Louisiana Morbidity Report

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

September-October 1999 **Volume 10 Number 5**

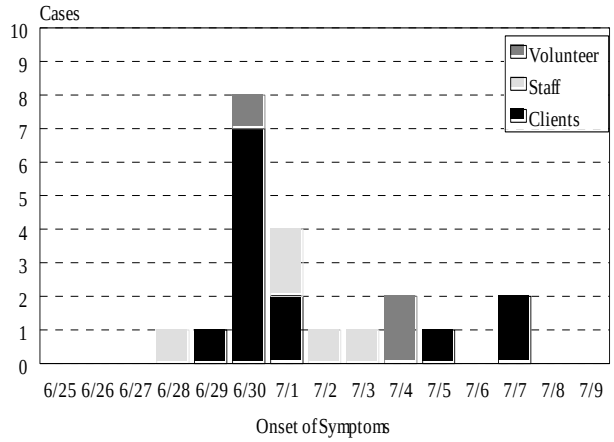
Influenza A Outbreak, Louisiana, July 1999

On July 9, 1999, the Infectious Disease Epidemiology Section was notified of a respiratory outbreak at an adult day center in Baton Rouge. From June 28th to July 7th, 21 (28%) of 74 clients and staff had onset of acute respiratory illness (Figure). The 21 ill persons ranged in age from 53 to 94 years (median: 76 years). All of those for whom clinical information was available reported fever and cough. The duration of cough ranged between 1 and 23 days (median: 10 days), while the fever lasted from 1 to 11 days (median 2 days). Six clients were hospitalized for respiratory illness with radiographic signs of pneumonia and all recovered. Results of serological testing showed that the outbreak was due to Influenza A and that 27 (36%) of 74 persons at the center were likely infected. In addition, several family members of clients and staff also became ill.

This outbreak was unusual because influenza does not typically happen in the summer and because the symptoms of influenza are usually more severe. While a summer outbreak of influenza is unusual, it is not unique. Similar respiratory outbreaks in the summer of 1999 in Oklahoma, Florida, Texas, and Arkansas were caused by Influenza A, H3N2 (Sydney). The subtype of influenza was not identified in this outbreak. The Sydney strain was part of the influenza vaccine given in the fall of 1998 and is scheduled to be a part of the vaccine for the fall of 1999.

No association was seen between illness in this outbreak and age, occupation, or medical history. Vaccination history did not appear to be significantly protective in this outbreak, but records show that only four people were not vaccinated in the fall of 1998 and clinical judgement would argue that the illness would have been more severe had the majority of people not been vaccinated. Vaccine protection begins to wane four months after vaccination, which may explain why there was an outbreak illness, and why the outbreak was relatively mild for influenza.

Figure: Influenza A outbreak in Louisiana, July, 1999



The incubation period for influenza is 1-3 days. Patients are most infectious in the 24 hours before the onset of symptoms. Viral shedding usually ends within 7 days of onset. Because influenza spreads so quickly, infection control practitioners should encourage anyone in a setting such as this, with many elderly and debilitated persons, to stay at home for one week after onset of a febrile respiratory condition. Antiviral prophylaxis may be warranted for high-risk individuals in these settings during an outbreak of febrile respiratory illness. Serum samples can be assayed for an elevated titer but the etiology of an outbreak can not be confirmed for several weeks until convalescent titers are evaluated or virus is isolated from naso-pharyngeal swabs.

Contents

Bulletin

In the Fall of 2003, varicella vaccination will be required for all children in child care centers and children entering kindergarten.

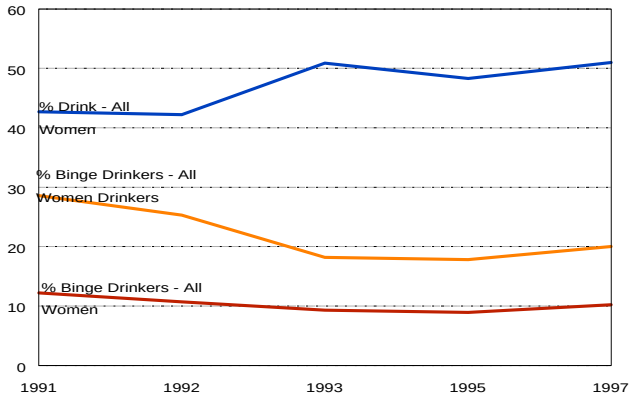
BRFSS: Alcohol Use Among Women

Data on self reported alcohol use among women of child bearing age (18-44 yrs) in Louisiana for the time period 1991-1997 is available for 5 years (1991, 1992, 1993, 1995, 1997) from the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is an ongoing statewide telephone surveillance system that collects data on self reported behaviors and conditions that place adults at risk for chronic diseases, injuries, and preventable infectious diseases. An average of 535 women per year, aged 18-44 years, were among those interviewed about their alcohol consumption behaviors during the preceding month.

