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Louisiana Morbidity Report

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LOUISIANA
Department of HEALTH and HOSPITALS
Rose V. Forrest
SECRETARY

March-April 1994 Volume 5 Number 2

Teenage Pregnancy and Birth Rates

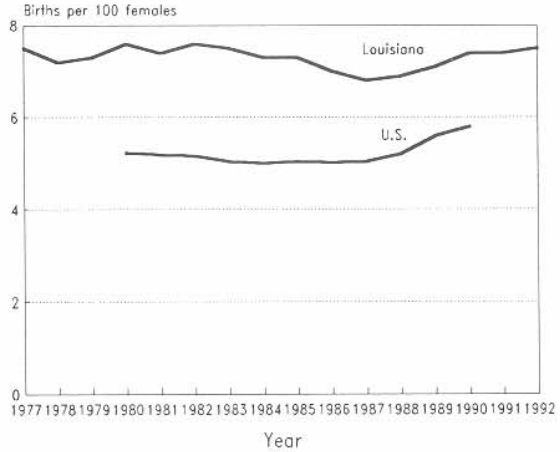
In 1992 in Louisiana 8% (13,274) of girls age 15-19 became pregnant; 93% (12,341) of these gave birth and 7% (933) had abortions. In 1990 Louisiana had a teen birth rate that is 28% higher than the U.S. as a whole (Figure 1). In the last four years, teen birth rates have increased in both Louisiana and in the U.S., reversing a decades-long declining trend. Among girls age 10-14 in 1992, 2.4 per 1,000 became pregnant, with 33% (191/586) of these having abortions; the pregnancy rate in this age group was 71% higher than the U.S.

Teenage pregnancy is a public health problem because infants of teenage mothers are at higher than average risk for low birth weight, poor growth, and long-term morbidity and mortality. In addition, girls who become pregnant as teenagers are also more likely to drop out of school than their peers who do not become pregnant.

Teenage birth rates are high across the state, but are higher in parishes in the northeastern part of the state (Figure 2). The parishes with birth rates for teens age 15-19 above 10% were E. Carroll, Caldwell, Richland, Sabine, Madison, Morehouse, and Orleans.

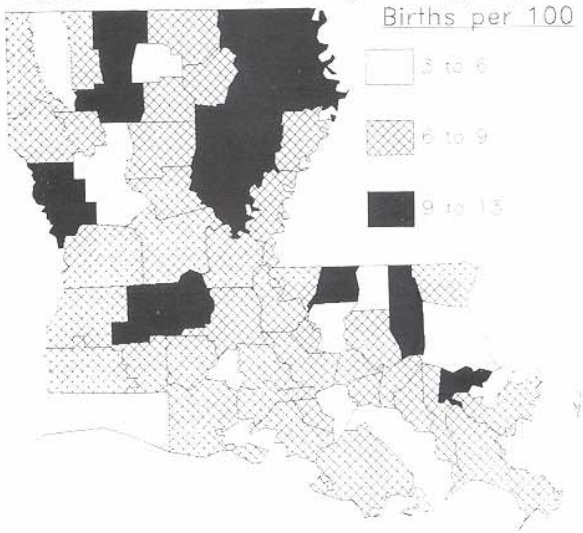
National surveys indicate that approximately 50% of girls age 15-19 are sexually active. Prevention of pregnancy in teens should focus on postponement of sexual activity, and for those who are sexually active, use of barrier contraceptives that will also prevent sexually transmitted diseases.

Figure 1: Birth rates among females age 15-19 in Louisiana and U.S., 1977-1992



Primary care physicians should be aware of the problem of teenage pregnancy in Louisiana and should discuss abstinence and contraception with girls at the time of menarche.

Figure 2: Birth rates among females age 15-19 by parish, 1992



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School-based Vaccination of Adolescents Against Hepatitis B

In Louisiana infants are routinely vaccinated against hepatitis B, but adolescents are not, in part because adolescents do not routinely visit health care providers. During the 1992-3 academic year, a pilot program in a Baton Rouge middle school was successful in vaccinating adolescents.

Westdale middle school had an enrollment of 654 students age 10-16 in 6th, 7th, and 8th grade and a special education class. Of these, 509 (78%) were black, 134 (20%) were white, and 10 (2%) were Asian. Westdale had a school-based clinic with a full-time nurse. The year of this program, there were 11 cases of sexually transmitted diseases and three pregnant students diagnosed, treated, or followed in the clinic.

