Louisiana Morbidity Report

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

July-August 1999 **Volume 10 Number 4**

Eastern Equine Encephalitis

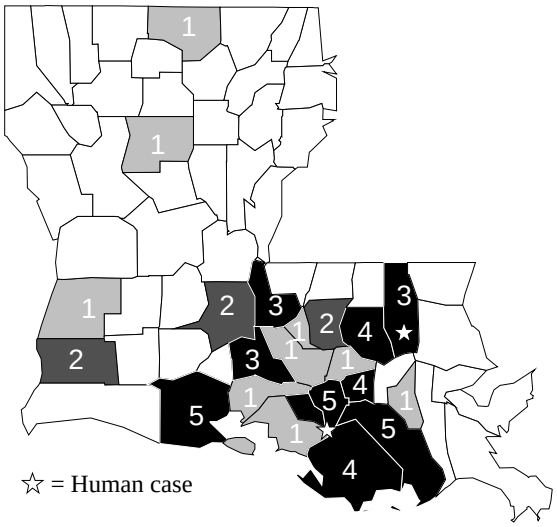
Since May, Louisiana has been experiencing an outbreak of Eastern Equine Encephalitis (EEE). As of the end of July 1999, confirmed EEE cases in 51 horses, 200+ emus, and two humans have been reported by the Office of Public Health.

In addition to the 51 horses with confirmed infection, numerous other horses have reportedly died with encephalitis-like illnesses that could not be confirmed because blood tests were not done. In June, deaths were reported from Vermilion Parish involving more than 200 emus (ostrich-like birds raised commercially), who are unusually susceptible to EEE virus. The two human EEE cases occurred in a 47 year old male from the Assumption - St. Mary Parish area and a 44 year old female from Tangipahoa Parish.

Horses with EEE were first recognized in early May and have continued to be reported through late July. Cases in horses have been reported from 21 parishes to date. Initial cases were reported from Southeast Louisiana - St. Mary, St. James, Assumption, Lafourche, Terrebonne, St. Charles, and Ascension parishes. More recent cases have been reported from Tangipahoa, Livingston, Point Coupee, West Baton Rouge, East Baton Rouge, Iberville, St. Landry, Calcasieu, Beauregard, Vermilion, Iberia, and St. Martin Parishes. Notably, two confirmed cases were reported from Winn and Union Parishes, which are in the northern part of the state (Figure).

Soon after the first horse was diagnosed, the parish governments and the public in affected areas were notified about the need to protect persons from mosquitoes that might carry the virus. It was recommended that parish governments spray to control mosquitoes in swampy areas, and people were cautioned to stay indoors around dusk and dawn and to wear long-sleeved shirts and long pants and use mosquito repellant when outdoors. At the same time, infection control practitioners were notified to alert medical staff regarding patients who may present with symptoms of viral encephalitis.

Figure: Cases of Eastern Equine Encephalitis in horses, Louisiana, May-July, 1999



The EEE virus is an arbovirus that lives naturally in wild birds in freshwater swamp areas of the Atlantic and Gulf coast areas of the U.S. It is transmitted between birds by mosquitoes and is incidentally transmitted by mosquitoes to horses or humans. The virus requires birds, who usually show no symptoms of infection, to replicate; infected horses and humans cannot transmit the infection to others either directly or via mosquitoes.

EEE is the most severe mosquito-borne viral encephalitis. Only a minority of infected persons will develop clinical disease, but among those who do, illness rapidly progresses to coma and death in one-third of patients. The onset may be abrupt, particularly in children, with fever

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Eastern Equine Encephalitis (Cont.)

and headache followed by lethargy, seizures, and coma. Residual neurological damage in surviving patients is frequent and ranges from mild unilateral spasticity to severe mental retardation and quadriplegia. While horses can be vaccinated against EEE, no specific vaccine or treatment is available for humans.

