Louisiana Morbidity Report

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www.dhh.louisiana.gov/LMR

Infectious Disease Epidemiology Main Webpage
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September - October 2014 **Volume 25, Number 5**

Cryptosporidium Outbreak Investigation - Louisiana, June-September, 2013

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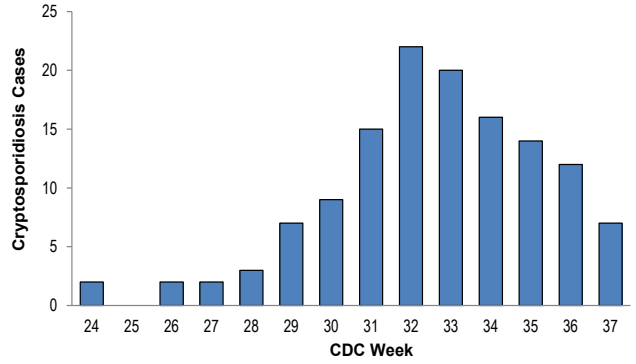
In the summer of 2013 there was an outbreak of *Cryptosporidium* among 141 persons in Louisiana (Figure).

Figure: *Cryptosporidium* Cases by Week of Onset - Louisiana, 2013



Cryptosporidium is a protozoan parasite that causes diarrheal illness in humans and animals. This parasite has many modes of transmission, including person-to-person and animal-to-person (e.g. pets); the most common is through water, particularly rec-

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Enterovirus D68 Louisiana, 2014

Julie Hand, MSPH

The United States is currently experiencing a nationwide outbreak of Enterovirus D68 (EV-D68) associated with severe respiratory illness. From mid-August to October 27, 2014, 1,035 people in 47 states, the District of Columbia, and including Louisiana, have been confirmed with a respiratory illness caused by EV-D68. There have been four cases of EV-D68 confirmed in Louisiana. Nationwide, EV-D68 has been detected in specimens from eight patients who died. Investigations are ongoing to determine if EV-D68 contributed to these deaths. No deaths have been reported in Louisiana.

Specimen guidelines for Louisiana are as follows:

- Samples will be tested at the state public health laboratory by respiratory virus panel (RVP), and if they are Rhinovirus/Enterovirus positive, they will be forwarded to the Centers for Disease Control and Prevention (CDC) for typing.
- Suspected clusters or severely ill patients are being tested; non-hospitalized individual cases will not be tested
- Samples that are tested by RVP at a hospital and are positive can be sent directly to the CDC; the hospital should also email julie.hand@la.gov for coordination.
- The swab type is the same used for influenza testing, but the specimen type has to be nasopharyngeal (NP); nasal is not acceptable.

The CDC is prioritizing testing of specimens from children with severe respiratory illness. There are likely many children affected with milder forms of illness. Of the 2,032 specimens tested at the CDC lab, about half have tested positive for EV-D68. About one-third have tested positive for an enterovirus or rhinovirus other than EV-D68. Almost all CDC-confirmed cases this year of EV-D68 have been among children; many of the cases had asthma or a history of wheezing.

The CDC continues to investigate reports of acute neurologic illness of unknown etiology in children characterized by acute focal limb weakness and spinal cord MRI lesions restricted to gray matter. As of October 30, the CDC has verified reports of 64 children in 28 states that meet the case definition. All had a fever and most with symptoms of respiratory illness (about one week before they felt muscle weakness). None of the children had any kind of virus found in their spinal fluid. It is possible that the correct tests have not been done yet, or that the specimens were collected too late to find a virus. However, that does not mean that a virus or other agent did not cause the damage to their spinal cord. About

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(Cryptosporidium ... continued from page 1)

reational water. The symptoms begin two to 14 days following ingestion of the parasite; as few as 10 oocysts can cause infection in a healthy person. Symptoms include diarrhea, vomiting, fever, fatigue, abdominal cramps, and weight loss. A stool test can be used to confirm cryptosporidiosis.

The Department of Health and Hospitals' (DHH) Infectious Disease Epidemiology Section collected information on identified cases and controls regarding recent possible exposures including recreational water use and pets in the home. The 2013 cases were primarily in Regions 2 (Baton Rouge area, n=43), 4 (Lafayette area, n=56), and 9* (St. Tammany area, n=32) (Table).

