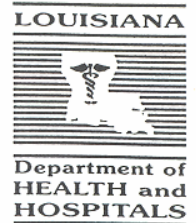




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Louisiana Morbidity Report

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SECRETARY

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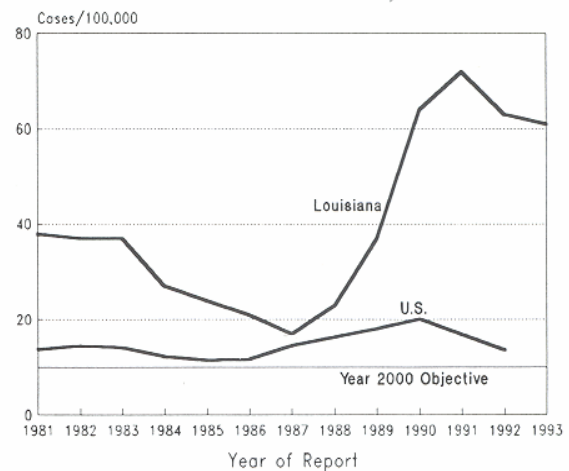
Jail Screening for Sexually Transmitted Diseases

Rates of syphilis, gonorrhea, and chlamydia are very high in Louisiana (Figure 1), and traditional control methods have not been able to substantially decrease these rates. To respond to this problem, the Office of Public Health (OPH) has tried alternative methods of control of sexually transmitted diseases (STDs). Persons who are arrested are at high risk for STDs, and many of these persons either have no symptoms of their disease or do not seek medical care for their symptoms. Most screening programs in jails and prisons test only those prisoners who are incarcerated for 14 days or more, which is only a small percentage of those arrested. In a pilot program to control STDs in this larger group of arrestees, the Office of Public Health worked with the Jefferson Parish Correctional Center (JPCC) to set up a program of screening and presumptive treatment for STDs among persons within 24 hours of booking.

Every weekday morning all arrestees awaiting bond at JPCC are offered immediate on-site screening and treatment for STDs. Blood samples from men and women are tested using the RPR test (with positive tests confirmed later at the state laboratory) and urine samples from men are tested using the Leukocyte Esterase (LE) test, which is a nonspecific indicator of urethritis.

From March through November 1993, 5,495 arrestees

Figure 1: Rates of primary and secondary syphilis in Louisiana and the U.S. as a whole, 1981-1993



were tested, representing approximately 50% of the persons brought to this jail during this period. Seven percent had positive RPR tests, and 1.7% (representing 82 cases) had untreated syphilis. Syphilis rates were higher among Blacks than Whites (2.3% vs 0.7%, RR=3.5) and were higher in women than men (3.1% vs 1.5%, RR=2.0; Table 1).

Of the 4,174 men tested for urethritis using the LE test, 541 (13%) had positive tests. The test positivity rate was higher in younger men, higher in black men compared to white men (15% vs 6%, RR=2.5), and higher in men reporting 2 or more sex partners (Table 2). Men with positive LE tests were twice as likely to have syphilis as those with negative tests (2.9% vs 1.3%, RR=2.3). Twenty-one percent of men with positive LE tests were confirmed to have either gonorrhea or chlamydia by a DNA probe test; other men probably had either urethritis from another cause or another source of genitourinary inflammation (e.g. prostatitis).

Persons with positive LE tests were treated immediately with antibiotics for gonorrhea and chlamydia infection. Persons with positive RPR tests were evaluated with a more detailed history and physical examination and treated with benzathine penicillin if they were thought likely to have untreated syphilis. In all, 48 persons with confirmed untreated syphilis and 87 persons with confirmed gonorrhea or chlamydia infection were treated during this study period.

This program has succeeded in identifying and treating persons with active STDs who do not recognize their
(Continued on page two)

Contents

Hepatitis A Outbreak in Sulphur Area	2
AZT Prevents HIV Spread to Infants	3
Galactosemia	3
1993-94 Influenza Season	4
1993 Louisiana Severe Traumatic Head Injury	4
AIDS Update.....	5
Annual Summary: Shigellosis 1993.....	7

symptoms and would otherwise be likely to spread disease to their sex partners. The program is currently being copied in other jails around the state.

