REPORTED MORBIDITY
JANUARY — APRIL, 1988

LOUISIANA MORBIDITY REPORT

EPIDEMIOLOGY

PUBLIC HEALTH STATISTICS

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HEMOPHILIA AND HIV INFECTION IN LOUISIANA

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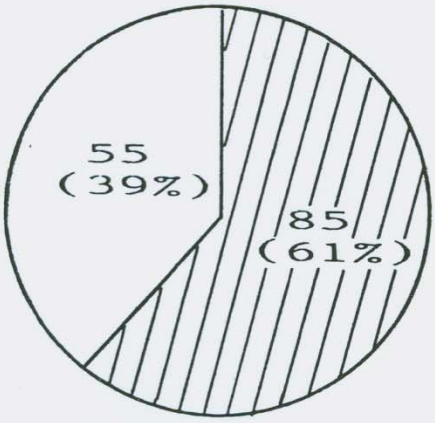
Hemophilia is a blood clotting disorder that affects approximately 1 in 10,000 of the male population. With the introduction of coagulation factor replacement therapy in the early 1970's, people with hemophilia were soon able to lead nearly normal, productive lives. But the utilization of factor concentrates also brought the threat of AIDS. At each infusion a person with hemophilia is exposed to between 2,000 - 25,000 plasma donors. A severe hemophiliac may receive 40 or more infusions per year. As a result, the number of hemophiliacs who have been exposed to Human Immunodeficiency Virus (HIV) is substantial. Factor concentrates have been heat-treated to eradicate HIV since late 1984. With this and the advent of blood donor screening since early 1985, the risk of further exposure to AIDS through these blood products has virtually been eliminated.

As of April 1988, 621 hemophiliacs in the United States have developed AIDS. This represents 1% of the total AIDS cases in this country and roughly 3% of the hemophilia population (1). The geographic distribution of AIDS in hemophiliacs is illustrated in Figure I. The percentage of hemophiliacs who develop AIDS-related illness appears to be increasing at a rate comparable to a closely studied cohort of homosexual patients in San Francisco. Over 50% of the individuals in California have HIV-related disease while the numbers for the hemophiliacs are somewhat lower. This may be due to the fact that the homosexual cohort was exposed to HIV approximately two years prior to the hemophilia population (2).

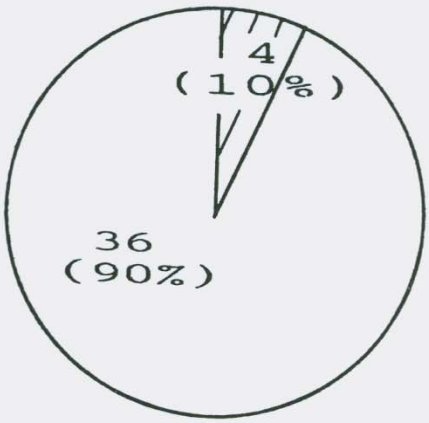
The HIV-related statistics for the hemophiliacs in Louisiana have been collected through the Louisiana Comprehensive Hemophilia Care Center where many of the hemophiliacs in the State are followed. The Center, located at Tulane University Medical Center, offers a multi-disciplinary approach to the treatment of this complex, chronic illness. Although treatment of bleeding episodes and management of orthopedic complications are of primary concern, the care of the hemophiliacs extends far beyond crisis intervention. An

