Edwin W. Edwards
GOVERNOR

# Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section
P.O. Box 60630, New Orleans, LA 70160 (504) 568-5005

LOUISIANA
Department of HEALTH and HOSPITALS
Rose V. Forrest
SECRETARY

January-February 1994 Volume 5 Number 1

## Syphilis Declared Public Health Emergency

At a press conference on December 13, 1993, DHH Secretary Rose Forrest declared the syphilis epidemic to be a public health emergency. She announced a department-wide plan to combat the epidemic and called upon physicians and citizens to take steps to stop the spread of the disease.

Syphilis rates began to rise in Louisiana in 1989, and by 1991 the case rate for primary and secondary (P&S) syphilis was 72 per 100,000, the highest rate in the nation and over seven times the US Public Health Services Year 2000 objective for the nation (Figure 1). In spite of efforts to improve case finding, treatment and follow-up, case rates have not decreased substantially since then. In 1993 there were a total of 2593 reported cases of P&S syphilis in the state (61 cases per 100,000) and 6852 syphilis cases overall. The epidemic is seen in all areas of the state and in small towns as well in cities (Figure 2).

The two major consequence of this AIDS epidemic are congenital syphilis and increased transmission of HIV. In 1993 there were over 150 cases of congenital syphilis. Syphilis causes lesions that make it easier for HIV to pass from one person to another through sexual contact. Therefore the syphilis epidemic will cause an increase in the spread of HIV, and an increase in the number of AIDS cases that will be seen years from now.

The Department plan to control the syphilis epidemic has four major elements: clinical services, notification of partners, screening, and public education. Clinical services will be expanded so that patients with sexually transmitted diseases can be treated quickly and easily five days a week in every parish in the state. Partner notification activities will be improved so that sex partners of persons with syphilis are treated quickly before they spread disease to others. Blood screening programs are being established in jails, emergency rooms, drug treatment centers, and family planning clinics. Finally, a media campaign for the prevention of AIDS and other sexually transmitted diseases will begin in 1994.

**Figure 1:** Rates of primary and secondary syphilis in Louisiana compared to the United States and the U.S. Public Health Service Year 2000 objective for the nation.

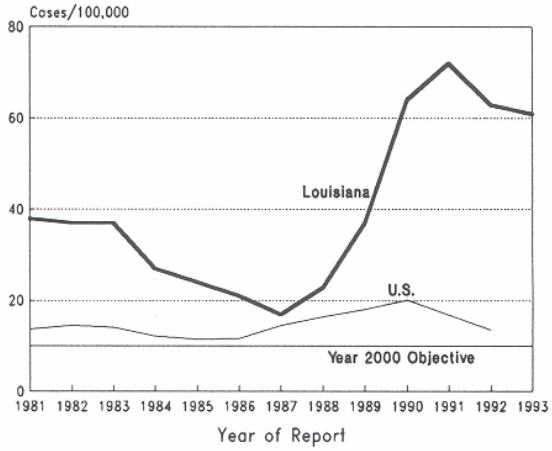
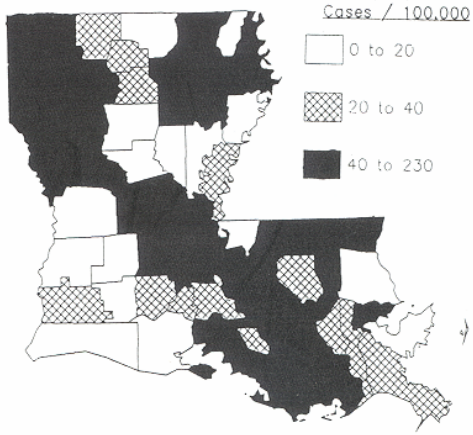



**Figure 2:** Rates of primary and secondary syphilis by parish, 1993




## Contents

*Syphilis Declared Public Health Emergency (Cont.)*

Private physicians should recognize that many patients with syphilis will not come in to public clinics for treatment, either because they do not know they have the disease or because they would prefer to be treated by their regular doctors. As part of the response to this epidemic, physicians are asked to "think syphilis," and carry out blood testing for persons at risk, including:

1. All persons with symptoms of syphilis, including genital sores, or rashes on the palms or soles.
2. All persons who are concerned about their risk and request testing.
3. All persons with other sexually transmitted diseases such as gonorrhea or chlamydia.
4. All persons with two or more sex partners in the last six months.
5. All persons who have had sexual contact with a prostitute or have exchanged drugs for sex.
6. All persons who use illicit drugs or who have sex partners who use illicit drugs.

