Louisiana Morbidity Report

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

Happy Holidays

November-December 1999 **Volume 10 Number 6**

Hepatitis C in Louisiana, 1992-1998

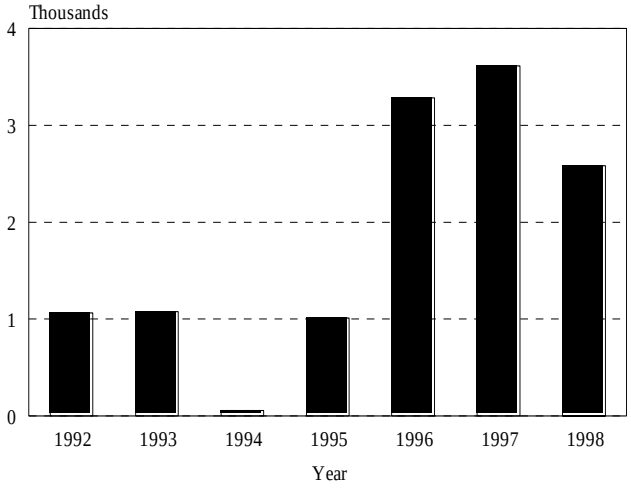
Hepatitis C virus is one of the most important causes of chronic liver disease in the United States. It accounts for about 20 percent of acute viral hepatitis, 60 to 70 percent of chronic hepatitis, and 30 percent of cirrhosis, end-stage liver disease, and liver cancer. Almost 4 million (1.8 percent) of the U.S population have antibody to HCV (anti-HCV), indicating ongoing or previous infection with the virus. Hepatitis C causes an estimated 8,000 to 10,000 deaths annually in the United States.

HCV is spread primarily by contact with blood and blood products. Injection drug use currently accounts for most HCV transmission in the United States. Other risk factors include high risk sexual behavior, multiple partners, sexually transmitted diseases, health care workers who suffer accidental needle stick injury, people who have frequent exposure to blood products; patients with hemophilia, chronic renal failure, organ transplant, cancer requiring chemotherapy, and infants born to HCV-infected mothers.

The number of hepatitis C positive cases reported to the Infectious Disease Epidemiology Section for the period 1992-1998 is shown in Figure 1. The highest number of cases was reported during 1996 and 1997 and the lowest number during 1994. The overall state rate for this period was 294 per 100,000.

Sex specific rates were nearly twice as high for males than females, 389 vs. 185 per 100,000, respectively. Sex-race specific rates were highest among African-American males

Figure 1: Cases of hepatitis C, 1992-1998

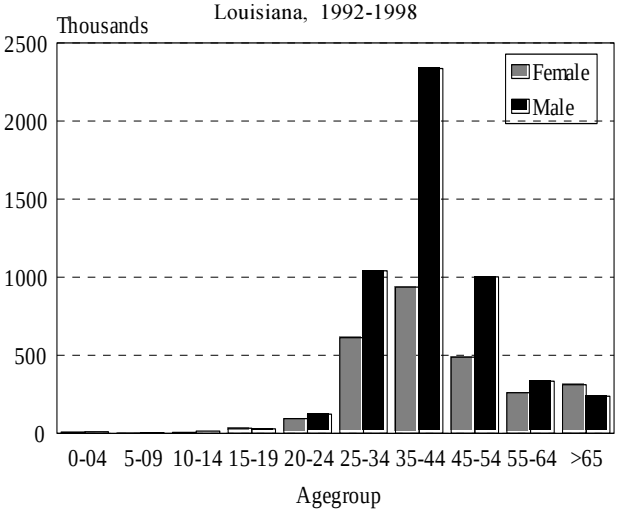


(389) followed by Caucasian males (148) per 100,000. Cases of hepatitis C by age groups (Figure 2) were highest among three different age groups: 35-44 years (528), 45-54 years (359) and 25-34 years (230) per 100,000. Parishes reporting the highest case rates per 100,000 (Figure 3) include Caddo (612), Bossier (356), East Baton Rouge (254), Lafayette (240), Iberia (223), Claiborne (212) and West Baton Rouge (210).

