Louisiana Morbidity Report

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

March-April 1997 **Volume 8 Number 2**

Louisiana STD Update

After a recent epidemic of syphilis, rates of sexually transmitted diseases in Louisiana have been falling steadily. Rates of syphilis and gonorrhea in the state are now among the lowest seen in the last 20-30 years. However, they are still among the highest of any state in the U.S., putting Louisiana at continued high risk for sexual transmission of HIV infection and high rates of AIDS in the future.

In 1996, 1,494 cases of early syphilis were reported, of which 533 were cases of primary and secondary (P&S) syphilis, for a P&S case rate of 13 per 100,000. This represents an 82% decrease from the peak rate of 72 per 100,000 in 1991 (Figure 1). As in the past, rates were far higher in African-Americans than whites (38 versus 1 per 100,000). Rates were highest in New Orleans and the Shreveport and Baton Rouge - Northshore regions of the state (Figure 2). Louisiana now ranks second in the nation for syphilis (after Mississippi).

There were 9,373 cases of gonorrhea reported, for a case rate of 222 per 100,000, which represents a decrease of 39% from 1991 (Figure 3). Gonorrhea cases are frequently asymptomatic, particularly in women, so case reports partially reflect the amount of STD screening being conducted by health care providers. The fact that rates of gonorrhea were highest in the most populous parishes (Figure 4), particularly Orleans Parish (608 per 100,000) may be in part explained by the availability of testing and screening. The age group with the highest rates of gonorrhea was 15-19, with an incidence of 959 per 100,000, or nearly 1%.

Nationally and in Louisiana, rates of these STDs have been declining for the last several years. The decrease may be due to changes in sexual behavior in response to the AIDS epidemic (e.g. decreases in the number of sex partners and/or increases in condom use), improved access to early treatment, or other unknown factors. In Louisiana, the response to the syphilis epidemic in the late 1980's and early 1990's included expansion of clinical services in public clinics statewide, distribution of condoms to persons at high risk and STD screening in sites such as family planning clinics, jails, and drug treatment centers. The sharp drop in syphilis is encouraging, and may be caused by these changes, however syphilis in the past has had 10-year epidemic cycles; rates *(Continued on next page)*

Figure 1: Rates of primary and secondary syphilis in Louisiana and U.S., 1981-1996

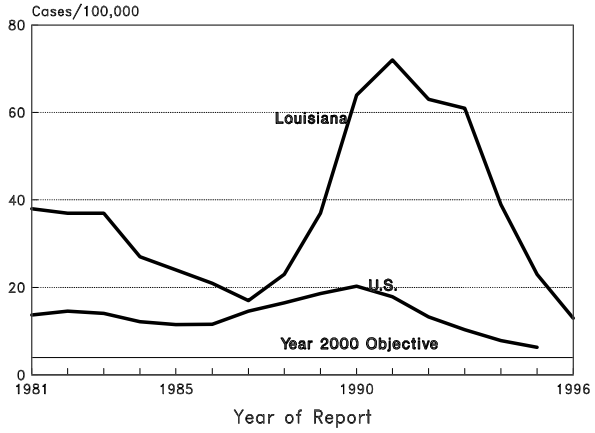
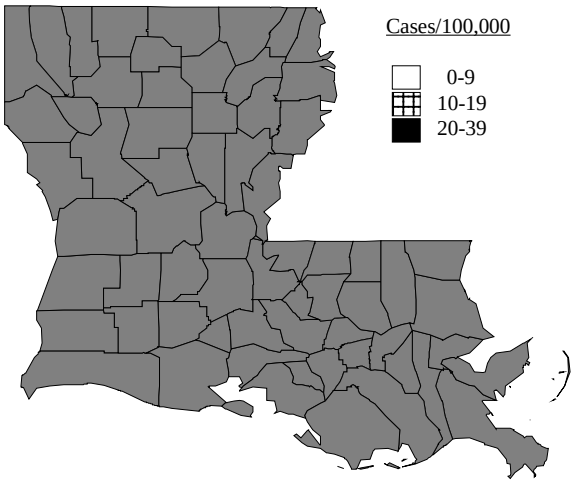


Figure 2: Rates of primary and secondary syphilis by parish, 1996



Contents

STD Update (Cont.)

were relatively low in 1976 and 1986 before increasing again, so it is possible that syphilis rates may begin to rise in the next few years.

