STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
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May-June 2010 **Volume 21 Number 3**

Norovirus Outbreak Investigation Raw Oyster Consumption - Gulf Coast - Spring, 2010

Erin Delaune, MPH

Background:

This is a report of multiple norovirus outbreaks that were associated with raw oyster consumption occurring during the Spring of 2010.

A) The Mississippi Outbreak

In mid-March, approximately 60 participants at a conference in Ocean Springs attended a dinner where raw oysters from Louisiana were served. During the next 2 days, there were numerous reports of illness. The investigation carried out by the Mississippi Department of Health showed a 45% attack rate (11/24) among those who ate raw oysters and only 4% among those who did not eat raw oysters, an odds ratio of 20.3 (significant at p=0.0006). Stools were collected and oysters were sent to the U.S. Food and Drug Administration (FDA) laboratory at Dolphin Island. Both the stools and the oyster meat were later shown to harbor noroviruses by reverse transcription polymerase chain reaction (RT-PCR) detection. Within 24 hours of learning of the outbreak and its association with consumption from oysters, the production area (Area #7) was closed and its oysters recalled by the Louisiana Office of Public Health (OPH) (Figure).

B) Restaurant

Two weeks later, the Infectious Disease Epidemiology Section (IDES) of OPH was notified by an oyster distributor that restaurant patrons were complaining of getting sick after eating oysters during the previous 2 days. Among the 15 patrons with illness, 14 had eaten raw oysters at the bar (an attack rate of 93%). For lack of controls, an odds ratio could not be calculated. Given that these 14 sick persons only had raw oyster consumption as a common exposure, it was concluded that the oysters were the cause of the outbreak and Area #3 where they came from, was promptly closed on March 25th. Only one stool sample was collected and it contained norovirus.

The Oyster Task Force was contacted and informed about the spread of norovirus throughout Louisiana. The Task Force was asked to talk to oyster harvesters and encourage them to not discharge human sewerage over board.

For all of these outbreaks, the incubation period ranged from 19 to 34 hours (with a mean of 25 hours). Symptom duration ranged from 5 to 60 hours (with a mean of 17 hours). The main symptoms were nausea, vomiting and diarrhea. No one was hospitalized. The incubation period and clinical presentation were typical of norovirus infections.

C) Wedding

At the end of March, IDES was notified of a gastrointestinal outbreak that occurred in association with a wedding that was held in New Orleans two days before. Raw oysters were served at the reception. Out of 250 guests, 40 were ill. The investigation showed an attack rate of 70% among those who ate raw oysters and 0% among those who did not eat raw oysters. The odds ratio could not be calculated because a cell in the table was 0 but the Fishers' exact test was extremely significant (p=0.0000012). Three stools were collected and returned positive for norovirus. The oysters came from Area #13 which was closed two days after the IDES notification.

D) Wedding

At the end of March, a guest at a wedding (that took place one week earlier), alerted by the press reports of oyster closures, reported that guests that consumed raw oysters had been sick. A few guests were contacted. The attack rate among raw oyster consumers was 100% and 0% among non- oyster consumers. Again, Fisher's exact test showed a very significant association (p=0.0003). No stools were collected due to the long delay in reporting. The oysters had come from Area #3 but were consumed before the closure of that area.

Other Reports

Following the publicity given to oyster bed closures, there were 11 reports of gastro-enteritis following consumption of raw oysters at restaurants. No outbreaks could be substantiated because these

(Continued on page 5)

Contents

Unintentional Falls Among Older Adults - Louisiana, 2007

Mariella Gastañaduy, MPH

Introduction

Unintentional falls are a common occurrence among older adults, affecting approximately 30% of people 65 years and older each year. The injuries received from a fall can result in death, hospital admission, disability, psychological consequences (e.g. fear of falling),and direct medical costs.

This study examines the epidemiology of unintentional falls that resulted in hospital admission or death among older adults, aged 65 and older, in Louisiana, 2007.

Methods:

Unintentional fall related hospitalization and death cases were abstracted from the 2007 Louisiana's Inpatient Hospital Discharged data (LAHIDD), and 2007 death certificate data, respectively. Frequencies, percentages and rates were calculated for demographic characteristics as well as for place of injury, discharged status, length of stay and direct cost. All data analysis was conducted using SAS version 9.1.

