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## MONTHLY MORBIDITY REPORT

### Provisional Statistics

FROM THE

BATON ROUGE, LA  
REPORTED MORBIDITY  
OCTOBER/NOVEMBER, 1976

OFFICE OF PUBLIC HEALTH STATISTICS

### PUBLIC HEALTH SERVICE RECOMMENDATIONS FOR VACCINATING NORMAL CHILDREN 3-18 AND HIGH RISK CHILDREN 6 MONTHS 3 YEARS AGAINST SWINE FLU\*

The Public Health Service said on November 17 that a safe and effective Swine Flu vaccine has been developed for children but that limited supplies would prevent a large scale immunizing effort for those between 3 and 18 years of age.

The announcement was made by Dr. Theodore Cooper, Assistant Secretary for Health, after receiving recommendations from PHS Advisory Committee on Immunization Practices (ACIP). The committee reported that a split virus A/New Jersey/76 vaccine would give good protection against swine flu without serious effects if administered by way of one (200 CCA units) inoculation followed by a (200 CCA units) booster shot 4 weeks later.

Dr. Cooper said that only 8 million doses of split virus monovalent vaccine suitable for children will be available before February. Because two inoculations would be required, only 4 million children could be immunized. "While it is clear", Dr. Cooper said, "that we have the formula to provide a safe and effective vaccine for children, it is also clear that not nearly enough will be available before the influenza season nears its end, despite productive efforts of the manufacturers of split virus vaccine."

"We would have preferred to have had sufficient vaccine to offer it to all children who are as susceptible to influenza as adults," Dr. Cooper said. "Fortunately," he added, "healthy children do not have the same risk of serious complications as older individuals."

He emphasized that there are sufficient quantities of the bivalent split virus vaccine available for children with chronic illness who are considered high risk to develop serious complications if infected by an influenza virus. Dr. Cooper said he was pleased that the American Academy of Pediatrics Committee on Infectious Diseases, after reviewing the data, recommended last week a formula for a safe and effective vaccine to protect high risk children between 6 months and 3 years. The formula calls for two inoculations of split virus bivalent vaccine separated by 4 weeks. The vaccine - 0.25ml - represents 50% of adult dose.

The limited quantities of vaccine for healthy children will be distributed to states on a per capita basis for distribution through neighborhood health centers and other urban sites for children whose living conditions may make them more susceptible to infection and through the offices of private physicians.

Another recommendation of the Advisory Committee of Immunization was that individuals between ages 18 and 24 should receive a second dose of either whole-virus or split virus swine flu vaccine to assure maximum protection.

### LOUISIANA MONTHLY MORBIDITY REPORT EDITOR'S NOTE

The statement above is a long awaited clarification on vaccination of the group 18-24. These people had poorer antibody response in field trials than older adults. Policy has been to vaccinate them with whole virus preparations only (Merrell and Merck, Sharpe and Dohme vaccines), since antibody response in the 18-24 age group is better with whole virus preparations

\*SOURCE: Telegram to LHHRA from J. Donald Millar, M.D., Director, Bureau of State Services, CDC, Atlanta, Georgia, Nov. 17, 1976.

than with split virus preparations (Wyeth and Parke-Davis). It has now been recommended that people 18-24 receive a second "booster" dose one month after receiving the first dose of either whole or split virus. This applies to individuals receiving either monovalent or bivalent vaccine. In field trials two doses resulted in a serocon-

version rate of 90% compared to about 50% with one dose of whole virus.<sup>1</sup>

#### REFERENCE

- <sup>1</sup> Center for Disease Control: *Morbidity and Mortality Weekly Report* 25 (45): 58, November 19, 1976.

