



M. J. "Mike" Foster, Jr.
GOVERNOR

Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
P.O. Box 60630, New Orleans, LA 70160 (504) 568-5005
www.dhh.state.la.us/OPH/infectepi/default.htm



David W. Hood
SECRETARY

May-June 2001

Volume 12 Number 3

It looked like a myocardial infarction after eating crawfish...Ever heard of Haff disease?

If you diagnose a case let us know...we need to identify the toxin.

Nevin Krishna, MS, MPH
Jennifer Wood, MPH,

In April, a 26 year old female ate boiled crawfish that she purchased at a seafood restaurant/market. She ate at 1:00 p.m. By 5:00 she had nausea, vomiting, chest pain, shortness of breath, and profuse sweating. By 7:00 she went to the local hospital emergency room and was hospitalized. She had been in good health, took no drugs, and drinks very moderately. The physical examination was normal and a complete evaluation for myocardial infarction was negative. The only abnormality was a level of creatine phospho kinase (CPK) of 1024, (normal = 0-162) and the diagnosis was rhabdomyolysis of undetermined origin. By 11:00 p.m. her CPK rose to 8670. The following day she felt better and was discharged. Two days later her CPK was 379.

Two days after the initial case another woman, 33, ate crawfish from the same establishment at 8:00 p.m. By 11:00 she had severe stomach cramps, chest and back pain, nausea, hematuria. At 1:00 a.m. she was admitted to a local hospital for chest pain and shortness of breath. Her physical exam was normal and there was no evidence of myocardial infarction. Her initial CPK was 884, the following day it rose to 8600, and then dropped to almost normal a day later.

Within seven days of the first case, there were seven additional people who were hospitalized with similar histories of chest pain, shortness of breath, nausea, and sweating. All had a history eating

crawfish purchased at the same establishment and developed symptoms within 3 to 16 hours (mean 8 hours) of their meals. Five were hospitalized and recovered swiftly without sequelae. All had a rise in CPK to 6000-8000 which returned to normal in a few days.

The cases all lived in several small towns within a 30 mile radius. Several controls who also ate crawfish did not get sick. Inquiries into other hospitals in the area did not reveal any additional cases.

The Office of Public Health conducted an environmental and epidemiologic investigations. The environmental inspection did not indicate any violations or evidence of cross contamination with chemicals or pesticides, and food preparation was deemed satisfactory. Crawfish samples were submitted to the Office of Public Health laboratory for analysis of heavy metals, pesticides and herbicides. All results were negative.

Creatine Phospho Kinase is an enzyme that is found in all muscle cells (cardiac and other muscles). High CPK in the blood means "damaged muscle cells". The enzymes more specific to the heart muscle (CK MB and troponin) were normal in all cases. Causes of **rhabdomyolysis** are numerous: vigorous exercise, certain drugs such as lipid lowering drugs, some herbal teas, substance abuse (cocaine, ecstasy, alcohol), snake bites, bee stings and some infectious diseases. None of these cases had any of these risk factors. Other suspected causes include a long list of metals and metalloids (copper, arsenic, chromium, barium...) and some pesticides, fungicides or herbicides.

A bibliographic review indicates that this outbreak is characteristic of **Haff disease**. A review of Haff disease was published in *Emerging Infectious Diseases*, Volume 6 No. 2/March - April 2000, *Dispatches Haff Disease: From the Baltic Sea to the U.S. Shore*. Udo Buchholz, Eric Mouzin et al.

In 1924, an outbreak of sudden, severe muscular pain and rigidity (often with dark urine) was described near the Königsberger Haff shores along the Baltic coast. Most patients survived without sequelae but a few died. During the next decade some 1,000 cases occurred in similar small outbreaks. The cases all had recently consumed cooked fish (turbot, eel, pike). Seabirds and cats also seemed to have been affected. Several hypotheses were considered, particularly arsenic poisoning, however all were disproven.

In the U.S. there have been very few cases reported:

- 1984: 2 cases from Texas
- 1985: 2 cases from California
- 1986: 2 cases from California
- 1997: 4 cases from California
2 cases from Missouri

(Continue on next page)

Contents

Myocardial Infarction	1
Newborn Screening for Congenital Hypothyroidism	2
Louisiana Rabies Testing 2000	3
Td Vaccine Shortage	4
Violence in Louisiana	4
Hazardous Substance Emergency Events Surveillance	5
Annual Summary: Vibrio infections - 2000	7

The 1997 US cases were defined as an illness in a person with unexplained rhabdomyolysis who had eaten fish within 24 hours of onset of symptoms. All ate buffalo fish that originated from Louisiana and Missouri. Buffalo fish (*Ictiobus cyprinellus*) is a bottom-feeding freshwater fish similar to carp. The laboratory marker used to define rhabdomyolysis is a fivefold or greater elevation in creatine kinase (CK) levels, with a muscle/brain (MB) fraction <5%. The same definition applies to the recent Louisiana cases except for a history of crawfish consumption.

