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Louisiana Morbidity Report

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Animal Shelter Inspections Louisiana, 2009

Gary Balsamo, DVM MPH & TM

The Infectious Disease Epidemiology Section (IDES) of the Office of Public Health (OPH), Louisiana Department of Health and Hospitals, began a program of inspections of public animal shelters in Louisiana in the summer of 2009. The state public health veterinarian is the coordinator of the program, which was initiated at the request of and through an agreement with the Louisiana Animal Welfare Commission (LAWC).

LAWC, whose members are appointed by the governor, was authorized by the Louisiana Legislature in 2008 to inspect all public animal shelters in the state, both parish and municipal. A similar program has been in existence for some time in New Jersey. The administrators of the New Jersey program have been instrumental in providing guidance in the creation of the program. Additional guidance has been provided by members of the Louisiana Animal Control Association, Louisiana State University School of Veterinary Medicine's Shelter Improvement Program and several humane organizations throughout the state.

The inspections evaluate the shelters' physical facilities, staff, procedural protocols, and hygiene. Data regarding intake of animals, pets returned to owners, and euthanasia levels are collected. This information is transferred to LAWC, which, in turn, generates a written evaluation that is submitted to the shelters' governing body.

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2009 H1N1 Monovalent Vaccine - Louisiana

Frank Welch, MD; Ruben A. Tapia, MPH; Stacy Hall, MSN

The 2009 H1N1 monovalent vaccine was distributed to persons in the target groups across Louisiana. Supplies increased after some delays in production. Louisiana received from the federal government 1.4 % of manufactured vaccine. There were 2 types of vaccine, the live attenuated (LAIV), and the inactivated (MIV) vaccine being produced by 5 manufacturers. Each formulation was for a specific population.

Based on recommendations by the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices, providers were instructed to first administer the appropriate vaccine to persons in the following 5 target groups (order of target groups did not indicate priority):

- pregnant women
- persons who live with or provide care for infants younger than 6 months of age (e.g., parents, siblings, and daycare providers)
- health-care and emergency medical services personnel
- persons aged 6 months to 24 years
- persons aged 25 to 64 years who have medical conditions that put them at higher risk for influenza-related complications.

These 5 target groups comprised an estimated 160 million persons in the United States and approximately 1.6 million persons in Louisiana. The state developed a vaccine distribution plan with distribution targets based on national guidance and federal projections. The type and amount of vaccine that was available had directed allocations. Louisiana had ordered the full amount of vaccine available to the state on a weekly basis until all of the vaccine was allocated. Vaccine was shipped directly to the providers, with no vaccine being held at the state level. This process was similar to those routinely used by immunization programs to order seasonal influenza vaccine.

Initial vaccines (LAIV) were directed to large volume pediatric clinics and obstetrics/gynecological clinics (MIV). During the second week of allocation, additional pediatric clinics and Tier 1 hospitals were provided vaccine. By mid- to late-October, all hospitals and primary care offices requesting vaccine received an allocation. By the end of October, many clinics, federally qualified health clinics, rural health clinics, emergency medical services, home health agencies, parish health units, and mental health facilities received vaccine for persons in the target groups.

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Assessment of the Medical Special Needs Shelter for Hurricane Gustav Evacuees - Central Louisiana, 2008

Shirley Burton, MPH

Background

In Louisiana, evacuations of coastal and southern parishes as a result of impending hurricanes are a frequent occurrence; most of the evacuated population seeks shelter in the central and more northern parts of the state. In Central Louisiana (Public Health Region 6*, Alexandria area), emergency preparedness personnel are responsible for providing health services to a portion of the evacuated population at a Medical Special Needs Shelter (MSNS). The MSNS is a 24-hour operation that provides services, particularly medical care services, to a specified group of evacuees who cannot care for themselves due to impairments that may include, but are not limited to their mental, physical, or sensory abilities.

Effective management of a MSNS necessitates a coordinated effort between local, state, and federal entities, as well as specific community agencies such as health and social services, law enforcement, and community and volunteer organizations. In Region 6, the Department of Social Services and the Office of Public Health respectively oversee the management and staffing of the MSNS. Such an undertaking requires reliable material and personnel resources and can possibly be in operation for at least 1 week.

Morbidity among shelter occupants is usually diverse, posing a challenge for shelter management with regards to resource and personnel procurement. Acceptance into the MSNS is rooted in a triage system guided by evacuees' medical need and shelter capabilities and is on a first-come-first-served basis. Via a triage line, a decision for acceptance into the shelter is made for potential occupants of the MSNS. Assessments are also made onsite for evacuees who do not access the triage line.

