Louisiana Morbidity Report

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http://www.dhh.louisiana.gov/offices/reports.asp?ID=249&Detail=7428

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November-December 2010 **Volume 21 Number 6**

2010-2011 Influenza Vaccine Update

Susan A. Wilson, RN MSN

Each year, before the start of influenza season, the Centers for Disease Control and Prevention (CDC) publishes guidelines for the control and prevention of influenza for the upcoming season. Vaccination reduces the risk for influenza and influenza-related complications. This year's flu vaccination efforts take place against the backdrop of the emergence of the 2009 H1N1 influenza virus, which occurred in April, 2009 and caused the first influenza pandemic in 40 years.

The 2009 H1N1 influenza virus will likely continue to circulate and cause illness during the 2010-2011 flu season. As with all seasonal flu vaccines, this year's vaccine is designed to protect against the 3 main viruses that research indicates will cause the most illness. The 2010-2011 trivalent vaccine will protect against strains A/California/7/2009 (H1N1)-like virus (the same strain as was used for 2009 H1N1 monovalent vaccines), an A/Perth/16/2009 (H3N2)-like virus, and a B/Brisbane/60/2008-like virus. Because this year's seasonal vaccine will protect against the 2009 H1N1 virus, 2 different flu vaccines will not be necessary.

This year, the recommendations from the CDC now include young adults aged 19 to 49 years who were impacted by the 2009 H1N1 pandemic virus. Everyone, aged 6 months and older should receive an influenza vaccine, since the flu can cause illness, including severe illness, in anyone. More importantly, people who are at higher risk for developing serious flu-related complications

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Sphingomonas Infection Southern Louisiana, 2010

Melissa Brown, MPH

In September, 2010, a hospital in southern Louisiana reported an increase of *Sphingomonas paucimobilis* cases to the Infectious Disease Epidemiology Section (IDES) of the Office of Public Health. Because Sphingomonas are uncommon pathogens, IDES staff was dispatched to investigate the upsurge of sphingomonas infections in the facility. In total, seven cases were observed over a five month period. All cases appeared to be community-acquired, with the exception of one case, which was likely due to contamination of the sample. No sphingomonas infections in this facility appeared to be hospital acquired. The following points were noted by IDES epidemiologists upon examination of the patients' charts:

- 3 cases - Older cancer patients (ages 67, 70 and 81 years) with multiple metastasis. Among these three patients, one experienced UTI with recurring prostate infections while another case presented with a peritoneal abscess. The final case in this category had a pleural catheter inserted approximately two weeks prior to being diagnosed with sphingomonas infection in the pleural fluid.
- 2 cases – Young patients (ages 18 and 47 years) with no significant health problems. These patients developed skin abscesses, were treated in their private physicians' offices and recovered without complications.
- 1 case - Patient with a history of aortic valve replacement and isolation of Sphingomonas in a blood culture. This patient was re-hospitalized in another state approximately one week later with isolation of Cardiobacterium.
- 1 case - A previously healthy 19 year-old with fever. Sphingomonas was isolated in the blood of this patient; the recovery was uneventful. This case was considered to be a possible contamination.

Sphingomonas, a bacterial genus defined in 1990, (includes at least 12 species) of which *Sphingomonas paucimobilis* is considered to be of the highest clinical importance. *S. paucimobilis* is strictly aerobic, gram-negative, weakly oxidase positive and catalase positive. These bacteria were formerly included in the genus Pseudomonas. Many of the species that were previously classified as Pseudomonas have been reclassified into the genera Sphingomonas, Burkholderia, Stenotrophomonas, Comamonas, Shewanella, Ralstonia, Methylobacterium, Acidovorax and Brevundimonas.