Samples of food were recovered and analyzed (Buchholz U, 2000). Recovered leftovers and uncooked fish from the same lot were tested for the toxin of ciguatera or saxitoxin, the toxin of paralytic shellfish poisoning, and the toxins of blue-green algae. To characterize the physicochemical properties of the toxin, extract from both cooked and uncooked fish was partitioned into water-soluble, nonpolar lipid (hexane) and polar lipid (chloroform) fractions. These fractions were then administered intraperitoneally and orally to laboratory mice. Fractions causing toxicity to mice were further analyzed for identification of the toxin.

The origin of the buffalo fish eaten by four of the patients was traced to the same wholesaler in Louisiana who receives fish from approximately 25 fishermen who fish rivers in Louisiana. No fish or unusual animal die-off was noted in the areas where buffalo fish were caught.

The next step in the current investigation is to identify the toxin and find the source. This is a long and complicated process. Samples of suspected food will be sent to the FDA laboratory for further identification.

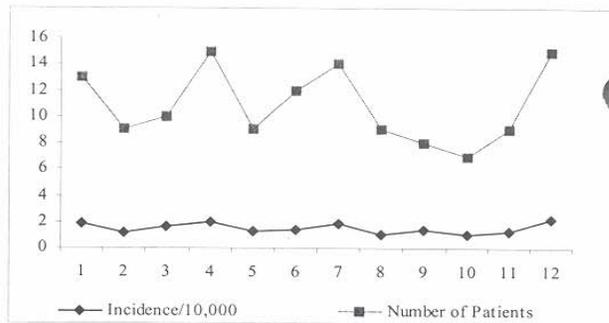
hypothyroidism is slightly higher in whites vs non-whites (1.5 vs 1.3/100,000 live births), a pattern similar to the U.S. rates.

The number of cases reported ranged from 7 to 15 per year with no significant trend. The total number of births has steadily decreased from 73,887 in 1988 to 67,034 in 1999. The incidence of CH per 10,000 newborns ranged from 1.1 to 2.2 (Figure 1). Sixty percent of the cases reported from 1990-1999 were females. White females had the most cases (48), followed by white males (24), non-white males (19), and non-white females (17; Figure 2).

Newborn screening for CH is done on all newborns using "filter paper" blood specimens. This screening for CH constitutes a major progress in early detection of a treatable condition, thereby preventing mental retardation. Screening in the DHH-OPH State Laboratory is done by assay of the thyroxine levels (T4). Then thyroid-stimulating hormone (TSH) levels are obtained for specimens with T4 results in the lowest 12% of the daily batch. Screening for CH is now also done in all fifty states; private laboratories performing screening tests must report positive results to the Office of Public Health.

In Louisiana this condition is much more common in newborn girls than in newborn boys, which has also been reported in the

Figure 1: Cases of Congenital Hypothyroidism, Louisiana 1988-1999



Bulletin

Notice: Varicella vaccination will be required for all first time school enterers and child care attendees beginning in the fall of 2003.

Newborn Screening for Congenital Hypothyroidism, LA, 1988-1999

Louis Trachtman, MD MPH, Juan Acuña, MD MPH,
Charles Myers, MPH, and Roma Oliveri, RN
Department of Health and Hospitals Office of Public Health
(DHH-OPH)
Gabriela Ivankovich, Visiting Medical Student
Tulane University and University of Costa Rica

Between January 1, 1988 and December 31, 1999 there were 827,863 newborns in Louisiana that were tested for congenital hypothyroidism (CH). One hundred thirty (130) infants were diagnosed with congenital hypothyroidism. This represents an incidence of 1.6 per 10,000 births or 1 in 6,250 births. The rate of congenital

Louisiana Morbidity Report

Volume 12 Number 23

May-June 2001

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

Assistant Secretary, OPH

Madeline McAndrew

State Epidemiologist

Raoult Ratard, MD, MPH MS

Editors

Karen Kelso, RNC MS

Susan Wilson, MSN

Buddy Bates, MSPH

Layout & Design

Ethel Davis, CSG

medical literature. The reason for this occurrence is unknown.

