

Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section
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Volume 8 Number 5

Tuberculosis in Louisiana - 1996

Louisiana reported 420 cases of tuberculosis in 1996, an 11.6% decrease from the 1995 total of 475. With a 1996 case rate of 9.6 per 100,000 Louisiana exceeds the 8.0 per 100,000 national rate. The Centers for Disease Control and Prevention (CDC) ranks Louisiana 10th in the nation according to tuberculosis case rate, and a comparison of tuberculosis cases and case rates for bordering states is shown in Table 1.

The regional distribution of cases within Louisiana is illustrated in Figure 1, and metropolitan New Orleans continues to lead the state in morbidity. The majority of pediatric cases were also reported in this region as the incidence of tuberculosis in children <15 increased each of the past three years from 4 (29%) in 1994 to 19 (59.4%) in 1996.

Persons of color continue to suffer a disproportionate impact of tuberculosis. Of the 420 cases reported in 1996, 57% were found in blacks (a case rate of 18.5 per 100,000) and 8% were reported in the Asian/Pacific Islander population (case rate of 80.3), compared to 34% in whites (case rate of 5.1).

Distribution by gender shows that males outnumber females by more than a 2 - 1 margin, with 283 (67%) of the total cases in 1996. Fifty-four percent of all persons with tuberculosis in 1996 were unemployed. Although the total number of cases declined in 1996, the decrease occurred in the ages of 45 and greater, while the number of new tuberculosis cases in children and young adults increased (Figure 2). (Continued on next page)

Table 1. Cases and rates of tuberculosis in Louisiana and neighboring states, 1996

State	# Cases	Case Rate
Arkansas	225	9.0
Texas	2,103	11.0
Louisiana	420	9.6
Mississippi	251	9.2

Figure 1: Tuberculosis cases in Louisiana by region, 1996. Total = 420

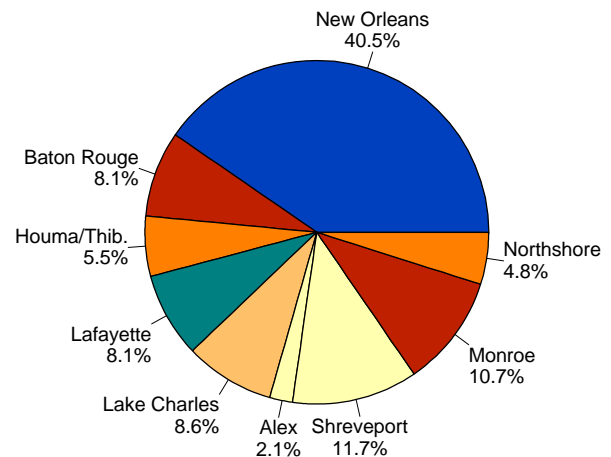
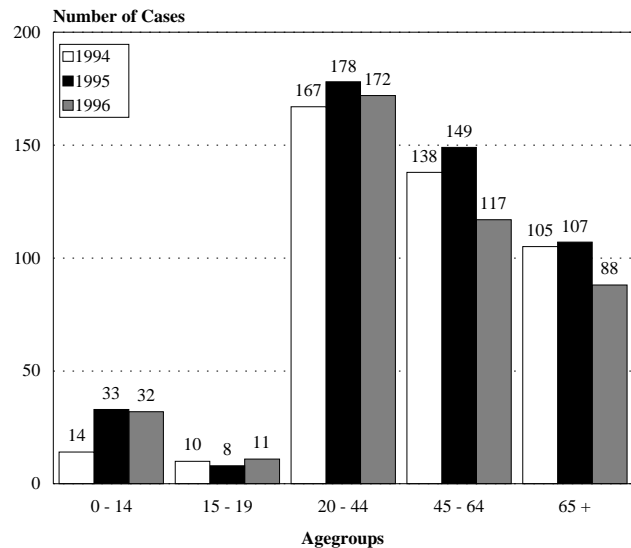


Figure 2: Tuberculosis cases in Louisiana by number and age groups, 1994-1996



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Tuberculosis in Louisiana - 1996 (Cont.)

The number of tuberculosis cases with HIV infection continued to rise despite the overall decrease in cases in 1996. A total of 47 (11.2%) HIV infected patients with tuberculosis were identified this year as opposed to 43 (9%) in 1995. The majority (66%) of HIV infected cases were reported in the New Orleans region.

