LOUISIANA MONTHLY MORBIDITY

DISEASES REPORTED DURING MONTH OF MARCH, 1971 BY PARISH OF RESIDENCE

ISONIAZID-ASSOCIATED LIVER DISEASE
PRELIMINARY RECOMMENDATIONS OF THE AD HOC COMMITTEE

The prevention and detection of hepatic toxicity make advisable screening and monitoring procedures suggested by the Ad Hoc Committee on Isoniazid and Liver Disease. This advisory committee to the U.S. Public Health Service made the general recommendation at its meeting on March 17 and 18, 1971, that mass tuberculin testing programs for placing tuberculin positive reactors on preventive therapy should be undertaken only if provisions are made for carrying out screening and monitoring procedures for all recipients of the drug.

Screening procedures for all patients considered for isoniazid preventive therapy should include:

1) A history of isoniazid administration to exclude those who have had an adequate course of the drug.

2) A history of adverse reactions to isoniazid to exclude those with significant hypersensitivity reactions, including liver disease.

(Continued on Page 3).

DIVISION OF PUBLIC HEALTH STATISTICS – – LOUISIANA STATE DEPARTMENT OF HEALTH

RELEASED APRIL 7, 1971	ASEPTIC MENINGITIS	DIPHTHERIA	ENCEPHALITIS	ENCEPHALITIS, POST INFECTIOUS	INFECTIOUS AND SERUM HEPATITIS	MEASLES	MENINGOCOCCAL INFECTIONS	PERTUSSIS	POLIOMYELITIS, PARALYTIC	RABIES IN ANIMALS	RHEUMATIC FEVER	RUBELLA *	SHIGELLOSIS	TYPHOID FEVER	OTHER SALMONELLOSIS	TETANUS	TUBERCULOSIS, PULMONARY	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY
TOTAL TO DATE 1970	5	7	5	6	165	38	32	1	0	33	7	53	10	1	15	0	180	2403	134
TOTAL TO DATE 1971	9	5	0	2	171	894	25	12	0	10	2	94	4	3	14	0	187	3376	163
TOTAL THIS MONTH	4	3	0	0	64	502	9	4	0	4	2	59	2	1	1	0	68	1281	64
ACADIA						9												8	1
ALLEN																			
ASCENSION								2									3		1
ASSUMPTION	1					1											1		
AVOYELLES					1													3	
BEAUREGARD																	1		
BIENVILLE																	1	1	
BOSSIER						24												10	1
CADDO					2	42											9	120	7
CALCASIEU					2	26						1					2	26	1
CALDWELL																			
CAMERON					1		1											2	
CATAHOULA						2													
CLAIBORNE										1								2	1
CONCORDIA						7													
DESOTO					1	4											2	2	
EAST BATON ROUGE		3			3	15											7	56	9
EAST CARROLL																		8	
EAST FELICIANA																			
EVANGELINE					1	1											2	3	3
FRANKLIN																		5	3
GRANT						1						27							
IBERIA						3						1					2		1
IBERVILLE					1	1											1	8	

* Includes Rubella, Congenital Syndrome

Louisiana Department

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JACKSON																			1
JEFFERSON					8	88	2	1			1	1	2					68	
JEFFERSON DAVIS					1	2												13	
LAFAYETTE					3	14											5	13	
LAFOURCHE	1																	9	
LASALLE																	1		
LINCOLN					2					3							1	1	
LIVINGSTON					1												1	3	
MADISON																	1	3	
MOREHOUSE						31		1										47	1
NATCHITOCHES					2	3												6	
ORLEANS	1				14	46	3					3		1	1		11	555	22
OUACHITA						19											7	74	4
PLAQUEMINES					1	2												5	
POINTE COUPEE						2													
RAPIDES					6	3												12	
RED RIVER						2												1	
RICHLAND																		16	
SABINE																	1		1
ST. BERNARD					3	20						22						4	
ST. CHARLES						4												6	
ST. HELENA																			
ST. JAMES																			
ST. JOHN					1	1												3	
ST. LANDRY						5												18	
ST. MARTIN																	1	2	
ST. MARY						13	1										1	2	2
ST. TAMMANY	1				4	12												39	
TANGIPAHOA						39					1							29	
TENSAS																			
TERREBONNE					2	4	2											3	
UNION						3											1	1	
VERMILION																	4		
VERNON					3	12												57	2
WASHINGTON						6												20	
WEBSTER						2												9	
WEST BATON ROUGE																	1	1	2
WEST CARROLL						14											1	3	
WEST FELICIANA																		3	
WINN					1	19						4						1	1
OUT OF STATE																			

From January 1 through March 31 of 1971, the following cases were also reported:
23 Malaria (contracted outside U.S.A.) and 1 Leptospirosis.