Although they have decreased, rates of STDs are still well above the Year 2000 goals for the nation (100 for gonorrhea, 4 for P&S syphilis), and still high enough to indicate that there are large numbers of persons at high risk HIV infection. The risk for HIV infection is due both to the fact that these persons are practicing unprotected sex and the fact that gonorrhea, syphilis and other bacterial STDs serve as "cofactors" that increase the likelihood of transmission of HIV from one person to another. It is becoming increasingly clear that the best way to prevent sexual transmission of HIV is to control these other diseases. Public health programs will emphasize STD control to an even greater extent in the future.

Figure 3: Rates of gonorrhea in Louisiana and U.S., 1970-1996

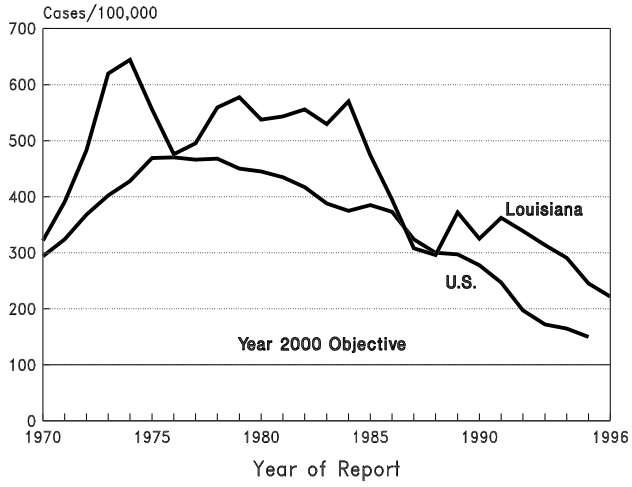
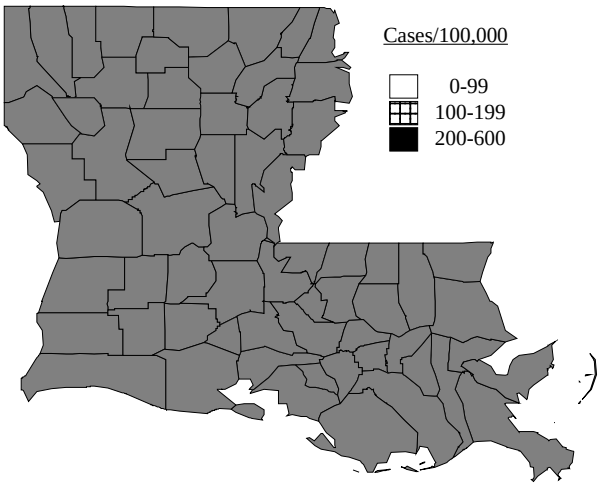


Figure 4: Rates of gonorrhea by parish, 1996



Unintentional Childhood Injury Fatality Report

Unintentional ("accidental") injuries are the leading killer of kids in the United States. Each year, more children ages 1-14 die from unintentional injuries than from all childhood diseases combined. Each year in the United States, 7,300 children ages 14 and under are killed and 50,000 are permanently disabled. For every child who dies from a preventable injury, over 40 others are hospitalized and 1,120 are treated in emergency rooms.

Injury is the leading cause of medical spending for children 5 to 14 years of age. The annual lifetime cost of unintentional injury among children ages 14 and under is $165 billion, which includes more than $90 billion in direct medical costs, $16 billion in future earnings and $140 billion in quality of life. For every child injured, total costs are nearly $12,000, including more than $650 in medical costs, nearly $1,200 in future earning and $10,000 in quality of life. Unintentional injuries disproportionately affect poor children, resulting in more fatalities when compared to children with greater economic resources.

