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Louisiana Morbidity Report

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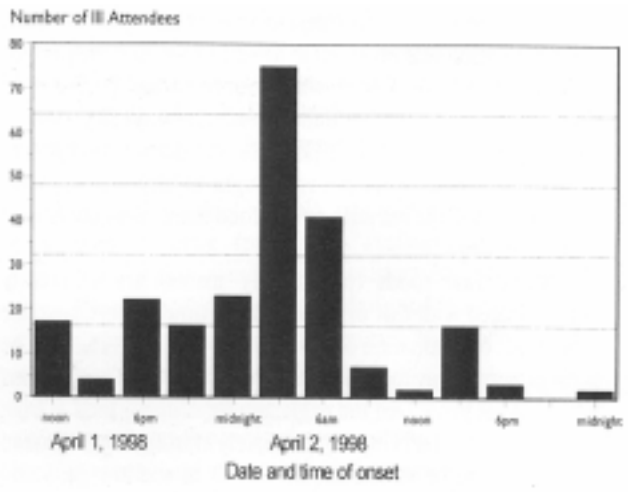
Outbreak of Gastroenteritis at a Conference

In April, 1998, the Epidemiology Section was notified about an outbreak of gastroenteritis among persons attending a statewide conference. A total of 557 persons attended the conference during April 1-2 and ate three meals together at the convention center. Beginning late afternoon on April I and continuing through April 2, a large number of attendees sought medical care for nausea and diarrhea at the medical booth set up for the conference. The conference was can- celled in the morning of its second day due to the high rate of illness in attendees.

A self-administered questionnaire was mailed out to conference attendees, asking about symptoms of gastr6enteritis, foods eaten at the convention center, hotel stays and dinner meals at other sites. Five hundred thirty-one of the 557 (95 To) attendees returned a completed questionnaire, of whom 219 (41 %) had diarrhea or cramps (Figure). Very few ill persons had either vomiting or fever. The median incuba- tion period was 13.5 hours and the median duration of illness was I day. Only four cases (2%) consulted physicians for their symptoms and one case with a previous history of gastroenteritis required intravenous rehydration.

Eating the lunch meal served on April I was strongly associated with illness (attack rate [AR] 43 % among lunch participants vs. 4.8% for non-participants, Relative Risk [RR] 9.6). None of the other catering events or any of the hotels or dinners shared by attendees was associated with the development of gastroenteritis. For persons who participated in the lunch meal, eggplant dressing, cornbread dressing and crawfish etouffe showed the strongest association with illness, however the relative risk for each individual food item was relatively low (RR 1.9, RR 1.6 and RR 1.6).

Figure: Cases of gastroenteritis in conference attendees by date and time of onset



Eleven of 12 'ill persons who submitted stool cultures tested positive for Clostridium pe&ingens. At least six cultures had very high colony counts for this bacteria (> 101 colonies per gram). Eight of the positive cultures showed an identical pattern by pulsed-field gel electrophoresis.

Of the three food items with the highest relative risks - combread dressing, eggplant dressing, and crawfish etouffe - two (cornbread and eggplant dressing) included a base ground beef mixture prepared the day before and the day of the event. It could not be established if the ground beef mixture was of the same batch and divided between these two items. The combread and eggplants were prepared on the day before the event and left at room temperature after cooking to cool down. Most of the other food items, including the crawfish etouffe, were prepared on the morning of the luncheon. The delivery van did not have any cooling or heating equipment to maintain tem- peratures. All of the food dishes were transported to the convention center where certain items were served directly hot or needed to be re-heated

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Outbreak of Gastroenteritis at a Conference (Cont.

at the center. *C. perfringens* is a toxin producing, spore forming, anaero- bic bacteria that lives naturally in the soil as well as in healthy people and animals. Gastroenteritis due to *C. perftingens* is usually a self-limited, mild illness associated with foodborne outbreaks. Large quantities (> 101 organisms per gram of food) of contamination are required to cause clinical symp- toms. The optimal temperature of growth of the bacteria is between 109.4 F and 116.6 F. Foods frequently causing *C. perftingens* outbreaks are meat stews, gravies and pies which are inadequately heated or reheated, cooled slowly, or stored at improper temperatures. Refrigeration and freezing substan- tially reduce the number of vegetative cells and spores, which can survive the curing and smoking of meat.