For the purposes of this report, a drinker is defined as reporting to have had at least one drink of any alcoholic beverage such as beer, wine, wine coolers, or liquor during the past month. A binge drinker is defined as having 5 or more drinks on at least one occasion during the past month.

From 1991-1992, an average of 42% of women reported having at least one drink in the last month (Figure 1). From 1993-1997, this proportion increased to approximately 50%. Even though more women reported drinking, binge drinking rates remained stable at approximately 10%. Among women who reported to be drinkers, the rate of binge drinking declined from an average of 27% (1991-1992) to 19% (1993-1997).

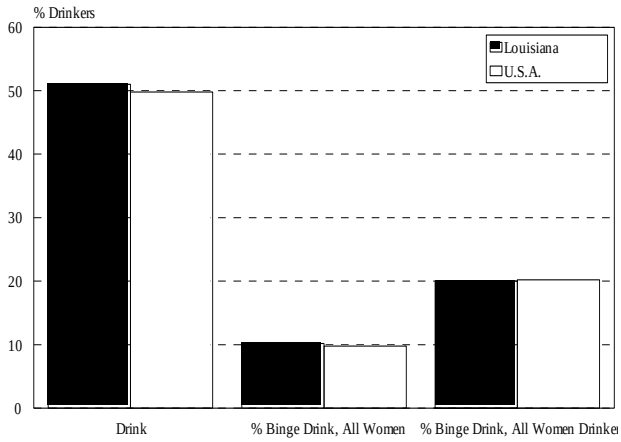
Figure 1: Self reported alcohol use among women of childbearing age, Louisiana, 1991-1997



The most recent rates from Louisiana (1997) were compared to the U.S. (Figure 2). Self reported alcohol use by women were similar for Louisiana and the U.S.; fifty one percent of women in Louisiana reported having had at least one drink in the last month compared to 49.8% for the U.S. The overall population of women in Louisiana had a binge prevalence of 10.2% compared to 9.8% for the U.S. Among women who drank, Louisiana had a rate of 20% for binge drinking compared to 20.2% for the country as a whole. The average number of drinks consumed in the last month for women in Louisiana was 5.8 compared to 5.4 for the U.S. population.

BRFSS data suggests that an increasing number of women (18-44 years of age) in Louisiana are drinking. Additionally, one out of every five women of child bearing age in Louisiana who drinks is at risk of binge drinking. This translates into 89,121 women who practice binge drinking.

Figure 2: Self reported alcohol use among women of childbearing age, Louisiana vs US, 1997



Alcohol use by women places them at greater risk for poor health outcomes, lower utilization of preventive health services, negative sexual and reproductive consequences, injury, and interpersonal violence. Alcohol use during pregnancy can also be harmful to the fetus. Effects include fetal alcohol syndrome, facial dysmorphology, growth retardation, and central nervous system deficits in the fetus.

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Clinicians should be alert to the signs and symptoms of alcohol abuse and should routinely discuss patterns of alcohol use with all patients. Caregivers must ask women direct questions about their alcohol use behaviors, including quantity, frequency, and pattern. Accurate information about the risks of drinking alcohol and the additional risks during pregnancy should also be given to women at risk. Current recommendations for those who chose to drink are no more than 2 drinks per day for men and 1 drink per day for nonpregnant women. Pregnant women should be advised to limit or cease drinking prior to and during pregnancy. Women of child bearing age receiving alcohol or other substance abuse services should receive pregnancy testing.

Influenza Immunization Program, 1999-2000 Season

Parish health unit clinics were to begin administering influenza immunizations the week of October 11 - 15, 1999, but Louisiana, like other states, expects further delays in vaccine production at the manufacturers' level. Influenza immunization should be administered 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 because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications)
- Children and teenagers (aged 7 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 influenza to high risk persons (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 1999-2000 season includes: A/Beijing/262/95-like (H1N1), A/Sydney/5/97-like (H3N2), and B/Yamanashi/166/98.