Various techniques were used to educate parents and students about the vaccination program and to encourage participation. Letters were sent to parents explaining the program and employing testimonials from patients with acute hepatitis B. Public service announcements were aired on local radio stations. Presentations were made in science classes. Students entered in a t-shirt contest publicizing the program, and those who were vaccinated received pens, coupons for soft drinks, and other incentives.

Vaccine was administered on a 0, 1 and 5 month schedule by two volunteer nurses provided by a local hospital. Students absent during vaccine administration were vaccinated at a later date by the school-based clinic nurse.

Of the 654 students, 519 (79%) recieved at least one dose of hepatitis B vaccine, 497 (76%) received at least two doses, and 425 (65%) received all three doses. There were no significant differences in receipt of vaccine by grade in school, gender, or enrollment in Medicaid. White students were significantly more likely than black students to receive at least one dose (75% vs 62%, p=.008). Once enrolled, white and black students were equally likely to finish the series.

Six weeks after the third dose of vaccine was administered students who had received all three doses were asked to volunteer for serologic testing for antibodies to hepatitis B. One hundred three students were tested. Of these, two (2%) had antibodies to hepatitis B surface antigen and hepatitis B core antigen (anti-HBS and anti-HBC), indicating immunity caused by natural infection, 96 (93%) had only anti-HBS, indicating vaccine-induced immunity, and four (4%) had neither antibody, indicating vaccine failure. Thus 96 (96%) of 102 susceptible students developed protective antibody as the result of vaccination.

The national strategy to control hepatitis B in the U.S. depends on vaccination of all infants and vaccination of high-risk adolescents. Infants are a beneficial group to vaccinate because the dose of vaccine is lower (thereby decreasing the cost of vaccination) and systems are already in place to provide vaccines to all infants. However, since most infection with hepatitis B occurs during and after adolescence, vaccination of infants will not have a substantial impact on rates of acute or chronic hepatitis B for many years. Vaccination of adolescents protects persons closer to the time at which they are at risk, but has the disadvantage that there is no well-established system of providing routine preventive medical care of any kind for adolescents in the U.S. Vaccination against hepatitis B is particularly difficult because of the schedule that requires three doses to be given over six months.

Delivering hepatitis B vaccine in middle or junior-high schools addresses these problems. Vaccinations given at school do not require students to miss class or parents to miss work. The school year of eight to nine months allows for three doses to be given over six months, even if some doses are missed and multiple clinics must be scheduled for each dose. Middle schools offer the added advantage that over 99% of children remain in school until age 13, after which dropout rates increase substantially. The presence of a school-based clinic in the school enhances these advantages. Parents and students are accustomed to the delivery of medical care at school. In addition, a full-time clinic nurse can vaccinate students who missed the regular vaccination day.

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Louisiana Smoking Trends: BRFSS 1991-1992

Smoking is one of the leading causes of preventable deaths in the United States and Louisiana. There are over 7,200 deaths each year in Louisiana that can be attributed to tobacco, approximately 20% of all deaths in the state. The annual economic costs of tobacco related morbidity and mortality are in excess of $215,000,000 as cited in Smoking Attributable Morbidity and Mortality Economic Costs (SAMMEC).

The Behavior Risk Factor Surveillance System data (1650 individuals annually) show the smoking prevalence in the state of Louisiana to be 24.2% in 1992 compared to 24.8% in 1991. Because of the small numbers involved, caution should be used in not over-interpreting the data. One possible explanation for the increase in smoking may be due to the dramatic rise in advertising by tobacco companies targeting African-American youth. Current smoking by males in the 18-24 age groups has increased from 24.9% in 1991 to 28.2% in 1992. There have also been significant increases in smoking prevalence among males in the 25-34 age group (27.1% in 1991 to 30.8% in 1992) as well as in the 35-44 age group (31.6% in 1991 to 32.5% in 1992). Conversely, smoking prevalence has decreased for males in the 45-54 and the 55-64 age groups, (Figure 1).

Smoking prevalence decreased in females aged 18-24 (17.2% in 1991 to 15.9% in 1992) while increasing for females in the 25-34 and 35-44 age groups, (Figure 2).

