

Louisiana Morbidity Report



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Hurricane Isaac Syndromic Surveillance Louisiana, August 27 - September 3, 2012

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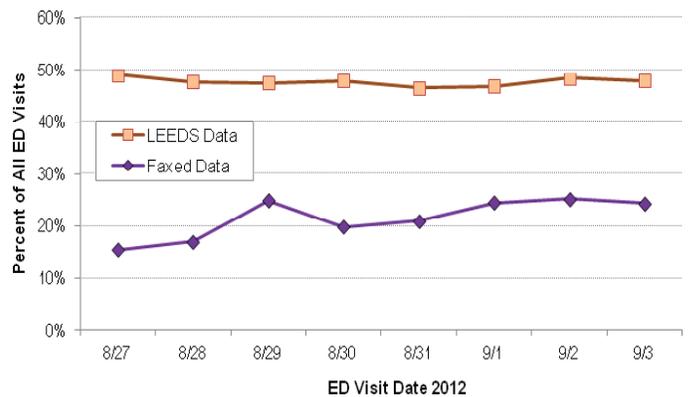
The Department of Health and Hospital's (DHH) Office of Public Health (OPH) Infectious Disease Epidemiology (IDEpi) Section is responsible for emergency department (ED) syndromic surveillance in the event of a hurricane or other natural disaster in Louisiana. The goal of this surveillance is to determine the extent of injuries and infectious diseases and institute prevention and control measures as soon as a public health concern is identified. Furthermore, data collected through syndromic surveillance can help IDEpi plan for future disasters.

To monitor the impact of Hurricane Isaac, IDEpi utilized two types of ED syndromic surveillance activities. Isaac made landfall in Louisiana on August 28, 2012. Louisiana Early Event Detection System (LEEDS), IDEpi's ongoing web-based syndromic surveillance system, had 20 participating hospitals submitting daily electronic data at the time. In addition to this electronic data, IDEpi also conducted ED surveillance by asking hospitals to complete a form reporting cumulative data and submit via fax on a daily basis. IDEpi began receiving faxed forms on August 27, 2012 and continued surveillance through September 3, 2012. The average number of forms submitted from hospitals each day was 42; the highest number of forms was submitted on August 27 and August 28 (65 forms collected both days).

Based on LEEDS data, infectious disease-related visits hovered around 50 percent over the period. This differed from faxed data, which showed a much lower percentage that increased slightly over the period (starting at 18.2 percent, peaking slightly on Au-

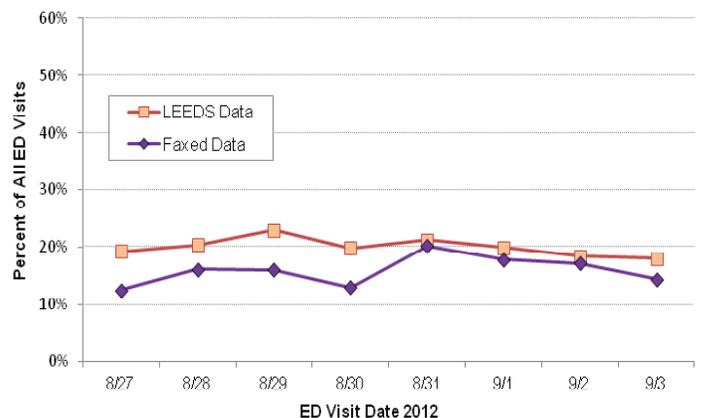
gust 29 at 24.9 percent, and ending at 19.8 percent) (Figure 1).

Figure 1: Comparison of Percentages For LEEDS Data Versus Faxed Data of Infectious Disease-Related ED Visits - Louisiana, August 27 - September 3, 2012



Based on LEEDS data, injury-related visits hovered around 20 percent over the period; faxed data showed a similar trend (Figure 2).

Figure 2: Comparison of Percentages of Injury-Related ED Visits - Louisiana, August 27 - September 3, 2012



The data prove to be difficult to compare considering the differences between the two systems. Both systems tallied two cat-
(Continued on Page 5)

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STD Surveillance Update - Louisiana, 2002-2011

Catherine Desmarais, M.P.H.; Mohammad Rahman, M.B.B.S., M.P.H., Ph.D.

April is 'STD Awareness Month' across the nation. Because Louisiana experiences some of the highest rates of sexually transmitted diseases (STD) in the nation, awareness is crucial, now more than ever. The Department of Health and Hospitals' Office of Public Health's, STD/HIV Surveillance Program (SHP) collects and analyzes data on cases of chlamydia, gonorrhea, syphilis (all stages), and congenital syphilis. Louisiana's Sanitary Code* mandates that all medical providers and laboratories report these STDs to SHP along with basic demographic and residence information.

The majority of new cases are received through paper and electronic laboratory reporting. Cases are also provided directly from public health providers throughout the state. In January 2013, the program released its Louisiana Annual Report with 2011 STD data, summarized in the Table.

