STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
P.O. Box 60630, New Orleans, LA 70160 - Phone: (504) 219-4563
http://www.dhh.louisiana.gov/offices/reports.asp?ID=249&Detail=7428

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

BOBBY JINDAL
GOVERNOR

BRUCE D. GREENSTEIN
SECRETARY

September-October 2010 **Volume 21 Number 5**

H1N1 Vaccination Campaign Louisiana, 2009-2010

David J. Holcombe, MD; Shirley Burton, MPH; Ruben Tapia, MPH; Andrea Gauthier, RN; Mike Powers, BA

Purpose:

In Autumn, 2009, the Louisiana Office of Public Health (OPH) embarked on a state-wide campaign in an effort to vaccinate the most vulnerable populations against influenza caused by the H1N1 virus. OPH hired teams of nurses (Strike Teams), under the state's direction to facilitate the administration of the H1N1 vaccine in all 9 public health regions in the state. (Map of regions on page 7)

The purpose of this project was to gather relevant information that could:

1) help to determine the best practices for the campaign

2) be beneficial for planning and strategic purposes to determine potential problems that may occur for subsequent, similar endeavors

3) provide insights into how potential problems can be avoided

4) aid in better planning and implementation of future, similar projects.

Methods:

A form for documenting the strategies used for vaccine administration, developed in Region VI, was completed by pertinent staff in each of the state's 9 public health regions. The quantitative data

(Continued on Page 4)

Contents

Rare Death *Chromobacterium violaceum* Eastern Louisiana, 2010

Armand Sprecher MD, MPH

Chromobacterium violaceum are a species of bacteria that are gram-negative, non-sporing, non-acid fast small rods or coccobacilli that produce a natural antibiotic with virulent strains producing an endotoxin.

C. violaceum are pathogenic and occasionally cause serious pyogenic or septicemic infections of mammals, including man. These bacteria are not present as part of the normal flora of humans or animals but they are part of the normal flora of water and soil of tropical and sub-tropical regions of the world. Infections due to soil or water contamination with the organisms can be quite varied, ranging from mild diarrhea to septicemia leading to a rapid death (cellulitis and skin abscesses with rapid progression to sepsis and multiple organ abscesses, predominantly in lungs, liver and spleen). Similar infections in animals have been reported.

Despite ubiquitous distribution, human infection with this organism is rare. Since the first human case was described in Malaysia in 1927, less than 150 human cases have been reported worldwide, with about 20 in the United States. Most reports worldwide have been associated with rural areas or stagnant water. Prior to this case, the last fatal case was in a boy in northern Louisiana in 2001. This recent fatal case presented in a 9 year-old boy in July, 2010. The symptoms observed over the first 24 hours were fever and lesions on his back described as 'large mosquito bites', with death following in 2 days from septic shock.

Human infection with *C. violaceum* results in systemic and severe disease with a case fatality rate above 60%. All previous case reports are of individual, apparently sporadic infections. Physicians treating patients with fever, hepatic abscesses and skin lesion cases, in tropical and subtropical regions should consider *C. violaceum* infection as part of the differential diagnosis of sepsis, especially when associated with skin or multiple organ abscesses or with a history of exposure to stagnant water.

In many cases this organism can show high level resistance to a range of antibiotics. The recommended treatment for *C. violaceum* infection is not well established; some survivors have been treated with quinolones such as ciprofloxacin, or carbapenems such as meropenem.

For more information, please contact Dr. Sprecher at (504) 219-4653 or e-mail to *armand.sprecher@la.gov*.

