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Louisiana Morbidity Report

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Seasons Greetings

November-December 1993

Volume 4 Number 6

Shigellosis at Institution for Developmentally Disabled

This summer, the Office of Public Health investigated an outbreak of shigellosis at an institution for the developmentally disabled. Shigellosis outbreaks can be severe and prolonged in these institutions, but this outbreak appears to have been ended as a result of careful attention to control measures by the staff.

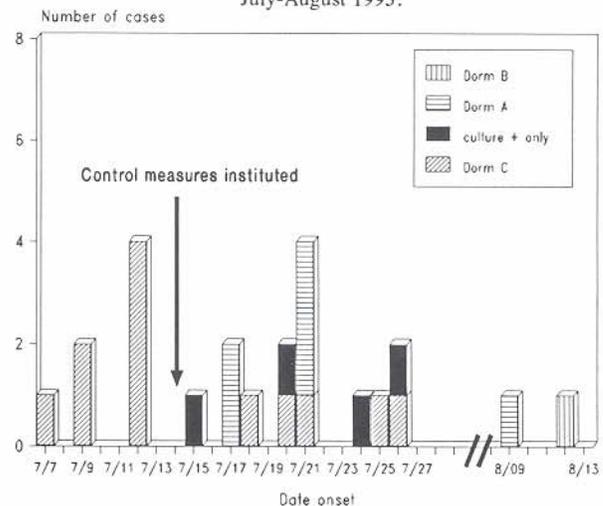
During June and July, an increase in shigellosis cases was detected in Rapides and Grant parishes. One of the cases reported by a physician in Rapides parish resided at a long term residential facility for the developmentally disabled and became ill on July 7th after returning from a weekend pass at home during the July 4th holiday. Follow-up done by the local health unit identified six additional shigellosis cases in this patient's dormitory. Facility A has three dormitories (Dorm A, B and C) with a total of 152 residents ranging in age from 5 to 22 years.

The following initial control measures were recommended by OPH before the investigation was completed: 1) cohort all cases with diarrhea in the infirmary; 2) treat all cases (asymptomatic and symptomatic) with trimethoprim/sulfamethoxazole; 3) initiate supervised handwashing by residents at least six times a day; 4) continue surveillance for additional residents with diarrhea; 5) minimize contact among residents and 6) exclude from work all employees identified with shigellosis. Recommendations were also made to exclude any ill foodhandler from work. All program

activities were canceled to minimize the degree of interaction among the residents of all three dorms.

Stool cultures were initially obtained for enteric pathogens on all residents and staff from Dorm C. Stool cultures were later obtained on all Dorm A residents when several residents from that dorm developed diarrhea. Between July 8th and August 13th, twenty three residents and 2 staff members had stool cultures positive for shigellosis (Figure 1), for an overall attack rate of 15 % (23/152). The attack rates among the dorms were: Dorm C [13/48 (27%)]; Dorm A [9/52 (17%)]; Dorm B [1/52 (2%)]. Attack rates increased with the severity of developmental disability: Mild [1/23 (4%)]; Moderate [3/23 (13%)]; Severe [10/23 (43%)]; Profound [9/23 (39%)]. A

Figure: Cases of shigellosis in institution by date of onset, July-August 1993.



total of 19 (83%) clients who had positive cultures had clinical manifestations of illness. These symptoms included diarrhea (19), fever (13), and bloody stools (2). Five cases were reported to have known seizure disorders. Of these cases, one resident had a seizure during this illness. Only one case was hospitalized, which was the index case.

Given the short incubation time of shigellosis and the fact that new cases continued to occur throughout the month, the pattern of spread strongly suggested person-to-person rather than a point source outbreak. Because of inadequately developed personal hygiene habits among residents of institutional settings, there is potential for rapid contact spread in this environment.

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Shigellosis at Ins. for Dev. Dis. (Cont.)

The low final attack rate in this outbreak suggests that the control measures instituted stopped the spread of shigella. In previous outbreaks known to OPH, residents treated with antibiotics had decreased duration of symptoms and their stool cultures became negative for shigella organisms more rapidly than those not treated. Reduction of shedding of shigella in stool may help prevent transmission from recovering clients to susceptible persons. Effective handwashing is difficult among institutionalized persons and requires considerable staff time and effort. By creating a schedule of supervised handwashing, the staff became aware and actively involved in improving client hygiene. In conclusion, antibiotic treatment, segregation of ill residents and supervised handwashing was useful in ending this outbreak of shigellosis.