Infection with EEE is best prevented by reductions in mosquito populations through chemical spraying of areas where transmission is occurring and elimination of mosquito breeding sites (such as stagnant water containers) near residences. Recommendations that individuals try to avoid contact with mosquitoes also may reduce the risk of infection. Most mosquitoes which are involved in EEE transmission feed in the evening, so greater precautions should be taken at that time of the day. EEE outbreaks tend to occur in late summer or early fall. However, this outbreak has started earlier than usual. It is unknown and unpredictable as to when this outbreak will subside.

Rotavirus and Intussusception

CDC recommends that healthcare providers and parents postpone use of the rotavirus vaccine for infants, at least until November 1999, based on early surveillance reports of intussusception (a type of bowel obstruction that occurs when the bowel folds in on itself) among some infants who received rotavirus vaccine. Although intussusceptions occur among infants who have not received rotavirus vaccine, CDC in collaboration with state and local health departments throughout the United States will be collecting additional data in the next several months that may indicate more clearly whether the rotavirus vaccine increases the risk of intussusception. The recommendation is being made with the consideration that rotavirus season is still 4-6 months away in most parts of the United States.

An estimated 1.5 million doses of rotavirus vaccine have been administered to infants since it was licensed on August 31, 1998. As of July 7, 1999, the Vaccine Adverse Event Reporting System (VAERS) has received 15 reports of intussusception. The rate of intussusception among children receiving the rotavirus vaccine appears to be increased in the first 2 - 3 weeks after vaccination. Parents and caretakers of infants should contact their health care provider if the child develops symptoms of intussusception (persistent vomiting, bloody stools, black stools, abdominal bloating or severe colic pain). Health care providers should be aware of the possible increased risk and consider this diagnosis among children presenting these symptoms. Parents and health care providers should report intussusception and other adverse events following vaccination to VAERS. VAERS reporting forms and information can be requested 24 hours a day by calling (800)822-7967 or accessing the World Wide Web at: http://www.cdc.gov/nip/vaers.htm.

Rotavirus is the most common cause of severe diarrhea in children in the United States. Virtually all children have one or more rotavirus infections in the first 5 years of life. Each year in the United States, rotavirus is responsible for approximately 500,000 physician visits and 50,000 hospitalizations. Severe diarrhea and dehydration occur primarily among children 3 months to 35 months of age. It is a seasonal disease in the United States with the vast majority of the disease occurring in the winter and spring months.
Source: Centers for Disease Control and Preventions, National Immunization Program

Seat Belt Use in Louisiana

Unintentional injuries are the fifth leading cause of death in the United States, accounting for more than 90,000 deaths in 1997. Motor vehicle injuries remain the most costly and fatal of unintentional injuries, and many of them are preventable. The National Highway Traffic Safety Administration estimates that if all occupants in passenger vehicles had used their safety belts, nearly one-half of the 41,000 motor vehicle deaths in 1996 could have been prevented. According to the Louisiana Highway Safety Commission, lack of seat belt use was a factor in 55% of the non pedestrian traffic fatalities that occurred on Louisiana's roadways in 1996.

The US Public Health Service has set a goal that 85% of persons use safety belts or child safety seats by the year 2000. To measure how close Louisiana is to that goal, the frequency of safety belt usage has been measured in Louisiana using the Behavioral Risk Factor Surveillance System

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The Louisiana Morbidity Report is published bimonthly by the Infectious Disease Epidemiology Section of the Louisiana Office of Public Health to inform physicians, nurses, and public health professionals about disease trends and patterns in Louisiana. Address correspondence to Louisiana Morbidity Report, Infectious Disease Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.

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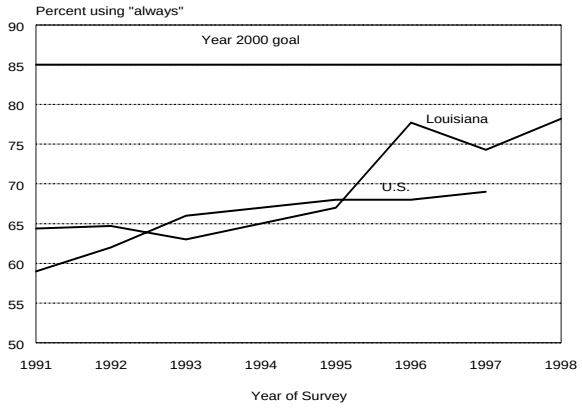
(BRFSS). The BRFSS is an annual, statewide, random digit telephone survey of the Louisiana adult population administered through the Chronic Disease Control program. Seat belt use data is available every year from 1991 to 1998 except for 1994.