It is interesting to note that in the 45-54 age group current female smoking has surpassed current male smoking in both 1991 and 1992. In the 45-54 age group, men often experience their first cardiovascular event, whereas women in this group still retain protection derived from premenopausal estrogen levels. As a result, women may be less likely to be concerned about the effect of smoking on their health at this time. On the other hand, men aged 45-54 may be quitting the smoking habit due to a recent cardiovascular event or fear of the possibility of heart attack.

Smoking prevalence increased in the Black population from 21.1% in 1991 to 24.8% in 1992. African American males in Southeast Louisiana already have the highest recorded rates of lung cancer in the world, and an increase in smoking prevalence can only have a negative impact for the future. During this same time period smoking prevalence decreased for Whites by 1.8% and for Hispanics by 1.3%, trends which are favorable but not yet demonstrably significant, (Table).

Figure 1: Male smoking in Louisiana, 1991-1992

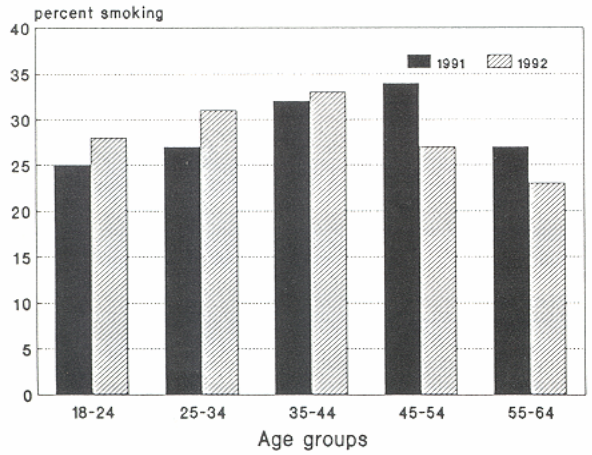
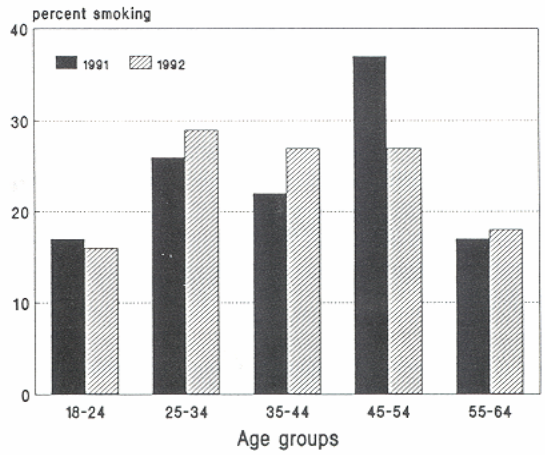


Figure 2: Female smoking in Louisiana, 1991-1992



Current Smoking by Race
BRFSS Data 1991 and 1992

	1991	1992
Black	21.1%	24.8%
White	25.7%	23.9%
Hispanic	18.8%	17.5%

Given the increase in smoking prevalence among Blacks as well as the economic impact of smoking, more effort should be made to direct anti-smoking messages and services to youth as well as African American males. Louisiana has made some general progress in reducing the overall smoking prevalence which is encouraging, however, the data show that the impact has been uneven across sex, race, and age categories.

Shots for Tots Update

The Louisiana Infant Immunization Initiative,Shots for Tots has as it's goal to have 90% of Louisiana's youngest residents fully immunized before their second birthday by 1996. Community involvement is an integral part of the overall strategies. Many regions have established active immunization coalitions. Through on-going efforts of coalitions several regions organize large scale promotional events, conduct after hours immunization clinics and establish alternate immunization sites at hospitals and community centers. To increase overall awareness about infant immunizations the Shots for Tots program will collaborate with the National Immunization Committee to celebrate National Infant Immunization Week, April 23-29.

Through a cooperative effort with the Junior Leagues of Louisiana a motivational video and two television commercials have been produced. The commercials will be airing this month in conjunction with Infant Immunization Week activities. The commercials will be aired in five pilot regions. The video has been distributed to all the health units around the state and to many private organizations. If you are interested in getting a copy of the video or any other information on the Shots for Tots program or National Infant Immunization Week, please contact Donna Sacknoff at (504) 568-5007.