Results/Discussion:

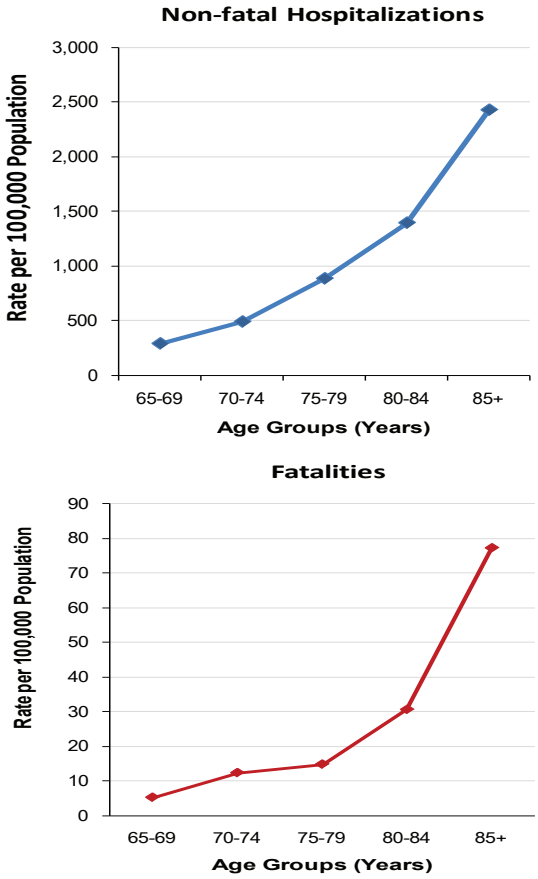
In 2007, unintentional falls were the leading cause of unintentional injury hospitalizations (n=4,661), and deaths (n=114) among older adults, surpassing motor vehicle traffic crashes, poisonings and suffocations (Table 1).

Table 1: Unintentional Injury-related Hospitalizations and Deaths Among Older Adults - Louisiana, 2007

Rank	Non-Fatal Injury Hospitalizations	Fatal Injuries
1	**Falls 4,661**	**Falls 114**
2	MV Traffic 289	Not Specified 106
3	Not Specified 204	MV Traffic 95
4	Poisonings 177	Suffocation 45
5	Struck by/against 83	Fire/Flame 31

Both hospitalization and death rates increased dramatically with age, with hospitalization rates ranging from 290.5 to 2,425.2 per 100,000 population and death rates ranging from 5.1 to 77.2 per 100,000 (Figure 1).

Figure 1: Unintentional Fall-related Hospitalization and Death Rates, by Age Groups - Louisiana, 2007



Additionally, hospitalization rates were higher in White females (1,221.1 per 100,000 population), and highest in Office of Public Health (OPH) Regions 9* and 2 (1,314.9 and 1,231.9 per 100,000 population). Deaths rates were slightly higher in White males (27.5 per 100,000 population), and highest in OPH Regions 8 and 9 (40.3 and 40.2 per 100,000 population) (Figure 2 and Tables 2 and 3).

** Map of Regions on Page 7*

Louisiana Morbidity Report

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Figure 2: Unintentional Fall-related Hospitalization and Death Rates Among Older Adults, by Gender & Race – Louisiana, 2007

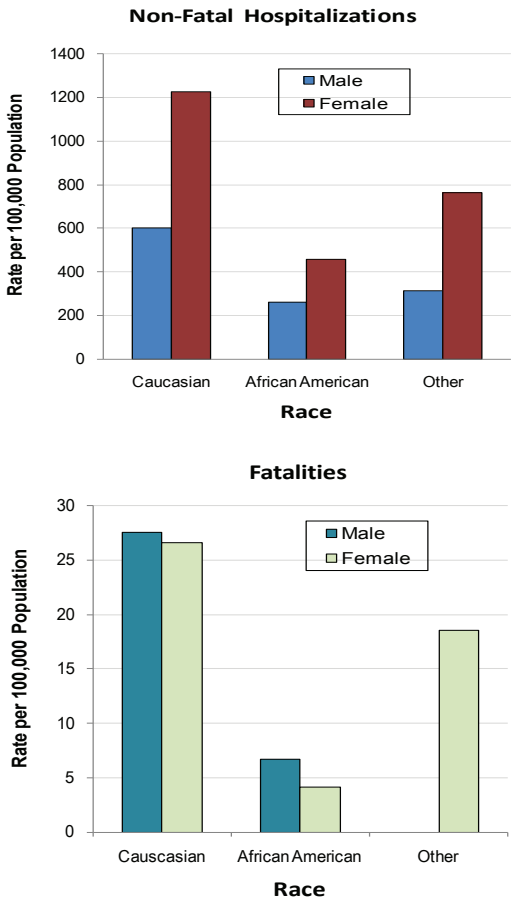


Table 2: Unintentional Fall-related Hospitalization Rates by OPH Region of Residence, Older Adults - Louisiana, 2007

