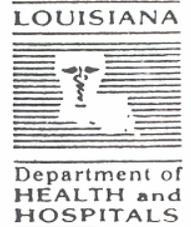




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Louisiana Morbidity Report

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Outbreak of Gastroenteritis Among Airline Passengers

In the spring of 1992, the Epidemiology Section investigated an outbreak of gastroenteritis linked to an airline flight. On April 6th, a travel agent from Seattle reported that nine of 13 travelers to New Orleans became ill with symptoms of nausea, vomiting, diarrhea, fever and chills with onset on the weekend of April 4-5. Two days later, on April 8th, a Los Angeles visitor called to report that four persons from two families had become ill with gastroenteritis during their stay in New Orleans during the same weekend. Symptoms among the family members were vomiting, abdominal cramps, chills and fever. No common food establishments in the New Orleans area were identified among the two tourist groups. However, the two groups had traveled together on the same airline flight on a leg from Los Angeles to New Orleans on April 3rd.

The flight was full with 148 passengers who were served lunch between Los Angeles and New Orleans. Of these, 100 passengers from eight different states were contacted and interviewed. Forty-three passengers had diarrhea and/or vomiting April 4-5, 1992 (Figure). The frequency of symptoms among cases is shown in Table 1. Of the 43 cases, four reported seeking medical help and one was hospitalized.

Coach class passengers eating regular meals were four times as likely to become ill than as first class or special menu passengers (51/91 vs. 1/8, RR = 4.5, P = 0.02). For coach (Continued on page 2)

Figure: Cases of gastroenteritis by date and time of onset

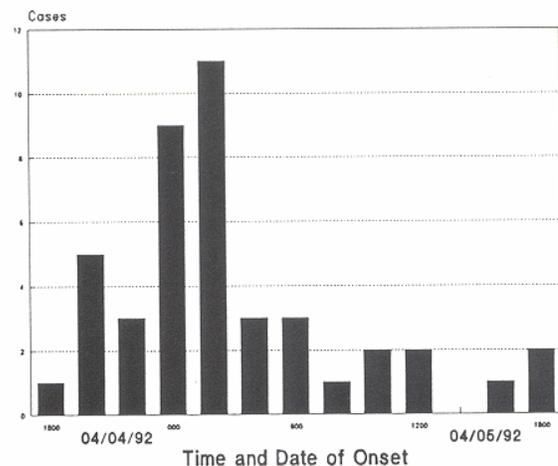


Table 1: Symptom frequency in case-patients

Symptom	Frequency	%
Nausea	38	88
Cramps	34	80
Diarrhea	34	80
Fever	29	67
Vomit	28	65
Headache	28	65
Muscleache	22	51

Table 2: Association between illness and consumption of specific food items in coach class

	Ate			Did Not Eat		
	Case	N-case	A.R.	Case	N-case	A.R.
Salad ¹	50	31	.51	0	11	.00
Beverage ²	41	48	.46	0	1	.00
Ice	38	40	.49	3	8	.25
Butter	27	20	.57	14	29	.32
Rice	28	23	.54	13	27	.48
Chicken	28	28	.50	13	22	.37
Roll	30	33	.47	10	15	.40
Veggies	28	31	.47	10	13	.43
Cake	30	35	.46	10	13	.43
Potatoes	12	19	.38	29	31	.48
Steak	12	21	.36	29	29	.50

1 - p = .0004

2 - p = 1.00

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Gastroenteritis Among Airplane Passengers (Cont.)

passengers (51/91 vs. 1/8, RR = 4.5, P = 0.02). For coach class passengers who ate the regular meal served, specific food items were analyzed (Table 2). Passengers who ate "spring salad" were significantly more likely to become ill than passengers who did not (50/81 vs. 0/11, RR = undefined, P = 0.0004, Table 2). Overall, those passengers who ate any salad, whether special menu, first or coach class, were six times more likely to become ill than those passengers who did not (52/85 vs 1/14, RR = 8.6, P = 0.0005). No association was found between eating in any site in New Orleans and becoming ill.