The incidence of drug-resistant tuberculosis declined slightly in 1996 with an initial INH resistance rate of 3.5% statewide. Nearly 86% of all culture positive tuberculosis cases in Louisiana had initial drug susceptibility tests performed. These susceptibility studies provide meaningful surveillance regarding the incidence of drug resistant disease and provide guidance in the establishment and maintenance of appropriate tuberculosis treatment regimens. The CDC defines multi-drug resistant (MDR) tuberculosis as those cases which exhibit resistance to at least Isoniazid and Rifampin. Although Louisiana reported no cases of MDR tuberculosis in 1996, a total of 14 cases were identified with resistance to at least one anti-tuberculosis drug. Of those resistant cases, 6 (43%) were identified in the New Orleans region.

Louisiana Office of Public Health, Tuberculosis Control Program, provides diagnostic, treatment, and prevention services through regional chest clinics and parish health units. Services include provision of case management such as directly observed therapy for persons with disease, and epidemiologic investigations to determine the potential for (or extent of) transmission of tuberculosis in the community.

Recommendations, based on current epidemiologic data, include continuation of an initial four-drug regimen statewide in the treatment of tuberculosis, and application of directly observed therapy where resources allow.

Louisiana's Tuberculosis Control Program, following consultation with the Governor's Task Force on Tuberculosis, has secured time-limited funds from CDC to address the immediate need for assistance in high incidence areas of the state. Near term goals for these areas include a re-emphasis on contact investigation to identify children at risk, and the application of "targeted" directly observed therapy to achieve the maximum public health impact for our limited resources. Mid-to-long term goals for high incidence areas include seeking assurance for future funding, assessment of staffing patterns, and adjustments to address the loss of skilled tuberculosis control staff. Expansion of public, private, and academic partnerships in high prevalence communities may also serve to multiply "points of access," and enhance continuity of care for the individual tuberculosis patient.

Adolescent Immunization

On May 10, 1997, the Office of Public Health - Immunization Program joined the US Public Health Services Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics (AAP) to implement a policy on the provision of immunizations to adoles-

cents.

Traditionally, immunization programs have focused on infants and children. These programs have successfully decreased the occurrence of many vaccine preventable diseases nationally; however, many adolescents continue to be susceptible to diseases that can be prevented through immunization.

This policy emphasizes vaccination of adolescents 11 through 12 years of age and is retroactive to May 1, 1996. Specifically, this policy recommends vaccination of un-immunized adolescents with varicella virus vaccine, hepatitis B, and/or the second dose of the measles, mumps and rubella (MMR) vaccine in addition to providing a booster dose of tetanus and diphtheria toxoid (if at least five years have lapsed since the last vaccine booster).

Children who received a second dose of MMR at school entry or who received two doses of MMR after one year of age do not need to be re-vaccinated with MMR vaccine at 11 - 12 years of age. Varicella vaccine should be given to 11 - 12 year-old adolescents if they have no history of chicken pox. Hepatitis B should be given to 11 - 12 year-old adolescents if they have not previously completed a 3-dose series. If they had a partial series, the series should be completed.

This new policy also emphasizes the vaccination of all children up to 19 years of age at high risk of HBV infection. This includes children or adolescents who are developmentally disabled, on hemodialysis, sexually active, users of illicit injectable drugs, or those who have sexual or household contact with a person who is hepatitis B surface antigen positive. In addition, children born since October

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1983 to women from areas of high hepatitis B endemicity are also eligible.

Presently, the Office of Public Health - Immunization Program is working with some school systems, school-based programs, juvenile detention centers, Vaccine For Children providers and special projects with local health units and others in attempting to get these catchment groups immunized.

Inquiries may be directed to the Immunization Program at (504) 483-1900.

Severe Pediatric Undernutrition

In Louisiana, in accordance with the State Sanitary Code, severe pediatric undernutrition (SPUN) is listed as a "Reportable Condition." A child, age 6-71 months, is considered a SPUN case if he or she meets one of the following criteria: 1.) weight for height percentile <5th, or 2.) hemoglobin <8g/dl or hematocrit <25% without hemoglobinopathy or acute blood loss, or 3.) unintentional absolute weight loss >10% over 6 months, or 4.) diagnosed vitamin/mineral or other deficiency.

A total of 316 cases of severe pediatric undernutrition were reported in 5 regions in Louisiana in 1996. The New Orleans region was not required in 1996 to submit SPUN reports. Of the 314 cases documented on reportable disease cards, 154 were followed up by Nutrition Epidemiologic Investigative Form which included demographics, income, use of federal programs, anthropometric and dietary information. The following statistics refer to the group of children followed with this form.

