

Louisiana Morbidity Report

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

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Volume 10 Number 1

Child Deaths in Louisiana

In a recent report, the Louisiana Child Death Review Panel found that most unexpected deaths in children in Louisiana in 1996 were due to unintentional injuries, and that most of these could have been prevented. The Panel is a committee which analyzes deaths among children less than 10 years of age and develops recommendations for decreasing those deaths. All unexpected deaths are investigated using death certificates, coroner's reports, autopsy reports and other pertinent reports (medical, police, hospital, fire, etc.), and the resulting data are analyzed by the OPH Injury Research and Prevention Section.

Excluding 73 deaths in infants due to Sudden Infant Death Syndrome (SIDS), there were 143 unexpected deaths among children under age 10 in Louisiana. The majority of these deaths occurred in the younger age groups, with 24% (34/143) under age 1, and 70% (100/143) under age 5 (Figure).

Black children were more than twice as likely as White children to die an unexpected death (Relative Risk 2.1). There was no substantial variation in the number of deaths by month, season, or public health region.

The most common causes of deaths were motor vehicle crashes, fires, suffocation, drowning, and beating (Table).

Among 135 deaths in which it was determined whether or not the death was intentional, 106 (79%) deaths were unintentional, and 29 (22%) were intentional. Among the 21 of the 29 intentional deaths for which the relationship of the perpetrator to the victim was known, 52% (11/21) of the deaths

Figure: Unexpected deaths in children by age, Louisiana 1996

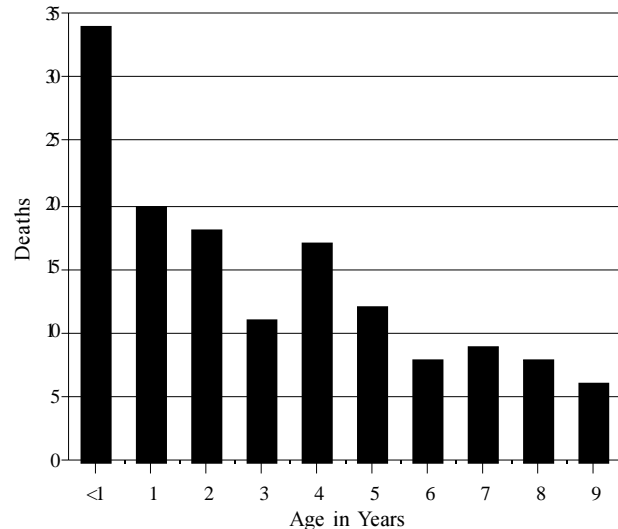


Table: Number and rates of unexpected child death by cause, excluding SIDS, Louisiana 1996

Cause of Death	Number* (%)	Rate**
Motor vehicle crash	51 (36)	8.1
Fire	23 (16)	3.7
Suffocation	21 (15)	3.3
Drowning	20 (14)	3.2
Beating	11 (8)	1.7
Firearms	9 (6)	1.4
Poisoning	3 (2)	0.5

*Number does not sum to 143 because the "other" category is omitted from the table

**Rate is number of deaths per 100,000 population of children age 0-9.

were inflicted by the child's parent, 29% (6/21) were inflicted by the mother's boyfriend, and 14% (3/21) were inflicted by a non-relative.

For each death, the Panel attempted to determine if a caretaker taking reasonable precautions could have prevented (Continue on next page)

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that death. In 23% (33/143) of the deaths the panel did not have adequate information to make this determination. Of the deaths for which adequate information was available, 84% were determined to be preventable through such reasonable precautions. The types of precautions that might have prevented these deaths are adequate supervision of young children and use of safety devices such as car seats, bicycle helmets, and life preservers.

This report demonstrates that prevention of deaths in young children will require more efforts by caretakers to prevent unintentional injuries, especially those related to motor vehicle crashes, fires, suffocation, and drowning.

Continued Risk Behavior in Gay Men

As treatment for HIV infection becomes more successful, an increasing number of persons are living with HIV infection. These persons, if they remain sexually active, could transmit the infection to others. In 1997, there were 4,004 HIV-infected men who have sex with men (MSM) living in Louisiana. Since 1995, the HIV/AIDS Program has conducted surveys with the help of community-based organizations throughout Louisiana among MSM attending gay bars. These self-administered anonymous surveys ask about high-risk sexual risk behavior in MSM and help to monitor HIV-related risk behavior.