FIGURE II

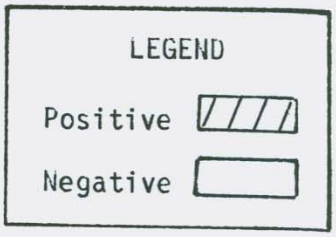
HIV ANTIBODY DATA FOR LOUISIANA HEMOPHILIACS

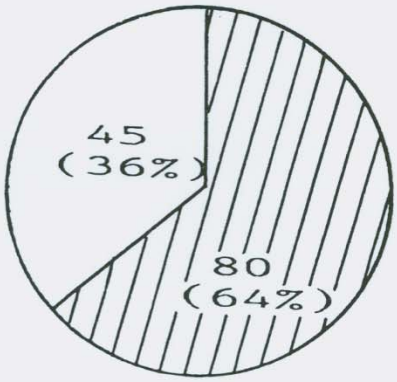


Factor VIII Deficiency

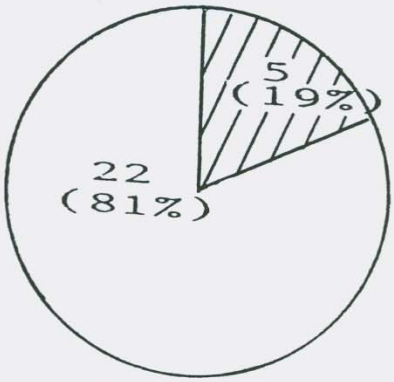


Factor IX Deficiency

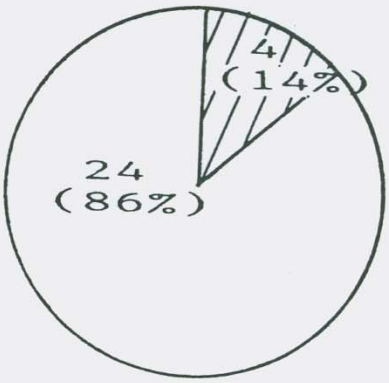




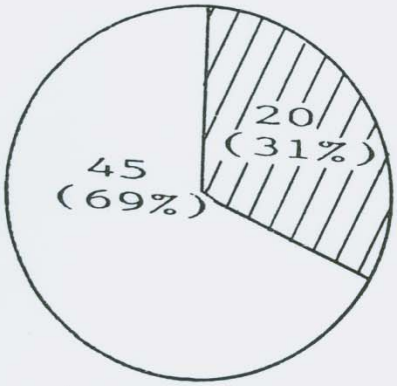
Severe Disease



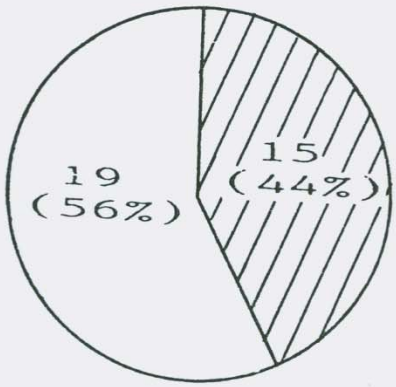
Moderate Disease



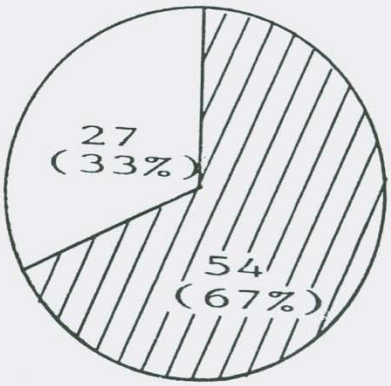
Mild Disease



0-12 Years

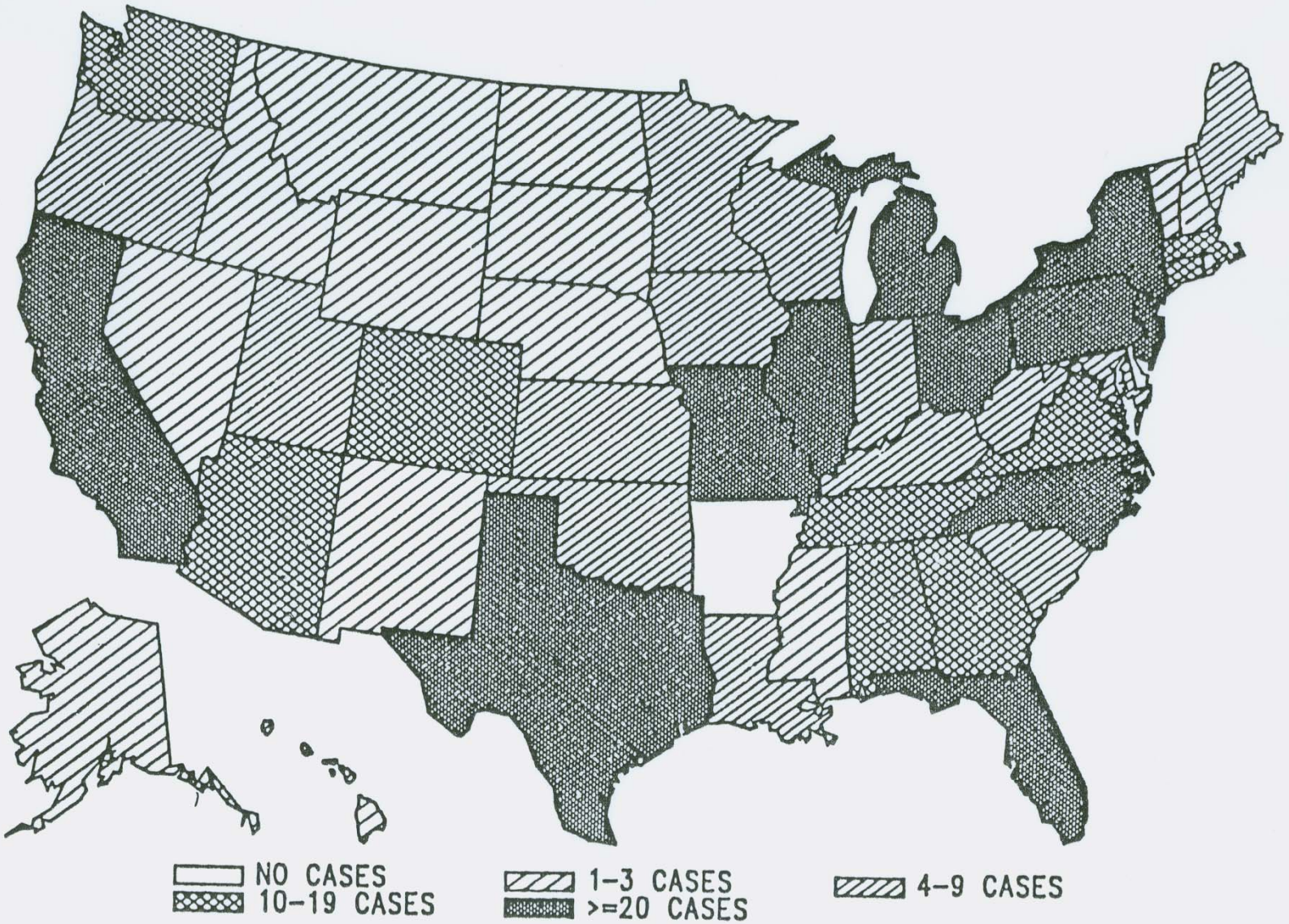


13-18 Years



Adult

CASES OF HEMOPHILIA–ASSOCIATED AIDS BY STATE
1/1/81–4/4/88



This map represents the number of reported cases of AIDS in persons with hemophilia using the 1985 and 1987 case definitions. Rates cannot be calculated because the number of persons with hemophilia in each state is unknown.

SOURCE: DHF, CID, CDC.

individual treatment plan which incorporates the hematological, nursing, psychosocial, dental, physical therapy and orthopedic needs of the patient is formulated at annual clinic visits (3).

The staff has studied 180 individuals who attend the Center on a regular basis. Figure II summarizes the data concerning their HIV antibody status. Overall, 50% of the patients are HIV antibody positive. Considerable differences are noted when the numbers are broken down by type of hemophilia, severity of disease and age.

To date, eight hemophiliacs in Louisiana have developed AIDS. Seven of the eight (88%) are deceased. The five adults with AIDS were all diagnosed with Pneumocystic Carinii Pneumonia (PCP) as their initial opportunistic infection while the three children had mycobacterium avium, cryptococal meningitis and wasting syndrome. Eighteen additional patients have developed symptoms related to their HIV infection including Idiopathic Thrombocytopenic Purpuras (ITP), significant weight loss, night sweats and fever. Of the four ITP patients, three required splenectomy.

