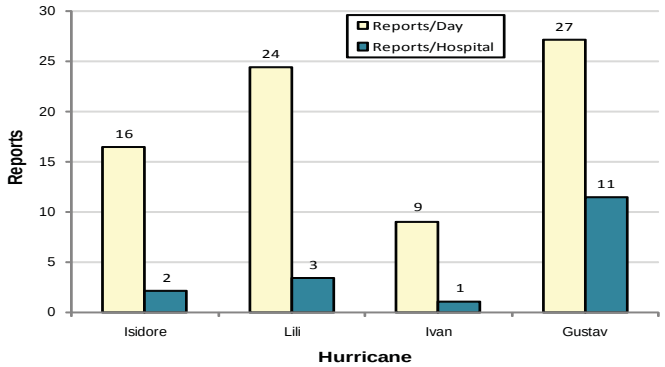
Erin Stanley MPH

The Office of Public Health (OPH) is responsible for Emergency Department (ED) surveillance in the event of a hurricane or other natural disasters in Louisiana. During the surveillance, ED staff are asked to report the total number of patients seen in the ED in a twenty-four hour time period, as well as the subset of those seen for injuries or infectious diseases. Information regarding the number of those seen who were admitted, transferred, discharged, or died is also collected. Surveillance activities are initiated in the early phases of the emergency and activities continue until the major clean-up phase following the disaster is complete. The goal of ED surveillance is to determine the extent of injuries and illnesses and to help plan for future disasters. Furthermore, surveillance helps OPH to institute control measures quickly as well as provide appropriate education and prevention messages.

ED surveillance has been implemented five times in the last six years for the following hurricanes: Isidore (2002); Lili (2002); Ivan (2004); Katrina (2005); Gustav (2008). For Hurricane Katrina, approximately forty Epidemic Intelligence Service (EIS) officers from the Centers for Disease Control and Prevention (CDC) managed the surveillance, reporting detailed information from twenty EDs. Because of the active involvement of the CDC and EIS officers, the surveillance system during Hurricane Katrina and its data cannot be compared to other years' ED surveillance.

This past hurricane season, the ED surveillance system was activated for Hurricane Gustav on August 29, 2008 and continued for three weeks until September 19th. (Hurricane Gustav made landfall in Louisiana on September 1, 2008.) This is the longest time period that the ED surveillance system has been implemented. Due to the large area potentially affected by the hurricane and the presence of shelters throughout the state, ED surveillance was used in all nine regions. In comparison to the other hurricanes when ED surveillance was implemented, the Gustav ED surveillance was the most successful. More reports per participating hospital and more reports per day were received for Gustav compared to previous hurricanes. (Figure 1)

Figure 1: Emergency department surveillance reports by hurricane – Louisiana, 2002-2008



(Continued on page 3)

Additions to Disease Reporting Requirements: Carbon Monoxide Poisoning

Baton Rouge – Carbon Monoxide Exposure and/or Poisoning was recently added to the list of Reportable Diseases and Conditions (Title 51, Part II, Chapter 1). Carbon monoxide (CO) is a colorless, odorless, poisonous gas produced through incomplete combustion of carbon-based fuels, including gasoline, oil and wood. Carbon Monoxide Poisoning is considered to be "any medical condition/visit resulting from carbon monoxide exposure as determined from the exposure history or patient statement and/or injury resulting from inhalation of carbon monoxide. Laboratory test results for carbon monoxide includes results of carboxyhemoglobin tests (blood samples), regardless of test result".

The State Health Officer must be notified within five business days of a poisoning. Reports can be sent to the Louisiana Department of Health and Hospitals, Office of Public Health, Section of Environmental Epidemiology and Toxicology by telephone at (504) 219-4518, facsimile at (504)219-4582, mail to the Environmental Epidemiology and Toxicology Section, Department of Health & Hospitals, Office of Public Health, 1450 L&A Rd, 2nd Floor, Metairie, LA 70001 or web at http://www.dhh.louisiana.gov/offices/page.asp?id=205&detail=8411.

The amended list of reportable diseases and conditions is included on the back of all Louisana Morbidity Reports. For references or more information, please contact Adrienne Katner at (504)219-4784 or email *adrienne.katner@la.gov* .