Diagnosis and Treatment of Hypertension in Adolescents, School-Based Health Centers - Louisiana - July 1, 2009 - March 31, 2010

Maxine Kimbrell, LCSW-BACS; Christine Armand-Perret, MPH; Virginia Moore, MN; Wendy Beron, RN; Michael Crapanzano, MD; Pam Wiseman, MD

The Office of Public Health Adolescent School Health Program (OPH/ASHP) has worked with 5 School-Based Health Centers (SBHC) across Louisiana on a pilot project to develop and implement best practice guidelines for the diagnosis, and treatment of hypertension in adolescents. Project Goals included:

1) reducing the long-term health risks for hypertensive children, and adolescents enrolled in Louisiana SBHCs through early diagnosis, and management

2) increasing awareness of the prevalence of hypertension among children and adolescents, and the need for early intervention among Louisiana SBHC providers, and private providers in targeted areas

3) assessing the impact of screening for, and treating hypertension in SBHCs

4) in partnership with the Louisiana Obesity Council, explor-ing opportunities for addressing childhood obesity through Louisiana SBHCs

5) identifying, and disseminating best practice obesity prevention, and management initiatives being implemented in SBHCs across the state.

Methods:

A thorough medical literature review, including national recommendations on best practice guidelines for the diagnosis, appropriate clinical workup, and treatment of hypertension in children, and adolescents was performed. The proposed guidelines and protocols were reviewed with the OPH/ASHP receiving ongoing consultation, and feedback on protocol development, and implementation of clinical procedures between July 1, 2009 and March 31, 2010.

The SBHCs chosen for the project include: West Monroe High School - Ouachita Parish - Region 8; Madison High School - Madison Parish – Region 8; Tioga Senior High School - Rapides Parish - Region 6; Chalmette High School - St. Bernard Parish – Region 1; Jonesboro Senior High - Jackson Parish - Region 8*. The staff at each site provided information and feedback on an ongoing basis so that program progress, success, and challenges can be monitored, tracked and revisited throughout the project timeline. This exchange of information and ongoing consultation allowed the OPH/ASHP to make adjustments, and fine tune specifics all along the way.

While the SBHCs, as a part of comprehensive service provision, see and treat hypertension in children and adolescents, this pilot project heightened SBHC staff awareness of the increased prevalence of elevated blood pressure, pre-hypertension, and hypertension in their students. Additionally, with the ability to provide more data through screenings and lab testing, the SBHC staff continues to collaborate with, and educate physicians in their local communities, and together, provide early intervention to adolescents at-risk.

Mechanisms were developed to track the number of students screened as well as the results of those screenings. The data tracking software used by OPH is Clinical Fusion; through this system the program team designed reporting formats, and templates to provide specific program data. Additionally, coding criteria was worked on, using information from certified coders, to assure that all participating sites were accurately coding blood pressure screenings, elevated blood pressure, and hypertension diagnoses as well as setting up codes to monitor, and track children and adolescents identified as pre-hypertensive. The team also wanted the ability to identify students who already had a diagnosis of hypertension prior to the start of the pilot program, so that the project data would accurately reflect the students identified through this project. Part of the project protocol included documentation and monitoring of the clinical workup and ongoing follow-up. The project team analyzed data by site on a monthly basis, and made improvements to the program and process as the project moved forward.

The team and the SBHC site staff shared information on obesity, diet, and exercise. Certainly the issue of childhood obesity is contributing to the increase in elevated blood pressure, pre-hypertension, and hypertension in adolescents; weight and BMI are calculated as part of the HTN screening protocol. Educational materials on obesity, diet, exercise, and weight management, with a connection to elevated blood pressure, have been incorporated into the counseling portion of the program, and protocols.

The program clients include students registered and treated at the 5 participating SBHCs. As of March 30, 2010 (representing 6 months of program implementation) are as follows:

Students screened for Hypertension	2524
Students identified with elevated Blood Pressure	246
Students confirmed with Pre-Hypertension	21
Students confirmed with Hypertension	20

Limitations:

The training and education of staff has needed to include clini-

* *Map of Regions on Page 7*

Louisiana Morbidity Report

Volume 21 Number 5 ***September-October 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.