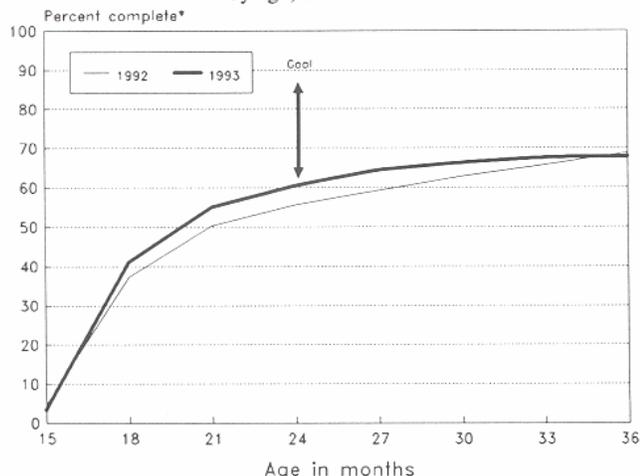
Improved Immunization Coverage in Public Clinics

The second annual public clinic survey has shown an increase in the immunization coverage of two-year-olds from 56% to 60% as a result of the "Shots for Tots" initiative.

The Office of Public Health, through its "Shots for Tots" initiative, is trying to raise the number of children adequately immunized by age two to 90% by the year 2000. As part of this initiative, surveys of over 100 public clinics are carried out annually. The surveys, which collect data on a statistical sample of children 24 to 35 months of age, are used to identify areas needing special attention and monitor progress toward the goal.

The percent of children up-to-date (having received four DTP, three OPV, and one MMR vaccine) in the 1993 survey was 55% at age 18 months and 60% at age 24 months. These percentages are consistently higher than those in the 1992 survey (Figure 1). Since many of the children in these clinics had already reached 24 months of age before any additional

Figure 1: Immunization coverage in public clinics by age, 1993 vs 1992

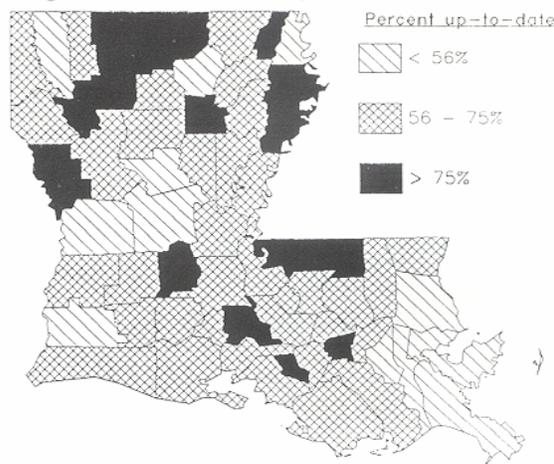


* Primary series: 4 DTP, 3 OPV, 1 MMR

resources were allocated, the improvements mainly reflect changes put in place by clinic staff in making clinics more efficient and in motivating parents to bring their children in early. Details of the extensive activities employed by these clinics were presented at the second annual "Shots for Tots" conference in November.

Of the 110 clinics surveyed in 62 parishes, the percent of children up-to-date by 24 months ranged from 15% to 94% (Figure 2). As was the case in 1992, coverage was highest in small clinics (following fewer than 300 two-year-olds) and lowest in large clinics (following more than 900 two-year-olds), but increases were seen in all clinic sizes.

Figure 2: Immunization average in public clinics by parish, 1993



Louisiana Morbidity Report
Volume 4 Number 6 November-December 1993

The Louisiana Morbidity Report is published bimonthly by the 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, Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.

