Louisiana

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF HEALTH SERVICES AND ENVIRONMENTAL QUALITY
BOX 60630 NEW ORLEANS, LOUISIANA 70160

MONTHLY MORBIDITY REPORT

Provisional Statistics

REPORTED MORBIDITY
JULY, 1982

PUBLIC HEALTH STATISTICS and
DIVISION OF DISEASE CONTROL

LYME DISEASE*

Lyme disease is an illness recently described in the United States and is named after Lyme, Connecticut, where the illness was first studied in 1975. The disease has subsequently been recognized in at least 13 additional states. Cases have been primarily reported from three geographic areas: the east (Connecticut, Massachusetts, Rhode Island, New York, New Jersey, Pennsylvania, Maryland, Georgia), the midwest (Wisconsin, Minnesota), and the west (Oregon, California, Nevada); a case has also been reported in Arkansas. As awareness of the disease increases, it is likely that additional states will be added to this list.

Lyme disease is a systemic illness characterized by a distinctive primary skin lesion (erythema chronicum

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* Schmid, G, M.D.: *Lyme Disease*, attachment to CDC Memorandum, July 9, 1982.

BULLETIN

INFLUENZA VACCINE 1982-83

During the 1981-82 winter, influenza activity was generally low in the United States, with no apparent peaks of excess mortality. According to the Centers for Disease Control, less than half the usual number of virus isolates were reported. The viruses isolated were influenza B, related antigenically to B/Singapore/222/79, influenza A(HINI) similar to A/England/333/80 and influenza A(H3N2) . Influenza B caused localized outbreaks among school children and nursing home patients. Sporadic illnesses and a few local outbreaks were caused by A(HINI), however H3N2 was reported only from a few sporadic cases in Florida and Texas. Influenza surveillance in Louisiana demonstrated low activity. Only influenza B virus was identified among the few cases reported during the 1981-82 season.

Influenza vaccine will again be offered this year to "high risk" individuals at parish health units beginning on September 13, 1982. The specific antigens and their potency in the 1982-83 influenza vaccine will be the same as in 1981-82: 15ug each of hemmagglutinin of A/Brazil/78 (HINI), A/Bangkok/79 (H3N2), and B/Singapore/79 viruses per 0.5 - ml dose. Studies indicate that A/Brazil/78 (HINI) antigen should protect against A/England/333/80-like HINI strains.

Adults and children 13 years of age and older will require only 1 dose of either whole or split virus vaccine. However, children who have already had at least 1 of the influenza vaccines recommended for use from 1978 to 1982 will require only 1 dose of the 1982-83 split virus vaccine.

The vaccine will be given free of charge to persons over 65 years of age and to all individuals (adults and children) at increased risk of adverse consequences from infections of the lower respiratory tract. Conditions predisposing to such risk include acquired or congenital heart disease associated with altered circulatory dynamics, chronic pulmonary dysfunction, chronic renal disease, diabetes mellitus and other metabolic disorders predisposing to infection, chronic anemia, and immune deficiency states.

There has been no evidence to suggest that influenza vaccination of pregnant women poses any special maternal or fetal risk; thus, pregnant females should be evaluated for vaccination according to the same criteria applied to other individuals. Present influenza vaccines have been associated with few side effects. These include local reactions, infrequent systemic symptoms of toxicity attributed to the inactivated virus itself, and rarely, hypersensitivity reaction in persons with allergy to egg protein.

Any questions relating to the influenza vaccination program should be directed to the Division of Disease Control, Vaccine Preventable Disease Section (504 - 568 - 5007).

LYME DISEASE – (continued from Page 1)

migrans – ECM) and, in many cases, subsequent development of significant cardiac, neurologic, and/or arthritic complications. Nonspecific systemic symptoms such as fever, chills, malaise, arthralgia and headache are also usually present.

EMC, the most characteristic feature of the disease, begins as a red macule or papule which expands in a circular manner over a number of days. As the lesion expands, central clearing often occurs. Lesions can reach diameters of 12 inches or more and many people will have multiple skin lesions, generally beginning several days after an initial lesion. With time, the skin lesions fade, lasting a median of 3 weeks.

Days to weeks after the skin lesion appears, cardiac, neurologic or joint manifestations may develop. Not all persons with ECM, however, will develop these complications. The usual cardiac manifestations are atrioventricular conduction defects, although electrocardiographic changes consistent with mycarditis or pericarditis may occur. The most common neurologic manifestations are consistent with meningoencephalitis. Cranial nerve palsies, as well as motor and sensory radiculitis, may also be seen. Both cardiac and neurologic abnormalities tend to be self-limited, although repeated episodes may occur.

