Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
P.O. Box 60630, New Orleans, LA 70160 - Phone: (504) 568-8313
http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2037

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

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

July - August 2011 **Volume 22 Number 4**

Mayaro Virus Infection Louisiana, 2011

Christine Scott-Waldron, MSPH; Susan L.F.McLellan, MD; Monica Dhand, MD

In June 2011, the Louisiana Department of Health and Hospitals, Infectious Disease Epidemiology Section received notification from the Centers for Disease Control and Prevention (CDC) Arboviral Diseases Branch that a sample from a male patient in his late 20s, seen at a Region 1* hospital, was confirmed for recent infection with Mayaro virus. Mayaro fever, also known as Uruma Fever, is a RNA virus transmitted by Haemagogus mosquitoes endemic to several tropical regions of South America (Figure).

Figure: *Haemagogus janthinomys* Mosquito; Image Courtesy of Judy Stoffer, Walter Reed Biosystematics Unit

(Continued on Page 4)

Contents

Mayaro Virus Infection - Louisiana, 2011 1
A *Taenia Saginata* Infection - Louisiana, 2011 1
Tobacco Use- Behavioral Risk Factor Survey - Louisiana, 1995-2009 2
Phtobacteriium Damselae, Rare Illness in Humans - Louisiana, 2011 4
The Relationship Between Health Insurance Coveage and Prenatal Care: Louisiana Prams, 2000-2004 5
Announcements - Updates: IDES Webpages 6
Infectious Disease Epidemiology Rapid Response Team Training - Louisiana, 2011 6
Erratum 6

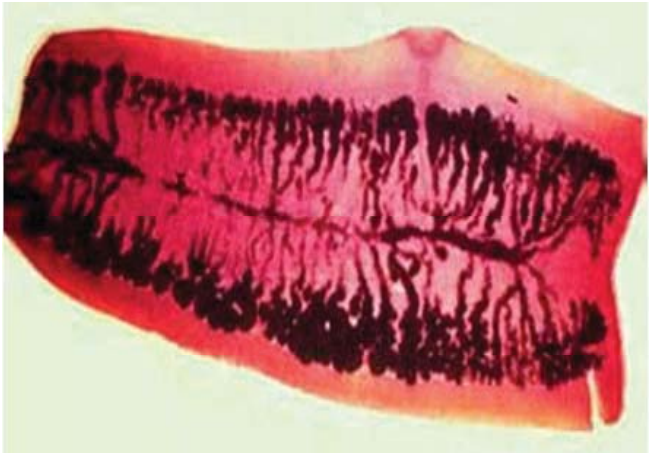
A *Taenia Saginata* Infection Louisiana - May, 2011

Susanne Straif-Bourgeois PhD, MPH, MS

A 26-year-old healthy male presented with complaints about abdominal pain and nausea to a Region 1* hospital's emergency department (ED). He had some mild abdominal pain off and on for the previous two months that became much more painful the night before his visit to the ED. The patient also stated that he had seen worms in his stool recently. He denied any recent travel but had moved from Lebanon to Louisiana about a year before.

The patient's stool sample was checked for worms and some Taenia proglottids were found. Microscopic identification of gravid proglottids identified the tapeworm as *Taenia saginata* (beef tape worm) (Figure).

Figure: Mature Proglottid of *T. Saginata*, Stained With Carmine. The Number of Primary Uterine Branches Is Used to Differentiate the Beef Tapeworm *Taenia saginata* from a More Serious *Taenia solium* (Pork Tapeworm) Infection. Image Courtesy of CDC.



Upon diagnosis, the patient was treated successfully with the antihelmintic drug Praziquantel.

T. saginata is a parasite of both cattle and humans, causing taeniasis in humans. *T. saginata* is normally 12 to 30 feet in length, but can become very large, over 36 feet long in some situations. The body is whitish in color, divided into the head-like part named the scolex, followed by a short neck and a highly extended body

(Continued on Page 3)

** Map of Regions on Page 7.*

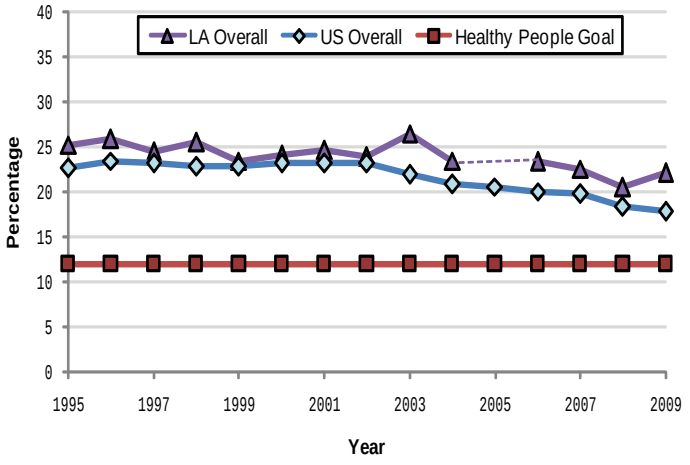
Tobacco Use - Behavioral Risk Factor Survey Louisiana, 1995-2009*