In addition, it is especially important that every pregnant woman be tested for syphilis early and again late in pregnancy. Most of the women who deliver infants with congenital syphilis have little or no prenatal care, but many come in contact with the medical care system in places like emergency rooms or walk-in clinics. Physicians who see pregnant women for reasons other than pregnancy should make sure that they are tested for syphilis.

Physicians and other health professionals can also help control this epidemic by talking frankly to their patients about how to prevent sexual spread of diseases. Sexual abstinence is the best way to prevent infection with syphilis or HIV. People who are sexually active should be reminded to decrease the number of sex partners and to use a condom every time they have sex.

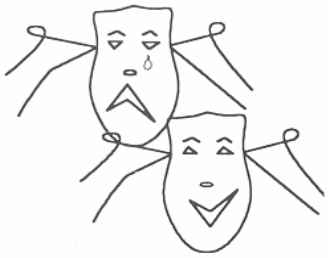
# Immunization Schedule Changes

The Advisory Committee on Immunization Practice (ACIP) of the Centers for Disease Control and Prevention (CDC) has recommended two changes in the current pediatric immunization schedule. The ACIP recommends that the third dose of polio vaccine (either OPV or IPV) should now be given at 6 months of age rather than 15 months. This will replace the 15 month dose of polio vaccine and will provide better protection for children from ages 6 to 15 months.

The ACIP also recommends that the first dose of measles, mumps and rubella (MMR) vaccines be given at 12 months rather than 15 months. Recent research has shown that young women immunized with MMR have lower antibody levels than women who experienced the corresponding diseases. Few of the women now entering their childbearing years have had these diseases, but developed their immunity through vaccination. These women have fewer antibodies to pass across the placenta to their infants before birth. The infants start with fewer antibodies and lose this passive immunity sooner, leaving them vulnerable to infection. In order to protect the growing cohort of children with mothers who received vaccine, the ACIP recommends giving the first dose of MMR at 12 months. This will replace the 15 month dose.

These recommendations have been reviewed by the Red Book Committee of the American Academy of Pediatrics, which agrees with these changes in the immunization schedule. Anyone with questions concerning these changes or other immunization issues can call Dr. Meg Lawrence, Ruben Tapia, or Herb Loy of the Immunization Program of the Office of Public Health at (504) 568-5007.

## *Happy Mardi Gras*



**Louisiana Morbidity Report**
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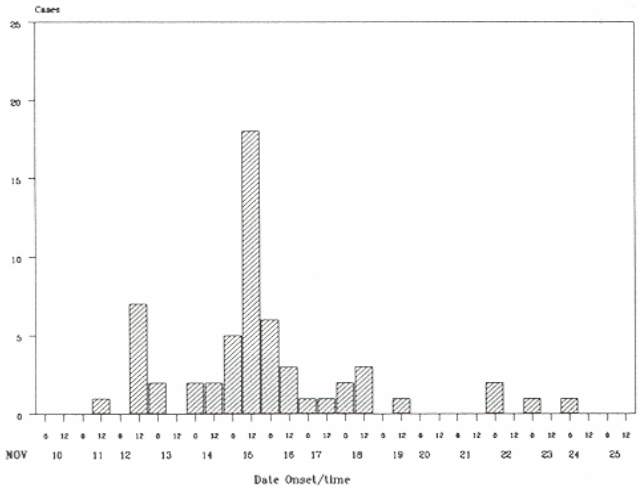
| | |
|---|---|
| *Assistant Secretary, OPH* | *Eric Baumgartner, MD MPH* |
| *State Epidemiologist* | *Louise McFarland, DrPH* |
| *Editors* | *Thomas Farley, MD MPH*<br>*Karen Kelso, RNC MS* |
| *Production Manager* | *Ethel Davis, CST* |
| *Contributors* | *Susan Wilson, BSN*<br>*Melvin Kohn, MD*<br>*Christopher Murrill, MPH*<br>*Meg Lawrence, MD MPH* |