Routine testing is recommended for individuals who have a history of blood transfusions and blood products prior to 1992 (U.S Public Health Service recommended), history of

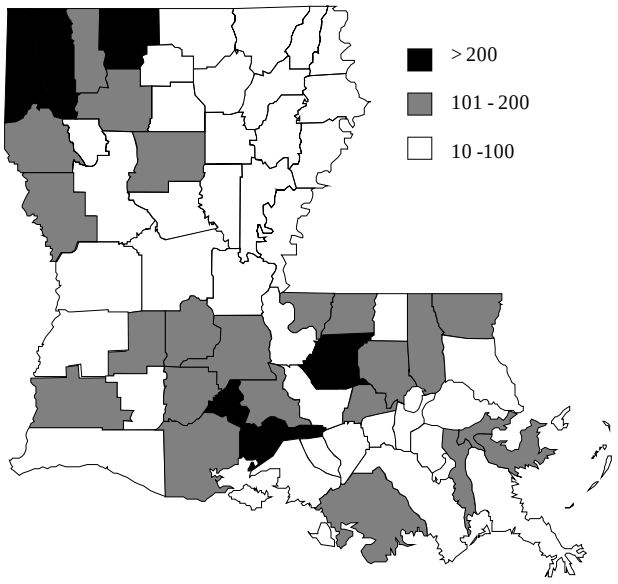
(Continue on next page)

Figure 2: Cases of hepatitis C, by age, sex specific groups, Louisiana, 1992-1998



Contents

Figure 3: Rates of hepatitis C by parish, 1992-1998



injection drug use, multiple sexual partners, spouses or close household contacts of someone with hepatitis C, or who share instruments for intranasal cocaine use.

Treatment is recommended for the group of patients with chronic hepatitis C who have persistently elevated ALT, positive HCV RNA, and a liver biopsy with either portal or bridging fibrosis and at least moderate degrees of inflammation and necrosis.

At present, the only means of preventing new cases of hepatitis C are to screen the blood supply, encourage health professionals to take precautions when handling blood and body fluids, and inform people about the high-risk behaviors. Programs to promote needle exchange offer some hope of decreasing the spread of hepatitis C among injection drug users. Vaccines and immunoglobulin products are not available for hepatitis C.

Counseling recommendations to prevent transmission of HCV to patients are: 1) 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 is neither recommendation against pregnancy nor breast-feeding for mothers tested positive 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 partners, the risk is low despite long term sexual activity. Infected persons should be informed of the potential risk for sexual transmission to assist in decision-making about precautions, 3) persons with multiple sex partners should adopt safer sex practices, including reducing the number of sex partners and using barriers (e.g., condoms) to prevent contact with body fluids.

Surveillance for HCV-related chronic liver disease can provide information to measure the burden of the disease, determine natural history and risk factors, and evaluate the effect of therapeutic and prevention measures on incidence and severity of disease.

Results from Clinical Trial studies with the new Combination therapy (Interferon plus Ribavarin) for either 24 or 48 weeks were superior to therapy with Interferon alone with respect to virologic, biochemical and histologic end points . Combination therapy should now be considered for the initial treatment of choice among patients with chronic hepatitis C who are suitable candidates.

Infection Control Practitioners Survey

In an effort to increase reporting of communicable diseases and to determine the training needs of Infection Control Practitioners (ICPs) in Louisiana, the Infectious Disease Epidemiology Section conducted a fact finding survey. The survey was designed to assess training needs, computer access and skills, barriers faced in reporting, and preferred training methods, and to ask questions regarding ways the Infectious Disease Epidemiology Section can better meet needs of ICPs and the needs of their community.

Forty-four (44) ICPs were interviewed throughout the state . ICPs spent an average of 22% of their time on disease reporting. Many ICPs maintain their own hospital surveillance system and are able to use the results to assist in making administrative decisions. Sixty-eight percent (68%) were very interested in an update training on reporting procedures (Table). Seventy-four percent (74%) expressed interest in receiving training in designing in-hospital studies and projects. Seventy-seven percent (77%) wanted an overview of dis-

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Assistant Secretary, OPH	*Jimmy Guidry, MD*
State Epidemiologist	*Louise McFarland, DrPH*
Editors	*Thomas Farley, MD MPH* *Karen Kelso, RNC MS*
Associate Editor	*Barbara Trahan, MPH*
Layout & Design	*Ethel Davis, CST*

Contributors

Susan Wilson, MSN
Sona Patel, MD
Kerry Chausmer, MPH
Krista Allen, MPH
Jeff Hanson, MPH

ease surveillance and trends. Some of the barriers in reporting that the ICPs faced were time contraints and finding a balance between ICP duties and the duties of the Public Health Nurses.