Annual vaccination using the currently recommended vaccine is necessary for immunity to the influenza virus strains expected during the 1999-2000 season and any remaining supplies from 1998-1999 should be discarded.

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. 48/No. RR-4, April 30, 1999.

Ten Great Public Health Achievements - United States, 1900-1999

During the 20th century, the health and life expectancy of persons residing in the United States improved dramatically. Since 1900, the average lifespan of persons in the United States has lengthened by >30 years; 25 years of this gain are attributable to advances in public health (see list below).

Many notable public health achievements have occurred during the 1900s, and other accomplishments could have been selected for the list.The choices for topics for this list were based on the opportunity for prevention and the impact on death, illness, and disability in the United States and are not ranked by order of importance.

Ten Great Public Health Achievements - United States, 1900-1999

- Vaccination
- Motor-vehicle safety
- Safer workplaces
- Control of infectious diseases
- Decline in deaths from coronary heart disease and stroke
- Safer and healthier foods
- Healthier mothers and babies
- Family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard

Source: MMWR, Vol. 98/No. 12

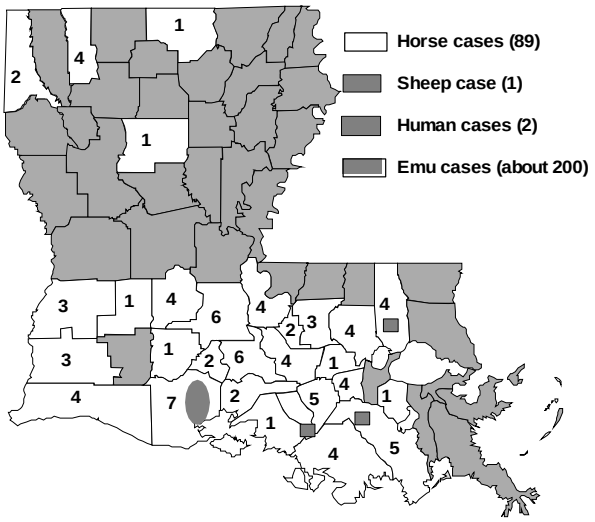
Eastern Equine Encephalitis Update

As reported in the last issue of the LMR, Louisiana has been experiencing an outbreak of Eastern Equine Encephalitis (EEE) since May. As of October 5, 1999, the Office of Public Health (OPH) has confirmed EEE cases from 28 parishes - two humans, one sheep, 200+ emus, and 89 horses (Figure). Most of the cases occurred in the southern half of the state, though cases have been reported from Winn, Webster, Caddo, and Union parishes as well. The outbreak seems to be coming to an end, with only six horse cases reported in September, in comparison to the 29 cases reported in August. No human case has been reported since the first half of July.

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 OPH lab, in conjunction with mosquito control boards throughout the state, monitors arboviral activity by testing bird bloods and mosquito samples.

It is unlikely that West Nile Virus (WNV), which has been found in humans and birds in New York City and is transmitted in the same fashion as EEE, will be seen in Louisiana. There has been some concern as to how this outbreak in New York will effect other parts of the nation, as this is a season in which birds migrate south. The migration pattern of birds from New York is along the Atlantic coast, not through Louisiana. There have been reports of dead crows in the northeast testing positive for WNV, and OPH has received calls from Louisiana citizens concerned about dead birds they have found. One bird is not a concern, but if a large number of dead birds is found, people are encouraged to contact our office at 504-568-5005.

Figure: Cases of Eastern Equine Encephalitis in Louisiana, May-October 5, 1999



CONFIDENTIAL DISEASE CASE REPORT

All diseases and conditions on the list of reportable diseases (see the back of this report) should be reported on an EPI-2430 card (below), or on other forms as stated. Please print out this form and forward reports by fax or mail to either the local parish health unit or to the Infectious Disease Epidemiology Section, Department of Health & Hospitals, Office of Public Health, P.O. Box 60630, New Orleans, LA 70160. The phone numbers are 504-568-5005 or 1-800-256-2748 or FAX 504-568-5006. All facsimile transmissions are considered part of the confidential disease case report, and as such, are not subject to disclosure. Xerox additional copies as needed. Your support in disease reporting will enhance disease surveillance activities.