Region	Number	Percent (%)	Rate
1	820	17.6	889.3
2	819	17.6	1,231.9
3	306	6.6	694.1
4	526	11.3	777.6
5	214	4.6	598.3
6	395	8.5	1,010.0
7	323	6.9	444.8
8	421	9.0	892.8
9	753	16.2	1,314.9
Missing	84	1.8	
Total	**4661**	**100**	

Table 3: Unintentional Fall-related Death Rates by OPH Region of Residence, Older Adults - Louisiana, 2007

Region	Number	Percent (%)	Rate
1	9	7.9	9.8
2	11	9.7	16.5
3	7	6.1	15.9
4	9	7.9	13.3
5	--	3.5	11.2
6	7	6.1	17.9
7	25	21.9	34.4
8	19	16.7	40.3
9	23	20.1	40.2
Total	**114**	**100.0**	

The data also showed that most fatal falls occurred in a home or a residential institution (n=77, 67.6%), and that most patients admitted to a hospital due to a fall, were discharged to another institution for further care (n=4,027, 86.9%). Additionally, for those hospitalized, the median length of stay was 5 days, while the median cost was $25,081, totaling approximately $140 million dollars in 2007.

Conclusion:

Falls are a serious problem facing older adults in Louisiana and the OPH – Injury Research and Prevention Program (IRP), along with the Louisiana Falls Coalition, is working towards implementing prevention programs, such as *Matter of Balance* and *Stepping On* that will reduce the risk and fear of falling among older adults. In addition, in future reports, other sources of data (e.g. emergency department and community level data) may be accessed, in order to see the true scope of the problem.

For references or more information please contact Ms. Mariella Gastanaduy at (504) 599-0221 or by e-mail *mariella.gastanaduy@la.gov* or Ms. Lynn Watson at (504) 568-7706 or by e-mail at *lynn.watson@la.gov*.

Save the Date! - October 1, 2010

New Orleans Viral Hepatitis Summit

For more informaton, see the 'Events' section on web page *http://www.dhh.louisiana.gov/offices/?ID=249*

Announcements

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

ANNUAL REPORTS: HIV/AIDS

EPIDEMIOLOGY MANUAL: Anthrax Summary; Environmental Cleaning and Disinfection of Viral Gastroenteritis Norovirus Guidelines; Listeria Case Form; Q Fever; Quarentine/Isolation Order; Reportable Diseases

FOODBORNE/WATERBORNE: Alfafa Sprouts Recall; Recreational Water Brochure - English and Spanish Versions

INFLUENZA: Weekly Report

VETERINARY: Contact Information for Ordering Rabies Vaccines

Relationship Between Pregnancy Intention and Fruit and Vegetable Consumption, Prams - Louisiana, 2004

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

Background

Pregnancy intention has been to known to correlate to maternal health habits throughout pregnancy. Maternal diet, specifically maternal fruit and vegetable consumption, heavily influences maternal and fetal outcomes. No previous studies have evaluated the effect of pregnancy intention on maternal diet. The purposes of this study were (1) to describe the status of daily consumptions of fruits or vegetables during pregnancy in different subgroups of the study population and (2) to determine a relationship between pregnancy intention and daily intake of fruits or vegetables during pregnancy.

Methods

The study used data collected from the 2004 Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS). The responses of 1,628 (68.3%) of 2,384 women sampled were analyzed. Multiple logistic regression was used to determine association between pregnancy intention and maternal fruit or vegetable consumption during pregnancy, controlling for mother's social and economic status, demographic characteristics, health behaviors during pregnancy and previous birth outcomes. SAS-callable SUDAAN 9.1 was used for data analysis.