Forty percent (62 SPUN cases) were reported from the Lake Charles Region, 36% (56 cases) were reported from the Shreveport Region, 21% (33 cases) were reported from the Lafayette region, 8 cases from the Alexandria Region and 1 case in the Monroe Region. Of 154 SPUN cases, the majority were black (65.8%), 33.6% were white and 0.7% were Asian (Figure 1). Boys made up 50.6% of the total. The average age of a SPUN case was 1 year, 5 months with the eldest case being 5 1/2 years of age and the youngest being 1 year old.

The risk factors that have been suggested for SPUN are antenatal factors, chronic disease, social factors, lack of food, abuse/neglect, and non participation in federal programs.

Mothers of SPUN cases had a mean age of 26 and the average size of a family was 4 members. The family income ranged from 0 to \$2600/month with the average income being \$777.75/month. Over 99% of the families fell below a cutoff 185% of the federal standard poverty line. Thirty percent of the parents were unemployed.

Lack of food and participation in federal programs were investigated as risk factors for SPUN. Participation in the programs was as follows: 31.8% AFDC, 5.2% Commodity Supplemental Foods, 42.2% Food Stamps, 96.1% WIC, and 7.1% received income from "Other" sources.

Child protection services were called to investigate 3.2% of the cases. Thirteen percent of families cited a recent family change including: divorce, death of mother, a recent change of address, or new baby. The most frequently observed chronic disease in this group was respiratory disease (42.9), predominantly asthma and allergies (75%). The most frequently reported acute illnesses were ear infections and colds.

Surprisingly, the SPUN group was comprised of only 21% low birth weight (<2500 g) infants and only 1 1/2% were born with extremely low birth weights (<1500 g). Nine infants were born prematurely and 4 SPUN cases were twins. Over half of the entire group was stunted (<5th percentile height/age). Of this group, 11.1% were extremely stunted (<3rd percent wt/ht). Nineteen percent of the stunted group were also anemic (<11.2 hgb). In the SPUN group, 44.2% were thin (wt/ht <5th percentile) and 9.7% were extremely thin (<3rd wt/ht; Figure 2). Twenty-six percent of the thin children were also anemic.

The Centers for Disease Control and Prevention initiated an Enhanced Pediatric Nutrition Surveillance System (PedNSS) which tracks children <5 years of age who are WIC participants in Louisiana. However, passive reporting of SPUN has continued and the type of information collected through the investigative form is currently only available through this method. Though this latter data system has limitations, it is clear that severe pediatric undernutrition exists in Louisiana despite participation in federal programs. The Nutrition Section recommends that SPUN reporting become an active reporting system for accurate counts and for patient follow up.

Figure 1: Cases of severe pediatric undernutrition by age and race

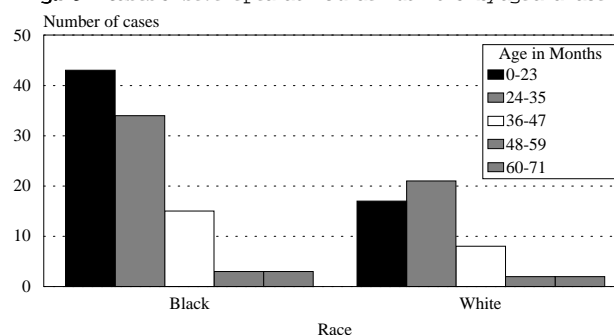
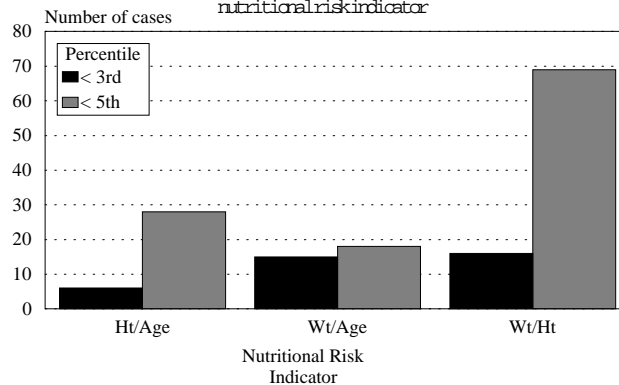