## PENICILLINASE-PRODUCING NEISSERIC GONORRHEA FIRST INTRUSION INTO THE UNITED STATES

### CDC REPORT OF THE PROBLEM AND LOUISIANA V.D. CONTROL UNIT RESPONSE

#### THE PROBLEM:

##### Follow-up on Penicillinase-producing *Neisseria gonorrhoeae*\*

The Center for Disease Control has now confirmed 12 cases of gonorrhea caused by penicillinase-producing *Neisseria gonorrhoeae* in the United States. These cases were detected in California, Maryland, Rhode Island, Arkansas, Iowa, New York, and Virginia in the period February-September 1976 in patients who were not cured after penicillin treatment. Eleven of the cases have been epidemiologically linked to individuals who recently traveled from the Far East. Assessment of the prevalence of these strains in selected populations in the Far East continues.

Forty cases of gonococcal infection with penicillinase-producing *N. gonorrhoeae* have been detected in Liverpool, England, since February 1976. Currently, these isolates comprise approximately 9% of routine isolates obtained from residents of that port city. No definite foreign source of these cases has been found. One additional case has been reported from London, with a possible source in West Africa.<sup>1</sup>

*Reported by Dept of Health and Social Security, England, and Bur of Laboratories, Bur of State Services, CDC.*

**Editorial Note:** A worldwide search for penicillinase-producing strains of *N. gonorrhoeae* has been initiated. CDC considers it likely that other countries will soon confirm the presence of such strains, and that continuing occasional importation into the United States will occur. The potential for spread within the United States is unknown,

but may be influenced by the adequacy of treatment and follow-up provided to infected patients. State health departments and military installations have been informed of this problem and are screening for these strains among infected persons, especially those returning to the United States from the Far East.

The CDC recommended treatment of choice for uncomplicated gonorrhea remains 4.8 million units of aqueous procaine penicillin G intramuscularly, administered together with 1 gram of probenecid orally (MMWR 23[40]). All patients with a positive follow-up culture after initial treatment with recommended doses of penicillin, ampicillin, or tetracyclin should receive 2 grams spectinomycin intramuscularly. If the infection is related to the Far East, follow-up cultures 3-7 days rather than 7-14 days after the completion of treatment are preferred. All cases of gonorrhea should be reported to health departments. Physicians should identify cases related to the Far East so that, if feasible, special health department assistance can be offered for screening for penicillinase-producing strains, case follow-up, and contact referral.

#### Reference

- <sup>1</sup> Phillips I: Beta-lactamase-producing, penicillin-resistant gonococcus. *Lancet* 2:656, 1976.

\*SOURCE: *Morbidity and Mortality Weekly Report*, Vol. 25, No. 38, Center for Disease Control, D.H.E.W., October 1, 1976, pp 307.

**OUR RESPONSE:** Louisiana V.D. officials are concerned that penicillinase-producing *Neisseria gonorrhoeae* will continue to be imported into the United States, and will reach Louisiana, since

the prevalence of these organisms among selected groups in the Far East is as high as 30-40%.<sup>1</sup> These organisms pose a serious threat to the control of gonorrhea, for which penicillin is



currently the mainstay of therapy.

We are beginning a search for these organisms in Louisiana immediately. All patients treated for gonorrhea should have "test of cure" cultures within 3-7 days after therapy and a follow-up culture in 6 weeks. "Test of cure" cultures which are submitted to state laboratories should have "Rx Control" clearly checked on the Gonorrhea Request Form (Blue "LAB 15" form). Any "test of cure" cultures which are positive will be subjected to antibiotic susceptibility tests. Isolates which are resistant to penicillin will be sent to the Center for Disease Control in Atlanta to be tested for penicillinase production.

If "test of cure" specimens submitted to labs other than the state labs are positive, the physician should contact the local parish health unit or the V.D. control unit in New Orleans (504-568-5275) to arrange for further testing and

immediate follow-up of contacts. Positive "test of cure" isolates should be retained so that they can be tested for penicillinase production.

For all patients with positive "test of cure" cultures, V.D. staff will carry out epidemiological investigations, first to confirm that the putative treatment failure had actually received appropriate treatment, and then to trace the source and the contacts. Spectinomycin will be used for the following: (1) patients with documented penicillinase producing organisms and their recent contacts, and (2) patients with a positive "test of cure" culture after treatment with recommended doses of penicillin, ampicillin, or tetracycline.