3) A history of other long-term medications such as diphenylhydantoin, meprobamate, hormone therapy, etc., to refer positive respondents for individual consideration regarding initiation of isoniazid preventive therapy, adjustment of the dose of other drugs, etc.

4) A history of current liver disease to permit deferring isoniazid preventive therapy until resolution of the acute process.

Note: As isoniazid-associated liver disease is considered an unpredictable hypersensitivity response, a history of past (non-isoniazid associated) liver disease or the existence of (non-isoniazid associated) chronic liver disease is not necessarily a contraindication to the initiation of isoniazid preventive therapy.

Patients receiving isoniazid preventive therapy should be monitored by monthly interviews and clinical observations including an appraisal of:

1) Symptoms consistent with those of hepatic damage - loss of appetite, fatigue, malaise.

2) Signs consistent with those of liver damage - dark urine (described as resembling "coffee," "tea," "mud," etc.), jaundice, scleral icterus ("yellow eyeballs").

The development of such symptoms and signs during preventive therapy should result in discontinuation of the drug and immediate referral of the patient to a physician.

3) The committee specifically recommended against routine monitoring by laboratory tests of liver dysfunction such as SGOT, SGPT, or other so-called "liver function" tests.

Note: No individual should receive more than a one month's supply of drug at one time. Each patient should be interviewed and his clinical status evaluated before a new supply is issued.

The committee restated existing priorities for preventive treatment (American Thoracic Society: Chemoprophylaxis for the Prevention of Tuberculosis). The groups are listed in order of declining priority from highest to lowest priority:

1) Household contacts: both tuberculin negative (especially the child) and tuberculin positive.

2) Recent converters of any age. (A recent converter is a person whose tuberculin test has converted or substantially increased in size the last 2 years. A conversion means a change from below 10 mm induration to above that level; a substantial change is one resulting in an increase of at least 6 mm or more.)

3) An individual with previously known tuberculosis whose status is now inactive and who has not had adequate chemotherapy.

4) An individual whose chest x-ray is abnormal, whose tuberculin test is interpreted as positive for infection with M. tuberculosis and who has not had previous chemotherapy.

5) Other medical conditions occurring in a reactor such as diabetes, reticuloendothelial disease, postgastrectomy status, the administration of immunosuppressive drugs or silicosis.

6) Positive tuberculin reactors under the age of 20.

7) Other identified positive tuberculin reactors.

Note: One must consider the consequences of the person becoming infectious, e.g. high priority is given to the positive reactor in a closed environment with numbers of susceptible individuals.

The Ad Hoc Committee making the above mentioned recommendations are prominent authorities in public health and private medicine, primarily experts in liver disease and tuberculosis control.

The Public Health Service convened the committee to review the available data regarding risk for both isoniazid-associated liver disease and tuberculosis following the late-1970 experience of isoniazid-associated hepatitis among Capitol Hill employees.

Among 2,321 tuberculin skin-test positive individuals who received INH, a total of 19 cases of hepatitis (as defined by presence of jaundice and/or dark urine) were found. Thus a clear excess of hepatitis cases occurred among INH recipients.

The risk of developing liver disease among patients on isoniazid are small, varying from 0 to 10 cases per 1,000 patients on isoniazid per year depending on factors not yet known. The development of liver disease is not predictable in any individual patient.

The morphologic pathology of isoniazid liver disease is not readily differentiable from that of viral hepatitis. Certain factors seem to increase the risk of isoniazid-associated liver disease, the predominant one being age. More liver disease is now being seen among recipients of isoniazid than was the case in early U.S. Public Health Service trials. The reasons for this is not known. The entire subject of isoniazid-associated liver disease continues under investigation.