DISEASE/CONDITION		DATE OF REPORT		DATE OF ONSET
PATIENT'S NAME		RACE*	ETHNIC**	SEX DATE OF BIRTH
	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 = American indian or Alaskan Native

** Hisp/Non-Hispanic

EPI-2430 Revised 6/98

HIV/AIDS Update
Microsporidial Infection Among HIV-Infected Patients

Microsporidia are intracellular parasites which are poorly understood but which cause diarrhea in HIV-infected persons. Several modes of transmission have been hypothesized including: waterborne, zoonotic (rabbits, dogs, birds, and insects), and by person-to-person contact. To identify environmental risk factors for enteric microsporidiosis among HIV-infected patients with symptoms of persistant diarrhea, a retrospective case control study was conducted at the HIV Outpatient Clinic in New Orleans.

Between October 1996 and May 1999 all HIV-infected patients eighteen years and older submitting stool specimens for symptoms of diarrhea who had a positive identification for microsporidiosis by modified trichrome stain were classified as cases. Control subjects were patients submitting stool specimens not positive for microsporidiosis and not having a history of microsporidial infection.

Participants were interviewed regarding contact with food, water, vegetation, animals, place of residence, and travel within the past five years.

During the study interval, 509 eligible patients submitted stool specimens and 129 participated in the study. Patients positive for microsporidia (N=34) were not significantly different from the control population with respect to demographic characteristics. Patients with microsporidiosis were significantly more likely to have used injection drugs (p value <0.05) and more likely to have had a CD4 cell count <50 cells/dL at diagnosis (p value <0.10).

Environmental exposures associated with microsporidial infection included use of a hot tub or spa, occupational contact with water, and having been stung by a bee, hornet, or a wasp (p value <0.05; Table). These findings are consistent with previous studies that have demonstrated a significant relationship between microsporidial infection and swimming in public pools, rivers, ponds, or lakes.

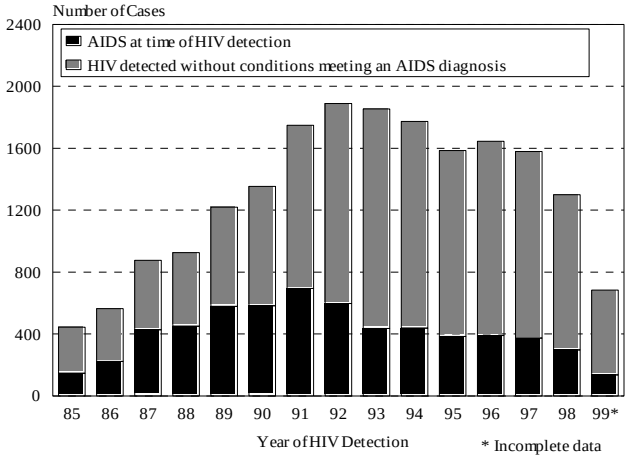
The CDC guidelines for cryptosporidiosis in HIV-infected patients include recommendations for consumption of boiled, filtered, or bottled water and limited swimming in rivers, lakes, pools, and hot tubs. This study indicates these suggestions may be appropriate for the prevention of enteric microsporidiosis as well.

Table: Environmental exposures associated with acquisition of microsporidial infection in HIV-infected patients.

Environmental Exposure	Cases N=34	Controls N=95
Stung by a bee, hornet, or wasp**	76.5%	56.5%
Use of hot tub or spa**	47.1%	29.5%
Use of public swimming pool	29.4%	24.2%
Occupational contact with water**	44.1%	26.3%
Occupational contact with food	35.3%	23.2%
Traveled to a tropical or developing country	26.5%	28.0%