# A Multi-state Outbreak of Gastroenteritis Linked to Louisiana Oysters

On November 15, 1993, the Louisiana Office of Public Health received a report of a family with gastroenteritis associated with consumption of raw oysters. Within several days we learned of 13 other groups of two or more persons in Louisiana who had become ill after eating raw oysters. One hundred and nineteen persons were interviewed. Of the 77 persons in these groups who ate raw oysters, 63 (82%) became ill with vomiting or diarrhea, while only two of the 42 persons who did not eat raw oysters became ill (relative risk = 17.2, 95% confidence interval 4.4 - 66.7). The median incubation period was 31 hours and the median duration of illness was 36 hours. We also documented 8 (11%) secondary cases who did not eat raw oysters among 74 household members of ill persons.

**Figure:** Cases of gastroenteritis in Louisiana linked to consumption of raw oysters by date of onset




Because a virus was suspected, stools were collected within 48 hours of onset of symptoms from nine persons among three groups involved in the outbreak. Small Round Structured Viruses similar to Norwalk virus were seen by electron microscopy in six (67%) out of nine stool samples. Norwalk-like viruses also were found by polymerase chain reaction (PCR) in nine (100%) out of nine stool specimens. Acute and convalescent serum samples on all nine persons showed a fourfold or greater rise of antibodies to Norwalk virus. PCR analysis of oysters from this outbreak using newly developed techniques is being performed by CDC and FDA.

Using tags on the sacks of oysters and by contacting oyster dealers, OPH traced oysters involved in these outbreaks to two neighboring oyster beds off the coast of southeastern Louisiana, with dates of harvest from November 9-13. On November 16 the Louisiana State Health Officer closed the two beds and recalled oysters that had already been harvested from there.

On November 17 CDC began to receive reports of outbreaks in other states linked to oysters from the two beds. Outbreaks in other states are summarized in Table 2. Viral sequences from ill persons in all three states are identical to those from ill persons in Louisiana, suggesting a common source for infection.

**Table 1**: Symptoms reported by ill persons (N=65)

| Symptom | Number | Percent of ill persons |
|---|---|---|
| Diarrhea | 63 | 97% |
| Cramps | 58 | 89% |
| Vomiting | 48 | 74% |
| Headache | 41 | 63% |
| Fever | 33 | 51% |

**Table 2**: Ill persons in other states linked to oysters from implicated beds

| State | Number of Outbreaks | Number of Ill Persons |
|---|---|---|
| Mississippi | 1 | 6 |
| Maryland | 5 | 80 |
| North Carolina | 3 | 31 |
| Pennsylvania | 1 | 2 |
| Total | | 119 |

The source of the oyster bed contamination is still under investigation. Oysters may hold on to enteric viruses for as long as 25 days. Accordingly, after being closed for one month the beds were re-opened on December 16. Since re-opening, no outbreaks of gastroenteritis from oysters have been reported.

# Federal Program To Provide Vaccine

Congress has approved a program which will provide free vaccine to healthcare providers for children who are Medicaid eligible, uninsured, Native American or who receive care through the Federally-qualified Health Centers. The program will begin in October, 1994. Federal officials are negotiating contracts with vaccine manufacturers currently. The state's Office of Public Health and the Bureau of Health Services Financing (Medicaid) are working to develop a system to register interested providers. The state will consider using manufacturers' current system of distribution to private providers for these vaccines.

Registered providers will be required to ask each patient whether they have Medicaid, are uninsured, or are Native American. The providers will not be required to verify the answers. Nationally standardized forms are being developed for these questions and for provider registration.

Vaccines for these children will be provided free and the provider will not be able to charge for vaccine, but will be able to charge an administration fee.

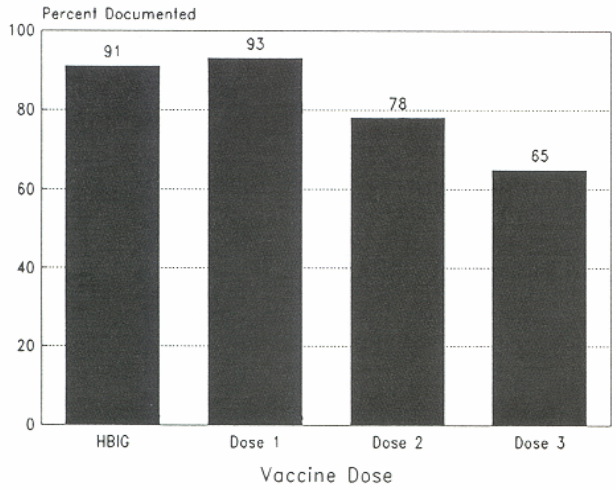
Further information about the vaccine distribution system and general immunization update materials will be sent out in the upcoming months. If you have questions, call Dr. Meg Lawrence at (504) 568-5504.