From 1991 to 1995, approximately 65% of persons in Louisiana used seat belts "always". However, in 1996 seat belt use increased to approximately 78% (Figure 1). Before 1996, citizens could be cited for non-use of a seat belt only if they were stopped for another offense. The increase in seat belt use in 1996 may be related to a revision in the law in 1995 which allowed police to stop and cite a citizen for lack of seat belt use alone.

While the revision of the law appears to have affected self reported seat belt usage for both men and women, a considerable and consistent gender gap exists for seat belt usage (Figure 2). Across all years, females reported always using seat belts more frequently than males (71% vs. 55%), and in 1996, females reached the target of 85% seat belt use.

Figure 1: **Trends in seat belt use, Louisiana vs U.S., 1991-1998**



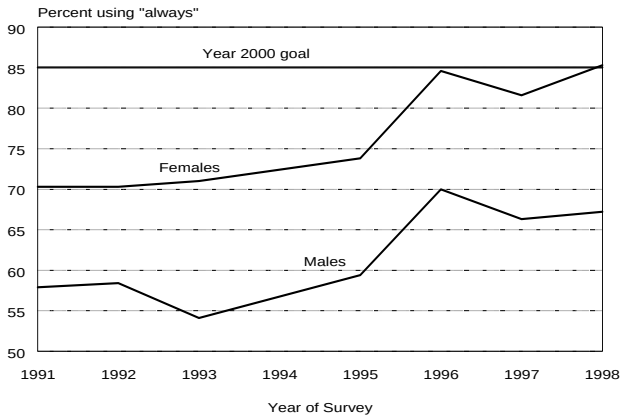
OPH-BRFSS;Data not avaiable for 1994

During the time period 1991-1998, the 18-24 year age group had the lowest rate of always wearing seat belts (50% - 66%), and the 65 year and older group had the highest rate of seat belt use (72% - 87%), but both groups increased their use after the new law took effect. In 1996, both 25-44 and 45-64 age groups were well above the national seat belt rate.

The revision of the law appears to have addressed the racial disparity in seat belt usage (Figure 3). From 1991-1995, whites consistently reported higher seat belt usage than nonwhites. After the revision of the law, nonwhites and whites reported similar seat belt usage rates.

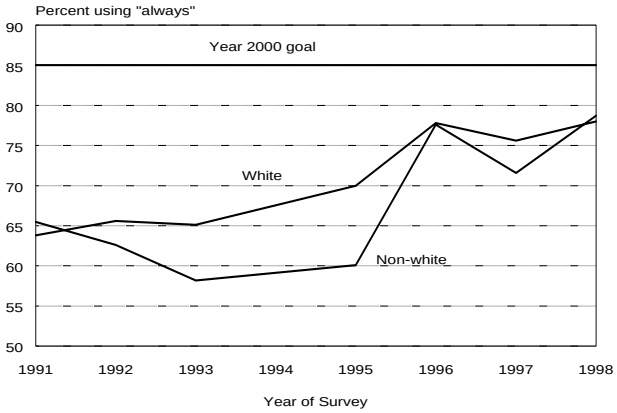
It appears that the law enabling enforcement of seat belt use has had a positive effect on seat belt use. Health care providers are encouraged to promote seat belt use as part of their routine preventive counseling.

