Louisiana Morbidity Report

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November - December, 2014 **Volume 25, Number 6**

IS IT TUBERCULOSIS? - Louisiana, 2014

Louis Trachtman, MD, MPH; Charles DeGraw BA

While the annual number of cases of both active tuberculosis (TB) and TB infection reported to the Department of Health and Hospitals' Office of Public Health (OPH) are low and declining, TB is still a danger in Louisiana. As the systems of medical care in the United States and in Louisiana undergo changes, those who work in the Tuberculosis Control Program wish to remind all physicians and allied health care providers that TB is neither a rare disease nor just a fascinating disease studied in school. It is certainly not a disease of the past (Photo 1).

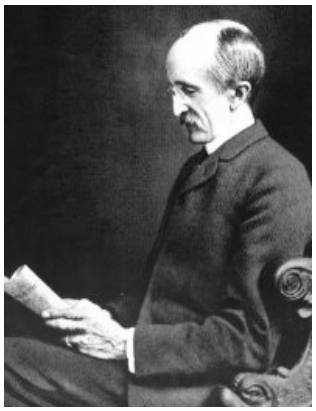
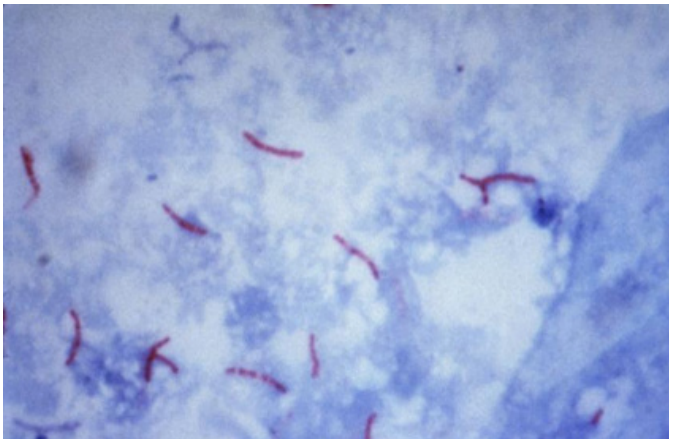


Photo 1:
Dr. Edward L. Trudeau (1848 - 1915) established the first laboratory dedicated to the study of tuberculosis (1894) at Saranac Lake, NY. (Credit: Wikipedia.org)

Case Study

In early 2014, two cases of active TB were reported to OPH. Both cases, each from different parts of Louisiana, were followed for weeks as out-patients for symptomatic chronic bronchitis with compatible chest x-ray findings. Neither patient gave a history of exposure to TB, but both patients seemed unresponsive to symptomatic treatment or antibiotics. Both patients' physicians chose to obtain sputum samples and have the sputum smears examined microscopically for acid-fast organisms. The samples were found to be positive (Photo 2).

Photo 2: *Mycobacterium tuberculosis (Credit: CDC/Dr. George P. Kubica)*



Testing of the patients for TB was done in quick order (also positive for *Mycobacterium tuberculosis).* Appropriate drug treatment was started, the cases were reported to OPH, interviews were conducted with the patients by public health workers, and contacts were notified and tested for TB. Unfortunately, several other close contacts, including children, were already infected and needed treatment. Fortunately, none of these contacts had yet developed the active disease. Several weeks later, sputum cultures from the cases proved positive for *M.tuberculosis*.

Mandatory Reporting

Health care practitioners who diagnose active TB, a Class B Disease,* are legally required report their diagnosis to OPH within one business day. Because of its scarcity and symptomatic similarity to other infections, cases of TB are often discovered later than other infectious diseases. Physicians and allied health care providers must keep TB in mind when diagnosing patients with TB symptoms.

* *Sanitary Code on Page 8*

(continued on page 2)

Contents

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What Does OPH Do With a TB Report?

(1) It is added to the count.

(2) The patient is interviewed as soon as possible for names and locations of close contacts.

(3) Close contacts are interviewed regarding whether or not they have any symptoms of TB and are offered testing for TB at no charge. They are also given the option of seeing their own physician for evaluation. The identity of the person originally diagnosed with TB is not revealed during an interview.

OPH now uses an interferon gamma release assay to test for TB infection. In rare cases in which blood samples are too difficult to obtain from very young children, a tuberculin skin test is used instead. This is in accord with recommendations of the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

(4) Those close contacts deemed to need medical evaluation because of a positive screening test or because of the closeness of contact to the index case (even in light of a negative test) are evaluated for treatment by a medical specialist in one of OPH's nine regional TB clinics around the state**.

