



Reported Morbidity
June, 1975

MONTHLY MORBIDITY REPORT

Provisional Statistics

FROM THE

OFFICE OF PUBLIC HEALTH STATISTICS

INFLUENZA, 1975 - 1976

Section of Epidemiology

Influenza occurs to some extent every year, although its incidence is quite variable. Generally a benign disease, among certain groups of individuals influenza can create much morbidity. Because some influenza occurs every year, annual vaccination of "high risk" patients is indicated as a routine procedure regardless of the amount of influenza expected in any specific geographical area.

The Public Health Service Advisory Committee on Immunization Practices reminds us that much of the morbidity associated with the disease is not being prevented. Now only 10-15 percent of the high risk individuals are vaccinated each year. Influenza vaccine should be given to chronically ill patients and to older persons in general, especially persons over age 65.

In recent years, the effectiveness of the available vaccine has improved, due to the addition of more antigen to the product. Current vaccines should provide good protection against influenza when the prevalent viruses are identical or similar to those in the vaccine. The 1975-

76 vaccine differs from last year's product; this year's vaccine contains 350 CCA (chick cell agglutinating) units of A/Port Chalmers/1/73 (H3N2), 350 CCA units of A/Scotland/840/74/ (H3N2) and 500 CCA units of a type B strain.

Available data indicate that a single dose of the current vaccine will provide good protection. Little additional benefit has been shown from a second dose. As the vaccine's protection is relatively short lived, and its composition differs year to year, no one should consider themselves immunized for the up-coming influenza season until vaccinated this year with the 1975-76 vaccine. The vaccine should be administered by mid-November, a few weeks before the usual start of the season.

Widespread vaccination of the general population to control the disease is not a public health objective, as there is a low frequency of serious complications from the disease in healthy people. However, prevention of predicted morbidity is a public health concern, and it is strongly recommended that physicians utilize the 1975-76 influenza vaccine in their "high risk" and elderly patients.

SELECTED REPORTABLE DISEASES

(By Place of Residence)

STATE AND PARISH TOTALS Reported Morbidity June, 1975	ASEPTIC MENINGITIS	DIPH THERIA	ENCEPHALITIS	ENCEPHALITIS, POST INFECTIOUS	HEPATITIS A AND UNSPECIFIED	HEPATITIS B	TUBERCULOSIS, PULMONARY	MENINGOCOCCAL INFECTIONS	PERTUSSIS	RABIES IN ANIMALS	RUBELLA*	SEVERE UNDERNUTRITION	SHIGELLOSIS	TYPHOID FEVER	OTHER SALMONELLOSIS	TETANUS	MEASLES	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY
TOTAL TO DATE 19 74	54	0	11	1	301	109	280	27	7	15	58	17	59	4	72	1	12	12392	331
TOTAL TO DATE 19 75	59	0	15	10	245	85	264	23	19	3	277	9	72	2	67	3	0	10960	258
TOTAL THIS MONTH	14	0	5	2	23	2	38	1	5	1	32	0	9	1	13	0	0	1781	43
ACADIA	1																		3
ALLEN							1												4
ASCENSION																			11
ASSUMPTION																			8
AVOYELLES																			3
BEAUREGARD																			2
BIENVILLE					1										1				21
BOSSIER																			3
CADDO							2						6		3				166
CALCASIEU							2				4								110
CALDWELL																			1
CAMERON																			6
CATAHOULA											1								2
CLAIBORNE																			2
CONCORDIA																			4
DESOTO															1				4
EAST BATON ROUGE			1		3		2								2				96
EAST CARROLL																			4
EAST FELICIANA																			
EVANGELINE																			2
FRANKLIN																			4
GRANT											1								2
IBERIA																			8
IBERVILLE							1												8
JACKSON																			2
JEFFERSON	1			1	2		2				23				1				114
JEFFERSON DAVIS																			5
LAFAYETTE			1								1								55
LAFOURCHE					2						1								10
LASALLE																			1
LINCOLN															1				24
LIVINGSTON																			7
MADISON																			7
MOREHOUSE																			14
NATCHITOCHE					2		1		2										62
ORLEANS	7		2		7		15			1			1	1					674
OUACHITA							7												3
PLAQUEMINES																			6
POINTE COUPEE																			72
RAPIDES					1		1												2
RED RIVER																			11
RICHLAND																			8
SABINE									3				1						8
ST. BERNARD					1	1									1				5
ST. CHARLES																			10
ST. HELENA																			2
ST. JAMES				1															6
ST. JOHN																			6
ST. LANDRY					1		2												24
ST. MARTIN																			17
ST. MARY			1								1								12
ST. TAMMANY					1														35
TANGIPAHOA																			29
TENSAS							1												5
TERREBONNE	1					1													5
UNION																			5
VERMILION							1								1				2
VERNON	4								1				1		1				16
WASHINGTON																			15
WEBSTER					1														8
WEST BATON ROUGE																			3
WEST CARROLL														1					22
WEST FELICIANA																			3
WINN																			3
OUT OF STATE																			3

* Includes Rubella, Congenital Syndrome

HEALTH SCREENING OF VIETNAMESE REFUGEES *

Relocation of over 119,000 Vietnamese refugees to thousands of American communities is currently under way. With the assistance of sponsors, these refugees will be learning how to adapt to a different life style and satisfy immediate as well as long-range needs. One obvious early need is on-going medical care. As physicians, many of you will be involved in caring for these people in your practice. In order to assist you, the following report has been developed to provide general information on the health status and health problems observed in the first 40,000 Vietnamese in the refugee camps. Particular emphasis has been placed on infectious diseases because of the nature of the screening and medical treatment provided in the camps.