Figure 2: **Trends in seat belt use by gender, Louisiana, 1991-1998**



OPH-BRFSS; Data not available for 1994

Figure 3: **Trends in seat belt use by race, Louisiana, 1991-1998**



OPH-BRFSS; Data not available for 1994

STD Treatment Guidelines Available

The prevalence of sexually transmitted disease in Louisiana remains high. Even though syphilis rates are declining in the majority of parishes, gonorrhea and chlamydia rates are increasing. To assist health care providers in accurate treatment of STDs, the STD Program has developed a one page summary of current recommended guidelines (see pages 4-5). This laminated front/back copy provides a quick overview of the recommended medications, dosage/route, and alternative treatment for 14 of the most common STDs. Free copies can be obtained from the STD Program at 504-568-5275 or 504-568-5085

1998 SEXUALLY TRANSMITTED DISEASES TREATMENT GUIDELINES

These STD Treatment Guidelines are a summary of the recommendations of the Louisiana Office of Public Health - STD Control Program and the 1998 CDC STD Treatment Guidelines. They are intended as a brief source of clinical guidance for treatment of STDs encountered in office practice and not a comprehensive list of all effective regimens. For the complete CDC guidelines, confidential partner notification of STDs /HIV, information and advise on STDs, or reporting of STDs, (all cases of syphilis, gonorrhea, chlamydia, chancroid and HIV infection should be reported to Office of Public Health) please call the STD Program in New Orleans at (504) 568-5275.

	DISEASE	RECOMMENDED RX	DOSE/ROUTE	ALTERNATIVES
Urethral - Cervical	**GONOCOCCAL INFECTIONS**			
	Urogenital, rectal, pharyngeal - *Adults/adolescents:*	Cefixime[2] (Suprax) OR Ceftriaxone (Rocephin) OR Ciprofloxacin[1] OR Ofloxacin[1] OR	400mg PO STAT 125mg PO STAT 500mg PO STAT 400mg PO STAT	Spectinomycin[2] 2g IM STAT Azithromycin 2 gm PO STAT
	- *Children /< 45kg!*	Ceftriaxone (Rocephin)	125mg IM STAT	Spectinomycin[2] 40mg/kg IM STAT (maximum 2g)
	- *Neonates born to infected mothers*	Ceftriaxone (Rocephin)	25-50 mg/kg IV or IM in single dose	
	Conjunctival - *Adults/Adolescents*	Ceftriaxone (Rocephin)	1g IM STAT AND irrigate eye with saline solution once.	
	- *Neonates*	Ceftriazone (Rocephin)	25-50 mg/kg IV or IM in single dose (maximum 125 mg).	
	CHLAMYDIAL INFECTIONS			
	Conjunctival, urethral, cervical, and rectal - *Adults/Adolescents*	Azithromycin (Zithromax) OR Doxycycline[4]	1g PO STAT 100mg PO BID x 7 days	Erythromycin base[5,6] 500mg PO QID x 7 days. OR Erythromycin ethylsuccinate[5] 800 mg PO QID x 7 days. OR Ofloxacin[1] 300 mg PO BID x 7 days
	- *Children /< 45kg! and neonates*	Erythromycin base[5]	50mg/kg/day (4 divided doses) x 10-14 days.	
	NONGONOCOCCAL URETHRITIS	Per CHLAMYDIAL INFECTIONS		
	EPIDIDYMITIS	Ceftriaxone (Rocephin) AND Doxycycline[4]	250mg IM STAT 100mg PO BID x10 days	Ofloxacin[1] 300mg PO BID x 10 days
	PELVIC INFLAMMATORY DISEASE Outpatient management	Ceftriaxone (Rocephin) AND Doxycycline[4] OR Cefoxitin AND Probenecid AND Doxycycline[4] OR Ofloxacin[1] AND Metronidazole (Flagyl)	250mg IM STAT 100mg PO BID x 14 days 2mg IM 1g PO STAT 100mg PO BID x 14 days 400mg PO BID x 14 days 500mg PO BID x 14 days	
Ulcerative Diseases	**SYPHILIS**			
	Early Syphilis - Primary, Secondary, or Latent ≤ 1year	Benzathine penicillin G (Bicillin)	2.4 million units IM STAT	Doxycyline[4,7] 100mg BID x 14 days
	Late Syphilis - Latent ≥ 1year, or unknown duration, or Tertiary (cardiovascular, gumma)	Benzathine penicillin G	2.4 million units IM x 3 doses at 1 wk intervals. (Total of 7.2 million units)	Doxycyline[4,7] 100mg BID x 28 days
	Neurosyphilis	Aqueous crystalline penicillin G	3 - 4 million units IV q 4hrs x 10-14 days. (18-24 million units per day)	Procaine penicillin G 2.4 million units IM x 10-14 days AND Probenecid 500mg PO QID x 10-14 days
	Congenital Syphilis - *Neonates*	Aqueous crystalline penicillin G OR Procaine penicillin G	100,000-150,000 units/kg/day (50,000 units/kg dose IV every 12 hrs during the first 7 days of life and every 8 hrs thereafter for a total of 10 days) 50,000 units/kg IM daily x 10 days	
	Early Syphilis - Primary, secondary or latent ≤ 1 year - *Children*	Benzathine penicillin G	50,000 units/kg IM STAT (Maximum 2.4 million units)	
	Late Syphilis - Latent ≥ 1 year, or unknown duration - *Children*	Benzathine penicillin G	50,000 units/kg IM x 3 doses at 1 wk intervals (Maximum total 7.2 million units)	
	CHANCROID	Azithromycin (Zithromax) OR Ceftriaxone (Rocephin) OR Ciprofloxacin[1]	1g PO STAT 250mg IM STAT 500mg PO BID x 3 days	Erythromycin 500 mg PO QID x 7 days