The specialized clinics (located in New Orleans, Baton Rouge, Houma, Hammond, Lafayette, Lake Charles, Alexandria, Shreveport and Monroe) are staffed either by infectious disease specialist physicians or pulmonary disease specialist physicians as well as public health nurses and disease investigators. All services, including medicines offered through these clinics, are completely free to the patient. The contacts are also given the option of having their medical evaluation done by their own physician. As indicated, anti-TB drugs are prescribed and then supplied free of charge to the contact.

(5) The index case is also offered free treatment through one of these nine TB clinics. He or she also has the option of being treated by his or her own physician.

(6) The treatment regimens used for TB in Louisiana are those recommended by the AAP, the American Thoracic Society, and the CDC.

What Does OPH Offer the Practicing Physician?

The Louisiana State Laboratory is totally prepared to offer the practicing physician complete diagnostic laboratory work regarding TB, including: a sputum smear looking for acid-fast organisms; the testing of a sputum sample to determine quickly if *M. tuberculosis* is present in the sample and if that micro-organism is sensitive to rifampin (an early indication of multi-drug resistant TB); and the culturing of a sample to definitively diagnosis the presence of the micro-organism and sensitivity to all of the commonly used anti-tuberculosis drugs. There is no charge to either the physician or the patient for these laboratory services.

As mentioned above, many persons may need medical attention for evaluation, diagnosis, and treatment of active TB or for evaluation, diagnosis and possible treatment for being a contact of another person with active TB. Many patients with either active TB or latent TB infection are referred by their own physician to an OPH TB clinic for care while the patient's own physician continues to see the patient for any other medical conditions the patient may have or develop during the course of treatment for TB.

** Map of Regions on Page 7

In Summary

TB is still a threat to the public health of the people of Louisiana. Recognition of this fact is extremely important for all health care providers. Vigilance in regard to the recognition of TB is what will eventually conquer this disease.

For more information, please go to the Tuberculosis Control Program webpage at *http://dhh.louisiana.gov/index.cfm/page/1005* or send an email to *louis.trachtman@la.gov* or *charles.degraw@la.gov*.

NHSN Training

Metairie, Louisiana - October 13, 2014

Erica Washington (left) and Dielda Robertson (right) led the first of a series of three National Healthcare Safety (NHSN) presentations done in Louisiana. The other two in the series were held in Shreveport (October 15, 2014), and Alexandria (October 16, 2014). For training information go to *http://new.dhh.louisiana.gov/index.cfm/page/824*.

Louisiana Morbidity Report
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Vaccination Coverage Among Children in Kindergarten Louisiana vs. United States, 2013–14 School Year*

Vaccination coverage data were provided for 4,252,368 kindergartners included in reports from 49 states and the District of Columbia (DC) to the Centers for Disease Control and Prevention (CDC) via federally funded state, local, and territorial immunization programs; exemption data were provided for 3,902,571 kindergartners from 46 states and DC. The total kindergarten population surveyed in Louisiana was 63,976.

The majority of reporting states submitted vaccination coverage rates among kindergartners at or near the 95% target set nationally by the Healthy People 2020 program, including four doses of diphtheria, tetanus toxoid, and acellular pertussis (DTap); two doses of measles, mumps, and rubella (MMR); and two doses of varicella vaccine.

Vaccination requirements for school entry as reported to the CDC varied. Kindergartners were considered up-to-date for any single vaccine if they had received all of the doses of that vaccine required for school entry in their jurisdiction. Nine states considered kindergartners up-to-date only if they had received all of the doses for all vaccines required for school entry in their jurisdiction. Louisiana is one of these nine states.

Twenty-three states reported vaccination coverage of greater than or equal to 95% for two doses of MMR vaccine, with eight states reporting coverage below 90%. Louisiana reported 96.8% MMR vaccination coverage. The median vaccination coverage was 94.7% (range = 81.7% - Colorado to ≥99.7% - Mississippi).

The median local requirement for DTaP vaccination coverage was 95.0% with 25 states reporting coverage of greater than or equal to 95%. Louisiana reported 98.3% DTaP vaccination coverage (range = 80.9% - Colorado to ≥99.7% - Mississippi).