Nikki Lawhorn MPP; Jenna Klink MPH; Jennifer Bentley MPH; Ty-Runet Bryant MPH

The Behavioral Risk Factor Surveillance System (BRFSS) collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. The state-based system of surveys is conducted annually among non-institutionalized adults aged 18 and older in the United States. In Louisiana, the survey is conducted by the Louisiana Department of Health and Hospitals in coordination with the U.S. Centers for Disease Control and Prevention.

Smoking prevalence has decreased in Louisiana since 1995; however, prevalence rates continue to be well above the Healthy People 2020 objective (retained healthy people target from 2010) of reducing the overall prevalence of cigarette smoking among U.S. adults to less than or equal to 12% (Figure 1).

Figure 1: Prevalence of Adult Cigarette Smokers – Louisiana and U.S. Residents, 1995-2009.



According to 2009 tobacco data, 22.1% of Louisiana adult residents aged older than, or equal to 18 years are current cigarette smokers, which is higher than the national median of 20.6%. The number of adults who report "everyday" smoking decreased during that time period; the number of adults reporting smoking "some days" has remained relatively constant. There was a statistically significant decrease in smoking prevalence among Louisiana adults between 2003 and 2008 ($p < 0.05$). The 2008 and 2009 rates for Louisiana are statistically similar (the confidence intervals overlap).

In order to have a sufficient sample size to provide smoking prevalence estimates at the parish level, estimates were combined for the periods from 2003 to 2006 and 2007 to 2009. In general, the smoking prevalence among Louisiana adult residents has decreased in southeast Louisiana parishes from the earlier period (2003 to 2006) to the later period (2007 to 2009). As smoking prevalence has decreased in Louisiana as a whole, it has also decreased in individual parishes (Figures 2a and 2b).

**Data not reported for Louisiana for 2005 due to Hurricanes Katrina and Rita.*

Figure 2a: Prevalence of Adult Smokers - Louisiana Parishes, 2003-2006

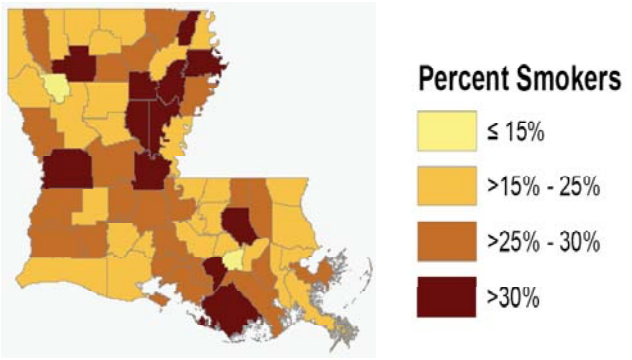
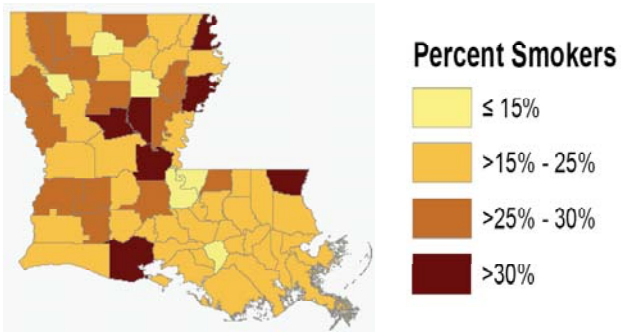


Figure 2b: Prevalence of Adult Smokers - Louisiana Parishes, 2007-2009



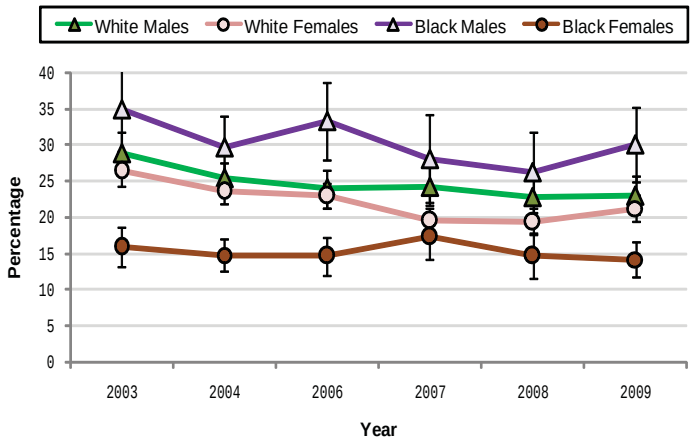
Before 2006, White adults in Louisiana were more likely to be smokers compared to Black adults in Louisiana. Since 2006, there has been a small decline in smoking prevalence across race and gender categories. When adult smoking prevalence rates are broken down by race and gender within Louisiana, Black males have higher reported smoking rates than all other racial and gender combinations; White males and females report median smoking rates; Black females have the lowest reported smoking rates (Figure 3).