The distribution of reported cases is statewide, showing no preference for any specific locale. Thirty two parishes had at least one reported case during 1988-1999, and these parishes are located in all nine regions of the state (Figure 3).

After verification and reporting to the infant's physician of the abnormal laboratory results of T4 and TSH levels, follow-up of the infant for further diagnostic work-up as to the etiology of CH and treatment is done by the infant's physician. Consultation is available from the State Genetic Diseases program. All reported cases of CH during 1988-1999 were started on thyroxine treatment.

Figure 2: Cases of congenital hypothyroidism by race and sex, Louisiana, 1990-1999

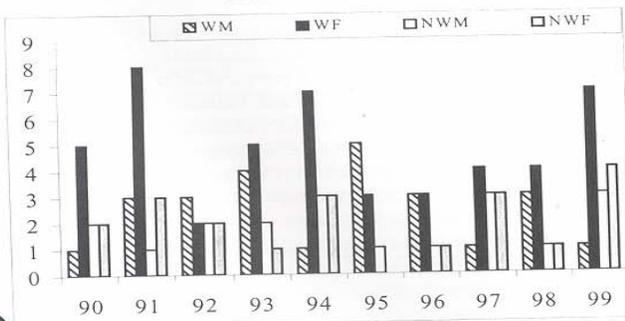
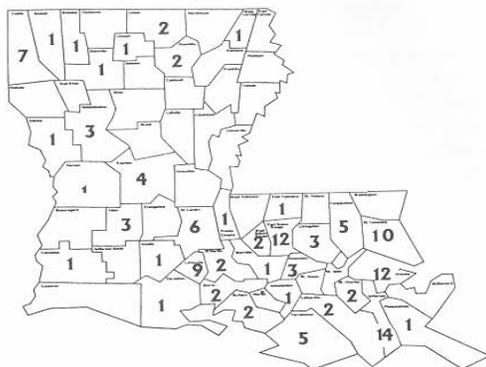


Figure 3: Cases of Congenital Hypothyroidism by parish, Louisiana 1988-1999



Louisiana Rabies Testing, 2000 Shelly Phillips, DVM MPH

Active surveillance for rabies continues in Louisiana. All animal bites or significant exposures to animal saliva need to be evaluated for possible rabies exposure. Bats and skunks are the main animals of concern. Bites accounted for 63% of the exposure types in samples submitted in 2000 (See Figure 1).

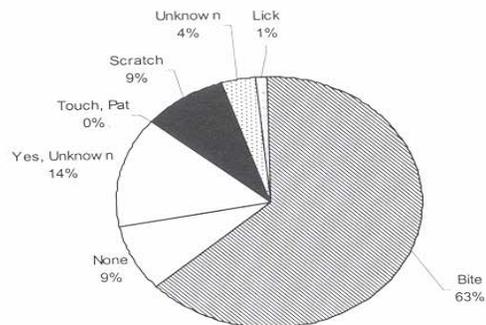
There were 726 animal heads submitted for rabies testing from 53 parishes in Louisiana in 2000 (Figure 2), of which 4 tested positive. These 4 positive cases were:

- 1 bat, Rapides Parish, July 2000
- 1 bat, Claiborne Parish, July 2000
- 1 skunk, Natchitoches Parish, September 2000
- 1 skunk, Acadia Parish, November 2000.

Although the positive rabies tests in Louisiana were found among bats and skunks, 82% of testing was performed on dogs and cats, whereas only 3.86% of testing was carried out on bat and skunk specimens (Table). Of the species tested, dogs accounted for 45% of the specimens, cats 37%, raccoons 5.4%, bats 2.6%, squirrels 2.3%, opossum 2.1% and skunks 1.2%.

Nationally, there were 7,067 cases of animal rabies in 1999. Ninety-one percent were found among wild animals and 8.5% were found in domestic species. Although the last human case of rabies in Louisi-

Figure 1: Exposure to animals by type, Louisiana, 2000



ana was in 1953, there have been 27 human cases of rabies between 1990 and 1999 diagnosed in the United States. One case was confirmed in 1998 and four human cases of rabies occurred in 2000. In the past 10 years, 20 out of 22 human cases of indigenously acquired rabies were associated with bat variants of the rabies virus. Only one case had a definite history of animal bite.