Nine states reported two-dose varicella vaccination coverage of greater than or equal to 95% . Louisiana reported 96.1%. The median among the 36 states and DC requiring and reporting the two-dose varicella was 93.3% (range = 81.7% - Colorado to ≥99.7% - Mississippi).

Although high levels of vaccination coverage by state are reassuring, vaccination exemptions have been shown to cluster geographically. Vaccine-preventable disease outbreaks can still occur where unvaccinated persons cluster in schools and communities. High exemption levels and suboptimal vaccination coverage leave children vulnerable to vaccine-preventable diseases.

The median total exemption rate was 1.8% among the 46 states plus DC reporting 2013-14 school vaccination exemption data. The percentage of kindergartners with an exemption was less than 1% for eight states and greater than or equal to 4% for 11 states (range = <0.1% - Mississippi to 7.1% - Oregon).

Louisiana had a total of 505 exemptions in the 2013-2014 school year, an increase of 14.3% from the 2012-2013 school year. Exemptions included both medical exemptions (n=83) and nonmedical exemptions (religious = 28; philosophical = 398). Kindergartners with exemptions represented a total of 0.8% of the kindergarten population.

Limitations with this report include: 1) not every state reported vaccination and exemption data; 2) vaccination and exemption status reflected the child's status at the time of assessment and not any updates; 3) a child with an exemption is not necessarily unvaccinated; 4) methodology varied by reporting program or between school years for the same program; 5) some programs were unable to provide detailed information limiting the validity of their reported estimates; and 6) it was assumed that non-responders and responders of the same school type had similar vaccination coverage and exemption rates.

**Excepted from the Morbiditiy and Mortality Weekly Report-October 17, 2014 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6341a1.htm?s_cid=mm6341a1_w*

Local Ties to Ebola Outbreak Louisiana, 2014

The Centers for Disease Control and Prevention (CDC) Epidemic Intelligence Officer Gregory Raczniak has been housed within the Office of Public Health's Infectious Disease Epidemiology Section (IDEpi) since the summer of 2013. The Centers for Disease Control and Prevention regularly sends its infectious disease personnel to different states for two-year periods to hone their skills in actual community outbreaks.

Dr. Raczniak returned from a month-long duty in Sierra Leone in October to IDEpi after serving as a 'contract tracer' for Ebola and spending the following three weeks being observed in Atlanta. Contract tracers are trained public health workers who use a special set of skills to track down everyone who had contact with an infected patient.

Dr. Raczniak has since left again for Liberia, where he will help treat health workers infected with Ebola.

Photo: CDC Officer Greg Raczniak (far right) sits down with members of Sierra Leone's Armed Forces to talk about efforts to contain Ebola: Credited to *CDC Global / Flickr*

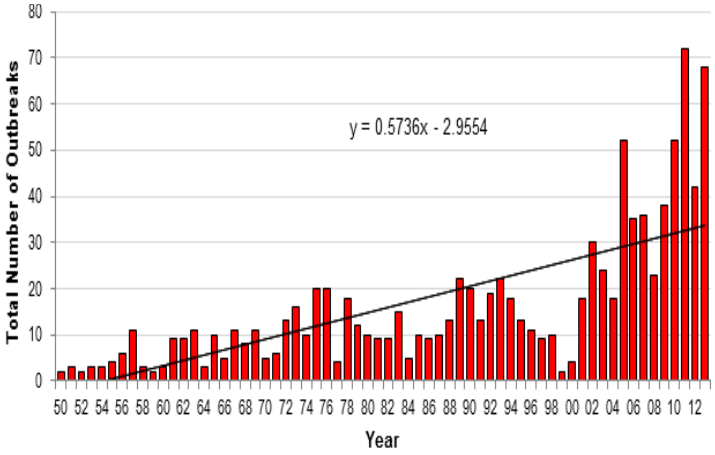
Outbreak Investigations - Louisiana, 1950 - 2013

Erin Delaune, MPH

Disease outbreaks are identified by the reportable disease surveillance system, by reports from the public, or by reports from health professionals. Outbreak investigations have been expanded beyond the usual foodborne outbreaks to include arthropod-borne diseases, hospital-acquired infections, and other infectious disease outbreaks in institutions. Investigations are carried out by regional teams that are supported by the Department of Health and Hospitals' Office of Public Health's Infectious Disease Epidemiology Section's (IDEpi) staff. Regional personnel, including Infectious Disease-Rapid Response Team (ID-RRT) staff, are regularly trained by IDEpi.