Table: Training interests of Infection Control Practitioners in Louisiana, 1999

Training Topic	Yes Interested	No, Not Interested	Already Trained
Update on reporting procedures	68%	23%	10%
Media relations during outbreaks	60%	38%	3%
Case investigation/follow up	84%	12%	5%
Childhood immunization	28%	54%	18%
Adult immunization	54%	28%	18%
Overview of disease surv/trends	77%	5%	19%
Universal precautions/inf.control	24%	29%	48%
Infect.waste/needlestick injury	37%	20%	44%
Interpret lab tests/results	55%	23%	23%
Implement surveillance system	56%	28%	15%
Data collection	55%	25%	20%
Data analysis	63%	17%	20%
Summarize findings	66%	17%	17%
Basic epidemiological principles	58%	21%	21%
Project designs and studies	74%	10%	15%
Role of Public Health	85%	5%	10%
Microorganisms	63%	20%	17%
Sanitary Code	83%	12%	5%

ICPs play a key role in maintaining the disease surveillance system in Louisiana. Disease surveillance is used to follow and describe the natural history of disease, plan public health interventions, detect outbreaks, and monitor the changes in infectious agents. The surveillance data is also used to provide disease specific data on a local and state level.

Information obtained from these surveys will be used to plan upcoming training seminars, assist ICPs in overcoming reporting barriers, and enhance communication between ICPs, Public Health Unit Nurses, and the Infectious Disease Epidemiology Section.

Airway Obstruction Deaths of Louisiana Children

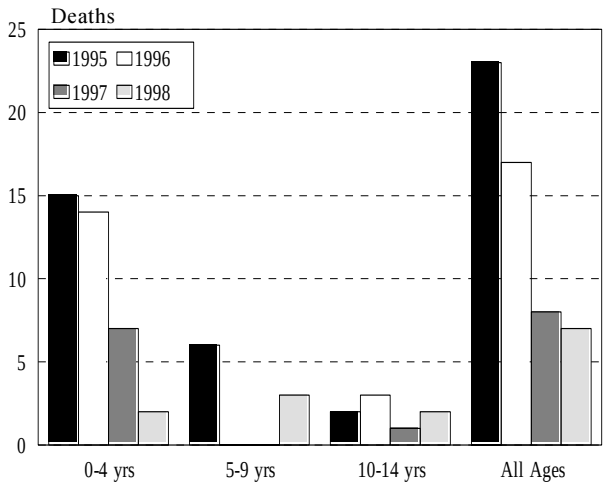
Airway obstruction, including choking, suffocation and strangulation, is the leading cause of unintentional injury death for children less than a year old nationally and the second leading cause of unintentional injury death for children four and under in Louisiana. These injuries occur when a child's normal airway becomes blocked and they can't breathe. Children, especially those under 3, are particularly vulnerable because of their smaller upper airways, relative inexperience chewing and their natural tendency to put things in their mouths.

In 1998, twenty-five Louisiana children aged 14 and under died from choking or suffocation. Eighty percent of these deaths were children less than 5 years old. This was a sharp increase in the number of young children, 0-4 years of age, who died from suffocation or choking from 1997. This increase in suffocation deaths resulted in an increased percentage of the total unintentional child death percentages, from 5 percent in 1997 to 15 percent in 1998..

To help prevent unintentional airway obstruction injury deaths (choking, suffocation, strangulation) the Louisiana SAFE KIDS Coalition recommends the following prevention tips:

- **Always supervise small children while eating and playing.**
- Keep round, hard food like grapes, popcorn, nuts, raisins out of children's reach. Also keep coins, safety pins, jewelry, buttons and other small objects out of children's reach.
- **Make sure kids play with age-appropriate toys according to safety labels.**
- Inspect old and new toys often for any damage or loose parts. Throw away or fix broken toys right away.
- **Place infants on their backs or sides on a firm, flat crib mattress.**
- Be sure the crib meets national safety standards - look for a JMPA certification label. Remove pillows, comforters, toys and other soft items from the crib.
- **Remove all hood and neck drawstrings from children's clothes.**
- Never allow children to wear necklaces, purses, scarves, or clothing with drawstrings on playgrounds to prevent strangulation.
- **Tie up all window blind and drapery cords or cut the ends and put on safety tassels.**
- Never hang anything on or above a crib with a string or ribbon longer than seven inches.