The airline catering facility consisted of a staff of 450 employees preparing approximately 10,000 to 14,000 meals per day. On April 3rd, 1,558 salads were prepared, which were distributed on 17 flights. Salad preparation involved four persons who cut lettuce and other ingredients. Three additional persons placed the ingredients on plates. Four individuals involved in salad preparation called in sick in the week prior to or the week after April 3rd. When interviewed, one of these employees admitted having had vomiting the week prior to April 3rd.

Clinical symptoms of acute enterocolitis such as vomiting, diarrhea, nausea, cramps, and vomiting as found in this outbreak are characteristic of viral gastroenteritis caused by Norwalk virus or a similar enteric virus. Transmission generally occurs through the fecal-oral route. Typically the incubation period is 24-48 hours. It is likely that one or all of the ingredients of the spring salad served on the airline flight was contaminated. Usually contamination of food by Norwalk virus occurs during preparation by employees who are working while ill with gastroenteritis. Recommendations were made to the foodservice management regarding the importance of foodhandlers handwashing and not working while ill with vomiting and/or diarrhea.

Tomorrow's Food Label

As a result of the Nutrition Labeling and Education Act (NLEA) of 1990, the Food and Drug Administration (FDA) has proposed a new format for food nutrition labels. In an effort to find the label format most effective in assisting consumers to select healthier diets, the FDA conducted two separate studies. Based on the evaluation of the results from these studies, the 'percent DV/DV (Daily Value) format' was selected as the preliminary choice for the design of the new food label. The proposed DV's (which refer to both the Daily Reference Value [DRV] and Reference Daily Intakes [RDI] for certain nutrients), are based on an intake of 2,350 calories daily. This caloric standard is estimated to apply to approximately 15% of the U.S. population. The information presented by this new format should help consumers understand and appropriately utilize the nutrition guidance toward more healthful dietary practices.

Figure: Food Nutrition Label

Nutrition Guide		
Serving Size	1/2 cup (114g)	Calories 260 (Calories from fat 120)
Servings per Container 4		
Per serving	% Daily Value	Daily Value
Fat (13g)	17%	Less than 75g*
Saturated Fat (5g)	20%	Less than 25g*
Cholesterol (30mg)	10%	Less than 300mg
Sodium (660mg)	28%	Less than 2400mg
Per serving	% Daily Value	Daily Value
Carbohydrate (31g)	10%	325g*
Complex Carbohydrate (26g)		
Sugars (5g)		
Dietary Fiber (0g)	0%	25g
Protein (5g)		50g*
Vitamins & Minerals % Daily Value		
Vitamin A 4%, Vitamin C 2%, Calcium 12%, Iron 4%		
*For a 2,350 calorie diet. Your Daily Value may be higher or lower, depending on your calorie intake.		

Warning Requirements On Consuming Raw Shellfish

The Office of Public Health is amending portions of Chapters IX, XXII, XXIII, and XXIII A of the State Sanitary Code to require the following statement on signs, container labels, menus, etc. that offer raw shellfish for sale: "There may be a risk associated with consuming raw shellfish as is the case with other raw protein products. If you suffer from chronic illness of the liver, stomach or blood or have other immune disorders, you should eat these products fully cooked." This Notice of Intent will appear in its entirety in the February 20, 1992 issue of the Louisiana Register.

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The Traumatic Spinal Cord Injuries to Louisiana Residents, 1991 article (Vol. 3 No. 6) was written by Rana Bayakly, MPH.

Expansion of the AIDS Case Definition

Effective January 1, 1993, the AIDS case definition will be broadened to include, in addition to the existing criteria published in 1987, all persons with documented HIV infection and any of the following conditions:

- * A CD4+ T-lymphocyte count < 200 cells per microliter (or a CD4+ percent < 14);
- * Pulmonary tuberculosis;
- * Recurrent pneumonia (within a 12 month period); or
- * Invasive cervical cancer.