Additional Resources:

Carbon Monoxide Sources, Health Effects and Prevention: http://www.cdc.gov/co/ and http://www.epa.gov/iaq/co.html

Louisiana Section of Environmental Epidemiology and Toxicology: http://www.dhh.louisiana.gov/offices/?ID=205

Louisiana Morbidity Report
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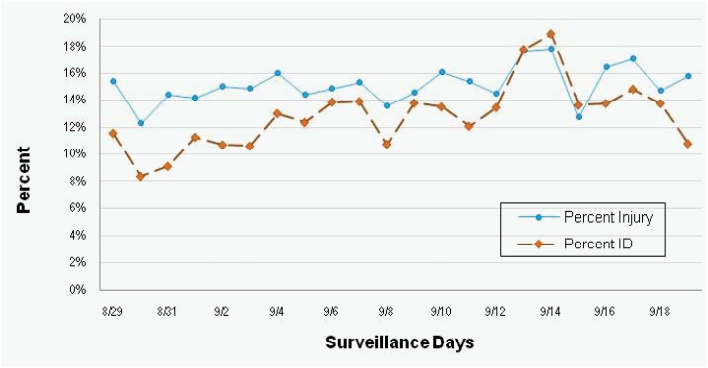
(Emergency Department.....Continued from page 2)

More than fifty hospitals throughout all nine state regions participated in ED surveillance for Hurricane Gustav. For the three-week duration of the surveillance, a total of 597 ED surveillance reports were received. There was a steady increase in the number of reports received from August 29th to September 3rd with a maximum of forty-five hospitals participating on September 3rd. The number of participating hospitals remained steady from September 4th to September 10th with over thirty hospitals reporting; the number then dropped to thirty or fewer reporting until the completion of the surveillance period.

During the Gustav ED surveillance, there were more visits reported for injuries than for infectious diseases. (Figure 2).

Figure 2: Percent injury and infectious disease among ED visits Hurricane Gustav – Louisiana, 2008



Visits due to injury or infectious diseases were considered severe if the patient was admitted or transferred. A higher percent of the visits due to infectious diseases were considered severe compared to the percent of the visits due to injuries. The percent of visits for severe injury remained below ten percent during the three-week surveillance. The average percent of visits due to infectious diseases that were considered severe over the three-week surveillance period was eleven percent, (range of 5% to 20%).

ED surveillance is used as a screening tool during emergencies to identify potential problem areas. If unusual patterns occur, OPH staff conduct follow-up investigations. Fortunately, no major problems arose during the recent surveillance period. Gustav ED surveillance would not have been as successful without the help of the OPH regional staff and participating hospitals. It is hoped that such high levels of participation will continue during future implementations of the ED surveillance system.

For more information please contact Ms. Stanley at (504) 219-4622 or email estanley@dhh.la.gov

Botulism Case Identification Louisiana

Botulism is a severe illness affecting primarily the nervous system (neuroparalytic disorder) caused by the neurotoxin produced by *Clostridium botulinum*. There are three main kinds of botulism differentiated according to the mode of acquisition of the toxin: foodborne, infant, wound.

Foodborne botulism is acquired by the ingestion of food in which toxin has been formed, predominantly after inadequate heating during preservation and without subsequent adequate cooking. Foods associated with botulism are mostly home-canned foods (65% of cases prior to 1960), and commercially processed foods (7% of pre-1960 cases) because these foods provide the anaerobic environment necessary for maturation of the spores and subsequent production of toxins.

Initial symptoms may include blurred or double vision, dysphagia, dry mouth, vomiting and constipation or diarrhea. The symptoms may extend to symmetric descending flaccid paralysis. The case-fatality rate in the U.S. is five percent to ten percent.

Prevention of foodborne botulism is best accomplished by proper preparation, handling and heating of canned or preserved foods. Commercial cans or home canned products with dents or bulging lids should not be opened. Foods exhibiting abnormal odors should not be consumed. All cases of foodborne botulism are treated as public health emergencies because the responsible food may still be available for consumption.