**p<0.05

HIV/AIDS TRENDS



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
July - August 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 July - Aug. 1999	July - Aug. 1998	Jan.-Aug. Cum 1999	Jan.-Aug. 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	9	3	0	3	3	1	2	1	1	25	19	126	92	+37.0
	Rate[1]	0.9	0.5	-	0.6	1.1	0.3	0.4	0.3	0.3	0.6	0.4	2.9	2.1	
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps		0	0	0	0	0	0	1	1	1	3	1	7	6	+16.7
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis		1	0	1	0	0	0	2	0	0	4	3	9	7	+28.6
Sexually-transmitted															
HIV/AIDS	Cases[2]	76	36	2	13	5	2	17	11	7	169	217	856	946	-9.5
	Rate[1]	7.0	6.5	0.5	2.6	1.9	0.6	3.3	3.2	2.0	3.9	5.0	19.8	21.9	
Gonorrhea	Cases	580	321	129	199	158	64	468	278	127	2324	2637	8482	8206	+3.4
	Rate[1]	55.8	56.5	34.2	38.6	59.0	21.0	92.5	79.2	33.0	55.1	62.5	201.0	194.5	
Syphilis (P&S)	Cases	14	16	12	11	12	1	1	1	6	74	109	200	278	-28.1
	Rate[1]	1.3	2.8	3.2	2.1	4.5	0.3	0.2	0.3	1.6	1.8	2.6	4.7	6.6	
Enteric															
Campylobacter		1	6	0	3	1	0	5	0	6	28	18	92	72	+27.8
Hepatitis A	Cases	8	17	1	32	2	1	3	0	5	70	10	148	67	+120.9
	Rate[1]	0.8	3.0	0.3	6.2	0.7	0.3	0.6	-	1.3	1.6	0.2	3.4	1.6	
Salmonella	Cases	18	22	14	21	5	8	7	11	26	133	130	316	345	-8.4
	Rate[1]	1.7	3.9	3.7	4.1	1.9	2.6	1.4	3.1	6.8	3.1	3.0	7.3	8.0	
Shigella	Cases	7	13	1	1	0	4	1	2	4	33	36	112	182	-38.5
	Rate[1]	0.7	2.3	0.3	0.2	-	1.3	0.2	0.6	1.0	0.8	0.8	2.6	4.2	
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	2	0	2	-
Vibrio, other		2	0	2	1	0	0	0	0	0	5	16	19	32	-40.1
Other															
H. influenzae (other)		0	0	0	0	0	0	0	0	0	0	3	11	21	-47.6
N. Meningitidis		3	0	1	0	0	0	1	0	0	5	7	50	53	-5.7
Tuberculosis		14	2	1	6	0	3	1	0	0	27	95	151	265	-43.0

1 = Cases Per 100,000

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

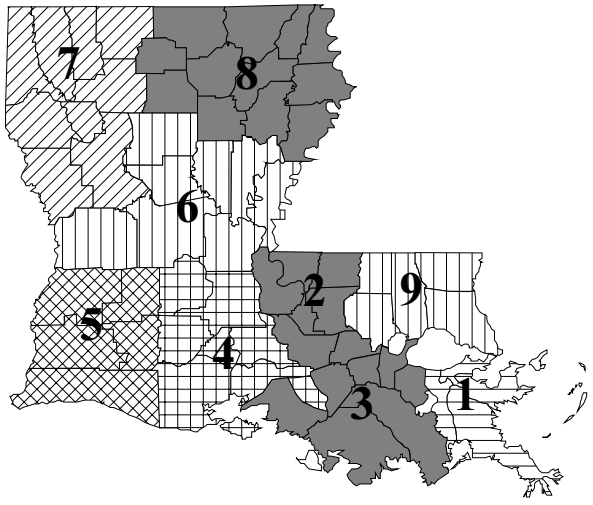


Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	3
E. coli O157:H7	9
Histoplasmosis	1
Lead Toxicity	15
Varicella	137
Rocky Mountain Spotted Fever	2
Legionellosis	1
Lyme Disease	5
Malaria	10
Tetanus	0

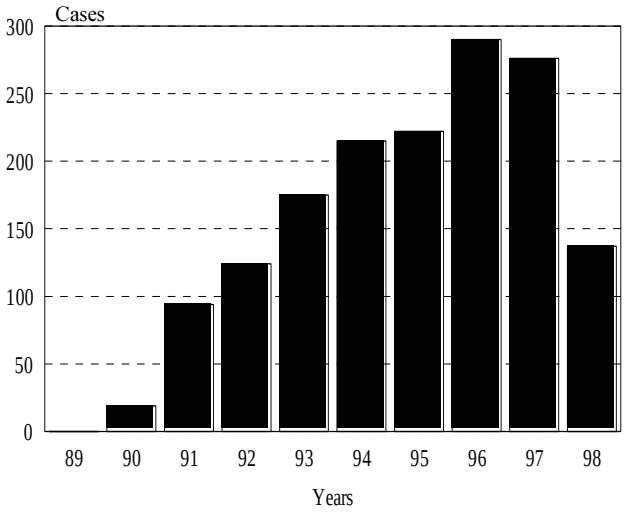
Table 3. *Animal Rabies (July - August 1999)*