	DISEASE	RECOMMENDED RX	DOSE/ROUTE	ALTERNATIVES
Ulcerative Diseases	**GENITAL HERPES SIMPLEX** (HSV)			
	First clinical episode of genital, anal, or oral HSV	Acyclovir[8] (Zovirax) OR Famciclovir[8] (Famvir) OR Valacyclovir[8] (Valtrex)	400mg PO TID x 7-10 days OR 200mg PO 5x/day for x 7-10 days 250 mg PO TID x 7-10 days 1g PO BID x 7-10days	
	Episodic recurrent infection	Acyclovir[8] OR Famciclovir[8] OR Valcyclovir[9]	400mg PO TID x 5 days OR 200mg PO 5x/day for5 days OR 800mg PO BID x 5 days 125mg PO BID x 5 days 500mg PO BID x 5 days	
	Suppressive Therapy[5]	Acyclovir[8] OR Famciclovir[8] OR Valcyclovir[9]	400mg PO BID 250mg PO BID 1000mg PO QD	Valcyclovir[8] 500mg PO BID
Miscellaneous	**HUMAN PAPILLOMA VIRUS** (HPV) External genital and perianal warts	Podophyllin resin[10] 10%-25% OR Trichloracetic Acid (TCA) OR Bichloracetic Acid 80%-90% OR Podofilox[10] 0.5% solution/gel (Condylox) OR Imiquimod[10] 5% cream (Aldara) OR Liquid nitrogen or cryoprobe	Apply small amount, dry. Wash off in 1- 4 hours. Repeat weekly PRN. Provider applied therapy. Apply BID x 3 days, rest x 4 days. Four cycles maximum. Patient applied therapy. Apply 3x weekly at h.s. Wash off in 6-10 hours. 16 week maximum. Patient applied therapy. Repeat application PRN q 1-2 weeks	Intralesional Interferon Laser surgery
	PEDICULOSIS PUBIS	Permethrin 1% creme rinse OR Lindane[11,12] 1% shampoo OR Pyrethrins with Piperonyl Butoxide	Apply to area, wash off after 10 min. Apply to area, wash off after 4 min. Apply to area, wash off after 10 min.	
	SCABIES	Permethrin 5% cream (Elimite)	Apply to all areas of body from neck down, wash off after 8-14 hours	Lindane 1%[11,12] 1 oz. of lotion or 30g of cream,. Apply thinly to body from the neck down; wash off after 8 hours.
Vaginitis	**TRICHOMONIASIS**	Metronidazole (Flagyl)	2g PO STAT	Metronidazole 500 mg BID x 7 days
	BACTERIAL VAGINOSIS	Metrondazole (Flagyl) OR Clindamycin cream[13] 20% OR Metronidazole gel 0.75% OR	500mg PO BID x 7 days One 5g applicator intravaginal q hs x 7 One 5g applicator intravaginal BID x 5	Metronidazole[14] 250mg TID x 7days Metronidazole 2g PO STAT Clindamycin 300mg PO BID x 7 days
	CANDIDIASIS	**RECOMMENDED RX**	**DOSE/ROUTE**	
		Fluconazole[10] (Diflucan) OR Butoconazole[15] OR Clotrimazole[15] OR Miconazole[15] (Monistat) OR Nystatin[15] OR Terconazole[15] (Terazol) OR Tioconazole[15]	150 mg PO STAT 2% cream 5g intravaginal x 3 days 1% cream 5g intravaginal x 7-14 days OR 100mg vaginal tablet x 7 days OR 100mg vaginal tablet, 2 tablets x 3 days OR 500mg vaginal tablet STAT 2% cream 5g intravaginal x 7 days OR 200mg vaginal suppository - one x 3 days OR 100mg vaginal suppository, one suppository x 7 days 100,000-unit vaginal tablet, 1 tablet x 14 days 0.4% cream 5g intravaginal x 7 days OR 0.8% 5g cream intravaginal x 3 days OR 80mg vaginal suppository, one suppository x 3 days 6.5% ointment 5g intravaginal in a single application.	