During the 2008 hurricane season, 2 hurricanes (Gustav and Ike) made landfall in Louisiana, resulting in mass evacuation of the southern parishes. The results of an assessment of the MSNS population in Region 6 for the first of these hurricanes, Hurricane Gustav, are presented here.

Results

Information for this assessment was abstracted from shelter occupants' (shelterees) triage forms, shelter medical assessment forms and discharge check lists. Among the 398 evacuees who contacted the triage line, a total of 130 shelterees, along with their caregivers, were accepted into the MSNS. The shelterees came mostly from Region 1 - New Orleans (35%), Region 3 - Thibodeaux (29%), and Region 4 - Lafayette (20%). The mean age of the shelterees was 68.3 ± 17 years with most of them being female (44.6%). In addition, 60% of the shelterees had a caregiver, 66.2% had insurance and 80% indicated that they would be in possession of their medication upon arrival at the shelter. A majority of the shelterees (57%) came to the shelter from their homes via private transportation, or from hospice care (36.3%). The average length of stay for shelterees at the MSNS was 4.3 days. The wide variety of reported illnesses by shelterees and/or their caregivers were categorized into morbidity conditions (Table 1).

* Map of regions on page 7

Table 1: Frequency of Morbidity Conditions Reported for Shelterees Hurricane Gustav, 2008

| Morbidity Category For Reported Illnesses | † Number Reported Among Shelterees | Percent Among Shelterees |
|---|------------------------------------|--------------------------|
| Arthritis | 5 | 3.8 |
| Cancer | 4 | 3.1 |
| Cardiac Problems | 47 | 36.2 |
| Digestive Problems | 1 | 0.8 |
| Diabetes | 46 | 35.4 |
| Hypertension | 68 | 52.3 |
| Infection | 1 | 0.8 |
| Injury | 3 | 2.3 |
| Mental Impairment | 18 | 13.9 |
| Mobility Impairment | 34 | 26.2 |
| Neurological Impairment | 36 | 27.8 |
| Obesity | 2 | 1.5 |
| Recent Surgery | 8 | 6.2 |
| Renal Problems | 14 | 10.8 |
| Respiratory Problems | 33 | 25.4 |
| Sensory Impairment | 18 | 13.9 |
| Urinary Problems | 2 | 1.5 |
| Wound | 1 | 0.8 |
| Other | 16 | 12.3 |
| No Morbidity Listed | 2 | 1.5 |

† Many shelterees had multiple morbidity conditions.

Based on reported illness, shelterees were assigned to the following locations within the MSNS: cardiac (14.1%); dialysis (4.7%); general/minimal care (21.9%); mobility (26.6%); respiratory (31.3%); special care/treatment (1.6%).

Shelterees required both routine and daily care. Some of the daily requirements included breathing treatments, diabetic care, injections, dressing, special feeding, and special assistance. Routine care included blood pressure checks, wound care, blood sugar checks, oral medication, dialysis, and lab work. Equipment needs, particularly those for mobility purposes, were also major needs among shelterees, in addition to oxygen concentrators and nebulizers.

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Assessment results indicate that many occupants of the 2008 MSNS, due to their morbidity and/or disability conditions, signify a vulnerable population that requires comprehensive services for not only physical and/or physiological ailments, but also for mental health and disease management concerns. Consequently, the range of personnel as well as equipment and other medical resources is quite varied and securing such resources in a timely manner, especially during times of emergency, is not always feasible. Other challenges include accurate documentation and tracking of shelterees to ensure operation completeness and efficiency. Moreover, future planning efforts may need to consider developing a mental health section within the shelter as many of the shelterees, as reported, had mental impairments. Knowledge of these challenges can help to improve operation efficiency and future planning efforts that can only serve to enhance subsequent operations. Limitations identified by this assessment, as indicated by inconsistencies on the triage, medical assessment, and discharge check lists derived mostly from a lack of complete documentation of

shelterees' morbidity conditions, key arrival, and departure times as well as documentation of needed resources such as equipment, medication or even caregivers.

Conclusion

Despite the varying challenges of operating a MSNS for occupants with a wide range of multiple morbidity factors, shelter management in Region 6 will continue to work towards learning from past operations and fine-tuning plans for future operations. Undoubtedly, each hurricane season will pose new challenges and resource procurement will continue to vary. Moreover, volunteers on all levels as well as shelter staff with specific medical skills, will continue to be a valued asset at the MSNS. Subsequently, assessing hurricane shelter operations and using the lessons learned from each one can only serve to enhance regional emergency preparedness efforts that can benefit all stakeholders, especially the shelterees.