Table: Cases and Case Rates of STDs by Sex, Race, Age Group and Region - Louisiana, 2011

TOTAL	Chlamydia		Gonorrhea		P&S Syphilis	
	Case Number	Rate per 100,000	Case Number	Rate per 100,000	Case Number	Rate per 100,000
Reported Sex	31,614	697.4	9,169	202.3	447	9.9
Female	23,390	1,010.8	5,263	227.4	179	7.7
Male	7,568	341.0	3,739	168.5	268	12.1
Unknown	656	-	167	-	0	-
Reported Race/Ethnicity						
Black/African American	17,831	1,236.2	6,105	423.2	370	25.7
Hispanic/Latino	445	231.1	88	45.7	4	2.1
White	4,066	148.7	689	25.2	68	2.5
Other/Multi-race	260	-	55	-	1	-
Unknown	9,012	-	2,232	-	4	-
Age Group						
0-9	71	11.4	27	4.4	0	0.0
10-14	541	176.3	146	47.6	3	1.0
15-19	11,390	3,485.5	2,976	910.7	77	23.6
20-24	11,875	3,510.1	3,284	970.7	112	33.1
25-29	4,714	1,415.9	1,424	427.7	92	27.6
30-34	1,723	583.1	646	218.6	54	18.3
35-39	651	172.9	278	73.8	27	7.2
40-44	299	103.8	151	52.4	24	8.3
45+	235	17.8	225	12.9	57	3.2
Unknown	39	-	12	-	1	-
Region						
1-New Orleans	6,862	821.5	1,877	224.7	90	10.8
2-Baton Rouge	4,155	626.5	1,210	182.4	55	8.3
3-Houma	2,402	590.1	458	112.5	14	3.4
4-Lafayette	3,633	622.0	1,024	175.3	32	5.5
5-Lake Charles	1,595	545.1	328	112.1	21	7.2
6-Alexandria	1,844	595.3	524	169.2	19	6.1
7-Shreveport	5,694	1,046.2	2,217	407.4	177	32.5
8-Monroe	3,268	918.6	1,097	308.4	26	7.3
9-Hammond/Slidell	2,128	393.2	427	78.9	13	2.4
Unknown	33	-	7	-	0	-

* Sanitary Code on page 8

Announcements

Updates: Infectious Disease Epidemiology (IDEpi) Webpages

<http://www.infectiousdisease.dhh.louisiana.gov>

ANNUAL REPORTS: Blastomycosis; Brucellosis; Hepatitis B; Hepatitis C; Streptococcus Group B; West Nile Encephalitis or Neuro-Invasive Disease (WNV-NID)

EPIDEMIOLOGY MANUAL: Amebic Encephalitis and Keratitis; Babesiosis Form (CDC); Creutzfeldt Jacob Disease (CJD); Legionella Questionnaire; Norovirus; Norovirus Public Information; Respiratory Syncytial Virus (RSV)

INFLUENZA: Weekly Report

LOUISIANA MORBIDITY REPORT: Indices 1995-96

ERRATUM

January-February 2013 - Page 3- Wildlife and Agricultural Animal Diseases: Dr. Balsamo's Phone Number (504)568-8315.

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Assistant Secretary, OPH J.T. Lane

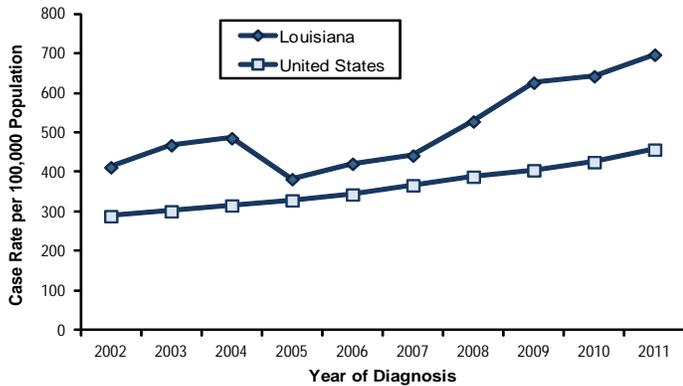
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The Chlamydia Epidemic in Louisiana

Nationally in 2011, chlamydia was the most frequently reported disease to the Centers for Disease Control and Prevention (CDC), with the highest number of reports of a single disease ever. In the most recent CDC STD Surveillance Report, Louisiana ranked third in the nation for chlamydia case rates. In 2011, there were 31,614 cases of chlamydia diagnosed in Louisiana with a case rate of 697.4 per 100,000 population, which was substantially higher than the national case rate of 457.6 per 100,000 population. Since 2005, Louisiana's chlamydia case rate has been steadily increasing (Figure 1).