Table: *Cryptosporidium* Case and Control Demographics - Louisiana, 2013

		Cases	Controls
	N	141	54
Age	Average (STDV)	17 (21)	16 (20)
	Range	<1 to 84	<1 to 71
Age Groups	<1	6	9
	1-4	46	17
	5-9	25	5
	10-19	19	6
	20-49	31	11
	50-74	9	6
	>75	5	0
Sex N (%)	Male	59 (20.6)	23 (42.6)
	Female	82 (58.2)	31 (57.4)
Region N (%)	1	0 (0)	0 (0)
	2	43 (30.5)	19 (35.2)
	3	1 (0.7)	0 (0)
	4	56 (39.7)	24 (44.4)
	5	8 (25)	3 (5.5)
	6	0 (0)	0 (0)
	7	0 (0)	0 (0)
	8	1 (.7)	0 (0)
	9	32 (22.7)	8 (14.8)

Cases were determined to be those with a positive lab result for Cryptosporidium either by microscopic examination, direct immunofluorescent antibody, or enzyme immunoassay. To focus on the specific role of Cryptosporidium on diarrhea, controls were those who sought care from a physician for diarrhea and were not diagnosed with Cryptosporidium by a stool test. Cases and controls were matched on demographics and collection dates.

Surveillance epidemiologists followed up with each case and control using a standardized questionnaire to assess for common exposures. Each person was asked if they did any of the following two weeks prior to onset:

- Travel
- Have contact with farm animals
- Swim in a recreational body of water
- Swim in a natural body of water

Exposure

The majority of cases (51%, 72/141) had recent water exposure in the past two weeks. Of those exposed to water, 33% (24/72) had been to a public pool, 25% (18/72) had been to a private pool, 19 % (14/72) had been to a public waterpark, and 14% (10/72) had been to a public splash park.

Results

The water venues with a significant association to illness were public pools and private pools. Cases were almost three times more likely to report exposure to a public pool prior to onset compared to controls. The category of 'public pool' includes, but is not limited to the following: hotel pools, neighborhood pools, apartment complex pools, and city pools. An odds ratio could not be calculated for exposure to a private pool due to zero controls reporting exposure to a private pool prior to illness. However, Fisher's p-value = 0.000, indicating that there was a significant association between being a case and exposure to a private pool. Cases were seven times more likely to report exposure to a public splash park compared to controls. This association was border-line significant. Cases were almost three times more likely to report going to a public water park prior to illness onset, but this was not a significant association. Other water venues reported included lakes, beaches, rivers, and temporary water structures, such as inflatable water slides. The association to these venues was not significant.

This is considered to be a confirmed outbreak of Cryptosporidiosis among residents of Louisiana, specifically those residing in Regions 2, 4, and 9. Of those interviewed, over 50% reported water exposure in the two weeks prior to illness onset compared to 20% of controls. Those with a diagnosis with Cryptosporidiosis were five times more likely to have been exposed to recreational or surface water prior to onset compared to those without a diagnosis of Cryptosporidiosis. No one water venue could be determined to be the cause of the illnesses; however, some recreational water venues were reported more than once. Also reported were private family pools and various public pools, such as neighborhood pools and various hotel pools, but not by more than one case or family. Although water exposure was significantly associated with illness, this does not appear to a point source outbreak, but a continuous community outbreak involving multiple water venues including public and private recreational water venues.

For more information please go to www.dhh.louisiana.gov/assets/oph/Center-PHCH/Center-CH/infectious-epi/PublicInfo/RecreationalWatersPublicInfo.pdf, or email Cara Bergo at cara.bergo@la.gov.

NOTICE: IDRIS 2 (Infectious Disease Reporting Information System - Version 2) will go live online on October 27, 2014. Training is in process and will continue through the live date. Please contact the infectious disease surveillance epidemiologist in your region for scheduling training. A recorded training can be viewed on Ilinc (web-based). Please contact rosemarie.robertson@la.gov for access. All Class A** diseases must still be called into the Infectious Disease Epidemiology Section.

* * Sanitary Code Page 8

* Map of Regions on Page 7

Louisiana Morbidity Report
Volume 25, Number 5 **September-October, 2014**

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

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HIV/AIDS Surveillance Update Louisiana, 2003-2012

Jessica C. Fridge, MSPH; Demerial Banks, MPH

The Department of Health and Hospitals' Office of Public Health STD/HIV Program's (SHP) HIV Surveillance Program conducts general case ascertainment through the receipt of reports of potential cases of HIV infection from clinical providers, laboratories, and other public health providers throughout the state. Basic demographic and risk information are also collected. In addition, the program monitors perinatal exposure to and transmission of HIV, HIV incidence, medication resistant strains of HIV, clinical manifestations of HIV disease, mortality, the utilization and impact of care and treatment, and measures of high-risk behavior.

In June 2014, the program released a summary of 2012 HIV Surveillance data.

