



Louisiana Morbidity Report

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Chlamydia Infections in Young Women

Chlamydia infection may be the most common sexually transmitted disease in the U.S, and it is a major cause of infertility and ectopic pregnancy. Because chlamydia infection is usually asymptomatic in women (and often asymptomatic in men also), the disease can only be recognized by conducting screening laboratory tests. However, because the cost of these tests can be high, it is reasonable to establish screening criteria based on the expected prevalence of disease. Recently, the STD section linked billing data from Family Planning clinics statewide with STD case reports for one month in 1995 to determine the prevalence of chlamydia in subgroups of women, so that screening criteria can be established.

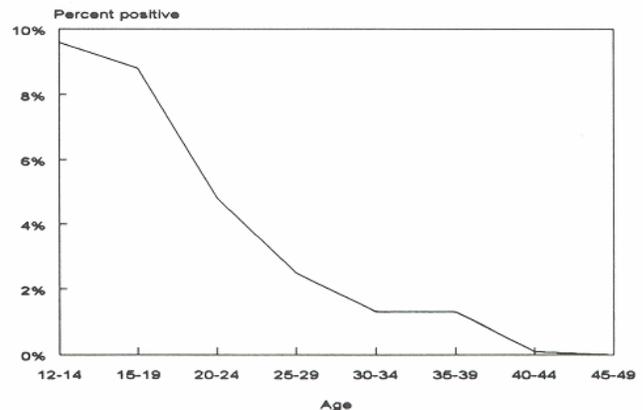
Overall, 4.6% (248/5,421) of women attending family planning clinics had chlamydia infection by a DNA probe test. This is substantially less than the 6.5% - 11% found in New Orleans in 1994 (see Louisiana Morbidity Report September-October 1994), but is still very high by national standards. Chlamydia prevalence was somewhat higher in black women than white women (5.5% vs. 2.6%), and somewhat higher in urban than rural parishes (6.3% vs. 4.0%), but otherwise did not vary substantially by sociodemographic characteristics (Table). In contrast, there was a striking relationship between chlamydia prevalence and age (Figure). The prevalence decreased steadily and

Table. Chlamydia prevalence by socioeconomic characteristics, Louisiana family planning clinics, January 1996

Characteristic	Positive/Tot	% Positive
Race		
Black	203/3,682	5.5%
White	43/1,666	2.6%
Other/Unknown	2/74	2.7%
Educational level		
≤ 9th grade	48/831	5.8%
10-11th grade	68/1,065	6.4%
HS diploma	95/2,545	3.7%
Some college	33/823	4.0%
College graduate	4/158	2.9%
Reported monthly income		
< \$200	68/1,372	5.0%
\$200-499	67/1,156	5.8%
\$500-799	42/1,111	3.8%
\$800-1,199	36/1,103	3.6%
≥ \$1,200	13/477	2.7%
Parish of residence		
Urban 1	86/1,371	6.3%
Rural	162/4,050	4.0%
TOTAL	248/5,421	4.6%

1. For this analysis, urban parishes were defined as Orleans, East Baton Rouge, and Caddo parishes.

Figure 1. Chlamydia prevalence in Louisiana family planning clinics by age, January 1996



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rapidly from 9.6% in girls age 12-14 to less than 1% in women age 45-49.

This strong relationship between age and chlamydia prevalence has been seen in many other areas of the U.S. Because of this, most other areas recommend chlamydia screening only for women below a certain age, usually 25. If family planning clinics in Louisiana used this criterion, we could reduce our testing by 39%, while identifying 86% of chlamydia cases. If the age criterion were raised to 26, we would reduce our testing by 34% and identify 89% of cases.

The STD section is currently reviewing this data and because of current budgetary problems, is considering establishing an age cutoff for chlamydia screening in family planning clinics. In view of the high rates of chlamydia in young women across all socioeconomic groups, other health care providers should screen sexually active women below the age of 25 for chlamydia whenever pelvic examinations are carried out.