In 1995, 167 Louisiana children under 15 years of age died from preventable injuries: 64 infants and children less than five years old, 45 children five to nine years old and 58 children ten to fourteen years old. The largest proportion of fatalities resulted from motor vehicle crashes (47%), with a rate of 7.5 per 100,000, followed by drowning (14%), and

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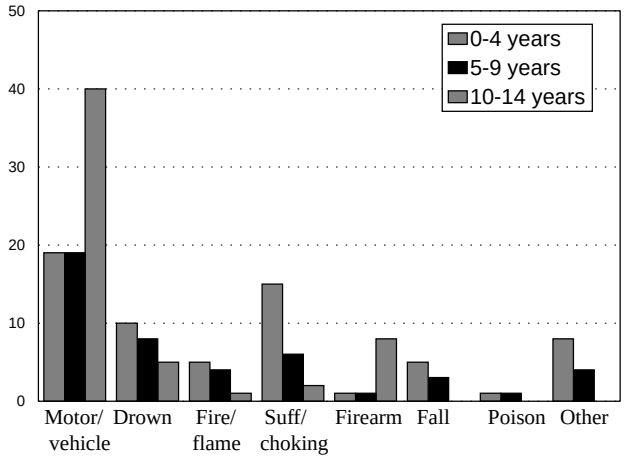
suffocation/choking (14%; Figure). For 5-14 year olds, the second largest proportion of fatalities resulted from drowning (13% or 1.9/100,000). Following motor vehicle crashes, more children under 5 years of age died from suffocation/choking than any other type of preventable injury (23% or 4.5/100,000).

The Louisiana SAFE KIDS Coalition, local chapters and coalitions are actively promoting injury prevention through activities and education. For more injury-specific information and prevention tips, call the Louisiana Safe Kids Coalition at 504-568-2508.

Figure: Unintentional injury deaths of children less than 15 years old



Cause of Death, 1995

Immunization Levels Rise in Louisiana

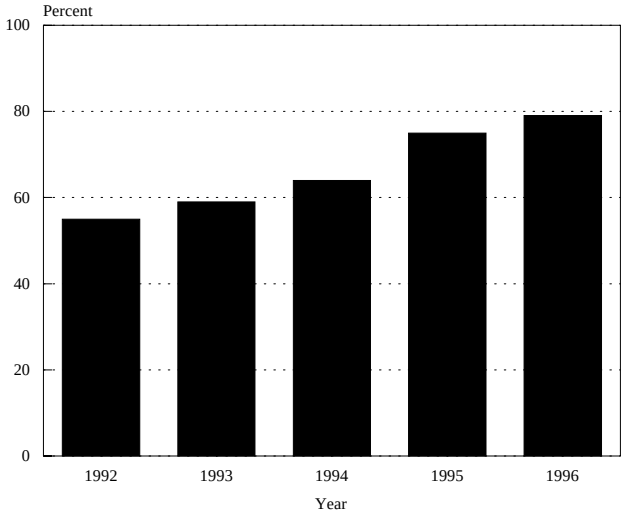
Recent surveys done by the Centers for Disease Control and Prevention (CDC) and by the Louisiana State Office of Public Health show that immunization levels among two-year-old children in Louisiana are improving steadily, but further improvement is still needed.

The National Immunization Survey (NIS) is a random digit dialing survey conducted nationwide through the CDC. For January to December, 1995, the NIS found that 77% of two-year-olds in Louisiana identified by the survey were up-to-date on their immunizations. This coincided with a survey done in November of 1995 by the Office of Public Health which reviewed the records of children receiving care in the public health units. That survey showed that 75% of two-year-old children were up-to-date. A follow-up survey of the health units in November of 1996 showed that 79% were up-to-date. All of these surveys are based on the child's having received 4 doses of diphtheria-tetanus-pertussis vaccine, 3 doses of polio vaccine, and 1 dose of measles-mumps-rubella vaccine by the second birthday. Both of these surveys show great improvement from immunization levels in the three previous years (Figure).