Infant botulism is often attributed to the ingestion of fresh honey that is contaminated with spores. However, other sources of botulism in infants, such as exposure to soil, have emerged since feeding honey to infants has been discouraged. (Honey should never be fed to infants under one year of age.) Illness typically begins with constipation, followed by lethargy, poor feeding, loss of head control and generalized weakness, difficulty swallowing and sometimes, respiratory insufficiency and arrest. The case-fatality rate of hospitalized cases in the U.S. is less than one percent.

Wound botulism results when the spores contaminate a wound in which anaerobic conditions develop. Wound botulism is often associated with illegal injectable drug use. Symptoms are similar to those of foodborne botulism, however, gastrointestinal symptoms do not occur. Prevention is best accomplished by properly seeking

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Erratum

November - December, 2008 Issue, Page 7

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

Sept.-Oct. 2008

		HEALTH REGION									TIME PERIOD				
DISEASE		1	2	3	4	5	6	7	8	9	Sept-Oct 2008	Sept-Oct 2007	Jan-Oct Cum 2008	Jan-Oct Cum 2007	Jan-Oct % Chg*
Syphilis (P&S)	Cases	22	14	5	24	7	0	29	14	16	132	131	522	451	15.7
	Rate[3]	3.2	2.2	1.2	4.2	2.5	0	5.5	4.0	3.1	3.1	3.1	12.2	10.5	NA*

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

[3] = Cases Per 100,000 based on 2007 estimated population

(Summary of Vibrio.....Continued from page 2)

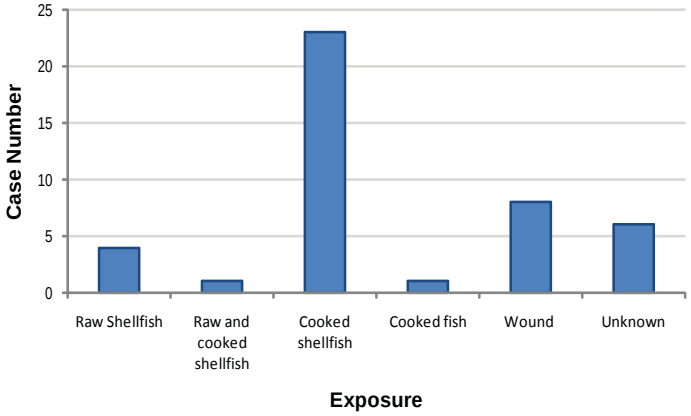
Based on twenty years of data, the average number of reported Vibrio infections is forty-three cases per year (range 28 to 66). Forty-two percent of cases were above the age of sixty-four years, sixty-nine percent of the cases were Caucasian and sixty-four percent were males. Sixty percent of Vibrio illnesses occurred in the summer months between May and July. Sixty-nine percent of patients were hospitalized. Of the five patients who died, four of them had septicemia due to infection with *V. vulnificus* and all of them had severe underlying conditions.

Exposures

One patient had *V. cholerae* O1 toxigenic, serotype Inaba, biotype El Tor. The patient was hospitalized and had reported eating crab that was locally caught by a friend. The other case of *V. cholerae* O1 was non-toxigenic. One case of toxigenic *V. cholerae* O141 was reported; the patient consumed cooked crab and crawfish.

Over fifty percent of illnesses was due to exposure to cooked shellfish. (Fully cooked seafood would kill the Vibrio bacteria and therefore poses no risk to humans.) Most likely these infections occurred because the shellfish were undercooked or through cross-contamination. Shellfish that caused these infections were mostly boiled crabs, boiled and cooked crawfish and shrimp as well as fried oysters. (Figure 1)