Assistant Secretary, OPH	***Clayton Williams, MPH***
State Epidemiologist	***Raoult Ratard, MD MPH***
Editors	***Susanne Straif-Bourgeois, PhD MPH*** ***Theresa Sokol, MPH*** ***Rosemarie Robertson, BS MT(C) CNMT***
Layout & Design	***Ethel Davis, CST***

cal providers as well as data entry personnel in order to assure accurate protocol implementation, data and tracking. SBHC sites differ somewhat on the methods used to schedule appointments (mostly based on size, and numbers of patients seen per day). The program had to allow for these differences while ensuring the accuracy of program data, and tracking mechanisms. Each site has differing ability to perform lab and EKG testing; therefore, the program had to develop site-specific methods to assure that these services could be performed or obtained throughout the project. Additionally, there are some slight discrepancies between guidelines on screening blood pressure in children, and adolescents, all published by the American Academy of Pediatrics (AAP). To assure that all at-risk students would be identified, the team adopted the AAP conservative guidelines (blood pressure > 120/80 for students based on age or gender) for the initial screening process, and only used the more expanded guidelines to identify students with hypertension (> 95th percentile). The extent of monitoring and coaching SBHC staff to assure program compliance has been more difficult than expected. Several of the above mentioned roadblocks made expanded education and intense site-specific work necessary to assure the significant progress, and program results that have been demonstrated to date.

Results:

Ten percent of students screened have been identified with elevated blood pressure; 9% of those students with elevated blood pressure have been confirmed with pre-hypertension; an additional 8% of students with elevated blood pressure have been confirmed with hypertension or suspected hypertension. The numbers of adolescents confirmed as pre-hypertensive or hypertensive exceeds the expectations contemplated at the start of this pilot project. Additionally, the pilot project identified some students who had been previously diagnosed with hypertension by other providers but were non-compliant with medications, diet, exercise, and/or counseling.

The SBHC site, and its ongoing relationships, trust of providers, use by the registered students, and partnerships with the schools and school systems have proven to be a critical component of the ability to identify, educate, and provide medical care and follow-up of students identified as at-risk for hypertension. The SBHCs' ability to see, screen, diagnose, and manage these adolescents is paramount to the successful diagnosis, care, and education of students on blood pressure management, and lifestyle changes necessary for these students to be aware of as they move into adulthood. Students have easy access to SBHCs because they are housed at the school, and SBHCs have direct access to students to assure patient follow-up resulting in increased patient compliance and consistent care. The educational component in monitoring, and treating hypertension, and pre-hypertension is significant. The SBHCs have involved nutritional counselors, diet, and exercise educational information, weight management groups, and clinical follow-up to assure that these students receive the information, and care necessary to manage their elevated blood pressure, and weight/obesity issues.

Summary:

The next steps are to broaden the reach of the study to have all 65 SBHCs in Louisiana use the best practice guidelines, and protocols to screen for high blood pressure. Expanded implementation will improve the diagnosis and treatment of hypertension in school age children, and increase opportunities to educate students, families, and medical professionals. There was a statewide educational session for SBHC sponsors in early June to share the pilot program results to date, and to introduce the guidelines and protocols established throughout this project. That will provide the first steps toward implementing the program at their individual sites.

For more information, please call Maxine Kimbrell at (504) 361-6900 or e-mail maxine.kimbrell@la.gov.

A Pre- and Post-Test Assessment of Asthma Educational Training for Healthcare Providers – Louisiana, 2010

Blessing Dube, MPH; Jude Haney, MPH

Background:

Asthma is a common disease which continues to be a leading cause of hospitalizations among children and adults in Louisiana. The age-adjusted hospitalization rate for 2000 to 2008 was 154 per 100,000 Louisiana residents. Health care providers can assist in decreasing hospitalizations, missed school and work days through evidence-based clinical guidelines targeted at providing appropriate care and ensuring that all patients have a management plan or asthma action plan.

The Louisiana Asthma Management and Prevention Program with its partners, developed a state plan which aims at reducing the burden of asthma from a public health perspective. One of the goals includes spearheading trainings for health care providers to use proven successful strategies recommended by the National Asthma Education and Prevention Program (NAEPP) in their Guidelines for the Diagnosis and Management of Asthma based on the 2007 expert panel review.