Figure 2: Cases of severe pediatric undernutrition by nutritional risk indicator

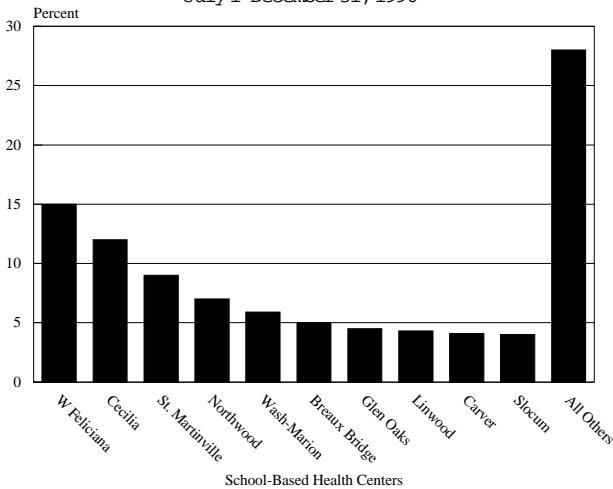


Louisiana School-Based Health Centers

The State Legislature passed the Adolescent School Health Initiative Act in 1991 to address the escalating rates of morbidity and mortality among youth in public middle and high schools. Since that time 23 school health centers have become operational. Agencies are funded to establish school health centers based on documented need and lack of access to health care in both inner-city urban and rural locations.

Between July 1 and December 31, 1996, 12,170 students made 42,630 visits to these school-based health centers in Louisiana, an average of 3.5 visits per student. Forty-three percent of these visits were to the following school-based clinics: West Feliciana (15%) followed by Cecilia (12%), St. Martinville (9%), and Northwood (7%; Figure 1). Utilization data indicate that the majority (39%) of visits occurred among students in grades 7, 8 and 9. There were no significant differences in the number of visits made by males and females.

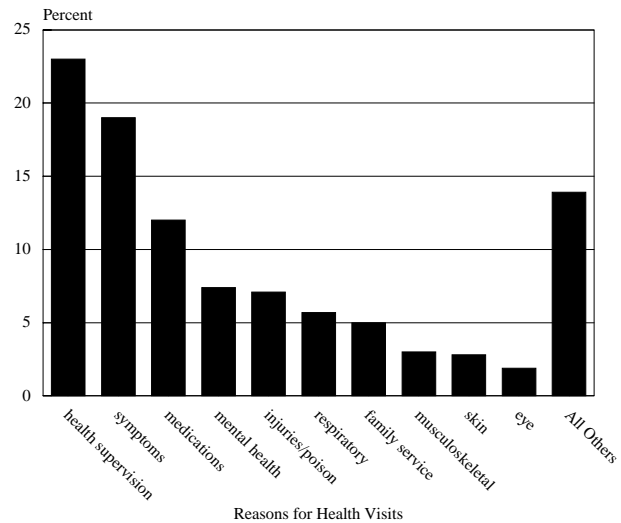
Figure 1: School-based health center visits by site, July 1-December 31, 1996



Twenty-three percent of the visits were for health supervision, which includes routine health checks, physical exams, immunizations, laboratory tests and follow-up, and dietary surveillance and counseling. The second most common reason for visits (19%) was symptoms (headache, cold, fever, abdominal pain, throat pain, backache, nausea, vomiting); followed by administration of medications (12%), mental health (7.4%) and injuries/poisons (7.1%; Fig. 2).

Evidence shows that most children served were formerly doing without primary and preventive care and going to emergency rooms for acute care. Approximately 25% of students registered at these health centers are on Medicaid, 65% are uninsured, and 10% are privately insured. In cases where a child has a private physician, the primary care physician is notified when the student is seen at the school-based clinic.

Figure 2: Reasons given for school-based center visits by category, July 1 - December 31, 1996



School-based health centers provide much needed preventive, physical and mental health care for the working poor and Medicaid-eligible families. While there is no data to estimate the cost-effectiveness of school health centers in relation to the reduction in emergency room visits, the Baton Rouge School Health Centers has estimated a decrease of 6,200 days of lost productivity by parents who would have had to take off of work to seek medical care for their sick children.

Change in Rabies Prophylaxis Recommendations

In the past, the Epidemiology Section has not recommended the testing of bats or the administration of rabies vaccine prophylaxis unless there was a history of human exposure through a bite or scratch. There have been a total of 21 cases of human rabies in the U. S. involving bat rabies virus since 1980. Of these cases, eight reported physical contact with a bat without an evident bite or other potential exposing event. A history of contact could not be established or excluded for the remaining 13 bat-related cases.