Table 1. Prevalence of syphilis among arrestees

	% syphilis	RR	P-value
Race			
Black	2.3	3.5	< .0001
White	0.7		
Sex			
Female	3.1	2.0	< .01
Male	1.5		
Age			
10-19	1.7		NS
20-29	1.4		
30-39	1.4		
40-49	1.6		
Booking charge			
Misdemeanor	2.2	1.5	.09
Felony	1.5		
Reported cocaine use			
Yes	2.0	1.2	NS
No	1.6		
Number of sex partners in last month			
0-1	1.6		
2 or more	2.0	1.3	NS

Table 2: Urine leukocyte esterase positivity among male arrestees

	% positive	RR	P-value
Race			
Black	15	2.5	< .0001
White	6		
Age			
10-19	15	1.9	< .001
20-29	13	1.6	
30-39	10	1.3	
40-49	8		
Reported cocaine use			
Yes	12		
No	13	1.1	NS
Number of sex partners in last month			
0-1	11		
2 or more	18	1.6	< .0001

BULLETIN

Recently several cases of diarrheal illness caused by *Shigella sonnei* that is resistant to commonly-used antibiotics have been identified in Iberia Parish. Although the number of reported cases is small, the unusual antibiotic resistance pattern probably indicates a new strain in the area. In view of this problem, it is recommended that all patients with gastrointestinal symptoms have a stool culture and all shigella isolates be tested for antibiotic sensitivity. Physicians should appropriately treat patients who are especially in high risk settings such as day care centers.

Hepatitis A Outbreak in Sulphur Area

Since January OPH has received reports of 32 persons with Hepatitis A in the Sulphur area. Twenty of these cases were in children who attend the same elementary school. Onset dates for illness suggests 3 "waves" of illness within this time period. How these children were exposed to hepatitis A is not clear, since it is thought that person-to-person transmission of Hepatitis A is rare among school-age children. Interviewing of cases and a site visit to the school and community did not uncover any obvious sites for transmission either in or out of the school. Classes with cases were given immune globulin prophylaxis.

We are planning to return to the community in June to collect blood specimens from children in classes in which a confirmed case occurred. We hope to identify asymptomatic cases in these classes so that a more accurate investigation of non-school risk factors can be conducted. In addition, we are contemplating doing a case-control study using children drawn from a local pediatric practice as controls to assess whether or not attending this school is truly associated with illness. A more detailed report will be published once the investigation is completed.

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AZT Prevents HIV Spread to Infants

On February 21, 1994, the National Institutes of Health announced preliminary results of a study that found that AZT (zidovudine) greatly decreases the transmission of HIV from mother to infant. Based on the results of this study, the Office of Public Health now recommends HIV counseling and testing of all pregnant women and consideration of treatment of HIV-infected pregnant women with AZT beginning in the second trimester.

The study was carried out in several medical centers around the country, including the Tulane/LSU Pediatric AIDS Clinical Trials Unit (ACTU) in New Orleans, which contributed the second largest number of patients to the study. In the study, women with HIV infection and CD4-cell counts of $>200/\text{microliter}$ were randomized to receive either AZT or placebo for the second and third trimester. The AZT or placebo treatment was continued intravenously during labor and delivery and was given orally to infants for six weeks after birth. The rates of transmission from mother to infant were 25.5% in the 184 children in the placebo group and 8.3% in the 180 children in the AZT group. This indicates a 67.5% reduction in the risk of HIV transmission.

Based on these results, this study has been stopped and all participating women offered AZT. The US Public Health Service (USPHS) has made interim recommendations that AZT should be considered beginning in the second trimester for HIV-infected pregnant women who meet the study criteria; more extensive recommendations will be made by USPHS later.

In Louisiana, 0.15% of childbearing women are infected with HIV (0.28% of Black women and 0.04% of White women). Based on this prevalence, approximately 100 infants are born to HIV-infected women each year. If all HIV-infected women were identified and treated, and if AZT had the same efficacy in this group as in the study, then approximately 19 infant HIV infections per year could be prevented. This compares favorably with the approximately 15 infants that are identified annually through neonatal screening for phenylketonuria (PKU) and hypothyroidism.