#### REFERENCE

- 1 Center for Disease Control: Expanded Guidelines Concerning Patients with Penicillinase-Producing *Neisseria gonorrhoeae*, p.1, October, 1976.

## ST. LOUIS ENCEPHALITIS IN LOUISIANA - 1976

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Epidemiology Unit, DHHR

With the emergence of what appears to be an early winter, our mosquito population should be greatly decreased, thus breaking the transmission cycle for St. Louis Encephalitis.

As of November 4, 1976, Louisiana had recorded eight confirmed cases of St. Louis Encephalitis, two presumptive cases, and one possible case. A "confirmed" case is defined as one showing at least a fourfold rise or fall in antibody titer to SLE, a "presumptive" case is one with a single titer of 1:80 or greater, and a "possible" case is one with a clinical diagnosis of encephalitis but not meeting the above criteria. Cases occurred sporadically throughout the summer and early autumn (Figure 1). Seven of the eleven cases occurred in the area from Baton Rouge east to Mississippi (Figure 2). All together, eight parishes had cases (Bossier - 1, East Baton Rouge - 3, Orleans - 1, Rapides - 1, Richland - 1, St. Tammany - 1, Tangipahoa - 2, and Washington - 1).

Five cases were males, ranging in age from 15 to 59 years (median 27), and six were females, with an age range of 41 to 77 years (median 54.5). The four youngest cases were males. All cases were hospitalized. There was one death - the one "possible" case referred to above.

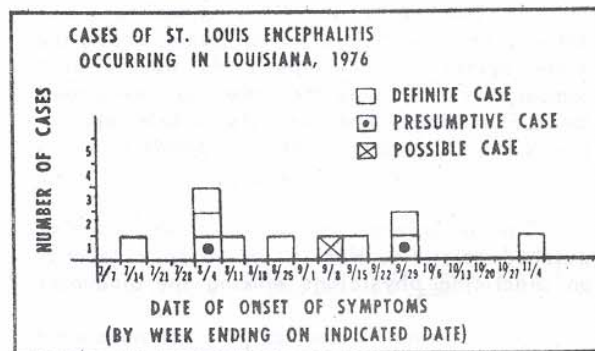


Figure 1

The 1976 experience in Louisiana was worse than that of 1975, when six cases were recorded in Louisiana. Nationwide, although 1976 was a relatively bad year for SLE, it was not nearly as bad as the severe epidemic year of 1975.

SLE is important to public health officials not only because it is a serious illness which arouses great public concern and even panic, but also because coordinated public activity through a variety of mosquito control activities can limit the occurrence of cases. Birds are the natural host of the SLE virus, with human cases

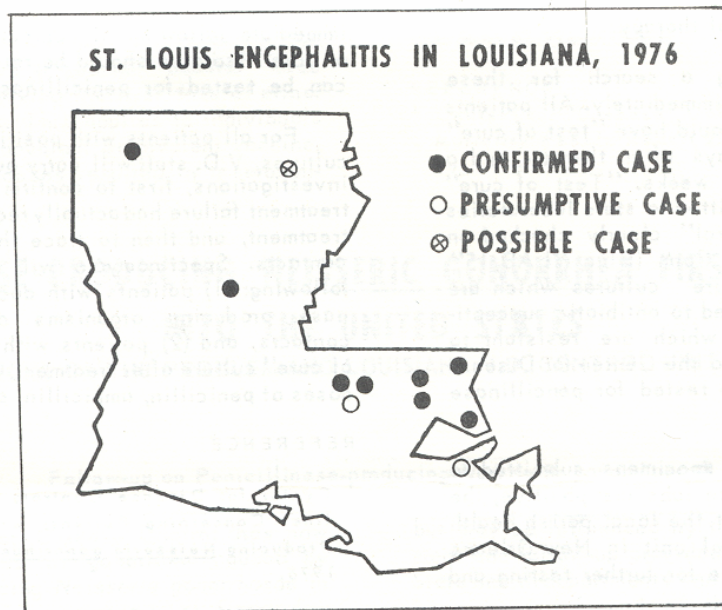


Figure 2

occurring as spillover when *Culex* mosquitoes bite infected birds and then bite susceptible humans. Hoping to find "hot spots" of virus activity in birds before human cases occur, the state systematically traps birds weekly at a number of sites around the state and bleeds them for SLE serology. When activity is detected, the Louisiana Mosquito Control program steps up its operations in that area.