Results

In general, prevalence of eating less than the daily recommended servings (ELTDRS) of fruits or vegetables (less than 5 servings), was still very high in Louisiana, which was 91% in 2004. Mothers reporting mistimed pregnancies were approximately 2 times more likely to eat less than the daily recommended servings of fruits or vegetables during the last 3 months of pregnancy than mothers reporting unwanted pregnancies. Data did not show statistical difference of ELTDRS between women with intended pregnancy and women with unwanted pregnancy. (Tables 1 and 2)

Table 1: Prevalence of eating less than the daily recommended servings of fruits or vegetables during last three months of pregnancy LaPRAMS, 2004

Variables		Number	Percent	95% CI
Pregnancy Intention	Intended	763	91.14	88.49-93.22
	Mistimed	543	92.86	89.87-95.01
	Unwanted	245	84.93	78.99-89.41
Smoking in Last 3 Months of Pregnancy	No	1315	90.51	88.47-92.23
	Yes	256	91.9	87.34-94.91
Multivitamin Use During Month Before Pregnancy	No	590	89.37	86.03-91.98
	Yes	991	91.63	89.41-93.43
Race	Black	640	86.87	83.16-89.86
	White	947	93.22	91.29-94.74
Mother's Age (Years)	< 20	225	89.97	84.09-93.83
	20-34	1194	90.45	88.32-92.23
	> 34	165	94.89	90.11-97.43
Mother's Education (Years)	≥ 12	1306	92.1	90.26-93.62
	<12	276	85.63	79.96-89.90
Marital Status	Married	879	92.99	90.93-94.61
	Other	751	88.13	84.86-90.78
WIC Participation During Pregnancy	No	701	92.35	89.80-94.30
	Yes	871	89.54	86.88-91.71
Medicaid Paid for Delivery	No	628	91.33	88.60-93.46
	Yes	954	90.65	88.16-92.66
Previous Low Birth Weight (LBW) or Preterm Birth (PTB)	Neither LBW nor PTB	633	92.51	89.80-94.54
	LBW and/or PT	191	84.88	76.97-90.42
	No Previous Live Birth	706	90.14	87.24-92.44
Number of Previous Live Births	None	697	90.06	87.14-92.37
	1-2	746	91.94	89.38-93.93
	> 2	140	88.11	79.74-93.31
Pre-pregnancy Weight Status Based on Body Mass Index	Underweight	222	88.3	82.86-92.18
	Normal Weight	729	90.91	88.10-93.11
	Overweight	191	91.24	85.07-95.02
	Obese	416	91.76	88.12-94.36
Early Prenatal Care Entry	Yes	1217	91.14	89.09-92.84
	No	327	89.18	84.54-92.55

(Continued on page 6)

Norovirus Outbreak ... Continued from Page 1

were individual reports (rarely, mostly 1 case) with no evidence that other patrons were sick. In 5 of the suspected cases, Area #3 oysters were involved.

This was the first time that so many norovirus/oyster outbreaks occurred during such a short period. The presence of norovirus is much more common than expected. During 2007, when the FDA did a year-long study of almost 400 lots of oysters throughout the U.S., 4% were contaminated with noroviruses. In this study, oysters coming from cooler areas such as the North Atlantic regions of the U.S. were more heavily contaminated (7.5% in the North Atlantic vs. 3% in the Gulf), and they were more contaminated during the winter months.