S. paucimobilis infections typically occur in immunocompro-

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(Sphingomonas Infection ... Continued from Page 1)

mised persons and can be community, as well as nosocomially acquired. In most nosococomial outbreaks, contaminated water has been reported to be the reservoir for Sphingomonas; however, infections have been seen in patients with catheter-associated bloodstream infections as well as in hemodialysis patients and after infusion of contaminated autologous bone marrow. Peritoneal catheter-associated peritonitis, meningitis, ventriculoperitoneal shunt infection, brain abscess, soft tissue infection, wound infection, postoperative endophthalmitis, adenitis, urinary tract infection, and a variety of visceral abscesses have also been reported as being associated with Sphingomonas. Due to the low virulence of Sphingomonas, recovery from infection is expected even in debilitated hosts.

Most isolates are susceptible to trimethoprim-sulfamethoxazole, carbapenems, aminoglycosides, tetracyclines, and chloramphenicol but susceptibility to β-lactam agents and flouroquinolones is variable. In Sphingomonas, resistance to penicillins and first-generation cephalosporins is common; however, patients have been reported to respond well even when empiric treatment did not correlate with subsequent susceptibility tests.

Sphingomonas are primarily environmental bacteria. They can be found in soil, water, plants, corals, and objects such as shower curtains, sinks, and door handles. Sphingomonas can survive in areas with minimal available nutrients. Colonies have been discovered in heavily polluted areas, suggesting that sphingomonas can survive in oil and a variety of toxins. In May 2008, it was discovered that Sphingomonas can degrade over 40% of the weight of plastic bags (polyethylene) in less than three months. Because of this property, Sphingomonas have been used in bioremediation, a process in which the bacteria are introduced into a contaminated area with the purpose of eliminating undesirable materials and toxins. In the process of consuming the oils, toxins, and other unwanted material in the area, the bacteria convert the materials into harmless substances which are easy and safe to clean up.

For more information, please contact Ms. Brown at (504) 219-4706 or email to *melissa.brown2@la.gov.*

(2010-2011 Influenza Vaccine ... Continued from Page 1)

should continue to get vaccinated, as well as those who live with or care for people at high risk for developing flu-related complications. People at higher risk include children younger than 5 years of age, especially children younger than 2 years; everyone 65 and older; pregnant and postpartum women; people with chronic medical conditions, such as asthma, diabetes, or a weakened immune system.

Influenza causes more hospitalizations among young children than any other vaccine-preventable disease, thereby stressing the importance for children to get the influenza vaccine. Most children 6 months through 8 years of age are recommended to receive 2 doses of the 2010-2011 flu vaccine 4 or more weeks apart to be fully protected. A child only needs one dose of this year's vaccine if they received at least one dose of the 2009 H1N1 vaccine last flu season, and either at least one dose of seasonal vaccine prior to the 2009-2010 flu season or received 2 doses of 2009-2010 seasonal flu vaccine last season (Table).

Table: Dosing Guidance for 2010-2011 Influenza Vaccine for Children 6 Months Through 8 Years

Number of influenza vaccine doses received in 2009-2010 season for **H1N1**	Number of influenza vaccine doses received in 2009-2010 season for **Seasonal**	Number of doses recommended for the 2010-2011 season
0	0, 1 or 2	2
1	0	2
1	1	2
1	2	1
2	2	1
2	0	2
2	1	2

Since children younger than 6 months old cannot receive the influenza vaccine, members of their household, healthcare workers and other close contacts, such as child care providers, should be vaccinated in order to protect them. Vaccine manufacturers project ample supplies of flu vaccine in the United States for the 2010-2011 flu season.

In addition, the CDC continues to emphasize a 3-step approach to protect against the flu: vaccination, implementing routine preventive actions such as frequent hand washing and staying at home when sick, and the appropriate use of antiviral drugs.

For more information please contact the Immunization Program at (504) 838-5300.

Happy Holidays

Louisiana Morbidity Report
Volume 21 Number 6 November-December 2010

The Louisiana Morbidity Report is published bimonthly by the Infectious Disease Epidemiology Section of the Louisiana Office of Public Health to inform physicians, nurses, and public health professionals about disease trends and patterns in Louisiana. Address correspondence to Louisiana Morbidity Report, Infectious Disease Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.