From 1950 to 2013, there were a total of 1004 recorded outbreaks in Louisiana (Figure 1).

Figure 1: Summary of total recorded outbreaks - Louisiana, 1950-2013



Outbreaks 2010 to 2013

Outbreaks have been primarily categorized by transmission type. For analysis purposes, 12 categories have been designated. Foodborne/enteric outbreaks have been the most common type of outbreak in Louisiana by far, accounting for 51% of the outbreaks. Respiratory outbreaks have made up between 12% to 26% of the outbreaks over the last four years (Table 1).

Table 1: Number of outbreaks by category and year
Louisiana, 2010-2013

Etiology Group	2010	2011	2012	2013	Total
Arbovirus	0	0	0	0	0
Foodborne /Enteric	28	27	20	36	111
Fungal	0	1	0	0	1
HAI*	1	3	0	2	6
Hepatitis	0	0	0	0	0
Other	0	1	2	0	3
Parasite	4	10	3	5	22
Respiratory	10	7	11	18	46
SSTI**	3	2	2	1	8
Virus	4	2	6	5	17
Waterborne	0	1	0	0	1
Zoonosis	0	1	0	1	2
Total	**50**	**55**	**44**	**68**	**217**

* *HAI: Healthcare-associated infection*
** *SSTI: Skin and soft tissue infection*

Between 2010 and 2013 there were no outbreaks caused by arboviruses or hepatitis, and few outbreaks caused by waterborne pathogens or by zoonosis. In the years 2010 to 2013, the most common causes of outbreaks were: foodborne and enteric pathogens (52% to 60%), respiratory (12% to 26%), parasites (6% to 20%), and skin and soft tissue infections (1% to 6%), (Table

Table 2: Number of outbreaks,by simplified category
Louisiana, 2010-2013

Numbers	2010	2011	2012	2013	Total
Food/Enteric	28	27	20	36	111
Respiratory	10	7	11	18	46
HAI	1	3	0	2	6
Parasite	4	10	3	5	22
SSTI	3	2	2	1	8
Total	**46**	**49**	**36**	**62**	**193***
Column Percent	**2010**	**2011**	**2012**	**2013**	**Total**
Food/Enteric	60.9	55.1	55.6	58.1	57.5
Respiratory	21.7	14.3	30.6	29.0	23.8
HAI	2.2	6.1	0	3.2	3.1
Parasite	6.6	20.4	8.3	8.6	11.4
SSTI	6.5	4.1	5.6	1.6	4.1
Total	**100**	**100**	**100**	**100**	**100**

**There were 24 outbreaks that were not classified in these five categories.*

The type of facility in which outbreaks occur often varies by the transmission mode of the disease. However, a commonality between all of these facilities is that they allow for large numbers of people to come in close contact with each other at any given point. This type of environment is conducive to the spreading of disease (Table 3).

Table 3: Foodborne, Respiratory, Parasite, and SSTI outbreaks by facility type - Louisiana, 2010-2013

2010-2013	Numbers					
Facility	FoodBorne /Enteric	Respiratory	HAI	Parasite	SSTI	Total
Area	15	2		3		20
Correction	2	2		1	1	6
Day Care	8	2				10
Group Party	4				1	5
LTCF	19	9	1	5	1	35
Medical	5	6	6	1	2	20
Other	3			1		4
Outside Party	3					3
Private Party	20	17		6		43
Restaurant	18	1				19
School	7	5		3	3	18
Ship		1				1
Total	**104**	**46**	**3**	**20**	**8**	**185**

The types of settings for these investigations were: area (geographical area such as a city, parish, or region), correctional

facility, day care center, school, medical facility, long term care facility (LTCF), restaurant, group party, private party, outside party (picnic, campsite), and ship.

Long term care facilities, geographic areas, restaurants and private parties are the main settings for foodborne and enteric disease outbreaks. The main settings for respiratory outbreaks are long term care facilities and private parties or residences.

For more information, go to *http://new.dhh.louisiana.gov/assets/oph/Center-PHCH/Center-CH/infectious-epi/Annuals/Outbreaks_LaIDAnnual.pdf* or contact Erin Delaune at (504) 568-8316 or email to *erin.delaune@la.gov.*

IDEpi Question/Answer Corner

Are there any special guidelines or procedures in place to educate providers or the public about the difference between flu and Ebola symptoms? What can be done to make sure that people get the proper care this season?