# Evaluation of Louisiana's Perinatal Hepatitis B Vaccination Program

Infants of women who have chronic hepatitis B virus (HBV) infection are at high risk of perinatal HBV transmission and subsequent liver disease. Since December 1990 the Louisiana Office of Public Health (OPH) has tracked these infants to ensure appropriate vaccination (three vaccine doses plus HBV immune globulin) and thereby prevent perinatal HBV transmission. Serologic testing is recommended at 15 months; infants who do not have protective levels of antibody to hepatitis B surface antigen (anti-HBS) are given a booster dose of vaccine. In order to evaluate tracking in our program, we examined records of children in the OPH database.

There were 426 children 15 months of age or older as of 7/1/93 in the database. Because of their age, these children should have had serologic testing done. There were 275 (65%) records containing information on administration of three doses of vaccine and only 162 (38%) of these also contained serologic testing results. Records could have been incomplete either because vaccination and testing were not done, or because the information was not reported to OPH. Incomplete records did not differ from complete records with regard to maternal age, race, or care received in the public or private sector. Incomplete records were more likely to pertain to infants in the New Orleans area than to infants in other parts of the state. The percentage of infants with documented vaccination in our database are shown for each vaccine dose in Figure.

**Figure**: Percentage of 426 infants with documented HBV vaccination, by vaccine dose.




Because timely serologic testing requires considerable effort, we wished to evaluate the usefulness of serologic testing and the impact of timing on test results. There were 194 infants 15 months or older as of July 1, 1993 who were followed by OPH and had serologic test results. This included 162 fully vaccinated children and 32 partially vaccinated children. Eighteen (56%) of the partially vaccinated and 22 (14%) of the fully vaccinated children did not have anti-HBs (Prevalence Ratio (PR)=4.1, 95% Confidence Interval (CI) 2.5-6.8). Three (9%) partially vaccinated and three (2%) fully vaccinated infants were HBV carriers.

Both vaccination and testing dates were available for 169 infants (including 140 fully and 29 partially vaccinated infants). There were 42 infants tested > 18 months after the last vaccine dose and 127 tested from one to 18 months after the last dose. Of those tested later, 18 (43%) did not have anti-HBS, compared to 18 (14%) of those tested earlier (PR=3.0, 95% CI 1.7-5.3). Even among children tested at <18 months, six (56%) of 11 partially vaccinated and 12 (10%) of 116 fully vaccinated infants did not have anti-HBS.

These data suggest that when used properly HBV vaccine prevents at least 90% of infants from becoming carriers. Both our program and individual clinicians should focus efforts on improving tracking of infants of carrier mothers and ensuring vaccination, especially in the New Orleans area. Despite the effort involved, post-vaccination serologic testing also should be continued, since it enabled us to identify a substantial number of unprotected infants and infants with chronic HBV infection. However, since levels of anti-HBs decline 18 months after the last dose, ensuring that testing is done in a timely fashion is important.

# Rabies Update

Cases of rabies in animals continue to be reported in southwestern Louisiana. To date there have been 11 rabid skunks identified in Lafayette Parish, two in Acadia, and one in Vermilion. There has also been a rabid cat reported from Ascension Parish. Laboratory specimens have been forwarded to the Centers for Disease Control and Prevention for additional studies. Physicians should be aware of the possibility of transmission of rabies to humans in these areas.