Louisiana Morbidity Report
Volume 22 Number 4 July-August 2011

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.

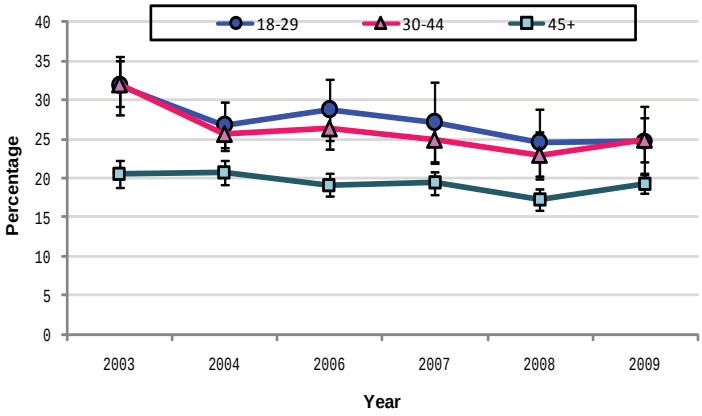
Assistant Secretary, OPH	*Clayton Williams, MPH*
State Epidemiologist	*Raoult Ratard, MD MPH*
Editors	*Susanne Straif-Bourgeois, PhD MPH* *Theresa Sokol, MPH* *Rosemarie Robertson, BS MT(C) CNMT*
Layout & Design	*Ethel Davis, CST*

Figure 3: Prevalence of Resident Adult Smokers by Race and Gender Louisiana, 2003-2009



Since 2003, there has been a 22% decrease in smoking prevalence among Louisiana smokers between the ages of 18 to 44 years (from 32% to 25%). From 2003 to 2009, there were no significant differences in smoking prevalence between Louisiana adults in the 18 to 29 year old age group, and those in the 30 to 44 year old group. Smoking prevalence among Louisiana adults ages 45 years and older has been significantly lower than among 18 to 44 year olds (Figure 4).

Figure 4: Prevalence of Resident Adult Smokers by Age Group Louisiana, 2003-2009



Maternal Smoking

In 2007, roughly 13% of women in Louisiana smoked during pregnancy and nearly 23% of them smoked during the three months prior to becoming pregnant. Smoking during pregnancy can cause severe negative health effects including premature rupture of membranes, placental abruption and placenta previa. Infants born to mothers that smoke are at an increased risk for low birth weight (LBW), respiratory illnesses during infancy, and Sudden Infant Death Syndrome (SIDS).

The Louisiana Campaign for Tobacco Free Living (TFL), in collaboration with the Louisiana Tobacco Control Program (LTCP), is working to address maternal smoking by: expanding its efforts to promote the Louisiana Tobacco Quitline (1.800.QUIT.NOW); through providing workshops; and a webinar series that will present current best-practice cessation counseling methods for health professionals working in a reproductive health setting. Presently, the Louisiana Tobacco Quitline offers a cessation program specific to pregnant women. All pregnant Louisiana residents (regardless of insurance status) are eligible for up to 10 free one-on-one counseling calls throughout the course of their pregnancy. In order to reduce the risk of relapse, they are also eligible for five free one-on-one calls with a 'Quit Coach' during the post-partum period.

A free upcoming webinar hosted by TFL and LTCP, and presented by Debbie Regan, R.N., IBCLC - *Breastfeeding and Tobacco Use*, will be held on October 5th, 2011. CE/CEU credits are pending. Interested parties may register at *http://www.zoomerang.com/Survey/WEB22BSMSALSZL/*.

To access the previously held webinars- *Barriers to Tobacco Cessation during Pregnancy* and *Preconception Health and Tobacco Use*, or for any other information on the maternal and child health cessation program, please contact Jennifer M. Bentley at (504) 301-9838, or email to *jbentley@lphi.org*.

For references and more information on the surveillance data presented above, please contact Jenna Klink at (504) 301-9829, or email to *jklink@lphi.org*.