While the specific foodhandling problems leading to this outbreak could not be established, the illness was clearly linked to food served at a single meal and within this meal, to certain food items - cornbread, eggplant and rice dressing - which shared ingredients likely to have been inherently contaminated with *C. perfringens* (spices and ground beef). No information was obtained to identify specific time periods in which food was left at warm temperatures during food preparation and storage that would allow growth of *C. perfringen*s. However, it is possible that during food preparation, food items were never brought to high enough temperatures to kill the bacteria or that food items were not cooled quickly enough.

Many raw foods (particularly meats) are inherently contaminated with this organism at the time of purchase due to animal contamination of raw meat in slaughterhouses. The most effective way to prevent outbreaks due to *C. perftingens* is to prevent growth of the organism by cooking food at high temperatures and serving it immediately after cooking. Cooked food that is to be stored should be put in shallow pans and refrigerated immediately after cooking for rapid cooling; the common misconception that cooked food should cool at room temperature before refrigeration is inaccurate and dangerous. Refrigerated food should be reheated to proper temperatures (165-212 F) before serving.

Recommendations for Occupational Exposure to Hepatitis C

Hepatitis C virus (HCV) infection, formerly known as non-A non-B hepatitis, is the most common cause of infectious liver disease. At least 85% of persons with HCV infection become chronically infected and are at risk for cirrhosis and primary hepatocellular carcinoma. Most cur- rent HCV transmission is associated with direct percutaneous exposure to blood. Follow-up studies of health care woykers (HCWS) who sustained a percutaneons exposure to blood from an anti-HCV-positive patient have reported an average incidence of anti-HCV seroconversion after unintentional needlesticks or sharps exposures of 1.8% (range: 0-7%). However, no vaccine is available to prevent hepatitis C, and immune globulin is not recommended for postexposure pro- phylaxis. The mechanisms of the effect of interferon in treating patients with hepatitis C are poorly understood; an established infection may need to be present for interferon to be an effective treatment. Also, interferon must be adminis- tered by injection and may cause severe side effects.

To address HCWs'concerns, CDC, in collaboration with the Hospital Infection Control Practices Advisory Committee, recommends that individual health-care institutions consider implementing policies and procedures for follow-up for HCV infection after percutaneous or permucosal exposures to blood. At a minimum, such policies should include:

- for the source, baseline testing for antibody to HCV (anti-HCV);
- for the person exposed to an anti-HCV-positive source, baseline and follow-up (e.g., 6-month) testing for anti-HCV and alanine aminotransferase activity;
- confirmation by supplemental anti-HCV testing of all anti-HCV results reported as repeatedly reactive by enzyme immunoassay (EIA);
- recommending against postexposure prophylaxis with immune globulin or anti-viral agents (e.g., interferon); and

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- education of HCWs about the risk for and prevention of bloodborne infections, including hepatitis C, in occupational settings, with the information routinely updated to ensure accuracy.

In the absence of postexposure prophylaxis, at least six issues need to be considered in defining a protocol for the follow-up of HCWs occupationally exposed to HCV:

1. There is limited data about the occupational risk for transmission. Needlestick exposure to infectious blood is known to be a risk factor for hepatitis C and this risk is intermediate between that of hepatitis B virus and human immunodeficiency virus. Data is limited or nonexistent about the risk for transmission associated with other types of occupational exposures.

2. There are limitations of available serologic testing for detecting infection and determining infectivity. The rate of false positivity for anti-HCV is at least 50% in many popula- tions, including HCWS. Approximately 5 % of infections will not be detected unless PCR is used to detect HCV RNA. The detection of HCV RNA may be intermittent, and a single negative PCR test result is not conclusive.

3. The risk for transmission by sexual and other exposures is poorly defined. Although epidemiologic studies have implicated exposure to infected sexual and household contacts as well as to multiple sex partners in the transmission of HCV, the efficiency of transmission from these exposures is low. The average rate of perinatal transmission has been docu- mented at 5%, increasing to 9% among infants bom to mothers who were HCV RNA-positive at the infant's birth. Acquisition of HCV infection from breast milk has not been documented.