Seasonal influenza, enterovirus D68 (EV-D68), and Ebola virus infection can cause some similar symptoms. Previous experience with limited United States respiratory disease outbreaks (e.g., SARS and MERS) suggests that there may be some level of public concern or confusion between seasonal influenza and Ebola. The Centers for Disease Control and Prevention (CDC) is addressing these concerns by developing messages and materials that clearly distinguish between these diseases; what the possible exposures are; and which explain the relative risk of getting the flu, EV-D68, or Ebola in the US during this flu season.

Flu-like symptoms in US residents this flu season will most likely be caused by seasonal influenza, not EV-D68, Ebola, or MERS. In the US, enterovirus infections (including EV-D68) are more common in the summer and fall and generally decrease during flu season. Over the last several months, the US has experienced a nationwide outbreak of EV-D68 associated with severe respiratory illness. Recent reports from states suggest that EV-D68 activity may be declining.

Fall and winter is the time for flu in the US. There are early signs that flu activity is beginning to pick up. While the exact timing and duration of flu seasons vary, flu activity usually peaks between December and February.

In the US, infections with Ebola virus have been exceedingly uncommon and have all been linked to travel to West Africa or to the care of an Ebola patient by a health care worker. If a person has not traveled to affected West African countries or cared for an Ebola patient, his or her chances of getting Ebola are very low (close to zero).

Early in the course of illness, it may be difficult to distinguish some symptoms of Ebola from those of EV-D68 or influenza; however, as the infections progress, the symptoms become very different. There are tests to detect EV-D68, seasonal influenza and Ebola infection. Doctors will determine if patients should be tested for an illness based on symptoms, clinical presentation, and recent travel or exposure history.

Some of the symptoms of infection are:

EV-D68 - mild to severe respiratory illness or no symptoms at all. Mild symptoms include fever, runny nose, sneezing, cough, body and muscle aches. Severe symptoms may include wheezing and difficulty breathing.

MERS - severe, acute respiratory illness with symptoms of: fever, cough, shortness of breath. Some people also presented gastrointestinal symptoms including diarrhea and nausea/vomiting.

Influenza - fever or feeling feverish, headache, muscle or body aches, feeling very tired (fatigue), cough, sore throat, runny or stuffy nose.

Ebola - fever, severe headache, muscle pain, feeling very tired (fatigue), vomiting and diarrhea develop after three to six days, weakness (can be severe), stomach pain, unexplained bleeding or bruising.

The CDC is preparing INFO responses, plain language fact sheets, foreign language translations, key points, and other materials as needed. This information is or will be provided online at *cdc.gov/flu* and *cdc.gov/vhf/ebola* as well as be disseminated nationally to public health information officers and other partners. There are also ongoing efforts to educate health care providers about the CDC's recommendations for the evaluation and treatment of febrile illnesses of different etiologies.

Can the State Laboratory do Botulism toxin antibody testing to determine if a patient has built up resistance to Botox injections?

Infectious Disease Epidemiology and the State Laboratory do not currently have any part in testing regarding resistance to Botox. There is currently no lab that does Botulism toxin antibody testing. Suspected cases of botulism are sent to the Centers for Disease Control and Prevention to test for the Botulism toxin.

For more information go to *http://new.dhh.louisiana.gov/assets/oph/Center-PHCH/Center-CH/infectious-epi/EpiManual/BotulismManual.pdf*

Announcements

Updates: Infectious Disease Epidemiology (IDEpi) Webpages
www.infectiousdisease.dhh.louisiana.gov

Annual Reports: *Clostridium difficile*; Norovirus; Outbreaks; Several Year Comparison 2012-2014; *Vibrios*

Epidemiology Manual: Blastomycosis; *Clostridium difficile*; Disinfectants for Use Against the Ebola Virus; Ebola Hemorrhagic Fever

HAI: Fall 2014 Newsletter; NSHN Training Videos-October 13, 2014

Influenza: Estimated Influenza Illnesses and Hospitalizations Averted by Vaccination - United States, 2013-14 Influenza Season (CDC); Influenza Surveillance Report 2013-2014 Season; Is It Flu or Ebola? (CDC); Weekly Report