In the surveillance of any disease, as knowledge of the disease process advances, the surveillance criteria for that disease must be revised to be consistent with medical practices. Monitoring of CD4+ T-lymphocyte counts has become standard in HIV care, enabling physicians to measure directly the immunosuppressive effects of HIV infection. Since severe immune deficiency has always been the basic definition for AIDS, the rationale to include cases with a low CD4+ count is obvious.

Pulmonary tuberculosis (TB) will be included in the new definition because it is a condition of major public health importance and there is a strong epidemiologic link between HIV infection and the development of tuberculosis. Persons co-infected with HIV and TB have a much greater risk of developing active TB than persons without HIV infection.

Pneumonia increases in frequency among HIV-infected persons as immunosuppression becomes more severe. Although this condition is common in persons without severe immunosuppression, recurrent pneumonia is much less frequent in persons with healthy immune systems and no other underlying diseases. In addition, recurrent pneumonia has been an AIDS defining illness in children since 1987.

The addition of invasive cervical cancer to the AIDS surveillance definition will highlight the need to identify women who are HIV infected, to provide routine gynecologic care for these women, and to evaluate these women for HIV-associated gynecologic conditions on a regular basis.

The expanded AIDS surveillance definition is expected to have a substantial impact on the number of reported cases. The immediate increase in cases will be largely due to the addition of severe immunosuppression; a smaller impact is expected from the addition of the other three conditions, since many of these persons will also have under a 200 CD4+ cell count. Current estimates are that the 1993 AIDS case count will increase by 75% over previous projections. The short term effects will be greater than the long term effects, because this change will simply be classifying an HIV infected person as "AIDS" earlier in the course of disease. Eventually, most HIV infected people develop a 1987 AIDS-defining condition. Only about 5% of immunosuppressed HIV infected persons die without meeting this definition.

Questions regarding the new case definition should be directed to HIV/AIDS Services at (504) 568-5013.

Agencies Unveil Food Guide Pyramid

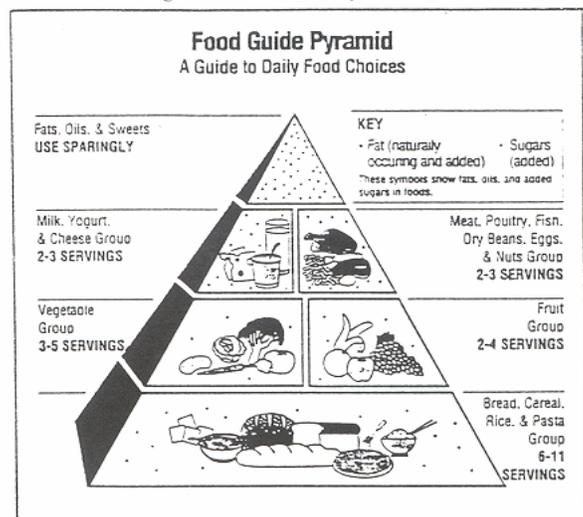
The nation's eating and drinking habits have been implicated in 6 of the 10 leading causes of death—heart disease, cancer, stroke, diabetes, atherosclerosis, and chronic liver disease and cirrhosis—as well as in several nonfatal but potentially disabling disorders, such as osteoporosis and diverticulosis.

The Food Guide Pyramid, a new nutrition guidance symbol developed by the U.S. Department of Agriculture, was announced by USDA and the Department of Health and Human Services in April of 1992. The new graphic (see below) "offers our best advice on nutrition," said Secretary of Agriculture Edward R. Madigan. "At a glance the pyramid will help Americans understand more about the foods they need, from what groups and in what amounts. For example, the pyramid clearly shows that fats, oils and sweets should be eaten sparingly." The pyramid conveys the three essential elements of a healthy diet: proportion, moderation and variety.

The new food guide was developed as a visual representation for the Dietary Guidelines for Americans, issued by the two agencies in November 1990. Various graphics were tested with children and adults, among white, African-American and Hispanic populations at all income levels and in English and Spanish. The pyramid was best in helping people understand the importance of eating different amounts of food from the different food groups and the need for moderation in the diet.