(A Taenia Saginata Infection ... Continued from Page 1)

part called the strobila. The scolex is composed of four powerful suckers; the strobila is composed of a series of ribbon-like segments called proglottids. *T. saginata* normally consists of 1000 to 2000 proglottids and can also have a lifespan of 25 years in a host's intestine. In the gravid proglottid, the branched uterus is filled with eggs. The gravid segments detach and are passed in the feces. Each of these segments can act like a worm. When the segments dry up, the proglottid ruptures, and the eggs are released. The eggs, which can only hatch in cows, then migrate as 'oncospheres' through the blood to the muscle. There, an oncophere can develop into an infective larval stage called cysticercoid cysticerci.

Humans only become infected when they eat beef that is not fully cooked. After consumption, it takes over two months for cysticerci to develop into an adult tapeworm; over time, more and more of the gravid proglottids are produced.

Based on the above case history, it is most likely that the patient was infected while still living in Lebanon where the disease is relatively common. Taeniasis is also often seen in Africa, Southeast Asia and Latin America. In the U.S. the prevalence is less than one percent (1%); most cattle are free of the parasite because of strict federal sanitation policies. In order to prevent *T. saginata* infections, persons should only eat cooked beef that it is no longer pink inside (cysticerci die at 56°C). Also, beef frozen at -5°C is considered to be safe to consume.

For more information, please contact Dr. Straif-Bourgeois at (504) 568-8292 or email to *susanne.straif-bourgeois@la.gov*.

Photobacterium damselae, Rare Illness in Humans Louisiana, 2011

Erin Delaune, MPH

Photobacterium damselae (previously classified as *Listonella damselae*; orginally classified as *Vibrio damselae)* is a Gram negative, halophilic bacterium. *P. damselae* is known to cause disease and skin ulcers in fish and other marine animals. In 1981, it was found to be the cause of ulcers in damselfish, which is where the bacterium got its name. Human infection from *P. damselae* can also occur. Worldwide, most cases of *P. damselae* are wound or soft tissue infections. Wound infections can occur when a preexisting wound is exposed to sea water, or when a person sustains a wound while in the sea water, or from handling marine animals. *P. damselae* produces an extracellular toxin called damselysin, which has the ability to break down red blood cells. Human wound infections can develop into necrotizing fasciitis, progress rapidly and may lead to death. Illness from seafood consumption is very rare, but possible if the infected fish or seafood is consumed raw.

Human infections caused by *Photobacterium damselae/Vibrio damselae* are rare in Louisiana. From 1982 to May of 2011, seven cases were reported. The majority of the cases (71%) were reported in the 1990s; the most recent case was reported in 2004. Most cases were male (86%), with the average age being 39 years old (range: younger than one year to 71 years). Two cases were known wound infections; one case was a septicemia. Although the exact location of exposure is not known, all cases resided in the following regions: 1, 2, 3, 4 and 9*.

Infection from Vibrios, including *P. damselae* is a class C disease; reporting is required within five business days. The State Public Health Lab accepts Vibrio isolates (including *P. damselae*) for confirmation and serotyping.

For more information, please contact Ms. Delaune at (504) 568-8316 or email to *erin.delaune@la.gov*.

** Map of Regions on Page 7*

(Mayaro Virus Infection ... Continued from Page 1)

Mayaro virus is an Alphavirus in the family Togaviridae, similar to Eastern Equine Encephalits and Western Equine Encephalitis. The virus is maintained in enzootic cycles circulating between vertebrate hosts (birds, rodents, and marmosets), and mosquitoes. The vector mosquito species *Haemagogus janthinomys* is well known for transmitting Yellow Fever. Humans are considered accidental hosts, becoming infected when they interact with these mosquitoes dwelling in the forest canopy. A 1998 seroprevalence study in French Guiana indicated a higher prevalence in persons living along the river and near the tropical forest. Mayaro virus is endemic to Trinidad, Brazil, Venezuela, Bolivia and Peru.

Mayaro virus, is similar to Dengue Fever and Chikungunya virus in clinical presentation; it causes an acute, self-limiting systemic febrile illness with headache, rash and severe arthralgia. The arthralgia can last for several weeks to months until full recovery. The virus was first isolated in 1954 from patients who recovered from febrile illness in Trinidad. In 1955, there were two reported outbreaks of "jungle fever" with 50 cases in Para, Brazil, and 400 settlers from Japan in Uruma, Bolivia. In 1977-1978, over the course of the rainy season another 4,000 persons in Brazil had complaints of arthralgia in ankles, wrists and toes, edema in joints and macropapular rash lasting three to five days.

On March 31, 2011, the patient became ill with a high fever (104°F) which persisted for three days accompanied by night sweats, neck stiffness and pain, swelling and stiffness in wrist, fingers and ankles. On April 4 2011, he complained of similar pain, swelling and stiffness in the knees. The fever resolved but the arthralgias persisted for months, even though there was an overall decrease in severity from the initial presentation. The patient did not report rash, lesions, lymphadenopathy, cough, bleeding or bruising.