Emerging Infections

With all the antibiotics available in the medical field today, we in public health and the medical profession in general have become complacent in our approach to bacterial infectious diseases. Recently, however, emerging infectious diseases have gotten attention internationally,nationally, and locally.

Newly emerging infectious diseases may result from changes or evolution of existing organisms and known diseases may spread to new geographic areas of new human populations. Previously unrecognized infections may appear in persons living or working in areas undergoing ecologic changes that increase their exposure to insects, animals or environmental sources that may harbor new or unusual infectious agents.

Reemergence may occur because of the development of antimicrobial resistance in existing agents such as gonococci, pneumococci, staphylococci, enterococci, TB and E. coli 0157:H7.

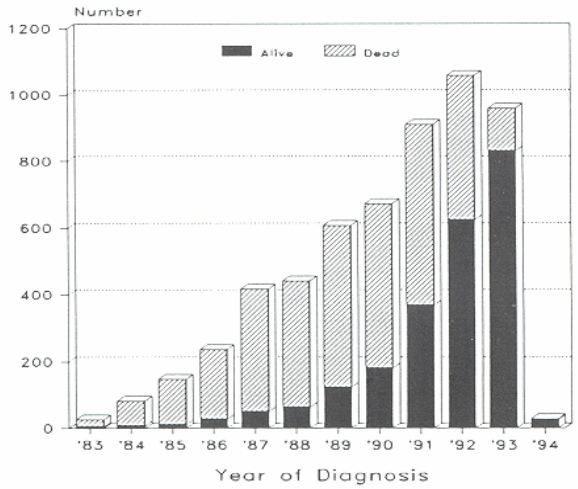
This phenomenon has developed because of the widespread use and misuse of antimicrobials. CDC, along with other federal agencies, state and local health departments, academic institutions, international organizations and others has developed a strategic plan emphasizing surveillance, research, and prevention activities to maintain a strong defense against infectious diseases that affect or threaten to affect the public health. As part of this plan, physicians are encouraged to identify new, unusual, or changing patterns of infectious agents and report these to the state health department and CDC.

Currently, CDC Hospital Infections Branch is especially interested in receiving isolates of enterococci that are resistant to Vancomycin and isolates of pneumococci that are resistant to Cefoxitin and Ceftriaxone. These isolates should be forwarded to the Office of Public Health Laboratory at 325 Loyola Avenue, New Orleans, LA 70112 and they will send them to CDC in Atlanta.

HIV Prevention Community Planning

This spring and summer, the HIV/AIDS section will be establishing and working with ten regional community groups to develop a statewide plan for HIV prevention. The purpose of this community planning process is to allow representatives of the community to participate in planning programs designed to prevent the spread of HIV. The ten planning groups will each put together a plan for their region of the state, and the regional plans will be combined into a statewide plan for HIV prevention. The statewide plan will be used as a basis for the grant application submitted by OPH to the Centers for Disease Control and Prevention. For more information, contact Lisa Longfellow at (504) 568-7524.

AIDS CASE TRENDS



AIDS Update
Survival Time

In March, 1994, the HIV/AIDS Services performed survival analyses of patients with AIDS in Louisiana. These analyses included 4,150 patients diagnosed between January, 1982 to December 1992.

The overall estimated median survival time, from diagnosis of AIDS to death, was 15.6 months; the cumulative probability of survival at one year was 56.2+-1.6 percent; at two years, 35.4+-1.6 percent. Survival time was not significantly different by gender (males 15.7 months vs females 14.9 months; P >=0.1). White patients had significantly longer survival time than black patients (P<0.01) (Fig. 1). Patients under 30 years survived longer than older patients (P<0.1) (Fig. 2). Within the major transmission risk groups, men having sex with men had survival time of 15.8 months, and the heterosexual risk group had 15.2 months. Patients diagnosed since 1986 survived longer than those diagnosed before 1986 (p<.001; Fig. 3).