The Healthcare-Associated Infections Initiative - Louisiana, 2010

Erica Washington, MPH

Louisiana's Healthcare-Associated Infections (HAI) initiative was launched in August, 2009 through the Centers for Disease Control and Prevention (CDC) Epidemiology and Laboratory Capacity (ELC) Recovery Act funding. Grant objectives target specific areas of surveillance and prevention to move our state toward the national goal of HAI elimination. In light of these grant goals, the Infectious Disease Epidemiology Section (IDES) has successfully established integration, collaboration, capacity building, and prevention to assist state healthcare facilities with HAI reduction.

There are two arms to the HAI grant: prevention of HAI events, and surveillance through the National Healthcare Safety Network (NHSN). Five statewide NHSN trainings were held from July 26 to August 11, 2010. The trainings lasted 8 hours each and provided an overview and live demonstration of the network, data entry, definitions, and analysis. Previously, there were 10 NHSN reporting facilities; however, in anticipation of the Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Prospective payment System (IPPS) 2011 rule (to report HAI through NHSN), our goal was to provide assistance and educational support for facilities that would be reporting data to NHSN for reimbursement requirements. Two CDC staff members dialed-in for question-and-answer periods at the conclusion of each training to assist infection preventionists with clinically-related questions.

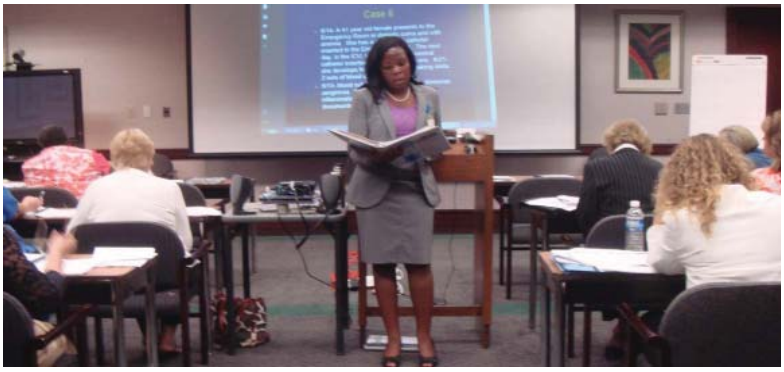
NHSN education will be ongoing as we have 3 webinars and statewide CLABSI trainings planned to increase competencies with reporting and usage of CDC's standardized definitions. In addition to the NHSN trainings, IDES has offered 4 statewide Epidemiology statistics trainings, which allows infection preventionists to see practical applications of Epidemiology in infection control.

Collaboration is being addressed through the establishment of The Greater New Orleans Central Line-Associated Bloodstream Infection (CLABSI) Prevention in ICUs and NICUs that was kicked off in June, 2010. Five facilities are participating in the initiative; the collaborative will conclude May, 2011. The River Region CLABSI Prevention Collaborative was kicked off on September 17, 2010. The geographical area includes the South Central portion of Louisiana; 16 facilities are participating in the River Region CLABSI Collaborative.

As part of the grant leadership, IDES formed a multidisciplinary advisory group which is comprised of experts and stakeholders in infection control. This multidisciplinary advisory group has recently been integrated into a legislative study group to report the most burdensome and costly HAI in Louisiana. IDES is compiling epidemiologic reports to report such infection rates for acute care and long-term care facilities. For complete information on the HAI grant, visit the Healthcare-Associated Infections Resource Center at *http://www.dhh.louisiana.gov/offices/page.asp?id=249&detail=7523*.

Infectious Disease Epidemiology Training - Louisiana, 2010

Erica Washington, Public Health Epidemiologist and HAI Coordinator giving the first National Healthcare Safety Network (NHSN) training in a series to Infection Preventionists at Ochsner Baptist Hospital, New Orleans, July, 26, 2010.