Many factors have contributed to the improved vaccination rates since 1992. The statewide Shots for Tots program has helped to publicize the need for parents to bring their children in for routine vaccinations. Outreach clinics in areas with poor immunization rates have helped by targeting high risk groups. The Vaccines for Children Program has provided federally-purchased vaccine to private providers for uninsured and Medicaid-eligible children, in order to decrease the cost of vaccinations. Training for public and private providers concerning true and false contraindications has also increased appropriate immunization at the earliest possible time. Finally, reminder and recall systems have been put into action in many clinics around the state, providing simple reminders to parents when their children are due or overdue for vaccinations. All of these efforts have helped to bring the immunization levels of two-year-old children in Louisiana up to their highest recorded levels.

Despite the steady progress, there is still much work to be done to reach the goal of 90% coverage of two-year-olds in the U.S. This goal was not randomly chosen, but represents the percentage of young children who need to be completely immunized in order to decrease spread of the vaccine preventable diseases in day care and pre-school settings.

Figure: Immunization levels of two-year-olds in Louisiana, 1992-1996



Revised Reportable Disease List

Effective January 20, 1997, the list of diseases that have been previously declared reportable have been revised. Diseases which may represent chronic or recurrent conditions with uncertain onset dates, diseases for which diagnostic criteria are not well defined, and extremely rare communicable diseases in Louisiana have been eliminated from the reportable list effective January, 1997.

The simplication of the reportable list will allow providers to focus on diseases that are actively tracked epidemiologically and diseases for which we have active prevention programs. Cases are to be reported via the same mechanisms currently being used. If there are any questions, please contact the Epidemiology Section at 504-568-5005 or 1-800-256-2748. The following is the revised list:

Acquired Immune Deficiency Syndrome (AIDS)
Amebiasis
Arthropod-borne encephalitis (Specify type)
Blastomycosis
Botulism[1]
Campylobacteriosis
Chancroid[2]
Chlamydial infection[2]
Cholera[1]
Cryptosporidiosis
Diphtheria
Enterococcus (infection; resistant to vancomycin)
Escherichia coli 0157:H7 infection
Gonorrhea[2]
Haemophilus influenzae infection[1]
Hemolytic-Uremic Syndrome
Hepatitis, Acute (A, B, C, Other)
Hepatitis B carriage in pregnancy
Herpes (neonatal)
Human Immunodeficiency Virus (HIV) infection[3]
Legionellosis
Lyme Disease
Lymphogranuloma venereum[2]
Malaria
Measles (rubeola)[1]
Meningitis, other bacterial or fungal
Mumps
Mycobacteriosis, atypical[4]
Neisseria meningitidis infection[1]
Pertussis
Rabies (animal & man)
Rocky Mountain Spotted Fever (RMSF)
Rubella (German measles)
Rubella (congenital syndrome)
Salmonellosis
Shigellosis
Staphylococcus aureus (infection; resistant to methicillin/ oxacillin or vancomycin)
Streptococcus pneumoniae (infection; resistant to penicillin)
Syphilis[2]
Tetanus
Tuberculosis[4]
Typhoid fever
Varicella (chickenpox)
Vibrio infections (excluding cholera)[1]

[1] Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.
[2] Report on STD-43 form. Report cases of syphilis with active lesions by telephone.
[3] Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.
[4] Report on CDC 72.5 (f. 5.2431) card.

All reportable diseases and conditions other than the venereal diseases, tuberculosis and those conditions with *'s should be reported on an EPI-2430 card and forwarded to the local parish health unit or the Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160, Phone: 504-568-5005 or 1-800-256-2748 or FAX: 504-568-5006. All facsimile transmissions are considered as part of the confidential disease case report, and as such, are not subject to disclosure.