1. Quinolones are contraindicated for pregnant or lactating women and children < 18 years of age. Quinolones should be used with caution in areas of emerging resistance of gonorrhea to quinolones.
2. Ceftibme and Spectinomycin may not be effective against pharyngeal gonococcal infection.
3. Use Rocephine with caution in hyperbilirubinemic neonates especially those born prematurely.
4. Doxycylines are contraindicated for pregnant or lactating women and children < 8 years of age.
5. Effectiveness of erythromycin treatment is approximately 80%. A second course of therapy may be required.
6. Erythromycin estolate is contraindicated in pregnancy.
7. Pregnant women with syphilis who are allergic to penicillin must be treated with penicillin after desensitization.
8. Safety during pregnancy has not been established. National registries have not indicted increased risk of birth defects.
9. Discontinue daily treatment after one year to assess frequency of recurrence.
10. Contraindicated in pregnancy.
11. Contraindicated for pregnant or lactating women or children < 2 years of age.
12. Lindane should not be used immediately after a bath and should not be used by persons who have extensive dermatitis.
13. Clindamycin intravaginal cream is not recommended in pregnancy.
14. CDC recommended treatment of BV in pregnancy
15. These creams and suppositories are oil-based and may weaken latex condoms and diaphragms.

CASES OF SYPHILIS, GONORRHEA, CHLAMYDIA, CHANCROID AND HIV SHOULD BE REPORTED TO OFFICE OF PUBLIC HEALTH

LOUISIANA
Department of HEALTH and HOSPITALS

LOUISIANA
OFFICE OF PUBLIC HEALTH
STD PROGRAM
(504) 568-5275

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
May - June 1999
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 1999	May-June 1998	Jan.-June Cum 1999	Jan.-June Cum 1998	% Chg
Vaccine-preventable														
H. influenzae (type B)	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	13	6	2	0	1	2	2	1	3	31	17	84	54	+55.6
Rate[1]	1.3	1.1	0.5	-	0.4	0.7	0.4	0.3	0.8	0.7	0.4	2.0	1.3	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	0	0	0	0	1	1	1	3	5	-40.0
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	3	3	3	-
Sexually-transmitted														
HIV/AIDS Cases[2]	71	35	8	12	2	14	14	16	7	179	249	638	730	-12.6
Rate[1]	6.5	6.4	2.1	2.4	0.8	4.4	2.7	4.6	2.0	4.2	5.8	14.8	16.9	
Gonorrhea Cases	565	272	134	224	80	50	403	171	113	2012	1923	6169	5569	+10.8
Rate[1]	54.4	47.9	35.5	43.4	29.9	16.4	79.6	48.7	29.4	47.7	45.6	146.2	132.0	
Syphilis (P&S) Cases	13	8	5	13	5	0	1	0	3	48	65	128	169	-24.3
Rate[1]	1.3	1.4	1.3	2.5	1.9	-	0.2	-	0.8	1.1	1.5	3.0	4.0	
Enteric														
Campylobacter	5	8	3	0	0	0	3	0	2	22	10	60	43	+39.5
Hepatitis A Cases	6	4	0	2	1	2	3	2	5	26	18	70	47	+48.9
Rate[1]	0.6	0.7	-	0.4	0.4	0.7	0.6	0.6	1.3	0.6	0.4	1.6	1.1	
Salmonella Cases	26	10	8	10	3	4	7	5	20	98	120	171	181	-5.5
Rate[1]	2.5	1.8	2.1	1.9	1.1	1.3	1.4	1.4	5.2	2.3	2.8	4.0	4.2	
Shigella Cases	5	7	2	3	0	0	2	0	1	20	26	70		-28.6
Rate[1]	0.5	1.2	0.5	0.6	-	-	0.4	-	0.3	0.5	0.6	1.6	2.3	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	1	0	1	-
Vibrio, other	1	0	2	0	0	0	0	0	2	5	10	9	14	-35.7
Other														
H. influenzae (other)	1	1	0	0	0	0	0	0	1	3	3	9	17	-47.1
N. Meningitidis	3	0	1	0	1	1	1	0	0	7	5	34	37	-8.1
Tuberculosis	19	1	1	0	4	2	4	5	0	36	55	124	170	-27.1