Postexposure Prophylaxis to HIV Update

Provisional Recommendations

A recent study published by the Centers for Disease Control and summarized in the January - February issue of the Louisiana Morbidity report suggested that zidovudine (ZVD) may reduce the risk for HIV transmission after occupational exposure to HIV-infected blood. Since that study was done, several new antiretroviral drugs have been approved for use by the FDA. New recommendations from the U.S. Public Health Service for needlesticks have been released. These guidelines are provisional because they are based on limited data regarding efficacy and toxicity of postexposure prophylaxis (PEP) and risk for HIV infection after different types of exposure. Because most occupational exposures to HIV do not result in infection transmission, potential toxicity must be carefully considered when prescribing PEP. When possible, these recommendations should be implemented in consultation with persons having expertise in antiretroviral therapy and HIV transmission. Changes in drug regimens may be appropriate, based on factors such as the probable antiretroviral drug resistance profile of HIV from the source patient; local availability of drugs; and medical conditions, concurrent drug therapy, and drug toxicity in the exposed worker.

The following table refers to the new provisional guidelines based on type of exposure and source material. For additional information, call the Epidemiology Section or refer to CDC's MMWR June 7, 1996/Vol. 45/ No. 22 issue. Footnote for the table is on page 3.

TABLE 1. Provisional Public Health Service recommendations for chemoprophylaxis after occupational exposure to HIV, by type of exposure and source material- 1996

Type of exposure	Source material*	Antiretroviral prophylaxis+	Antiretroviral regimen:
Percutaneous	Blood ^		
	Highest risk	Recommend	AZT plus 3TC plus IDV
	Increased risk	Recommend	AZT plus 3TC+ IDV**
	No increased risk	Offer	AZT plus 3TC
	Fluid containing visible blood, other potentially infectious fluid, ++ or tissue	Offer	AZT plus 3TC
	Other body fluid (e.g., urine)	Not offer	
Mucous membrane	Blood	Offer	AZT plus 3TC, +IDV**
	Fluid containing visible blood, other potentially infectious fluid, ++ or tissue	Offer	AZT, +3TC
	Other body fluid (e.g., urine)	Not offer	
Skin, increased risk***	Blood	Offer	AZT plus 3TC, +IDV**
	Fluid containing visible blood, other potentially infectious fluid, ++ or tissue	Offer	AZT, +3TC
	Other body fluid (e.g., urine)	Not offer	

AZT - Zidovudine
3TC - Lamivudine
IDV - Indinavir

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*Any exposure to concentrated HIV (e.g., in a research laboratory or production facility) is treated as a cutaneous exposure to blood with highest risk.

+*Recommend*-Postexposure prophylaxis (PEP) should be recommended to the exposed worker with counseling (see text). *Offer*-PEP should be offered to the exposed worker with counseling (see text). *Not offer*-PEP should not be offered because these are not occupational exposures to HIV.

:Regimens: zidovine (AZT), 200 mg three times a day; lamivudine (3TC), 150 mg two times a day; indinavir (IDV), 800 mg three times a day (if IDV is not available, saquinvir may be used, 600 mg three times a day). Prophylaxis is given for 4 weeks. For full prescribing information, see package inserts.

^*Highest risk*-BOTH larger volume of blood (e.g., deep injury with large diameter hollow needle previously in source patient's vein or artery, especially involving an injection of source-patient's blood) AND blood containing a high

titer of HIV (e.e., source with acute retroviral illness or end-stage AIDS; viral load measurement may be considered, but its use in relation to PEP has not been evaluated). *Increased risk*-EITHER exposure to larger volume of blood OR blood with a high titer of HIV. *No increased risk*-NEITHER exposure to larger volumes of blood, NOR blood with a high titer of HIV (e.g. solid suture needle injury from source patient with asymptomatic HIV infection).