The inability of health-care providers to elicit information surrounding potential exposures may be influenced by the limited injury inflicted by a bat bite (in comparison with lesions inflicted by terrestrial carnivores) or by circumstances that hinder accurate recall of events. Therefore, post-exposure prophylaxis is also appropriate even in the absence of a demonstrable bite or scratch, in situations in which there is reasonable probability that such contact occurred (e.g., a sleeping person awakes to find a bat in the room or an adult witnesses a bat in the room with a previously unattended child, mentally disabled person, or intoxicated person). In these instances, the bat should be sent in for rabies testing, if possible, prior to the initiation of prophylaxis.

AIDS UPDATE

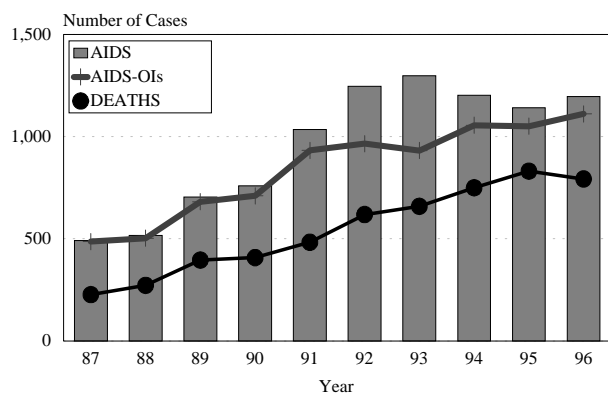
Profile of the Epidemic, 1996

Recently, the Centers for Disease Control reported that for the first time their national data showed a decline in the number of cases of AIDS with opportunistic infections (AIDS-OIs). In contrast, Louisiana data still show an increasing trend in AIDS-OIs, although there are important differences in different population subgroups.

Trends in AIDS-OIs are followed because the AIDS case definition was changed in 1993, including persons with CD4 cell counts below 200 who had not experienced an opportunistic infection. This change in the case definition caused misleading case trends, which can be corrected by adjusting the data using estimates (based on national studies) of the proportion of cases which would be expected to have experienced opportunistic infections by certain time periods. Because estimates of new AIDS-OIs do not reflect the impact of protease inhibitors on persons with a previous AIDS diagnosis, the number of AIDS-OIs may be slightly overestimated for Louisiana as well as the nation during the recent time periods.

After adjusting Louisiana data in this way, the number of AIDS-OIs have continued to increase in recent years, although the increase may be leveling somewhat (Figure 1). Consistent with the national trends, the number of deaths attributable to AIDS may be declining for the first time in Louisiana (Figure 1). However, deaths related to AIDS still remains one of the most frequent causes of death in men ages 25-44 (Figure 2).

Figure 1: Cases of AIDS, AIDS with opportunistic infection, and AIDS-related deaths, Louisiana, 1987-1996



The AIDS epidemic continues to affect certain populations disproportionately. Although the estimated number of new AIDS-OIs in men who have sex with men (MSM) is declining, this subpopulation still remains the largest of any exposure group. The number of AIDS-OIs related to drug use or high risk heterosexual transmission continues to rise (Figure 3).

A very clear and alarming trend is the continuously increasing incidence of AIDS-OIs among African-Americans. The number of new AIDS-OIs estimated for 1996

among African-Americans has far exceeded the peak reached by cases in whites in the early 90s, and does not appear to be slowing down (Figure 4). There appears to be a genuine decline in the incidence of AIDS in caucasians.

As new antiviral medications are used earlier in the course of HIV disease, the incidence of AIDS and AIDS-OIs may decrease regardless of the direction of the trend in HIV transmission. Surveillance for the HIV epidemic may have to shift more toward following trends in HIV infection than trends in AIDS cases.

Figure 2: Rates of leading causes of deaths among men age 25-44, Louisiana, 1984-1995

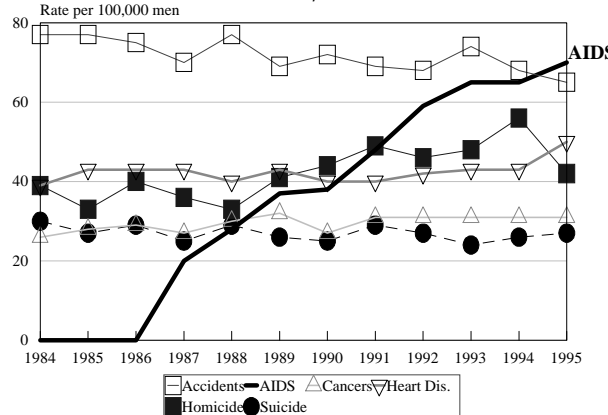


Figure 3: Estimated number of cases of AIDS with opportunistic infection by exposure category, 1987-1996. MSM - men who have sex with men, IDU - injection drug user, Hetero - heterosexual contact