Methodology:

Health care trainings were conducted in 4 regions of Louisiana (New Orleans, Baton Rouge, Monroe and Shreveport) that aimed at reinforcing the NAEPP Guidelines. These trainings consisted of a slide presentation tutorial by an asthma specialist who emphasized the guidelines followed by demonstrations on how to use asthma medication. A total of 97 participants were trained, including nurses and doctors. In 3 of the trainings (done on June 8 and June 28, 2010), a pre- and post- test was conducted to help assess the impact of the training on the providers given by Louisiana Office of Public Health's Asthma Management and Prevention Program. The pre-test was given to participants before the start of the conference with approximately 20 minutes to complete before being collected. At the conclusion of

(Continued on Page 6)

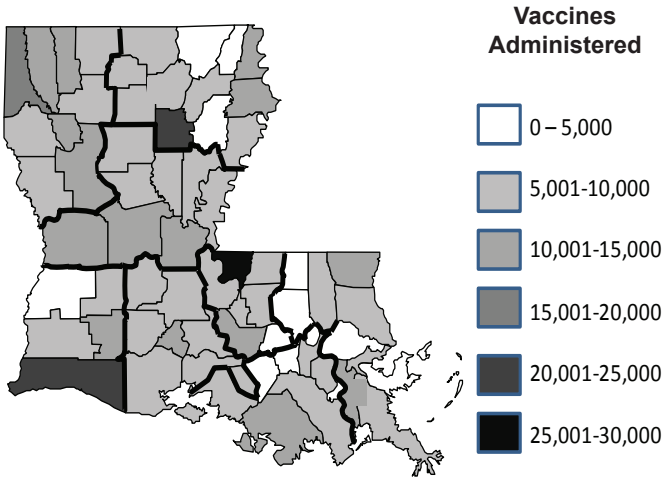
(H1N1 Vaccination ... Continued from Page 1)

used to analyze the number of vaccines administered came from the Immunization Program's database, the Louisiana Network for Kids Program (LINKS).

Results:

A total of 452,565 H1N1 vaccines were administered statewide, with the strike teams' efforts accounting for 21%. Absolute numbers of H1N1 vaccines administered varied from parish to parish, with 1,000 to 20,000 vaccines being administered in most parishes throughout the state. Less than 1,000 vaccines were administered in only a few parishes (n=10), and even fewer parishes (n=6) had more than 20,000 vaccines administered. To obtain a more accurate picture of the variation of vaccines administered in each parish given the difference in population density, per capita vaccination rates were computed. (Figure)

Figure: H1N1 Vaccines per 100,000 Population by Parish - Louisiana, October 8, 2009 - May 5, 2010



In regions 5, 6, and 7, the strike teams administered at least 30% or higher of the overall H1N1 vaccines. Statewide, the strike teams administered 30% or more of the vaccines in 27 (42.2%) parishes. Based on the collected information, it appears that the intended population for the strike teams' focus was school children, as most of the pods (points of dispensing) were held at schools, during school hours. For the schools/school districts that opted not to, or could not participate in the campaign, community pods were held. Some schools were self-sufficient, and did not utilize the strike teams. In some instances, school nurses and/or the parish health unit nurses participated in the administration of vaccines as well. Vaccines for the wider population were administered by others at physicians' offices, hospitals, clinics and pharmacies, to name a few. Very few pods were held after working hours or for the community at large, and for pods that were not held at a school, the locations were varied; moreover, pods were held at multiple locations on any given day.

To determine whether the strike teams' efforts made a difference with regards to the overall number of vaccines given per population, compared to the vaccines given by other entities in each parish, the two variables were correlated. The results show that the variables (vaccines given by strike teams and vaccines given by other entities) had the same, moderate influence on the overall number of vaccines given ($r=0.488$; $p=<0.01$, respectively) indicating that neither method had a greater impact on the total number of vaccines given compared to the other.

Discussion:

Based on results, the effort of this campaign, though focused primarily on school-aged children, was widespread, and many students and citizens toward the latter part of the campaign, had an opportunity to receive the vaccine, despite the controversy surrounding its safety. It appears that schools in most of the parishes in the state supported this campaign.

Although the actual influence of the strike teams' effort cannot be readily measured with regards to the number of strike teams per the total number of vaccines given per population, the methods employed in regions where the strike teams are credited for a vast proportion of the vaccines administered (at least 30% or higher) should be explored. If the strategies employed are solely independent of any other effort, they could be looked at in more detail for future, similar endeavors, as well as for best practice methods.