He lived and worked in the Amazon basin near Iquitos, Peru from March 5 to April 5, 2011, traveling to Iquitos three times a year for one month at a time since July 2009. The patient also visited central Brazil in the fall of 2010 and reported multiple mosquito bites during this trip. He had taken malaria prophylaxis prior to his travels and during his stay, but did not complete the course of treatment. He was vaccinated against yellow fever in 2009. On May 5, 2011, the patient with no past medical history, presented to a Region 1 hospital with a one month history of migratory polyarthralgias. The physician sent a serum sample to the CDC, as the provider suspected Mayaro virus infection. The arboviral testing was positive for Mayaro virus by IgM and IgG ELISA capture. The CDC confirmed that the serology tests can be cross-reactive with related alphaviruses including Eastern Equine Encephalitis and Chikungunya viruses. This patient was cross-reactive for IgG antibodies. The CDC confirmed Mayaro virus with neutralization assays (plaque-reduction neutralization tests) which are more specific.

The signs and symptoms of this case were similar to previous clinical descriptions of the disease in the geographical area in which this patient traveled. Increasing industrialization, changing land use of these tropical forests and humans living closer to infected mosquitoes could increase the frequency of human Mayaro fever cases. It should be noted that the vector mosquito species capable of transmitting Mayaro virus is found in Louisiana. All suspect cases of Mayaro fever should be investigated.

For more information, please call Ms. Scott-Waldron at (504) 568-8301 or email to *christine.scott-waldron@la.gov*.

Save The Date!

Field Epidemiology Training

New Orleans - September 13, 2011
Lake Charles - September 29, 2011
Shreveport - October 26, 2011

For more details and to download registration forms please go to
http://www.dhh.louisiana.gov/offices/page.asp?id=249&detail=9560

The Relationship Between Health Insurance Coverage and Prenatal Care: Louisiana Prams, 2000-2004

Blessing Dube, MPH; Rodney Wise, MD; Lyn Kieltyka, MPH, PhD

Background:

Receipt of early and adequate prenatal care is an important agenda in the Healthy People initiative. The goals of increasing early access to prenatal care to 90% of all pregnant women and eliminating racial disparities have been continuously recommended for all pregnant women because of the potential to improve health for mothers and infants. While prenatal care alone cannot be expected to overcome a lifetime of poor health and/or habits, some studies report that inadequate use of prenatal care is associated with increased risk for low infant birth weight, preterm delivery, neonatal mortality, infant mortality, and maternal mortality. Thus, early initiation of prenatal care is one factor that can help address early detection and treatment of medical conditions, encourage healthy behavior, and educate women about factors that may affect pregnancy outcomes. Despite the potential benefits of entering prenatal care early in pregnancy, little is known about the relationship between pre-pregnancy insurance and receiving prenatal care as early in pregnancy as wanted. The findings in this report may help identify the needs or gaps in increasing the prevalence of receiving early prenatal care among Louisiana mothers.

Methods:

Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data linked with Vital records birth data from the years 2000 to 2004 was used to evaluate the study question, 'Is there an association between pre-pregnancy health insurance coverage type and receiving prenatal care as early in pregnancy as wanted?' PRAMS is an ongoing population based surveillance system funded by the Centers for Disease Control and Prevention and the Louisiana Maternal and Child Health Program which obtains self reported information from mothers concerning their health, pregnancy and newly born infants. A stratified random sampling technique based on birth weight (<1500g, >1500g) and geographical area (urban, rural) was used. Mailings were sent to selected study participants and non-respondents were followed up through telephone interviews. A 70% or higher response rate was achieved for each year over the five year study period. Survey responses from 9,712 Louisiana resident mothers whose pregnancy resulted in a singleton, twin, or triplet live birth and delivered within state boundaries were included in the study. Data were weighted to be representative of the entire population of Louisiana resident mothers meeting study criteria in the five-year period. Unadjusted and adjusted odds ratios were estimated using simple and multivariable logistic regression. Backward elimination was used to build the multivariable logistic regression model in SAS-callable SUDAAN.