# 1992 Annual Report Available

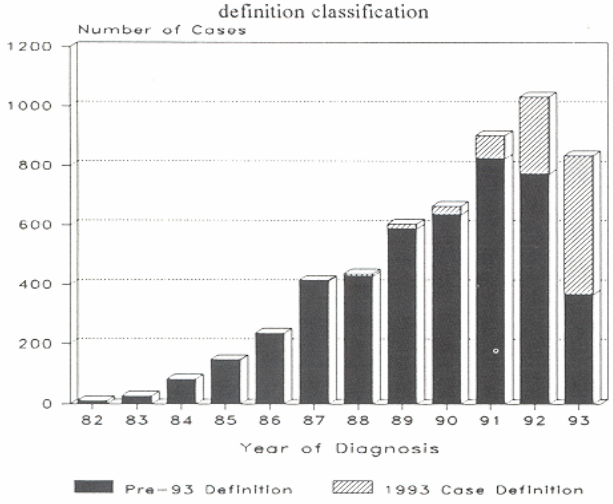
The 1992 Epidemiology Annual Report has been published and will be sent to those already on the mailing list. Other interested individuals may contact the Epidemiology Section at 504-568-5005 for a copy. A new section, Summary of Special Studies/Surveillance has been added to the report. Comments regarding the format or usefulness or topics of interest not yet covered are welcome.

## *AIDS Update*

## 1993 CDC AIDS Case Definition: Impact on the Number of Cases in Louisiana

On January 1, 1993, the Centers for Diseases Control (CDC) implemented a nationwide revision and expansion of their 1987 AIDS case definition for adults and adolescents. Changes to the 1987 definition were the inclusion of HIV infected persons who have < 200 CD4+ T-lymphocytes/uL or a CD4+ percentage of total lymphocytes < 14 and are not necessarily currently diagnosed with an opportunistic disease. Also, in addition to the 23 opportunistic diseases which were included in the 1987 definition, three additional opportunistic diseases were added: pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer. The change in the case definition takes into account the importance of CD4+ T-lymphocytes as a biological marker for the progression AIDS.

**Figure 1**: AIDS cases by year of diagnosis and case definition classification

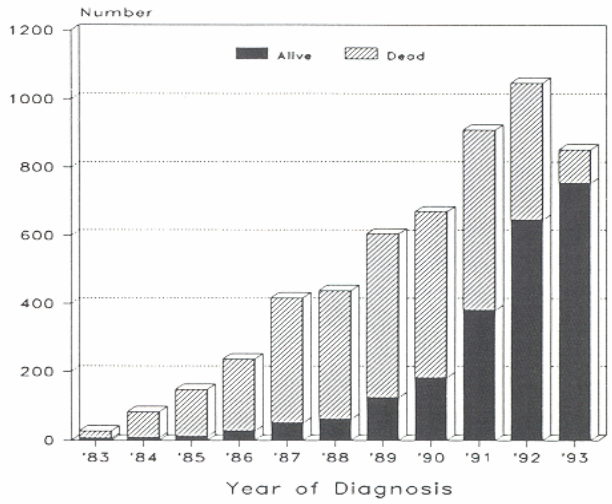



The CDC has estimated that the change in the case definition would contribute to a significant nationwide increase of AIDS cases reported during 1993. Figure 1 illustrates an increase of the number of diagnosed cases during the past six years as a result of the new case definition. 25% of the 1992 diagnosed cases and 56% of the 1993 diagnosed cases were identified only by the new definition. To date, an additional 861 cases were reported statewide to OPH based on the recent change. This represents approximately 16% of the cumulative cases for Louisiana.

Of the cases who were identified with the revised case definition 50% were African American, 47% Caucasian, 84% male, and 16% female. 44% of these cases were men who have sex with men, 18% were intravenous drug users, 9% were heterosexuals, and 16% did not have a reported risk to date. In comparison, of the cases identified by the 1987 case definition 36% were African American, 61% Caucasian, 92% male, and 8% female. Men who have sex with men represent 63% of these cases, intravenous drug use 11%, heterosexuals 5% and unidentified risk 8%.

The 1993 expansion of the CDC's AIDS case definition will simplify the procedure for diagnosing AIDS cases throughout the state. Such a change will contribute to an increased number of AIDS case diagnosed and reported in Louisiana during the near future. The long-term impact of the change in the case definition will be minimal because the new cases are simply being diagnosed at an earlier stage of the disease progression, and eventually nearly all cases would meet the 1987 case definition.