Between 1995 and 1998, a total of 3,684 surveys were conducted in all of the nine regions of Louisiana, with most of the surveys having been collected in 1997. Twenty-five percent of the surveys were conducted in New Orleans. While 48% of surveyed MSM were 20 to 29 years old, 7% were between 15 and 19 years and 24% were 40 years and older. Sixty-seven percent of the surveyed MSM were white and 25% were African-American.

The majority (70%) of MSM surveyed reported that they had had more than one sex partner in the previous 12 months. The survey then asked specifically about sexual risk behavior in the previous 30 days. Twenty-nine percent of MSM reported having engaged in unprotected insertive anal sex, and 27% reported having engaged in unprotected receptive anal sex in this time period. Significantly more likely to practice unprotected receptive anal sex were younger MSM, those who used crack or cocaine, MSM who exchanged sex for drugs or money, and MSM surveyed in bars in New Orleans.

Seventy-eight percent of MSM knew their HIV status, and 12% of these reported that they were HIV positive. In the previous 30 days, 25% of HIV-negative MSM had practiced unprotected receptive anal sex; and 24% of HIV-positive MSM had engaged in unprotected insertive anal sex. Fifty-eight percent of MSM knew the HIV status of all their sex partners; of those, 78% of HIV positive respondents had had at least some HIV-negative partners and 17% of HIV negative respondents had knowingly had at least some HIV-posi-

tive sex partners. Among these HIV-discordant couples, 27% of HIV negative MSM had practiced unprotected receptive anal sex; and among HIV positive respondents, 19% had practiced unprotected insertive anal sex in the previous 30 days.

In summary, the surveys found that a surprisingly high percentage of MSM in gay bars throughout the state continue to practice sexual behavior likely to lead to HIV transmission. To prevent AIDS in the future, counseling and other prevention activities need to focus on MSM in gay bars, particularly younger men, those who use crack or cocaine, those who exchange sex for drugs or money, and those attending gay bars in New Orleans (both locals and tourists).

Costs of Smoking in Louisiana

Heart disease and cancer are two of the leading medical causes of death in Louisiana and the United States. About one-quarter of all heart disease deaths and 30% of all cancer deaths are attributed to smoking. In addition, cigarette smoking also causes chronic illnesses, notably cardiovascular and chronic lung diseases, which significantly diminish the quality of life and contribute to substantial time lost from work.

African-American men have the highest percentage of smokers in Louisiana (35.7%), while African-American women have the lowest percent (17.7%). White Louisiana men and women have intermediate rates at 27.6% and 23.9% respectively.

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Estimates of health and economic costs of smoking can be calculated using a computerized model developed by the Centers for Disease Control and Prevention. The Chronic Disease Section used this model and Louisiana data on disease, health care expenditures, and smoking prevalence for 1994 to make estimates for the state.

This analysis estimated that twenty percent (7,951) of all deaths in Louisiana in 1994 were attributable to cigarette smoking. These deaths occurred mainly because of cancer, heart disease, strokes, vascular and respiratory diseases. The table below shows gender specific smoking-attributable deaths and total deaths with selected causes for Louisiana in 1994. Cardiovascular disease and neoplasms accounted for the highest percentage of smoking attributable and total deaths in Louisiana.

Smoking-related illnesses and premature deaths can be reduced if current smokers stop smoking, if smoking is not initiated by children and youths, and if all people are protected from environmental tobacco smoke. Due to the addicting nature of nicotine in cigarettes, public health efforts should include the prevention of tobacco use initiation by children and youth, and promotion of and assistance with cessation. To protect non-smokers, indoor air should be free of all tobacco smoke.

Table: Gender specific smoking-attributable deaths and total deaths by selected causes, Louisiana, 1994.

Diagnosis	Smoking-Attributable		Total Deaths	
	Males	Females	Males	Females
Neoplasms	1909	846	2458	1484
Cardiovascular	2403	1379	7064	7800
Respiratory	798	546	1288	1195
Perinatal	18	12	149	103
Other	21	19	21	19
Total	5149	2802	10980	10601

An Outbreak of Pesticide Poisoning

Cholinesterase inhibitor pesticides (organic phosphates and carbamates) are widely used in agriculture, and can cause illness in humans if they contaminate food or drinking water. Aldicarb, a carbamate pesticide, is used primarily by cotton farmers to control infestation by nematodes, certain insects and mites. Aldicarb is one of the most potent pesticides in the United States. Because of its high toxicity, the U.S. Department of Agriculture requires that applicators be certified. The Epidemiology Section investigated an outbreak of severe aldicarb poisoning in which the pesticide was mistaken

as black pepper because it was stored in a reused container.