** Possible toxicity of additional drug may not be warranted (see text).

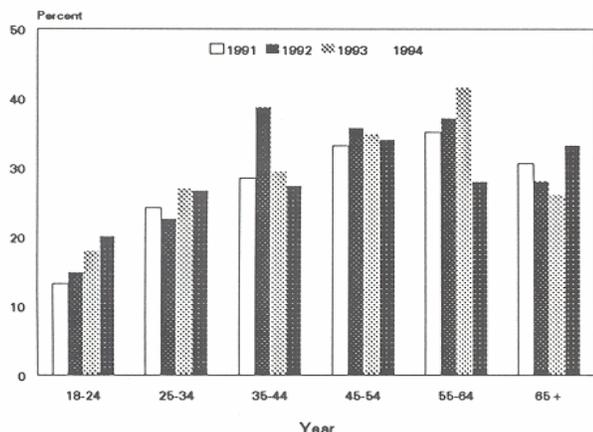
++ Includes semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.

*** For skin, risk is increased for exposures involving a high titer of HIV, prolonged contact, an extensive area, or an area in which skin integrity is visibly compromised. For skin exposures without increased risk, the risk for drug toxicity outweighs the benefit of PEP.

Obesity and Nutrition, Louisiana 1991-1994

More than one in four Louisiana adults are obese (persons who are 20% or more above their ideal body weight are considered obese and are 20% more likely to die from all causes than persons at normal weight). Obesity rates in Louisiana did not change significantly from 1991 to 1994. Persons between 45 and 64 years of age were significantly more likely to be obese than those younger or older (Figure 1).

Figure 1: Obesity among Adults by age 1991 - 1994



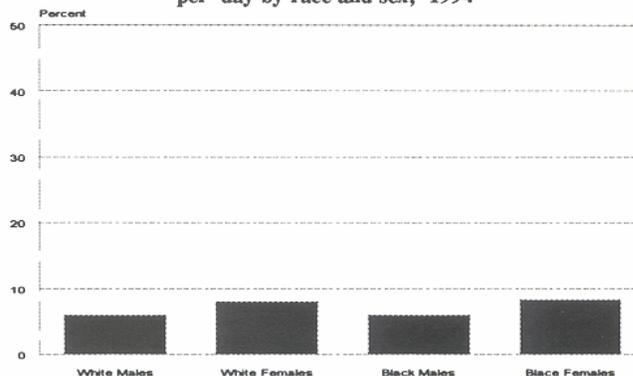
Females (28.7%) were significantly more likely to be obese than males (27.3%) and African Americans were significantly more likely to be obese than Whites (35.4% vs 25.5%).

One way of achieving and maintaining normal weight is a healthy diet. A healthy diet includes two servings of fruits

and three servings of vegetables each day. Fruits and vegetables should be eaten without added sugar or fats and with little added salt. Ideally they should be eaten raw or lightly steamed to preserve vitamins and minerals.

Only about one in five (19.3%) adults in Louisiana consume five fruits and vegetables a day, while one in six (16.5%) persons ages 18-44 and one in four (25.7%) persons ages 45 and older consume five fruits and vegetables a day. Moreover, females (13.5%) were twice as likely ($p < 0.01$) to consume five fruits and vegetables each day as males (6.6%; Figure 2).

Figure 2: Adult consumption of five fruits and vegetables per day by race and sex, 1994



This data is taken from the Louisiana Behavior Risk Factor Surveillance System which has been collected on an annual basis since 1991. Louisiana BRFSS data on fruit and vegetable consumption was only collected in 1994. The national Healthy People 2000 objective for obesity is to reduce obesity to a prevalence of no more than 20 percent

Obesity and Nutrition, Louisiana 1991-1994 (cont.)

among people aged 20 and older and no more than 15 percent among adolescents aged 12-19. The Healthy People 2000 objective for nutrition is to increase complex carbohydrate and fiber-containing foods in the diets of adults to five or more daily servings for vegetables (including legumes) and fruits, and to six or more daily servings for grain products. Physicians should encourage patients to achieve normal weight and eat five fruits and vegetables a day as one way of adopting healthier life styles.