## AIDS CASE TRENDS




## Reporting of HIV and AIDS Cases

Contact Sue Troxler - (504) 568-5013
or the regional surveillance epidemiologist:

| | |
|---|---|
| Deborah Edwards | (504) 568-7526- Metro New Orleans area |
| Elizabeth Cross | (504) 568-5390- Houma area |
| Patricia Johnson | (504) 359-9462- Baton Rouge area |
| Rosalie Ardoin | (318) 262-5335- Lafayette/Lake Charles |
| LaVerne Chance | (318) 676-5071- Shreveport area |
| Sue Bennett | (318) 362-5232- Monroe/Alexandria |

**Remember: Numbers mean funding!**

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE,
NOVEMBER - DECEMBER, 1993
PROVISIONAL DATA

**Table 1.** *Disease Incidence by Region and Time Period*

| DISEASE | | HEALTH REGION 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | TIME PERIOD Nov-Dec 1993 | Nov-Dec 1992 | Cum 1993 | Cum 1992 | % Chg |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Vaccine-preventable | | | | | | | | | | | | | | | |
| Measles | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | -- |
| Mumps | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 3 | 20 | 27 | -26 |
| Rubella | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | -- |
| Pertussis | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 4 | 13 | 15 | +13 |
| Sexually-transmitted | | | | | | | | | | | | | | | |
| AIDS | Cases | 136 | 49 | 5 | 9 | 9 | 9 | 3 | 10 | 18 | 253 | 154 | 1226 | 961 | |
| | Rate[1] | 18.5 | 6.5 | 1.7 | 1.6 | 3.5 | 2.9 | 0.5 | 3.3 | 4.0 | 6.0 | 3.7 | 29.1 | 22.8 | +28 |
| Gonorrhea | Cases | 827 | 310 | 116 | 190 | 94 | 152 | 332 | 159 | 154 | 2334 | 2285 | 13260 | 14485 | |
| | Rate[2] | 11.3 | 4.1 | 3.8 | 3.4 | 3.7 | 4.9 | 6.0 | 5.3 | 3.4 | 5.3 | 5.4 | 31.4 | 34.3 | -8.4 |
| Syphilis(P&S) | Cases | 51 | 104 | 30 | 57 | 1 | 22 | 47 | 23 | 17 | 352 | 332 | 2593 | 2646 | |
| | Rate[2] | 0.7 | 1.4 | 1.0 | 1.0 | 0.0 | 0.7 | 0.8 | 0.8 | 0.4 | 0.8 | 0.8 | 6.1 | 6.3 | -2.0 |
| Enteric | | | | | | | | | | | | | | | |
| *Campylobacter* | | 4 | 4 | 3 | 3 | 0 | 2 | 0 | 0 | 2 | 18 | 36 | 159 | 235 | -32 |
| Hepatitis A | Cases | 9 | 2 | 0 | 1 | 0 | 0 | 3 | 0 | 3 | 18 | 27 | 96 | 219 | |
| | Rate[1] | 1.2 | 0.3 | -- | 0.2 | -- | -- | 0.5 | -- | 0.7 | 0.4 | 0.6 | 2.3 | 5.2 | -56 |
| *Salmonella* | Cases | 43 | 12 | 7 | 16 | 5 | 2 | 22 | 0 | 15 | 122 | 114 | 492 | 521 | |
| | Rate[1] | 5.9 | 1.6 | 2.3 | 2.9 | 1.9 | 0.6 | 4.0 | -- | 3.3 | 2.9 | 2.7 | 11.7 | 12.4 | -5 |
| *Shigella* | Cases | 6 | 4 | 7 | 21 | 7 | 3 | 2 | 3 | 2 | 55 | 22 | 48 | 108 | |
| | Rate[1] | 0.8 | 0.5 | 2.3 | 3.8 | 2.7 | 1.0 | 0.4 | 1.0 | 0.4 | 1.3 | 0.5 | 9.9 | 2.6 | +287 |
| *Vibrio cholera* | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | -50 |
| *Vibrio*, other | | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 6 | 38 | 34 | +12 |
| Other | | | | | | | | | | | | | | | |
| Hepatitis B | Cases | 21 | 9 | 4 | 0 | 0 | 1 | 6 | 0 | 1 | 42 | 46 | 241 | 209 | |
| | Rate[1] | 2.9 | 1.2 | 1.3 | -- | -- | 0.3 | 1.1 | -- | 0.2 | 1.0 | 1.1 | 5.7 | 5.0 | +15 |
| Meningitis/Bacteremia | | | | | | | | | | | | | | | |
| *H. influenzae* | | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 5 | 1 | +400 |
| *N. meningitidis* | | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 4 | 4 | 40 | 29 | +38 |
| Tuberculosis | Cases | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | |
| | Rate[1] | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