The Center has also been collecting data on the sexual partners of the adult patients. Four of the 32 female partners tested (12%) have been found to be HIV antibody positive. None of the women have developed AIDS and one has a child who remains HIV antibody positive at 13 months. Considerable educational efforts are being directed toward this group of women in the areas of recognizing their potential exposure, practicing safer sex, delaying pregnancy and maximizing personal coping strategies. Outreach to the sexual partners of adolescents and unmarried patients is being attempted but reaching these individuals is often difficult. Because of this, rigorous patient education is essential for this segment of the hemophilia population.

At present the vast majority of the HIV antibody positive hemophiliacs in Louisiana continue to be well. This established cohort is an ideal group to participate in drug trials of antiviral agents. Research efforts, together with heat-treated blood products and healthy lifestyles offer hemophiliacs and their families hope for the future.

REFERENCES:

1. La. Dept. of Health and Human Resources. AIDS Surveillance Report: April 1988.

2. Conversation with Janine Jason MD, Chief of the Epidemiology Section of the CDC.

3. Hilgartner, Margaret W: Hemophilia in the Child and Adult. MASSON Publishing USA Inc. New York, 1982.

LOUISIANA CHOSEN FOR PEDIATRIC UNDERNUTRITION GRANT BY CDC

Severe undernutrition has been a reportable condition in Louisiana since 1969. The intent of the reporting requirement was to allow for investigation of undernutrition cases and to provide appropriate intervention. Severe Pediatric Undernutrition (SPUN) is recognized as an indicator of inadequacy in the social environment and of deficits in essential nutrition and health services.

Louisiana has been selected by the Centers for Disease Control (CDC) to conduct a newly-initiated four state (Florida, Louisiana, Mississippi, Massachusetts) demonstration project on SPUN surveillance.

The purpose of SPUN is to (1) demonstrate the use of a population-based surveillance system for identifying preschool children with severe pediatric undernutrition, including the collection and analysis of data on prevalence, etiologies and associated risk factors and (2) to facilitate the referral of children confirmed with SPUN to appropriate sources of intervention.

Case definition emphasizes the identification of children with low weight-for-height or low hemoglobin or hematocrit values or any of the classical nutritional deficiency syndromes as supported by appropriate biochemical or clinical evidence.

The State Health Department, Office of Public Health (OPH), formerly Office of Preventive and Public Health Services (OPPHS) will consider various case sources including an urban and rural hospital-based site at Charity Hospital in New Orleans and South East Louisiana Medical Center in Houma.

Nutrition surveillance in Louisiana presently consists of (1) mandatory reporting by individual physicians and other health care providers (2) EPSDT anthropometric and biochemical data and (3) death certificate monitoring. A feasibility study for monitoring birth certificates will be piloted to determine if the data are useful for identifying children under age of one year who may be at risk of SPUN.

Surveillance of this vulnerable population is an important first step in the need for a comprehensive nutritional monitoring in the United States.

OPH will create and maintain a central registry to track the prevalence of SPUN in Louisiana. The surveillance program data from Louisiana will be used by CDC in the development of a model state system for SPUN reporting nationwide.

An update on the progress of the implemented SPUN strategies, to include SPUN cases identified and highlights of the data collected, will be published in a future issue.

Pamela McCandless is the principal investigator and Chief Nutritionist of the OPH Nutrition Section and can be reached at (504) 568-5065 for additional information about SPUN.

LOUISIANA AIDS UPDATE

	CASES	DEATHS	PERCENT
1988 (thru 4/30/88)	52	14	27
TOTAL, ALL YEARS	832	521	63

* National Childhood Vaccine Injury Act: Requirements for Permanent Vaccination Records and for Reporting of Selected Events After Vaccination

Title XXI of the Public Health Service Act, enacted by the National Childhood Vaccine Injury Act of 1986, as amended on December 22, 1987, requires health care providers who administer certain vaccines and toxoids to record permanently certain information and to report certain events beginning March 21, 1988. The vaccines and toxoids for which these requirements are applicable are presented in Table 1 and are: diphtheria and tetanus toxoids and pertussis vaccine (DTP); pertussis vaccine (P); measles, mumps and rubella single antigen vaccines and combination vaccines (MMR, MR); diphtheria and tetanus toxoids (DT); tetanus and dipthteria toxoids (Td); tetanus toxoid (T); poliovirus vaccine live, oral (OPV); and poliomyelitis vaccine inactivated (IPV). The requirements also will apply to DTP combined with inactivated poliovirus vaccine (DTP/Polio combined) if it becomes available.

Requirements for Recording

Specifically, all health-care providers who administer one or more of these vaccines or toxoids are required to ensure that there is recorded in the vaccine recipient's permanent medical record (or in a permanent office log or file) the date the vaccine was administered, the manufacturer and lot number of the vaccine, and the name, address, and title of the person administering the vaccine. The term health-care provider is defined as any licensed health-care professional, organization, or institution, whether private or public (including federal, state, and local departments and agencies), under whose authority a specified vaccine is administered.

Requirements for Reporting

Health-care providers are required to report to the U.S. Department of Health and Human Services (DHHS) selected events occurring after vaccination. Reportable events applicable to the previously mentioned vaccines and toxoids are shown in Table 1 and include events described in the vaccine manufacturer's package insert as contraindications to receiving additional doses of the vaccine.

Methods for Reporting

In the United States, vaccines are either publicly or privately purchased. Publicly purchased vaccines are bought with federal, state, and/or local government funds. At present, the method and route for reporting adverse events depend on whether the vaccine administered is publicly or privately purchased. Events occurring after receipt of publicly purchased vaccines are reported through local, county, and/or state health departments to the Centers for Disease Control (CDC) on its Report of Adverse Events Following Immunization (CDC form 71.19). Events occurring after receipt of a privately purchased vaccine usually are reported directly to the Food and Drug Administration (FDA) on its Adverse Reaction Report (FDA form 1639) by the health-care provider or the manufacturer.