Active Surveillance Program for Drug-Resistant Pathogens

The documentation of the spread of drug-resistant microorganisms is in its early stages, but all studies agree that their prevalence has seen a dramatic increase. At the same time, our ability to detect, contain, and prevent infections caused by these pathogens has been limited. In order to more effectively detect cases and provide timely information to the health care providers, the Epidemiology and the HIV/AIDS Surveillance Sections have jointly begun an active surveillance program for drug-resistant *Streptococcus pneumoniae* (DRSP) and vancomycin resistant Enterococci (VRE). Selected hospitals (hospitals with 175 or greater beds) and reference laboratories will report (monthly) aggregate data on the number of isolates screened and number of those demonstrating drug-resistance. Resistant isolates will be forwarded to the state laboratory for additional standardized drug sensitivity testing. Additionally, basic demographic and clinical data (i.e., site of specimen) will be obtained on all patients with positive drug-resistant isolates.

Data on drug-resistance in Louisiana is limited but telling. At LSU Medical Center in Shreveport one study (Silberman) documented that in 1993 5% of *S. pneumoniae* isolates were penicillin-resistant, as compared to 1995 when 30% of isolates demonstrated some degree of penicillin-resistance. A cross sectional study of children in day care centers in Lake Charles in 1995 (Foch, Unkel) found that 37% of their sample carried *S. pneumoniae*, and that 40% of these cultures were drug-resistant. Data from a sample of Louisiana hospitals places the estimated rates at 2 cases/1000 beds per year for VRE. For DRSP the rate was 86 cases/1000 beds, with sensitivity patterns cited ranging from 24% to 36% of *S. pneumoniae* isolates screened testing positive for penicillin-resistance.

The surveillance system will provide data that will help determine the risks associated with the acquisition and spread of drug-resistant infections, monitor changes in resistance trends, and provide early detection of new resistance patterns. Each participating facility will be given findings from the surveillance system in the form of both community-specific and statewide resistance patterns to assist physicians in deciding on the most effective antibiotic therapy. The data will also be used to evaluate national trends in DRSP and VRE as a health priority.

Traumatic Brain Injuries Among Louisiana's Infants

Traumatic brain injuries are a leading cause of severe disability and death from injury among children and young adults. Infants, because of the fragility of their skulls, may have an increased risk of brain injury in an event that would not necessarily cause significant injury to an older child or adult.

Eighty-four cases of traumatic brain injury among children less than one year of age were reported in Louisiana during 1995. Of these, 81 had a specified cause of injury. The majority (75%) were sustained as a result of falls (Figure 1). Eighty-seven percent of the falls were from one level to another. Of these, 38% of the infants were dropped by their caretaker. The remainder fell when they were left unrestrained in car seats or infant carriers that were placed on other furniture, infant swings, shopping carts, etc.

Fifty-eight percent of the infants sustained a skull fracture and 33% had an intracranial lesion (i.e. hematoma, hemorrhage, contusion, laceration, trauma induced brain edema). Eighty-one of the infants had an outcome specified. Of these, 4% of the infants died and 5% had some degree of disability upon discharge from the acute care facility (Figure 2). However, deficits from a brain injury are not always immediately identifiable and impairment may become noticeable later in life.

Brain injuries, like other injuries, are often predictable and preventable. The majority of the brain injuries to infants were fall-related. This underscores the need for close supervision of infants at all times and the proper use of infant carriers, shopping carts, and car seats, including the use of restraints in such devices.