Figure: Airway obstruction deaths, 1998, Louisiana, 0-14 years of age



The Louisiana SAFE KIDS Coalition, co-founded by the Louisiana Office of Public Health and Children's Hospital, is dedicated to preventing unintentional injuries to children 14 and younger – their number one killer. Louisiana SAFE KIDS is made up of public, private and voluntary organizations working to prevent unintentional injuries to children age 0-14 through a multifaceted approach of increasing public awareness, providing education and advocating for environmental and public policy changes. Call (504) 568-2508 for more information.

Prenatal Group B Streptococcal Screening

Group B Streptococcus (GBS) is a leading cause of neonatal sepsis in the United States. CDC, in collaboration with the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, recommends that laboratories adopt optimal screening practices to identify GBS and to promptly report test results so that GBS-colonized pregnant women can receive antibiotics during labor. Optimal detection of GBS depends on culture of combined vaginal/rectal swabs collected from women at 35 to 37 weeks'gestation and the use of selective broth media (Todd-Hewitt broth with either colistin and nalidixic acid or gentamicin and nalidixic acid). Prenatal screening is one of two strategies recommended for perinatal GBS disease prevention; the alternative is risk-based and identifies candidates for intrapartum antimicrobial prophylaxis based on risk factors present during labor (i.e., gestation at <37 weeks, duration of rupture of membranes ≥ 18 hours, and maternal fever).

To assess GBS screening practices in clinical laboratories, state health departments surveyed microbiology laboratories in Connecticut, Georgia, and Minnesota. The survey found that the practices of some participating laboratories were suboptimal, particularly in their lack of use of selective broth media for culture of GBS.

Selective broth media was used in 24 (62%) laboratories in Connecticut, 15 (39%) in Georgia, and 42 (42 %) in Minnesota (Table 1). Some laboratories (4%-14 % in each state) used antigen detection kits for detecting GBS directly from clinical specimens without culture backup. Providers were notified when an inappropriate (other than vaginal/rectal) specimen was received in 20 (5 1 %) laboratories in Connecticut and one (3%) in Georgia. In Minnesota, 17 (17%) laboratories informed providers that the specimen was inappropriate when a cervical specimen was submitted. In Connecticut, if specimens were not labeled for a GBS screen, 18 (5 1%) laboratories processed the specimens without specific steps for GBS identification, 13 (37%) processed specifically for GBS, and four (11%) processed specimens based on anatomical site. In 1998 in Georgia, 19 (58%) of 33 laboratories did not process for GBS when they received genital specimens without specific labeling for GBS. Laboratories used a variety of methods to report test results to health-care providers (Table 1).

During March-May 1998, each of the three state health departments provided the participating laboratories with survey results and recommendations designed to optimize identification of pregnant women colonized with GBS. Follow-up data indicated that in Connecticut, the use of selective broth media increased from 62% to 92%; in Georgia, it increased from 39% to 67%. Minnesota data were not available for this report. *(Source: MMWR 1999; 48, No. 20)*

Table 1. Microbiology laboratory practices for group B streptococcal specimen processing and feedback- Connecticut, Georgia, and Minnesota, 1997-1998

	Connecticut (n=39)		Georgia (n=38*)		Minnesota (n=101)	
Practice	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Receive combined vaginal/rectal specimens	27	(69)	18	(47)	55	(54)
Use selective broth media	24	(62)	15	(39)	42	(42)
Use antigen kits without culture backup	4	(10)	5	(14)	4	(4)
Method of reporting laboratory results to the provider**						
Electronic	29	(74)	30	(79)	40	(40)
Courier	26	(67)	13	(34)	57	(56)
Telephone	23	(59)	21	(55)	45	(45)
Fax	23	(59)	19	(50)	36	(36)
Mail	10	(26)	8	(21)	7	(7)
Other	2	(5)	4	(11)	26	(26)

* Denominator varied because of missing responses.

**More than one method could be used.

HIV/AIDS Update

STDs Cause HIV Spread in Louisiana

Since early in the HIV epidemic, studies have suggested that both ulcerative STDs (such as syphilis or chancroid) and non-ulcerative STDs (such as gonorrhea or chlamydia) facilitate HIV transmission. However, few carefully designed studies of HIV incidence have demonstrated these associations in the US, particularly in predominantly heterosexual populations. OPH's ongoing seroincidence study provided an opportunity to study the relationship between specific STD diagnoses and the risk of subsequent incident HIV infection in a high risk population.