4. There is limited benefit of therapy for chronic disease. Alpha interferon therapy is safe and effective for the treatment of chronic hepatitis C, but sustained response rates generally are low (10% - 20% in the United States).

5. Cost of follow-up for each person for a 6-month course of therapy is an estimated $200,000.

6. Medical and legal implications: a postexposure follow-up protocol will address individual workers' concerns and identify those HCWs who become infected with HCV; this information provides HCWs with the opportunity to be counseled about their risk for transmitting HCV to others and to be evaluated for development of chronic disease.

Counseling recommendations to prevent transmission of HCV to others are that I)persons who are anti-HCV-positive should refrain from donating blood, organs, tissues, or semen, and 2) household contacts should not share toothbrushes and razors. There are neither recommendations against pregnancy or breastfeeding nor recommendations for changes in sexual practices among HCV-infected persons with a steady partner. Although HCV sometimes can be transmitted from persons with chronic disease to their steady sex partners, the risk for transmission is low despite long-term, ongoing sexual activity. Infected persons should be informed of the potential risk for sexual transmission to assist in decision-making about precautions. Persons with multiple sex partners should adopt safer sex practices, - including reducing the number of sex partners and using barriers (e.g., latex condoms) to prevent contact with body fluids.

Takenfrom MMWR, VoL 46INo. 26, Iuly 4, 1997.

Emerging Pathogens Advisory Committee To Develop Guidelines

In May 1998, the Emerging Pathogens Advisory Committee was reconvened. Its objectives are to review the epidemiology and impact of drug resistant pathogens and emerging diseases on the state; to develop a strategic plan to enhance the detection, surveillance, and prevention of emerging diseases (with emphasis on drug-resistant pathogens); to develop strategies to increase awareness of drug resistant pathogens; and to establish mechanisms and partnerships needed to ensure the development and implementation of prevention measures.

The final product of this committee will be written guidelines on drug (penicillin) resistant *Streptococcus pneumoniae* and on vancomycin resistant *Enterococcus* species. These guidelines are being designed to assist infection control practitioners, physicians, nurses and other personnel with the management of patients with infection(s) due to the above mentioned drug resistant pathogens. The guidelines would cover such areas as infection control, treatment and lab specifications, and education (for professional and public information) and are similar in format to the 1992 MRSA guidelines. Watch future editions of the LMR to see when these guidelines are available.

Reminder

In the fall of 1998 a complete series of hepatitis B vaccination will be required for school and day care center registration. For additional information/ assistance please call the Immunization Program at 504-483-1900.

Influenza Immunization Program, '98-'99 Season

Parish health unit clinics throughout the state will begin to administer influenza immunizations the week of October 12 - 17, 1998 to individuals who are at high risk of serious illness or death from influenza infection. Groups that are considered to be at high risk are:

- Persons aged > 65 years - Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions

- Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including children with asthma

- Adults and children who have required regular medical follow-up or hospitalization during the preceding year be- cause of chronic metabolic diseases (including diabetes mel- litus), renal dysfunction, hemoglobinopathies, or immuno- suppression (including immunosuppression caused by medi- cations)

- Children and teenagers (aged 6 months-18 years) who are receiving long-term aspirin therapy and therefore might be at risk for developing Reye syndrome after influenza

- Women who will be in the second or third trimester of pregnancy during the influenza season.

Data suggests that influenza infection may cause increased morbidity among women during the second and third trimesters of pregnancy. Pregnant women who have medical conditions that increase their risk for complications from influenza should be vaccinated before the influenza season-regardless of the stage of pregnancy.

Groups potentially capable of nosocomial transmission of influenzatohighriskpersons (e.g., physicians, nurses, and others with extensive contact with high risk patients) are encouraged to see their own physicians and/or organize their own immunization programs.

The trivalent influenza vaccine prepared for the 1998-99 seasonwill includeA/Beijing/262/95-like (HINI), A/ Sydney/ 5/97-like (H3N2), and B/Beijing/184/93-like hemagglutinin antigens. Annual vaccination using the currently recom- mended vaccine is necessary for immunity to the likely infective strains of influenza virus during the 1998-99 season and any remaining supplies from 1997-98 should be dis- carded.