Broader community partnerships are favorable in such undertakings; thus, effort should be made to actively involve the wider community in such campaigns since future, similar endeavors may entail incidents where school children are not one of the high risk groups, and schools/school districts may not be accommodating in allowing health officials to use their facilities.

Considering the severity of the illness, and the population most at risk (school children), it seems surprising that a few schools/school districts opted not to participate in the campaign. Moreover, it was not anticipated that a number of parents would not provide consent. There appears to be considerable local authority and autonomy among school boards and superintendents with respect to authorizing participation in vaccination campaigns, something which would appear to be a public health and safety issue. Identifying the reason(s) why some schools/school districts and/or other groups that were asked to participate in the campaign, but opted not to participate, would be useful with respect to future planning of similar campaigns.

In an effort to measure the effectiveness of such campaigns, measurable goals and objectives need to be set prior to the campaign, and stringent methods need to be developed in order to effectively assess all campaign activities. Cost benefit analyses should also be considered, and future assessments should consider a prospective approach.

Limitations:

Due to the retrospective nature of this assessment, personnel completing the data collection form did not have the opportunity to thoroughly describe the decision process that they used prior to choosing the method(s) for vaccine administration, but rather was given the opportunity to only state what they did, when and where they conducted pods, and to what population groups.

Another limitation was accurately measuring the impact of the strike teams' efforts compared to the other vaccine administrators. Since the vaccination efforts at physicians' offices, pharmacies, health units, industries, or even the schools that were self-sufficient could not be easily identified, and had to be grouped together and compared to the strike teams' efforts, the results cannot clearly

describe how effective the strike teams were.

Based on the information collected, 'best practices' could not be clearly identified for this campaign. In regions 5, 6 and 7, the crude numbers of vaccines administered by the strike teams were higher compared to those in the other regions, although not significantly evident when calculated by per capita. Nonetheless, this may indicate a different approach by the strike teams or level of cooperation and participation by the schools, and other entities not captured by the data collection instrument, and may need to be explored further.

Conclusion:

Due to the extent of the H1N1 vaccination campaign, clear indicators of the more successful practices used in the campaign were anticipated. However, limitations including the lack of available data for best practice methods proved to hinder the goal of the assessment. What appears clear is that, at least as far as school age children are concerned, active participation by schools/school districts appears important, if not indispensable for success. Moreover, policy decisions regarding cooperation with public health officials by relatively autonomous school districts appear advisable. Comprehensive data collection should also be an integral part of any future vaccination campaigns and determining best practices should be a priority of any public health endeavor.

For more information, please contact Dr. Holcombe at (318) 487-5762 or e-mail to *david.holcombe@la.gov*.

Field Epidemiology Training

Metairie - September 23
Alexandria - October 13
Lafayette - October 26

For agenda and registration form, please see website
http://www.dhh.louisiana.gov/offices/page.asp?id=249&detail=9560

Listeria Cluster Identified, Associated With Consumption of Hog's Head Cheese - Louisiana, 2010

Erin Delaune, MPH

Listeria monocytogenes, is a gram-positive non-spore forming rod shaped bacteria. Listeria can be found in soil and water and has been found in a variety of raw foods, such as uncooked meats and vegetables. Vegetables can become contaminated from the soil or from manure used as fertilizer. Animals can carry listeria without showing any signs of infection and can contaminate foods of animal origin, such as meat and dairy products. Unpasteurized (raw) milk or foods made from unpasteurized milk can contain listeria. Processed foods such as soft cheeses and ready-to-eat deli meats can become contaminated after processing. Listeria can grow in a wide range of pH values, in relatively high salt concentrations, as well as in cold environments. These attributes allow the bacteria to thrive in food processing plants if not properly monitored and controlled.