Booklets with additional information are available for \$1.00 each from: Consumer Information Center, Dept. 159-Y, Pueblo, Colorado 81009. Make checks payable to "Superintendent of Documents." (Taken from *FDA Consumer*, July-August 1992).

Figure: Food Guide Pyramid



Immunization Coverage in Public Clinics

Overall, 56% of children vaccinated in public clinics throughout the state are up-to-date on their immunizations by their second birthday, according to a survey conducted during the fall of 1992. The survey was consistent with an earlier statewide retrospective survey of children entering kindergarten, but provided results for each parish.

The Office of Public Health, through its "Shots for Tots" initiative, is trying to raise the number of children adequately immunized by age two to 90% by the year 2000. As part of this initiative, surveys of public clinics will be carried out annually. The surveys, which collect data on a statistical sample of children 24 to 35 months of age, are used to identify areas needing special attention and monitor progress toward the goal.

The percent of children up-to-date (having received four DTP, three OPV, and one MMR vaccine) increased from 37% at age 18 months to 55% at age 24 months and 63% at age 30 months. Of the 110 clinics surveyed in 62 parishes, the percent of children up-to-date by 24 months varied from 5% to 89% (Figure 1). Coverage was highest in small clinics (following fewer than 300 two-year-olds) and lowest in large clinics (following more than 900 two-year-olds; Figure 2). The results of the clinic surveys were presented in the first annual Shots for Tots conference in November 1992, and recognition was given to clinics with the highest rates in each category.

Figure 1: Immunization coverage in public clinics by parish, 1992

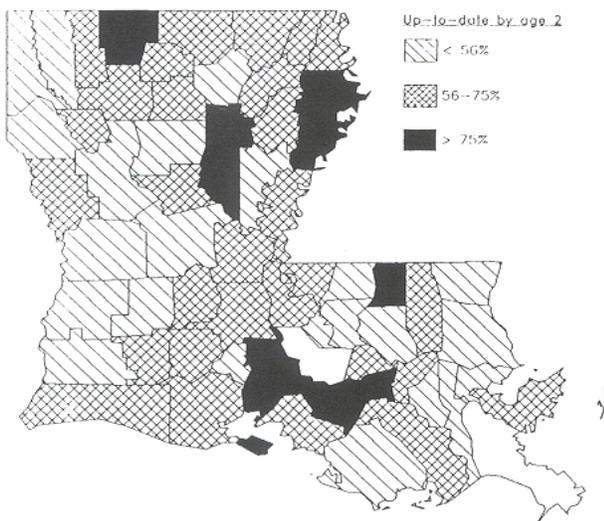
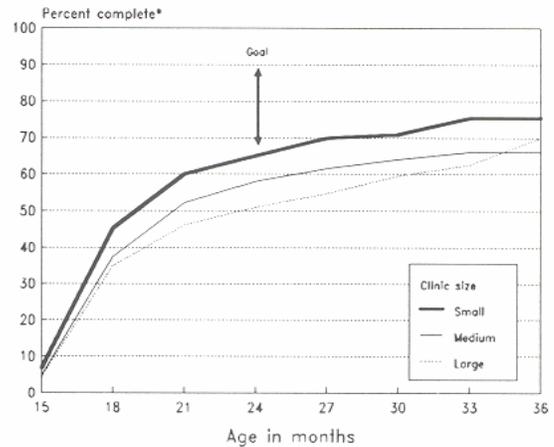


Figure 2: Immunization coverage in public clinics by age and clinic size, 1992



* Primary series: 4 DTP, 3 OPV, 1 MMR

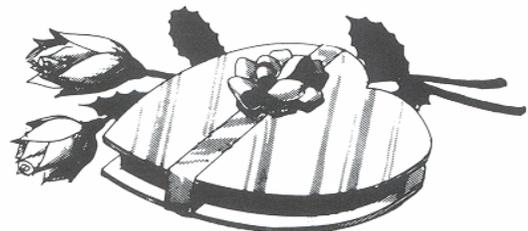
Obesity in Louisiana

Probably the most reliably insubstantial and widespread New Year's Resolution is to lose those "Excess Pounds". Data from the 1991 Louisiana Behavioral Risk Factor Survey (BRFS) illustrates that almost a third of us probably had good reason to put "Excess Pounds" at the top of our list.