Parish	No. Cases	Species
Iberville	1	Horse

Annual Summary
Hepatitis C - 1998

The number of hepatitis C cases reported in Louisiana in 1998 decreased by 50% from 1997 (Figure 1). The case rate in Louisiana is nearly three times the national case rate (3.2 vs 1.4 per 100,000), but much lower than the Healthy People 2000 target rate of 13.7 cases per 100,000. Sex-race specific rates are higher among black males (6.7) and black females (3.2) than white males (2.5) and white females (1.6 per 100,000). Cases of hepatitis C by age and sex clustered in the 35-44 year age group and accounted for 43% of all reported cases (Figure 2). Risk factor information was collected for several cases for the 6 weeks to 6 months prior to infection. Of the 29 cases disclosing drug use information, 7% reported using drugs. Eighty-nine percent (25/28) reported their sexual preference as heterosexual and 96% (25/26) reported greater than 2 sexual partners in the 6 weeks to 6 months prior to infection. Of the 32 patients reporting medical information, 39% were hospitalized for hepatitis C. One death was reported as a result of hepatitis C infection. Parishes reporting the highest case rates per 100,000 include West Carroll (17), Pointe Coupee (13), and Catahoula (9; Figure 3).

Figure 1: Cases of hepatitis C in Louisiana by year, 1989-1998



Comment:

The decrease in the number of cases may have been due to enhanced traceback of reported cases that were mostly related to screening and not to acute cases. Infection with hepatitis C causes liver inflammation and can lead to cirrhosis and cancer of the liver. Those most at risk for hepatitis C infection include: anyone who had a blood transfusion before 1990, health care workers who are exposed to blood, IV drug users, hemodialysis patients, infants born to infected mothers, and those with multiple sex partners. There is a new combination drug therapy that shows promise in the treatment of hepatitis C infections. Hepatitis C can be prevented by modifying high risk behaviors (i.e. protected sex, not using or sharing needles), cleaning up all blood spills with bleach while wearing protective gloves, and not sharing razors or toothbrushes.

Figure 2: Cases of hepatitis C by sex and age group, 1998

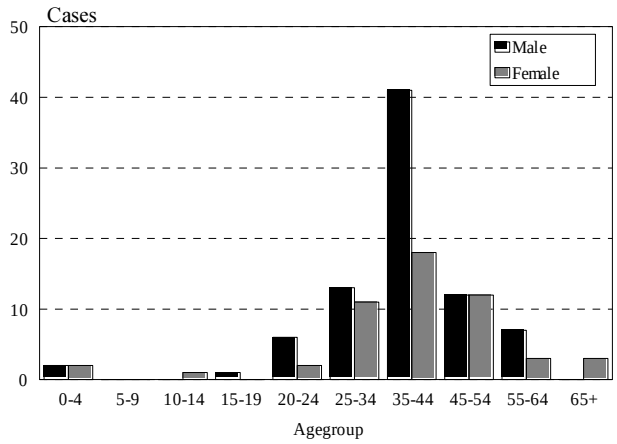
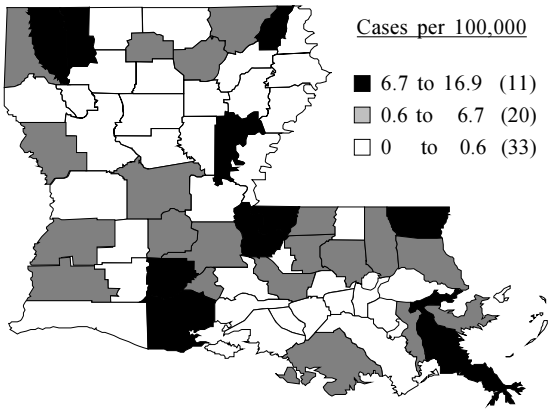


Figure 3: Rates of hepatitis C by parish, 1998



Louisiana Fact

In line with responsibilities of the State Board of Health, sanitary engineering was continually being upgraded. Mr. John H. O'Neill, in charge of the Bureau of Sanitary Engineering, put an assistant totally in charge of malaria-mosquito control work in 1923. This additional Bureau function had its origins in the 1918 control campaigns which were conducted in the cantonment cities of Alexandria and Pineville. The assistant, half of whose salary and expenses were paid by the International Health Board of the Rockefeller Foundation, soon was operating in 12 communities with a population in excess of 137,000 population. The malaria death rate was cut by nearly 50% between 1918 and 1923. By 1926 O'Neill's Bureau was giving civic and health authorities in 34 Louisiana towns assistance in developing their own malaria control program. Taken from the "Louisiana State Board of Health, The Progressive Years" by Gordon Gillson.

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

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