Dr. Armand Sprecher, EIS Officer (CDC) presenting an 'Outbreak Exercise' during the Field Epidemiology Training class in Metairie, October 6, 2010.

HIV/AIDS Surveillance Louisiana, 2000-2009

Jessica C. Fridge, MSPH

The Louisiana Office of Public Health HIV/AIDS Program's (HAP) Surveillance Program conducts general case ascertainment through the receipt of reports of potential cases of HIV infection from clinical providers, laboratories and other public health providers throughout the state. Basic demographic and risk information are also collected. In addition, the program monitors perinatal exposure to and transmission of HIV, HIV incidence, medication resistant strains of HIV, clinical manifestations of HIV disease, mortality, the utilization and impact of care and treatment, and measures of high-risk behavior.

The HIV Epidemic in Louisiana

In the most recent Centers of Disease Control and Prevention (CDC) HIV Surveillance Report (Vol. 20), Louisiana ranked fourth highest in estimated state AIDS case rates and 11th in the estimated number of AIDS cases in 2008. The metropolitan Baton Rouge area ranked second and the New Orleans metropolitan area ranked third in estimated AIDS case rates in 2008 among the large metropolitan areas in the nation.

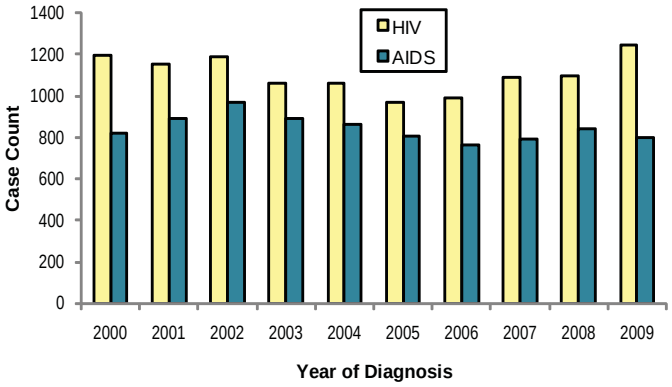
HAP has recently begun analyses for the 2009 Annual Report that will be published in early 2011. The preliminary findings of this analysis are reported here.

In 2009, there were 1,242 new HIV diagnoses and 798 new AIDS diagnoses in the state of Louisiana. A total of 17,155 persons were living with HIV infection in Louisiana as of December 31, 2009. There are persons living with HIV infection in every parish in Louisiana.

In 2009, there were new HIV diagnoses in all nine public health regions and in 58 of Louisiana's 64 parishes. Almost 57% of all new HIV diagnoses occurred in the New Orleans and Baton Rouge regions and 60% of all persons living with HIV infection live in those two regions. The region with the third largest number of new diagnoses and persons living with HIV infection is the Shreveport region.

The number of new HIV infections has varied across the past 10 years with a significant decrease in 2005 due to the impact of Hurricane Katrina. The number of new HIV diagnoses in 2009 is the highest it has been in the past 10 years (Figure 1).

Figure 1: Number of New HIV and AIDS Diagnoses by Year of Diagnosis - Louisiana, 2000-2009



Since 2007, there has been a significant increase in HIV testing in the state due to a federally-funded testing initiative which has expanded rapid testing in emergency rooms, correctional facilities, and other clinical settings. The number of tests conducted at publicly funded HIV testing sites in Louisiana increased from 69,391 in 2008 to 100,787 in 2009, a 45% increase.

How to Become a Sentinel Site for Influenza Surveillance

The Infectious Disease Epidemiology Section (IDES) of the Louisiana Office of Public Health (OPH) conducts year-round enhanced surveillance for influenza through the sentinel provider network (SPN). Participating sites include private physicians' offices, urgent care clinics and hospital emergency rooms. Sentinel sites provide weekly data on cases of influenza like illness (ILI) and laboratory confirmed influenza throughout the year. The Centers for Disease Control and Prevention (CDC) definition of ILI is fever (>100˚F, 37.8˚C), and sore throat or cough, in the absence of a known cause. Although all cases of ILI are not attributable to influenza viruses, it is a good proxy measure of influenza activity.