These refugees are generally healthy and well nourished and present no greater public health risk than any other aliens arriving in the United States.

All refugees routinely receive visa medical clearance exams including an RPR card test for syphilis, a chest X-ray (individuals greater than 15 years) and a TB skin test (individuals less than 15 years). When an RPR test is positive, the FTA absorption test is performed. Appropriate treatment is instituted, where necessary, and information regarding test results and therapy is recorded on Form FS-398, Medical Examination of Visa Applicants. Copies of the form are provided to the individual as well as to the appropriate State Health Department for follow-up if any of the tests are positive.

An immunization program for children 1-5 years of age was initiated. It is estimated that between 90 and 100 percent of these children will have received at least initial vaccinations against polio, measles, rubella, and diphtheria, pertussis, and tetanus. Vaccination programs are not uniform throughout the camps. Actual vaccinations administered to each child are recorded on the individual's WHO immunization card which can be used by the physician assuming responsibility for the child's care in the community.

A variety of illnesses were observed in the refugees. The following is a brief summary to

alert the physician to disease entities that might be encountered after relocation of the refugees. There has been no attempt to provide statistical information or details on diagnosis and treatment.

1. Conjunctivitis was extremely common and felt to be primarily of viral etiology. In the case of a persistent conjunctivitis, the physician should consider the possibility of trachoma.
2. Skin diseases, especially impetigo, were frequently observed. Hence, the physician should be alert to possible immunologic complications associated with streptococcal infection.
3. Gastrointestinal disorders were a common complaint. Diarrhea was frequently observed, usually transient, and of nonspecific etiology. In cases where causative organisms were cultured, *E. coli*, *Shigella*, and *Salmonella* were frequently found. Another possible cause of diarrhea which physicians should consider is *Vibrio parahaemolyticus*.

Parasitic infection of the G.I. tract is very common in Vietnam and may account for a variety of gastrointestinal signs and symptoms including diarrhea. Parasites recovered from stool specimens of refugees on Guam included *Ascaris*, *Trichuris*, *Giardia*, and hookworm. *Ascaris* was the most common parasite identified.

Previous studies of Oriental adults revealed a high prevalence of varying degrees of lactose intolerance with clinical onset in children between 2 and 10 years of age. Significance of this deficiency has not been well delineated; however, the physician should consider this entity in a patient presenting with diarrhea.

A few cases of typhoid fever were identified. Although, in most cases, the organism was sensitive to both ampicillin and chloramphenicol, chloramphenicol is the drug of choice.

4. Although only a few cases of hepa-

* Communication received from the Center for Disease Control, July 10, 1975.

titis were diagnosed in the refugee population, hepatitis A and hepatitis B are very common in Vietnam. In patients presenting with signs and symptoms of hepatitis, these diagnoses should be considered.

5. Although isolates of N. gonorrhoeae that are relatively resistant to antibiotics are common in Vietnam, recommended initial therapy is 4.8×10^6 units procaine penicillin IM and 1.0 gram probenecid PO. However, follow-up culture 3-7 days after therapy is very important to detect resistant strains. Infection that persists after treatment should be treated with spectinomycin 2 grams IM.

All cases of syphilis identified by the serologic testing are treated with at least 2.4 million units of benzathine penicillin IM (7.2 million units of benzathine penicillin IM were administered in all cases of syphilis other than primary or secondary because lumbar punctures were not performed in the camps. Follow up of treated patients should include serial quantitative VDRL and, when indicated, lumbar puncture).

6. Although malaria was present in 1 percent of returning servicemen, only 90 cases of vivax and falciparum malaria were diagnosed to date in the 119,000 refugees. Chloroquine-resistant falciparum malaria has been observed in Vietnam. In vivax malaria, relapses have been observed from 2 months to 3 years after treatment has been completed. Therefore, consultation should be sought in the diagnosis and treatment of all cases of malaria.

Approximately 10 to 12 percent of Vietnamese have G6PD deficiency with 4% having a severe enzyme deficiency. This should be kept in mind when primaquine is being considered for treatment of malaria.

7. Dengue fever, an arbovirus infection spread by the Aedes mosquito, has been diagnosed in 6 refugees and may present as an influenza-like illness. Given the short incubation

period and the brief viremic stage, it is felt that most cases would become clinically apparent before the individuals reach the U.S. mainland. Vector control measures for Aedes and Anopheles mosquitoes have been instituted at all the refugee camps in the United States.

8. In screening children for tuberculosis, positive skin tests were noted in only 11 percent despite the alleged administration of BCG vaccination to many Vietnamese children. The physician should keep in mind that active pulmonary tuberculosis may be present in children in whom it is difficult to obtain sputa and that non-pulmonary foci of infection are not unusual.

In children with positive PPDs (greater than 10mm) and a negative chest X-ray, isoniazid prophylaxis should be considered.

Twenty-three of the first 28,000 adults screened had sputa positive for tuberculosis. Appropriate chemotherapy was initiated.

In conclusion, the vast majority of Vietnamese refugees appeared to be free of infectious diseases. When illness was present it represented a personal rather than a public health problem. Although the physician can expect to see many of the same common disease entities that are readily diagnosed and treated in the American population, there are diseases seen in Vietnamese with which the American physician has little or no experience. This summary is an effort to provide the practicing physician with an overview of the various health problems observed in the refugees and, in particular, call attention to some diseases which might present a diagnostic problem.

Physicians with refugee patients may obtain additional information from CDC by calling:

404 633-3311
(daytime number until 5:00 p.m. EDT)

404 633-2176
(night number)

Family planning services may have been provided to the refugees in the camps. Physicians in the communities should be prepared to provide information on or accessibility to such services.