West Nile Virus: Weekly Report

World Leprosy Week

January 25 - 31, 2015

Subject Index for the Louisiana Morbidity Report, 2013-2014

Note: Year and Issue Number are listed after the comma on each line - 13/06 = Issue Number 6 (Nov-Dec) for the Year 2013. Indices for the years 1967-2012 can be found on http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2226

Table: Communicable Disease Surveillance, Incidence by Region and Time Period, September-October, 2014

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Sep-Oct* 2014	Sep-Oct 2013	Jan-Dec Cum 2014	Jan-Dec Cum 2013	Jan-Dec % Chg*
Vaccine-preventable															
Hepatitis B	Cases	1	4	2	0	1	1	0	1	2	12	14	66	61	8.2
	Rate[1]	0.1	0.7	0.5	0	0.4	0.3	0	0.3	0.5	0.3	0.3	1.5	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	0	1	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		1	0	0	0	0	2	0	2	1	6	27	69	158	-56.3
Sexually-transmitted															
HIV/AIDS	Cases[2]	49	16	5	10	5	4	13	7	10	119	255	1128	1123	0.4
	Rate[1]	5.9	2.4	1.2	1.7	1.7	1.3	2.4	2.0	1.8	2.6	5.6	24.9	24.8	NA*
Chlamydia	Cases[1,3]	329	234	160	249	87	147	262	259	88	1,815	5,135	19,370	22,059	-12.2
	Rate[1]	37.9	34.8	39.5	42.1	29.5	47.3	47.6	72.7	15.9	39.4	111.6	420.9	479.3	NA*
Gonorrhea	Cases[1,3]	112	62	38	57	20	40	103	85	21	538	1,627	5,861	6,711	-12.7
	Rate[1]	12.9	9.2	9.4	9.6	6.8	12.9	18.7	23.9	3.8	11.7	35.4	127.4	145.8	NA*
Syphilis (P&S)	Cases[1,3]	35	16	12	15	2	1	21	14	4	120	112	455	350	30.0
	Rate[1]	4.0	2.4	3.0	2.5	0.7	0.3	3.8	3.9	0.7	2.6	2.4	9.9	7.6	NA*
Enteric															
Campylobacter	Cases	5	2	0	2	7	4	11	3	3	37	45	219	227	-3.5
Hepatitis A	Cases	0	0	0	0	0	0	0	0	0	0	3	6	9	NA*
	Rate[1]	0	0	0	0	0	0	0	0	0	0	0.1	0.1	0.2	NA*
Salmonella	Cases	37	40	24	46	19	28	20	33	34	281	327	1030	1123	-8.3
	Rate[1]	3.6	7.0	6.4	8.9	7.1	9.2	4.0	9.4	8.8	6.5	7.6	23.9	26.0	NA*
Shigella	Cases	3	2	1	1	0	2	1	0	1	11	77	120	326	-63.2
	Rate[1]	0.3	0.4	0.3	0.2	0	0.7	0.2	0.0	0.3	0.3	1.8	2.8	7.6	NA*
Vibrio, cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other	Cases	5	0	3	0	0	0	0	0	0	8	9	44	38	15.8
Other															
H. influenzae (other)		1	0	0	1	0	0	0	1	1	4	7	30	50	-40.0
N. Meningitidis		0	0	0	0	0	0	0	0	0	0	6	6	12	-50.0

[1] = Cases Per 100,000 Population.

[2] = These totals reflect people with HIV infection whose status was first detected during the specified time period. This includes people who were diagnosed with AIDS at the time HIV first was detected. Because of delays in reporting HIV/AIDS cases, the number of persons reported is a minimal estimate. Data should be considered provisional.

[3] = Prelminary data.

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

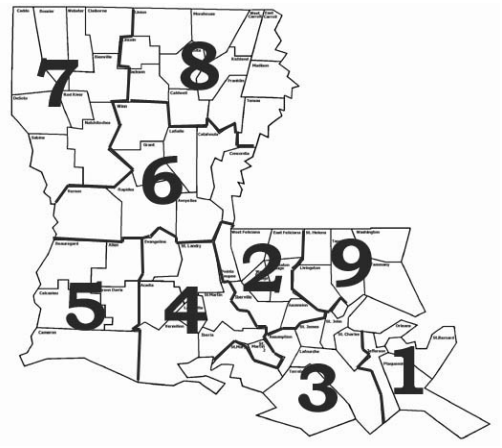
Table 2. Diseases of Low Frequency, January-December, 2014

Disease	Total to Date
Legionellosis	51
Lyme Disease	0
Malaria	12
Rabies, animal	3
Varicella	34

Table 3. Animal Rabies, September-October, 2014

Parish	No. Cases	Species
Ouachita	1	Dog

Figure: Department of Health and Hospitals Regional Map



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.