Results:

Over the study period, about 85% of women entered prenatal care in the first trimester, and 1% of women did not receive any prenatal care during pregnancy. While 57.1% of women reported having their delivery paid by Medicaid during the study period, insurance coverage prior to pregnancy differed from that at delivery. Specifically, approximately 51% had private/HMO health insurance, 11% had Medicaid (prior to pregnancy, does not include LaMOMS but does include LaCHIP), and 38% had no insurance prior to pregnancy. Overall, 23% of women reported not receiving prenatal care as early in pregnancy as wanted. Results stratified by pre-pregnancy insurance type indicated that 34% of uninsured women, 31% of Medicaid women, and 13% of women with private or other insurance reported not receiving care as early in pregnancy as wanted. Additional characteristics of the study population include:

- approximately 59% were White
- 40% had 16 or more years of education
- 53% were married
- approximately 15% were under 20 years of age
- 10% were over the age of 35 years
- nearly half of the women reported a normal BMI; 23% were obese
- nearly 20% reported ever having smoked before pregnancy
- approximately 60% had an alcoholic drink within the past two years
- almost 60% had a previous live birth; among these 11% had either a preterm or low birth weight in their last pregnancy
- approximately 17% reported having hypertension before and/or during pregnancy
-2% reporting developing diabetes during pregnancy (Table 1).

Table 1: Selected Characteristics of the Study Sample By Receiving Prenatal Care As Early As Wanted – Louisiana, 2000-2004

Characteristic	Received prenatal care as early as wanted				p-value *sig at 0.05
	Yes		No		
	n	%	n	%	
Pre-pregnancy Insurance					0.0000*
Medicaid	739	69.01	328	30.99	
Private/HMO	4199	86.78	699	13.22	
None (uninsured)	2289	66.24	1213	33.76	
Maternal Age (years)					0.0000*
<20	950	65.96	542	34.04	
20-24	2085	71.55	850	28.45	
25-34	3407	83.10	705	16.90	
35+	790	86.05	144	13.95	
Maternal Education					0.0000*
0-11 years	1294	63.35	664	31.65	
12 years	2537	74.72	894	25.28	
13+ years	3360	83.54	681	16.48	
Maternal Race					0.0000*
White	4324	82.05	919	17.95	
Black	2784	69.59	1285	30.41	
Other	124	75.37	37	24.63	
Marital Status					0.0000*
Married	4326	85.11	763	14.89	
Not married	2903	67.64	1476	32.36	
First Trimester Prenatal Care Entry					0.0000*
No	486	43.86	659	56.14	
Yes	6729	83.38	1574	17.62	
Pregnancy Intention					0.0000*
Intended	3895	86.10	638	13.90	
Unintended (mistimed or unwanted)	3252	68.90	1573	31.10	

** Significant at alpha=0.05*

Percents are weighted to represent the resident population of Louisiana women giving birth during this time

Compared to women with private/HMO insurance, women with Medicaid insurance were 1.4 times (95% CI= 1.1,1.8) as likely to not receive prenatal care as early in pregnancy as wanted whereas women not having any health insurance were 2.1 times (95% CI= 1.8,2.4) as likely to not receive prenatal care as early as wanted, after controlling for maternal characteristics and other significant covariates (Table 2).

Table 2: Unadjusted and Adjusted Odds Ratios of Not Receiving Prenatal Care As Early As Wanted - Louisiana PRAMS, 2000-2004

Characteristics		Did Not Receive Prenatal Care As Early As Wanted		Reference Group
		Unadjusted OR, 95%CI	Adjusted OR, 95%CI	
Insurance Coverage	Medicaid	2.95, 2.44-3.56	1.43, 1.13-1.81	Private/HMO Insurance
	None	3.35, 2.94-3.81	2.07, 1.77-2.41	
Maternal Age (Years)	<20	2.54, 2.15-2.99	1.34, 1.09-1.65	25-34
	20-24	1.96, 1.71-2.24	1.16, 0.99-1.36	
	35+	0.80, 0.62-1.03	0.82, 0.62-1.08	
Maternal Education	<11 years	2.35, 2.02-2.74	*	13+ years
	12 years	1.72, 1.50-1.96	*	
Maternal Race	Other	1.49, 0.98-2.28	1.22, 0.73-2.05	White
	Black	2.00, 1.77-2.25	1.22, 1.05-1.41	
Marital Status	Not married	2.74, 2.43-3.08	*	Married
First Trimester Prenatal Care Entry	No	5.98, 5.14-6.97	4.26, 3.59-5.06	Yes
Pregnancy Intention	Unintended	2.80, 2.47-3.17	1.66, 1.43-1.92	Intended
Previous Smoking	Yes	1.42, 1.26-1.62		No
Stress Due to Partner Argument	Yes	1.79, 1.60-2.02	*	No
Stress Due to Traumatic Event	Yes	2.59, 2.21-3.04	1.44, 1.19-1.75	No
Stress Due to Financial Issues	Yes	1.95, 1.72-2.20	1.57, 1.36-1.81	No
Stress Due to Illness Or Death	Yes	1.18, 1.05-1.33	*	No
Weeks When Sure Pregnant	7-12 weeks	1.29, 1.10-1.52	1.19, 0.99-1.43	1-6 weeks
	13+ weeks	4.57, 3.22-6.50	3.07, 1.95-4.84	