On July 19, 1998 twenty employees from a company participated in a lunch meal prepared from homemade food items. Within minutes after eating, several participants developed neurological and gastrointestinal symptoms. Ten ill participants visited a hospital emergency room, including two who were hospitalized.

All lunch participants were interviewed about illness and foods consumed during the meal. Fourteen (70%) participants reported having developed either gastrointestinal or neurological symptoms. Among those who became ill the most common gastrointestinal symptoms were diarrhea (86%), abdominal cramps (93%), and nausea (93%). Neurological symptoms included dizziness (93%), sweating (86%), muscle fasciculations (86%), eye twitching (57%) and blurred vision (43%). The initial illness lasted a median of 4 hours (range, 1-8 hours). The median time period before symptoms developed was 45 minutes (range, 40 minutes – 3 hours) from the beginning of the meal. Of the two people who were hospitalized, one had a heart rate of 20 beats/min by the time he arrived at the hospital. He quickly responded to treatment with atropine.

The cabbage salad was the only food found to be significantly associated with illness. The lunch consisted of pork roast, boiled rice, cabbage salad, biscuits, and soft drinks. Sixteen persons ate the cabbage salad, including all 14 persons who became ill; four people who did not eat the cabbage salad did not develop any symptoms (attack rate = 88%, relative risk = undefined, p-value = 0.003).

The employee who prepared the cabbage salad reported that he had mixed two one-pound bags of pre-cut and pre-packaged cabbage in a bowl with vinegar and ground black pepper. The "black pepper" came from a can labeled as black pepper, that had been found by the salad preparer six weeks before the date of the lunch in the truck of a deceased relative. The "black pepper" in this can had not been used for food preparation before the lunch meal. The cabbage salad was prepared the night before the lunch meal and stored in the refrigerator until it was brought to work the next morning and served at approximately 11:00 a.m.

Qualitative testing for carbamate pesticides by high performance liquid chromatography identified the "black pepper" as aldicarb. Quantitative testing found the granules to contain 13.72% aldicarb by weight and suggested that the granules were TEMIK. The analysis of a six gram subsample of cabbage salad showed 272.6 ppm aldicarb. This concentration was clearly high enough to be toxic to humans. If a 70 kg person had eaten 63 g of cabbage salad (assuming all 16 persons ate equal amounts of the approximately 1000 g of salad prepared), he would have consumed 17 mg aldicarb, or 0.24 mg/kg bodyweight, which is approximately ten times the Lowest Observed Effect Level (LOEL) for subclinical blood cholinesterase depression (0.025 mg/kg bodyweight). Levels of 0.0011 mg/kg bodyweight (well below the LOEL) have been seen to cause symptoms in humans.

(Continue on next page)

The original owner of the pepper can was a crawfish farmer. It was speculated that he used aldicarb on bait to control the destruction of crawfish nets, ponds and levees by wild dogs and raccoons. The source of the TEMIK itself could not be determined despite an extensive trace-back effort by the Louisiana Department of Agriculture and Forestry.

In this outbreak, aldicarb was mistaken for black pepper because it was stored in a black pepper can by a farmer who was not a certified applicator. Aldicarb is a classified Restricted Use Pesticide under the Federal Insecticide, Fungicide and Rodenticide Act (FIFRA), and applicators are required to wear personal protective equipment. Unprofessional users of pesticides should be warned about possible adverse effects of pesticides, particularly aldicarb, to humans; and certified applicators need to be warned about the medical and legal risks involved in the distribution of pesticides to non-certified persons. Any pesticide should be stored exclusively in containers clearly and correctly labeled, and secured by safety caps. The use of highly toxic pesticides such as aldicarb should be more tightly restricted and controlled.

Public Health Satellite Broadcast Training

The following public health satellite broadcast trainings are targeted for physicians, nurses, immunization specialists, laboratory staff, and other health care providers. Please check downlink sites in your area.

