Louisiana

LOUISIANA HEALTH AND HUMAN
RESOURCES ADMINISTRATION
DIVISION OF HEALTH

MONTHLY MORBIDITY REPORT

Provisional Statistics

FROM THE

OFFICE OF PUBLIC HEALTH STATISTICS

Reported Morbidity
August, 1976

INFLUENZA

Questions and Answers

1. **Q. Is there any evidence of swine flu or other influenza in the United States or elsewhere in the world at this time?**

   A. There is no evidence of any swine flu activity right now. According to the National Influenza Immunization Program weekly surveillance report of August 25, 1976, there have been 10 isolates of A/Victoria, 8 isolates of B/Hong Kong, and no isolates of A/New Jersey (swine) since May 22, 1976. There is scattered A/Victoria and B/Hong Kong activity in other parts of the world but no swine flu in humans at this time.[1]

2. **Q. Does this mean there will not be an epidemic this year?**

   A. No. There is no way of predicting for sure whether an epidemic will occur. The meaning of the quiescent period we are currently experiencing may be that the improved influenza surveillance maintained at this time detected an antigenic shift very early in the evolution of an epidemic, and that we are now in a period of silent dissemination of virus. It is possible that the Fort Dix isolation was a biological fluke. In any case the following facts remain: a) an antigenic shift in the influenza virus is expected at this time on the basis of the apparent 10 year periodicity of the virus; b) an antigenic shift in type A influenza has never been detected without a pandemic occurring shortly thereafter; c) the world population is very susceptible to swine influenza virus; d) although the swine influenza virus has been present in swine for years and there have been isolated cases in human exposed to swine, the Fort Dix outbreak was the first documentation of human to human transmission of this virus since the 1920's.

3. **Q. What is the difference between type A and type B influenza?**

   A. There are actually three types of influenza: A, B, and C. These refer to differences in the nucleoprotein core. Only types A and B have caused epidemics. Type A tends to cause more serious disease. Recent epidemic strains of flu virus have been A/Port Chalmers, A/Victoria, and B/Hong Kong. The first letter designates the type, the name indicates the place of initial isolation.

4. **Q. What are monovalent and bivalent vaccines?**

   A. Monovalent vaccines contain only one strain of influenza virus. Bivalent vaccines contain two strains. The preparations this year are monovalent A/New Jersey (swine), bivalent A/New Jersey (swine) and A/Victoria combined (available from Division of Health only),

and monovalent B/Hong Kong (available commercially only).

5. Q. Is the vaccine a live virus or an inactivated virus?

A. The vaccine is an inactivated or dead virus vaccine. Thus there is no risk of contracting influenza from the vaccine.

6. Q. What reactions can be anticipated to the vaccine?

A. Past experience with other influenza vaccines and field trials with the current vaccine in people over 18 have shown it to be very safe. Side effects were low grade fever, malaise, and myalgia occurring in about 2% of adults tested in field trials with 200 CCA units of vaccine (the recommended dose).[2]

7. Q. Are there allergic reactions to the flu vaccine?

A. Yes. Individuals allergic to egg protein could have hypersensitivity reactions. Individuals with history of egg allergy could have skin testing with the vaccine as antigen to confirm allergy, and then not receive the vaccine if they are truly allergic.

8. Q. When will vaccine be available this year?

A. We still have not received a date for the beginning of distribution. Manufacture and packaging are underway, and the state expects to receive the first vaccine around the first week of October.

9. Q. Who should get the vaccine? Who gets monovalent and who gets bivalent?

A. High risk individuals (See next question) should receive bivalent vaccine (A/New Jersey [swine] and A/Victoria). All others over 18 need only monovalent A/New Jersey (swine). The safety and efficacy of the vaccine for those under 18 still has not been determined, and there is still no decision from the Center for Disease Control (CDC) about whether they should be vaccinated, or if so, how. Monovalent A/New Jersey (swine) and bivalent vaccine will be available only through the State Division of Health. It will be distributed to organizations and private physicians participating in the vaccination program.