Vaccination of domestic livestock and companion animals, oral vaccination programs targeting wildlife, ongoing education programs, and other activities conducted by public health authorities have contributed to reduced transmission of rabies variants to human beings. Vaccination of pets provide a barrier to infection of human beings; a fact that cannot be overemphasized.

Post-exposure prophylaxis (PEP) should be administered to any person that has been bitten or scratched by a wild animal (except rodents and rabbits) that is not available for testing. Patients that have been bitten or scratched by dogs or cats may need PEP as well depending on the circumstances and vaccine status of the animal. Immediate PEP administration is not always indicated. Every effort should be made to locate and quarantine biting dogs and cats to

(Continue on next page)

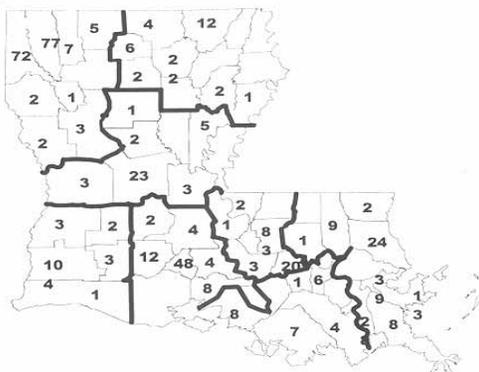
Table: Positivity rates of rabies for tested animals, Louisiana 1998-2000

Species	1998			1999			2000		
	Tested	Pos.	%	Tested	Pos.	%	Tested	Pos.	%
Dog	396	0	0	222	0	0	326	0	0
Cat	355	0	0	203	0.5	0	268	0	0
Raccoon	70	0	0	0	55	0	39	0	0
Bat	30	3	10	19	2	10.5	19	2	10.5
Skunk	5	0	0	22	2	18.2	9	2	22.2

avoid costly PEP administration and unnecessary euthanasia.

Please call the Infectious Disease Epidemiology Section at (504)568-5005 or 1-800-256-2748 if any questions or concerns arise.

Figure 2: Number of animal heads submitted by parish, 2000



Td Vaccine Shortage

Ruben Tapia, MPH
 Patricia Simon

The Office of Public Health needs to continue prioritizing Td vaccine use until further notice. In order to assure vaccine availability the National Immunization Program issued a statement on June 25, 2001 asking the states to delay all routine Td boosters for adolescents and adults until 2002. School immunizations requirement should be only applied to adolescent first time enterers into the schools and any person entering a school of higher learning. Changes to the school immunization requirements should not affect any vaccines other than Td, nor should they affect the primary immunization series for children. Please observe the following priorities:

- Provide vaccine to children 7 years of age who are first time enterers into the school.
- Provide Td when needed to complete primary series.
- Provide Td vaccination to prenatal patient as protocol dictates.
- Provide Td vaccination for wound management as protocol dictates, but refer patients to emergency room care as appropriate.

Violence in Louisiana

Buddy Bates, MSPH

Violence is a significant public health problem that can have lasting and pervasive effects on the mental and physical health of the victim. The National Violence Against Women Survey, conducted in 1995-96, estimates that each year in the United States 5.9 million physical assaults are perpetrated against women and 7.9 million physical assaults are perpetrated against men. Almost two percent (1.9%) of all women and 3.4% of all men are victims of such assaults. A survey was conducted that shows **Louisiana's annual rate of physical violence is significantly higher than the national average.** These results emphasize the need for further violence prevention efforts in the state.

The Office of Public Health administered a statewide random-digit-dialed survey from July 1998 to June 2000. During this time, 2353 women and 1258 men, age 18 years and older, were interviewed about their perceptions of safety and violence, and their experiences with physical violence, sexual violence, and stalking.

Fifty-three percent (n=1924) of the survey participants believed that violence was a big problem in their community. Almost 30% (n=1047) of the people surveyed reported that they knew someone who had been a victim of physical or sexual violence in the last year. Thirty percent (n=1081) of the residents also reported that the fear of violence had prevented them from doing something that they otherwise would have done.

Seven percent of men (n=89) and four percent of women (n=100) reported having been physically hurt by another person in the last year. Forty-six percent of the respondents who reported being physically hurt reported that the perpetrator was under the influence of [drugs or alcohol] at the time of the physically violent incident. Almost 13% of the victims reported that they had been using drugs or alcohol at the time of the victimization.