Based on the results of this study, the Office of Public Health now recommends HIV counseling of all pregnant women, with HIV testing offered routinely. Prenatal care providers taking care of patients with HIV infection should counsel them about the potential benefits and risks of AZT and consider treating them with AZT (beginning in the second trimester) or referring them to providers who will treat them. Questions about AZT treatment of HIV-infected pregnant women should be directed to providers with experience in this area, including regional HIV Ambulatory Care Sites (usually at the Louisiana Health Care Authority

hospitals), and the Tulane/LSU Pediatric AIDS Clinical Trials Unit at (504) 585-7153.

For more details about the national study, see the April 29 issue of the CDC Morbidity and Mortality Weekly Report 43(16):285-287.

Galactosemia

The Genetic Diseases Program is launching an effort to inform the state's physicians on galactosemia, an inborn error of galactose metabolism. Early recognition of this disorder enables prevention of serious morbidity and even death. Physicians who suspect galactosemia in an infant should institute immediate measures to confirm the diagnosis and begin treatment as well as obtain biochemical genetics consultation for further management. Although several variants of galactosemia have been described, this article deals specifically with galactosemia due to virtual complete deficiency of the enzyme galactosyl-1-phosphate uridyl transferase.

How does galactosemia present in the newborn?

Galactose is part of the disaccharide, lactose (milk sugar). Galactosemia occurs due to a genetic inability to metabolize galactose, resulting in cytotoxicity (especially in the central nervous system, liver, eyes, and kidneys). Therefore, the symptoms develop within a few days of milk (breast or cow's) feeding by the infant. The vast majority of those affected exhibit vomiting or diarrhea as well as failure to thrive. During the second week of life these infants almost always have abnormal liver functions, jaundice and eventually hepatomegaly. Cataracts are another common complication and may appear in the first few days of life. These can be missed by ophthalmoscopy and may require slit lamp examination. Other laboratory findings include reducing substances in the urine (galactose), albuminuria, aminoaciduria, hyperchloremic metabolic acidosis, and occasionally hypoglycemia. Untreated galactosemic infants have an increased susceptibility to *E. coli* sepsis some of whom die from this infection in the neonatal period.

How is galactosemia diagnosed?

Evidence for galactosemia can be provided by performing thin layer chromatography (TLC) for sugars in the urine of patients who are on a galactose containing diet. The definitive diagnostic test is direct assay of galactosyl-1-phosphate uridyl transferase, usually in red blood cells. In rare cases, however, a similar clinical picture is caused by uridine diphosphate galactose-4-epimerase deficiency. These

(Continued on page four)

Galactosemia (Cont.)

tests should be performed in a certified clinical biochemical genetics laboratory; they are available in Louisiana at the Biochemical Genetics Laboratory at the Tulane University School of Medicine.

How is galactosemia managed?

The management of galactosemia mainly consists of the elimination of galactose from the diet. Besides milk, galactose is present in a wide variety of foods; therefore, virtual complete elimination from the diet is difficult. This task requires the close involvement of a nutritionist with experience in nutritional management of biochemical disorders.

What is the outcome of treatment?

Infants who are diagnosed early and maintained on a galactose-free diet do not have the acute effect of toxicity, including jaundice, liver disease and death. However, in some patients who are in full compliance with the diet, later sequelae have been described, e.g., ataxia, tremor and academic difficulties.

1993-94 Influenza Season

Louisiana reported the first cases of influenza in the United States for the 1993-94 flu season with three outbreaks occurring between August 12, 1993 and September 2, 1993. These outbreaks involved residents in two nursing homes and workers on a dredging barge. The annual tracking of influenza activity throughout the state is monitored through laboratory identification of influenza cultures and by semi-quantitative reports of influenza-like illness from more than 20 physicians, 16 schools, 9 hospitals, and 3 walk-in clinics. Widespread influenza activity was reported in Louisiana in late 1993 and early 1994 with activity peaking during the two weeks ending 1/8/94 and 1/15/94. 1635 influenza-like illnesses were identified by participating sentinel health care facilities for that period. During the months of December, January, and February, influenza was listed as the cause of death in 33 patients. As of April 30, 1993, a total of 311 positive isolates and/or paired sera were identified. All were influenza type A/Beijing, a component contained in this year's influenza vaccine.

During this influenza season, the Office of Public Health provided a total of 78,402 doses of influenza vaccine to its medically high risk and elderly population. Even with the early reporting of influenza cases during the 1993-94 flu season, there are no plans to change the starting date of next year's influenza immunization campaign. If early cases occur this coming season, we will send out a press release.