For the time being, these two systems for reporting adverse events are to be used

* SOURCE: MMWR, Centers for Disease Control, April 8, 1988, Vol. 37, pp 197-200

TABLE 1. Reportable events following vaccination

Vaccine/Toxoid	Event	Interval from Vaccination
DTP, P, DTP/Polio Combined	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Encephalopathy (or encephalitis)*	7 days
	C. Shock-collapse or hypotonic-hyporesponsive collapse*	7 days
	D. Residual seizure disorder*	(See Aids to Interpretation*)
	E. Any acute complication or sequela (including death) of above events	No limit
	F. Events in vaccinees described in manufacturer's package insert as contraindications to additional doses of vaccine† (such as convulsions)	(See package insert)
Measles, Mumps, and Rubella; DT, Td, Tetanus Toxoid	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Encephalopathy (or encephalitis)*	15 days for measles, mumps, and rubella vaccines; 7 days for DT, Td, and T toxoids
	C. Residual seizure disorder*	(See Aids to Interpretation*)
	D. Any acute complication or sequela (including death) of above events	No limit
	E. Events in vaccinees described in manufacturer's package insert as contraindications to additional doses of vaccine†	(See package insert)
Oral Polio Vaccine	A. Paralytic poliomyelitis	
	—in a non-immunodeficient recipient	30 days
	—in an immunodeficient recipient	6 months
	—in a vaccine-associated community case	No limit
	B. Any acute complication or sequela (including death) of above events	No limit
	C. Events in vaccinees described in manufacturer's package insert as contraindications to additional doses of vaccine†	(See package insert)
Inactivated Polio Vaccine	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Any acute complication or sequela (including death) of above event	No limit
	C. Events in vaccinees described in manufacturer's package insert as contraindications to additional doses of vaccine†	(See package insert)

***Aids to Interpretation:**

Shock-collapse or hypotonic-hyporesponsive collapse may be evidenced by signs or symptoms such as decrease in or loss of muscle tone, paralysis (partial or complete), hemiplegia, hemiparesis, loss of color or turning pale white or blue, unresponsiveness to environmental stimuli, depression of or loss of consciousness, prolonged sleeping with difficulty arousing, or cardiovascular or respiratory arrest.

Residual seizure disorder may be considered to have occurred if no other seizure or convulsion unaccompanied by fever or accompanied by a fever of less than 102 °F occurred before the first seizure or convulsion after the administration of the vaccine involved,

AND, if in the case of measles-, mumps-, or rubella-containing vaccines, the first seizure or convulsion occurred within 15 days after vaccination OR in the case of any other vaccine, the first seizure or convulsion occurred within 3 days after vaccination,

AND, if two or more seizures or convulsions unaccompanied by fever or accompanied by a fever of less than 102 °F occurred within 1 year after vaccination.

The terms seizure and convulsion include grand mal, petit mal, absence, myoclonic, tonic-clonic, and focal motor seizures and signs. Encephalopathy means any significant acquired abnormality of, injury to, or impairment of function of the brain. Among the frequent manifestations of encephalopathy are focal and diffuse neurologic signs, increased intracranial pressure, or changes lasting at least 6 hours in level of consciousness, with or without convulsions. The neurologic signs and symptoms of encephalopathy may be temporary with complete recovery, or they may result in various degrees of permanent impairment. Signs and symptoms such as high-pitched and unusual screaming, persistent unconsolable crying, and bulging fontanel are compatible with an encephalopathy, but in and of themselves are not conclusive evidence of encephalopathy. Encephalopathy usually can be documented by slow wave activity on an electroencephalogram.

†The health-care provider must refer to the CONTRAINDICATION section of the manufacturer's package insert for each vaccine.

to implement the requirement of Title XXI of the Public Health Service Act for reporting adverse events to DHHS (Table 2).

Reportable events occurring after receipt of a publicly purchased vaccine shall be reported to local, county, and/or state health departments through channels currently in place at those institutions. The Report of Adverse Events Following Immunization, available at each state health department, shall be completed and sent by the state health department to CDC.

TABLE 2. Reporting of events occurring after vaccination

	Vaccine Purchased with Public Money	Vaccine Purchased with Private Money
Who Reports:	Health-care provider who administered the vaccine	Health-care provider who administered the vaccine
What Products To Report:	DTP, P, Measles, Mumps, Rubella, DT, Td, T, OPV, IPV, and DTP/Polio Combined	DTP, P, Measles, Mumps, Rubella, DT, Td, T, OPV, IPV, and DTP/Polio Combined
What Reactions To Report:	Events listed in Table 1 including contraindicating reactions specified in manufacturers' package inserts	Events listed in Table 1 including contraindicating reactions specified in manufacturers' package inserts
How To Report:	Initial report taken by local, county, or state health department. State health department completes CDC form 71.19	Health-care provider completes Adverse Reaction Report-FDA form 1639 (include interval from vaccination, manufacturer, and lot number on form)
Where To Report:	State health departments send CDC form 71.19 to: MSAEFI/IM (E05) Centers for Disease Control Atlanta, GA 30333	Completed FDA form 1639 is sent to: Food and Drug Administration (HFN-730) Rockville, MD 20857
Where To Obtain Forms:	State health departments	FDA and publications such as *FDA Drug Bulletin*

Reportable events occurring after receipt of a privately purchased vaccine shall be reported by the health-care provider directly to the FDA on the Adverse Reaction Report (FDA form 1639). Health-care providers will need to ensure that the name of the vaccine manufacturer, the lot number of the vaccine, and the interval between vaccination and onset of the reaction are included on this form. FDA form 1639 can be obtained directly from Food and Drug Administration, HFN-730, Rockville, Maryland 20857. The form also is printed in *FDA Drug Bulletin,* the physician's edition of the *Physicians' Desk Reference, USP Drug Information for Health Care Providers,* and *AMA Drug Evaluations* and can be duplicated.

Health-care providers are requested not to provide the names and other personal identifiers of patients on FDA form 1639. Such information will be reported for publicly purchased vaccines to state and local health departments, which in turn will remove the names and personal identifiers when submitting CDC form 71.19 to CDC.

* FACTS YOU MAY WANT TO KNOW ABOUT
ST. LOUIS ENCEPHALITIS

Q. What is encephalitis?

A. Encephalitis is an infection of the brain. It may be caused by several things, including germs, some chemicals, and poisons. Encephalitis is sometimes called "Sleeping sickness."