Twenty-one percent of all persons reporting an experience of physical violence in the last year indicated that the violent event included being threatened with a knife, gun, or other weapon. Almost 60% of the respondents who had been physically assaulted reported that they had sustained an injury as a result of the assault.

Of the men and women who were physically assaulted in the previous twelve months, 44.4% reported the situation to the police. Of those who reported an injury as a result of the physical abuse, only 19% sought medical care.

Overall, 77% of women who were physically assaulted reported that the perpetrator was someone known to them (intimate partner, relative, friend, or acquaintance), while only 39% of the men reported knowing their perpetrator. Of the women who were physically assaulted in the previous year, 52% were assaulted by an intimate partner (See Table 1 for a comparison of responses by men versus women).

Training health care providers to routinely screen patients for intimate partner violence and to refer victims to community resources is an important part of taking care of the needs of the victims. Additionally, there are many programs available which instruct people on diminishing the likelihood that they will be victims. However, perpetrators can easily target others as victims. In order

to decrease the prevalence of violent incidents, it is necessary for perpetrators to reform, and to prevent potential perpetrators from committing their first act of violence.

Violent behavior is often learned at an early age. Therefore violence prevention programs that start early in a child's life, involve the child's family, and are reinforced during adolescence are crucial to efforts focused on diminishing the magnitude of the problem. Anger management and conflict resolution are strategies deemed effective by the Surgeon General for preventing youth violence.

Table: Circumstances surrounding the most recent act of physical violence*

Physical Violence	Male	Female
Sustained an injury	42.7% (n=38)	73% (n=73)
Perpetrator under influence of drugs/alcohol	51.7% (n=46)	41% (n=41)
Victim under influence of drugs/alcohol	21.3% (n=19)	5% (n=5)
Threatened with weapon	29.2% (n=26)	14% (n=14)
Sought medical care	11.2% (n=10)	26% (n=26)
Reported situation to police	41.6% (n=37)	47% (n=47)
Perpetrator someone known	39.3% (n=35)	77% (n=77)
Perpetrator intimate partner	9% (n=8)	52% (n=52)

*N=189

Hazardous Substances Emergency Events Surveillance

Paige Mobley, MPH

In 2001 there has been over 700 incidents of exposure to hazardous waste spills in Louisiana. The Office of Public Health maintains a database to track these events and their potential health consequences.

In August of 2000 the Louisiana Office of Public Health (LOPH) Section of Environmental Epidemiology and Toxicology (SEET) was awarded funds from the Agency for Toxic Substances and Disease Registry (ATSDR) to participate in their Hazardous Substances Emergency Events Surveillance (HSEES) project. HSEES is a nationwide surveillance system comprising data collected by 16 states, one-third of the U.S. population and one-third of the U.S. land mass (excluding Alaska).

The HSEES database addresses hazardous substance spills, air releases, threatened releases and spills and associated health consequences including evacuations, injuries and deaths. This database expands already existing hazardous substance databases such as those of the National Response Center, the Department of Environmental Quality and the Louisiana State Police (LSP). In contrast to the data already being collected, the HSEES project focuses on the public health consequences of the exposed population i.e., injuries, medical care, evacuations, in-place sheltering, and community emergency planning.

The specific objectives of HSEES are 1) to describe the distribution of hazardous substance emergencies within Louisiana; 2) to describe the injury and death experiences within 24-hours of the spill/release by employees, first responders, and the general public; 3) in conjunction with the ATSDR, identify risk factors associated

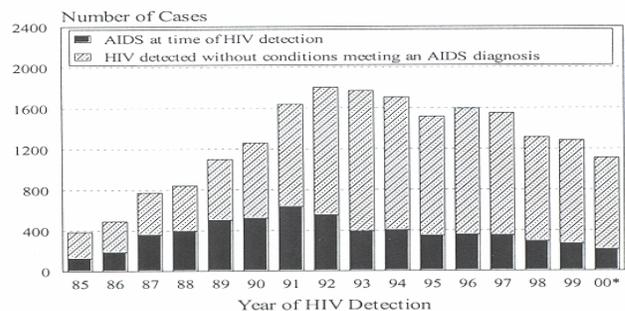
with the injury and death from the release of hazardous substances; and 4) also, in conjunction with the ATSDR, develop strategies to reduce subsequent injury and death associated with the release of hazardous substances.