- Acute Flaccid Paralysis
- Anthrax
- Avian or novel strain Influenza A (initial detection)
- Botulism
- Brucellosis
- Cholera
- *Clostridium perfringens* (foodborne infection)
- Diphtheria
- Fish/Shellfish Poisoning (Domoic Acid, neurotoxic, Cigueatera, paralytic, Scombroid)
- Foodborne Infection
- *Haemophilus influenzae* (invasive disease)
- Influenza-associated Mortality
- Measles (Rubeola imported or indigenous)
- N*eisseria meningitidis* (invasive infection)
- Outbreaks of Any Infectious Disease
- Pertussis
- Plague (*Yersinia pestis*)
- Poliomyelitis (paralytic & non-paralytic)
- Q Fever (*Coxiella burnetii)*
- Rabies (animal and human)
- Ricin Poisoning
- Rubella (congenital syndrome)
- Rubella (German Measles)
- Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)
- Smallpox
- *Staphylococcus aureus*, Vancomycin Intermediate or Resistant (VISA/VRSA)
- Staphylococcal Enterotoxin B (SEB) Pulmonary Poisoning
- Tularemia (*Francisella tularensis*)
- 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.

- Amoeba (free living infection: *Acanthamoeba, Naegleria, Balamuthia,* others)
- Anaplasmosis
- Arthropod-Borne Neuroinvasive Disease (West Nile, St, Louis, California, Eastern Equine, Western Equine, others)
- Aseptic Meningitis
- Babesiosis
- Chagas Disease
- Chancroid
- Dengue Fever
- *Escherichia coli*, Shig-toxin producing (STEC), including *E. coli* 0157:H7
- Granuloma Inguinale
- Hantavirus (infection or Pulmonary Syndrome)
- Hemolytic-Uremic Syndrome
- Hepatitis A (acute disease)
- Hepatitis B (acute illness and carriage in pregnancy)
- Hepatitis B (perinatal infection)
- Hepatitis E
- Herpes (neonatal)
- Human Immunodeficiency Virus[2] [(HIV), infection in pregnancy]
- Human Immunodeficiency Virus[2] [(HIV), perinatal exposure]
- Legionellosis (acute disease)
- Malaria
- Mumps
- Salmonellosis
- Shigellosis
- Syphilis[1]
- Tetanus
- Tuberculosis[3] (*M. tuberculosis, M. bovis, M. africanum*)
- 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[3] (AIDS)
- Anaplasma Phagocytophilum
- Blastomycosis
- Campylobacteriosis
- Chlamydial infection[1]
- Coccidioidomycosis
- Cryptococcosis
- Cryptosporidiosis
- Cyclosporiasis
- Ehrlichiosis (human granulocytic and monocytic, *Ehrlichia chaffeensis)*
- Enterococcus, Vancomycin Resistant [(VRE), invasive disease]
- Giardia
- Glanders
- Gonorrhea[1] (genital, oral, ophthalmic, pelvic inflammatory disease, rectal)
- Hansen's Disease (leprosy)
- Hepatitis B (carriage, other than in pregnancy)
- Hepatitis C (acute illness)
- Hepatitis C (past or present infection)
- Human Immunodeficiency Virus[2] (HIV (infection other than as in Class B)
- Human T Lymphocyte Virus (HTLV I and II infection)
- Leptospiriosis
- Listeria
- Lyme Disease
- Lymphogranuloma Venereum[1]
- Meliodosis (*Burkholderia pseudomallei)*
- Meningitis, Eosinophilic
- Nipah Virus Infection
- Psittacosis
- Spotted Fevers [Rickettsia species including Rocky Mountain Spotted Fever (RMSF)]
- *Staphylococcus aureus*,(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*, invasive disease
- Transmissible Spongiform Encephalopathies (Creutzfeldt-Jacob Disease & variants)
- Trichinosis
- Varicella (chickenpox)
- Vibrio Infections (other than cholera)
- Yersiniosis

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]
- Heavy Metal (Arsenic, Cadmium, Mercury) Exposure and/or Poisoning (all ages)[5]
- 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[4] (newborns)
- 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