Children 6 months to 8 years of age who have not received influenza vaccine previously should receive two doses of split virus vaccine at least a month apart. If vaccine has been administered previously, one dose is sufficient. The dosage of split virus vaccine for children is 0.25 mL for those 6 to 35 months of age, and 0.5 mL for those children 3 years and older. Only one 0.5 mL dose of whole or split virus vaccine is required for persons greater than 12 years of age.

For information on time and days of the clinics, please contact your local parish health unit.

For any additional information, call the Immunization Program at (504) 483-1900.

Taken from MMWR, Vol 47/No. PR-6, May 1, 1998

CONFIDENTIAL DISEASE CASE REPORT

All reportable diseases and conditions listed on the back page of this report should be reported on an EPI-2430 card, or on other forms as stated. Please forward reports by fax or mail to either the local parish health unit or to the Epidemiology Section. All facsimile transmissions are considered part of the confidential disease case report, and as such, are not subject to disclosure. Detach the following form (EPI-2430) to report disease cases. Xerox additional copies as needed. Your support in disease reporting will enhance surveillance activities.

DISEASE/CONDITION		DATE OF REPORT		DATE OF ONSET	
PATIENT'S NAME		RACE*	ETHNIC**	SEX	DATE OF BIRTH
ADDRESS	STREET NO. (R.F.D. If rural)			ZIP CODE	
	CITY	PARISH			
HEAD OF HOUSEHOLD		PHONE NO.			
DAY CARE CENTER ASSOCIATED: YES _____ NO _____ NAME OF DCC:		DATE		SPECIMEN TYPE	
LAB RESULTS					
COMMENTS:					
PHYSICIAN/HOSPITAL		PHONE NUMBER			

* Wh = White, not of Hispanic origin, Bl = Black, Pac Is/Asi = Pacific islander or Asian, Am Ind/Al Na = American indian or Alaskan Native

** Hisp/Non-Hispanic

EPI-2430

☐ Check here if additional cards are needed

HIV Prevalence Among Persons With Syphilis

To estimate the prevalence of HIV infection in persons at increased risk, OPH conducts an annual blinded seroprevalence survey in a New Orleans STD clinic. Blood samples that are tested for other purposes, such as VDRL, are tested for HIV after identifying information is removed.

Because African-Americans represent 97% of the popu- lation attending this clinic, other ethnic groups were omitted from this analysis. For surveys conducted between 1989- 1997, all prevalence estimates were stratified by the presence of syphilis currently or in the past. Presence of syphilis was defined as any physician diagnosis of syphilis or a reactive VDRL at the time of visit.

Whereas HIV prevalence remained steady among those without syphilis, HIV prevalence increased over recent years among those with syphilis (Figure 1). Overall, cases with a syphilis diagnosis were 3.5 times more likely to be HIV positive than those without syphilis (95%Cl: 2.8-4.4). The HIV prevalence was highest among men who have sex with men (MSM), and injecting drug users (IDU), and increased with age, peaking at 35-39; this trend is most pronounced for those with syphilis (Table 1).

In the 1997 survey, HIV prevalence was particularly high among men with syphilis (I 7.2%). As the syphilis epidemic in Louisiana subsides, the subset of persons being diagnosed with syphilis may increasingly represent a core group of persons who are at very high risk for HIV. Prevention efforts may be enhanced by the prompt treatment of syphilis and other STDS in order to reduce the increased risk of HIV transmis- sion due to the presence of STDS.

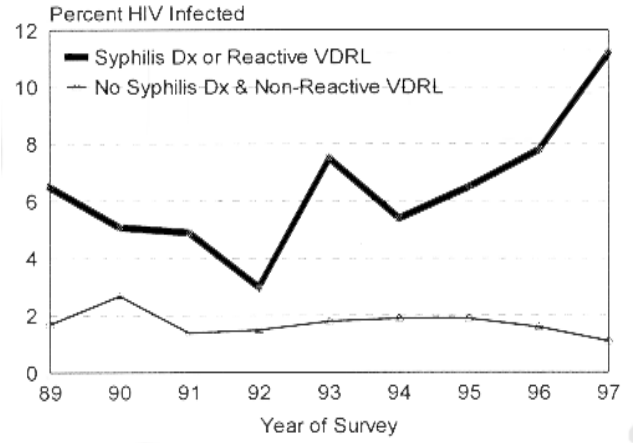
Table 1: Prevalence of HIV infection among STD clinic patients with and without syphilis, by demographic and risk groups, 1989-1997.