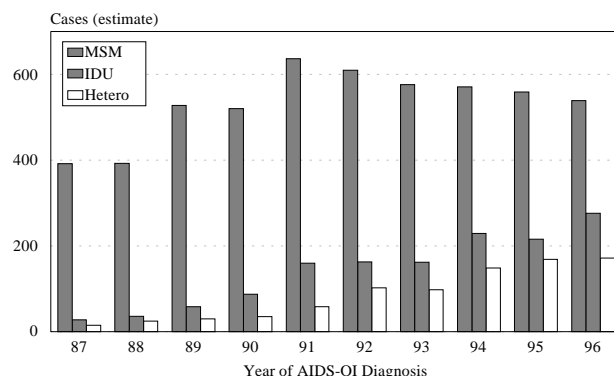
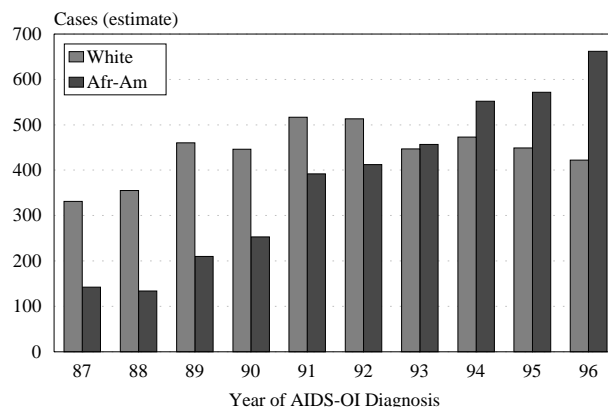


Figure 4: Estimated number of cases of AIDS with opportunistic infection by race, Louisiana, 1987-1996



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
Sept-Oct, 1997
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	Sept Oct 1997	Sept Oct 1996	Cum 1997	Cum 1996	% Chg
Vaccine-preventable														
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	1	0	1	0	1	3	1	15	17	-12
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	1	-100
Pertussis	1	0	1	0	0	0	0	0	0	2	1	20	9	+122
Sexually-transmitted														
AIDS	157 Cases Rate ¹	47 8.5	4 1.1	13 2.6	10 3.8	3 0.9	23 4.5	13 3.7	13 3.6	283 6.6	188 4.4	864 20.0	1333 30.9	-35
Gonorrhea	569 Cases Rate ¹	166 29.2	103 27.3	240 46.5	95 35.4	83 27.2	378 74.7	233 66.4	89 23.1	1956 46.4	1701 40.3	8539 202.3	7907 187.4	+8
Syphilis(P&S)	24 Cases Rate ¹	10 1.8	9 2.4	1 0.19	0 0	0 0	4 .79	4 1.1	2 .51	54 1.3	67 1.6	306 7.3	475 11.3	-35
Enteric														
<i>Campylobacter</i>	7	4	3	4	0	0	0	2	2	23	23	141	134	+5
Hepatitis A	8 Cases Rate ¹	1 0.2	1 0.3	5 1.0	8 3.0	3 1.0	14 2.8	7 2.0	1 0.3	48 1.1	43 1.0	219 5.1	183 4.2	+20
<i>Salmonella</i>	22 Cases Rate ¹	25 4.4	10 2.7	29 5.6	5 1.9	9 3.0	9 1.8	13 3.7	12 3.1	140 3.2	130 3.0	477 11.1	508 11.8	-6
<i>Shigella</i>	7 Cases Rate ¹	0 -	2 0.5	9 1.7	3 1.1	0 -	1 0.2	0 -	1 0.3	23 0.5	41 0.9	115 2.7	511 11.8	-78
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	1	0	1	-100
Vibrio, other	2	1	1	1	0	1	0	0	0	6	10	29	37	-22
Other														
Hepatitis B	5 Cases Rate ¹	3 0.5	3 0.8	5 1.0	4 1.5	4 1.3	7 1.4	3 0.9	3 0.8	37 0.9	42 1.0	154 3.6	142 3.3	+9
Meningitis/Bacteremia														
<i>H. influenzae</i>	0	0	0	0	0	0	0	0	1	1	1	13	5	+160
<i>N. meningitidis</i>	1	0	0	0	0	0	0	0	0	1	8	47	58	-19
Tuberculosis	39 Cases Rate ¹	15 N/A	2 N/A	6 N/A	2 N/A	4 N/A	8 N/A	0 N/A	0 N/A	76 N/A	74 N/A	183 4.2	184 4.2	-0.5