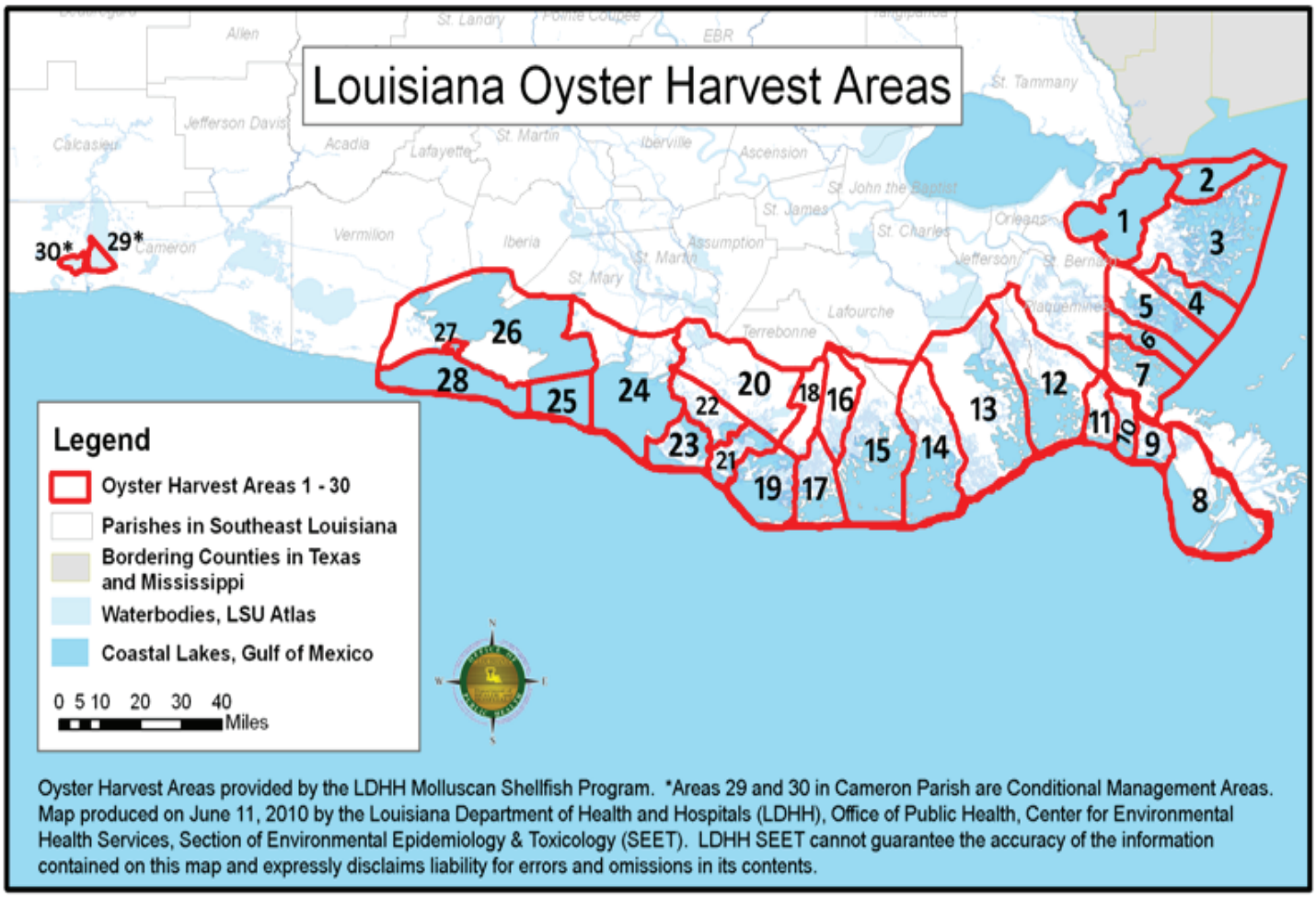
The problem is observed worldwide: In another study, oysters imported into Hong Kong from 11 countries over a 3-year period were screened by RT-PCR. Overall, 53 out of 507 (10.5%) of the samples were positive for norovirus-RNA and a wide variety of strains were found. From January to March 2010, the European Centre for Disease Prevention and Control (ECDC) was informed of norovirus outbreaks linked to consumption of oysters in five EU/EEA countries: the United Kingdom (UK), Norway, France, Sweden and Denmark. In total, 65 small clusters involving 334 cases were reported. Most cases had eaten oysters in restaurants.

The source of contamination may be, depending on the circumstances, fishermen relieving themselves in the oyster bed areas or, sewerage overflow. Oysters can concentrate up to 99 times the norovirus in their tissues. Coliform monitoring, while very useful to monitor fecal pollution from bacterial origin, is not adequate for monitoring norovirus presence. Noroviruses are small non-enveloped viruses that are very resistant to disinfectants and very resistant in the environment. Sewage treatment does not seem to be effective at inactivating them and they may be propelled up to oyster beds depending on the location, tides and currents. In the summer, noroviruses are rapidly inactivated by sunlight and hotter temperatures. In the winter, they are less apt to be inactivated.

Recently, a new strain of norovirus has spread throughout the United States. This new strain has caused countless outbreaks in groups, particularly in nursing homes but also in schools, offices, families and sports teams in Louisiana.

Rapid closure of oyster beds even preceding the full completion of the epidemiologic investigations seemed to have played an important role in limiting the extent of the outbreaks. For references or more information, contact Erin Delaune at (504) 219-4622 or email *erin.delaune@la.gov*.