Figure 1: Chlamydia Case Rates - Louisiana and the United States, 2002-2011

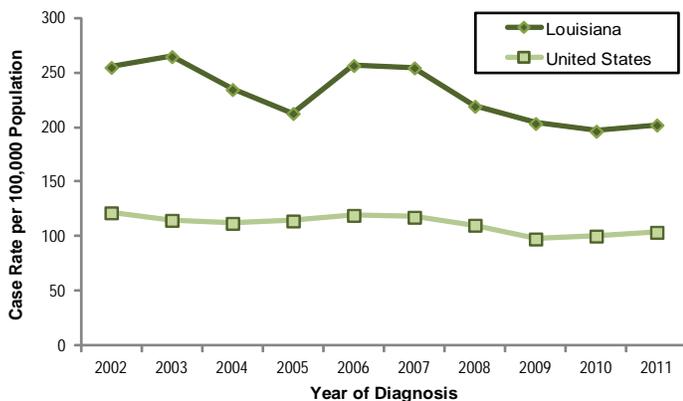


The majority of new chlamydia cases were diagnosed among women between the ages of 15 to 24 years. Almost 80 percent of cases with a reported race were diagnosed among African-Americans. Louisiana has a targeted gonorrhea and chlamydia screening program in family planning clinics for women younger than 31 years of age, where the majority of cases are diagnosed and treated.

The Gonorrhea Epidemic in Louisiana

In 2011, Louisiana ranked first in the nation for gonorrhea case rates. In 2011, there were 9,169 cases of gonorrhea diagnosed in Louisiana with a case rate of 202.3 per 100,000 population. The gonorrhea case rate slightly increased in Louisiana from 2010 to 2011, but it remained almost twice as high as the national rate of 104.2 per 100,000 population in 2011 (Figure 2).

Figure 2: Gonorrhea Case Rates - Louisiana and the United States, 2002-2011

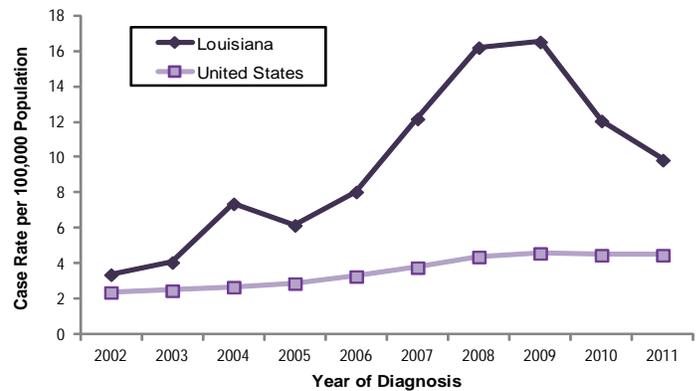


The majority of new gonorrhea cases diagnosed in Louisiana in 2011 were among women between the ages of 15 to 24 years. Additionally, almost 89 percent of cases with a reported race were African-American.

The Syphilis Epidemic in Louisiana

Since 2006, Louisiana has ranked first in the nation for primary and secondary (P&S) syphilis case rates. In 2011, there were 447 cases of P&S syphilis diagnosed in Louisiana with a case rate of 9.9 per 100,000 population. From 2005 to 2009, Louisiana's case rate almost tripled. Since 2009, the P&S syphilis rate has significantly declined, although it still remains over twice as high as the national rate (4.5 per 100,000 population) (Figure 3).

Figure 3: Primary and Secondary Syphilis Case Rates - Louisiana and the United States, 2002-2011



In 2011, new diagnoses of P&S syphilis occurred in 35 of Louisiana's 64 parishes. The Shreveport region had the highest number of new diagnoses (177 cases). The New Orleans region had the second highest number of new cases (90 cases), followed by the East Baton Rouge region (55 cases).

The majority of the newly diagnosed syphilis cases in Louisiana were among African-Americans. Although African-Americans make up only 33 percent of Louisiana's population, almost 84 percent of all new syphilis diagnoses were among this population. The majority of new syphilis cases were diagnosed in persons between the ages of 15 to 29 years.

The Congenital Syphilis Epidemic in Louisiana

In 2011, there were 18 cases of congenital syphilis reported from Louisiana. Louisiana ranked third in the nation for congenital syphilis rates, with a rate of 29.3 per 100,000 live births. More than half of all congenital syphilis cases in 2011 were born in the Greater Shreveport and Greater Baton Rouge regions, and an additional 22 percent were born in the Greater Lafayette region. Approximately 83 percent of the mothers of congenital syphilis cases were African-American.

The SHP office regularly reports and publishes data on websites www.std.dhh.louisiana.gov and www.HIV411.org. For more information, please contact Mohammad Rahman at (504) 568-7474 or email to mohammad.rahman@la.gov.

Recommendation: Syphilis Screening For All Women Diagnosed Pregnant While Cared For in ED Settings

STD/HIV Program and Bureau of Family Health

Congenital syphilis (CS) is a preventable disease which is an essential public health priority. Acquisition occurs via transmission of the bacterium, *T. pallidum* from mother-to-fetus in utero or at the time of delivery. The risk of infection in the fetus correlates with the stage of pregnancy at which the woman acquired the infection and the length of exposure the fetus has to the bacterium. Untreated syphilis can result in infant prematurity, perinatal death and multiple organ disease in infancy and childhood. Maternal treatment of syphilis, if initiated prior to the last month of pregnancy, can reduce the risk of CS by more than 90 percent.