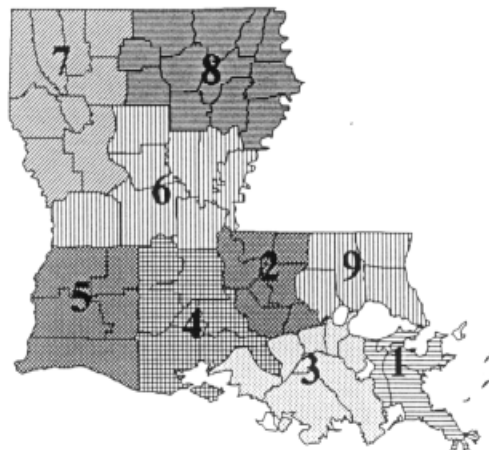
¹ = Cases per 100,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	4
E. coli 0157:H7	6
Histoplasmosis	3
Lead Toxicity	76
Varicella	65
Rocky Mountain Spotted Fever	2
Legionellosis	6
Lyme Disease	3
Malaria	14
Tetanus	0

Table 3. Animal Rabies (Sept-Oct, 1997)

Parish	No. Cases	Species
Lafayette	1	Skunk
Bienville	1	Dog
E. Baton Rouge	1	Bat



Annual Summary

Meningococcal Disease - 1996

In 1996, sixty-six cases of meningococcal disease were reported. The overall state case rate was 1.5 per 100,000. Cases of meningococcal disease increased by 6% from 1995 and by 40% from 1994 (Figure 1). Sex-specific rates were higher for males than females (1.8 vs 1.3 per 100,000) while race-specific rates were twice as high for African-Americans than for whites (2.5 vs 1.0 per 100,000). Fifty percent of the reported cases were less than 15 years of age (Figure 2). A seasonal trend is evident with 53% of the cases reported in the early months of the year (Figure 3). Sixteen (27%) cases with reported outcome were fatal. Forty-three isolates (66%) were serotyped and identified in which Group C (20) was most frequently reported followed by Group Y (14) and Group B (9). Nearly 81% of the cases were isolated from blood vs cerebrospinal fluid. No clustering or outbreaks were identified. Parishes reporting the largest number of cases include: Orleans (23), Jefferson (6) and Calcasieu (5, Figure 4).

Comment:

Meningococcal disease is an infection of normally sterile sites by the bacteria, *Neisseria meningitidis*, resulting primarily in sepsis and meningitis. Transmission is by person-to-person through respiratory droplets from the nose and throat of infected persons. The currently licensed meningococcal vaccine is not effective among children in the high risk groups, those less than two years of age. Routine immunization of the public is not generally recommended. Serotyping of meningococcal isolates would be most beneficial in establishing clustering of cases or identifying outbreaks.