When an uncontrolled or illegal release occurs in Louisiana the LSP is notified within 24 hours. Upon notification a report is sent to LOPH with preliminary information on the location of the release, the material involved, whether there were any injuries, evacuations, in-place sheltering or road closures. SEET staff then investigate further to gather data on factors contributing to the release, environmental sampling, follow-up health activities, specific information on injured persons, information about decontamination, orders to evacuate or in-place shelter, and land use and population information to estimate the number of persons at home or work who were potentially exposed. Starting in January 1, 2001, LOPH has received over 3000 LSP reports and of those over 700 have qualified for HSEES.

The HSEES system generates data used to provide information to industries to help plan prevention strategies. In addition HSEES data is used to provide information for Hazardous Material Training courses, including data on the risk of injury from methamphetamine laboratories. HSEES data can also be used to develop fact sheets on frequently spilled chemicals that cause a disproportionate number of injuries, such as chlorine and ammonia. Other HSEES activities include distributing newsletters to industry, responder and environmental groups, and providing presentations for state and local emergency planners.

To date, of the nationwide HSEES data that has been analyzed, fixed-facility events represent 80% and transportation events represent about 20% of all reported events. Most events occur between 6 a.m. and 6 p.m. on weekdays with an increased number of events occurring in the spring and summer when agricultural activities are at a peak. Employees, which includes students, is the population most often injured followed by the general public and first responders with respiratory irritation being the most commonly reported injury. Other frequent injuries include eye irritation, gastrointestinal irritation, vomiting, headache and dizziness. It has been found that the majority of injured persons do not wear personal protective equipment, or those who do wear equipment, that equipment is not protective against chemicals.

HIV/AIDS Case Trend



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
March - April, 2001
PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period
HEALTH REGION TIME PERIOD

DISEASE	HEALTH REGION									TIME PERIOD					
	1	2	3	4	5	6	7	8	9	Mar-Apr 2001	Mar-Apr 2000	Jan-Apr Cum 2001	Jan-Apr Cum 2000	% Chg	
Vaccine-preventable															
<i>H. influenzae (type B)</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-	
Hepatitis B Cases	4	1	0	0	0	0	1	1	0	7	17	20	46	-56.5	
Rate ¹	0.4	0.2	-	-	-	-	0.2	0.3	-	0.2	0.4	0.5	1.1	-	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-	
Mumps	0	1	0	1	0	0	0	0	0	2	1	2	3	-33.3	
Rubella	0	0	0	0	0	0	0	0	0	0	1	0	1	-	
Pertussis	1	0	0	0	0	0	0	0	0	1	3	1	4	-75.0	
Sexually-transmitted															
HIV/AIDS Cases ²	26	35	6	13	11	12	13	11	4	131	188	286	388	-27.0	
Rate ¹	2.6	6.1	1.6	2.4	4.0	4.0	2.6	3.1	0.9	3.0	4.3	6.5	8.9	-	
Gonorrhea Cases	583	258	105	120	71	82	405	203	83	1911	2098	3805	4227	-10.0	
Rate ¹	56.1	45.4	27.9	23.3	26.5	26.9	80	57.8	21.6	45.3	49.7	90.2	100.2	-	
Syphilis (P&S) Cases	4	5	6	9	1	3	0	1	2	32	33	49	69	-29.0	
Rate ¹	0.4	0.9	1.6	1.7	0.4	1.0	-	0.3	0.5	0.8	0.8	1.2	1.6	-	
Enteric															
Campylobacter	6	4	5	2	0	0	0	4	0	27	11	42	28	+50.0	
Hepatitis A Cases	18	0	1	2	0	0	1	0	0	22	9	37	26	+42.3	
Rate ¹	1.7	-	0.4	0.2	-	-	0.2	-	-	0.5	0.2	0.9	0.6	-	
Salmonella Cases	37	6	4	4	0	3	2	3	5	119	29	186	69	+170.0	
Rate ¹	3.6	1.1	1.1	0.8	-	1.0	0.4	0.9	1.3	2.8	0.7	4.3	1.6	-	
Shigella Cases	1	2	2	3	0	0	0	2	2	44	19	77	66	+16.7	
Rate ¹	0.1	0.4	0.5	0.6	-	-	-	0.6	0.5	1	0.4	1.8	1.5	-	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	2	0	2	-	
Vibrio, other	3	0	2	0	0	0	0	0	0	5	1	5	1	+400.0	
Other															
<i>H. influenzae (other)</i>	1	0	0	0	0	0	0	0	0	1	2	2	6	-66.7	
<i>N. Meningitidis</i>	11	2	3	7	1	1	1	1	1	28	8	50	25	+100.0	
Tuberculosis	-	3	5	5	3	-	5	5	-	27	59	29	78	-62.8	