Figure 1: Survival after diagnosis of AIDS by race

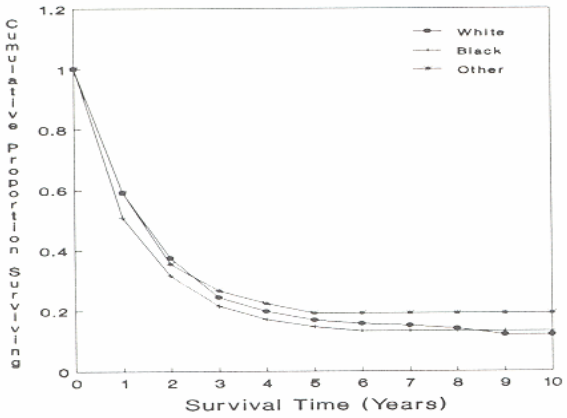
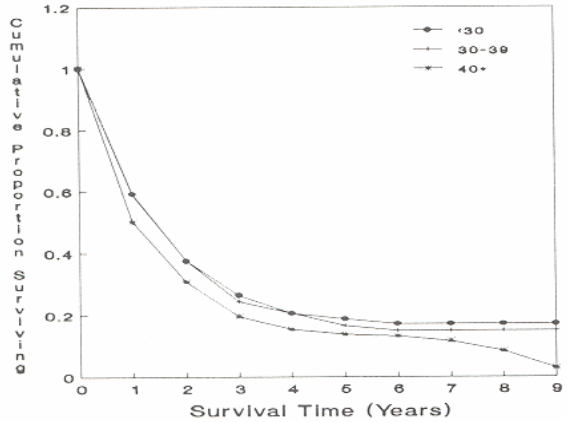


Figure 2: Survival after diagnosis of AIDS by age group



There was no significant difference in median survival time among cases diagnosed with Pneumocystis carinii pneumonia (PCP), Kaposi's sarcoma (KS), or other diseases of initial diagnoses (P>0.1). Patients residing in Orleans (16.8 months), Lake Charles (16 months), and Shreveport (16.4 months) had longer survival time than patients in Baton Rouge (11.2 months), and Houma (12.1 months). The median survival time of some selected variables are shown in Table 1.

Louisiana's estimated median survival time of 15.6 months is consistent with those found elsewhere in the nation. The difference in survival time by race and region, emphasize the need for increased targeted education and health services outreach to minority communities and in rural areas of the state.

Figure 3: Survival after diagnosis of AIDS by year of diagnosis

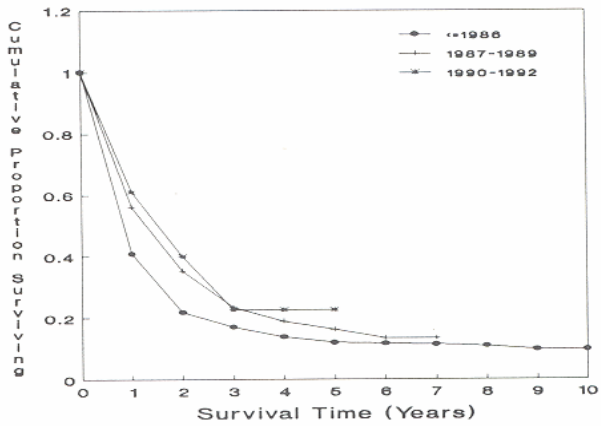


Table: Survival Time in patients with AIDS by demographic characteristics, 1982-1992

Variable	Median Survival time (in months)
Race	
White	17.0
Black	12.5
Other	16.7
Gender	
Male	15.7
Female	14.9
Age (Years)	
Under 30	17.1
30-39	17.0
40+	12.1
Year of Diagnosis	
<=1986	10.2
1987-1989	15.5
1990-1992	18.4
Initial Diagnosis	
Kaposi's Sarcoma	15.2
Pneumocystis Carinii	16.4
Other	14.9

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE,
JANUARY - FEBRUARY, 1994
PROVISIONAL DATA