Figure 1: Cases of meningococcal disease, 1987-1996

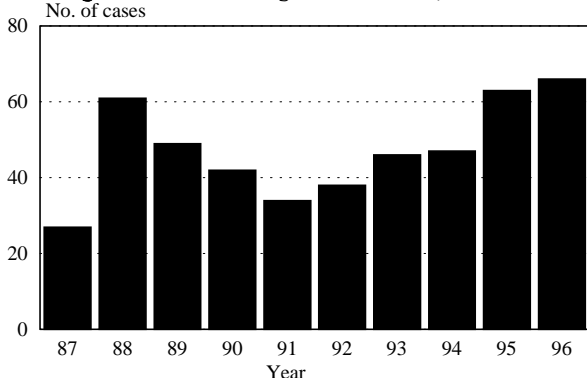


Figure 2: Cases of meningococcal disease by age group and sex, 1996

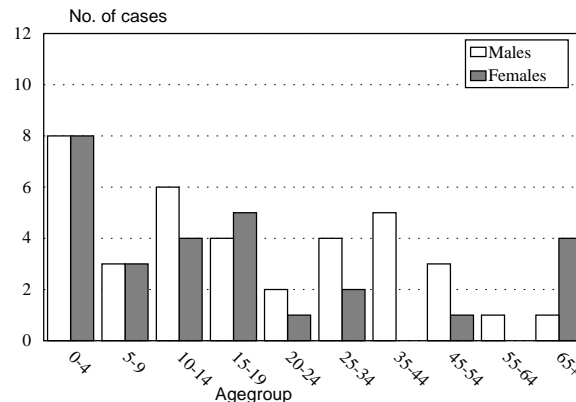


Figure 3: Cases of meningococcal disease by month, 1994-1996

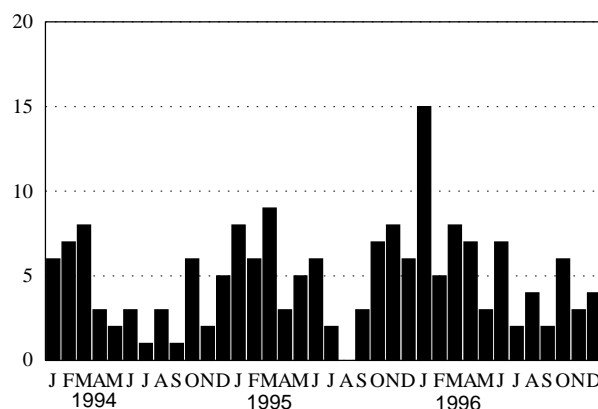
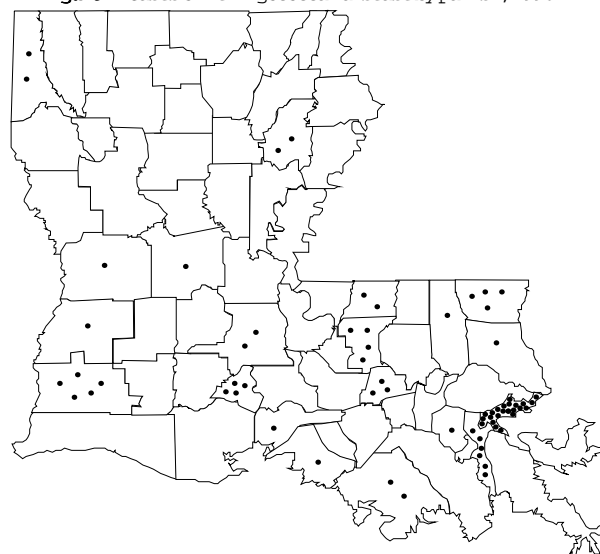


Figure 4: Cases of meningococcal disease by parish, 1996



Louisiana Fact

Some of the earliest modern day concerns and regulations on environmental pollution in the U. S. occurred as early as 1840. In Louisiana, efforts were initiated in 1872 by the President, New Orleans Board of Health, to enact ordinances to remedy the "smoke nuisance" by manufacturing pursuits. It should be noted that "no notice was taken by the Administrators of the City. Certain citizens, however, took the matter of the nuisance caused by one of these establishments into the courts, and in this instance secured its abatement." (Reports, Louisiana Board of Health, 1872 - 1875, Vol. 1, pages 32 - 37).

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS	
Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis, Acute (A, B, C, Other)	Rubella (German measles)	Cancer
Amebiasis	Hepatitis B carriage in pregnancy	Rubella (congenital syndrome)	Complications of abortion
Arthropod-borne encephalitis (Specify type)	Herpes (neonatal)	Salmonellosis	Congenital hypothyroidism*
Blastomycosis	Human Immunodeficiency Virus (HIV) infection ³	Shigellosis	Galactosemia*
Botulism ¹	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Hemophilia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Lead Poisoning
Chancroid ²	Lymphogranuloma venereum ²	Syphilis ²	Phenylketonuria*
Chlamydial infection ²	Malaria	Tetanus	Reye ' Syndrome
Cholera ¹	Measles (rubeola) ¹	Tuberculosis ⁴	Severe traumatic head injury**
Cryptosporidiosis	Meningitis, other bacterial or fungal	Typhoid fever	Severe undernutrition (severe anemia, failure to thrive)
Diphtheria	Mumps	Varicella (chickenpox)	Sickle cell disease (newborns)*
Enterococcus (infection; resistant to vancomycin)	Mycobacteriosis, atypical ⁴	Vibrio infections (excluding cholera) ¹	Spinal cord injury**
Escherichia coli 0157:H7 infection	Neisseria meningitidis infection ¹		Sudden infant death syndrome (SIDS)
Gonorrhea ²	Pertussis		
Haemophilus influenzae infection ¹	Rabies (animal & man)		
Hemolytic-Uremic Syndrome	Rocky Mountain Spotted Fever (RMSF)		

¹Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.

²Report on STD-43 form. Report cases of syphilis with active lesions by telephone.

³Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.

⁴Report 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 to Injury Research & Prevention Section (504-568-2509).

Numbers for reporting communicable diseases

1-800-256-2748

Local # 568-5005

FAX # 504-568-5006

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