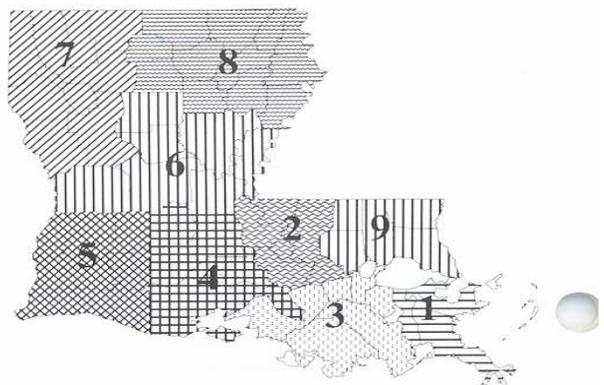
1 = Cases Per 100,000

2=These totals reflect persons with HIV infection whose status was first detected during the specified time period. This includes persons who were diagnosed with AIDS at time HIV was first detected.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Legionellosis	2
Lyme Disease	1
Malaria	1
Rabies, animal	3
Varicella	33

Animal Rabies (March-April, 2001) None



Annual Summary Vibrio Infections - 2000

The total number of Vibrio infections reported for Year 2000 was essentially unchanged from 1999 (Figure 1). The overall state case rate was 0.8 per 100,000. Sex specific rates for males were higher than females, 1.2 per 100,000 vs 0.3 per 100,000 respectively. Eighty percent of the cases reported occurred among Caucasians. Vibrio cases ranged in age from 15 to 80 years with nearly 50% of cases occurring within the 45-64 year age group (Figure 2). Onset of illnesses occurred from March to November with a peak onset beginning in May (Figure 3). Vibrio cases were reported most frequently from Jefferson (9), St. Bernard (5), Orleans (3) and Lafayette (3) parishes (Figure 4). Of the reported Vibrio cases with known exposures, 15 cases had contact with saltwater or raw seafood drippings while 19 cases reported seafood consumption prior to onset of illness. The most frequently reported Vibrio species included: *V. parahaemolyticus* (11), *V. vulnificus* (9), and *V. cholera non-01* (6). Nine cases (29%) of *V. vulnificus* (*Vv*) were reported this year as compared to 13 *Vv* cases in 1999. Of the three *Vv* cases that consumed oysters, two cases had consumed raw oysters. A total of four deaths occurred among *V. vulnificus* cases of which one death was associated with raw oyster consumption. The most frequently reported underlying conditions among *Vv* cases were liver disease (5), alcoholism (4), heart disease (2) and diabetes (2).

Three cases of *V. cholera-01, toxigenic* were reported this year. The cases occurred among two Caucasian males and one Caucasian female between the ages of 20 and 64 years. Onsets of illnesses occurred in April and June. Cases were reported from St. Bernard and Vermilion parishes. Two of the three cases resulted from shellfish consumption. All cases survived.