Sentinel sites provide IDES OPH with weekly numbers of ILI cases by 4 age groups: preschoolers (0-4 years-old), school-aged children and adolescents (5-24 years-old), adults (24-64 years-old), and 65 years-old or older. Sites also provide the total number of patients seen for any reason. Using this data, weekly ILI proportions and total case counts are calculated. Data generated is also shared with the CDC as part of the U.S. Outpatient ILI Surveillance Network (ILINet). The Louisiana SPN has 81 private providers, or one per 70,000 population, that regularly contribute weekly the total number of patient visits and number of patients with ILI; this exceeds the recommendation by the CDC of one site per 250,000.

In addition, sentinel sites submit throat swabs on patients with ILI to the State OPH Laboratory for laboratory confirmation of influenza. These specimens are important as they ensure that Louisiana strains are characterized each year (there are many different strains of influenza virus). These specimens also ensure that Louisiana strains are considered for inclusion in each year's vaccine.

A weekly report of ILI for Louisiana can be found at website *http://www.dhh.louisiana.gov/offices/page.asp?id=249&detail=7358*.

For more information or to become a Sentinel Site, please contact Julie Hand at (504) 219-4542 or e-mail to *julie.hand@la.gov*.

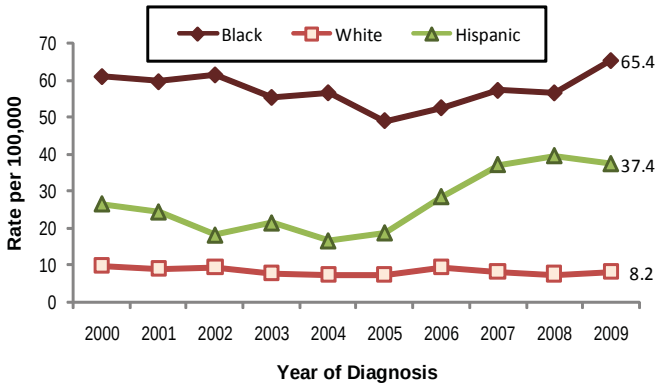
The goal of this initiative is to increase testing among African-Americans and decrease the percent of people who are unaware of their status. The CDC currently estimates that 21% of all people infected with HIV in the U.S. are unaware of their HIV status.

Although HIV testing has increased in Louisiana, people are still being diagnosed late in their HIV disease progression. In 2009, 24% of the new HIV diagnoses were concurrently given an AIDS diagnosis; an additional 7% had an AIDS diagnosis within the next 6 months. More work must be done to get people tested earlier, link them to primary medical care, and provide them with important prevention services.

The Disproportionate Impact of HIV

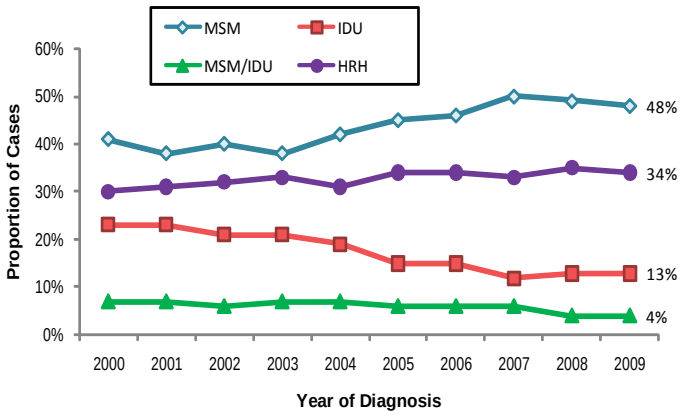
The HIV rate for African-Americans in Louisiana continues to be disproportionally high; the rate for African-Americans was 8 times higher than among whites in 2009 and almost twice as high as Hispanics. Although African-Americans make up only 32% of the state's population, 75% of the newly diagnosed HIV cases and 76% of the newly diagnosed AIDS cases were among African-Americans in 2009 (Figure 2).