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Infant Car Seat Use - Louisiana, 1998-2004

Amber Haynes, MPH; Lillian Funke, MPH; Tri Tran, MD, MPH

Background

The national rate of child restraint use is 97.5% among infants and toddlers. There is no state specific data for car restraint system (CRS) use among infants. The objectives of this study were to describe the trend and racial disparity between Blacks and Whites of not utilizing infant CRS most of the time in Louisiana from 1998 to 2004.

Methods

The study used the 1998-2004 Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS) for data analysis. Only Black and White women were included in the study. Women whose babies died or whose infants were not living with them were excluded from the analysis. Logistic regression was used to evaluate racial disparity and the trend of not utilizing an infant car seat (NUICS) over 7 years from 1998 to 2004. One-sided testing was used when determining statistical significance of the trends. The mother's social, economic and demographic characteristics, health behavior, and prenatal care counseling for seat belt usage were controlled for in the multiple logistic regression model. SAS-callable SUDAAN 9.1 was used for data analysis.

Results

In general, the prevalence of NUICS among infants was very low in Louisiana, 0.87% between 1998 and 2004. Over the 7 years included in the study, the prevalence NUICS decreased by 12% each year. Black mothers were 4.61 times more likely to report NUICS than white mothers. The trend of NUICS decreased annually by 25% for Whites from 1998 to 2004. There was no significant trend of NUICS in Blacks. Additionally, maternal education and prenatal care counseling on seat belt use were significantly associated with NUICS (Tables 1, 2 and 3).

Table 1. Trend (%) of Not Utilizing a Car Seat Most of the Time by Race LaPRAMS, 1998-2004

| Years | Total | | Black | | White | |
|-----------|---------|-----------|---------|-----------|---------|-----------|
| | Percent | 95% CI | Percent | 95% CI | Percent | 95% CI |
| 1998-2004 | 0.87 | 0.70-1.08 | 1.61 | 1.24-2.08 | 0.37 | 0.25-0.55 |
| 1998 | 1.43 | 0.92-2.21 | 2.29 | 1.29-4.04 | 0.84 | 0.44-1.61 |
| 1999 | 1.16 | 0.73-1.86 | 1.76 | 0.96-3.20 | 0.75 | 0.3-1.59 |
| 2000 | 0.68 | 0.35-1.30 | 1.6 | 0.83-3.07 | 0.00 | 0.00-0.01 |
| 2001 | 0.74 | 0.42-1.31 | 1.2 | 0.59-2.42 | 0.43 | 0.17-1.11 |
| 2002 | 0.62 | 0.30-1.26 | 1.19 | 0.52-2.71 | 0.23 | 0.06-0.91 |
| 2003 | 0.89 | 0.47-1.69 | 1.9 | 0.92-3.90 | 0.25 | 0.07-0.94 |
| 2004 | 0.54 | 0.26-1.14 | 1.27 | 0.56-2.85 | 0.11 | 0.02-0.63 |

Table 2. Adjusted Trend of Infants Riding Without a Car Seat LaPRAMS, 1998-2004

| Race | Odds Ratio* | 95% CI | P-Value |
|-------|-------------|-----------|---------|
| Total | 0.88 | 0.80-0.98 | 0.0248 |
| White | 0.75 | 0.62-0.91 | 0.0068 |
| Black | 0.93 | 0.83-1.05 | 0.1737 |

* Odds ratios of infants riding without car seat of current year to the previous year.

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Vaccination Coverage Among Adolescents Aged Thirteen to Seventeen Years - Louisiana and the United States, 2008

Excerpted from the MMWR – September 18, 2009/ 58(36); 997-1001 “National, State and Local Area Vaccination Coverage Among Adolescents Aged 13-17 Years - United States, 2008”

In recent years, the Advisory Committee on Immunization Practices (ACIP) has recommended 3 newly licensed vaccines: meningococcal conjugate vaccine (MCV4; 1 dose); tetanus, diphtheria, acellular pertussis vaccine (Tdap; 1 dose); (for girls) quadrivalent human papillomavirus vaccine (HPV4; 3 doses). ACIP also recommends that adolescents receive recommended vaccinations that were missed during childhood: measles, mumps, rubella vaccine (MMR; 2 doses); hepatitis B vaccine (HepB; 3 doses); varicella vaccine (VAR; 2 doses). Since 2006, the Centers for Disease Control and Prevention (CDC) has conducted the National Immunization Survey-Teen (NIS-Teen) to estimate vaccination coverage from a national sample of adolescents aged 13 to 17 years.

The vaccination information for the latest survey was collected on those born between January 1990 and February 1996 nationwide using a random-digit-dialed sample of household telephone numbers. After parents/guardians granted permission, surveys were mailed to all of the adolescents' vaccination providers identified by the parents/guardians to obtain vaccination histories.