	Syphilis Diagnosis or Reactive VDRL Test			No Syphilis Dx and Non-Reactive VDRL		
	Total Tests	No HIV+	% HIV+	Total Tests	No HIV+	% HIV+
Total	1,617	99	6.1	15,133	266	1.8
Gender						
Men	836	79	9.4	10,598	215	2.0
Women	778	20	2.6	4,520	51	1.1
Age Group						
15-19	277	7	2.5	3,589	24	0.7
20-24	368	9	2.4	4,383	54	1.2
25-29	224	14	6.3	2,435	62	2.5
30-34	250	19	7.6	1,869	49	2.6
35-39	203	30	14.8	1,249	36	2.9
40-44	116	11	9.5	738	21	2.8
45+	156	8	5.1	682	16	2.3
Risk Group						
MSM*	36	20	55.6	187	32	17.1
MSM/IDU	5	1	20.0	30	3	10.0
HRH**	1,313	53	4.0	12,458	166	1.3
HRH/IDU	37	6	16.2	138	9	6.5
Other	10	2	20.0	61	2	3.3
Unknown	216	17	7.9	2,259	54	2.4

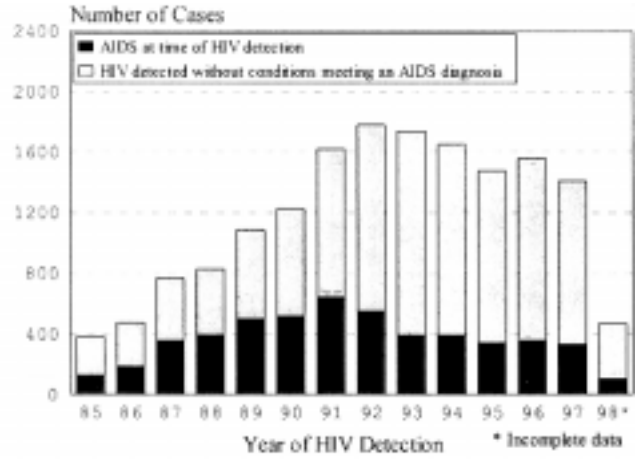
*Men who have sex with men

**High-risk heterosexual

Figure 1. Prevalence of HIV infection among STD clinic patients with and without syphilis, 1989-1997.



HIV/AIDS CASE TRENDS



Comment:

Consistent with the changing HIV/AIDS epidemic, the monitoring of HIV/AIDS data has moved toward the surveil. lance of HIV. In this and future editions of the Louisian, Morbidity Report, the graph on the left will reflect all HIN and AIDS cases by year of HIV detection rather than onl3 persons with full-blown AIDS. These cases are stratified b3 those who did and did not meet AIDS defuiing criteria at tht initial time of HIV detection rather than only persons witt full-blown AIDS. Note that cases that are identified in ont year may have been infected several years earlier.

AIDS case counts will continue to be represented in the Provisional Data provided on the following page.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
May -June, 1998
PROVISIONAL DATA