1993 Louisiana Severe Traumatic Head Injury

In May of 1990 the Disability Prevention Program initiated a pilot study on severe traumatic head injury (THI). Children's Hospital, Lafayette General Hospital, and Schumpert Medical Center were involved in the pilot study. Since then, reporting of THI became mandatory.

A total of 261 cases were reported in 1993 (6.4 per 100,000). Males are three times as likely to be injured as females (10/100,000 vs. 29/100,000). The majority of these injuries was due to motor vehicle crashes (54%), violence (firearm and assault; 21.8%), falls (18.4%), other and unknown (3.5%), sports (1.5%), and falling objects (0.8%). Causes of THI differ by race (Figure 1). Most of these injuries occurred to adolescents and young adults (Figure 2). The majority of these injuries (60%) were discharged with severe outcome (persistent vegetative state, severe disability, or death), others had moderate outcome (25.1%), good recovery (independent, resumes normal activity; 13.6%), and unknown outcome (0.4%). Nine cases of severe traumatic head injury occurred to infants under one year of age. Causes of these injuries were falls (33%), and motor vehicle crashes; child abuse and other/unknown represented (22%) each.

Figure 1: Cases of severe traumatic head injury by cause, 1993

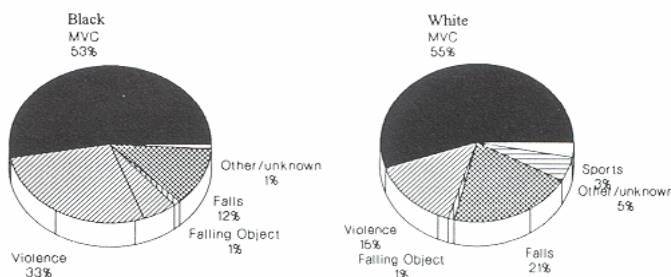
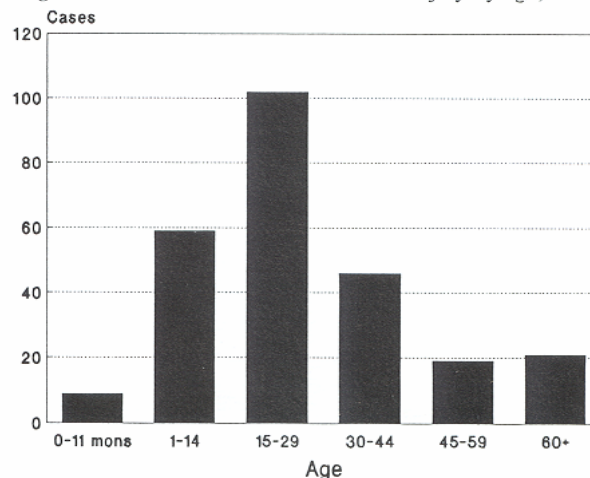


Figure 2: Cases of severe traumatic head injury by age, 1993



AIDS Update

HIV Infection in Louisiana

In February 1993, Louisiana joined 25 other states nationwide who have confidential HIV infection reporting. To date, Louisiana's Office of Public Health HIV/AIDS Surveillance Program has received 2,885 HIV infection (non-AIDS) case reports. The end of year total for 1993 for all 26 states as reported by the Centers for Disease Control was 55,343.

Accurate data on HIV infections provides a portrayal of recent infections and the direction in which the epidemic may be heading. Data from diagnosed AIDS cases in effect only yields information on infections which have occurred up to ten years in the past.

Of the total reported HIV infections, 24.5% were female, 62% African American, 35% Caucasian, and 2% of Hispanic origin. To date, 15 HIV infections have been reported in persons less than 13 years of age. 41% of the total reported infections were between the age of 20-29, and 33% between 30-39.

Men who have sex with men represented 26% of the reported adult/adolescent HIV infections, intravenous drug users 18%, heterosexuals 9% and persons without an identified risk 40%. The above characteristics are consistent with nationally reported HIV infections (Table).