The serotypes of *Listeria monocytogenes* most responsible for human illness are: 1/2a, 1/2b and 4b. The incubation period for listeriosis is variable and can range from a few days to greater than 3 weeks. Foodborne listeriosis can present in 2 forms: (1) adult infection and (2) fetal or neonatal infection. The result of adult infection is often asymptomatic or is characterized by acute gastroenteritis. In immune-compromised individuals and the elderly, the disease may invade the central nervous system and cause meningitis.

Follow-up is routinely conducted on all listeria cases reported in Louisiana. Outbreaks or clusters of listeriosis require more intense and focused investigations. As of August 2010, 14 cases of listeriosis were reported in Louisiana. Twelve of these cases were confirmed by the State Public Health Laboratory. After being confirmed by the State lab, isolated bacteria are submitted to the State's Pulse Field Gel Electrophoresis (PFGE) lab. There, enzymes are used to cut the bacteria's DNA to determine the DNA "fingerprint" or pattern. These patterns are uploaded onto a database (PulseNet) supported by the Centers for Disease Prevention and Control (CDC) and used by State and County Public Health Labs. PFGE patterns from the following bacteria are commonly uploaded onto PulseNet: salmonella, shigella, campylobacter, *E. coli*, listeria and vibrio. Clusters and outbreaks are detected through this database as bacterial DNA patterns are compared from across the country. Isolates from food and environmental samples can also be uploaded onto PulseNet which can aid in focusing the outbreak investigation. A cluster of 8 listeria cases in Louisiana were detected through PulseNet. Eight of the 12 isolates submitted to the State's PFGE lab had the same DNA pattern. This finding triggered a more thorough investigation into the cases. It was discovered that 3 of the cases reported eating hog's head cheese. Samples of the product were collected and tested for listeria at the CDC. One of the samples grew *Listeria monocytogenes* with a PFGE pattern that matched the PFGE pattern of the human isolates. The positive listeria culture resulted in the recall of 500,000 pounds of hog's head cheese as well as sausage that was produced at the same facility. Without the PulseNet program and the participation of hospital laboratories in sending bacterial isolates to the State Public Health Laboratory, this cluster may have gone undetected and potentially, more people would have become ill.

For more information please call Ms. Delaune at (504) 219-4622 or e-mail to *erin.delaune@la.gov*.

(Pre- and Post-Test Assessment ... Continued from Page 3)
the training, participants were given another 20 minutes to complete the post-test.

Approximately 70 participants completed both the pre- and post-tests which consisted of 21 multiple choice questions based on the training and the guidelines. There were some individuals overlooked who were late to the training or decided not to take the test.

The results presented here are based on the Shreveport and Baton Rouge asthma health care provider trainings. The dependent paired t-test was used to assess if there were any significant differences in conducting the trainings; SPSS version 12.0 was used for this analysis. The dependent t-test for correlated means was used to examine the hypothesis that there was a significant difference between healthcare provider's knowledge of NAEPP guidelines before and after the training. The probability of a type I error was set at α=0.05.

Results:

The pre- and post-tests were collected and scored to determine if the training made any difference in what the participants already knew about the NAEPP guidelines for the diagnosis and management of asthma prior to attending the training. On average, participants had a higher score during the post-test (M=17, SE = 0.38), than the pre-test (M = 15, SE = 0.32). The difference was found to be statistically significant ($t(26) = -5.57$, $p < 0.05$).

The distribution of the data shows increases in the mean, mode, and median (a 4-point increase in the mode and a 2-point increase in both the median and mode). There was more variation in the post-test scores and after the training individual health providers scores were further apart than their pre-test scores. This is much more evident in the variances of the scores. As shown in the histogram provided, the data was normally distributed in the pre-test and slightly skewed to the left in the post-test reflecting the greater number of higher scores in the post-test (Figures 1 & 2).