10. Q. Who are high risk individuals and how should they be vaccinated?

A. Everybody over 65 is considered "high risk." Also "high risk" are people with the following: congestive heart failure, rheumatic or congenital heart disease, chronic pulmonary disease, chronic renal disease, diabetes, and other chronic metabolic disorders. People being treated with steroids and other immunosupressive drugs like cyclophosphamide and azothiaprine are also considered "high risk." High risk patients should be vaccinated with bivalent vaccine (containing A/New Jersey and A/Victoria).[3] See insert page 5 re high risk children and Q. 17 re type B vaccine.

11. Q. How will the vaccine be distributed?

A. All organizations which have medical facilities, such as schools, universities, hospitals, and workplaces, will be asked to immunize their own personnel. There will be mass vaccination clinics run by the state, which will administer only monovalent vaccine. Vaccine will be distributed at no cost to private physicians. Private physicians may charge patients for the cost of administering the vaccine but not for the vaccine itself. High risk patients will receive vaccine either through private physicians or through the local health departments.

12. Q. What is the liability of individuals participating in the immunization program?

A. The recent federal legislation requires the federal government to defend any suit brought against any individual who participates on a voluntary basis in the immunization program and to pay any damages which are awarded. If the government feels that an individual's negligence was responsible, the government may in turn bring suit against that individual for a portion or all of the damages awarded. Physicians who charge for services rendered, or who do not use the standardized informed consent

form, do not fall under the recent legislation and may be subject to suits, as in other phases of medical practice.[3]

13. Q. Does the patient have to give informed consent before receiving the vaccine?

A. Yes. Written informed consent will be required from all patients of age (parent or guardian) except those receiving the vaccine from their private personal physician, in which case informed consent is considered to be implicit in the patient-physician relationship.

14. Q. Can other vaccines be given at the same time as the influenza vaccine?

Other vaccines such as measles, mumps, rubella, and DTP should not be given within two weeks of the influenza vaccine, either before or after.

15. Q. Will the vaccine have any effect on the TB skin test (Mantoux test)?

A. This possibility has been raised on a theoretical basis. The answer is not known, but to be safe, Mantoux testing should be deferred for at least one month after influenza vaccination.

16. Q. Can last year's flu vaccine be used this year?

A. Last year's vaccine contained A/Port Chalmers, A/Scotland, and B/Hong Kong, and is not recommended for use this year. If given, it will not provide protection against strains other than those contained in the vaccine. Thus, for example, last year's polyvalent vaccine would substitute only for this year's monovalent B/Hong Kong. Only high risk individuals need the B/Hong Kong vaccine, and these individuals would still need to be vaccinated against A/New Jersey and A/Victoria. Monovalent type B/Hong Kong is available this year through commercial channels.

17. Q. What is the recommendation for the commercially available monovalent type B vaccine?

A. The CDC recommends one dose of monovalent B influenza vaccine for high risk persons 18 years of age and older. It can be given at the same time as the bivalent A vaccine or at another time. If given concurrently, slightly enhanced side effects might be observed. If the individual has previously experienced significant side effects, it would be prudent to give the two vaccines separately, preferably with the bivalent A vaccine being given a few days or a week or more before the monovalent B vaccine.

18. Q. Should pregnant women be vaccinated?

A. An Advisory Committee of the Public Health Service examined this question and reported that "there are no data specifically to contraindicate vaccination with the available killed virus vaccine in pregnancy. Women who are pregnant should be considered as having the same balance of benefits and risk regarding influenza vaccination and influenza as the general population."[2]

19. Q. What about amantadine?

A. Amantadine is a drug which prevents entry of influenza virus into cells. It has been shown to be effective both in prevention and treatment of influenza. It is not being recommended for mass use in the United States, but might be used in individual cases, at the physician's discretion. For prevention of influenza, amantadine must be taken daily for the entire period when a person might be exposed to the influenza virus.

REFERENCE:

[1] Center for Disease Control: National Influenza Immunization Program. Weekly Surveillance Report, 8/25/76.

[2] Center for Disease Control: Recommendations of the Public Health Service Advisory Committee on Immunization Practice. Morbidity and Mortality Weekly Report, 28:227, 1976

[3] Summary of PL 94-380 ("National Swine Flu Immunization Program of 1976") by Charles Gozansky Legal Advisor, CDC.