OTHER REPORTABLE CONDITIONS

Cancer
Complications of abortion
Congenital hypothyroidism*
Galactosemia*
Hemophilia*
Lead Poisoning
Phenylketonuria*
Reye's Syndrome
Severe traumatic head injury**
Severe under nutrition (severe anemia, failure to thrive)
Sickle cell disease (newborns)*
Spinal cord injury**
Sudden infant death syndrome (SIDS)

* Report to the Louisiana Genetic Diseases Program Office by telephone (504) 568-5070 or FAX (504) 568-7722.
** Report on DDP-3 form

Revised 4-97

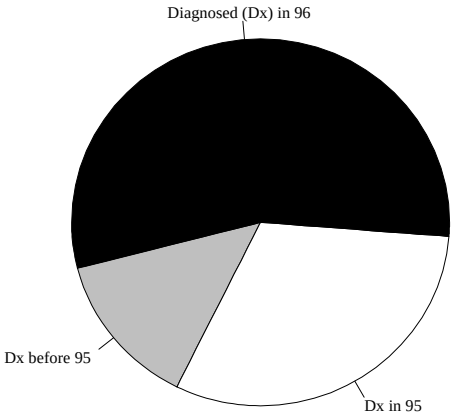
AIDS UPDATE
Epidemiology of AIDS in Baton Rouge

In CDC's recent publication of updated AIDS statistics[1], the 1996 AIDS rate in the metro Baton Rouge area was listed as 10th highest among major U.S. cities. The published rate (58.5 per 100,000 persons) was more than double the rate for 1995. Because of delays in reporting to CDC, these AIDS rates can be misleading.

Although the numbers of cases printed in the CDC publication are accurate, these numbers represent cases that OPH reported to CDC during the year. Due to expanded surveillance activities in the Baton Rouge area, 45% of the cases reported to CDC during 1996 were actually diagnosed in earlier years (Figure 1). The use of cases diagnosed during the year provides a better indicator for determining the AIDS incidence.

The appropriate estimate of AIDS incidence in 1996 for metro Baton Rouge is 48.1 per 100,000. Nonetheless, attention to AIDS in the Baton Rouge area is warranted

Figure 1: Cases of AIDS reported to CDC in 1996, Baton Rouge Metro Area



because cases continue to increase steadily (Figure 2) and the incidence rate is rapidly approaching that of metro New Orleans (52.3 per 100,000).

The epidemic in intravenous drug users (IDUs) in the Baton Rouge area has been sharply increasing during recent years, with more new cases related to intravenous drug use than to men who have sex with men (MSM) (Figure 3). Of the new IDU cases, 95% were in African-Americans. The cases with homosexual/bisexual exposure were evenly distributed between African-American and white men (50%). Since 1991, the case rates for African-American men has been disproportionately high, increasing at a faster rate than any other demographic group in the Baton Rouge area.

Although the statewide trend is increasing among cases with intravenous drug exposure, Baton Rouge is the only metro area where intravenous drug use has become the predominant risk factor. Increases in AIDS rates in IDUs will be followed by increases in cases in women, many of whom become infected through sexual transmission from IDUs. An increase in HIV-infected women in turn increases the number of infants who acquire HIV through perinatal transmission. Efforts to prevent community wide transmission of HIV in Baton Rouge (and other areas of Louisiana) should include drug treatment programs and activities which promote clean needle use among IDUs who are not in drug treatment.