Figure 1: Cases of vibrio infections by year, 1991-2000

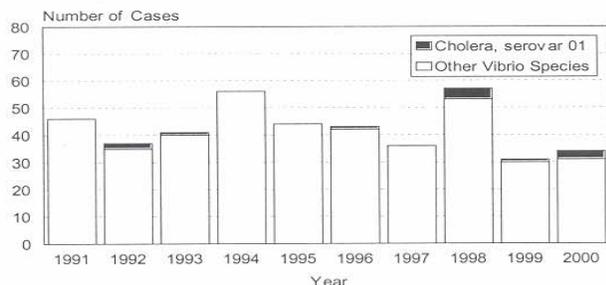


Figure 2: Cases of vibrio infections by sex and age group, 2000

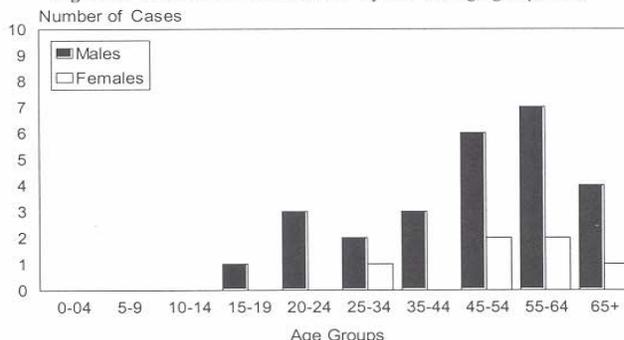


Figure 3: Cases of vibrio infections by month of onset, 2000

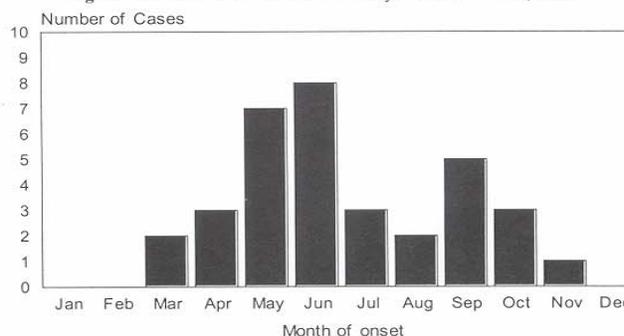
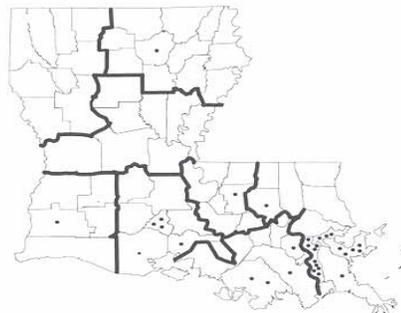


Figure 4: Cases of vibrio infections by parish, Louisiana, 2000



Louisiana Fact

"The merit of local public health organizations was more than amply demonstrated during the great flood of 1927. This flood, often considered the greatest natural disaster in American history, inundated some 200,000 square miles of land and directly affected the lives of a million and a half persons. Within ten days from the beginning of the emergency, fourteen Public Health Service officers, trained in emergency health work and familiar with the flooded localities, were in the field assisting state health authorities. Volunteer agencies, particularly the American Red Cross, were also quickly on the job. Much of the work necessarily had to be done by medical and auxiliary personnel living in or near the stricken areas. After the battle had been won parish and municipal health officers and their assistants received abundant praise for having set up refugee camps, for providing thousands of typhoid fever and smallpox immunizations, and for sacrificing themselves physically and financially. The United States Public Health Service observed that wherever full-time parish or county health units were operating, emergency work proceeded promptly and efficiently."

Source: *The Progressive Years* by Gordon E. Gillson

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis, Acute (A, B, C, Other)	Cancer
Amebiasis	Hepatitis B carriage in pregnancy	Complications of abortion
Arthropod-borne encephalitis (Specify type)	Herpes (neonatal)	Congenital hypothyroidism*
Blastomycosis	Human Immunodeficiency Virus (HIV) infection ³	Severe traumatic head injury**
Botulism ¹	Legionellosis	Galactosemia*
Campylobacteriosis	Lyme Disease	Hemophilia*
Chancroid ²	Lymphogranuloma venereum ²	Lead Poisoning
Chlamydial infection ²	Malaria	Phenylketonuria*
Cholera ¹	Measles (rubeola) ¹	Reye's Syndrome
Cryptosporidiosis	Meningitis, other bacterial or fungal	Severe under nutrition (severe anemia, failure to thrive)
Diphtheria	Mumps	Sickle cell disease (newborns)*
Enterococcus (infection; resistant to vancomycin)	Mycobacteriosis, atypical ⁴	Spinal cord injury**
Escherichia coli O157:H7 infection	Neisseria meningitidis infection ¹	Sudden infant death syndrome (SIDS)
Gonorrhoea ²	Pertussis	Traumatic Brain Injury
Haemophilus influenzae infection ¹	Rabies (animal & man)	
Hemolytic-Uremic Syndrome	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	

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

Web site: <http://www.dhh.state.la.us/oph/infectepi/default.htm>

This public health document was published at a total cost of \$1,125.00. Seven thousand five hundred (7,500) copies of this public document were published in this first printing at a cost of \$1,125.00. The total cost of all printings of this document, including reprints is \$1,125.00. This document was published by Moran Printing, Inc., 5425 Florida Blvd., Baton Rouge, LA 70806, to inform physicians, hospitals, and the public of current Louisiana morbidity status under authority of R.S. 40:36. This material was printed in accordance with the standards for printing for state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with the provisions of Title 43 of Louisiana Revised Statutes.

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

PRSRSTD
U.S. POSTAGE
PAID
Baton Rouge, LA
Permit No. 1032