Figure 1: Pre-test Scores, Asthma Management and Prevention Program - Louisiana, 2010

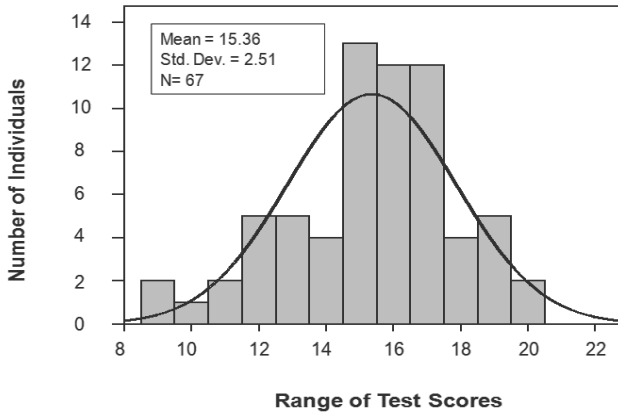
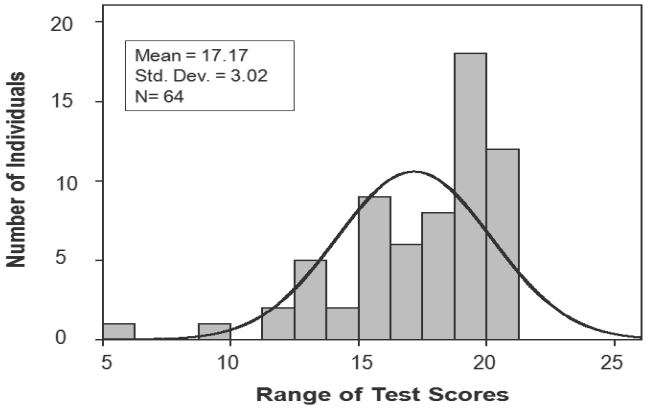


Figure 2: Post-test Scores, Asthma Management and Prevention Program - Louisiana, 2010



Limitations:

Neither pre- nor post-test results were collected for the individuals that left early or arrived late to the training, accounting for the missing and incomplete tests. Although pre-tests were collected just before the training, there is a possibility that some individuals may have changed their answers during the training. The New Orleans location did not have testing. The sample in the Monroe location was too small to be included; too many missing.

Discussion and Conclusion:

The current trends in asthma hospitalization among children and adults in Louisiana prompted the development of this training. Further research is necessary to evaluate whether the training can reduce asthma hospitalizations. The funds, provided by the Centers for Disease Control and Prevention to provide Louisiana healthcare providers with current asthma-related national recommendations and strategies, is an effective way to educate healthcare providers. As this training had a significant impact on health provider knowledge about asthma management for patients in health care settings, this program is recommended for training health care providers.

For more information, please contact Ms. Dube at (225) 342-9306 or e-mail to *blessing.dube@la.gov*.

Announcements

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

ANNUAL REPORTS: Botulism; Comparison of Rates in Louisiana and Other Southern States -2007; Meningococcal Infections; Psittacosis; Pertussis; Syphilis; Trichinosis

EPIDEMIOLOGY MANUAL: CDC-Cholera/Vibrio Form; CDC- Malaria Form and Instruction; Infection Control in Barber Shops; LA Adminstrative Code - Barbers; The Prevention and Control of Bed Bugs

FOODBORNE/WATERBORNE: Recalls- Hog's Head Cheese and Sausage; Eggs

HEATHCARE ASSOCIATED INFECTION: CMS IPPS Rule: July 30, 2010; Health Care Associated Grant Summary; NHSN Data Import Templates and Presentations; Statewide NHSH Training Slides

INFLUENZA: Prevention and Control of Influenza with Vaccines - Recommendations of the ACIP, 2010; Weekly Report

VETERINARY INFORMATION: Microbiological Makeup of Common Veterinary Infections, Second Quarter, 2010 – Canine and Equine; Specimen Collection Guide for Rabies or Bovine Spongiform Encephalopathy (BSE) Sampling from Cattle, Horses, and Other Large Animals

Table. Communicable Disease Surveillance, Incidence by Region and Time Period, July-August, 2010