Figure 2: AIDS incidence cases, Baton Rouge Metro Area

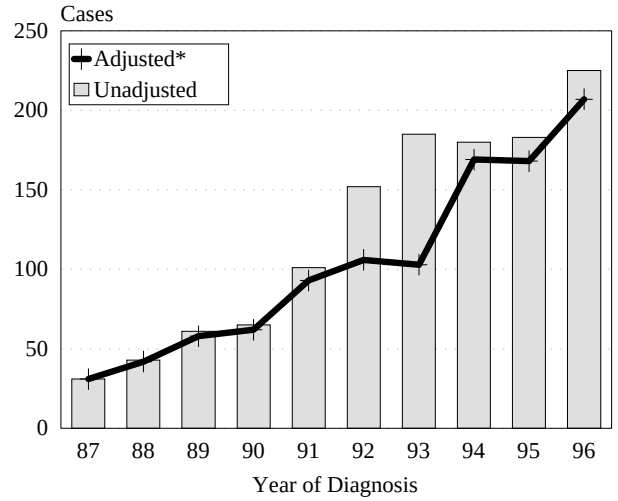
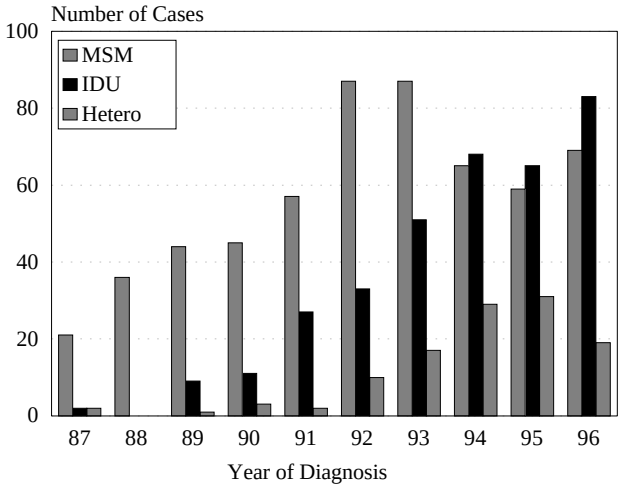


Figure 3: Trends in exposure categories, Baton Rouge Metro Area (unadjusted)



Trends are adjusted for reporting delay and the 1993 case definition change.

[1] Centers for Disease Control and Prevention. HIV/AIDS Surveillanc Report, 1996; 8 (no .2): p.8

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
March - April , 1997
PROVISIONAL DATA

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

	HEALTH REGION									TIME PERIOD				
DISEASE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Mar-Apr 1997**	**Mar-Apr 1996**	**Cum 1997**	**Cum 1996**	**% Chg**
Vaccine-preventable														
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	1	1	0	0	0	0	0	0	2	4	2	7	9	-22
Rubella	0	0	0	0	0	0	0	0	0	0	1	0	1	-
Pertussis	4	0	1	0	0	0	0	0	0	5	1	7	3	+133
Sexually-transmitted														
AIDS Cases	41	10	1	4	5	2	6	3	3	75	203	203	445	-54
Rate[1]	3.8	1.8	0.3	0.8	1.9	0.6	1.2	0.9	0.9	1.7	4.7	4.7	10.3	
Gonorrhea Cases	506	134	106	137	65	48	204	130	45	1375	1383	2571	3249	-21
Rate[1]	48.7	23.6	28.1	26.6	24.3	15.7	40.3	37.0	11.7	32.6	32.8	60.9	77.0	
Syphilis(P&S) Cases	13	8	3	7	0	1	6	4	1	43	119	135	229	-41
Rate[1]	1.3	1.4	0.8	1.4	0.0	0.3	1.2	1.1	0.3	1.0	2.8	3.2	5.4	
Enteric														
Campylobacter	8	5	0	1	0	0	0	1	2	18	12	29	31	-6
Hepatitis A Cases	1	0	0	3	1	0	7	18	1	31	30	74	51	+45
Rate[1]	0.1	-	-	0.6	0.4	-	1.4	5.1	0.3	0.7	0.7	1.7	1.2	
Salmonella Cases	10	5	5	7	0	2	2	4	8	43	32	75	54	+39
Rate[1]	1.0	0.9	1.3	1.4	-	0.7	0.4	1.1	2.1	1.0	0.7	1.7	1.3	
Shigella Cases	6	6	0	0	0	0	2	2	1	17	69	36	154	-77
Rate[1]	0.6	1.1	-	-	-	-	0.4	0.6	0.3	0.4	1.6	0.8	3.6	
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	2	2	2	0
Other														
Hepatitis B Cases	6	1	2	0	0	0	2	2	1	14	29	43	44	-2
Rate[1]	0.6	0.2	0.5	-	-	-	0.4	0.6	0.3	0.3	0.6	1.0	1.0	
Meningitis/Bacteremia *H. influenzae*	1	0	0	0	0	0	0	0	0	1	0	2	1	+100
N. meningitidis	5	2	1	0	0	0	1	1	1	11	15	27	33	-18