- *Tuberculosis Control in Correctional Facilities*, Wednesday, February 24, 12-3 p.m., presented by the Texas Dept. of Health and Dept. of Criminal Justice.
- *Preparing for the Next Influenza Pandemic*, Thursday, February 25, 8-10:30 a.m. and 12-2:30 p.m., presented by the CDC.
- *Vibrio Vulnificus: Not a pearl you want to find*, Friday, February 26, 1-3 p.m., presented by the National Laboratory Training Network and the University of South Florida.
- *Epidemiology and Prevention of Vaccine Preventable Diseases*, March 25, and April 1, 8, 15, 11-2:30 p.m., presented by the National Immunization Program and Public Health Training Network.

For further information call the Infectious Disease Epidemiology Section at 504-568-5005.

Survey on School-Based Health Centers

Currently there are 36 school-based health centers operating throughout Louisiana. These clinics provide services to school-aged children such as immunizations, physical exams, diagnosis and treatment or referral for acute medical problems, prevention counseling and health education. In order to determine the need for and interest in establishing additional centers, in December 1998 the Florida Parishes Social Science Research Center at Southeastern Louisiana University conducted a telephone survey of school principals for the Adolescent and School Health Program.

Two principals from each of the 66 school districts throughout the state were randomly selected. A total of 116 surveys were completed (88% response rate) by principals, of which 31% were from high schools, 41% were from middle schools or junior high schools, and 28% were from schools with both junior high and high school grades. Seventy-eight percent of the schools surveyed were rural.

The following were the key findings from the survey:

- 81% of principals surveyed felt there was moderate to great need for a school-based health center (SBHC) at their schools.
- 64% of principals surveyed were interested or very interested in opening a SBHC.
- 53% of principals surveyed felt there would be school board support for opening a SBHC.
- 82% of principals surveyed felt there would be community support for a SBHC at their school.
- 59% of principals surveyed said they would be likely or very likely to respond to an RFP for a SBHC.
- 39% of principals surveyed felt they would be able or very able to establish a partnership with a qualified medical provider for a SBHC and an additional 28% felt they would be somewhat able to do so.
- Only 23% of principals surveyed, however, felt there would be space available within or near the school for a SBHC.
- Only 21% of principals surveyed said they would be able or somewhat able to secure matching dollars for a SBHC.

When asked what are the major barriers to establishment of a SBHC, the top responses were funding, locating adequate physical space in the school, and finding qualified medical personnel to staff the clinics. Many principals, however, felt there would be no barriers to implementation.

HIV/AIDS UPDATE

AIDS Related Mortality

In Louisiana, AIDS-related mortality declined for the first time in 1996 (Figure), coinciding with the emergence of more effective treatments, and the decline is continuing. In 1997 only 9% of persons with AIDS died during the year, which was less than half of the 20% mortality rate for persons with AIDS in 1995. In 1996, AIDS dropped from the first to the second leading cause of death among 25-44 year old men in Louisiana. However, the death rate continued to increase among 25-44 year old women.

As treatments slow the progression from HIV to AIDS and from AIDS to death for people infected with HIV, AIDS cases and deaths no longer provide as much information about the occurrence of new HIV infections. These data, however, do continue to provide some measure of the continuing impact of treatment.

From 1996 to 1997, Louisiana AIDS deaths dropped 37% (Table). Although this decline in the number of AIDS-related deaths reflects a decrease in the number of new AIDS cases, it also reflects the degree to which AIDS patients access treatment and the corresponding levels of treatment efficacy.

Treatment of HIV infection and prevention of HIV infection are related in a complex way. While treatment of HIV infection may decrease the infectivity of HIV-infected persons, this effective treatment will lead to more HIV-infected persons living longer. It is therefore increasingly important that physicians, nurses, and counselors working with HIV-infected persons stress the importance of their practicing abstinence or safe sex to avoid infecting others.