** Not Statistically Significant*

Implications:

Both Medicaid and not having insurance prior to pregnancy are associated with not receiving prenatal care as early in pregnancy as wanted, after controlling for other factors. Because the additional consideration of common barriers to receipt of prenatal care services did not meaningfully change this finding, it is likely that novel approaches specifically targeting these groups of women are required. Specific barriers were more common based on insurance type. For example, lack of insurance coverage and monetary concerns were most commonly cited as the reasons for not receiving care as early as wanted among women with no insurance. Because 89.1% of the women who were uninsured prior to pregnancy reported having Medicaid paid deliveries, there may be additional opportunities to target these women for earlier pregnancy awareness and access to care. In contrast, being too busy, not having transportation, and having other children to care for were most commonly cited as reasons among women with Medicaid insurance.

The additional relationship with knowledge of the pregnancy (weeks when sure pregnant) and pregnancy intention may have additional implications on the association between insurance status and receiving prenatal care as early as wanted. Among women who reported receiving prenatal care as early as wanted, over 98% of women with each insurance type knew they were pregnant by 12 weeks gestation; among women not receiving care as early as wanted, only 91% of Medicaid, 94% of private/HMO insurance, and 96% of uninsured women reported knowing they were pregnant by 12 weeks gestation. While both knowledge of the pregnancy and pregnancy intention were statistically controlled for in this report, further exploration of this complex relationship may provide future directions for where interventions may be most effective. Reviewing systems processes for prenatal care services may also help eliminate any functional barriers that might exist.

In alignment with the new health care reform, policy approaches and programs should aim at addressing these gaps and improving early prenatal care services for women who seek such care. Regardless of insurance type, women who knew they were pregnant prior to 13 weeks were more likely to report receiving care as early as wanted. Access to pre- and inter- conception care for all women of reproductive age may further help facilitate receipt of prenatal care as early in pregnancy as wanted.

For more information, please contact Dr. Kieltyka at (504) 568-3511 or email to *lyn.kieltyka@la.gov*.

Announcements

Updates: Infectious Disease Epidemiology (IDES) Webpages

http://www.infectiousdisease.dhh.louisiana.gov

ANNUAL REPORTS: Amebiasis; Disease Listing by Year 1990-2010
ANTIBIOTIC SENSITIVITY: Louisiana Antibiogram 2009-2010; Trends in Antibiotic Sensitivity-2010
EPIDEMIOLOGY MANUAL: Amebic Encephalopathy and Keratitis; Brucellosis Summary; Campylobacter; Campylobacter Summary; *Clostridium Difficile* Summary; Giardiasis Summary; Meningitis; Plague Summary; Streptococcal Group A (GAS) Upper Respiratory Tract Infection (URTI) Summary; Tularemia; Tularemia Summary
HAI: Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011; Multi-society Guideline for Reprocessing Flexible Gastrointestinal Endoscopes
INFLUENZA: Weekly Summary
PUBLIC INFO: Communicable Disease Chart
SCHOOL RESOURCES: Handwashing Poster
VETERINARY: Common Veterinary Infections, Second Quarter, 2011-Canine, Equine and Feline; Non-human Primates as Pets; Post-Exposure Protocol for Unvaccinated Dogs, Cats or Ferrets

Infectious Disease Epidemiology Rapid Response Team Training-Louisiana, 2011

Dr. Gary Balsamo Presenting to Rapid Response Team Members Metairie - May, 2011.

Erratum: May-June Issue; Volume 22 Number 3; Page 3 -Last Paragraph; UV Exposure Cluster - Regions 4 and 5 - Louisiana, 2011

For more information, please contact Caroline Holsinger at (504) 568-8307 or email to *caroline.holsinger @la.gov*.

Table. Communicable Disease Surveillance, Incidence by Region and Time Period, May-June, 2011