Q. What is St. Louis Encephalitis?

A. St. Louis Encephalitis (SLE) is caused by one specific germ — a virus. The first recorded outbreak of the disease occurred in St. Louis, Missouri, in 1933. That is why the disease bears that particular name. SLE occurs most frequently during summer and fall.

Q. How is SLE spread?

A. SLE is *NOT* spread by direct contact from person to person. It can only be spread by the bite of an infected mosquito. SLE mainly affects birds. In Houston and Harris County, this virus is spread from bird to bird by only one of the more than 50 types of mosquitoes. The mosquito that spreads SLE is called the *Culex* mosquito.

When a *Culex* mosquito bites an infected bird it picks up the SLE virus and spreads it to another bird by biting it.

Q. How do humans get SLE?

A. Humans can get SLE only by the bite of an infected mosquito. Although the *Culex* mosquito would prefer to feed on a bird, it will bite a human if it cannot find a bird.

Q. Do the birds or mosquitoes that are infected with SLE get sick?

A. No.

Q. What are the symptoms of SLE?

A. SLE is usually a sudden illness with the following symptoms:

1. Fever
2. Headache
3. Nausea and/or vomiting
4. Stiff Neck
5. Change in mental function, including sleepiness, inability to awaken a sleeping person, and confusion
6. Convulsions
7. Inability of muscles to work properly; trembling of the body is common.

You may have all or only a few of these symptoms.

Q. If I am bitten by an infected *Culex* mosquito, what are my chances of getting sick?

A. Only one out of 200 people infected with SLE will usually feel sick enough to seek medical treatment.

Q. How long would it take for me to become sick if I were bitten by an infected *Culex* mosquito?

A. It would take about 5-10 days.

Q. Who is most likely to get sick with SLE?

A. Young children and the elderly are more likely to feel sick. However, anyone can get the disease.

Q. Are there certain times of day that I would be more likely to be bitten by the *Culex* mosquito?

A. Yes. The *Culex* mosquito likes to feed at dusk, night, and early morning.

Q. Is SLE a serious disease?

A. Yes. It may lead to temporary brain damage and hospitalization.

Q. Can SLE result in death?

A. Yes. As many as 5 percent of the people who are seriously ill with the disease may die.

Q. Is there any medicine to prevent or cure SLE?

A. No. General supportive care is all that can be given.

Q. What should I do if someone in my household gets symptoms of SLE?

A. See a doctor immediately. The only way to diagnose SLE is with a special blood test drawn two weeks apart. *Remember to have the second blood drawn.*

Q. What can I do to protect myself from getting SLE?

A. The following measures should be followed:

1. *Drain water* from old tires, flower pots, bird baths, etc.; dispose of, turn over or cover these containers. Remember, mosquitoes must have water in which to breed. So you must empty these containers.
2. *Repair* your *leaky plumbing.*
3. *Frequently move drain hoses* of window or central air conditioning units so that water does not stand in one location for a long period of time.
4. *Check screens* on all windows and doors; patch them if necessary. Screen rain barrels and openings to water tanks or cisterns.
5. *Use a good insect repellent,* especially at night because the SLE mosquito is a night feeder.
6. *Wear protective clothing,* especially long sleeves and slacks.

* SOURCE: The City of Houston Department of Health and Human Services, Harris County Health Department and the Harris County Mosquito Control District.

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TICK BITES CAN CAUSE SERIOUS ILLNESS

- Ticks are blood-sucking arachnids capable of transmitting serious and sometimes fatal illness.

- Late spring and summer are the peak times for exposure to ticks - the transmitters of Rocky Mountain Spotted Fever (RMSF) and Tick paralysis (tick toxicosis).

- Both diseases affect children more frequently than adults.

- Ninety-four percent of cases of RMSF occur between April 1st and September 30th.

- Risk of RMSF fatality is associated with age 30 years or older; exposure to ticks; failure to recognize the early signs of the illness and subsequent delays in diagnosis and treatment.

- Most tick bites resolve uneventfully.

RMSF is a reportable disease in Louisiana.

TICK REMOVAL PROCEDURE

"IT IS SUGGESTED THAT THE MECHANICAL REMOVAL TECHNIQUE BE USED FOR ALL TICK REMOVAL."

- It is important that a tick be removed from the host as soon as possible after it is discovered.

- Proper removal of the tick is just as important in reducing the chance of infection as timely removal.

- Exercise the same precautions when removing ticks from animals as when removing ticks from humans.

- Children should not be permitted to remove ticks.

* Pediatrics June 1985 (Pg. 1002)

Cement is secreted by the salivary glands of the tick and soon hardens into a tough collar surrounding the mouthparts. The cement collar looks somewhat like skin sourrounding the mouthparts of a tick after removal. If no "flesh-like" material is attached to the mouthparts, then it (cement) is still in the skin.

- If the cement or mouthparts remain in the skin, then extract them if that is practical.

Ticks that have been on the host for a long time may be firmly attached due to the secretion of additional attachment cement.

1) DISINFECT THE SITE prior to tick removal.

2) GRASP THE TICK AS CLOSE TO THE SKIN AS POSSIBLE using a blunt curved forceps or tweezers.

3) If fingers are used, shield them with a tissue, paper towel, or rubber gloves. GRASP THE TICK AS CLOSE TO THE SKIN AS POSSIBLE.

4) PULL UPWARD WITH A STEADY EVEN PRESSURE. Do not twist or jerk as this may cause the mouthparts to break off leaving them and the cement collar in the skin.

5) TAKE CARE NOT TO SQUEEZE, CRUSH, OR PUNCTURE THE BODY OF THE TICK as its fluids may contain infective agents.

6) After removing the tick, throughly DISINFECT THE BITE SITE and

* SOURCE:
North Dakota State Department of Health, Division of Disease Control.

WASH HANDS WITH SOAP AND WATER.

7) APPLY A STERILE ADHESIVE DRESSING STRIP (band-aid type) to prevent secondary infection.

8) TICKS CAN SAFELY BE DISPOSED OF by placing them in a container of alcohol or be flushing them down the toilet.

9) DO NOT HANDLE TICK WITH BARE HANDS, as infectious agents may enter via mucous membranes or breaks in the skin.