Figure: Louisiana AIDS-related mortality, 1988-1997

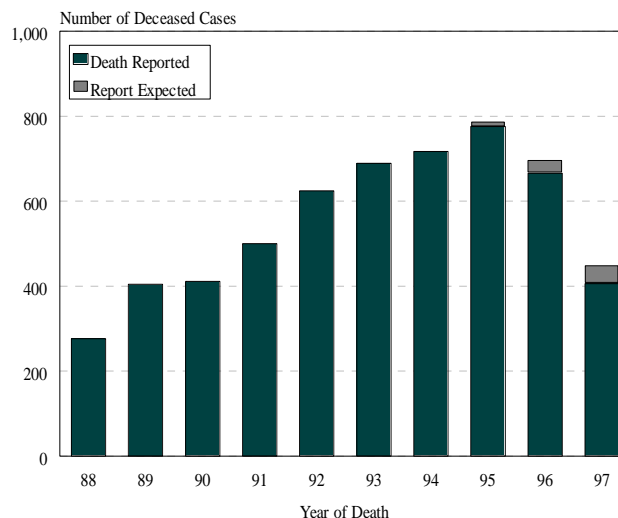
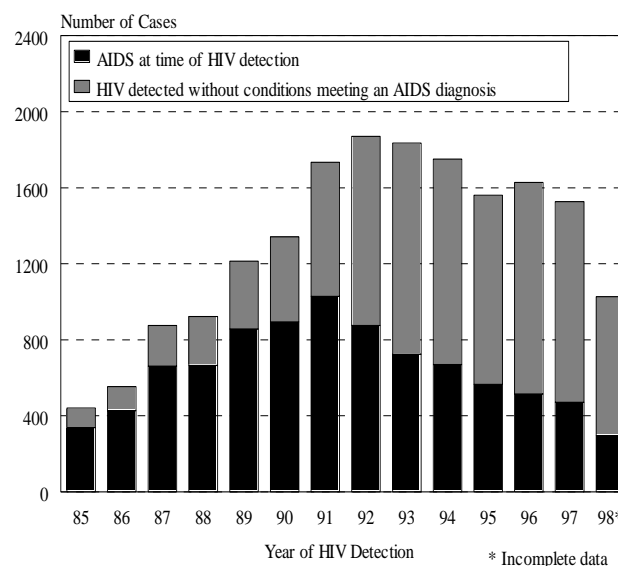


Table: Louisiana AIDS cases and deaths from 1996-1997, by gender and ethnicity

	AIDS Cases			AIDS Deaths		
	1996	1997	Percent Decrease	1996	1997	Percent Decrease
Total	1,156	952	18%	726	461	37%
GENDER						
Men	911	748	18%	597	377	37%
Women	245	204	17%	129	84	35%
ETHNICITY						
African-American	732	654	11%	419	326	22%
White	401	271	32%	288	129	55%

HIV/AIDS Case Trends



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
November - December 1998
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	Nov.-Dec. 1998	Nov.-Dec. 1997	Jan.-Dec. Cum 1998	Jan.-Dec. Cum 1997	% Chg
	Vaccine-preventable													
<i>H. influenzae (type B)</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	9	5	3	2	0	0	3	3	4	29	15	192	170	+13
Rate ¹	0.9	0.9	0.8	0.4	-	-	0.6	0.9	1	0.7	0.3	4.4	3.9	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	0	0	0	0	0	0	2	8	17	-53.0
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	0	0	0	0	0	0	0	0	0	0	1	11	21	-48
Sexually-transmitted														
HIV/AIDS Cases ²	70	27	2	17	5	3	5	3	2	134	217	1292	1526	-15.3
Rate ¹	6.5	4.9	0.5	3.4	1.9	0.9	1	0.9	0.6	3.1	5	30	35.4	
Gonorrhea Cases	500	280	124	276	109	78	425	177	101	2070	2222	12489	10761	+16.1
Rate ¹	48.1	49.3	32.9	53.5	40.7	25.6	84	50.4	26.2	49.1	52.7	295.9	255.0	
Syphilis (P&S) Cases	23	3	13	6	3	0	4	3	6	61	58	430	363	+18.5
Rate ¹	2.2	0.5	3.4	1.2	1.1	-	0.8	0.9	1.6	1.4	1.4	10.2	8.6	
Enteric														
Campylobacter	4	2	4	2	0	1	0	0	4	17	8	126	166	-24
Hepatitis A Cases	7	0	1	26	2	4	1	3	3	47	33	160	258	-38
Rate ¹	0.7	-	0.3	5	0.7	1.3	0.2	0.9	0.8	1.1	0.8	3.7	6	
Salmonella Cases	16	14	3	21	4	4	4	7	12	85	116	687	626	+9.7
Rate ¹	1.5	2.5	0.8	4.1	1.5	1.3	0.8	2	3.1	2	2.7	16.0	15	
Shigella Cases	13	5	0	10	0	0	3	6	1	38	35	327	168	+95
Rate ¹	1.3	0.9	-	1.9	-	-	0.6	1.7	0.3	0.9	0.8	7.6	3.9	
Vibrio cholera	0	1	0	0	0	0	0	0	0	1	0	3	0	-
Vibrio, other	3	0	4	2	0	0	0	1	1	11	3	54	35	+54
Other														
<i>H. influenzae</i> (other)	1	3	0	0	0	0	0	0	0	4	2	28	16	+75
N. Meningitidis	6	1	1	1	0	0	2	0	0	11	0	70	49	+42.9
Tuberculosis	30	18	5	4	0	1	10	14	0	82	176	379 ³	406	-6.6