Effective public health prevention efforts call for adequate testing, treatment, and follow-up of individuals and their partners infected with syphilis. The U.S. Preventive Services Task Force (USPSTF), and the American Academy of Pediatrics and American Congress of Obstetricians and Gynecologists **recommends syphilis screening for all pregnant women at the first prenatal visit**, based on convincing evidence that the universal screening of pregnant women decreases the proportion of infants with manifestations of syphilis infection.

Late entry into prenatal services, sporadic care, and the lack of prenatal care are major risk factors associated with CS. An initial pregnancy diagnosis is often made when a woman visits the emergency department (ED) for care that may, or may not be unrelated to pregnancy symptoms. With an initial pregnancy diagnosis, women are referred to initiate formal prenatal care with the expectation of appropriate follow through. However, for women with poor or absent prenatal care use behaviors, an initial hospital evaluation in the ED or Labor and Delivery (L&D) Triage unit often serves as a surrogate initial prenatal visit. Accordingly, sexually transmitted disease (STD) screening services received

during an ED encounter for a woman newly diagnosed pregnant should be considered an initial prenatal care visit as an important public health safety net activity. A serologic specimen for syphilis obtained at that time (in addition to baseline HIV and Hepatitis B serology), would be a critical component of initial prenatal screening process.

Based upon 2010 Louisiana STD surveillance data which demonstrates that more than 60 percent of mothers of CS cases had no prenatal care or fewer than five prenatal visits, the Department of Health and Hospital's (DHH) Office of Public Health STD/HIV (SHP) and Bureau of Family Health Programs jointly advise the following:

Recommendations for all women diagnosed pregnant while receiving care in ED settings:

-All women that are diagnosed as pregnant during an ED visit receive a serologic test for syphilis if there is no available documentation of recent syphilis screening; and

-ED personnel should emphasize with patients the importance of timely initiation of prenatal care services and follow-up of syphilis (and other basic STD screening) results with their prenatal provider.

-Syphilis screening is recommended for all pregnant women who present for hospital L&D unit evaluation without documented syphilis screening during the current pregnancy.

For USPSTF recommendations, go to <http://www.uspreventiveservicestaskforce.org/recommendations.htm>.

For more information, please call Dr. Stephanie Taylor at (504) 658-2622 or email to staylo2@lsuhsc.edu, or Dr. Robert Maupin at (504)568-3504 or email to rmaupi@lsuhsc.edu.

Infants With Positive Salmonella Cultures - Louisiana, 2013

When she was two weeks old, Jane (pseudonym) had diarrhea. Her stool culture was positive for *Salmonella newport*; two weeks later her stool culture was negative. At five months of age, Jane had another episode of diarrhea; her stool culture was again positive for *S. newport*. Her mother had intermittent loose stools around the time of delivery, but the mother's culture had been negative after delivery.

What Could Be the Source of Infection for This Infant?

The Department of Health and Hospital's laboratory was asked to compare the first and second culture by Pulse Field Gel Electrophoresis (PFGE), a type of finger printing of bacteria. The first culture had been done previously and the PFGE pattern saved in the PFGE bank. The second culture proved to have an identical PFGE pattern to the first one.

It would be extremely unlikely that on two occasions, an

identical *Salmonella* strain coming from an environmental surface would infect the infant. It is possible that the mother became a carrier and that her stool was negative by chance. The other possibility is that the infant became a carrier. How common would that be?

In fact, according to the *Red Book*® of the American Academy of Pediatrics: "Twelve weeks after infection with the most common nontyphoidal *Salmonella* serotypes, approximately 45% of children younger than 5 years of age excrete organisms, compared with 5% of older children and adults; antimicrobial therapy can prolong excretion. Approximately 1% of adults continue to excrete *Salmonella* organisms for more than 1 year."

The age group that has the highest incidence rate of *Salmonella* infections are infants, not because they have more exposure to *Salmonella*, but because they are the group that is being brought in for medical evaluation of diarrhea - the group for whom stool cultures are most often done.

Treatment Recommendations:

The *Red Book*® continues, "Antimicrobial therapy usually is not indicated for patients with either asymptomatic infection or un-

complicated (noninvasive) gastroenteritis caused by nontyphoidal *Salmonella* serotypes, because therapy does not shorten the duration of diarrheal disease and can prolong duration of fecal excretion. Although of unproven benefit, antimicrobial therapy is recommended for gastroenteritis caused by nontyphoidal *Salmonella* serotypes in people at increased risk of invasive disease, including infants younger than 3 months of age and people with chronic gastrointestinal tract disease, malignant neoplasms, hemoglobinopathies, HIV infection, or other immunosuppressive illnesses or therapies.”

For more information, please call Infectious Disease Epidemiology at (504) 568-8313.