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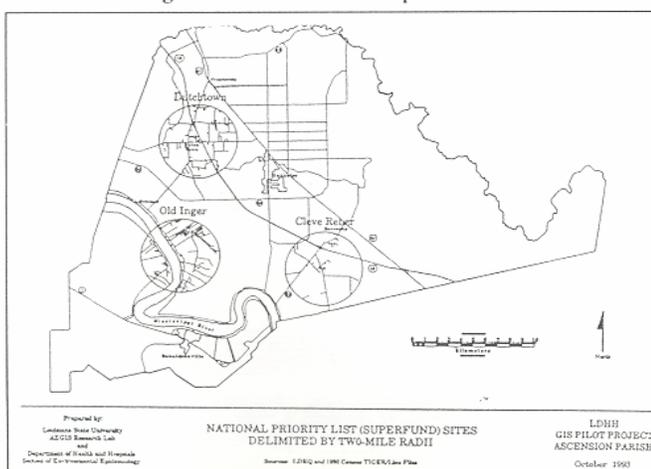
Environmental Epidemiology Geographic Information System

Since December 1990, the Section of Environmental Epidemiology (SEE) has been developing a Geographic Information System (GIS) to analyze and map health, environmental and population data. A GIS is a computerized database and mapping system that allows users to ask questions of the data and receive graphic answers. This system is being used for: 1) a lead study of Metropolitan New Orleans and Lafourche parish; 2) a pilot project in Ascension Parish; and 3) a statewide environmental health surveillance system.

The lead study utilizes GIS to assess the relationship of the pattern of blood lead levels in children six and under to soil lead levels, socioeconomic status, race, and age of housing. The datasets are organized by Census Tract (an area of approximately 4,000 people) and provide information on risk of exposure under a variety of urban conditions. Data from Metropolitan New Orleans is compared with similar data from Lafourche Parish to show the differences in urban and rural exposures.

The Ascension Parish pilot was designed to demonstrate GIS capabilities and expand study methods for environmental health surveillance. The health data for the pilot project are 1985-1992 low weight births. The environmental data for the pilot are samples from the parish's 130 public water supply systems. Hazardous waste sites and industrial plants are mapped, as are registered private water wells. All data are mapped at the Census Block Group level (approximately 640 people). Two mile radii were generated around the parish's three Superfund sites (Cleve Reber, Dutchtown, and Old Inger), where SEE is investigating environmental justice issues and identifying high risk populations (Figure). A local Community Assistance Panel (CAP) and public meetings allow for public input.

Figure: Ascension Parish Superfund Sites



Statewide surveillance will be developed in 1994 using vital records (Live Birth file, Death file, and the Louisiana Tumor Registry (LTR)). SEE will map rates for the state at the Census Block Group level for four types of health outcomes (1985-1992): selected causes of death including cancer mortality, congenital anomalies, low birth weight, and stillbirths. LTR began collecting cancer incidence data for south Louisiana in 1983. SEE will map rates for south Louisiana for the seven available years of cancer incidence (1983-1989). Statewide environmental indicators will include drinking water and Toxic Release Inventory (TRI) data.

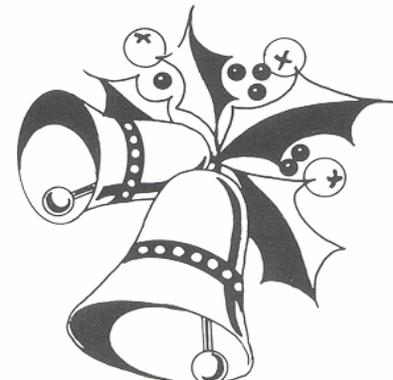
Rimantadine Approved for Influenza A Treatment and Prophylaxis

On September 20 the FDA approved a new drug, rimantadine, for treatment and prophylaxis of influenza A in adults. This drug appears to have fewer side effects than the only currently approved drug for influenza A, amantadine.

Rimantadine has been shown to reduce the duration of fever and other symptoms if taken within 48 hours of the onset of symptoms. The drug is recommended to be given twice a day for seven days. For prophylaxis, the drug has been proven safe and effective if taken twice a day for up to six weeks. The drug has not been approved for use in children. Rimantadine is marketed as Flumadine, and is available as 100mg coated tablet and as a syrup.

In a study comparing amantadine and rimantadine, 14.7% of healthy adults taking amantadine had adverse reactions, compared with 6.9% of those taking rimantadine. The most common side effects of rimantadine were insomnia, nausea and dizziness.