There are several traditional or "folk" methods recommended for inducing a tick to "back out" of the skin. Most are based on the fear that if a tick is pulled off the "head" (mouthparts) will remain in the skin.

A recent study reported in Pediatrics June 1985, evaluated 5 methods commonly advocated for tick removal: petroleum jelly, fingernail polish, rubbing alcohol, hot kitchen match, and forcible removal. None of the passive techniques induced self-detachment. All forcibly removed ticks were removed without breaking the mouthparts. The cement collar was extracted along with the mouthparts when removing dog ticks but remained in the host when removing lone star ticks.

Petroleum jelly was not effective because the respiratory rate in ticks is so slow that occluding the air supply even for a few hours would not cause the tick to self-detach

Nail polish may actually have hindered self-detachment by the tick because they were unable to move once the polish had hardened.

The isopropyl Alcohol helps to disinfect the bite site but this is the only benefit to its application.

A hot match is not recommended for many reasons:

1) the risk of burns;

2) it could cause the tick to burst and result in exposure to infected body fluids;

3) this method did not affect detachment;

4) hot objects can induce the tick to salivate and regurgitate infected fluids into the wound.

PERSONAL PREVENTION

- Avoid known tick-infected areas.
- Apply repellents such as diethyltoluamide (Deet) and dimethylphthalate to clothing and exposed parts of the body. (These repellents are active ingredients in many popular insect repellents - read ingredient labels).
- Wear clothing that interferes with tick attachment (boots, full length and one-piece outer garments).
- Avoid sitting on grass and logs where exposure to ticks would be increased.
- Inspect the entire body daily, including hairy parts, to detect and remove attached ticks.
    - Children should be inspected at least twice daily.
    - In heavily infested areas, inspection should be done every 3 to 4 hours.
    - Victims are seldom aware of

crawling ticks or even the process of attachment.

- Ticks seldom attach immediately and rarely transfer infection until they have fed for several hours.

ENVIRONMENTAL PREVENTION

- Keep weeds and grass cut in yards and recreational areas.
- Clear brush along paths.
- De-ticking of dogs minimizes the tick population in areas near residences.

EARLY SYMPTOMS

ROCKY MOUNTAIN SPOTTED FEVER

Chills, headache, muscle pains, high fever, nausea, abdominal pains, loss of appetite, sometimes diarrhea, and rash which usually begins on the hands and feet and spreads centrally toward the trunk and head.

Symptoms usually appear 6 to 8 days after the bite of an infected tick but may appear as early as 3 days or as late as 14 days after tick bite exposure

Prompt medical attention is required.

TICK PARALYSIS (TICK TOXICOSIS)

The first signs of tick paralysis are weakness in the legs and an inability to stand or walk.

Search the body and scalp and remove the tick. Symptoms usually subside within a few hours. Seek medical consultation.

LYME DISEASE

Lyme disease usually begins with a distinctive skin lesion(s) which may be accompanied by fatigue, fever, headache, stiff neck, muscle aches, loss of appetite, sore throat, abdominal pain, and/or joint pains.

Prompt diagnosis and treatment is required to prevent adverse manifestations of the illness.

BULLETIN

This is a reminder that the State Health Laboratory in New Orleans has obtained transport media kits for confirmation of cultures of nasopharyngeal swabs on suspected pertussis cases. These kits are being sent to the Regional Laboratories throughout the state. Increased efforts should be made to confirm suspected cases, either by culture or by DFA test, preferably during the initial three weeks of illness and before antibiotics are instituted. We had hoped to have the transport media kits available by mid-October but budget contraints delayed availability until now. Please contact your local parish health unit for information on how to obtain supplies when needed.

Selected Reportable Diseases

(By Place of Residence)

State and Parish Totals REPORTED MORBIDITY JANUARY, 1988	VACCINE PREVENTABLE DISEASES					ASEPTIC MENINGITIS	HEPATITIS A AND UNSPECIFIED **	HEPATITIS B	LEGIONELLOSIS	MALARIA ***	MENINGOCOCCAL INFECTIONS	SHIGELLOSIS	TUBERCULOSIS, PULMONARY	TYPHOID FEVER	OTHER SALMONELLOSIS	UNDERNUTRITION SEVERE	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY	RABIES IN ANIMALS (Parish totals cumulative, 1988)
	MEASLES	RUBELLA	MUMPS	PERTUSSIS	TETANUS														
TOTAL TO DATE 1987	0	0	0	0	0	1	3	17	0	0	2	14	21	0	109	0	1101	47	1
TOTAL TO DATE 1988	0	0	5	0	0	0	2	0	0	0	0	2	18	0	3	0	2102	38	0
TOTAL THIS MONTH	0	0	5	0	0	0	2	0	0	0	0	2	18	0	3	0	2102	38	0
ACADIA																	6		
ALLEN													1				2		
ASCENSION																	2		
ASSUMPTION																	5		
AVOYELLES													1				4		
BEAUREGARD																	1		
BIENVILLE																			
BOSSIER							1										8		
CADDO													2				147	1	
CALCASIEU			3										1				109		
CALDWELL																			
CAMERON																	1		
CATAHOULA																	5		
CLAIBORNE																	1		
CONCORDIA																	2		
DESOTO																			
EAST BATON ROUGE													1				133	11	
EAST CARROLL																	11		
EAST FELICIANA																			
EVANGELINE			1														5		
FRANKLIN																	3		
GRANT																	1		
IBERIA																	21		
IBERVILLE																	4		
JACKSON			1														3		
JEFFERSON												1					97	2	
JEFFERSON DAVIS																	7		
LAFAYETTE																	37		
LAFOURCHE																	20		
LASALLE																			
LINCOLN																	2	2	
LIVINGSTON													1				4		
MADISON																	9	1	
MOREHOUSE																	27		
NATCHITOCHES																	1		
ORLEANS							1					1	6		3		1009	14	
OUACHITA																	108	1	
PLAQUEMINES																	1		
POINTE COUPEE																			
RAPIDES																	102	1	
RED RIVER																			
RICHLAND													1				6		
SABINE																	1		
ST. BERNARD																	2		
ST. CHARLES																	4	1	
ST. HELENA																	1		
ST. JAMES																	8		
ST. JOHN																	4		
ST. LANDRY																	17		
ST. MARTIN																	15		
ST. MARY																	9	1	
ST. TAMMANY													3				23		
TANGIPAHOA																	3		
TENSAS																	2	1	
TERREBONNE																	50	1	
UNION																	14		
VERMILION																	4		
VERNON																	21		
WASHINGTON													1						
WEBSTER																	14	1	
WEST BATON ROUGE																	1		
WEST CARROLL																	1		
WEST FELICIANA																			
WINN																	2		
OUT OF STATE																	2		

* Includes Rubella, Congenital Syndrome.
** Includes 1 case of Hepatitis Non A, Non B.
*** Acquired outside United States unless otherwise stated.