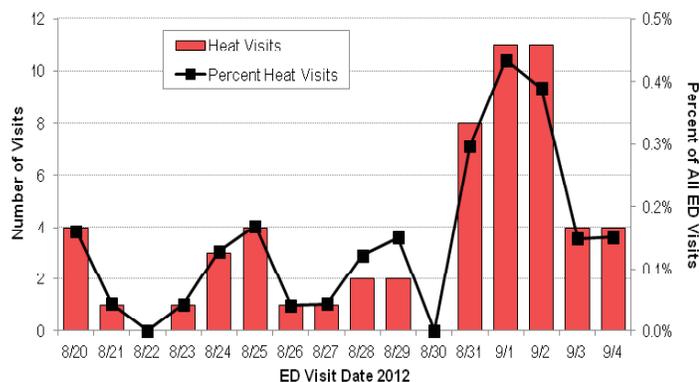
(Hurricane Isaac ...Continued from Page 1)

egories of visits – infectious disease and injury visits – as well as specific syndromes tracked by IDEpi within each category. Daily percentages were then calculated for each category and syndrome, out of the total visits during the period. LEEDS, an automated system, collects electronic data from EDs and tags certain text strings from patient chief complaints with syndromes tracked by IDEpi. The use of faxed forms - a manual system, is dependent on staff at the hospitals tallying and categorizing different types of visits into the categories and syndromes tracked by IDEpi. The same syndromes are tracked in both systems, but the different methods of collection result in discrepancies between the two data sources.

An evaluation of data quality from both data sources determined that LEEDS served as a more robust surveillance system and was therefore utilized in analysis of specific syndromes over the period. IDEPI monitored visits related to syndromes including upper and lower respiratory irritation, asthma, gastrointestinal symptoms, chemical exposures, carbon monoxide exposures, lacerations, motor vehicle accidents (MVA) and heat-related symptoms. The only syndromes that showed any changes over the period were heat, lacerations and MVAs.

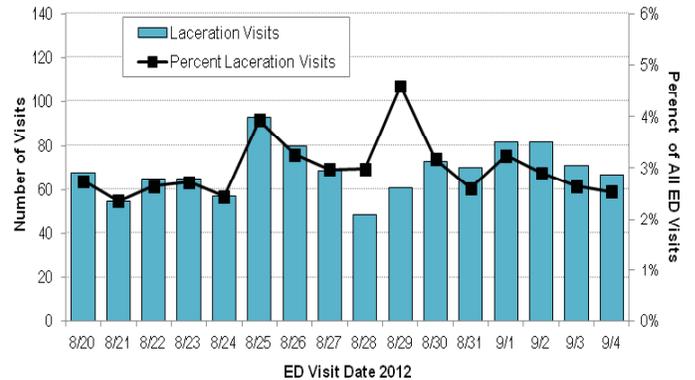
LEEDS captures chief complaints including heat stroke, overheated, etc., as ‘heat-related’ visits. There were very low numbers of visits related to heat over the period, averaging four visits a day. A slight increase in heat-related visits occurred on August 31 (eight visits), September 1 (11 visits) and September 2 (11 visits). This increase occurred after a few days in which many residents were without power in the summer heat (Figure 3).

Figure 3: ED Visits Related to Heat - Louisiana, August 20 - September 4, 2012



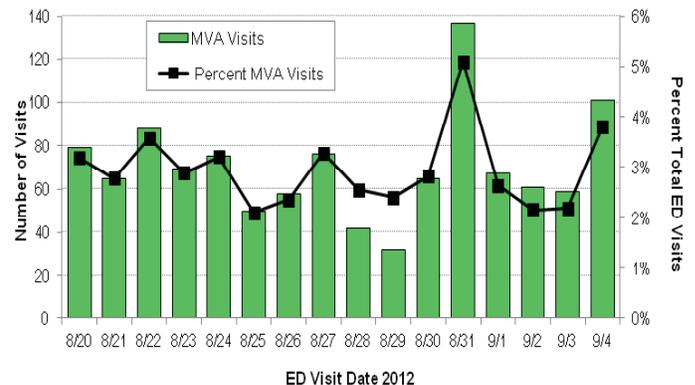
LEEDS captures chief complaints including abrasion, gash, laceration, puncture, etc., as ‘laceration’ visits. The percentage of visits related to lacerations peaked slightly on August 29, from an average of 2.98 percent over the period, to 4.58 percent (Figure 4).

Figure 4: ED Visits Related to Lacerations - Louisiana, August 20 - September 4, 2012



LEEDS captures chief complaints including MVA, MVC (motor vehicle collision), wreck, etc., as ‘motor vehicle accident’ visits. The percentage of visits related to MVAs peaked on August 31, from an average of 2.94 percent over the period, to 5.09 percent (Figure 5).

Figure 5: ED Visits Related to MVAs - Louisiana, August 20 - September 4, 2012



The collection of faxed forms and electronic data from hospital EDs before, during and after Hurricane Isaac-impacted Louisiana, provided DHH OPH important situational awareness necessary to indicate if, and when, the utilization of additional public health resources and messaging may have been needed in efforts to prevent additional injury and illness. As IDEpi continues to expand participation of EDs in LEEDS, and as the quality and robustness of data collected through LEEDS is demonstrated through more and more special event analyses, it is anticipated that Hurricane Isaac will be the last time that faxed forms are used; there will be a transition to relying fully on LEEDS data for syndromic surveillance during hurricanes and any other natural disasters.

For more information please contact Jenna Iberg Johnson at (504)568-8312 or email to jenna.iberger@la.gov

Rare *Salmonella* Uganda Outbreak Associated With Hog Head Cheese - Louisiana, 2012

Erin Delaune, M.P.H.