The survey data show that overweight status is equally common in males and females, is lowest in Hispanics (26%), and modestly higher in Whites (30%) and African-Americans (35%). Not surprisingly, overweight increases in both genders with age from about 15% in 18-24 year-olds to a high of 44% in middle age for males and a female high of 51% in post-65 year-old females. Males show a decline in percent overweight beginning in the 55-64 age group (42%), groups vary only slightly around the 32% median, and therefore do not necessarily predict higher risk of overweight.

Obesity is a risk factor for the top three causes of mortality in Louisiana: heart disease, cancer, and stroke. As such, attention to programs promoting increased energy output, such as community-based walking projects and local government attention to safe and accessible sports facilities can moderate this risk factor. In addition, efforts to influence children to sample and consume lower fat/lower sugar foods may have a lifetime effect on their adult food preferences.

Happy Valentine



AIDS Update Idiopathic CD4-T- Lymphocytopenia (ICL)

Persons with unexplained CD4+ T-lymphocyte depletion, but without evidence of HIV infection, were reported at the VIII International Conference on AIDS in Amsterdam this past July. Since then, a national surveillance system for collecting and reporting information on persons with this syndrome has been instituted by CDC. The criteria for ICL cases include: 1) Low CD4+ T cell levels (absolute CD4+ level < 300 cell/ul or CD4 < 20%) on more than one determination, and 2) no serologic evidence of HIV infection, and 3) no defined immunodeficiency or therapy associated with depressed CD4+ levels. Persons must fulfill all three components of the definition.

As of September 28, 1992, CDC has identified 47 persons in 20 states (4 from Louisiana) who met the ICL case definition. Persons with ICL included 29 men and 18 women, with a mean age of 43 years; 39 were white, 4 Asian, 2 Hispanic, and 2 black. Eighteen patients (38%) had 1 or more risk factors for HIV infection; 29 (62%) patients had no identified risk factors. Clinically, 19 (40%) persons had AIDS defining illnesses, 25 (53%) had other non-AIDS defining conditions, and 3 (6%) were asymptomatic. Of special note is that 20 sex, blood, and household contacts of the ICL patients were investigated and found to be immunologically and clinically normal.

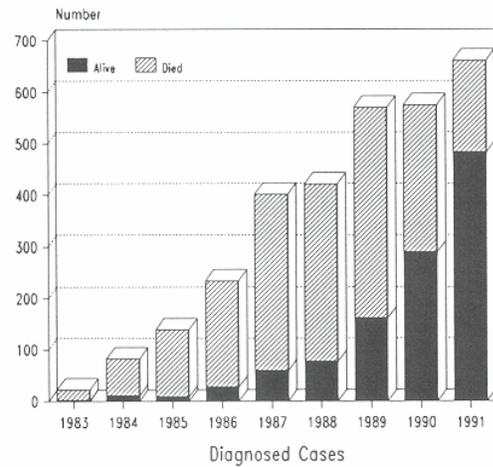
ICL cases vary demographically from AIDS cases (Table). Cases of unexplained opportunistic diseases and CD4+ T-lymphocytopenia in the absence of HIV infection are apparently rare, have occurred for the past several years and possibly longer, and comprise different clinical and immunologic states. No geographic clustering has been found. No connection between ICL and chronic fatigue syndrome, or other known syndromes has been discovered.

Further studies are being conducted to determine the natural history and etiology(ies) of unexplained lymphocytopenia. However, at this time it does not appear that these cases represent infection with HIV or any other transmissible agent.