Selected Reportable Diseases

(By Place of Residence)

State and Parish Totals REPORTED MORBIDITY FEBURARY, 1988	VACCINE PREVENTABLE DISEASES					ASEPTIC MENINGITIS	HEPATITIS A AND UNSPECIFIED **	HEPATITIS B	LEGIONELLOSIS	MALARIA	MENINGOCOCCAL INFECTIONS	SHIGELLOSIS	TUBERCULOSIS, PULMONARY	TYPHOID FEVER	OTHER SALMONELLOSIS	UNDERNUTRITION SEVERE	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY	RABIES IN ANIMALS (Parish totals cumulative, 1988)
	MEASLES	RUBELLA *	MUMPS	PERTUSSIS	TETANUS														
TOTAL TO DATE 1987	0	0	16	2	0	3	12	75	0	0	5	29	38	0	185	0	2894	100	2
TOTAL TO DATE 1988	0	0	24	1	0	2	10	32	0	1	2	34	46	1	26	0	2684	112	0
TOTAL THIS MONTH	0	0	19	1	0	2	8	32	0	1	2	32	28	1	23	0	582	74	0
ACADIA													1				2		
ALLEN													1				1		
ASCENSION												1	1						
ASSUMPTION																	4		
AVOYELLES																	1		
BEAUREGARD			1																
BIENVILLE																	2		
BOSSIER													1				13		
CADDO								1				2					77	1	
CALCASIEU			2					1					2				44	1	
CALDWELL																	4		
CAMERON																			
CATAHOULA																	1		
CLAIBORNE																	1		
CONCORDIA													1						
DESOTO																			
EAST BATON ROUGE			2				3				1		3				64	5	
EAST CARROLL			1														3		
EAST FELICIANA																			
EVANGELINE			10															1	
FRANKLIN																	4		
GRANT																	1		
IBERIA																	7		
IBERVILLE															1		2		
JACKSON																	1	1	
JEFFERSON				1			2	9				2			1		33	4	
JEFFERSON DAVIS																	4		
LAFAYETTE						1		1				5	1				8	3	
LAFOURCHE																	14	2	
LASALLE																			
LINCOLN																		2	
LIVINGSTON																			
MADISON			1														4	1	
MOREHOUSE																	9		
NATCHITOCHES			1														2		
ORLEANS							3	13		1		22	6	1	1		89	38	
OUACHITA													3				39	1	
PLAQUEMINES																			
POINTE COUPEE													1				1	1	
RAPIDES								1					1		15		13		
RED RIVER																			
RICHLAND																	5		
SABINE																			
ST. BERNARD						1											4	1	
ST. CHARLES								1			1						3		
ST. HELENA																	1		
ST. JAMES																	1	2	
ST. JOHN																	3	2	
ST. LANDRY													2				4	4	
ST. MARTIN															1		2	1	
ST. MARY																	3		
ST. TAMMANY								3							1		13		
TANGIPAHOA								1									12	2	
TENSAS																			
TERREBONNE													1		1		18		
UNION																			
VERMILION													1		1		1		
VERNON																	42		
WASHINGTON			1					1									6		
WEBSTER													2		1		14		
WEST BATON ROUGE																		1	
WEST CARROLL																	4		
WEST FELICIANA																			
WINN																			
OUT OF STATE																			

* Includes Rubella, Congenital Syndrome.
** Includes 2 cases of Hepatitis Non A, Non B.
*** Acquired outside United States unless otherwise stated.

(By Place of Residence)

STATE AND PARISH TOTALS REPORTED MORBIDITY MARCH, 1988	VACCINE PREVENTABLE DISEASES					ASEPTIC MENINGITIS	HEPATITIS A AND UNSPECIFIED**	HEPATITIS B	LEGIONELLOSIS	MALARIA***	MENINGOCOCCAL INFECTIONS	SHIGELLOSIS	TUBERCULOSIS, PULMONARY	TYPHOID FEVER	OTHER SALMONELLOSIS	UNDERNUTRITION SEVERE	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY.	RABIES IN ANIMALS (PARISH TOTALS CUMULATIVE, 1988)
	MEASLES	RUBELLA*	MUMPS	PERTUSSIS	TETANUS														
TOTAL TO DATE 1987	0	0	60	5	0	3	23	99	0	0	8	47	53	0	215	0	4024	156	3
TOTAL TO DATE 1988	0	0	68	2	1	10	29	62	1	1	14	67	67	2	73	0	3706	187	0
TOTAL THIS MONTH	0	0	44	1	1	8	19	30	1	0	12	33	21	1	47	0	1030	75	0
ACADIA																	6		
ALLEN			1																
ASCENSION													1				1		
ASSUMPTION																	2		
AVOYELLES																	1		
BEAUREGARD			1														2		
BIENVILLE																			
BOSSIER															6		13		
CADDO								4			1	1	2		6		104	1	
CALCASIEU			19				1				1	1			2		34		
CALDWELL																			
CAMERON																			
CATAHOULA																	1		
CLAIBORNE																	2		
CONCORDIA								1									1		
DESOTO			1					1									1		
EAST BATON ROUGE			2			2	1	2			1				4		75	14	
EAST CARROLL																	4		
EAST FELICIANA							1								1				
EVANGELINE																	1		
FRANKLIN											1		1						
GRANT																			
IBERIA						1		1			1				1		13		
IBERVILLE																	1		
JACKSON							1										1		
JEFFERSON			13	1		2	10	4				3	3	1	5		58	4	
JEFFERSON DAVIS																	2		
LAFAYETTE								5			1				4		37		
LAFOURCHE																	5		
LASALLE																			
LINCOLN																	4		
LIVINGSTON									1										
MADISON							1	1					1				4	3	
MOREHOUSE													1						
NATCHITOCHES																	2		
ORLEANS			1			2		1			3	20	6		8		444	46	
OUACHITA						1						6	2				20		
PLAQUEMINES																			
POINTE COUPEE																	1		
RAPIDES								1					1		1		54		
RED RIVER																			
RICHLAND																			
SABINE																			
ST. BERNARD							1				1	1					1		
ST. CHARLES					1		1	1							1		2		
ST. HELENA																			
ST. JAMES																			
ST. JOHN																	2		
ST. LANDRY								3					1				13		
ST. MARTIN																	7	1	
ST. MARY																	4		
ST. TAMMANY			5				1	1			1				1		4		
TANGIPAHOA												1					8		
TENSAS																		1	
TERREBONNE			1					2					1		4		14	2	
UNION																		1	
VERMILION								1							3		8		
VERNON													1				29	1	
WASHINGTON								1									8		*
WEBSTER																	24		
WEST BATON ROUGE											1						3	1	
WEST CARROLL																			
WEST FELICIANA																	1		
WINN							1										8		
OUT OF STATE																			