Figure 1: Cause of traumatic brain injury among infants, Louisiana 1995

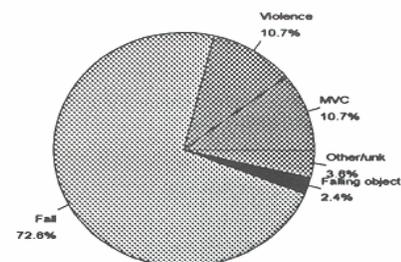
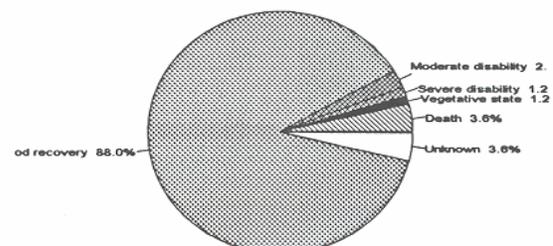


Figure 2: Outcome of traumatic brain injuries among infants, Louisiana 1995



AIDS UPDATE

HIV Seroincidence in a New Orleans STD Clinic

Data from AIDS case reporting and seroprevalence surveys have provided useful information to monitor the impact of the HIV/AIDS epidemic. However, in order to help target and monitor the effectiveness of HIV prevention programs, it is important to measure the rate of new infections in a population, i.e. the HIV incidence rate.

OPH is currently conducting a study in a New Orleans STD clinic in order to estimate the incidence of HIV in the clinic population and to monitor trends in incidence over time. The clinic provides services free of charge and serves a population which is 67% male and 94% African-American. All clients who enter the clinic receive HIV counseling and are offered HIV testing unless the client has visited the clinic in the previous 90 days. HIV test results and information from the STD clinic visit are entered into a computer database. This analysis includes all clients who visited the clinic between January 1990 and May 1996 and had at least 2 HIV tests.

A seroconverter is a person who had a negative HIV test and a subsequent positive HIV test. As shown in Table 1, the total number of seroconverters during the study time period was 99 and the incidence rate was 0.55/100 person-years (p-y) or 0.55% per year. Incidence rates were higher in males (0.59/100 p-y) than in females (0.37/100 p-y). Rates were highest in persons age 40 and over, but were also very high among clients under age 20. Incidence was highest in 1991 and 1992 and appears to be decreasing in subsequent years.

Table 2 shows incidence rates associated with specific risk behaviors reported by the clients during their HIV counseling and testing session. Among males, incidence rates were very high among those who had sex with other men (2.20/100 p-y) and among men who reported injecting drug use (1.21/100 p-y). Rates among heterosexual men who exchanged sex for money or drugs (but did not inject drugs or have sex with men) were higher than among heterosexuals who did not exchange sex. Among females, the number of seroconversions was small; however, incidence rates were highest in women whose sex partners injected drugs (1.73/100 p-y). Many of the seroconverters had no acknowledged risk because either they were unaware of their sex partners' risk behaviors or they were reluctant to report their own risk behaviors.

This study has helped to identify the populations who are currently at greatest risk of HIV infection in order to more effectively target prevention resources. We will continue to monitor incidence patterns and trends over time in this STD clinic population.

**Table 1: HIV Incidence in a New Orleans STD Clinic
January 1990 - May 1996**

	No. of Converters	Rate/100 person-years
Total	99	0.55
Sex		
Male	85	0.59
Female	14	0.37
Age		
<20	16	0.63
20-29	43	0.45
30-39	23	0.54
40+	17	0.92
Year		
1990	3.8	0.41
1991	18.5	0.61
1992	26.2	0.64
1993	22.3	0.55
1994	18.6	0.53
1995	8.5	0.40

Table 2: HIV Incidence by Risk Factor January 1990 - May 1996

	No. of Converters	Rate/100 person-years
Males		
Men who have sex with men	21	2.20
Injecting drug users	9	1.21
Exchanged sex for money or drugs	22	0.79
No acknowledged risk	32	0.32
Females		
Injecting drug users	1	0.80
Sex partner of injecting drug use	3	1.73
Exchanged sex for money or drugs	1	0.36
No acknowledged risk	9	0.28