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	4
Histoplasmosis	1
Lead Toxicity	15
Varicella	120
Rocky Mountain Spotted Fever	0
Legionellosis	1
Lyme Disease	0
Malaria	7
Tetanus	0

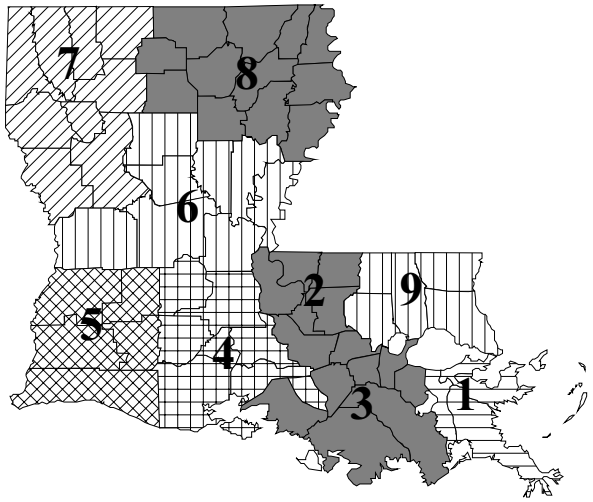


Table 3. *Animal Rabies (May - June 1999)*

Parish	No. Cases	Species

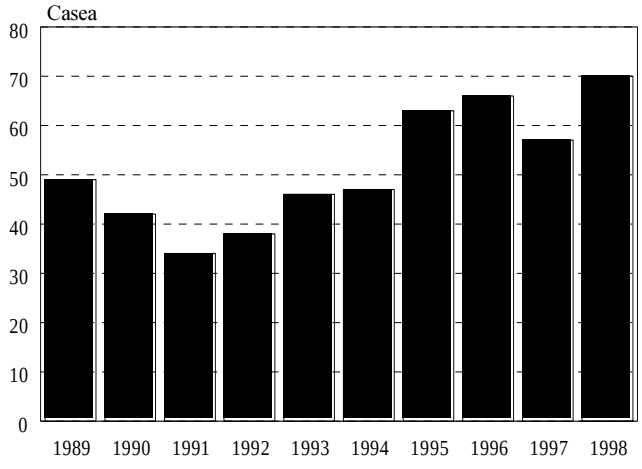
No rabies reports for this quarter.