Substantial differences were observed in vaccination coverage estimates among states and local areas. Louisiana was 1 of the states listed with coverage at greater than 50% for at least 1 of the 3 vaccines, (≥1 dose of MCV4, Table 1).

Table 1: Estimated Vaccination Coverage Among Adolescents Aged Thirteen to Seventeen Years, By Selected Areas and Selected Vaccines and Doses National Immunization Survey-Teen, Louisiana and the United States, 2008

| | Vaccine Doses Routinely Recommended During Childhood | | | | | | Vaccine Doses Routinely Recommended for Adolescents | | | | | | | |
|----------------------|--|-------------|---------|-------------|--------|-------------|---|-------------|---------|-------------|---------|-------------|---------|-------------|
| | (Adolescent Catch-up Vaccines) | | | | | | | | | | | | | |
| | ≥2 MMR | | ≥3 HepB | | ≥1 VAR | | ≥1 Td or Tdap | | ≥1 Tdap | | ≥1 MCV4 | | ≥1 HPV4 | |
| | % | (95% CI)** | % | (95% CI) | % | (95% CI) | % | (95% CI) | % | (95% CI) | % | (95% CI) | % | (95% CI) |
| United States | 89.3 | (88.4-90.2) | 87.9 | (86.9-88.8) | 81.9 | (80.2-83.5) | 72.2 | (70.8-73.4) | 40.8 | (39.3-42.3) | 41.8 | (40.3-43.2) | 37.2 | (35.2-39.3) |
| Louisiana | 89.0 | (84.8-92.2) | 85.1 | (80.3-88.9) | 68.9 | (57.3-78.6) | 74.9 | (69.3-79.8) | 35.3 | (29.8-41.3) | 53.6 | (47.5-59.6) | 36.6 | (28.3-45.6) |

** Confidence interval

Infant Car Seat ... Continued from page 3

Table 3. Variables Associated with Infants Riding without a Car Seat LaPRAMS, 1998-2004

| Variables | Odds Ratio | 95% CI | P-Value |
|---|------------|-----------|---------|
| Maternal Race | | | |
| Black | 4.61 | 2.87-7.40 | 0.0000 |
| White | 1.0 | | |
| Maternal Education | | | |
| Less Than High School | 2.29 | 1.46-3.58 | 0.0003 |
| High School or More | 1.0 | | |
| Health Care Worker Talked To Mothers About Using Seatbelt During Prenatal Care | | | |
| No or No Prenatal Care | 2.33 | 1.46-3.70 | 0.0004 |
| Yes | 1.0 | | |

Conclusions

In January 2002, Louisiana enacted a state law requiring infants or children under 20 pounds to be restrained in a rear-facing child safety seat; this may account for some of the decline of NUICS in the overall population. State funding for education programs aimed at populations at risk for NUICS (e.g., Blacks), increasing awareness of injuries resulting from NUICS, enforcement of the Louisiana State Child Occupant Protection Law and increasing routine child safety seat check sites could increase car seat use as well as reduce infant mortality and/or morbidity due to motor vehicle accidents statewide.

For more information, please contact Dr. Tran at (504) 568-3519 or e-mail tri.tran@la.gov.

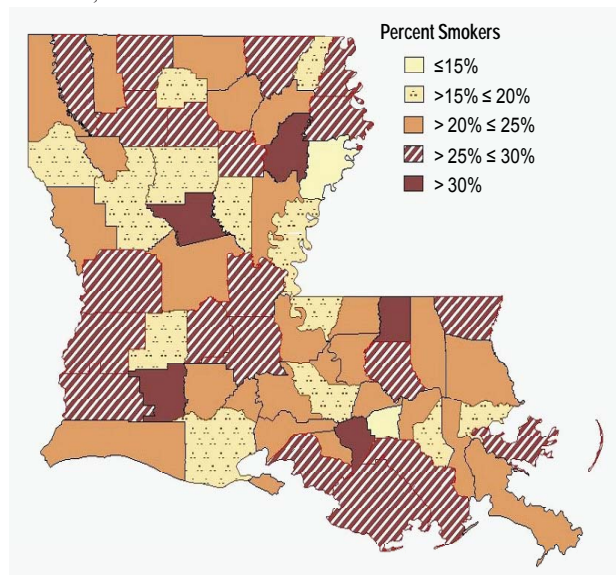
Tobacco Use - Behavioral Risk Factor Survey Louisiana, 2004-2006*

Todd Griffin, MSPH

According to the Behavioral Risk Factor Survey (BRFSS), nearly 1 out of every 4 residents in Louisiana smokes. BFRSS is a method of data acquisition utilizing phone surveys and questionnaires solicited from Louisianians aged 18 years and older. All of the data were analyzed using Microsoft Excel and SAS version 9.1.3 software.