Vaccination is still the best way to protect against influenza infection, because it gives longer-lasting protection and because it gives immunity to both influenza A and B. In addition, use of rimantadine may lead to the development of resistant influenza A virus. The Centers for Disease Control therefore still recommends vaccination as the preferred method for preventing influenza.



Hantavirus Pulmonary Syndrome in Louisiana

In late June the CDC received a report from Dr. Ken Steier about a man who died from Adult Respiratory Distress Syndrome (ARDS) of unknown etiology. Subsequent investigation confirmed that this illness was associated with a Hantavirus.

Hantaviruses are a family of viruses which are known to cause hemorrhage, fever and renal failure (hemorrhagic fever with renal syndrome). Since May of 1993, however, public health officials have been investigating a previously unrecognized Hantavirus-related pulmonary syndrome. This illness was first noted in Arizona, New Mexico, Colorado and Utah where the deer mouse has been implicated as the reservoir for the virus. Transmission to humans is thought to occur by direct contact or by aerosolization of rodent body fluids. The illness begins with an influenza-like prodrome, and then progresses to ARDS and severe hypotension. 42 cases in 12 states have been identified in the US so far; 26 (62%) of these cases have been fatal. Treatment for this illness is largely supportive, although the Centers for Disease Control is conducting an investigational protocol using Ribavirin.

The Louisiana case occurred in a previously healthy 58 year-old. He was routinely exposed to rodents at work.

No other members of this man's family or his co-workers have become ill or have serologic evidence of Hantavirus exposure. Despite an extensive search, no other cases of similar illness have been identified in Louisiana. Of note, the deer mouse does not live in Louisiana; the reservoir for the virus here is not known.

Although this case appears to have been a rare occurrence, the Office of Public Health continues to send tissue and serum samples to the Centers for Disease Control for Hantavirus testing. Physicians who wish to have samples considered for testing or who wish to inquire about the Ribavirin protocol should contact the Office of Public Health, Epidemiology Section at (504)568- 5005.

Hepatitis C Test Approved

A new supplemental test for hepatitis C virus, a recombinant immunoblot assay (RIBA), has been approved by the U.S. Food and Drug Administration. The new three-stage test uses recombinant HCV antigens immobilized on test strip bands which change to a blue-black color if HCV antibodies are present in the serum or plasma specimens. This test is designed as a second generation confirmatory test and should eliminate false-positive test results by current laboratory methods. The new test should improve diagnostic accuracy, eliminate unnecessary treatment, and enhance the safety of blood supplies. The (RIBA) test is considered sufficiently accurate by the FDA that it has been approved to "re-enter" blood donors who may have tested false positive under current tests.

Changes in TB Therapy Regimen

The Office of Public Health is recommending two changes in the therapy of patients with active tuberculosis in Louisiana. These changes follow new recommendations by the Centers for Disease Control and Prevention (CDC). These two changes are the use of Directly Observed Therapy for all patients with active tuberculosis and the addition of a fourth drug, Ethambutol, to the initial regimen for new TB cases.

Directly Observed Therapy is a method to guarantee compliance with TB therapy. It involves placing the patient on a regimen of TB medications given 2-3 times per week with each dose being observed by a healthcare provider. The observation can be done at a health unit, a physician's office, a substance abuse clinic, the patient's home or another designated site. This has been recommended by the CDC because many studies have shown that the majority of TB patients do not take their medications regularly for the entire 6-12 month course of therapy. In addition, studies have shown that healthcare providers cannot determine prospectively which patients will comply with therapy. In 1991, 28% of TB patients in Louisiana did not complete their course of therapy within 1 year. This can lead to continued spread of disease and the development of resistant strains of TB organisms.

The addition of Ethambutol to the initial regimen for new tuberculosis cases also follows CDC recommendations. Outbreaks of highly resistant tuberculosis have occurred in several states. If a new patient has been infected with a resistant strain and is started on drugs to which the organism is not sensitive, the patient's disease continues to progress and the patient continues to spread infection to those around them. The CDC recommends adding Ethambutol to the initial drug regimen in areas where more than 4% of new TB patients have organisms resistant to one or more medications. In Louisiana, 4.4% of new TB patients have organisms resistant to at least one medication. Once the drug sensitivities of the patient's TB organism are available, therapy can be adjusted to eliminate any extra medications.