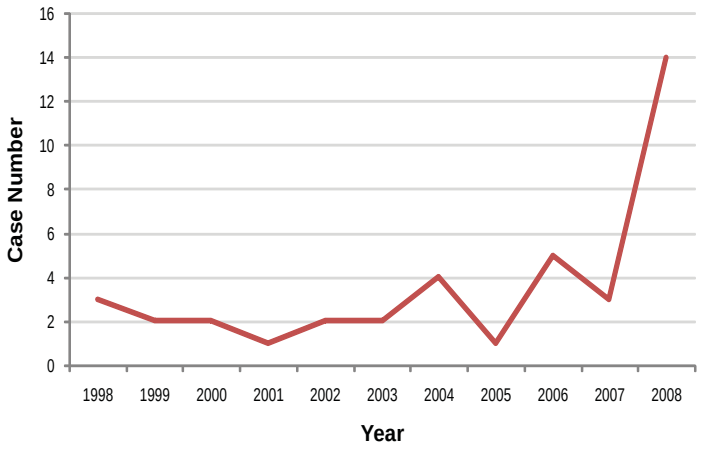
Figure 1: Vibrio infections (n= 45) by exposure – Louisiana, 2008



Vibrio mimicus

In past years, *V. parahaemolyticus* and *V. vulnificus*, each accounted for about twenty-five percent of annual cases, approximately twenty percent of cases are due to *V. cholerae* non O1 and the remaining thirty percent cases include all other Vibrio species. The most frequently reported serotype in 2008 was *V. mimicus* with fourteen cases (31%). (Figure 2)

Figure 2: *Vibrio mimicus* cases – Louisiana, 1998-2008



V. mimicus is a human pathogen closely related to *V. cholerae* that causes sporadic watery diarrhea and food poisoning after consumption of raw or cooked fish or shellfish. Eighty-five percent of *V. mimicus* cases reported in 2008 was related to the consumption of cooked fish or cooked shellfish.

V. mimicus can produce enterotoxins which are virtually identical to the Cholera toxin (CT), produced by *V. cholerae*. Ten of the fourteen isolates were tested at the Centers for Disease Control and Prevention (CDC); six isolates showed the presence of CT using Polymerase chain reaction (PCR). Pulse-field gel electrophoresis (PFGE) was performed on all ten isolates to determine molecular subtype of the bacteria. All ten *V. mimicus* isolates differed in their PFGE pattern. The six patients, whose isolates were positive for CT, volunteered to have their blood tested for the presence of antibodies to CT. Serum collected from three of the patients tested positive for the presence of antibodies to the Cholera toxin. This was the first occurrence of identifying antibodies to CT in patients infected with *V. mimicus.* Antibodies to CT do not seem to be sufficient to protect against further infections.

Testing for Vibrios

In 2008, a survey was conducted to determine the procedures for the identification of Vibrio in hospital laboratories in southern Louisiana. This included Regions 1 through 5 and Region 9 (map on page 7). Fifty-eight hospitals from six regions participated in this survey. Sixty-two percent (n = 36) of hospitals isolate Vibrio bacterium in stool using culture media; twenty-nine percent of the hospitals refer testing to reference laboratories such as LabCorp or Quest.

Thiosulfate Citrate Bile Sucrose Agar (TCBS) is the media of choice used for the isolation and selective cultivation of *V. cholerae* and other enteropathogenic Vibrio species. Seventy-five percent (n = 27) of hospital laboratories that do culture for Vibrio species use TCBS media. Ninety-two percent (n = 33) of hospitals use an automated identification system such as MicroScan or Vitek to determine the serotype or species.

Positive specimens should be forwarded to the state OPH Laboratory since MicroScan or Vitek may lead to misidentification.

For more information, please contact Ms. Thomas at (504) 219-4547 or email aethomas@dhh.la.gov

Botulism.....Continued from page 3)

medical care for infected wounds and by not using injectable street drugs.

No vaccine for botulism is available, antitoxins are not useful in prevention and there is no natural immunity to the disease.

Laboratory Testing

Laboratory testing for botulism is available through the Centers for Disease Control and Prevention (CDC). A toxin neutralization bioassay in mice is used to identify botulinum toxin. Both stool and serum should be obtained from persons with suspected botulism. The CDC or Infectious Disease Epidemiology Section of the Louisiana Office of Public Health should be consulted prior to specimen submission to obtain approval for botulism testing.

Case Management - Treatment

Foodborne and wound botulism can be treated with an antitoxin (Botulism Immune Globulin - BIG) derived from horse serum distributed by the CDC.