Using computerized medical records, a retrospective cohort study was done of patients attending a New Orleans STD clinic between January 1990 and April 1998. Multivariate Cox regression analysis was used to identify risk factors for HIV seroconversion among clients repeatedly HIV tested, while controlling for the effects of behavioral risks.

Table 1: HIV incidence by STD history among males

Characteristic	SC	Rate*	Rate Ratio	95% CI
No STD diagnoses	10	.212	1.00	
Gonorrhea	80	.558	2.61	(1.35 - 5.42)
Chlamydia	10	.186	0.93	(0.39 - 2.23)
Primary syphilis	17	1.354	6.33	(2.90 - 13.82)
Secondary syphilis	8	2.110	9.85	(3.89 - 24.97)
Early latent syphilis	8	1.194	5.58	(2.20 - 14.15)
Late latent syphilis	7	2.146	10.03	(3.82 - 26.34)
Genital ulcer disease	19	1.380	6.45	(3.00 - 13.88)

*Per 100 person years

Table 2: HIV incidence by STD history among females

Characteristic	SC	Rate*	Rate Ratio	95% CI
No STD diagnoses	7	.310	1.00	
Gonorrhea	16	.635	2.03	(0.84 - 4.94)
Chlamydia	8	.456	1.47	(0.53 - 4.05)
Primary syphilis	2	1.945	6.23	(1.29 - 29.99)
Secondary syphilis	4	.697	2.25	(0.66 - 7.69)
Early latent syphilis	3	.504	1.62	(0.42 - 6.26)
Late latent syphilis	2	1.040	3.34	(0.69 - 16.05)
Genital ulcer disease	1	.891	2.86	(0.35 - 23.23)

*Per 100 person years

The analysis showed that males with gonorrhea were 2.6 times more likely to seroconvert than those with no STD diagnoses (Table 1). Among males, genital ulcer disease (GUD) and all stages of syphilis were strongly associated with increased risk of seroconversion, with relative risks ranging from 5.58 for early latent syphilis to 10.03 for late latent syphilis. Among females, the risks associated with these ulcerative conditions were elevated but more moderate, ranging from 1.62 to 6.23 (Table 2). In both males and females, chlamydia did not appear to be associated with risk of HIV incident infection.

Tables 3 and 4 present results from the multivariate analyses for males and females, respectively. Those males reporting sex with a male or exchanging sex for money or drugs were at significantly increased risk of HIV seroconversion (hazard ratio [HR]=3.33 and 1.55, respectively). Among females, sex with an HIV-infected partner was the only behavioral risk factor strongly associated with HIV risk (HR=9.5 1). While controlling for behavioral risks, having a recent syphilis or GUD diagnosis was associated with roughly four and five-fold increases in risk of HIV seroconversion in males and females, respectively. Among males, a recent non-ulcerative STD diagnosis was associated with a 40% increase in risk of seroconversion (p=. 127). While not statistically significant, this last finding potentially represents an association with public health implications as important as those of the stronger syphilis association, given the widespread prevalence and persistence of non-ulcerative STD.

This study suggests that both ulcerative and non-ulcerative STD may be associated with increased risk of HIV transmission and therefore that comprehensive STD control programs may be particularly effective tools for HIV prevention.

Table 3: Multivariate analysis, Males

Covariate	p-value	HR**	95% CI
Age at first clinic visit	.041	1.02	(1,00-1.04)
Risk:			
Male sex with male	<.001	3.33	(2.05-5.43)
Injecting drug use	.877	.94	(.45-1.99)
Sex with IDU	.638	.81	(.33-1.98)
Exch.money/drugs for sex	.043	1.55	(1.02-2.36)
STD history in the preceding year:			
No STD		1.00	
Non-ulcerative STD only*	.127	1.43	(.90-2.26)
Any syphilis or GUD	<.00l	4.65	(2.13-10.15)
N=8044, 106 seroconverters			

* Gonorrhea, chlamydia or NGU
** Hazard ratio

Table 4: Multivariate analysis, Females

Covariate	p-value	HR**	95% CI
Age at first clinic visit	.974	.99	(.95-1.05)
Risk:			
Sex with HIV+ partner	.003	9.51	(2.13-42.52)
Injecting drug use	.632	.66	(.12-3.64)
Sex with IDU	.281	2.02	(.57-7.19)
Exch. money/drugs for sex	.448	1.53	(.51-4.55)
STD history in the preceding two years:			
No STD		1.00	
Non-ulcerative STD only*	.856	.89	(.26-3.08)
Any syphilis or GUD	<.001	5.02	(1.94-12.99)
N=2679, 29 seroconverters			