Table: Cumulative Reported HIV infections (non-AIDS) in Louisiana and the United States

	LA		US	
	#	%	#	%
GENDER				
Male	2174	75.5	43,245	79.3
Female	707	24.5	11,273	20.7
Total	2881		54,518	

RACE				
Caucasian	1004	34.8	23,893	45.1
African American	1791	62.1	25,796	48.7
Hispanic	53	1.8	2,795	5.3
Other	37	1.3	447	0.8
Total	2885		52,931	

TRANSMISSION				
MSM	849	30.2	19,644	36.7
IDU	538	19.1	9,290	17.3
MSM/IDU	198	7.0	2,867	5.4
Hetero	278	9.9	6,042	11.3
Unknown	951	33.8	15,740	29.4
Total	2814		53,583	

AGE				
13-19	199	7.2	1,803	3.3
20-29	1173	42.3	21,937	40.2
30-39	965	34.8	21,567	39.6
40-49	335	12.1	7,084	13.0
50+	101	3.6	2,127	3.9
Total	2773		54,518	

Interpretation of such data is limited due to several biases which exist. Not all HIV infected persons are tested and not all persons with positive tests are reported to the health department. Therefore, the reported infections are by no means representative of all persons infected with HIV who reside in Louisiana. In addition, due to the relatively high rate of anonymous reporting which continues to occur in Louisiana, the reports of infections are not representative of persons being tested in the state. Currently HIV cases from the public sector (public hospitals, STD clinics, HIV clinics, etc.) are being over-represented, with a bias towards females and African Americans.

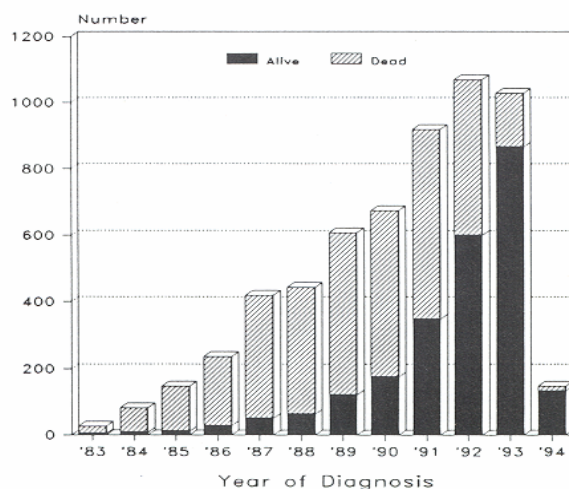
With time HIV data will provide valuable information for more effective planning and funding of prevention programs and early intervention services.

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 Area	
Laverne Chance	(318) 676-5071
Shreveport Area	
Sue Bennett	(318) 362-5232
Monroe-Alexandria Area	

AIDS CASE TRENDS



NOTE:
Regional changes

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE,
MARCH - APRIL, 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	Mar-Apr 1994	Mar-Apr 1993	Cum 1994	Cum 1993	% Chg
<u>Vaccine-preventable</u>														
Measles	1	0	0	0	0	0	0	0	0	1	0	1	1	--
Mumps	0	0	1	1	0	2	3	0	1	8	1	10	6	+67
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	--
Pertussis	1	0	0	0	0	1	0	0	1	3	4	4	4	--
<u>Sexually-transmitted</u>														
AIDS Cases	83	25	3	1	3	10	10	7	8	15	245	299	464	-64
AIDS Rate ¹	8.0	4.6	0.8	0.2	1.2	3.2	1.8	2.3	2.3	3.6	5.8	7.1	11.0	
Gonorrhea Cases	875	208	87	168	89	105	272	98	85	1987	2082	3815	4292	-11
Gonorrhea Rate ²	8.4	3.8	2.8	3.0	3.5	3.4	4.9	3.2	2.4	4.7	4.9	9.1	10.2	
Syphilis(P&S) Cases	52	58	12	44	5	13	55	27	31	297	416	616	886	-31
Syphilis(P&S) Rate ²	0.5	1.1	0.4	0.8	0.2	0.4	1.0	0.9	0.9	0.7	0.9	1.5	2.1	
<u>Enteric</u>														
Campylobacter	4	3	0	2	2	2	0	0	1	15	25	21	47	-55
Hepatitis A Cases	9	1	0	3	24	0	0	1	1	39	14	55	29	+90
Hepatitis A Rate ¹	0.9	0.2	--	0.6	9.3	--	--	0.3	0.3	0.9	0.3	1.3	0.7	
Salmonella Cases	19	12	10	9	1	3	10	2	6	74	42	86	81	+6
Salmonella Rate ¹	1.8	2.2	2.8	1.8	0.4	1.0	2.0	0.6	1.7	1.8	1.0	2.0	1.9	
Shigella Cases	20	1	0	16	1	16	4	0	1	60	34	73	49	+6
Shigella Rate ¹	1.9	0.2	--	3.2	0.4	5.1	0.8	--	0.3	1.4	0.8	1.7	1.2	
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	1	2	4	3	4	-25
<u>Other</u>														
Hepatitis B Cases	23	5	3	3	1	0	2	3	3	43	43	55	61	-10
Hepatitis B Rate ¹	2.2	0.9	0.8	0.6	0.4	--	0.4	0.9	0.8	1.0	1.0	1.3	1.4	
Meningitis/Bacteremia														
H. influenzae	0	0	0	0	0	0	0	0	0	0	1	2	3	-33
N. meningitidis	7	0	1	0	0	0	1	2	1	12	11	19	18	+6
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	--
Tuberculosis Rate ¹	--	--	--	--	--	--	--	--	--	--	--	--	--	