1 = Cases Per 100,000

2 = These totals reflect cumulative totals of HIV+ and AIDS cases.

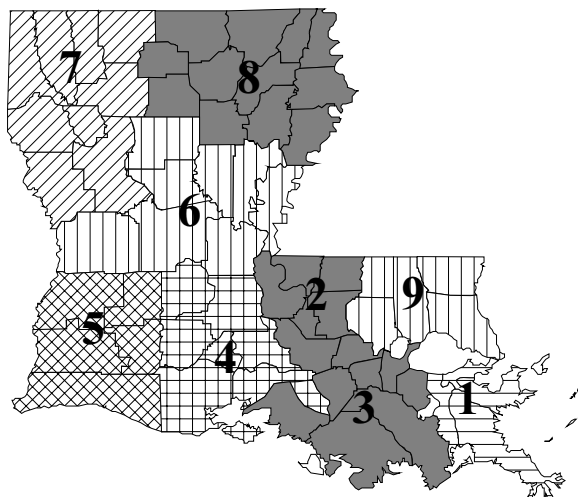
Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	1
E. coli O157:H7	0
Histoplasmosis	0
Lead Toxicity	9
Varicella	8
Rocky Mountain Spotted Fever	0
Legionellosis	0
Lyme Disease	3
Malaria	0
Tetanus	0

Table 3. Animal Rabies (¶ (November - December, 1998)

Parish	No. Cases	Species
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No rabies reports for this quarter.



Annual Summary

Vibrio Infections - 1997

Thirty-six cases of vibrio infections were reported in 1997, a 14% decrease from 1996 (Figure 1). The overall case rate was 0.8 per 100,000. Sex specific rates were nearly twice as high for males than females, 1.1 vs 0.6 per 100,000, respectively. Unlike previous years, black females had a rate similar to white males (1.0 vs 1.1 per 100,000). Age specific rates were reportedly highest in the age group 75 years and older (Figure 2). The most frequently reported vibrio serotypes were *V. parahaemolyticus* (25%), *V. vulnificus* (22%), and *V. mimicus* (22%; Table 1). Vibrio cases occurred most frequently between the months of May and September (Figure 3). Of the reported Vibrio cases with known exposures (including multiple exposures), 21 (60%) cases were associated with seafood consumption, while 18 (51%) cases had contact with saltwater or seafood drippings. Of patients with reported risk factors, 20 cases had pre-existing conditions; most frequently reported conditions were diabetes, alcoholism, liver disease, and heart conditions. Eight (22%) cases were associated with infections due to *V. vulnificus*. Three cases developed septicemia and five cases were identified as wound infections. One case was fatal as a result of a wound infection. Two *V. vulnificus* cases had reported raw oyster consumption and both survived. All *V. vulnificus* cases had underlying conditions. Parishes reporting the largest number of cases include: Orleans (11), Jefferson (7), Terrebonne (5), and Calcasieu (3). No cases of *V. cholera* - 01 were reported this year. No outbreaks or unusual clusters of Vibrio infections were reported.