Salmonella are a genus of bacteria that can cause gastroenteritis and less often, other infections such as septicemia. People can become infected by eating contaminated food or beverages, through contact with animals, or less frequently by contact with an infected person. The incubation period for gastroenteritis caused by *Salmonella* typically ranges from 12 to 36 hours, but can be as short as six hours, or as long as 72 hours.

Salmonella enterica has six subspecies, and each subspecies has associated serovars that differ by antigenic specificity. There are thousands of *Salmonella enterica* serovars (also known as serotypes). In Louisiana the most common serotypes are Newport, Typhimurium, and Mississippi. *Salmonella enterica* serotype Uganda is a rare serotype locally and nationally. Nationwide, the only previously published *Salmonella* Uganda outbreak was in 2001 involving cases associated with consuming pork products. In Louisiana, no cases of *Salmonella* Uganda were reported in the state in the last five years, up until 2012.

Between the end of October and the beginning of December 2012, six cases of *Salmonella* Uganda were confirmed by the Louisiana Department of Health and Hospitals (DHH) Public Health Laboratory and were found to have matching Pulse Field Gel Electrophoresis (PFGE) patterns. A seventh case was reported at the end of February, 2013. The average age of the cases was 73 years with a range of 58 to 87 years; the majority of the cases were male (57%). Illness onset dates ranged from mid-October to mid-January. Seventy-one percent of the cases were hospitalized with no deaths reported. The cases resided in DHH Regions 2* (14%), 4* (43%), 5 (29%) and 7 (14%). During the initial investigation, no cases were reported in other states.

All cases were interviewed to assess for exposures, using a standardized questionnaire which asked about all food exposures prior

* Map of Regions on Page 7

to illness onset. No food item was reported being eaten by more than one case. Based on the demographics, location of the cases, and the past outbreak involving pork products, the hypothesis was made that the source of the *Salmonella* was a regional meat-based food item. All cases were re-interviewed using a questionnaire that focused on meat-based food items popular in Louisiana; all seven cases reported consuming hog head cheese in the seven days prior to illness onset. Five of the seven cases reported consuming Brand A hog head cheese. No other food items were reported being eaten by more than one case.

Four intact packages of Brand A hog head cheese were purchased from a grocery store for *Salmonella* testing at the state laboratory. *Salmonella* was not detected in these four packages.

Brand A hog head cheese is produced in an out-of-state facility that is inspected by the United States Department of Agriculture (USDA). The USDA was notified of the illnesses possibly associated with consumption of Brand A hog head cheese; as a result, the facility was inspected and their procedures were reviewed. Product testing at an independent laboratory found *Salmonella* in four of nine packages of Brand A hog head cheese. These findings resulted in the recall of 4,700 pounds of hog head cheese. The serotype and PFGE pattern of the *Salmonella* isolated from the product is unknown.

Salmonella is a class B disease and should be reported to the State Health Department within one business day. Hospitals and laboratories are encouraged to send *Salmonella* isolates to the DHH State Public Health Laboratory for confirmation, serotyping and PFGE. Without the state laboratory and the participation of hospital laboratories, this cluster may have gone undetected; potentially more people would have become ill.

For more information, please contact Erin Delaune at (504) 568-8316 or email to erin.delaune@la.gov.

Prevalence of *Legionella* Antibodies - Louisiana

The Department of Hospitals and Health Infectious Disease Epidemiology (IDePi) Section Surveillance program often receives reports of legionellosis based on a single serologic test result. The Centers for Disease Control and Prevention laboratory criteria for diagnoses are the following:

- Isolation of *Legionella* from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluids, or
- Demonstration of a four-fold or greater rise in the reciprocal immunofluorescence antibody (IFA) titer to greater than or equal to 128 against *Legionella pneumophila* serogroup 1 between paired acute- and convalescent-phase serum specimens, or
- Detection of *L.pneumophila* serogroup 1 in respiratory secretions, lung tissue, or pleural fluid by direct fluorescent antibody testing, or
- Demonstration of *L. pneumophila* serogroup 1 antigens in urine by radioimmunoassay or enzyme-linked immunosorbent assay.

A diagnosis based on a single IFA titer lacks specificity for surveillance and is no longer used. The reason is that a large pro-

portion of the population has high titers of *Legionella* antibodies. To verify this, the DHH Laboratory performed *Legionella* serologic testing on both young adults that submitted blood for routine screening in prenatal clinic and laboratory personnel; none of the 60 tested had respiratory conditions (Table).

Table: Results -*Legionella* Serologic Testing - Louisiana, 2007

Result	Number	Percent
Negative	6	10.0
1/64	17	28.3
1/128	10	16.7
1/256	13	21.7
1/512	13	21.7
1/1024	1	1.7

This survey confirmed that a large proportion of the Louisiana population has high antibody titers to *Legionella*. Given the ubiquity of *Legionella* in water and particularly in hot water systems, it is not a surprising result. For more information, please call IDePi at (504) 568-8313.