* Gonorrhea or chlamydia
** Hazard ratio

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
September - October, 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 Sept - Oct 1999	Sept - Oct 1998	Jan - Oct Cum 1999	Jan - Oct 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	8	3	0	3	2	0	1	1	1	19	38	154	151	+2
Rate[1]	0.8	0.5	-	0.6	0.7	-	0.2	0.3	0.3	0.4	0.9	3.6	3.5	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	1	0	1	0	1	3	0	10	8	+25
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	1	0	0	0	0	0	0	0	0	1	0	10	11	-9
Sexually-transmitted														
HIV/AIDS Cases[2]	88	38	8	10	8	4	11	5	5	177	227	1075	1168	-8
Rate[1]	8.1	6.9	2.1	2	3	1.3	2.2	1.4	1.4	4.1	5.3	24.9	27	
Gonorrhea Cases	712	263	124	264	154	144	622	198	176	2657	2153	11137	12489	-11
Rate[1]	68.5	46.3	32.9	51.2	57.5	47.2	122.9	56.4	45.7	63	51	264	296	
Syphilis (P&S) Cases	9	10	9	12	10	0	1	0	8	59	89	259	369	-30
Rate[1]	0.9	1.8	2.4	2.3	3.7	-	0.2	-	2.1	1.4	2.1	6.1	8.7	
Enteric														
Campylobacter	2	6	2	2	0	0	3	1	1	17	20	113	100	+3
Hepatitis A Cases	3	2	0	27	2	0	1	2	2	39	23	187	107	+75
Rate[1]	0.3	0.4	-	5.2	0.7	-	0.2	0.6	0.5	0.9	0.5	4.3	2.5	
Salmonella Cases	18	17	8	34	4	7	19	5	40	153	175	476	567	-16
Rate[1]	1.7	3	2.1	6.6	1.5	2.3	3.8	1.4	10.4	3.5	4.1	11	13.1	
Shigella Cases	11	11	0	3	0	0	0	0	5	30	55	144	254	-43
Rate[1]	1.1	1.9	-	0.6	-	-	-	-	1.3	0.7	1.3	3.3	5.9	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	2	-
Vibrio, other	2	0	1	0	0	0	0	0	0	3	10	23	43	-47
Other														
H. influenzae (other)	0	1	0	0	0	0	0	0	0	1	1	12	23	-48
N. Meningitidis	0	0	0	0	0	0	1	2	1	4	4	55	58	-5
Tuberculosis	33	0	2	10	8	2	4	12	7	78	43	229	308	-26

1 = Cases Per 100,000

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

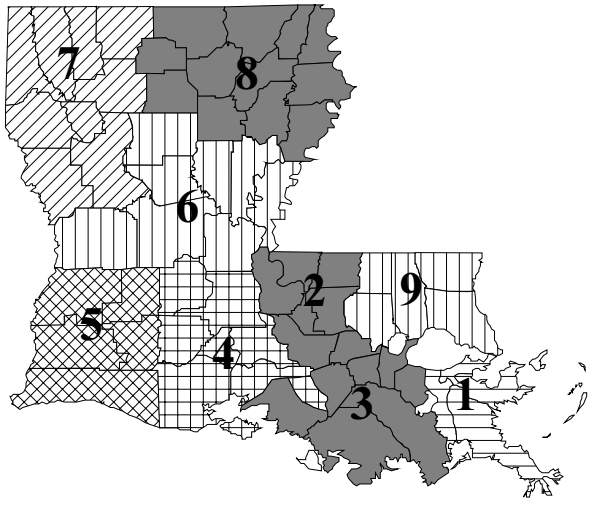


Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	3
E. coli O157:H7	11
Histoplasmosis	1
Lead Toxicity	15
Varicella	143
Rocky Mountain Spotted Fever	2
Legionellosis	4
Lyme Disease	10
Malaria	11
Tetanus	0

Table 3. Animal Rabies (September - October, 1999)