Figure 2: Trends in HIV Rates by Race/Ethnicity - Louisiana, 2000-2009



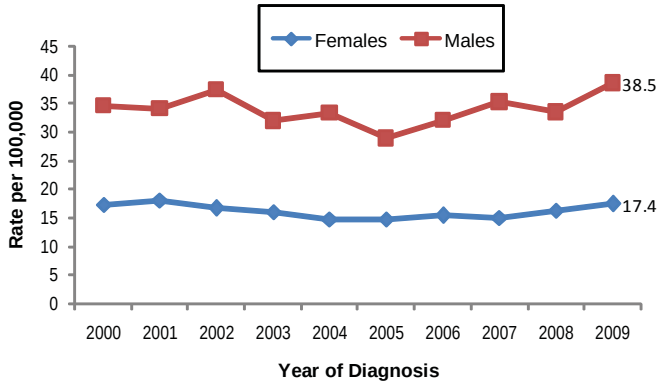
Over the past 10 years, the proportion of adult HIV cases attributed to male-to-male sexual contact (MSM) has increased from 41% in 2000 to 48% in 2009, and in 2007, it was as high as 50%. The proportion of cases associated with injection drug use (IDU) has declined since 2000 and the proportion of cases associated with high-risk heterosexual contact (HRH) has increased slightly since 2000 (Figure 3).

Figure 3: Trends in HIV Cases by Risk - Louisiana, 2000-2009



Women made up 32% of the new HIV diagnoses and 31% of new AIDS diagnoses in 2009. The HIV rate among women has remained relatively stable with a small increase since 2005. The HIV rate for men is over twice as high as it is for women (Figure 4).

Figure 4: Trends in HIV Rates by Sex - Louisiana, 2000-2009



The HAP office regularly reports and publishes data on: *www.hiv.dhh.louisiana.gov* and *www.HIV411.org*. HAP produces quarterly reports, an Annual Report, and numerous fact sheets that are available on both websites. For more information, please contact Jessica Fridge at (504) 568-5566 or email to *jessica.fridge@la.gov*.

Announcements

Aim at Lead Safety

The Office of Public Health, Environmental Epidemiology and Toxicology Section, has developed a fact sheet aimed at providing information to those who may be exposed to lead particles at firing ranges. A pdf can be downloaded from webpage *http://www.dhh.louisiana.gov/offices/page.asp?id=205&detail=8411*

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

ANNUAL REPORTS: Amebiasis; *Clostridium difficile*; Giardia; H1N1 Summary; Measles; Mumps; Rubella; Streptococcal Invasive Disease-Group A, Group B and Unspecified; Tetanus; Vibrios

EPIDEMIOLOGY MANUAL: Chagas Disease; *Clostridium difficile;* Cysticercosis; Enterobacteriaceae*;* Klebsiella*;* Rabies; Varicella (Chickenpox) Herpes Zoster; Water Bacteria

HEATHCARE ASSOCIATED INFECTION: Surveillance Survey Report

INFLUENZA: Weekly Report

SPECIAL STUDIES: Description of Non-arbo-related Encephalitis Associated Hospitalizations in Louisiana, 1999-2007

VETERINARY INFORMATION: Microbiological Makeup of Common Veterinary Infections, Second Quarter, 2010 - Feline

Subject Index for the Louisiana Morbidity Report, 2009-2010

Note: Year and Issue Number are listed after the comma on each line - 09/06 = Issue Number 6 (Nov-Dec) for the Year 2009. Indices for the years 1967-1981 and 2000-2006 can be found on *http://www.dhh.louisiana.gov/offices/page.asp?id=249&detail=7428*

Table. Communicable Disease Surveillance, Incidence by Region and Time Period, September-October, 2010