Using the data for 2006, an estimated 787 986 Louisiana residents were current smokers. A geographic representation can be seen in Figure 1.

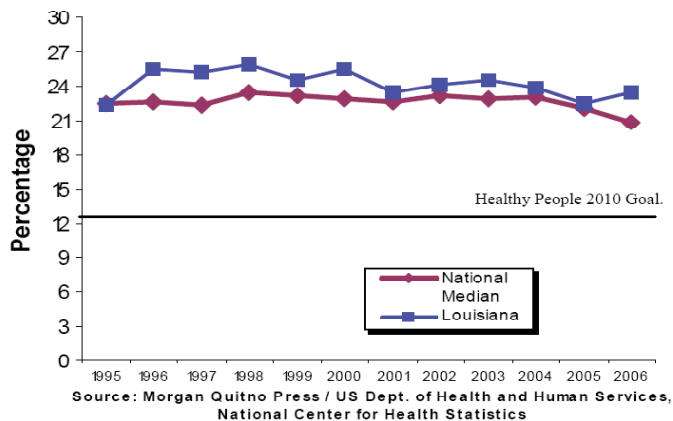
Figure 1: Prevalence of Current Smokers by Parish Louisiana, 2004-2006



Men were more likely to smoke when compared to women, and there were similar rates for current smokers among race groups. Louisiana residents that did not receive a high school diploma had the highest prevalence of smoking when compared to those with a higher level of education. Residents with reported household incomes of less than \$25 000 per year had the highest prevalence of smoking when compared to households with a greater income level. Louisiana residents who indicated that they were unable to work or were unemployed had higher rates of smoking compared to other categories related to employment. There were more males in Louisiana that indicated that they were former smokers than females in 2006. More Whites claimed to be former smokers (23%) when compared to Blacks (13.8%). Those that indicated that they were disabled due to emotional, physical, or mental causes had a higher prevalence (27.5%) for smoking compared to those who were not disabled (22.2%).

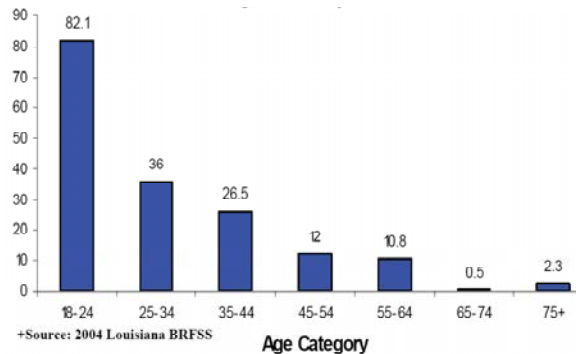
Rates for smoking have steadily decreased since 2003, however, the smoking rate in 2006 for Louisiana residents (23.4%) was still higher than the national median (20.8%). (Figure 2)

Figure 2: Prevalence of Adult Smokers - Louisiana and U.S. Residents, 1995-2006



Results from the 2004 Louisiana BRFSS show that an estimated 105 800 Louisiana residents have attempted to quit smoking within the year. As expected, the prevalence of former smokers increases with age. The proportion of smokers that attempt to quit is very high in the younger age group (82% in the 18-24 year group). This proportion increases with age (Figure 3).

Figure 3: Percentage of Residents That Attempted to Quit Smoking Within a Year - Louisiana, 2004



* Excerpted from the Behavioral Risk Factor Survey, 2004-2006 Department of Health and Hospitals, Chronic Disease / Tobacco; see full article at <http://www.dhh.louisiana.gov/offices/publications/pubs-245/7056.pdf>

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Animal Shelter Inspections ... Continued from page 1

The purpose of the reports is to make municipal and parish governments aware of the conditions present in respective animal shelters and to suggest improvements. At present, LAWC has no authority to impose sanctions on shelters with deficiencies, but, adhering to LAWC's original mission of ensuring and promoting the proper treatment and well-being of animals, the commission's hope is to facilitate improvements over time.

IDES is involved out of a desire to further improve the state-wide rabies surveillance program, which OPH administers. Public animal shelters often serve as rabies observation stations, permitting public health officials time to assess dogs, cats, or ferrets for the possibility of transmission of rabies to human bite victims. Effective quarantine of these animals results in substantial savings in medical costs, often eliminating the need for rabies post-exposure

prophylaxis. Additionally, IDES is interested in evaluating the disease burden in Louisiana shelters and characterizing the incidence of shelter associated zoonotic diseases. IDES is also a source of information to shelter management regarding infection control and hygiene.