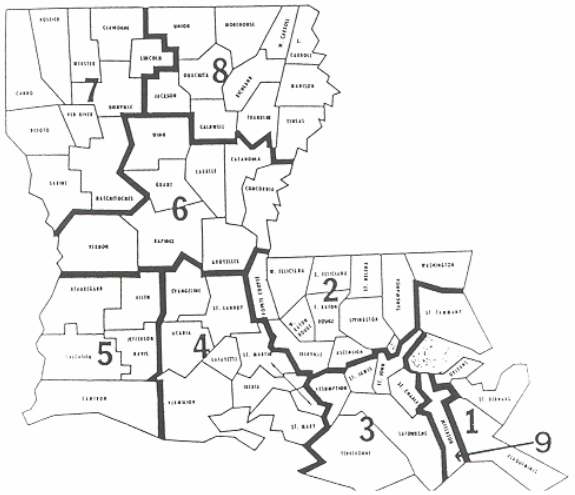
1 = Cases per 100,000
2 = Cases per 10,000

**Table 2.** *Diseases of Low Frequency*

| Disease | Total to Date |
|---|---|
| Blastomycosis | 8 |
| Brucellosis | 1 |
| Histoplasmosis | 3 |
| Lead Toxicity | 0 |
| Legionellosis | 7 |
| Lyme Disease | 2 |
| Malaria | 6 |
| Rocky Mountain Spotted Fever | 2 |
| Typhoid | 1 |

**Table 3.** *Animal Rabies (Nov-Dec, 1993)*

| Parish | No. Cases | Species |
|---|---|---|
| Lafayette | 5 | Skunk |
| Ascension | 1 | Skunk |
| Acadia | 1 | Cat |
| Vermilion | 1 | Skunk |



## *Annual Summary Hepatitis B 1992*

In 1992, there were 261 cases of hepatitis B reported to the Epidemiology Section, an overall case rate of 6.2 per 100,000. Reported cases of hepatitis B has decreased 28% from 1991 (362 cases) and has continued on a gradual decline since 1987. Of the 261 cases reported, 155 (59%) were male and 104 (40%) were female. Case rates by race continued to show rates for blacks almost three times higher than whites (10.2 vs 3.7 per 100,000). There were more cases reported in males of all age groups except in the 15-19 year and 55-64 year age groups (Figure 1). Nine parishes exceeded the overall state case rate nearly two times and greater (Figure 2).

**Figure 1**: Cases of hepatitis B by age and sex, 1992

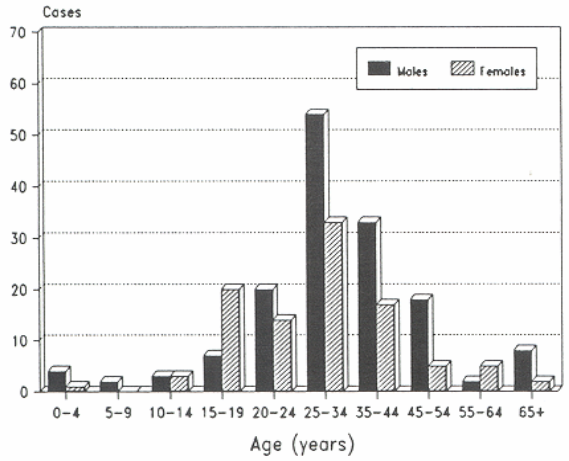
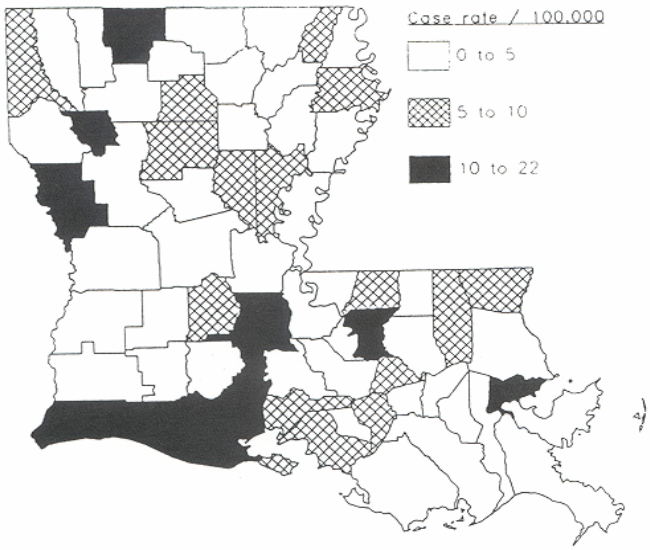