The HIV Epidemic in Louisiana

In the most recent Centers for Disease Control and Prevention (CDC) HIV Surveillance Report (Vol. 23*), Louisiana ranked fourth highest in estimated state AIDS case rates and 11th in the estimated number of AIDS cases in 2011. The metropolitan Baton Rouge area ranked first and the New Orleans metropolitan area ranked fourth in estimated AIDS case rates in 2011 among the large metropolitan areas in the nation.

This surveillance update includes data for persons diagnosed with HIV or AIDS through December 31, 2012 and reported to SHP before September 3, 2013. The report presents both numbers and rates of HIV and AIDS diagnoses. New HIV diagnoses are the number of people diagnosed with HIV at any stage of the disease within a given year. New HIV diagnoses include people diagnosed with both HIV and AIDS in the same year and people diagnosed with HIV who do not receive an AIDS diagnosis in the same year. New AIDS diagnoses include people who were newly diagnosed with AIDS within the calendar year and who received their HIV diagnosis in the same year or any prior year.

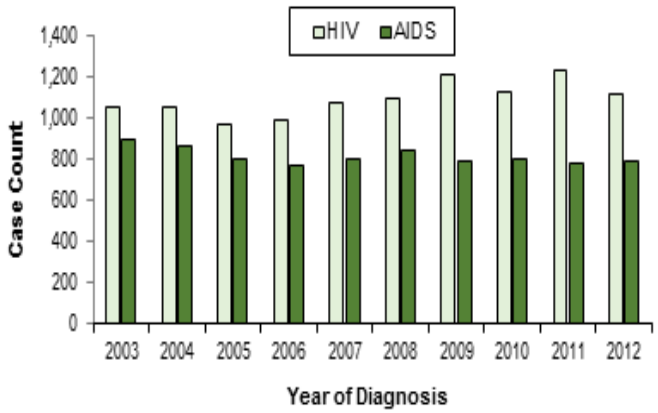
In 2012, there were 1,122 new HIV diagnoses and 793 new AIDS diagnoses in the state of Louisiana. A total of 18,240 persons were living with HIV infection in Louisiana as of December 31, 2012. There are persons living with HIV infection in every parish in Louisiana.

In 2012, there were new HIV diagnoses in all nine public health regions and in 58 of Louisiana's 64 parishes. Over 56% of all new HIV diagnoses occurred in the New Orleans and Baton Rouge regions; 60% of all persons living with HIV infection live in those two regions. The region with the third largest number of new diagnoses and persons living with HIV infection is the Monroe region.

The number of new HIV infections has varied across the past 10 years from a low of 971 new diagnoses in 2005 (due to the impact of Hurricane Katrina), to a high of 1,229 diagnoses in 2011 (Figure 1).

* *http://www.cdc.gov/hiv/library/reports/surveillance/2011/surveillance_Report_vol_23.html*

Figure 1: Number of New HIV and AIDS Diagnoses by Year of Diagnosis Louisiana, 2003-2012



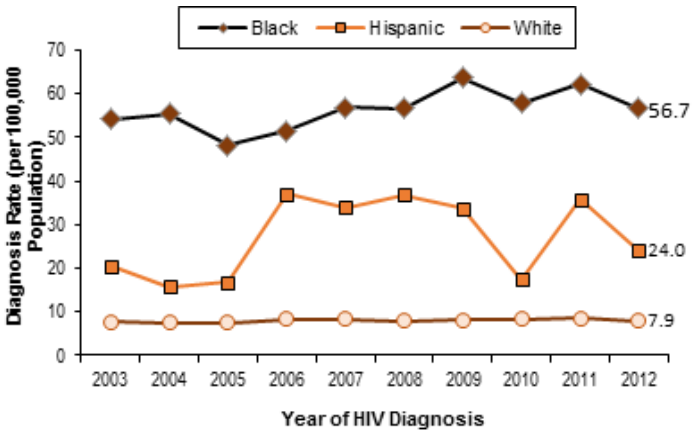
SHP supports HIV testing through contracts with community-based organizations and through partnerships with parish health units (which provide STD, family planning, TB, and other public health services), hospital emergency departments, correctional facilities, substance abuse treatment programs, Federally Qualified Health Centers, and school-based health clinics. Persons who test positive are provided prevention counseling and referrals and linkage to care services to connect them to medical care and other support services. In 2012, a total of 98,834 HIV tests were conducted, of which 1,054 tests (1.1%) were positive; 449 tests (43%) were new diagnoses.

The CDC currently estimates that 16% of all people infected with HIV in the United States are unaware of their HIV status. Although HIV testing has increased in Louisiana, people are still being diagnosed late in their HIV disease progression. In 2012, 28% of the new HIV diagnoses were concurrently given an AIDS diagnosis; an additional 8% had an AIDS diagnosis within the next six months. More work must be done to get people tested earlier, link them to primary medical care, and provide them with important prevention services.