1 = Cases per 100,000

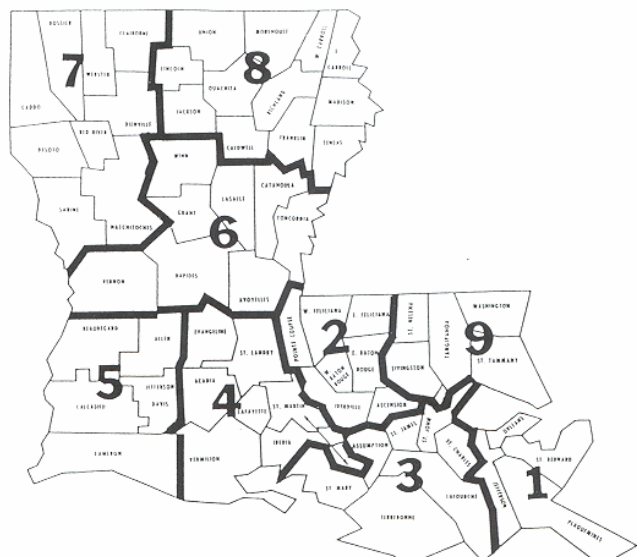
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	0
Brucellosis	2
Histoplasmosis	0
Lead Toxicity	0
Legionellosis	0
Lyme Disease	0
Malaria	0
Rocky Mountain Spotted Fever	0
Typhoid	2

Table 3. Animal Rabies (Mar-Apr, 1994)

Parish	No. Cases	Species
Natchitoches	1	Skunk
St Landry	3	Skunks
Lafayette	5	Skunks
Vermilion	2	Skunks
Acadia	1	Skunk



Annual Summary Shigellosis 1993

In 1993, 482 cases of shigellosis were reported to the Epidemiology Section, representing a 60% increase from 1992. The overall case rate was 11.4 per 100,000. Sex and race-specific rates were slightly higher among females than males, 12 vs 10 per 100,000, and among blacks than whites, 7 vs 6 per 100,000. Fifty-eight percent of the total cases occurred in the age groups less than 10 years of age (Figure 1). Two outbreaks were identified last year which contributed to the increase of shigellosis. One outbreak involved children in a parish community in which a case-control study was performed (see Louisiana Morbidity Report, Vol 4 No. 4, May-June 1993). The second outbreak occurred in an institution for the developmentally disabled (see Louisiana Morbidity Report, Vol 4 No. 6, Nov-Dec 1993). Parishes exceeding the overall case rate (per 100,000) included: Calcasieu (53), Grant (23), Rapides (58), Terrebonne (69), Vermilion [28, Figure 2].

Comments:

Even though the infective inoculum for *Shigella* infection is small and person-to-person contact spread is common, it is surprising how effective simple hygiene measures can be in control and prevention of shigellosis. Handwashing and sanitary disposal of feces constitute keystones of personal hygiene and will minimize the spread of infection within the household. It is wise for physicians making the diagnosis of acute shigellosis in one family member, usually a young child, to consider the whole family to be at risk. Physician should also be aware of the potential spread in day

care centers if the acute case is enrolled. Infected children who attend day care, as well as infected children and persons with close household members should be treated with antibiotics to decrease the chance of transmission to others. To avoid emerging resistant shigella strains, all isolates of shigella species should be tested for sensitivity to determine the correct antibiotic therapy.