**Figure 2**: Rates of hepatitis B by parish, 1992




Reporting symptomatic hepatitis infection provides a reliable indication of the rate of infection within the community, and with the widespread availability of serological testing for HBV infection, this diagnosis can now be made easily. A serum sample positive for HBsAg indicates presence of HBV infection, but it does not fully determine the stage of the disease without additional clinical information. All HBsAg-positive persons should be considered potentially infectious; however the relative degree of infectivity and stage of infection can be assessed by the presence of other markers.

## Notice to Hospital Infection Control Practitioners

The Association for Professionals in Infection Control and Epidemiology, Inc. will be conducting a basic training course, The Fundamentals of Surveillance, Prevention, and Control of Nosocomial Infections on February 20-26 and again on July 17-23, 1994 in Chicago, Illinois at the Palmer House. Interested individuals should contact the national APIC office at 1016 16th St., NW, Sixth Floor, Washington, DC 20036; phone number 202-296-2742. The cost is $495 for members and $560 for non-members.

There are quite a number of seminars being offered around the country this year on epidemiology issues and/or infection control. For additional information, contact the Epidemiology Section at 504-568-5005.

*LOUISIANA FACTS*

In 1882, the Legislature passed an act to provide for the organization of local boards of health in the State of Louisiana. The municipal authorities of all incorporated towns were authorized to constitute themselves local boards of health with power to pass ordinances for the prevention of contagious disease, to abate nuisances dangerous to the public health, to regulate drainage and ventilation for all buildings, and to record vital statistics. These boards of health were required to choose registered physicians as health officers. The police jury in each parish was empowered to constitute itself a board of health for the parish, with powers identical to those granted to the municipal boards.

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
P.O. BOX 60630 NEW ORLEANS LA 70160



## LIST OF REPORTABLE DISEASES/CONDITIONS

### REPORTABLE DISEASES

Acquired Immune Deficiency Syndrome (AIDS)
Amebiasis
Anthrax
Aseptic meningitis
Blastomycosis
Botulism*
Brucellosis
Campylobacteriosis
Chancroid**
Cholera*
Chlamydial infection**
Diphtheria*
Encephalitis (Specify primary or post-infectious)
Erythema infectiosum (Fifth Disease)
Foodborne illness*
Genital warts**
Gonorrhea**
Granuloma Inguinale**
Hepatitis (Specify type)
Herpes (genitalis/ neonatal)**
Human Immuno-deficiency Virus (HIV)
Legionellosis
Leprosy
Leptospirosis
LymeDisease
Lymphogranuloma venereum**
Malaria
Measles (rubeola)*
Meningitis, Haemophilus
Meningococcal Infection (including meningitis)*
Mumps
Mycobacteriosis, atypical***
Ophthalmia neonatorum*
Pertussis (whooping cough)
Plague*
Poliomyelitis
Psittacosis
Rabies (animal & man)
Rocky Mountain Spotted Fever
Rubella (German measles)*
Rubella (Congenital syndrome)
Salmonellosis
Shigellosis
Syphilis**
Tetanus
Trichinosis
Tuberculosis***
Tularemia
Typhoid fever
Typhus fever, murine (fleaborne endemic)
Vibrio infections (excluding cholera)
Yellow fever

### OTHER REPORTABLE CONDITIONS

Cancer
Complications of abortion
Congenital hypothyroidism
Lead poisoning
Phenylketonuria
Reye Syndrome
Severe Traumatic Head Injuries+
Severe undernutrition severe anemia, failure to thrive
Sickle cell disease (newborns)
Spinal cord injury+
Sudden infant death syndrome (SIDS)

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 FAX # 504-568-3206

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