These changes in therapy have been successful in other states and have decreased the spread of disease and decreased the development of new resistant organisms. Questions concerning the new recommendations can be answered by Dr. Meg Lawrence or Mr. Charles DeGraw of the TB Control Program at (504) 568-5015.



AIDS Update

Tuberculosis and AIDS

To date, Louisiana's Office of Public Health AIDS Surveillance Program has received reports on a cumulative total of 5,098 AIDS cases. Of these cases, 248 (4.9%) have a definitive or presumptive diagnosis of infection with tuberculosis; either pulmonary or extrapulmonary. Of the cases diagnosed with *M. Tuberculosis*, 49% have died. Compared to other opportunistic diseases, tuberculosis ranks as the 11th most common disease among these cases.

Of the cumulative male AIDS cases, 5.0% have been diagnosed with *M. tuberculosis*, whereas only 3.4% of female AIDS cases have been diagnosed. This gender breakdown was similar to that for several common opportunistic diseases in which a greater percentage of male cases have been diagnosed than female cases (Table 1).

Table 1: Opportunistic diseases associated with AIDS

Disease:	% of LA cumulative cases with disease*		
	Male (N=4710)	Female (N=494)	Total (N=5204)
Pneumocystis Pneumonia	43.7	32.2	43.2
Wasting Syndrome	17.6	21.9	18.1
Esophageal Candidiasis	15.7	18.8	16.1
Kaposi's Sarcoma	11.6	2.0	10.8
Mycobacterium Avium	9.2	7.3	9.1
Cryptococcosis	8.6	6.1	8.5
HIV Encephalopathy	7.3	6.7	7.3
Cytomegalovirus Retinitis	5.4	3.4	5.2
Herpes Simplex	5.1	3.4	5.1
Toxoplasmosis of Brain	5.1	3.2	5.0
<i>M. Tuberculosis</i> (Pulmonary & Extrapulmonary)	5.0	3.4	4.9
Cryptosporidiosis	4.2	4.9	4.3
Cytomegalovirus Disease	4.0	3.4	4.0

*As of December 1, 1993.

Tuberculosis was most frequently found in Hispanic (7.3%) followed by African-americans (5.5%) and whites (4.3%) (Table 2). The risk category with the greatest frequency of TB was intravenous drug users (6.1%).

Data from the New Orleans site of CDC's Adult Spectrum of Disease Study currently consists of 2,674 cases. Of these cases, 106 have been diagnosed with tuberculosis. CD4 counts were measured on 74% of these patients within six months of their TB diagnosis resulting in an average CD4 count of 194. Other commonly diagnosed opportunistic diseases had lower average CD4 counts at time of diagnosis. When considering CD4 counts at time of entry into the study, a greater percentage (6.0%) of cases with CD4 counts less than 200 were eventually diagnosed with TB as compared to only 1.0% of cases with CD4 counts greater than 500 (Table 3).

M. Tuberculosis, both pulmonary and extrapulmonary, continues to be present in all subgroups of persons with AIDS. The recent addition by the CDC of pulmonary TB to the list of opportunistic infections demonstrates its association with AIDS. Continued attention towards prevention measures (PPD skin testing of HIV positive persons and HIV testing of PPD-positive persons with preventive treatment of those infected with both organisms) is necessary in order to control the spread of TB in this population.

Table 2: Percentage of cases within specific sub-groups diagnosed with tuberculosis

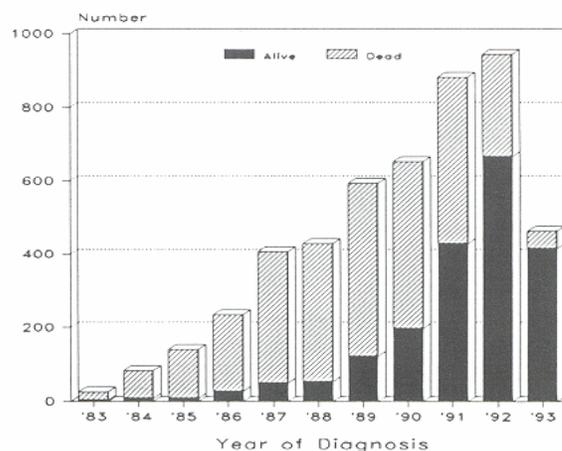
	N	% Diagnosed with TB
Gender:		
Male	4710	5.0
Female	494	3.4
Race/Ethnicity:		
Caucasian	3073	4.3
African American	1992	5.5
Asian	146	2.7
Hispanic	124	7.3
Risk Category:		
Homo/bisexual	3587	5.0
IDU	1091	6.1
Transfusion	146	2.7
Hemophiliac	59	0.0
Heterosexual	264	2.7