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

DISEASE	HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD May June 1998	May June 1997	Cum 1998	Cum 1997	% Chg
Vaccine-preventable														
H. influenzae	1	1	0	0	0	0	1	0	0	3	2	17	7	+143
Hepatitis B Cases	7	1	1	1	0	1	1	0	5	17	25	54	79	-32
Rate[1]	0.7	0.2	0.3	0.2	-	0.3	0.2	-	1.3	0.4	0.6	1.3	1.8	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	1	0	0	0	0	0	0	0	1	1	5	11	-55
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	1	0	0	0	1	0	0	1	0	3	4	3	12	-75
Sexually-transmitted														
AIDS Cases	61	27	8	9	8	3	7	5	5	133	154	461	573	-20
Rate[1]	5.6	4.9	2.1	1.8	3.0	0.9	1.4	1.4	1.4	3.1	3.6	10.7	13.3	
Gonorrhea Cases	568	272	107	184	84	73	416	147	82	1933	1786	5588	4364	+28
Rate[1]	54.7	47.9	28.4	35.7	31.3	23.9	82.2	41.9	21.3	45.8	42.3	132.4	103.4	
Syphilis(P&S) Cases	28	6	18	1	1	1	2	2	6	66	62	170	197	-14
Rate[1]	2.7	1.1	4.8	0.2	0.4	0.3	0.4	0.6	1.6	1.6	1.5	4.0	4.7	
Enteric														
Campylobacter	0	2	4	1	0	0	0	0	3	10	38	43	71	-39
Hepatitis A Cases	3	1	1	0	1	0	2	10	0	18	31	47	117	-60
Rate[1]	0.3	0.2	0.3	-	0.4	-	0.4	2.8	-	0.4	0.7	1.1	2.7	
Salmonella Cases	22	16	19	3	8	4	13	9	22	120	70	181	146	+24
Rate[1]	2.1	2.8	5.0	0.6	3.0	1.3	2.6	2.6	5.7	2.8	1.6	4.2	3.4	
Shigella Cases	16	1	0	1	2	0	3	0	2	26	16	98	61	+61
Rate[1]	1.5	0.2	-	0.2	0.7	-	0.6	-	0.5	0.6	0.4	2.3	1.4	
Vibrio cholera	0	0	0	0	0	1	0	0	0	1	0	1	0	-
Vibrio, other	3	0	6	0	0	0	0	0	1	10	3	14	3	+367
Other														
N. Meningitidis	0	1	1	0	2	0	0	0	1	5	10	37	40	-8
Tuberculosis Cases	24	3	3	6	8	2	4	1	4	55	37	170	85	+100
Rate[1]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3.9	2.0	

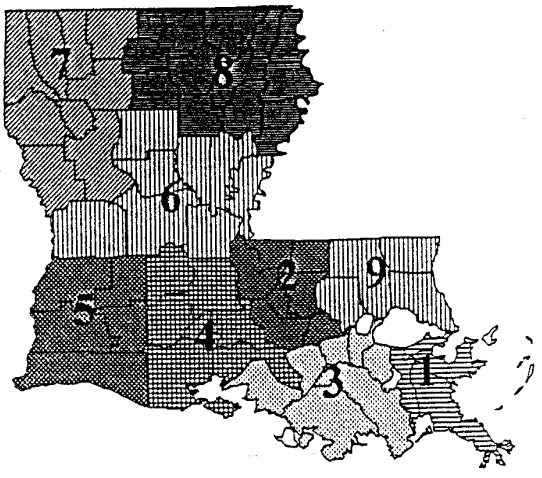
1 = Cases per 100,000

Table 2. *Diseases of Low Frequency*

Disease	Total to Date
Blastomycosis	1
E. coli 0157:H7	3
Histoplasmosis	1
Lead Toxicity	17
Varicella	126
Rocky Mountain Spotted Fever	0
Legionellosis	2
Lyme Disease	0
Malaria	4
Tetanus	1

Table 3. *Animal Rabies (May - June, 1998)*

Parish	No. Cases	Species
Caddo	1	Bat



Annual Summary Campylobacteriosis - 1997

For 1997 one hundred eighty one cases of campylobacteriosis were reported to the Epidemiology Section. The overall state case rate was 4.2 per 100,000.Case reports for 1997 increased by 14% from 1996. Rates have remained fairly constant with the exception of years 1991 and 1992. (Figurel.) A seasonal variation is seen with Campylobacteriosis, with the highest number of cases identified in May (Figure 2). Sex-specific rates were almost identical in males and females (4.3 vs 3.7 per 100,000). Race- specific rates, however, were twice as high for Whites as compared to Blacks (3.2 vs 1. 6 per 100,000 respectively).The largest number of cases were seen in males in the age group of 0-4 years with a peak in adults 25-44 years old (Figure 3). Parishes reporting the highest case rate per 100,000 include La Salle (I 4), Ascension and Terrebonne (I 2) each, and East Baton Rouge (II).