LAWC will provide the governor's Office of Community Programs and the Louisiana Legislature with an annual report summarizing the status of animal shelters within the state. The ultimate goal of the program is to improve shelters in Louisiana by informing municipal, parish, and state leadership of present conditions and helping to educate the public on the importance of efficient, hygienic and humane shelters to Louisiana's communities.

For more information, please contact Dr. Balsamo at (504)219-4593 or e-mail gary.balsamo@la.gov.

Tobacco Use ... Continued from page 5

Smoking seems to begin with younger age groups. The majority of Louisiana residents claimed to have their first smoke between the ages of 12 and 17 years.

Examining the responses for secondhand policies within households in 2006, 19.2% of residents in Louisiana allow smoking within their households. This percentage has decreased since the question was asked in the 2003 survey in which 26.1% of the respondents stated that smoking was allowed within their households. Louisiana residents that work indoors indicated that 17% of workplaces allowed smoking in indoor designated areas (lobbies, restrooms, or lunch rooms), and 3% of the work environments allowed smoking in all areas.

According to the results from the 2004 BRFSS, 15.3% of the adult population has used smokeless tobacco at least once in their lifetimes. Overall, 4% of Louisiana residents in 2004, used smokeless tobacco products on a regular basis.

Summary

Cigarette smoking causes heart disease, several kinds of cancer and respiratory diseases among U.S. residents. Tobacco alone is responsible for more than 430 000 deaths per year among adults living in the United States. Medical costs related to smoking exceed \$75.5 billion dollars per year, and costs related to smoking during pregnancy are estimated to be \$1.4 billion dollars per year. Each year exposure to secondhand smoke causes an estimated 3000 deaths among nonsmokers and causes lower respiratory tract infections for 150 000 to 300 000 infants in the United States.

Prevention programs should note that:

- smoking rates are higher among households with lower incomes, and residents without a high school diploma or GED
- smoking is more likely to begin between the ages of 12 and 17 years
- younger age groups are more likely to attempt to quit smoking when compared to older age groups.

For references or more information, please contact Todd Griffin at (225) 342-2027 or e-mail todd.griffin@la.gov.

Announcements

Columbia University professor John Mutter is interested in documenting indirect deaths that could be considered related to Hurricane Katrina. For more information go to <http://www.dhh.louisiana.gov/offices/miscdocs/docs-249/HurKat%20study.pdf>.

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

ANNUAL REPORTS: Cryptococcus; Cyclosporiasis; Guillain-Barré Syndrome

EPIDEMIOLOGY MANUAL: Botulism Summary; Creutzfeldt Jacob Disease; Hepatitis A Summary (2); Hepatitis B Summary; Hepatitis C Summary; Meningitis Summary; Rabies Summary; Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection (MMWR); Shigella Summary

HEALTH CARE ASSOCIATED GRANT: Health Care Associated Infection Definitions; Health Care Associated Infection Rates; ICD-9 Code Sheet; National Healthcare Safety Network (NHSN) Enrollment Guide; IDES NHSN Quick Guide; NHSN Procedure-Associated Module; NHSN Healthcare Personnel Safety Component; NHSN Biovigilance Component

INFLUENZA: Respirator Fit Testing; Weekly Report

H1N1 Vaccine ... Continued from page 1

In early November, vaccine providers included universities, retail pharmacies, and Department of Public Safety and Correction facilities. At that time, there were 816 providers of 2009 H1N1 vaccine in Louisiana. There are over 2000 providers requesting vaccine through the Louisiana Immunization Network for Kid Statewide (LINKS) system. School-based vaccination campaigns began in mid-November.

The number of doses of H1N1 vaccine in Louisiana exceeded 1 million. Decisions about expanding vaccination to include additional populations beyond the 5 initial target groups was made by the DHH executive leadership team following national recommendations. There was enough 2009 H1N1 flu vaccine for anyone who chose to get vaccinated. The website www.fighttheflu.com provided helpful guidance and current information.