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Sep-Oct 2010	Sep-Oct 2009	Jan-Oct Cum 2010	Jan-Oct Cum 2009	Jan-Oct % Chg*
Vaccine-preventable															
Hepatitis B	Cases	1	1	0	0	0	0	1	0	0	3	20	43	61	-29.5
	Rate[1]	0.1	0.2	0	0	0	0	0.2	0	0	0.1	0.5	1.0	1.4	NA*
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Mumps		0	0	0	0	0	0	0	0	0	0	0	5	1	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		1	2	0	1	0	0	0	0	1	5	13	26	130	-80.0
Sexually-transmitted															
HIV/AIDS	Cases[2]	26	24	7	11	3	2	10	9	9	101	184	890	1061	-16.1
	Rate[1]	2.6	4.2	1.8	2.0	1.1	0.7	2.0	2.6	2.1	2.3	4.2	20.4	24.3	N/A
Chlamydia	Cases[3]	1297	533	246	464	282	387	683	670	282	4844	4526	12162	24524	-50.4
	Rate[1]	160.7	82.8	62.3	80.3	99	128.9	128.0	193.0	54.1	109.8	102.6	275.7	556	N/A
Gonorrhea	Cases[3]	462	167	63	127	76	84	263	292	50	1584	1459	3479	7954	-56.3
	Rate[1]	57.2	26.0	16.0	22.0	26.7	28.0	49.3	84.1	9.6	35.9	33.1	78.9	180.3	N/A
Syphilis (P&S)	Cases[3]	6	4	4	9	15	7	12	2	8	67	95	353	653	-45.9
	Rate[1]	0.7	0.6	1.0	1.6	5.3	2.3	2.2	0.6	1.5	1.5	2.2	8.0	14.8	N/A
Enteric															
Campylobacter	Cases	0	2	1	15	3	1	3	1	4	30	15	181	87	108.0
Hepatitis A	Cases	0	0	0	1	0	0	0	0	2	3	2	8	5	NA*
	Rate[1]	0	0	0	0.2	0	0	0	0	0.5	0.1	0	0.2	0.1	NA*
Salmonella	Cases	29	35	45	70	13	13	25	27	39	296	291	1149	1021	12.5
	Rate[1]	2.8	6.2	11.9	13.6	4.9	4.3	4.9	7.7	10.1	6.9	6.7	26.6	23.7	NA*
Shigella	Cases	19	2	7	4	0	2	2	8	5	49	17	229	161	42.2
	Rate[1]	1.8	0.4	1.9	0.8	0	0.7	0.4	2.3	1.3	1.1	0.4	5.3	3.7	NA*
Vibrio cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other	Cases	0	0	2	0	1	0	0	0	0	3	6	22	47	-53.2
Other															
H. influenzae (other)		0	1	0	0	0	0	1	1	0	3	2	24	16	50.0
N. Meningitidis		0	0	0	0	0	0	0	0	0	0	5	12	26	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.

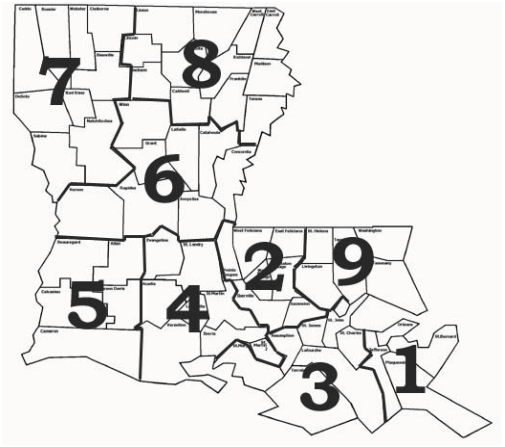


Table 2. Diseases of Low Frequency, January-October, 2010

Disease	Total to Date
Legionellosis	9
Lyme Disease	2
Malaria	4
Rabies, animal	4
Varicella	69

Table 3. Animal Rabies, September - October, 2010

Parish	No. Cases	Species
Iberia	1	Skunk

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
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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
- 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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