The arthritic manifestations, which begin weeks to as long as 2 years (median, 4 weeks) after the appearance of ECM, are characterized by intermittent attacks of acute arthritis, usually of the large joints, with each episode lasting days to several months. About 10% of people with Lyme disease, primarily those with preceding attacks of acute arthritis, subsequently develop chronic arthritis, most commonly in the knee.

Lyme disease is thought to be caused by an infectious agent transmitted by *Ixodes* ticks, although other vectors could be involved. In Connecticut, about 20% of patients remember a bite by an *Ixodes dammini* tick 3 - 30 days prior to the appearance of ECM at the site. In California and Oregon, *I. pacificus* ticks have been implicated. Further evidence for an infectious etiology of the disease is that antimicrobial therapy has been shown to significantly alter the course of the disease. Penicillin V or tetracycline, 250 mg, orally, four times a day for 10 days, can successfully treat the early phases of the disease when ECM is present and prevent, or at least ameliorate, the subsequent, more severe cardiac, neurologic or arthritic phases.

Work to identify an agent of the disease and to develop a diagnostic laboratory test is ongoing. Recently, a spirochete was isolated from *I. dammini* ticks; indirect fluorescent antibody testing of patient sera suggests that this may be the etiologic agent of Lyme disease. At present, however, the diagnosis of Lyme disease rests on clinical grounds. This is based principally on recognition of typical ECM skin lesions in association with cardiac, neurologic, and arthritic abnormalities.

The majority of cases of Lyme disease have onset in the summer months. Because the full geographical distribution and magnitude of numbers of cases of Lyme disease are not known, the Conference of State and Territorial Epidemiologists and the Centers for Disease Control are attempting to identify all cases of Lyme disease occurring this year in the United States. We would greatly appreciate notification of any case of suspected Lyme disease.

SUGGESTED READING

1. Steere AC, Malawista SE, Hardin JA, Ruddy S, Askenase PW, Andiman WA. Erythema chronicum migrans and Lyme arthritis. Ann Intern Med 1977;86(6): 685–98.
2. Steere AC, Malawista SE, Newman JH, Spieler PN, Bartenhagen NH. Antibiotic therapy in Lyme disease. Ann Intern Med 1980;93(1):1 –8.
3. CDC. Lyme disease – United States, 1980. MMWR 1981;30:489–97.
4. Burgdorfer W, Barbour AG, Hayes SF, Benach JL, Grumwaldt E, Davis JP. Lyme disease - a tick-borne spirochetosis? Science 1982; 216: 1317–19.

Physicians in Louisiana are requested to report suspected cases of Lyme disease to Dr. Charles T. Caraway or Dr. Louise McFarland, Division of Disease Control, Office of Health Services and Environmental Quality, P.O. Box 60630, New Orleans, Louisiana 70160, (504) 568-5005. In addition, clinical specimens for suspected cases such as skin biopsies (either fresh or formalin fixed), acute and convalescent sera and spinal fluid should be sent to the Louisiana Bureau of Laboratories in New Orleans for forwarding to the Centers for Disease Control in Atlanta, Georgia.

SELECTED REPORTABLE DISEASES

(By Place of Residence)