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

DISEASE	HEALTH REGION									TIME PERIOD				
	1	2	3	4	5	6	7	8	9	Jan-Feb 1994	Jan-Feb 1993	Cum 1994	Cum 1993	% Chg
Vaccine-preventable														
Measles	0	0	0	0	0	0	0	0	0	0	1	0	1	--
Mumps	0	0	0	1	0	1	0	0	0	2	5	2	5	-60
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	--
Pertussis	1	0	0	0	0	0	0	0	0	1	0	1	0	--
Sexually-transmitted														
AIDS Cases	72	17	2	9	4	4	4	4	9	125	219	125	219	-43
Rate[1]	9.8	2.3	0.6	1.6	1.5	1.3	0.7	1.3	2.0	3.0	5.2	3.0	5.2	
Gonorrhea Cases	642	205	119	171	63	116	237	113	163	1829	2210	1829	2210	-17
Rate[2]	8.7	2.7	3.9	3.1	2.5	3.7	4.3	3.7	3.6	4.3	5.2	4.3	5.2	
Syphilis(P&S) Cases	54	104	23	36	8	8	39	36	12	320	470	320	470	-31
Rate[2]	0.7	1.4	0.7	0.6	0.3	0.3	0.7	1.2	0.3	0.8	1.1	0.8	1.1	
Enteric														
Campylobacter	0	2	2	1	0	0	0	0	1	6	23	6	26	-77
Hepatitis A Cases	3	4	0	0	1	4	1	0	0	13	11	13	11	+18
Rate[1]	0.4	0.5	--	--	0.4	1.3	0.2	--	--	0.3	0.2	0.3	0.2	
Salmonella Cases	1	1	2	5	1	1	1	0	0	12	41	12	41	-7
Rate[1]	0.1	0.1	0.7	0.9	0.4	0.3	0.2	--	--	0.3	0.9	0.3	0.9	
Shigella Cases	3	1	1	3	1	2	0	0	1	12	12	12	12	0
Rate[1]	0.4	0.1	0.3	0.5	0.4	0.6	--	--	0.2	0.3	0.2	0.3	0.2	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	0	--
Vibrio, other	1	0	0	0	0	0	0	0	0	1	0	1	0	--
Other														
Hepatitis B Cases	3	3	0	2	3	0	4	2	2	20	14	20	14	+43
Rate[1]	0.4	0.4	--	0.4	1.2	--	0.7	0.7	0.4	0.5	0.3	0.5	0.3	
Meningitis/Bacteremia														
H. influenzae	0	1	1	0	0	0	0	0	0	2	2	2	2	0
N. meningitidis	0	2	1	0	0	0	2	1	1	7	6	7	6	+17
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]	--	--	--	--	--	--	--	--	--	--	--	--	--	

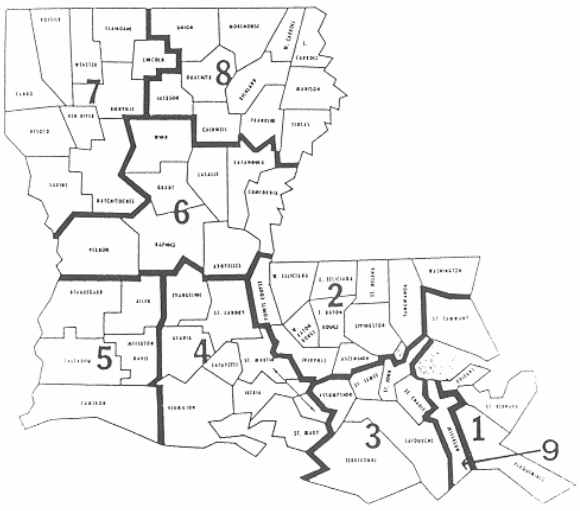
1 = Cases per 100,000
2 = Cases per 10,000

Table 2. *Diseases of Low Frequency*

Disease	Total to Date
Blastomycosis	0
Brucellosis	0
Histoplasmosis	0
Lead Toxicity	0
Legionellosis	0
Lyme Disease	0
Malaria	0
Rocky Mountain Spotted Fever	0
Typhoid	0

Table 3. *Animal Rabies (Jan-Feb, 1994)*

Parish	No. Cases	Species
St Landry	2	Skunks
Lafayette	4	Skunks
Vermilion	1	Skunk
Iberia	1	Skunk
Acadia	6	Skunk



Annual Summary Hepatitis A 1993

In 1993, 105 cases of hepatitis A were reported to the Epidemiology Section, a 55% decrease from 1992 of 235 cases. The overall case rate was 2.5 per 100,000. Sex-specific rates were higher in males than females (2.8 vs 2.2 per 100,000) and race-specific rates were higher in blacks than whites (2.6 vs 1.6 per 100,000). Approximately 57% of the cases occurred within agegroups 20 to 54 years while 18% occurred in children less than 15 years (Figure 1). Of the known reported risk factors, enrollment in a day care and/or contact of a day care enrollee, as well as close contact with a confirmed hepatitis A case continue to be the most common sources of transmission. Parishes with the highest rates per 100,000 were E. Carroll (41), Claiborne (11), St. Tammany (7), Orleans and Jackson [6, respectively (Figure 2)].