Figure: Louisiana Shellfish Harvest Areas



Environmental Health Program Receives 5-year Federal Grant Louisiana, 2010

Emán Williams, MSPH

The Louisiana Department of Health and Hospitals (LDHH) has received a grant of $678,510 from the Centers for Disease Control and Prevention (CDC) for each of the next 5 years to build a statewide Environmental Public Health Tracking (EPHT) Program. The money will support the tracking of environmental hazards, and health in Louisiana. The purpose is to provide the public with a better understanding of how the environment can affect people's health.

The EPHT Grant will support development of a user friendly tracking system that is available to the public. This dynamic website will feature environmental and health data tracked by the LDHH, including statistics on low birth weights, children who have tested positive for lead poisoning and incidences of cancer, as well as environmental issues such as air, and water quality hazards. None of the data that is collected for this program will be traceable to individuals.

When complete, LDHH's website will link Louisiana to the web-based National EPHT Network which is maintained by the CDC. The CDC tracking portal can be found at www.cdc.gov/ephtracking. Both the CDC and the LDHH networks will allow scientists, health professionals, policymakers, and members of the public to:

- assess unusual trends and events
- evaluate, using standard measurements, where environmental hazards and health problems are occurring
- observe how hazards and health problems are changing over time.

The LDHH EPHT Program will allow the agency to provide information to environmental and public health professionals, legislators, community and other non-profit organizations, researchers, and the public to assist them in making better health decisions. The goal of LDHH's tracking program is to develop a network that meets the needs of the residents of Louisiana. Input from the public is welcome. LDHH would like to keep the public informed about environmental health topics that are of interest to them, and provide them with relevant data and resources for improving environmental public health in their communities. Webpage *www. lepht.dhh.louisiana.gov* has additional information about the program.

Please contact Emán Williams by e-mail *Eman.Williams@la.gov* or call 1(888) 293-7020 to share any concerns, suggestions, feedback, questions, or ideas about the LDHH or the National program.

Relationtionship Between Pregnancy ... Continued from Page 4

Table 2: Variables Associated With Eating Less Than Daily Recommended Servings of Fruits or Vegetables During Last 3 Months of Pregnancy LaPRAMS, 2004

Variables	Odds Ratio	95% CI	P-value
Pregnancy Intention			
Intended	1.35	0.73-2.47	0.4322
Mistimed	2.1	1.15-3.83	0.0179
Unwanted	1.0		
Previous LBW or PTB			
Neither LBW nor PTB	1.99	1.05-3.74	0.0269
No previous live birth	1.27	0.69-2.35	0.3296
LBW and/or PTB	1.0		
Race			
White	1.9	1.22-2.94	0.0048
Black	1.0		
Education			
>= 12 years	1.94	1.18-3.19	0.0064
<12 years	1.0		

Conclusions

Prenatal care providers, physicians and public health professionals, nurses and nutritionists may find expanding the population of mothers targeted for maternal dietary programs useful. In addition, emphasis on the long and short term effects of unhealthy eating behaviors on both infant and mother may be beneficial regardless of whether mothers intended to conceive. Motivating healthy maternal diet on advertised popular free-access social-networking websites could prove effective in educating those at high risk for ELTDRS.

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

Infectious Diseases Rapid Response Training - New Orleans, Louisiana
May 4-5, 2010

Instructors: Elizabeth Ostertag, Mark Schmidt, Wright Culpepper, Ricardo Encarnacion

Working Team: (From 9 o'clock) Shelly Narcisse, Karen Wolfe, Glenda Young, Tim Travasos, Emilie Kelley, Pamela Kreyling, Karen Buroker, Caroline Holsinger

Table. Communicable Disease Surveillance, Incidence by Region and Time Period, March-April, 2010