Figure 2: Rates of shigellosis per 100,000 by parish

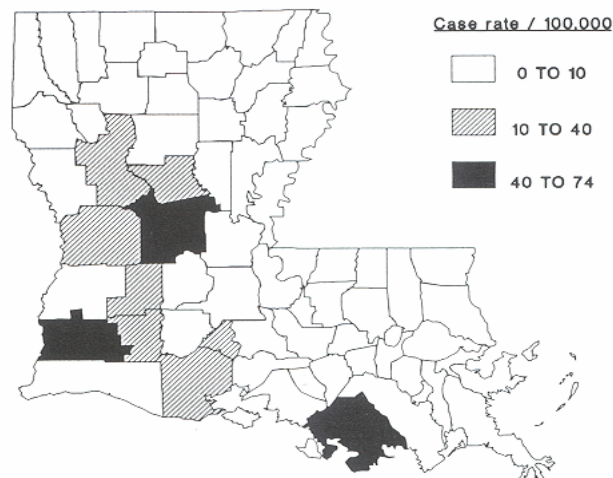
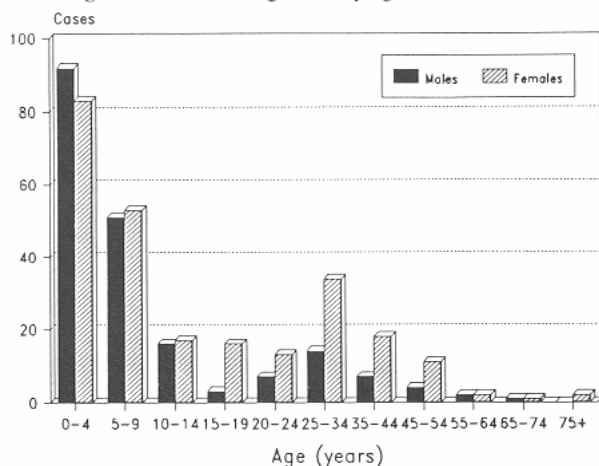


Figure 1: Rates of shigellosis by age and sex, 1993



LOUISIANA FACTS

Drinking Water of Earlier Days: Part I

The report of the Board of Health for the year 1850 contains the following statement: "It is painful to reflect upon the frequent sufferings of the working classes from the want of an abundance of pure water. Cisterns are at times of drought soon emptied, the means to purchase water hauled from the river to the back parts of the city are soon exhausted and then no resource remains but an impure well water. The Board of Health is firmly convinced that much of the cholera victims are most numerous, by drinking this polluted water." Raw river water was used for many years by the citizens of New Orleans for drinking water. Each family had its own system of purification, consisting of earthen jars in which the raw river water was collected and allowed to stand in contact with alum. (*Report of the Health and Sanitary Survey of the City of New Orleans, 1918-1919*)

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Granuloma Inguinale**	Cancer
Amebiasis	Hepatitis (Specify type)	Complications of abortion
Anthrax	Herpes (genitalis/ neonatal)**	Congenital hypothyroidism
Aseptic meningitis	Human Immuno- deficiency Virus (HIV)	Lead poisoning
Blastomycosis	Legionellosis	Phenylketonuria
Botulism*	Leprosy	Reye Syndrome
Brucellosis	Leptospirosis	Severe Traumatic Head Injuries +
Campylobacteriosis	Lyme Disease	Severe undernutrition severe anemia,
Chancroid**	Lymphogranuloma venereum**	failure to thrive
Cholera*	Malaria	Sickle cell disease (newborns)
Chlamydial infection**	Measles (rubeola)*	Spinal cord injury +
Diphtheria*	Meningitis, Haemophilus	Sudden infant death syndrome (SIDS)
Encephalitis (Specify primary or post-infectious)	Meningococcal Infection (including meningitis)*	
Erythema infectiosum (Fifth Disease)	Mumps	
Foodborne illness*	Mycobacteriosis, atypical***	
Genital warts**	Ophthalmia neonatorum*	
Gonorrhea**	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	

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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