Figure 1: Cases of vibrio infection by year, 1988-1997

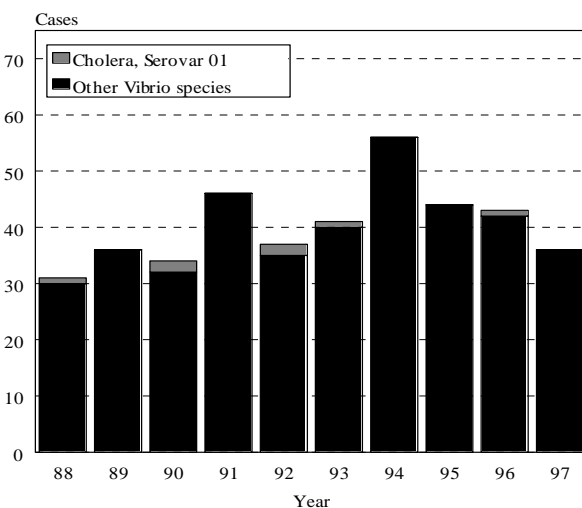


Figure 2: Cases of vibrio infection by sex and age groups, 1997

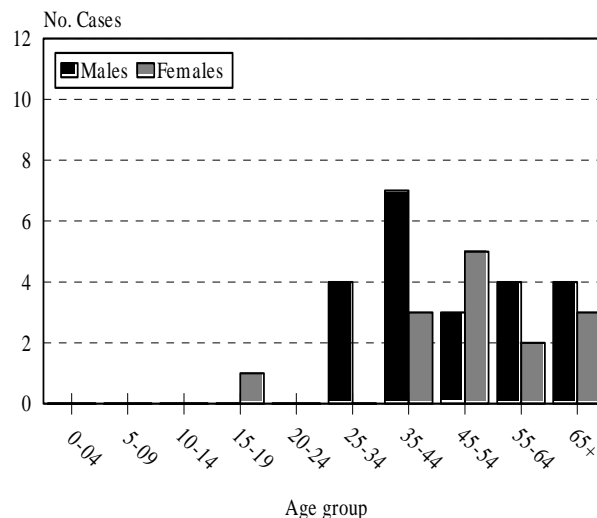


Figure 3: Cases of vibrio infection by month of onset, 1997

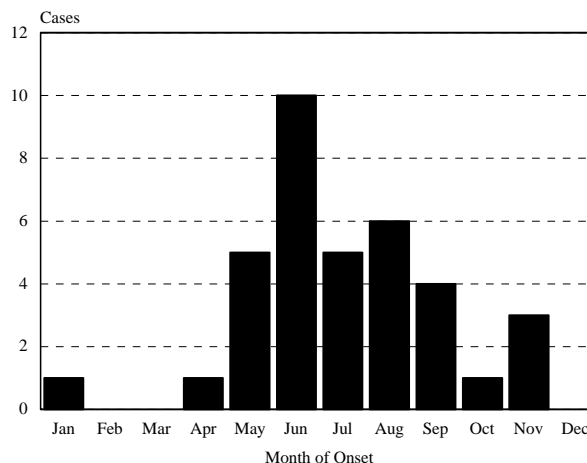


Table: Vibrio species by year, 1995-1997

Species	1995	1996	1997
<i>parahaemolyticus</i>	14	7	9
<i>vulnificus</i>	17	13	8
<i>mimicus</i>	1	5	8
<i>fluvialis</i>	2	1	5
<i>cholera, Non-01</i>	7	11	5
<i>alginolyticus</i>	4	1	1
<i>hollisae</i>	1	2	1

TOTAL 49* 42 37*

* Several cases with multiple serotypes.

Louisiana Fact

Did you know that the oldest Health Maintenance Organization in the nation was started in Baton Rouge in 1924 by Standard Oil (now Exxon)?
(Louisiana Almanac)

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	Severe traumatic head injury**
Botulism ¹	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Galactosemia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Hemophilia*
Chancroid ²	Lymphogranuloma venereum ²	Syphilis ²	Lead Poisoning
Chlamydial infection ²	Malaria	Tetanus	Phenylketonuria*
Cholera ¹	Measles (rubeola) ¹	Tuberculosis ⁴	Reye's Syndrome
Cryptosporidiosis	Meningitis, other bacterial or fungal	Typhoid fever	Severe under nutrition (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)		

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, phone reports, or electronic transmission.

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.

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

** Report on DDP-3 form; preliminary phone report from ER encouraged (504-568-2509). Information contained in reports required under this section shall remain confidential in accordance with the law.

Numbers for reporting communicable diseases

1-800-256-2748

Local # 568-5005

FAX # 504-568-5006

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