To obtain antitoxin, healthcare providers are advised to call the CDC directly. Antitoxin therapy should be started as early in the illness as possible and should not be delayed while waiting for laboratory confirmation. A member of the CDC staff will ask questions to determine whether antitoxin therapy is indicated. The primary number for the CDC Emergency Operations Center is (770) 488-7100. Ask for the 'Botulism Officer' on call. Alternate phone numbers are (404) 639-2206 during workdays or (404) 639-2888 at other times.

Forms and more information on botulism are available at website http://www.dhh.louisiana.gov/offices/page.asp?id=249&detail=6481. These forms are used by the CDC to determine whether antitoxin is indicated. It is useful to fill out the forms before calling the CDC. After CDC approval is obtained, finalize the forms and send them with the sample to the OPH central laboratory.

Human botulism antitoxin is the drug recommended for infants. BabyBIG®, (Botulism Immune Globulin Intravenous (Human) - BIG-IV), is an orphan drug that consists of human-derived botulism antitoxin antibodies that is approved by the U.S. Food and Drug Administration for the treatment of infant botulism types A and B. It is available through the Infant Botulism Treatment and Prevention Program (IBTPP) in Berkeley, California. BabyBIG® is only available through the California Department of Health which holds a license on the drug. Call the IBTPP at (510) 217-4449 (24 hours a day).

To obtain BabyBIG® for a patient with suspected infant botulism, the patient's physician must first contact the IBTPP on-call physician at (510) 231-7600 to review the indications for such treatment. The link for more information is http://www.infantbotulism.org/.

Botulism in Louisiana

An average of 110 cases of botulism is reported annually in the United States. Infant botulism accounts for seventy percent of reported cases.

Since 1965, isolated cases of botulism in Louisiana have been reported for foodborne botulism in the years 1984, 1989, 1992, 1995, 1996, 1997, 2001 and infant botulism in the years 1984, 1999, 2003 and 2005.

The single case reported in Louisiana in 2005 involved a three-week old infant from the Shreveport/Bossier region who presented to the emergency room with constipation, weakness and lethargy that progressed to neurological involvement. The physician noted a weak gag reflex and decreased respiration. Testing indicated botulism. The infant was treated with anti-toxin and recovered. The baby had been fed infant formula and honey had been used as a sweetener.

Field Epidemiology Training

New Orleans - October, 2008

Dielda Robertson - 'Hepatitis'

Dr. Gary Balsamo
'Public Health Veterinarian Update'

Postal Plan.....Continued from page 1)

of providing medications to the public through the SNS Program. PODs are medication dispensing locations for persons who are currently healthy but may have been exposed and need prophylactic medication to prevent illness. The federal government, through the Department of Health and Human Services (DHHS) has identified several other dispensing modalities for guiding state and local planners. Communities throughout Louisiana are operationalizing planning for identified PODs and exploring alternated modes of dispensing to meet the forty-eight hour goal for mass prophylaxis.

One of these alternate modalities is the United States Postal Service (USPS) Postal Plan. In February 2004, the Secretary of Health and Human Services, the Secretary of Homeland Security and the Postmaster General signed a Memorandum of Agreement to make resources of the USPS available to help deliver medical countermeasures community-wide in response to a biological terrorism incident. This offer of USPS assistance is called the Postal Plan. It may be adopted by any metropolitan statistical area that is part of a CRI. A CRI Postal Plan Development Pilot was conducted in Seattle in late 2005 and early 2006.

The USPS Postal Plan is the home delivery of antibiotics by the United States Postal Service. The Postal Plan was conceptualized as a way of reducing the number of persons at PODs, with the intent of providing rapid delivery of medications to the public. With the Postal Plan, mail carriers deliver small quantities of antibiotics to the homes within selected zip codes under the authority of state health officials in coordination with national stakeholders. The rapid delivery of medication through the Postal Plan facilitates the initial prophylaxis of the public within the forty-eight hour time requirement. Additional prophylaxis may be required based on the epidemiologic investigation of a specific incident. The USPS option is entirely voluntary for the employees of the USPS and can occur in jurisdictions with an approved USPS Dispensing Plan.