Table 3: Percentage of cases within a specific CD4 count range with a diagnosis of tuberculosis*

CD4 Count	% Diagnosed with TB
< 200	6.0
200-500	2.0
> 500	1.0
Unknown	11.0

*Source: CDC's Adult Spectrum Of Disease Study (New Orleans Site).

AIDS CASE TRENDS



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE,
 SEPTEMBER- OCTOBER, 1993
 PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD					
	1	2	3	4	5	6	7	8	9	Sept-Oct 1993	Sept-Oct 1992	Cum 1993	Cum 1992	% Chg	
<u>Vaccine-preventable</u>															
Measles	0	0	0	0	0	0	0	0	0	0	0	1	0	--	
Mumps	0	2	0	0	0	0	1	0	1	2	2	17	22	-23	
Rubella	0	0	0	0	0	0	0	0	0	0	0	1	0	--	
Pertussis	1	1	0	0	0	0	0	1	0	3	3	12	9	+33	
<u>Sexually-transmitted</u>															
AIDS	Cases	57	24	4	11	4	7	5	9	7	130	127	903	782	+15
	Rate ¹	7.8	3.2	1.3	2.0	1.5	2.2	0.9	3.0	1.6	3.1	3.0	21.4	18.6	
Gonorrhea	Cases	722	305	69	180	85	117	299	117	113	2007	2789	10916	12200	-10.5
	Rate ²	9.8	4.1	2.3	3.2	3.3	3.8	5.5	3.9	2.5	4.8	6.6	25.9	28.9	
Syphilis(P&S)	Cases	67	156	24	51	4	19	89	40	23	473	502	2239	2314	-3.2
	Rate ²	0.9	2.1	0.8	0.9	0.2	0.6	1.6	1.3	0.5	1.1	1.2	5.3	5.5	
<u>Enteric</u>															
<i>Campylobacter</i>		6	4	3	1	3	0	0	0	4	22	41	136	196	-31
Hepatitis A	Cases	4	2	1	0	0	0	5	1	1	15	28	72	188	-62
	Rate ¹	0.5	0.3	0.3	--	--	--	0.9	0.3	0.2	0.4	0.7	1.7	4.5	
<i>Salmonella</i>	Cases	11	12	5	7	10	3	10	5	8	74	108	370	390	
	Rate ¹	1.5	1.6	1.7	1.3	3.9	1.0	1.8	1.6	1.8	1.8	2.6	8.8	9.2	
<i>Shigella</i>	Cases	1	7	7	6	9	28	2	1	4	66	24	369	85	7.4
	Rate ¹	0.1	0.9	2.3	1.1	3.5	9.0	0.4	0.3	0.9	1.6	0.6	8.8	2.0	
<i>Vibrio cholera</i>		0	0	0	0	0	0	0	0	0	0	1	1	1	0
<i>Vibrio, other</i>		4	1	1	0	0	0	0	0	1	9	0	32	26	+23
<u>Other</u>															
Hepatitis B	Cases	13	2	0	0	2	1	5	1	1	26	28	184	150	+23
	Rate ¹	1.8	0.3	--	--	0.8	0.3	0.9	0.3	0.2	0.6	0.7	4.4	3.6	
Meningitis/Bacteremia															
<i>H. influenzae</i>		0	0	0	0	0	0	1	0	0	1	0	4	0	--
<i>N. meningitidis</i>		1	0	1	0	0	0	2	1	0	5	2	35	25	+40
Tuberculosis	Cases	N/A	N/A	N/A	N/A	N/A	--								
	Rate ¹	--	--	--	--	--	--	--	--	--	--	--	--	--	