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
May - June, 1996
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	May-June 1996	May-June 1995	Cum 1996	Cum 1995	% Chg	
Vaccine-preventable															
Measles	0	0	0	0	0	0	0	0	0	0	17	0	17	-	
Mumps	0	0	0	0	0	0	0	0	1	1	2	11	8	+38	
Rubella	0	0	0	0	0	0	0	0	0	0	0	1	0	-	
Pertussis	0	0	1	1	0	0	0	0	0	2	8	5	9	-44	
Sexually-transmitted															
AIDS	Cases Rate ¹	62 5.7	20 3.6	3 0.8	3 0.6	0 0	5 1.6	5 1.0	1 0.3	2 0.6	100 2.3	183 4.2	501 11.6	483 11.2	+3.7
Gonorrhea	Cases Rate ²	631 6.1	109 1.9	77 2.0	127 2.5	68 2.5	83 2.7	196 3.9	123 3.5	52 1.4	1466 3.5	2197 5.2	4720 11.2	5870 13.9	-20
Syphilis(P&S)	Cases Rate ²	47 0.45	11 0.19	6 0.16	5 0.10	1 0.04	0 -	12 0.24	13 0.37	7 0.18	102 0.24	160 0.38	332 0.79	536 1.27	-38
Enteric															
Campylobacter		7	3	5	2	2	1	0	1	2	28	44	63	82	-23
Hepatitis A	Cases Rate ¹	5 0.5	5 0.9	0 -	4 0.8	0 -	0 -	1 0.2	11 3.1	7 1.8	35 0.8	14 0.3	86 2.0	49 1.2	+75
Salmonella	Cases Rate ¹	16 1.5	25 4.4	8 2.1	18 3.5	5 1.9	4 1.3	6 1.2	9 2.6	13 3.4	116 2.8	95 2.2	172 4.1	135 3.2	+27
Shigella	Cases Rate ¹	46 4.4	60 10.6	5 1.3	8 1.6	2 0.7	3 1.0	43 8.5	1 0.3	29 7.5	208 4.9	91 2.1	361 8.6	166 3.9	+117
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	-
Vibrio, other		7	0	2	0	0	0	0	0	1	12	12	14	13	+8
Other															
Hepatitis B	Cases Rate ¹	1 0.1	2 0.4	0 -	3 0.6	2 0.7	1 0.3	8 1.6	2 0.6	0 -	20 0.5	33 0.8	63 1.5	105 2.5	-40
Meningitis/Bacteremia <i>H. influenzae</i>		0	0	0	0	1	0	0	0	0	1	0	2	1	+100
<i>N. meningitidis</i>		3	0	1	1	1	0	0	0	0	6	8	39	33	+18
Tuberculosis	Cases Rate ¹	5 0.5	0 -	0 -	2 0.4	1 0.4	0 -	0 -	0 -	0 -	8 0.2	-	66 1.6	-	-

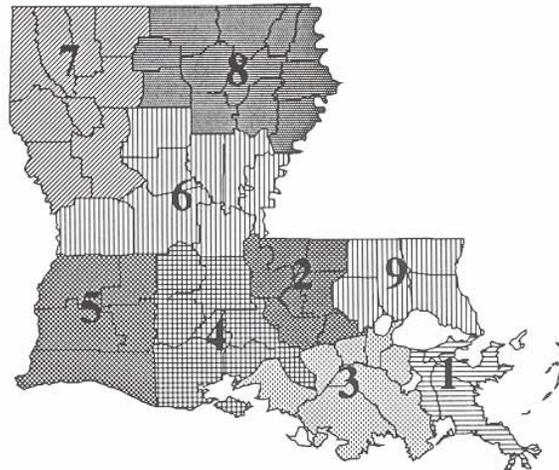
1 = Cases per 100,000
 2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	1
Histoplasmosis	1
Lead Toxicity	16
Typhoid	1
Rocky Mountain Spotted Fever	0
Lyme Disease	1