Postal Plan exercises were conducted in Seattle in November, 2006 and in Philadelphia and Boston in 2007. Lessons learned were incorporated into both strategic and tactical planning materials which became available in 2008. The Postal Plan requires extensive pre-event planning with response stakeholders and the full participation of local law enforcement. The Louisiana DHH OPH has begun the planning process to utilize the Postal Plan in Louisiana.

For more information please email Ms. Hall at *shall@dhh.la.gov* or call (504) 568-5022.

Infectious Disease Epidemiology Web Statistics July – December, 2008

For the period of time from July 15, 2008 to December 31, 2008, approximately twenty-five percent of web searches on the Office of Public Health (OPH) pages, landed on Infectious Disease Epidemiology (IDE) webpages (http://www.dhh.louisiana.gov/offices/?ID=249). This is 2.5 percent of all of web hits for the Department of Health and Hospitals (DHH) for Louisiana.

Forty-eight states plus the District of Columbia have visited our site. Louisiana residents account for most of the visits (69.8 %) followed by Texas (5.3%), California (2.3%), Florida (1.8%), Georgia (1.7%), New York (1.7%) and Mississippi (1.1%). The two states that are not on the list for visits during this time period are North Dakota and Wyoming.

Of the webpages for IDE, the Epi Manual had the most visits (38%) followed by Publications (22.1%), Annual Reports (17.4), Veterinary Information (10.8), Louisiana Morbidity Reports (10.8), West Nile Virus (10.2), and MRSA (8.1). Within Publications, Infection Control Materials were the most requested at (25.8%). Within the Veterinary webpages, Rabies information was the most requested.

A list of the most popular webpages and their addresses can be found at http://www.dhh.louisiana.gov/offices/reports.asp?ID=249&Detail=611.

While the majority of visits came from within the United States (97%), the following countries also visited our site: Canada, United Kingdom, Philippines, India, Ireland, Germany, Australia and Spain.

Announcements

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

ANNUAL REPORTS: Botulism; *Escherichia coli*; Hepatitis A; Hepatitis C; Histoplasmosis; Legionella; Salmonella; Shigella
ANTIBIOTIC RESISTANCE: The Louisiana Antibiogram, 2005-2006
EPIDEMIOLOGY MANUAL: Cryptosporidiosis; Ehrlichiosis; Giardiasis Form: Influenza; Lyme Disease; Measles (Rubeola); Norovirus; Psittacosis; Rocky Mountain Spotted Fever; Rubella (German Measles); Sample Collection for Diagnosis of Rabies in Humans; Smallpox Revaccination
FOODBORNE: Peanut Butter Recall; *Salmonella typhimurium* Investigation
INFLUENZA: Weekly Report; U.S. CDC link
LOUISIANA MORBIDITY REPORT: Index 1982
PROFESSIONAL EDUCATION: List of the Most Popular IDES Web-Pages - July-December, 2008
PUBLIC INFORMATION: Norovirus
WEST NILE VIRUS: 2008 Summary Report
VETERINARY INFORMATION: Antimicrobial Sensitivity Profiles and Trends - 2008 - Canine, Equine and Feline