The occurrence of human cases is also watched carefully. Human surveillance depends on practicing physicians making the diagnosis of SLE, which necessarily involves sending blood to the state lab for acute and convalescent serology, and reporting cases to the local health

units.

Louisiana's neighboring states of Texas and Mississippi reported a significantly higher number of cases than we reported, with 26 confirmed cases occurring in Mississippi and 23 in Texas. We have no definite way of knowing whether Louisiana's relative good record is the result of mosquito control activities, or whether physicians are not obtaining the acute and convalescent phase blood for the serological studies necessary to make the diagnosis of SLE. For next summer we urge physicians to draw SLE serologies on suspect cases and report these cases to the local health units.



# SELECTED REPORTABLE DISEASES

(By Place of Residence)

STATE AND PARISH TOTALS	ASEPTIC MENINGITIS	DIPHTHERIA	ENCEPHALITIS	ENCEPHALITIS, POST INFECTION	HEPATITIS A AND UNSPECIFIED	HEPATITIS B	TUBERCULOSIS, PULMONARY	MENINGOCOCCAL INFECTIONS	PERTUSSIS	RABIES IN ANIMALS	RUBELLA*	SEVERE UNDERNUTRITION	SIGELLOSIS	TYPHOID FEVER	OTHER SALMONELLOSIS	TETANUS	MEASLES	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY
Reported Morbidity October, 1976																			
TOTAL TO DATE 19 75	124	0	31	10	479	158	428	36	52	7	287	12	114	10	204	4	1	18776	457
TOTAL TO DATE 19 76	58	0	27	4	436	144	426	41	14	8	90	10	76	3	102	2	222	16182	498
TOTAL THIS MONTH	6	0	5	0	55	12	28	2	9	2	3	1	4	1	16	0	23	1788	56
ACADIA					2										1			11	
ALLEN																		4	
ASCENSION							1											3	
ASSUMPTION																	4	2	
AVOUELLES																		4	
BEAUREGARD																		2	
BIENVILLE																		9	
BOSSIER																		16	
CADDO					3	2			1	1				1	2			134	2
CALCASIEU					1		2	1										85	
CALDWELL																		3	
CAMERON																		3	
CATAHOULA																			
CLAIBORNE																		6	
CONCORDIA																		7	1
DESOTO										1								4	
EAST BATON ROUGE					6		4								3		1	30	
EAST CARROLL							2						1		1			5	
EAST FELICIANA																		3	
EVANGELINE																		1	
FRANKLIN																		8	
GRANT					1														
IBERIA							1											12	
IBERVILLE																		1	
JACKSON																		3	
JEFFERSON	1				12	3	1				1		2		1			61	4
JEFFERSON DAVIS																		10	2
LAFAYETTE																		43	
LAFOURCHE											2						1	18	1
LASALLE																		1	
LINCOLN					1		2											8	
LIVINGSTON			1			1												3	1
MADISON					1													10	
MOREHOUSE																		8	
NATCHITOCHE							1											13	
ORLEANS	4		1		18	3	7		8						2		7	873	30
OUACHITA							1										1	68	1
PLAQUEMINES					1												3	5	
POINTE COUPEE																		1	
RAPIDES							2								3			59	4
RED RIVER																		1	
RICHLAND							1											8	
SABINE															1				
ST. BERNARD					4										1		1	2	
ST. CHARLES							1											4	1
ST. HELENA																		1	
ST. JAMES																		2	1
ST. JOHN																		3	1
ST. LANDRY						1											5	14	
ST. MARTIN	1					1									1			6	1
ST. MARY							1											3	
ST. TAMMANY					2			1					1					27	
TANGIPAHOA			2									1						10	2
TENSAS																			
TERREBONNE						1												2	
UNION																		13	1
VERMILION																		1	
VERNON					2													57	1
WASHINGTON			1				1											19	
WEBSTER					1													44	
WEST BATON ROUGE																		4	1
WEST CARROLL																		5	
WEST FELICIANA																		18	
WINN																		5	1
OUT OF STATE																		2	