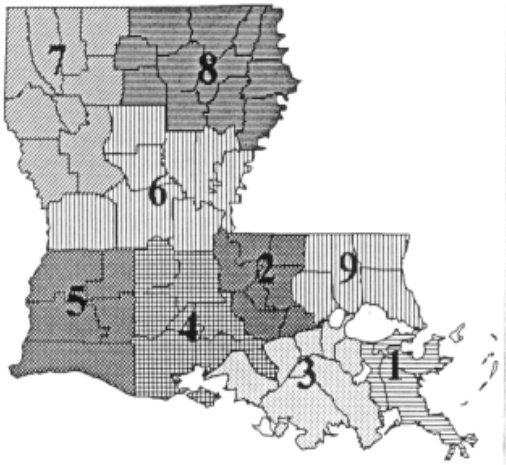
1 = Cases per 100,000

Table 2. *Diseases of Low Frequency*

Disease	Total to Date
Blastomycosis	0
Brucellosis	0
Histoplasmosis	1
Lead Toxicity	3
Typhoid	0
Rocky Mountain Spotted Fever	0
Legionellosis	1
Lyme Disease	1
Malaria	4
Tetanus	0

Table 3. *Animal Rabies (March- April ,1997)*

Parish	No. Cases	Species
Lafayette	1	Bat



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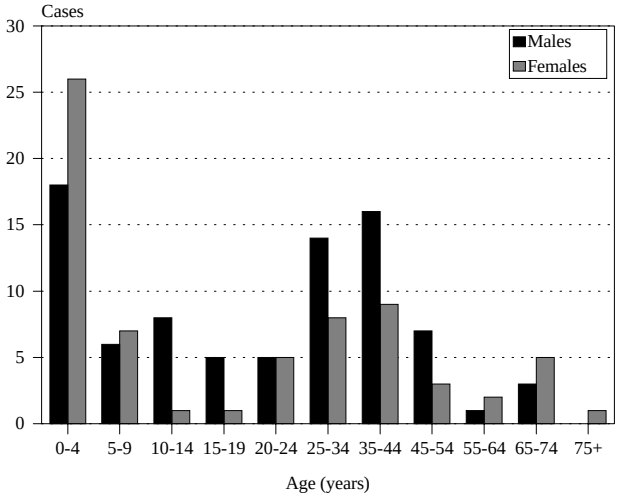
Annual Summary Campylobacteriosis - 1996

For 1996, one hundred sixty-one cases of campylobacteriosis were reported to the Epidemiology Section. The overall state case rate is 3.7 per 100,000. Distribution by age, race and sex follow similar patterns from previous years. Case rates were highest in children less than ten years of age and adults between 25 - 45 years of age (Figure 1). Sex-specific rates were higher for males than females (4.2 vs 3.2 per 100,000) and race-specific rates (per 100,000) were higher for whites than non-whites (2.1 vs 1.7). Outbreaks associated with campylobacter are infrequent and usually have a marked bimodal distribution, with peaks in May and October, and the low point in summer. In contrast, sporadic cases peak in the summer, which is consistently demonstrated as so over the last three years (Figure 2). Parishes reporting the highest case rate per 100,000 include: Terrebonne (11), Red River (10), and Washington (7).

Figure 1: Cases of campylobacteriosis by age and sex, 1996



Comment:

Campylobacter is recognized as one of the most common causes of bacterial gastroenteritis in humans in the U.S. The incubation period ranges from 1 to 10 days, generally within 2 - 5 days. Most campylobacter infections occur as sporadic cases, e.g., individual cases that are not associated with a recognized outbreak and usually peak in summer. This seasonality difference suggests that the epidemiologic characteristics of these cases are different than the epidemiology of outbreak-associated cases. Mishandled poultry is the food believed to be most commonly associated with sporadic, individual cases of campylobacteriosis. Prevention and control rests primarily on safe food handling practices and thoroughly cooking foods.