STATE AND PARISH TOTALS REPORTED MORBIDITY JULY, 1982	VACCINE PREVENTABLE DISEASES					ASEPTIC MENINGITIS	HEPATITIS A ** AND UNSPECIFIED	HEPATITIS B	LEGIONNAIRES DISEASE	MALARIA ***	MENINGOCOCCAL INFECTIONS	SHIGELLOSIS	TUBERCULOSIS, PULMONARY	TYPHOID FEVER	OTHER SALMONELLOSIS	UNDERNUTRITION SEVERE	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY	RABIES IN ANIMALS (PARISH TOTALS CUMULATIVE, 1982
	MEASLES	RUBELLA*	MUMPS	PERTUSSIS	TETANUS														
TOTAL TO DATE 1981	2	9	4	5	2	47	466	198	0	4	91	44	224	2	100	1	12793	984	22
TOTAL TO DATE 1982	2	1	5	9	4	62	549	165	0	3	40	50	239	3	96	5	14058	1076	20
TOTAL THIS MONTH	0	0	2	4	2	21	72	22	0	0	5	9	15	2	24	0	1971	181	5
ACADIA						1		1							1		18	3	
ALLEN																	4		
ASCENSION													1				7		
ASSUMPTION											1	2					4	2	
AVOYELLES																	6		
BEAUREGARD								2									2		
BIENVILLE																	6	1	1
BOSSIER																	32	2	1
CADDO						1		1					2		1		259	23	1
CALCASIEU												1	1		1		100	4	
CALDWELL																			
CAMERON																	1		
CATAHOULA																	4		
CLAIBORNE																	2		1
CONCORDIA								1									3		
DESOTO																	4		
EAST BATON ROUGE							1				1		1		2		136	18	1
EAST CARROLL																	4		
EAST FELICIANA																	5		
EVANGELINE						1		1									7		
FRANKLIN																	3	1	
GRANT																	4		
IBERIA					1	1	28	1				1			2		10	2	
IBERVILLE											1						5		
JACKSON							1										4		1
JEFFERSON				2		3	6	2							2		120	13	
JEFFERSON DAVIS							1										4	1	
LAFAYETTE						6	3								2		49	9	
LAFOURCHE												1					25	1	
LASALLE																	4		
LINCOLN																	15	4	3
LIVINGSTON																	4		
MADISON																			
MOREHOUSE							3										18	2	
NATCHITOCHES																			3
ORLEANS				1		1	9	7							4		763	69	
OUACHITA							3	1					2				87	2	
PLAQUEMINES								1									5		
POINTE COUPEE																	2	1	
RAPIDES							1										47	3	3
RED RIVER																	1	1	
RICHLAND																	6		
SABINE																	1	1	
ST. BERNARD							3						1				3		
ST. CHARLES																	8	1	
ST. HELENA																			
ST. JAMES																	4		
ST. JOHN				1													9		
ST. LANDRY						1	1	1			1	1	3		3		8	1	
ST. MARTIN							2				1		1				7	2	
ST. MARY							2						1	1			7	2	
ST. TAMMANY					1		1					1					19	3	
TANGIPAHOA							1						1		1		17	2	
TENSAS																		1	
TERREBONNE						6	1	1				1	1		2		35		
UNION														1			6	1	4
VERMILION															1		6		
VERNON			2				2	1									5	2	1
WASHINGTON							1	1							1		1	1	
WEBSTER							1										30	2	
WEST BATON ROUGE																	4		
WEST CARROLL												1					6		
WEST FELICIANA							1										3	3	
WINN																	1		
OUT OF STATE															1		11		

*Includes Rubella, Congenital Syndrome
** Includes 13 cases of Hepatitis, Non A and Non B reported Jan.-July, 1982
*** Acquired outside United State Unless otherwise stated.
From January 1, 1982-July 31, 1982 the following cases were also reported. 1-Psittacosis

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THE CENTERS FOR DISEASE CONTROL REQUESTS REPORTING OF UNUSUAL DIARRHEAL ILLNESS

The Centers for Disease Control (CDC) and the state health departments of Oregon and Michigan have recently investigated 2 outbreaks of an unusual bloody diarrheal illness, and the CDC is asking that similar illnesses be reported. The disease is characterized by sudden onset of severe, crampy abdominal pain, followed by watery diarrhea, and then by bright-red, grossly bloody diarrhea, resembling lower-gastrointestinal bleeding; fever is absent or minimal, and the illness lasts 2 - 7 days. Patients have ranged in age from 8 - 78 years. Barium enema and sigmoidoscopic examinations revealed normal-appearing sigmoid and rectal mucosa, but marked edema of the ascending colon was identified radiographically and by laparotomy in a few cases. The stool examinations did not yield *Salmonella, Shigella, Campylobacter, Yersinia,* toxigenic or invasive *E. coli,* or ova or parasites. No complications or deaths have been reported. In Oregon, 26 cases were found in February – March, and in Michigan at least 23 cases were found in May – June, 1982. Because of the bloody diarrhea, many of these patients were referred for gastroenterologic evaluation.

The cause of this illness is unknown and further epidemiologic and laboratory studies are in progress. The CDC has asked state epidemiologists to report cases with this distinctive clinical picture. Physicians in Louisiana are asked to report any illness or cluster of illness resembling the above description to the Epidemiology Section (504) 568-5005. In addition to performing the routine laboratory studies, physicians are asked to arrange to obtain and freeze stool (preferably frozen at $-70^{\circ}F$ or on dry ice) and obtain and freeze acute and convalescent (at about 3 weeks after onset) sera for testing at CDC. Since the barium enema may show a distinctive pattern, it should also be considered.

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