Figure 1: Cases of hepatitis A by age and sex, 1993

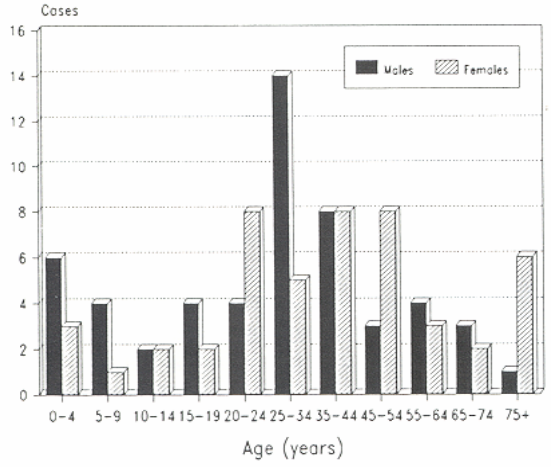
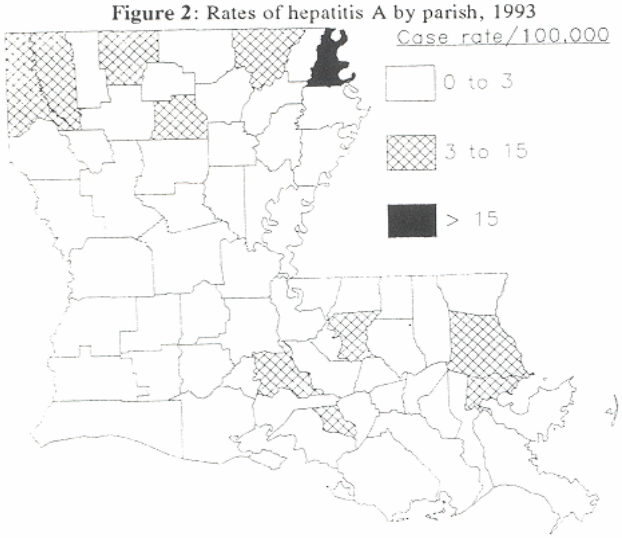


Figure 2: Rates of hepatitis A by parish, 1993



Hepatitis A transmission in child care settings such as day care centers can be insidious because children of this age group are often asymptomatic when infected. Physicians and health care providers should interview suspect cases, especially young children, for possible association within high risk settings such as day care centers. Early identification of an acute case and institution of control measures such as administration of immune globulin in such high risk settings can minimize the outbreak potential within the community. Education of the parents and the child care center staff regarding hepatitis A transmission is also an essential element in limiting the spread within the community.

Evaluation of STD Reporting

Louisiana is participating in a national evaluation of the surveillance of sexually transmitted diseases (STDs). The purpose of this survey is to determine the percentage of cases of STDs that are reported to the health department, and the type of follow-up that occurs for those that are reported. This survey is under the supervision of the Centers for Disease Control and Prevention (CDC) and will be carried out under contract by Abt Associates. As part of the survey, randomly-selected physicians and/or clinics will be contacted by Abt officials and asked to participate. If you are contacted, we hope that you can participate in this important project. If you have questions, contact the STD program at (504) 568-5275.

LOUISIANA FACTS

Early Method of Handling Garbage:

The City of New Orleans employed several methods of taking care of garbage in the years prior to 1900 .

"Up to the year 1900 garbage boats were in use, the garbage being loaded on to boats from certain designated garbage wharves and dumped from the boat into the Mississippi River. Originally garbage was dumped into the river near the city, but as this created a local nuisance, the boats pulled down stream several miles before discharging their cargo.

"Even this did not prove entirely satisfactory, and an attempt was made to bury the garbage in unpopulated areas, but trouble was experienced as a result of tidal overflows. For a brief period a somewhat primitive reduction process was in vogue, but this was a failure because of the small quantity of grease recovered by the process, due to the economy of the housewife, and lack of separating the garbage from other waste. A nuisance was also created from the disagreeable odor given off by the plant through faulty handling and exposure of the garbage." *(Report of the Health and Sanitary Survey of the City of New Orleans, 1918-1919)*

DEPARTMENT OF HEALTH AND HOSPITALS
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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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