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Jul-Aug 2010	Jul-Aug 2009	Jan-Aug Cum 2010	Jan-Aug Cum 2009	Jan-Aug % Chg*
Vaccine-preventable															
Hepatitis B	Cases	1	2	0	0	2	1	3	0	1	10	10	34	41	-17.1
	Rate[1]	0.1	0.4	0	0	0.7	0.3	0.6	0	0.3	0.2	0.2	0.8	1.0	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	4	1	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		1	0	0	0	0	1	1	0	0	3	30	18	117	-84.6
Sexually-transmitted															
HIV/AIDS	Cases[2]	40	29	5	7	2	8	9	6	6	112	192	706	878	-19.6
	Rate[1]	4.0	5.0	1.3	1.3	0.7	2.7	1.8	1.7	1.4	2.6	4.4	16.1	20.1	NA*
Chlamydia	Cases[3]	725	482	330	389	173	78	454	182	265	3078	3611	7419	23590	-68.6
	Rate[1]	89.8	74.9	83.6	67.3	60.8	26.0	85.1	52.4	50.8	69.8	81.9	168.2	534.8	NA
Gonorrhea	Cases[3]	260	143	67	103	24	18	111	52	40	818	1138	2021	7640	-73.5
	Rate[1]	32.2	22.2	17.0	17.8	8.4	6.0	20.8	15.0	7.7	18.5	25.8	45.8	173.2	NA
Syphilis (P&S)	Cases[3]	0	4	1	14	0	5	41	7	3	75	57	237	580	-59.1
	Rate[1]	0	0.6	0.3	2.4	0.0	1.7	7.7	2.0	0.6	1.7	1.3	5.4	13.1	NA
Enteric															
Campylobacter	Cases	1	5	1	13	3	1	3	3	5	35	23	141	72	95.8
Hepatitis A	Cases	0	0	0	0	0	0	0	0	0	0	1	5	3	NA*
	Rate[1]	0	0	0	0	0	0	0	0	0	0	0	0.1	0.1	NA*
Salmonella	Cases	40	34	43	50	14	12	25	42	43	303	320	781	730	7.0
	Rate[1]	3.8	6.0	11.4	9.7	5.2	3.9	4.9	12.0	11.2	7.0	7.4	18.1	16.9	NA*
Shigella	Cases	11	0	0	5	1	0	1	11	3	32	35	162	144	12.5
	Rate[1]	1.1	0	0	1.0	0.4	0	0.2	3.1	0.8	0.7	0.8	3.8	3.3	NA*
Vibrio cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other	Cases	0	0	0	0	0	0	0	0	0	0	16	18	41	-56.1
Other															
H. influenzae (other)		0	1	0	0	0	0	0	0	0	1	2	20	14	42.9
N. Meningitidis		0	0	0	0	0	1	0	0	0	1	1	12	11	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).

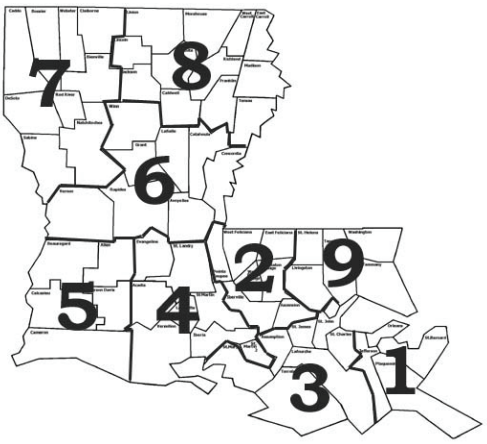
* Percent Change not calculated for rates or count differences less than 5.

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

Disease	Total to Date
Legionellosis	5
Lyme Disease	1
Malaria	1
Rabies, animal	3
Varicella	50

Table 3. Animal Rabies, July - August, 2010

Parish	No. Cases	Species
	0	



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

PRSRT STD
U.S. POSTAGE
P A I D
Baton Rouge, LA
Permit No. 1032

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.

This public health document was published at a total cost of $1,575.00. Seven thousand six hundred copies of this public document were published in this first printing at a cost of $1,575.00. The total cost of all printings of this document, including reprints is $1,575.00. This document was published by Moran Printing to inform physicians, hospitals, and the public of current Louisiana morbidity status under authority of R.S. 40:36. This material was printed in accordance with the standards for printing for state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with the provisions of Title 43 of Louisiana Revised Statutes.