\* Includes Rubella, Congenital Syndrome

From January 1 through October 31, the following cases were also reported: 5-Brucellosis; 2-Leptospirosis; 2-Malaria contracted outside the U.S.A.

# **SELECTED REPORTABLE DISEASES** (By Place of Residence)

STATE AND PARISH TOTALS REPORTED MORBIDITY NOVEMBER, 1976	ASEPTIC MENINGITIS	DIPHTHERIA	ENCEPHALITIS	ENCEPHALITIS, POST INFECTION	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	128	0	35	10	526	176	474	38	56	7	288	12	117	10	221	5	1	19949	498
TOTAL TO DATE 1976	64	0	29	4	480	152	471	45	14	8	93	10	82	3	110	2	282	17462	544
TOTAL THIS MONTH	7	0	3	0	45	8	45	4	0	0	3	0	7	0	8	0	60	1295	47
ACADIA					1	1	1											5	1
ALLEN																		4	
ASCENSION																		1	1
ASSUMPTION																	26	1	
AVOYELLES																		6	
BEAUREGARD													1					5	
BIENVILLE																		3	
BOSSIER													1					7	
CADDO							3											105	
CALCASIEU						1	1											88	3
CALDWELL																			
CAMERON					1													2	1
CATAHOULA																		1	
CLAIBORNE																		6	
CONCORDIA							1												
DESOTO							1											6	
EAST BATON ROUGE					5	1	3				3		1		1			65	1
EAST CARROLL																		6	
EAST FELICIANA																			
EVANGELINE							1												
FRANKLIN							1											3	1
GRANT																		2	
IBERIA							1											10	
IBERVILLE					2		1											7	
JACKSON																		1	
JEFFERSON	1				14													61	9
JEFFERSON DAVIS							2											4	
LAFAYETTE							3											55	2
LAFOURCHE					1											1		6	
LASALLE																			
LINCOLN					3													30	
LIVINGSTON																			1
MADISON																		5	
MOREHOUSE																		9	
NATCHITOCHES																		17	
ORLEANS	5				8	2	17	1					2		3		5	448	14
OUACHITA																		40	1
PLAQUEMINES			1		1												2	2	
POINTE COUPEE																		1	
RAPIDES					2	1												69	3
RED RIVER																		2	
RICHLAND																		6	
SABINE						1												1	
ST. BERNARD	1				1			1							1		2	4	
ST. CHARLES					1		2											4	
ST. HELENA																		2	1
ST. JAMES																		2	4
ST. JOHN					1		1											1	
ST. LANDRY																		10	
ST. MARTIN																	6	8	
ST. MARY																	16	14	
ST. TAMMANY					1	1		1										32	
TANGIPAHOA			2		2												1	12	
TENSAS							1												
TERREBONNE							3								1		1	5	2
UNION							1											4	
VERMILION					1													6	
VERNON													1		2			38	
WASHINGTON																		9	
WEBSTER								1										8	
WEST BATON ROUGE							1											16	
WEST CARROLL													1					2	
WEST FELICIANA																		23	
WINN																		4	2
OUT OF STATE																		1	

\* Includes Rubella, Congenital Syphilis

From January 1 through November 30, the following cases were also reported: 5-Brucellosis; 2-Leptospirosis;  
2-Malaria contracted outside the U.S.A.