Table. Communicable disease surveillance, incidence by region and time period, September-October, 2009

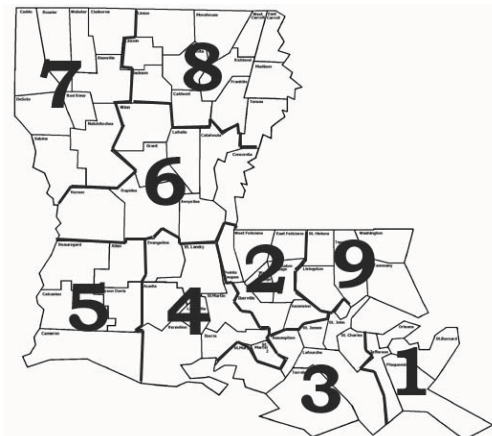
| DISEASE | HEALTH REGION | | | | | | | | | | TIME PERIOD | | | | |
|-----------------------------------|---------------|------|------|------|------|------|-------|-------|------|-----------------|-----------------|------------------------|------------------------|--------------|--|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Sep-Oct 2009 | Sep-Oct 2008 | Jan-Oct Cum 2009 | Jan-Oct Cum 2008 | Jan-Oct % | |
| Vaccine-preventable | | | | | | | | | | | | | | | |
| Hepatitis B Cases | 7 | 1 | 2 | 1 | 0 | 1 | 2 | 2 | 3 | 19 | 16 | 61 | 79 | -22.8 | |
| Hepatitis B Rate ¹ | 0.7 | 0.2 | 0.5 | 0.2 | 0 | 0.3 | 0.4 | 0.6 | 0.8 | 0.4 | 0.4 | 1.4 | 1.8 | NA* | |
| Measles | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 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 | 2 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 4 | 13 | 121 | 65 | 86.2 | |
| Sexually-transmitted | | | | | | | | | | | | | | | |
| HIV/AIDS Cases ² | 31 | 21 | 4 | 11 | 5 | 9 | 12 | 5 | 14 | 112 | 202 | 1018 | 982 | 3.7 | |
| HIV/AIDS Rate ¹ | 3.1 | 3.6 | 1.0 | 2.0 | 1.8 | 3.0 | 2.4 | 1.4 | 3.2 | 2.6 | 4.6 | 23.3 | 22.5 | NA* | |
| Chlamydia Cases ³ | 723 | 496 | 275 | 386 | 154 | 221 | 540 | 466 | 280 | 3611 | 3928 | 23590 | 19077 | 23.7 | |
| Chlamydia Rate ¹ | 104.4 | 77.4 | 68.5 | 67.3 | 54.2 | 73.8 | 101.6 | 133.3 | 54.5 | 84.1 | 91.5 | 549.5 | 444.4 | NA* | |
| Gonorrhea Cases ³ | 255 | 106 | 62 | 139 | 37 | 60 | 227 | 168 | 69 | 1138 | 1599 | 7640 | 8125 | -5.9 | |
| Gonorrhea Rate ¹ | 36.8 | 16.5 | 15.5 | 24.2 | 13.0 | 20.0 | 42.7 | 48.1 | 13.4 | 26.5 | 37.2 | 178.0 | 189.3 | NA* | |
| Syphilis (P&S) Cases ³ | 4 | 4 | 1 | 19 | 5 | 0 | 16 | 1 | 7 | 57 | 132 | 580 | 522 | 11.1 | |
| Syphilis (P&S) Rate ¹ | 0.6 | 0.6 | 0.2 | 3.3 | 1.8 | 0 | 3.0 | 0.3 | 1.4 | 1.3 | 3.1 | 13.5 | 12.2 | NA* | |
| Enteric | | | | | | | | | | | | | | | |
| Campylobacter Cases | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 5 | 3 | 11 | 14 | 82 | 79 | 3.8 | |
| Hepatitis A Cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 3 | 5 | 10 | -50.0 | |
| Hepatitis A Rate ¹ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.3 | 0 | 0 | 0.1 | 0.1 | 0.2 | NA* | |
| Salmonella Cases | 28 | 23 | 26 | 25 | 13 | 11 | 23 | 42 | 56 | 247 | 271 | 965 | 1003 | -3.8 | |
| Salmonella Rate ¹ | 2.7 | 4.0 | 6.9 | 4.8 | 4.9 | 3.6 | 4.5 | 12.0 | 14.5 | 5.7 | 6.3 | 22.4 | 23.2 | NA* | |
| Shigella Cases | 4 | 1 | 0 | 0 | 1 | 2 | 3 | 1 | 1 | 13 | 93 | 158 | 582 | -72.9 | |
| Shigella Rate ¹ | 0.4 | 0.2 | 0 | 0 | 0.4 | 0.7 | 0.6 | 0.3 | 0.3 | 0.3 | 2.2 | 3.7 | 13.5 | NA* | |
| Vibrio cholera Cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | NA* | |
| Vibrio, other Cases | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 8 | 43 | 42 | NA* | |
| Other | | | | | | | | | | | | | | | |
| <i>H. influenzae</i> | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | 1 | 16 | 9 | 77.8 | |
| <i>N. Meningitidis</i> | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 4 | 2 | 15 | 19 | 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 the 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.