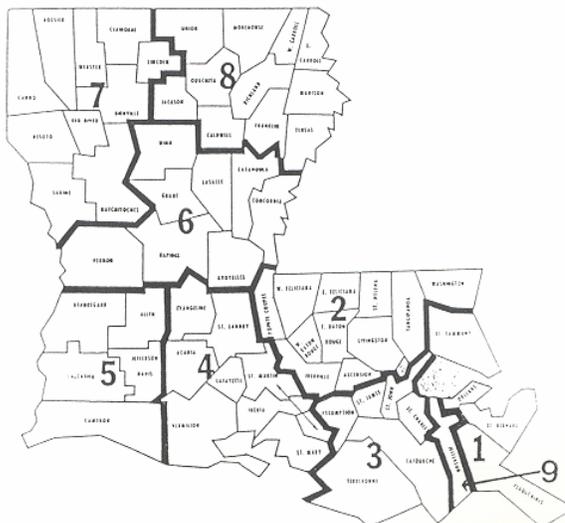
1 = Cases per 100,000
 2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	7
Brucellosis	1
Histoplasmosis	1
Lead Toxicity	0
Legionellosis	3
Lyme Disease	2
Malaria	4
Rocky Mountain Spotted Fever	1
Tetanus	0
Typhoid	1

Table 3. Animal Rabies (Sept-Oct 1993)

Parish	No. Cases	Species
Lafayette	1	Skunk



Annual Summary Salmonellosis 1992

In 1992, 639 salmonella cases were reported to the Epidemiology Section, a case rate of 15.1 per 100,000. Salmonella case reports decreased 17% from 1991 and 22% from 1990. Sex-specific rates were slightly higher for males than females (16 vs 14 per 100,000) and race-specific rates were similar between blacks and whites (10.2 vs 9.6 per 100,000). The majority of cases occurred in children and teenagers less than 15 years of age. Nearly 36% (228 cases) of the total reported cases was in the 0 - 4 year age group (Figure 1). The top five parishes reporting the highest case rates per 100,000 were: Assumption (39), LaSalle (37), St. Tammany (36), Terrebonne (35) and Lafayette (28; Figure 2). Of the 26 serotypes identified in 1992, *S. newport* (32 cases) and *S. typhimurium* (29 cases) were the most frequently reported followed by *S. enteritidis* (23 cases), *S. mississippi* and *S. heidelberg* (10 cases each; Table).

Figure 1: Cases by age and sex, 1992

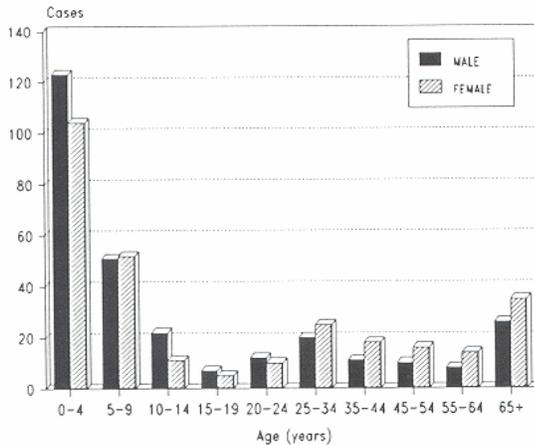


Figure 2: Rates of salmonellosis by parish, 1992

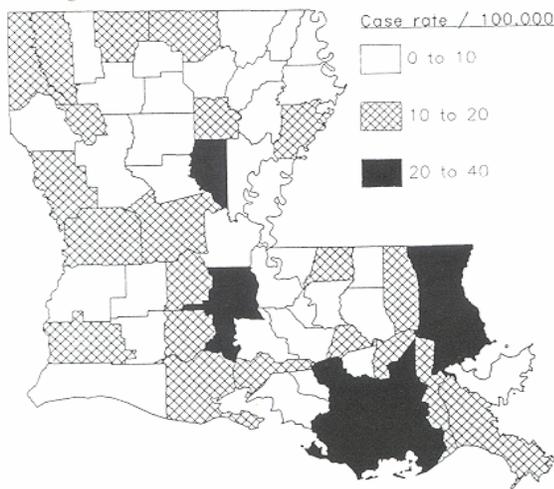


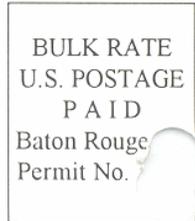
Table: Frequency of salmonella serotypes, 1990-1992