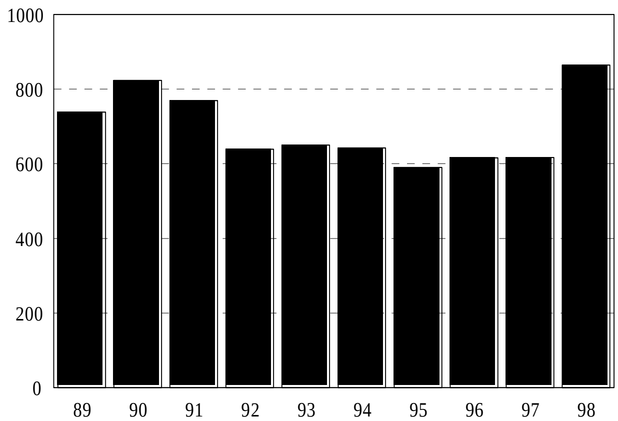
Parish	No. Cases	Species

No rabies reports for this period.

Annual Summary
Salmonellosis - 1998

In 1998, 864 cases of salmonellosis were reported. This was a 40% increase from 1997 (Figure 1). Louisiana's rate of 20.0 per 100,000 is higher than the national rate of 15.7 per 100,000. Sex-specific rates per 100,000 were slightly higher for males than females (20.7 vs. 19.2 respectively). Sex-race specific rates per 100,000 for Whites were nearly identical with rates of 15.9 (males) and 16.0 (females). Case rates for Black males (13.3/100,000) were higher than Black females (9.8). The 0-4 years age group represented fifty-three percent of the cases (Figure 2).

Figure 1: Cases of salmonellosis by year, 1989-1998



Reported cases by month of onset began to increase during the summer months and peaked in October. Parishes reporting the highest case rates per 100,000 were Terrebonne (47), Washington (39), and Catahoula (36). Of the 36 identified serotypes for Salmonella, the three most frequently isolated were *S. newport* (17.4%), *S. typhimurium* (14.7%), and *S. javiana* (11.6%; Table). One case of *S. typhi* was identified in Caddo parish involving a 52 year old woman.

An outbreak of salmonellosis was investigated in August 1998 in Lafayette parish. Sixty-three people became ill, and an association with a rice dressing mix was identified.

Comments:

The Infectious Disease Epidemiology Section conducted a year long case-control study to assess the risk factors for acquiring sporadic salmonellosis in adults ($\geq$15 years of age). The increase in cases reported in 1998 may be partly due to this study. The study began in May, 1998 and ended in April, 1999. This study focused on food handling practices and personal hygiene. One hundred and fifteen cases and 115 matched controls were interviewed. Among cases and controls who prepared foods, significantly more cases never or rarely washed their hands every time between preparation of meats and non-meat items (OR = 8.3).

For adults, consumption of undercooked meat and/or poultry products (including runny eggs) were found as risk factors in previous studies, as well as handling of ground or cut raw beef. In individual food preparation, just as in commercial food preparation, proper handwashing has to be a priority in the preparation of foods.

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

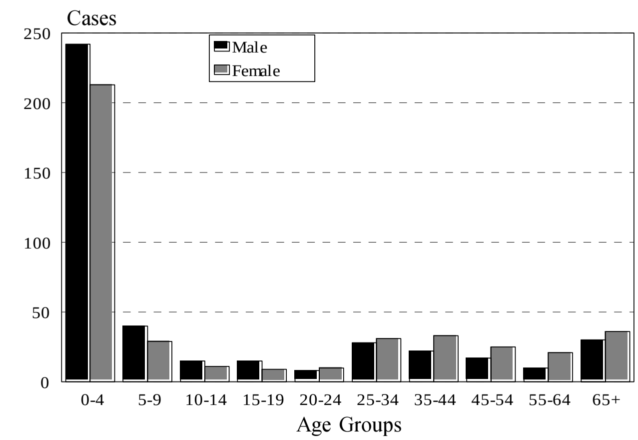


Table: Frequency of salmonella serotypes, 1996-1998

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Louisiana Fact

Partly as a result of World War I the Bureau of Venereal Diseases, a Division of the State Board of Health, was formally instituted in January, 1918, and in March Dr. Henry F. Ader was appointed its first Director. Dissemination of educational literature designed to curtail the spread of syphilis, gonorrhea, and chancroid had been started by the State Board in 1910, and three years later these diseases were added to the reportable list. Only minimal effort was expended in combating this type of illness until after America entered the war in 1917. Then the federal government urged adoption of a venereal disease eradication program for Louisiana in accord with a general outline provided by the United States Public Health Service.

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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DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
P.O. BOX 60630 NEW ORLEANS LA 70160

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