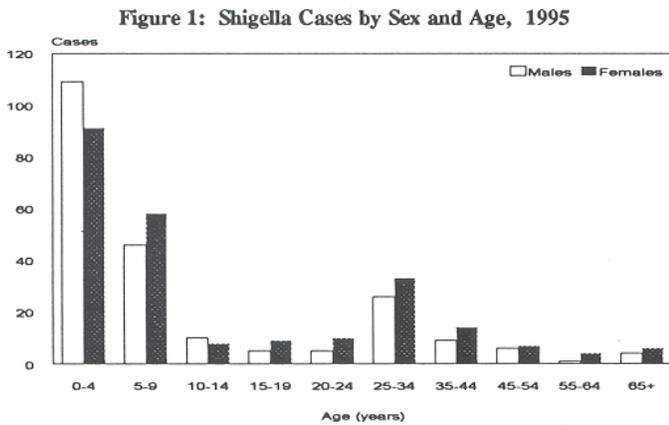
Table 3. Animal Rabies (May-June 1996)

Parish	No. Cases	Species
Lafayette	1	Skunk
Evangeline	1	Skunk
Webster	1	Skunk



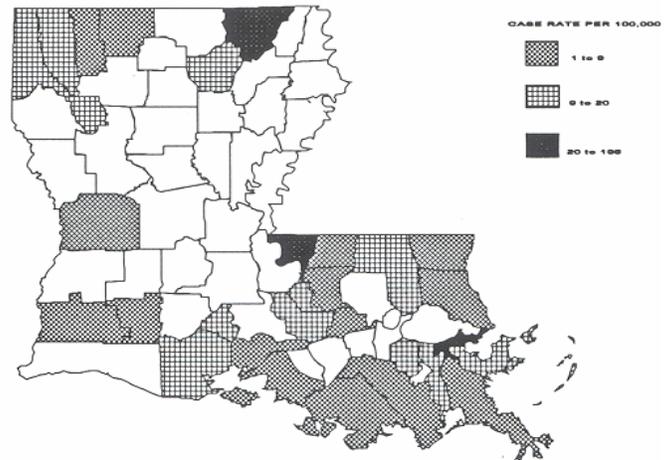
ANNUAL SUMMARY Shigellosis - 1995

Four hundred eighty-five cases were reported to the Epidemiology Section for 1995, an overall state case rate of 11.2 per 100,000. The number of cases this year increased by 2% than from last year. Sex-specific rates were similar between males and females (11.0 vs 10.9 per 100,000), while race-specific rates were twice as high for blacks as whites (10.8 vs 5.3 per 100,000). Sixty three percent of the cases were in children less than 10 years of age, which is consistent with previous years [Figure 1].



Fifty-six per cent of the cases were reported from three parishes: Orleans (143), Jefferson (68) and Morehouse (61). Several outbreaks were associated with day care settings in which fifty-two (11%) were reported, while a large majority was associated with household and/or close contact. Parishes with the highest case rates per 100,000 include: Morehouse (197), Orleans (30), W. Feliciana (23), Vermilion (16), Jefferson (15), and Ouachita (14), [Figure 2]. Of 478 isolates serotyped, 98% were identified as *S. sonnei*.

Figure 2: Rates of Shigellosis by Parish, 1995



LOUISIANA FACTS

Analyses of Air in New Orleans in 1873.