Table: Communicable Disease Surveillance, Incidence by Region and Time Period, January-February, 2013

DISEASE	HEALTH REGION									TIME PERIOD				
	1	2	3	4	5	6	7	8	9	Nov-Dec 2012	Nov-Dec 2011	Jan-Dec 2012 Cum	Jan-Dec 2011 Cum	Jan-Dec % Chg*
	Vaccine-preventable													
Hepatitis B Cases	0	0	1	0	0	0	0	1	8	10	10	10	10	NA*
Hepatitis B Rate ¹	0	0	0.3	0	0	0	0	0.3	2.1	0.2	0.2	0.2	0.2	NA*
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Mumps	0	0	0	1	0	0	0	0	0	1	0	1	0	NA*
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis	1	4	0	2	0	0	1	0	1	9	2	9	2	350.0
Sexually-transmitted														
HIV/AIDS Cases ²	38	27	6	9	1	2	13	6	9	111	192	111	192	-42.2
HIV/AIDS Rate ¹	3.8	4.7	1.6	1.7	0.4	0.7	2.6	1.7	2.1	2.5	4.4	2.5	4.4	NA*
Chlamydia Cases ³	686	230	148	233	100	84	270	225	187	2,163	912	2,163	912	137.2
Chlamydia Rate ¹	82.1	34.7	36.4	39.9	34.2	27.1	49.6	63.2	34.6	47.7	20.1	47.7	20.1	NA*
Gonorrhea Cases ³	256	60	32	81	20	26	89	81	42	687	440	687	440	56.1
Gonorrhea Rate ¹	30.6	9.0	7.9	13.9	6.8	8.4	16.4	22.8	7.8	15.2	9.7	15.2	9.7	NA*
Syphilis (P&S) Cases ³	5	6	1	5	0	3	14	4	2	40	35	40	35	14.3
Syphilis (P&S) Rate ¹	0.6	0.9	0.2	0.9	0.0	1.0	2.6	1.1	0.4	0.9	0.8	0.9	0.8	NA*
Enteric														
Campylobacter Cases	3	2	6	0	1	2	3	2	6	25	41	25	41	-39.0
Hepatitis A Cases	1	1	0	0	1	0	0	0	1	4	0	4	0	NA*
Hepatitis A Rate ¹	0.1	0.2	0	0	0.4	0	0	0	0.3	0.1	0	0.1	0	NA*
Salmonella Cases	10	15	10	8	8	3	8	10	8	80	108	80	108	-25.9
Salmonella Rate ¹	1.0	2.6	2.7	1.6	3.0	1.0	1.6	2.8	2.1	1.9	2.5	1.9	2.5	NA*
Shigella Cases	5	2	0	3	2	0	1	1	10	24	41	24	41	-41.5
Shigella Rate ¹	0.5	0.4	0	0.6	0.7	0	0.2	0.3	2.6	0.6	1.0	0.6	1.0	NA*
Vibrio cholera Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other Cases	0	0	2	0	0	0	0	0	0	2	3	2	3	NA*
Other														
<i>H. influenzae (other)</i>	2	1	1	1	1	1	1	0	4	12	15	12	15	NA*
<i>N. Meningitidis</i>	0	0	2	0	0	0	1	0	0	3	1	3	1	NA*

¹ = Cases Per 100,000.

² = These totals reflect people with HIV infection whose status was first detected during the specified time period. This includes people who were diagnosed with AIDS at the time HIV first was detected. Because of delays in reporting HIV/AIDS cases, the number of persons reported is a minimal estimate. Data should be considered provisional.

³ = Preliminary data.

* = Percent Change not calculated for rates or count differences less than 5.

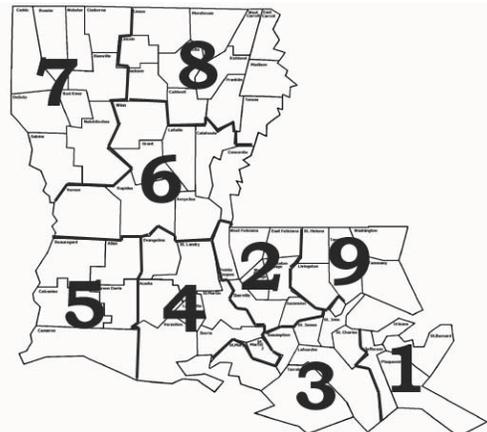
Table 2. Diseases of Low Frequency, January-December, 2013

Disease	Total to Date
Legionellosis	3
Lyme Disease	0
Malaria	0
Rabies, animal	1
Varicella	9

Table 3. Animal Rabies, January-February, 2013

Parish	No. Cases	Species
Calcasieu	1	Skunk

Figure: Department of Health and Hospitals Regional Map



**Sanitary Code - State of Louisiana
 Part II - The Control of Disease**

LAC 51:II.105: The following diseases/conditions are hereby declared reportable with reporting requirements by Class:

Class A Diseases/Conditions - Reporting Required Within 24 Hours

Diseases of major public health concern because of the severity of disease and potential for epidemic spread-report by telephone immediately upon recognition that a case, a suspected case, or a positive laboratory result is known; [in addition, all cases of rare or exotic communicable diseases, unexplained death, unusual cluster of disease and all outbreaks shall be reported.