HEPATITIS SURVEILLANCE IN LOUISIANA

June 1, 1975 - April 30, 1976

INTRODUCTION

All cases of hepatitis that are reported to health unit officials are tabulated by the Epidemiology Unit. In addition, health unit personnel are expected to gather data on both patient and physician to establish certain epidemiologic information such as patient's occupation, type of hepatitis, family contacts of patient . . . .

Physicians are expected (by law) to report to their local health unit all cases of hepatitis they treat. As a service to the physician and patient, the Division of Health upon request will supply all family contacts of type A hepatitis the gamma globulin that is prescribed by the physician.

This report analyzes the data received by the Epidemiology Unit. Cases with onset from June, 1975 through April, 1976 are included.

NUMBER OF CASES

Table I lists the cases by type during this study period. Cases were defined as type A (infectious, Australian antigen negative), type B (serum, Australian antigen positive), or unspecified. In some, but not all instances differentiation of type of hepatitis was based on Australian antigen serology. This means of differentiation is encouraged by the Epidemiology Unit. The data show that 54% (291 of 541) of the cases reported were defined as hepatitis A, 28% (152 of 541) as B, and 18% as not specified.

Of note, those parishes that reported more than 10 cases during the 11 month period are as follows: Orleans (125), Jefferson (92), Caddo (42), Vernon (32), East Baton Rouge (28), St. Tammany (19), Acadia (14), Terrebonne (13), St. Bernard (12), and St. Landry (12).

Those parishes that did not report any cases are Assumption, Avoyelles, Caldwell, Cameron, Catahoula, Iberia, Jackson, LaSalle, Morehouse, St. Helena, St. James, St. John, Tensas, and Winn. Better reporting from physicians in these areas is encouraged.

EPIDEMIOLOGY

No outbreaks with obvious common exposure were noted during the study period. No obvious case clustering was seen. However, there are some data that suggest raw shellfish consumption

Table 1

CASES OF HEPATITIS REPORTED IN LOUISIANA WITH ONSET BETWEEN JUNE 1, 1975 - APRIL 30, 1976

PARISH	TYPE A	TYPE B	TYPE NOT SPECIFIED	TOTAL
TOTAL	291	152	98	541
Acadia	6	2	6	14
Allen	4	–	–	4
Ascension	1	–	–	1
Assumption	–	–	–	–
Avoyelles	–	–	–	–
Beauregard	3	–	2	5
Bienville	–	1	–	1
Bossier	–	1	4	5
Caddo	24	14	4	42
Calcasieu	6	2	–	8
Caldwell	–	–	–	–
Cameron	–	–	–	–
Catahoula	–	–	–	–
Claiborne	–	–	1	1
Concordia	5	3	1	9
DeSoto	–	1	–	1
East Baton Rouge	10	7	11	28
East Carroll	2	–	–	2
East Feliciana	1	1	–	2
Evangeline	2	–	1	3
Franklin	6	–	–	6
Grant	1	–	–	1
Iberia	–	–	–	–
Iberville	1	–	–	1
Jackson	–	–	–	–
Jefferson	56	20	16	92
Jefferson Davis	1	–	–	1
Lafayette	2	3	1	6
Lafourche	3	2	–	5
LaSalle	–	–	–	–
Lincoln	4	1	–	5
Livingston	1	–	–	1
Madison	5	–	1	6
Morehouse	–	–	–	–
Natchitoches	2	–	–	2
Orleans	51	61	13	125
Ouachita	7	–	1	8
Plaquemines	1	3	1	5
Pointe Coupee	2	–	–	2
Rapides	6	1	2	9
Red River	–	1	–	1
Richland	2	–	1	3
Sabine	1	–	–	1
St. Bernard	6	3	3	12
St. Charles	–	1	–	1
St. Helena	–	–	–	–
St. James	–	–	–	–
St. John	–	–	–	–
St. Landry	4	7	1	12
St. Martin	–	1	1	2
St. Mary	2	2	2	6
St. Tammany	14	1	4	19
Tangipahoa	6	1	2	9
Tensas	–	–	–	–
Terrebonne	11	–	2	13
Union	1	–	–	1
Vermilion	4	3	2	9
Vernon	12	8	12	32
Washington	2	–	–	2
Webster	3	–	2	5
West Baton Rouge	2	–	–	2
West Carroll	7	–	–	7
West Feliciana	1	1	1	3
Winn	–	–	–	–