³ = Data should be considered provisional.

Figure. Department of Health and Hospitals regional map



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

Table 2. Diseases of Low Frequency, January-December, 2009

| Disease | Total to Date |
|----------------|---------------|
| Legionellosis | 8 |
| Lyme Disease | 1 |
| Malaria | 5 |
| Rabies, animal | 4 |
| Varicella | 128 |

Table 3. Animal Rabies, September-October, 2009

| Parish | No. Cases | Species |
|------------|-----------|---------|
| Calcasieu | 2 | Bat |
| Vermillion | 1 | Bat |

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 Twenty-Four Hours

Diseases of major public health concern because of the severity of disease and potential for epidemic spread-report by telephone immediately upon recognition that a case, a suspected case, or a positive laboratory result is known; [in addition, all cases of rare or exotic communicable diseases, unexplained death, unusual cluster of disease and all outbreaks shall be reported.

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

Class B Diseases/Conditions - Reporting Required Within One Business Day

Diseases of public health concern needing timely response because of potential of epidemic spread-report by the end of the next business day after the existence of a case, a suspected case, or a positive laboratory result is known.

| | | |
|--|---|---------------------------|
| Arthropod-Borne Neuroinvasive Disease and other infections (including West Nile, St. Louis, California, Eastern Equine, Western Equine and others) | Hemolytic-Uremic Syndrome | Pertussis |
| Aseptic meningitis | Hepatitis A (acute disease) | Salmonellosis |
| Chancroid ¹ | Hepatitis B (acute illness & carriage in pregnancy) | Shigellosis |
| Escherichia coli, Shig-toxin producing (STEC), including E. coli 0157:H7 | Hepatitis B (perinatal infection) | Syphilis ¹ |
| Hantavirus Pulmonary Syndrome | Hepatitis E | Tetanus |
| | Herpes (neonatal) | Tuberculosis ² |
| | Legionellosis (acute disease) | Typhoid Fever |
| | Malaria | |
| | Mumps | |

Class C Diseases/Conditions - Reporting Required Within Five 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 | Gonorrhea ¹ | Staphylococcal Toxic Shock Syndrome |
| Blastomycosis | Hansen Disease (leprosy) | Streptococcal disease, Group A (invasive disease) |
| Campylobacteriosis | Hepatitis B (carriage, other than in pregnancy) | Streptococcal disease, Group B (invasive disease) |
| Chlamydial infection ¹ | Hepatitis C (acute illness) | Streptococcal Toxic Shock Syndrome |
| Coccidioidomycosis | Hepatitis C (past or present infection) | Streptococcus pneumoniae, penicillin resistant [DRSP], invasive infection] |
| Cryptococcosis | Human Immunodeficiency Virus (HIV Syndrome infection) ³ | Streptococcus pneumoniae (invasive infection in children < 5 years of age) |
| Cryptosporidiosis | Listeria | Transmissible Spongiform Encephalopathies |
| Cyclosporiasis | Lyme Disease | Trichinosis |
| Dengue | Lymphogranuloma Venereum ¹ | Varicella (chickenpox) |
| Ehrlichiosis | Psittacosis | Vibrio Infections (other than cholera) |
| Enterococcus, Vancomycin Resistant [(VRE), invasive disease] | Rocky Mountain Spotted Fever (RMSF) | |
| Giardia | Staphylococcus Aureus, Methicillin/Oxacillin Resistant [(MRSA), invasive infection] | |

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

| | | |
|---|---|--|
| Cancer | Heavy Metal (Arsenic, Cadmium, Mercury) Exposure and/or Poisoning (All ages) ⁵ | Severe Traumatic Head Injury |
| Carbon Monoxide Exposure and/or Poisoning (All ages) ⁵ | Lead Exposure and/or Poisoning (All ages) ⁵ | Severe Undernutrition (severe anemia, failure to thrive) |
| Complications of Abortion | Pesticide-Related Illness or Injury (All ages) ⁵ | Sickle Cell Disease (newborns) ⁴ |
| Congenital Hypothyroidism ⁴ | Phenylketonuria ⁴ | Spinal Cord Injury |
| Galactosemia ⁴ | Reye's Syndrome | Sudden Infant Death Syndrome (SIDS) |
| Hemophilia ⁴ | | |

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>.

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

²Report on CDC72.5 (f.5.2431) card.

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

⁴Report to the Louisiana HIV/AIDS Program: see www.hiv.dhh.louisiana.gov for regional contact information, or call 504-568-7474.

⁵Report to the Section of Environmental Epidemiology & Toxicology: www.seet.dhh.louisiana.gov or 888-293-7020.

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