Anthrax	Measles (rubeola)	Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)
Avian Influenza	Neisseria meningitidis (invasive disease)	Smallpox
Botulism	Plague	Staphylococcus Aureus, Vancomycin Intermediate or Resistant (VISA/VRSA)
Brucellosis	Poliomyelitis, paralytic	Tularemia
Cholera	Q Fever (Coxiella burnetii)	Viral Hemorrhagic Fever
Diphtheria	Rabies (animal and human)	Yellow Fever
Haemophilus influenzae (invasive disease)	Rubella (congenital syndrome)	
Influenza-associated Mortality	Rubella (German measles)	

Class B Diseases/Conditions - Reporting Required Within 1 Business Day

Diseases of public health concern needing timely response because of potential of epidemic spread-report by the end of the next business day after the existence of a case, a suspected case, or a positive laboratory result is known.

Arthropod-Borne Neuroinvasive Disease and other infections (including West Nile, St. Louis, California, Eastern Equine, Western Equine and others)	Hepatitis A (acute disease)	Malaria
Aseptic meningitis	Hepatitis B (acute illness & carriage in pregnancy)	Mumps
Chancroid ¹	Hepatitis B (perinatal infection)	Pertussis
Escherichia coli, Shig-toxin producing (STEC), including E. coli 0157:H7	Hepatitis E	Salmonellosis
Hantavirus Pulmonary Syndrome	Herpes (neonatal)	Shigellosis
Hemolytic-Uremic Syndrome	Human Immunodeficiency Virus [(HIV), infection in pregnancy] ²	Syphilis ¹
	Human Immunodeficiency Virus [(HIV), perinatal exposure] ²	Tetanus
	Legionellosis (acute disease)	Tuberculosis ²
		Typhoid Fever

Class C Diseases/Conditions - Reporting Required Within 5 Business Days

Diseases of significant public health concern-report by the end of the workweek after the existence of a case, suspected case, or a positive laboratory result is known.

Acquired Immune Deficiency Syndrome (AIDS) ³	Gonorrhea ¹	Staphylococcal Toxic Shock Syndrome
Blastomycosis	Hansen Disease (leprosy)	Streptococcal disease, Group A (invasive disease)
Campylobacteriosis	Hepatitis B (carriage, other than in pregnancy)	Streptococcal disease, Group B (invasive disease)
Chlamydial infection ¹	Hepatitis C (acute illness)	Streptococcal Toxic Shock Syndrome
Coccidioidomycosis	Hepatitis C (past or present infection)	Streptococcus pneumoniae, penicillin resistant [DRSP], invasive infection]
Cryptococcosis	Human Immunodeficiency Virus [(HIV syndrome infection)] ²	Streptococcus pneumoniae (invasive infection in children < 5 years of age)
Cryptosporidiosis	Listeria	Transmissible Spongiform Encephalopathies
Cyclosporiasis	Lyme Disease	Trichinosis
Dengue	Lymphogranuloma Venereum ¹	Varicella (chickenpox)
Ehrlichiosis	Psittacosis	Vibrio Infections (other than cholera)
Enterococcus, Vancomycin Resistant [(VRE), invasive disease]	Rocky Mountain Spotted Fever (RMSF)	
Giardia	Staphylococcus aureus, Methicillin/Oxacillin Resistant[(MRSA), invasive infection]	

Class D Diseases/Conditions - Reporting Required Within 5 Business Days

Cancer	Hemophilia ⁴	Severe Undernutrition (severe anemia, failure to thrive)
Carbon Monoxide Exposure and/or Poisoning ⁵	Lead Exposure and/or Poisoning (children) ⁴ (adults) ⁵	Sickle Cell Disease (newborns) ⁴
Complications of Abortion	Pesticide-Related Illness or Injury (All ages) ⁵	Spinal Cord Injury
Congenital Hypothyroidism ¹	Phenylketonuria ⁴	Sudden Infant Death Syndrome (SIDS)
Galactosemia ⁴	Reye's Syndrome	
Heavy Metal (Arsenic, Cadmium, Mercury) Exposure and/or Poisoning (All ages) ⁵	Severe Traumatic Head Injury	

Case reports not requiring special reporting instructions (see below) can be reported by mail or facsimile on Confidential Disease Report forms (2430), facsimile (504) 568-8290, telephone (504) 568-8313, or 1-800-256-2748 for forms and instructions.

¹Report on STD-43 form. Report cases of syphilis with active lesions by telephone, within one business day, to (504) 568-8374.

²Report to the Louisiana HIV/AIDS Program: Visit www.hiv.dhh.louisiana.gov or call 504-568-7474 for regional contact information.

³Report on CDC72.5 (f.5.2431) card

⁴Report to the Louisiana Genetic Diseases Program and Louisiana Childhood Lead Poisoning Prevention Programs: www.genetics.dhh.louisiana.gov or call (504) 568-8254.

⁵Report to the Section of Environmental Epidemiology and Toxicology: www.seet.dhh.louisiana.gov or call 1-888-293-7020

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