From January 1, 1988 - March 31, 1988, the following cases were also reported:
2-Amebiasis.

* Includes Rubella, Congenital Syndrome.

** Includes 4 cases of Hepatitis Non A, Non B.

*** Acquired outside United States unless otherwise stated.

SELECTED REPORTABLE DISEASES
(By Place of Residence)

STATE AND PARISH TOTALS REPORTED MORBIDITY APRIL, 1988	VACCINE PREVENTABLE DISEASES					ASEPTIC MENINGITIS	HEPATITIS A AND UNSPECIFIED**	HEPATITIS B	LEGIONELLOSIS	MALARIA ***	MENINGOCOCCAL INFECTIONS	SHIGELLOSIS	TUBERCULOSIS, PULMONARY	TYPHOID FEVER	OTHER SALMONELLOSIS	UNDERNUTRITION SEVERE	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY	RABIES IN ANIMALS (PARISH TOTALS CUMULATIVE, 1988)
	MEASLES	RUBELLA*	MUMPS	PERTUSSIS	TETANUS														
TOTAL TO DATE 1987	0	0	165	9	0	11	37	166	2	0	10	84	75	0	252	0	5300	230	4
TOTAL TO DATE 1988	0	0	129	2	1	16	64	109	3	2	29	157	101	2	150	0	4801	263	0
TOTAL THIS MONTH	0	0	61	0	0	6	35	47	2	1	15	90	34	0	77	0	1099	76	0
ACADIA												2			1		6		
ALLEN			1												1				
ASCENSION												1			3		2		
ASSUMPTION											1						6	1	
AVOYELLES																	2		
BEAUREGARD															1		1		
BIENVILLE																			
BOSSIER								3							2		19		
CADDO						1	3	5			1	4	3		10		99	3	
CALCASIEU			15				1	1				1			2		40	1	
CALDWELL			5																
CAMERON																	1		
CATAHOULA																	3		
CLAIBORNE																	3		
CONCORDIA																	2	1	
DESOTO							1	1			1							1	
EAST BATON ROUGE			4			2	7	1			2	2	2		20		72	7	
EAST CARROLL																			
EAST FELICIANA																	2		
EVANGELINE							1										4		
FRANKLIN													1				3		
GRANT																	5		
IBERIA								2									20	3	
IBERVILLE													1				24		
JACKSON			1				3	8			1	8	3		1		72	4	
JEFFERSON								1					1				1		
JEFFERSON DAVIS												1			5		25	2	
LAFAYETTE																	9	1	
LAFOURCHE																	2		
LASALLE																	3		
LINCOLN							1										3		
LIVINGSTON			30												1		1	1	
MADISON																	1	1	
MOREHOUSE								2					2		1		11		
NATCHITOCHES																	1		
ORLEANS						2	10	13			2	42	4		12		422	40	
OUACHITA							1						4		2		38	1	
PLAQUEMINES												1						1	
POINTE COUPEE													2				4		
RAPIDES							1	5				1			3		42		
RED RIVER																			
RICHLAND							1	1					2		1		1		
SABINE													2						
ST. BERNARD												12	1						
ST. CHARLES												1			1		3		
ST. HELENA																	2		
ST. JAMES																	1		
ST. JOHN												2					2		
ST. LANDRY									2				1		2		14	2	
ST. MARTIN						1					3						3		
ST. MARY											2	3	1				5		
ST. TAMMANY			5					1				1			2		10	1	
TANGIPAHOA												2			1		16	1	
TENSAS																	1		
TERREBONNE							2			1		4	2		3		41		
UNION																	2		
VERMILION												1			1		2		
VERNON							1	1			1						21	2	
WASHINGTON							1	2									7	1	
WEBSTER							1						2		1		10		
WEST BATON ROUGE												1					4	1	
WEST CARROLL																			
WEST FELICIANA											1						3		
WINN																			
OUT OF STATE																			

From January 1, 1988 - April 30, 1988, the following cases were also reported:
3-Amebiasis.

* Includes Rubella, Congenital Syndrome.

** Includes 10 cases of Hepatitis Non A, Non B.

*** Acquired outside United States unless otherwise stated.

Department of Health and Human Resources
Office of Preventive and Public Health Services
P.O. Box 60630, New Orleans, LA 70160

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BULLETIN

Due to budgetary constraints, executive orders and publishing schedules, the Louisiana Monthly Morbidity Report has not been published or has been delayed well beyond normal timelines. We are hoping to return to normal and resume timely publication in the future. In order to assist us in this endeavor, we will be printing one report for the months - January through April. Hereafter, bimonthly reports will be prepared and distributed. We appreciate your patience and understanding and continued cooperation.

If there are any articles of interest that you have not seen pubilished in the Monthly Morbidity Report that you feel would be of interest and/or beneficial to the health care community, please contact the Epidemiology Section at 504-568-5005.

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