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Mar-Apr 2010	Mar-Apr 2009	Jan-Apr Cum 2010	Jan-Apr Cum 2009	Jan-Apr % Chg*
Vaccine-preventable															
Hepatitis B	Cases	1	2	1	0	0	0	0	1	1	6	10	18	20	NA*
	Rate[1]	0.1	0.4	0.3	0	0	0	0	0.3	0.3	0.1	0.2	0.4	0.5	NA*
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Mumps		0	0	0	0	1	0	0	0	1	2	0	2	1	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		0	0	0	0	0	0	0	0	1	1	36	8	54	-85.2
Sexually-transmitted															
HIV/AIDS	Cases[2]	31	25	8	12	5	4	7	5	9	106	228	303	446	-32.1
	Rate[1]	3.1	4.3	2.1	2.2	1.8	1.3	1.4	1.4	2.1	2.4	5.2	6.9	10.2	NA*
Chlamydia	Cases[3]	59	13	68	6	2	0	28	5	10	191	2143	3127	7029	-55.5
	Rate[1]	7.3	2.0	17.2	1.0	0.7	0.0	5.2	1.4	1.9	4.3	48.6	70.9	159.4	NA*
Gonorrhea	Cases[3]	14	2	9	2	0	0	0	3	0	30	478	942	2152	-56.2
	Rate[1]	1.7	0.3	2.3	0.3	0.0	0.0	0.0	0.9	0	0.7	10.8	21.4	48.8	NA*
Syphilis (P&S)	Cases[3]	0	2	2	6	0	0	1	4	3	18	89	81	224	-63.8
	Rate[1]	0.0	0.3	0.5	1.0	0.0	0.0	0.2	1.2	0.6	0.4	2.0	1.8	5.1	NA*
Enteric															
Campylobacter	Cases	0	1	0	10	1	2	4	3	2	23	13	51	25	104.0
Hepatitis A	Cases	0	0	0	0	0	1	0	0	0	1	0	2	1	NA*
	Rate[1]	0	0	0	0	0	0.3	0	0	0	0	0	0	0	NA*
Salmonella	Cases	12	31	11	7	2	2	14	8	38	125	102	205	176	16.5
	Rate[1]	1.2	5.5	2.9	1.4	0.7	0.7	2.8	2.3	9.9	2.9	2.4	4.8	4.1	NA*
Shigella	Cases	3	1	0	1	0	0	5	28	0	38	29	59	84	-29.8
	Rate[1]	0.3	0.2	0	0.2	0	0	1.0	8.0	0	0.9	0.7	1.4	1.9	NA*
Vibrio cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other	Cases	1	0	0	0	0	0	0	0	0	1	7	1	8	-87.5
Other															
H. influenzae (other)		1	2	0	0	0	0	1	1	0	5	5	12	9	NA*
N. Meningitidis		1	0	0	0	0	0	0	2	0	3	1	8	8	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] = Transition to a new system has delayed the morbidity reporting; Numbers may be artificially low; Per 100,000 population (2008 population estimate).

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

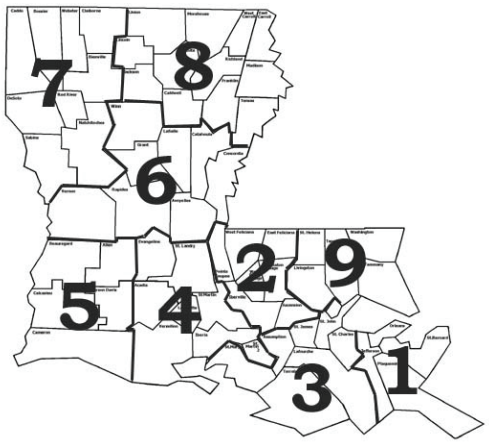
Table 2. Diseases of Low Frequency, January-April, 2010

Disease	Total to Date
Legionellosis	1
Lyme Disease	0
Malaria	0
Rabies, animal	2
Varicella	24

Table 3. Animal Rabies, March-April, 2010

Parish	No. Cases	Species
	0	

Figure. Department of Health and Hospitals Regional Map



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

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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[4]
- Carbon Monoxide Exposure and/or Poisoning (all ages)[6]
- Complications of Abortion
- Congenital Hypothyroidism[5]
- Galactosemia[3]
- Hemophilia[3]
- Heavy Metal (Arsenic, Cadmium, Mercury) Exposure and/or Poisoning (all ages)[6]
- Lead Exposure and/or Poisoning (all ages)
- Pesticide-Related Illness or Injury (all ages)[6]
- Phenylketonuria[5]
- Reye's Syndrome
- Severe Traumatic Head Injury
- Severe Undernutrition (severe anemia, failure to thrive)
- Sickle Cell Disease (newborns)[5]
- 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 HIV/AIDS Program: www.hiv.dhh.louisiana.gov for regional contact information, or call (504) 568-7474.
[4]Report to the Louisiana Tumor Registry: http://publichealth.lsuhsc.edu/tumorregistry/ or call (504) 568-5757.
[5]Report to the Louisiana Genetic Diseases Program Office by telephone at (504) 219-4413 or facsimile at (504) 219-4452.
[6]Report to the Section of Environmental Epidemiology & Toxicology: www.seet.dhh.louisiana.gov or call (888) 293-7020.

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