Annual Summary

Meningococcal Infection - 1998

Seventy cases of invasive meningococcal infection were reported in 1998, a 23% increase from 1997 (Figure 1). The state rate (1.6 per 100,000) was slightly higher than the national rate of 1.2 cases per 100,000, but well below the Healthy People 2000 target of 4.7 cases per 100,000. Sex-specific rates were similar among males and females, while the race-specific rates were nearly three times higher among Blacks than for Whites (2.7 vs. 1.1 per 100,000 respectively). Fifty-nine percent of the cases occurred in children 19 years of age and younger (Figure 2). The case fatality rate was 15% for the 53 cases where outcome was reported. *Neisseria meningitidis* was isolated from blood in 72% of cases, and from CSF in 22% of cases. Of the thirty-seven (59%) isolates serotyped, Group Y (18) was most frequently identified followed by Group C (10) and Group B (5). The distribution of cases by month appears to indicate a mild seasonal trend which peaks around the early spring (Figure 3). Cases were most frequently reported in January, February, and May. No clusters or outbreaks were reported or identified. Parishes reporting the highest number of cases include: Caddo (10), Orleans (9), East Baton Rouge (7), and Jefferson (7).

Figure 1: Cases of meningococcal infection by year, 1989-1998



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 is most beneficial in establishing clustering of cases or identifying outbreaks.

Figure 2: Cases of meningococcal infection by age group and sex, 1998

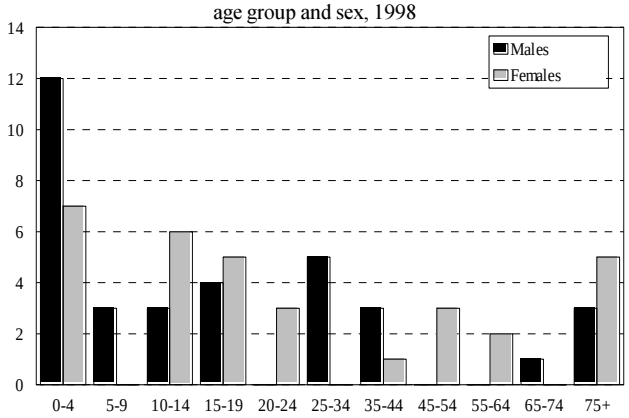
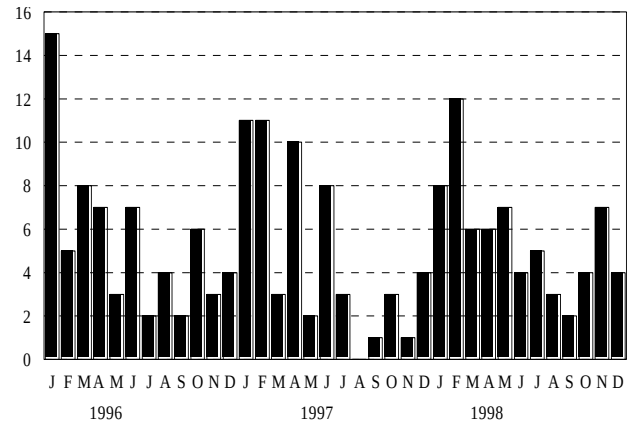


Figure 3: Cases of meningococcal infection by month, 1996-1998



Louisiana Fact

Louisiana's nationally famous state health officer, Dr. C. B. White, was one of the founders of the American Public Health Association (APHA) in 1872 and was elected to its presidency in 1880. In 1880, Dr. D. C. Holliday was elected to the executive committee, and during these public health pioneering days many more of our socially oriented physicians played important roles on various committees of the Association which carried on missionary work in the science of community health. Many important papers in public health were delivered by Louisiana physicians at the annual meetings of the APHA. Indeed, during the first two decades of the existence of the APHA an exceptionally large proportion of its members were physicians from Louisiana. Those men were highly conscious of what it took to control or to eliminate epidemic disease. The articles with which they filled the medical journals were cogent testimonials of their breadth of vision, their scientific and philosophic attainments in the field of knowledge, and the enlightened cultural background with which they approached their professional activities. This is our medical heritage of public health in Louisiana.

Taken from a reprint of The Journal of the Louisiana State Medical Society.

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

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

This public health document was published at a total cost of . Seven thousand copies of this public document were published in this first printing at a cost of . The total cost of all printings of this document, including reprints is . This document was published by to inform physicians, hospitals, and the public of current Louisiana morbidity status under authority of R.S. 40:36. This material was printed in accordance with the standards for printing for state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with the provisions of Title 43 of Louisiana Revised Statutes.

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