Table. Comparison of ICL and AIDS cases in the United States

	ICL	AIDS
Age Median	43	36
Sex		
Male	62%	89%
Females	38%	11%
Race		
White	83%	53%
Black	4%	30%
Other	13%	17%
HIV Risk Factors		
Yes	38%	96%
No	62%	4%

AIDS Case Trends

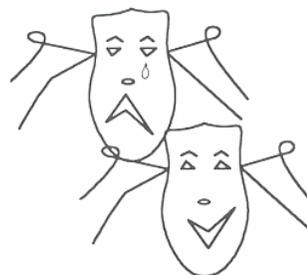


Responsibility for Disease Reporting Clarified

Physicians are designated as the primary group responsible for reporting notifiable diseases to the Epidemiology Section in the Louisiana Office of Public Health. In the past there has been confusion about the legality and responsibility of reporting by other health care professionals. Because of this confusion, a change has been made in the Sanitary Code which now states: "It shall be the duty of every osteopath, coroner, medical examiner, dentist, homeopath, infection control practitioner, medical records director, nurse, nurse midwife, nurse practitioner, pharmacist, physician assistant, podiatrist, social worker, veterinarian, and any other health care professional to report a confirmed case of reportable disease as specified in Section 2:003 in which he or she has examined or evaluated, or for which he or she is attending or has knowledge."

OPH hopes that this change will improve reporting from a variety of sources. Persons who previously had some concerns about reporting because they were not physicians can now clearly do so.

Happy Mardi Gras



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE,
NOVEMBER - DECEMBER, 1992
PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD				% Chg	
	1	2	3	4	5	6	7	8	9	Nov-Dec 1992	Nov-Dec 1991	Cum 1992	Cum 1991		
<u>Vaccine-preventable</u>															
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	--	
Mumps	1	0	1	1	0	0	0	0	0	3	8	27	37	-27	
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	--	
Pertussis	2	0	0	1	0	0	0	0	1	4	0	15	12	+25	
<u>Sexually-transmitted</u>															
AIDS	Cases	51	15	3	6	3	17	9	5	7	117	109	740	740	0
	Rate ¹	6.9	1.9	1.0	1.0	1.2	5.4	1.6	1.6	1.6	2.7	2.5	17.6	17.6	
Gonorrhea	Cases	927	360	98	155	91	103	297	113	141	2285	2033	14485	15254	-5
	Rate ²	12.6	4.8	3.3	2.8	3.5	3.3	5.4	3.7	3.1	5.4	4.9	34.4	36.2	
Syphilis(P&S)	Cases	57	88	23	29	8	15	66	20	26	332	414	2646	3022	-12
	Rate ²	0.8	1.2	0.8	0.5	0.3	0.5	1.2	0.7	0.6	0.8	1.0	6.3	7.2	
<u>Enteric</u>															
<i>Campylobacter</i>		13	4	6	5	0	0	1	0	7	36	4	235	80	+194
Hepatitis A	Cases	12	2	0	1	5	0	2	3	2	27	19	219	125	+75
	Rate ¹	1.6	0.3	--	0.2	1.9	--	0.4	1.0	0.4	0.6	0.4	5.2	2.9	
<i>Salmonella</i>	Cases	24	10	14	10	8	8	17	3	13	114	121	521	709	-26
	Rate ¹	3.3	1.3	4.6	1.8	3.1	2.6	3.1	1.0	2.9	2.7	2.8	12.4	16.2	
<i>Shigella</i>	Cases	3	5	5	2	1	0	2	0	4	22	26	108	186	-4
	Rate ¹	0.4	0.7	1.7	0.4	0.4	--	0.4	--	0.9	0.5	0.6	2.6	4.2	
<i>Vibrio cholera</i>		0	0	0	0	0	0	0	0	0	0	0	2	0	--
<i>Vibrio, other</i>		3	0	1	0	0	0	0	0	2	6	3	34	41	-17
<u>Other</u>															
Hepatitis B	Cases	14	14	2	7	1	0	4	0	3	46	66	209	323	-35
	Rate ¹	1.9	1.9	0.7	1.3	0.4	--	0.7	--	0.7	1.1	1.5	5.0	7.4	
Meningitis/Bacteremia															
<i>H. influenzae</i>		1	0	0	0	0	0	0	0	0	1	2	1	22	-95
<i>N. meningitidis</i>		1	0	0	0	1	0	0	1	1	4	1	29	31	-6
Tuberculosis	Cases	51	11	3	14	4	1	12	6	21	123	59	369	367	+1
	Rate ¹	6.9	1.5	1.0	2.5	1.5	0.3	2.2	2.0	4.7	2.9	1.4	8.8	8.7	