Comment

Campylobacteriosis is an acute bacterial enteric disease characterized by onset of diarrhea, abdominal pain, fever, nausea, and vomiting. The illness usually lasts between 2-5 to 10 days. Sources of human infection are most frequently poultry and cattle. The mode of transmission is by ingestion of the organisms in undercooked chicken or pork, contami- nated food, especially poultry from cutting boards, and water or raw milk. Individuals not treated with antibiotics will usually shed the organism for up to 7 weeks in the stool. An important precaution is to avoid cross-contamination from uncooked foods to cooked foods in the kitchen.

Figure 1: Cases of campylobacteriosis by year, 1988-1997

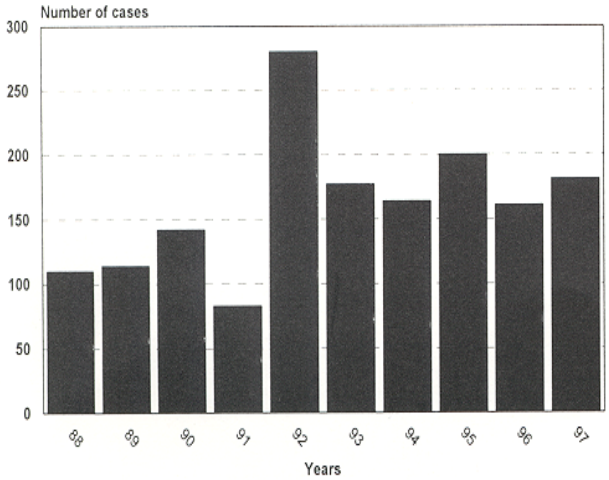


Figure 2: Cases of campylobacteriosis by month of onset, 1997

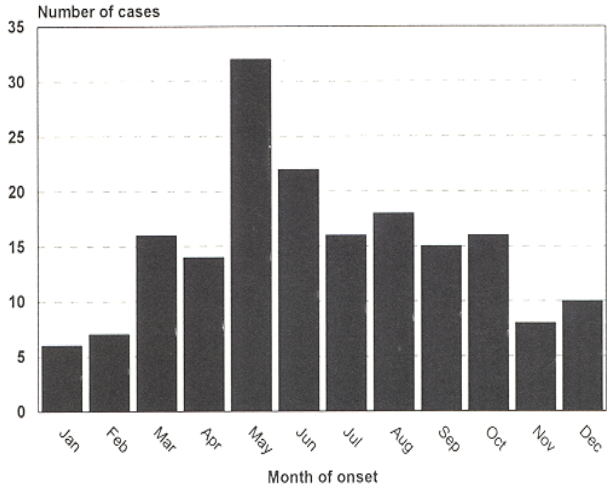
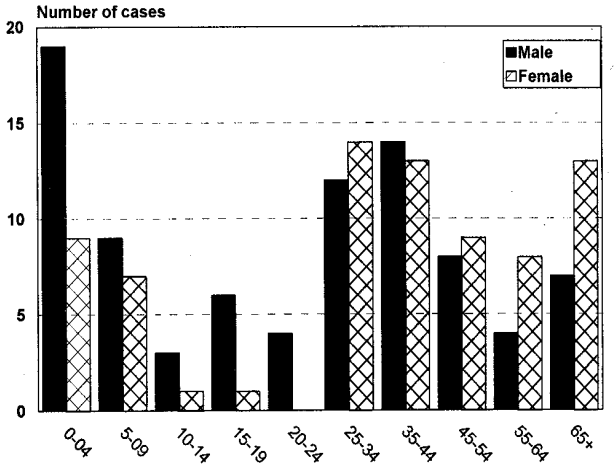


Figure 3: Cases of campylobacteriosis by age group and sex, 1997



Louisiana Fact

Did you know that the New Orleans Medical & Surgical Journal (now the Journal of Louisiana Medical Society) is considered the oldest medical publication in the South?

Taken from the Louisiana Almanac

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' 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 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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