Serotype	1990			1991			1992		
	Cases	Rank	%	Cases	Rank	%	Cases	Rank	%
newport	25	3	11	63	3	13	32	1	17
typhimurium	67	1	21	71	1	15	29	3	16
enteritidis	37	2	12	71	1	15	23	3	13
mississippi	21	5	7	36	4	8	10	4	5
javiana	28	4	9	31	5	6	5	5	3

Food is an effective vehicle for transmission of the bacteria, although most commonly associated with consumption of contaminated eggs or poultry. Prevention of disease outbreaks due to the organism rests on controlling the conditions that allow for bacterial growth. The diagnosis of Salmonellosis is made by stool culture and should be considered in any patient with acute gastroenteritis; the presence of headache or fever makes the possibility of this disease more likely. Intervention and treatment should include boosting handwashing practices and reserving usage of antibiotics for certain high risk individuals, such as the elderly or infants.

LOUISIANA FACTS

The first Board of Health was organized in New Orleans in 1816-17, as a result of a prevailing yellow fever epidemic. The early laws were quite comprehensive. Yards of the city were ordered to be kept clean and free from stagnant water; privy holes were not to be dug within three feet of a boundary line, and privies when full were to be emptied during the night hours; no oysters were to be sold during May to September; no filth was to be deposited in drain canals or gutters; stables were to be kept clean; slaughter houses within the city limits were to be licensed, and all other slaughtering of animals within the city limits was to be abated; dressed meat in transit through the city streets was to be covered, and no burials were to be made except in public burying grounds. Garbage and street cleanings were collected by a private contractor, who was obliged to hand a bell around the neck of his horse in order to let householders know of his approach. The public markets were to remain open until noon, at which time they must close and each stall be thoroughly cleaned. These regulations were enforced by the police. A form of quarantine was in vogue; the Mayor had the right to prevent any infected matter dangerous to health to be landed in the city from ships. This health organization was in operation until 1819, when the act was repealed, and the Governor was invested with the right to establish quarantine by proclamation.



LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Granuloma Inguinale**	Plague*	Cancer
Amebiasis	Hepatitis (Specify type)	Poliomyelitis	Complications of abortion
Anthrax	Herpes (genital/neonatal)**	Psittacosis	Congenital hypothyroidism
Aseptic meningitis	Human Immuno-deficiency Virus (HIV)	Rabies (animal & man)	Lead poisoning
Blastomycosis	Legionellosis	Rocky Mountain Spotted Fever	Phenylketonuria
Botulism*	Leprosy	Rubella (German measles)*	Reye Syndrome
Brucellosis	Leptospirosis	Rubella (Congenital syndrome)	Severe Traumatic Head Injuries +
Campylobacteriosis	Lyme Disease	Salmonellosis	Severe undernutrition severe anemia, failure to thrive
Chancroid**	Lymphogranuloma venereum**	Shigellosis	Sickle cell disease (newborns)
Cholera*	Malaria	Syphilis**	Spinal cord injury +
Chlamydial infection**	Measles (rubeola)*	Tetanus	Sudden infant death syndrome (SIDS)
Diphtheria*	Meningitis, Haemophilus	Trichinosis	
Encephalitis (Specify primary or post-infectious)	Meningococcal Infection (including meningitis)*	Tuberculosis***	
Erythema infectiosum (Fifth Disease)	Mumps	Tularemia	
Foodborne illness*	Mycobacteriosis, atypical***	Typhoid fever	
Genital warts**	Ophthalmia neonatorum*	Typhus fever, murine (fleaborne endemic)	
Gonorrhoea**	Pertussis (whooping cough)	Vibrio infections (excluding cholera)	
		Yellow fever	

Report cases on green EPI-2430 card unless indicated otherwise below.

*Report suspected cases immediately by telephone. In addition, report all cases of rare or exotic communicable diseases and all outbreaks.

**Report on STD-43 form. Report syphilis cases with active lesions by telephone.

***Report on CDC 72.5 (f 5.2431) card

+ Report on DDP-3 form; preliminary phone report from ER encouraged (568-2509).

The toll free number for reporting communicable diseases is
 1-800-256-2748 FAX # 504-568-3206

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