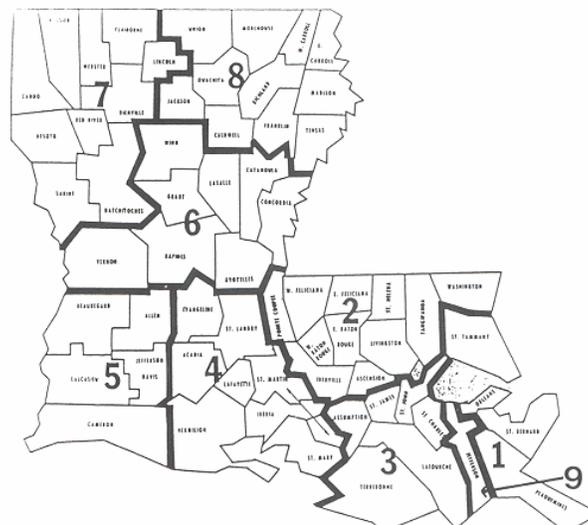
1 = Cases per 100,000
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	8
Brucellosis	1
Histoplasmosis	0
Lead Toxicity	18
Legionellosis	6
Lyme Disease	6
Malaria	1
Rocky Mountain Spotted Fever	2
Tetanus	0
Typhoid	1

Table 3. Animal Rabies (Nov-Dec, 1992)

Parish	No. Cases	Species
No rabies cases reported.		



LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Gonorrhea**	Plague*	Cancer
Amebiasis	Granuloma Inguinale**	Poliomyelitis	Complications of abortion
Anthrax	Hepatitis, (Specify type)	Psittacosis	Congenital hypothyroidism
Aseptic meningitis	Herpes (genitalis/ neonatal)**	Rabies (animal & man)	Lead poisoning
Blastomycosis	Legionellosis	Rocky Mountain Spotted Fever	Phenylketonuria
Botulism*	Leprosy	Rubella (German measles)*	Reye Syndrome
Brucellosis	Leptospirosis	Rubella (Congenital syndrome)	Severe Traumatic Head Injuries +
Campylobacteriosis	Lyme Disease	Salmonellosis	Severe undernutrition severe anemia, failure to thrive
Chancroid**	Lymphogranuloma venereum**	Shigellosis	Sickle cell disease (newborns)
Chlamydial infection**	Malaria	Syphilis**	Spinal cord injury +
Diphtheria*	Measles (rubeola)*	Tetanus	Sudden infant death syndrome (SIDS)
Encephalitis (Specify primary or post-infectious)	Meningitis, Haemophilus	Trichinosis	
Erythema infectiosum (Fifth Disease)	Meningococcal Infection (including meningitis)*	Tuberculosis***	
Foodborne illness*	Mumps	Tularemia	
Genital warts**	Mycobacteriosis, atypical***	Typhoid fever	
	Ophthalmia neonatorum*	Typhus fever, murine (fleaborne endemic)	
	Pertussis (whooping cough)	Vibrio infections (excluding cholera)	
		Yellow fever	

Report cases on green EPI-2430 card unless indicated otherwise below.

*Report suspected cases immediately by telephone. In addition, report all cases of rare or exotic communicable diseases and all outbreaks.

**Report on STD-43 form. Report syphilis cases with active lesions by telephone.

***Report on CDC 72.5 (f 5.2431) card

+Report on DDP-3 form; preliminary phone report from ER encouraged (568-2509).

The toll free number for reporting communicable diseases is
 1-800-256-2748

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