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

November - December, 2008

Table 1. Disease Incidence by Region and Time Period

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Nov-Dec 2008	Nov-Dec 2007	Jan-Dec Cum 2008	Jan-Dec Cum 2007	Jan-Dec % Chg*
Vaccine-preventable															
Hepatitis B	Cases	0	0	0	4	1	0	0	0	1	6	15	81	100	-19.0
	Rate[1]	0	0	0	0.8	0.4	0	0	0	0.3	0.1	0.3	1.9	2.3	NA*
Measles		0	0	0	0	0	0	0	0	0	0	0	1	0	NA*
Mumps		0	0	0	0	0	0	0	0	0	0	0	1	1	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		0	1	1	1	0	1	0	1	0	5	0	68	18	277.8
Sexually-transmitted															
HIV/AIDS	Cases[2]	32	20	1	9	3	2	8	5	4	84	176	1039	1152	-10.2
	Rate[1]	3.2	3.5	0.3	1.7	1.1	0.7	1.6	1.4	0.9	1.9	4.0	23.8	26.3	NA*
Chlamydia	Cases	595	317	217	400	160	162	530	403	195	3067	2635	22630	20012	13.1
	Rate[1]	85.9	49.5	54.1	69.7	56.3	54.1	99.7	115.3	37.9	71.5	61.5	527.8	466.7	NA*
Gonorrhea	Cases	213	101	57	216	63	66	225	170	52	1194	1469	9478	11447	-17.1
	Rate[1]	30.7	15.8	14.2	37.6	22.2	22.0	42.3	48.6	10.1	27.8	34.3	221.1	266.9	NA*
Syphilis (P&S)	Cases	5	5	1	12	7	2	28	11	5	94	76	631	547	15.4
	Rate[1]	0.7	0.7	0.2	2.1	2.5	0.6	5.3	3.1	0.9	2.2	1.8	14.7	12.8	NA*
Enteric															
Campylobacter		0	0	1	2	0	1	0	0	2	6	12	85	105	-19.0
Hepatitis A	Cases	0	0	1	0	0	0	0	0	0	1	1	11	28	-60.7
	Rate[1]	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.6	NA*
Salmonella	Cases	6	7	5	12	5	4	9	5	17	70	139	1004	978	2.7
	Rate[1]	0.6	1.2	1.3	2.3	1.9	1.3	1.8	1.4	4.4	1.6	3.2	23.3	22.7	NA*
Shigella	Cases	2	6	8	1	5	1	9	3	10	45	47	603	498	21.1
	Rate[1]	0.2	1.1	2.1	0.2	1.9	0.3	1.8	0.9	2.6	1.0	1.1	14.0	11.5	NA*
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other		1	0	1	0	0	0	0	0	0	2	2	44	28	57.1
Other															
H. influenzae (other)		2	0	0	0	1	0	0	0	0	3	7	11	13	NA*
N. Meningitidis		0	0	0	0	0	0	1	0	0	1	4	20	30	-33.3

[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.

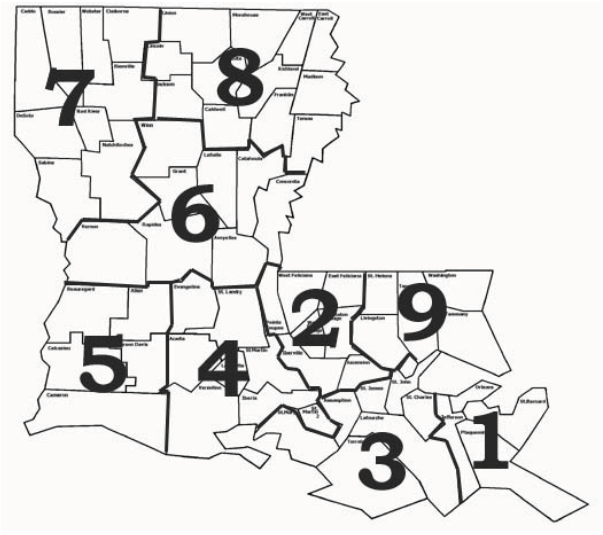
* Percent Change not calculated for rates or count differences less than 5

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

Disease	Total to Date
Legionellosis	10
Lyme Disease	3
Malaria	4
Rabies, animal	6
Varicella	20

Table 3. Animal rabies (November-December, 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)3
- 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)[3]
- 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
- Carbon Monoxide Exposure and/or Poisoning (All ages)[5]
- Complications of Abortion
- Congenital Hypothyroidism[4]
- Galactosemia[4]
- Hemophilia[4]
- Heavy Metal (Arsenic, Cadmium, Mercury) Exposure and/or Poisoning (All ages)[5]
- Lead Exposure and/or Poisoning (All ages)
- Pesticide-Related Illness or Injury (All ages)[5]
- Phenylketonuria[4]
- Reye's Syndrome
- Severe Traumatic Head Injury
- Severe Undernutrition (severe anemia, failure to thrive)
- Sickle Cell Disease (newborns)[4]
- 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 based 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.
[4]Report to the Louisiana HIV/AIDS Program: see www.hiv.dhh.louisiana.gov for regional contact information, or call 504-568-7474.
[5]Report to the Section of Environmental Epidemiology & Toxicology: www.seet.dhh.louisiana.gov or 888-293-7020.

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