may be linked to cases that had onset in October, 1975. The data are meager at best, but an investigation is being contemplated (e.g. In October 1975, the number of cases reported dropped from a monthly average of 47 to 34, but the percent of reported cases giving a history of raw shellfish consumption in the 2 months prior to onset climbed from an average of 15% to 23% [not interviewed patients are excluded from this percentage]. Considering type A cases only, this percentage climbed from 17% to 30%).

THE NEED TO REPORT -
(All cases should be reported to the local unit)

Hepatitis can be prevented. (1) Type A patients can be identified and their household contacts can be given prophylactic treatment; (2) Outbreaks can be uncovered, especially if cases occur in clusters; and (3) Food handlers who develop hepatitis should be observed; surveillance of them and their work associates can lead to early identification of outbreaks.

Australian antigen (AA) testing should be performed on every case. The epidemiology and management of AA positive cases is different from that of AA negative cases.

Recommendations of the Committee on Infectious Diseases of the American Academy of Pediatrics

Immunization of Children at High Risk from Influenza Infection*

Children considered to be at high risk of serious illness if infected with influenza viruses include those with: 1) chronic bronchopulmonary disease, such as asthma and cystic fibrosis; 2) heart disease; 3) chronic renal disease; 4) diabetes and other chronic metabolic diseases; 5) chronic neuromuscular disorders; and 6) malignancies and immunodeficient states. It is recommended that these high-risk children be immunized against influenza.

The following recommendations are based on data from continuing clinical trials to evaluate the potency and safety of influenza vaccines in children 3 and over. The trials are not yet completed but do provide sufficient information at the present time from which to formulate recommendations for immunizing children 3 years and over and adolescents at high risk from influenza.

BIVALENT A VACCINE

Dose: Children and adolescents ages 3-18 years should receive 2 intramuscular injections (0.5 ml each) of split virus ("subvirion," "split product") vaccine containing 200 CCA units each of A/New Jersey/76 and A/Victoria/75 antigens separated by at least 4 weeks. *Split-virus vaccine is recommended* because the field trials showed that whole-virus vaccines produced substantially more side effects. Two doses of split-virus bivalent A vaccine should induce a good antibody response in most children and adolescents 3-18 years of age. A single dose of split-virus vaccine would be far less satisfactory. Therefore, it is important that parents of children at high risk be informed of the inadequacy of a single dose and be urged to see that their children receive a second dose.

Data are not yet available from the current field trials to derive recommendations for immunizing children less than 3 years of age. The Committee, therefore, recommends that current studies be extended to include immunization of infants and young children. It is hoped that the continuing field trials of influenza vaccines will provide data on which to base vaccine recommendations for normal children.

Side effects: In the clinical trials of split-virus vaccines conducted this year, side effects were mild and infrequent: low-grade fever (less than 101°) occurred in approximately 2% of vaccinated children. The symptoms reported were local reactions, fever, headache, malaise, and abdominal pain which usually occurred 6-12 hours after vaccination and rarely lasted more than 24 hours. The incidence of these symptoms was not significantly different from that observed in recipients of the placebo preparation. There were no seizures.

MONOVALENT B VACCINE

Over the past several years, limited clinical trials of vaccine containing the B/Hong Kong/72 antigen have been conducted in children. Since no new data are available, dosage recommendations will remain unchanged. Physicians should refer to individual manufacturers' package circulars for the recommended dosage of monovalent B vaccine. These instructions call for administering a fraction of the adult dosage to children 10 years of age or less. Because of the risk of increasing the frequency of side effects, it is desirable to avoid administering the monovalent B and bivalent A vaccines at the same time.

PRECAUTIONS

Whole-virus bivalent A vaccine should not be used in place of the split-virus vaccine. If whole-virus vaccine were used, side effects would be greatly accentuated.

Other vaccines should not be given at the same time as influenza vaccine because side effects would be difficult to classify and interpret.