Figure 2: Cases of campylobacteriosis by month of onset, 1994-1996

Louisiana Fact

The system of offering free vaccinations and conducting school audits for immunization status dates back to the 1800's in Louisiana with some similar problems encountered. The following is an excerpt from the 1875 Annual Report of the Board of Health." The system of free vaccinations on Saturdays, has not been productive of much good during the year, owing to an existing disinclination to come on Saturdays, and to a somewhat general prejudice against vaccination or indifference to danger among the people. Whenever this disease (smallpox) shows a tendency to spread from an infected house the neighbors will then consent to be vaccinated, or will come themselves to the office, but seldom otherwise. During the months of November and December the public schools were visited in order to examine and vaccinate those pupils having no certificate of vaccination, or showing no good pock-mark of protection from small-pox, according to the custom of the inspectors in their respective districts, during the fall of the year. The children generally are generally well protected, but have been admitted into the different public schools without a certificate of vaccination, thus endangering to some extent the health of those not so well protected. This is a matter deserving of the attention of the Board of Health. Something more than a mere inspection and report afterward by an inspector is needed. The re-vaccinations in these schools are a source of annoyance and trouble, because it is so difficult a matter to meet again the same scholars on subsequent visits, for the reason they frequently leave the school either permanently or temporarily, and are absent sometimes for several days at a time."

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES

Acquired Immune Deficiency Syndrome (AIDS)
Amebiasis
Arthropod-borne encephalitis (Specify type)
Blastomycosis
Botulism[1]
Campylobacteriosis
Chancroid[2]
Chlamydial infection[2]
Cholera[1]
Cryptosporidiosis
Diphtheria
Enterococcus (infection; resistant to vancomycin)
Escherichia coli 0157:H7 infection
Gonorrhea[2]
Haemophilus influenzae infection[1]
Hemolytic-Uremic Syndrome
Hepatitis, Acute (A, B, C, Other)
Hepatitis B carriage in pregnancy
Herpes (neonatal)
Human Immunodeficiency Virus (HIV) infection[3]
Legionellosis
Lyme Disease
Lymphogranuloma venereum[2]
Malaria
Measles (rubeola)[1]
Meningitis, other bacterial or fungal
Mumps
Mycobacteriosis, atypical[4]
Neisseria meningitidis infection[1]
Pertussis
Rabies (animal & man)
Rocky Mountain Spotted Fever (RMSF)
Rubella (German measles)
Rubella (congenital syndrome)
Salmonellosis
Shigellosis
Staphylococcus aureus (infection; resistant to methicillin/ oxacillin or vancomycin)
Streptococcus pneumoniae (infection; resistant to penicillin)
Syphilis[2]
Tetanus
Tuberculosis[4]
Typhoid fever
Varicella (chickenpox)
Vibrio infections (excluding cholera)[1]

OTHER REPORTABLE CONDITIONS

Cancer
Complications of abortion
Congenital hypothyroidism*
Galactosemia*
Hemophilia*
Lead Poisoning
Phenylketonuria*
Reye's Syndrome
Severe traumatic head injury**
Severe under nutrition (severe anemia, failure to thrive)
Sickle cell disease (newborns)*
Spinal cord injury**
Sudden infant death syndrome (SIDS)

[1] Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.
[2] Report on STD-43 form. Report cases of syphilis with active lesions by telephone.
[3] Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.
[4] Report on CDC 72.5 (f. 5.2431) card.
*Report to the Louisiana Genetic Diseases Program Office by telephone (504) 568-5070 or FAX (504) 568-7722.
**Report on DDP-3 form

Numbers for reporting communicable diseases

1-800-256-2748 Local # 568-5005 FAX # 504-568-5006

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