Date.	PLACE.	Time.	Wind.	Conditions.	Grammes Ammonia per 1,000,000 Cubic Metres Air.	Grammes Alb. Ammonia per 1,000,000 Cubic Metres Air.	REMARKS.
June 4	Corner Perdido and Liberty streets.	9 a. m.	Fresh.	No smell.	270	720	
" 2	131 Rousseau street.	10 a. m.			270	360	
" 10	183 Jackson street.	10 a. m.			231	99	
" 12	Corner Magazine and Seventh streets.	10 a. m.			100	150	
" 16	Villero, b. C'mhouse & Bienville sts.	10 a. m.		Gutters filthy; no smell.	200	200	
" 17	" St. Louis & Toulouse sts.	10 a. m.		" "	283	283	
" 18	Derbigny, b. C'mhouse & Bienville sts.				224	304	
July 1	Corner Conti and Franklin streets.		S. fresh.		128	144	
" 3	Old Magazine and St. Mary streets.				200	176	
" 12	Corner Greatmen and Port streets.	9 a. m.	W. fresh.	Stagnant water in vicinity.	280	520	
" 15	" Franklin and Customhouse.		N. E.	Gutters filthy.	240	400	
Aug. 13*	Lovee st., bet. Fifth and Sixth sts.	8 a. m.	W. fresh.	off the river.	99	264	
" 15*	Tchoupitoulas, b. First & Second sts.	9 a. m.	W. light.	"	99	231	
" 16*	41 Washington street.	9 a. m.	"	"	165	297	
" 30*	Corner Rousseau and First streets.	9 a. m.	No wind.	"	600	400	
Sept. 9*	" " and Saraparu streets.	9 a. m.	N.E. fresh.	"	200	350	
" 11*	" Josephine and Rousseau.	9 a. m.	E.	"	280	560	
" 12*	" Chippewa and Fourth streets.	9 a. m.	E.	"	216	560	
Oct. 29*	" Rousseau and Adele streets.	9 a. m.	N. W.	"	240	720	
Nov. 7*	" Saraparu streets.	9 a. m.	"	"	270	560	
" 12*	" Water and Josephine streets.	9 a. m.	"	"	240	800	Very dusty day.
" 13	Wharf, between Sixth & Seventh sts.	9 a. m.	N. E.	off river.	160	180	
" 14	Corner Lafayette and Liberty sts.	9 a. m.	"	Gutters pretty dirty.	300	560	Dusty.
" 15	" Liberty and Gravier streets.	9 a. m.	No wind.	"	180	270	

ALFRED W. PERRY, M. D.

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Hemolytic-Uremic Syndrome	Cancer
Amebiasis	Hepatitis, Acute (A, B, C, Other)	Complications of abortion
Anthrax	Hepatitis B in pregnancy	Congenital hypothyroidism
Aseptic meningitis	Herpes (genitalis/neonatal)**	Galactosemia
Blastomycosis	Human Immunodeficiency Virus (HIV) infection****	Hemophilia
Botulism*	Legionellosis	Lead poisoning
Brucellosis	Leprosy	Phenylketonuria
Campylobacteriosis	Leptospirosis	Reye Syndrome
Chancroid**	Lyme disease	Severe Traumatic Head Injuries +
Cholera*	Lymphogranuloma venereum**	Severe undernutrition
Chlamydial infection**	Malaria	severe anemia, failure to thrive
Diphtheria*	Measles (rubeola)*	Sickle cell disease (newborns)
Encephalitis (specify primary or post-infectious)	Meningitis, (Haemophilus)*	Spinal cord injury +
Erythema infectiosum (Fifth Disease)	Meningococcal infection (including meningitis)*	Sudden infant death syndrome (SIDS)
Escherichia coli 0157:H7	Mumps	
Foodborne illness*	Mycobacteriosis, atypical***	
Genital warts**	Ophthalmia neonatorum**	
Gonorrhea**	Pertussis	
Granuloma Inguinale**	Plague*	
	Poliomyelitis	
	Psittacosis	
	Rabies (animal & man)	
	Rocky Mountain Spotted Fever (RMSF)	
	Rubella (German measles)	
	Rubella (congenital syndrome)	
	Salmonellosis	
	Shigellosis	
	Syphilis**	
	Tetanus	
	Trichinosis	
	Tuberculosis***	
	Tularemia	
	Typhoid fever	
	Typhus fever, murine (fleaborne, endemic)	
	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 Lab 94 form (Retrovirus). Name and street address are optional but city and ZIP code must be recorded.

+ 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 # 504-568-5006**

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