Children highly sensitive to egg protein should not be given influenza vaccine except under close supervision of a physician. They should be skin tested or otherwise evaluated and should not be vaccinated if a severe reaction occurs.

Vaccination of children with acute febrile illness should be postponed.

* The Committee on Infectious Diseases of the American Academy of Pediatrics developed these recommendations on request from the Public Health Service's National Influenza Immunization Program. The Committee reviewed all available data from the current series of influenza vaccine field trials in children and adolescents and directs its advice both to private physicians and to the health agencies which may be providing vaccine to high-risk children.

SOURCE: Morbidity and Mortality Weekly Report, Vol. 25, No. 36, Center for Disease Control, D.H.E.W., September 17, 1976, p 285.

SELECTED REPORTABLE DISEASES

(By Place of Residence)

STATE AND PARISH TOTALS REPORTED MORBIDITY AUGUST 1976	ASEPTIC MENINGITIS	DIPHTHERIA	ENCEPHALITIS	ENCEPHALITIS, POST INFECTIOUS	HEPATITIS A AND UNSPECIFIED	HEPATITIS B	TUBERCULOSIS, PULMONARY	MENINGOCOCCAL INFECTIONS	PERTUSSIS	RABIES IN ANIMALS	RUBELLA*	SEVERE UNDERNUTRITION	SHIGELLOSIS	TYPHOID FEVER	OTHER SALMONELLOSIS	TETANUS	MEASLES	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY
TOTAL TO DATE 1975	116	0	23	10	369	122	341	30	40	3	284	12	95	4	110	4	1	14884	337
TOTAL TO DATE 1976	42	0	13	4	331	108	356	39	3	5	86	9	35	2	61	2	191	12658	390
TOTAL THIS MONTH	3	0	5	0	47	24	37	7	0	2	0	0	2	0	10	0	9	1368	29
ACADIA						2												9	
ALLEN							1											2	
ASCENSION																		2	
ASSUMPTION							1											2	
AVOYELLES																		5	
BEAUREGARD							1											5	1
BIENVILLE																		1	
BOSSIER															2			8	
CADDO						2				2			1					19	2
CALCASIEU					2		2								1			93	
CALDWELL																		1	
CAMERON							1											1	
CATAHOULA					2	1	1											1	
CLAIBORNE																		2	
CONCORDIA						1												3	
DESOTO																		5	
EAST BATON ROUGE	1				3		1								3			75	2
EAST CARROLL							1											3	
EAST FELICIANA																			1
EVANGELINE																			
FRANKLIN																		5	
GRANT																		3	
IBERIA					1		1											8	2
IBERVILLE					1													2	
JACKSON					3	3	3	2									4	87	3
JEFFERSON	1																	9	
JEFFERSON DAVIS			1															35	
LAFAYETTE			1		2			1										12	
LAFOURCHE																			
LASALLE																		2	1
LINCOLN							1											5	
LIVINGSTON			1				1											11	
MADISON																		12	
MOREHOUSE																		11	
NATCHITOCHES			1		17	12	9	2					1				5	464	12
ORLEANS					1		4											86	
OUACHITA			1															2	
PLAQUEMINES							1											1	
POINTE COUPEE					1		1											68	1
RAPIDES																		1	
RED RIVER							1											5	
RICHLAND					2													2	
SABINE								1										1	
ST. BERNARD					1													3	
ST. CHARLES																		6	
ST. HELENA					3		3											18	
ST. JAMES							1								2			5	
ST. JOHN					5			1										3	1
ST. LANDRY	1					1												39	
ST. MARTIN																		21	
ST. MARY					2													1	
ST. TAMMANY							1											5	1
TANGIPAHOA																		4	
TENSAS																		3	
TERREBONNE					1	1												11	
UNION																		13	1
VERMILION						1	1											25	
VERNON							1											12	
WASHINGTON																		2	
WEBSTER																		18	1
WEST BATON ROUGE																		1	
WEST CARROLL																		2	
WEST FELICIANA																			
WINN																			
OUT OF STATE																			

* Includes Rubella, Congenital Syndrome

From January 1, through August 31, the following cases were also reported: 4-Brucellosis, 2-Leptospirosis, 1-Malaria contracted outside the U.S.A.