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD May-Jun 2011	May-Jun 2010	Jan-Dec Cum 2011	Jan-Dec Cum 2010	Jan-Dec % Chg*
Vaccine-preventable															
Hepatitis B	Cases	1	1	0	0	0	0	0	1	4	7	4	26	26	NA*
	Rate[1]	0.1	0.2	0	0	0	0	0	0.3	1.0	0.2	0.1	0.6	0.6	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	2	0	4	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	7	14	15	NA*
Sexually-transmitted															
HIV/AIDS	Cases[2]	41	34	10	8	8	6	14	14	6	141	200	586	596	-1.7
	Rate[1]	4.1	5.9	2.6	1.5	2.9	2.0	2.8	4.0	1.4	3.2	4.6	13.4	13.6	NA*
Chlamydia	Cases[3]	1469	677	428	664	209	409	887	460	456	5659	4923	12856	14510	-11.4
	Rate[1]	182.0	105.2	108.4	114.9	73.4	136.3	166.2	132.5	87.4	128.3	111.6	291.5	329	NA*
Gonorrhea	Cases[3]	366	165	96	186	50	95	281	130	83	1452	1423	3623	4122	-12.1
	Rate[1]	45.4	25.6	24.3	32.2	17.6	31.6	52.7	37.5	15.9	32.9	32.3	82.1	93.5	NA*
Syphilis (P&S)	Cases[3]	30	12	4	13	10	12	84	11	5	70	76	181	201	-9.9
	Rate[1]	3.7	1.9	1.0	2.2	3.5	4.0	15.7	3.2	1.0	1.6	1.7	4.1	4.6	NA*
Enteric															
Campylobacter	Cases	1	5	3	20	3	4	2	1	1	40	44	101	107	-5.6
Hepatitis A	Cases	0	0	0	0	0	0	0	0	0	0	3	1	5	NA*
	Rate[1]	0	0	0	0	0	0	0	0	0	0	0.1	0.0	0.1	NA*
Salmonella	Cases	10	25	13	35	14	9	18	20	17	161	243	363	467	-22.3
	Rate[1]	1.0	4.4	3.4	6.8	5.2	3.0	3.6	5.7	4.4	3.7	5.6	8.4	10.8	NA*
Shigella	Cases	8	5	1	11	0	45	5	1	0	76	65	161	129	24.8
	Rate[1]	0.8	0.9	0.3	2.1	0	14.8	1.0	0.3	0	1.8	1.5	3.7	3.0	NA*
Vibrio cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other	Cases	2	2	4	1	1	2	0	0	1	13	13	23	18	NA*
Other															
H. influenzae (other)		3	2	1	0	1	0	1	0	1	9	6	35	19	84.2
N. Meningitidis		0	0	0	0	0	0	0	2	0	2	2	8	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] = Preliminary Data

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

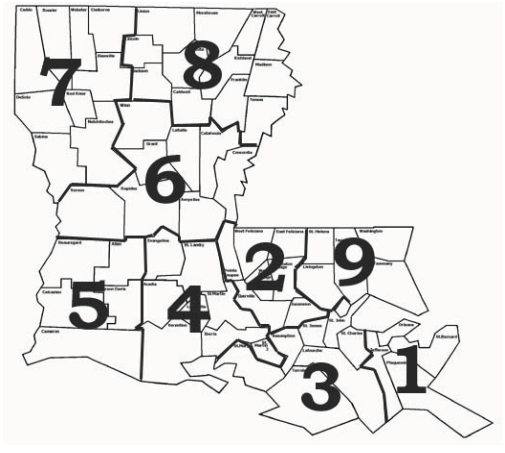
Table 2. Diseases of Low Frequency, January-December, 2011

Disease	Total to Date
Legionellosis	7
Lyme Disease	0
Malaria	1
Rabies, animal	1
Varicella	48

Table 3. Animal Rabies, May - June, 2011

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

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 Disease

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)
- Human Immunodeficiency Virus [(HIV), infection in pregnancy][2]
- Human Immunodeficiency Virus [(HIV), perinatal exposure][2]
- 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)][2]
- Listeria
- Lyme Disease
- Lymphogranuloma Venereum[1]
- Psittacosis
- Rocky Mountain Spotted Fever (RMSF)
- *Staphylococcus aureus*, Methicillin/Oxacillin Resistant[(MRSA), invasive infection]
- Staphylococcal Toxic Shock Syndrom
- 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[5]
- Complications of Abortion
- Congenital Hypothyroidism[4]
- Galactosemia[4]
- Hemophilia[4]
- Lead Exposure and/or Poisoning (children)[4] (adults)[5]
- 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 mail or facsimile on Confidential Disease Report forms (2430), fascimile (504) 568-8290, telephone (504) 568-8313, or 1-800-256-2748 for forms and instructions.

[1]Report on STD-43 form. Report cases of syphilis with active lesions by telephone, within one business day, to (504) 568-8374.

[2]Report to the Louisiana HIV/AIDS Program: Visit www.hiv.dhh.louisiana.gov or call 504-568-7474 for regional contact information.

[3]Report on CDC72.5 (f.5.2431) card

[4]Report to the Louisiana Genetic Diseases Program and Louisiana Childhood Lead Poisoning Prevention Programs: www.genetics.dhh.louisiana.gov or call (504) 568-8254.

[5]Report to the Section of Environmental Epidemiology and Toxicology: www.seet.dhh.louisiana.gov or call 1-888-293-7020

This public health document was published at a total cost of . Seven thousand copies of this public document were published in this first printing at a cost of . The total cost of all printings of this document, including reprints is . This document was published by 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 Statues.