The Disproportionate Impact of HIV

At seven-times higher than the rate of HIV infection among whites and almost two-and-a-half times higher than the rate among Hispanics in 2012, the HIV rate for African Americans in Louisiana continues to be disproportionately high (Figure 2).

Figure 2: Trends in HIV Rates by Race/Ethnicity - Louisiana, 2003-2012



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IDEPI Question/Answer Corner

Do amebas cause intestinal problems, or are they harmful in the stomach?

No. The stomach's natural acids kill the ameba once it enters the digestive system so it cannot travel from stomach to brain.

Is water safe to drink with ameba in it?

Yes. The ameba can only access the brain through very small holes at the top of the nasal cavity (the tiny holes that allow the sense of smell). The ameba cannot harm humans when they drink water that contains them.

If there is an open cut or boil on skin that is exposed to ameba in water, can it result in a brain infection?

No. The ameba cannot travel through the skin or blood stream to the brain.

Is a chlorine burn bad for your health?

No. A chlorine burn may involve changing the type of disinfectant used from monochloramine (chlorine combined with ammonia) to free chlorine (no ammonia), which increases the level in drinking water, but not to an extent that would be a public health concern. A chlorine burn may require only that chlorine levels be at 1.0 mg/L throughout a water system. The EPA maximum level for chlorine is 4.0 mg/L. Many water systems routinely operate at levels above 1.0 mg/L. While it may be slightly higher in some areas of a distribution system, a chlorine burn does not require the chlorine level to be anywhere near a level that would cause a public health concern.

Why does the chlorine smell so strong during a chlorine burn?

The initial change in chemistry from monochloramine to free chlorine will cause compounds that have taste and odor characteristics to form briefly before final conversion to free chlorine. Once this is complete, the chlorine is at higher levels than normal in order to kill the ameba throughout a distribution system. This change is detectable by the human body; the smell can be noticeable even though there is a relatively small amount of chlorine in the water.

Does running water for five minutes help during a chlorine burn, or does that make more chlorine come into the system as in when a hydrant may be flushed?

Running the water for five minutes can help clear out old water that may be in house pipes. Running the water will help ensure that the home is getting new water, with a safe level of chlorine in it while the burn is occurring. It does not get rid of the chlorine.

Can ameba affect animals?

Yes, it can affect animals, but only in the same way it might affect humans. It is important to remember that the ameba exists naturally throughout our environment - for example in a lake where pets might play. However, it is extremely rare for an animal to be impacted by amebas.

How does ameba affect those with cancer or diseases?

The ameba impacts all individuals the same way. If getting water high in the nose is avoided, exposure to the ameba can be prevented.

How does a chlorine burn affect residents with cancer or diseases?

The recommended levels of chlorine are protective of everyone's health. Hospitals and dialysis centers in the area should also be notified about the extra chlorine in order for them to change filters used in procedures more often.

How long does it take to kill an ameba, years?

The ameba can be killed quickly with chlorine, but it is required that the chlorine burn to allow the chlorine time to reach all parts of a distribution system and flush or clean off the biofilm along the pipes where the ameba and certain kinds of bacteria might live. The ameba is present in nature normally, which it is why it is important that a water system maintain the required level of chlorine in the system at all times. The required chlorine level will prevent ameba from being able to live in the water system.

Why might the water turn brown during flushing?

This is most likely caused by mineral deposits in the water distribution system. Brown water is safe to drink, although it may look unappealing or have a slight smell. The water supplier should always be contacted anytime one experiences brown water.

Is water safe to drink and bathe in with high amounts of chlorine in it?

The level of chlorine required for the chlorine burn is safe for normal drinking and bathing. Bathing in pure chlorine is definitely not recommended, but the levels required for a burn and for the normal residuals is safe for regular use.

Does a 'boil water advisory' affect the chlorine burn?

Boil water advisories are typically issued only when a pressure loss has occurred in a distribution system leaving open the potential for contaminants to enter the system, or when harmful contaminants have been detected in the system necessitating the need for boiling water prior to use in order to protect health. A chlorine burn would help mitigate risk during either of these scenarios due to the increased chlorine levels being maintained in the system, but boil advisories should still be followed.

Is bottled water needed for drinking after ameba is detected in a water system?

No because water with the ameba in it is safe to drink.

Are amebas in any other systems in this state or country?

Yes. The ameba has been detected in other water systems.

Announcements

Updates: Infectious Disease Epidemiology (IDEpi) Webpages

www.infectiousdisease.dhh.louisiana.gov

Annual Reports: Several Year Comparison 2012-2014

Epidemiology Manual: Enterovirus D68 and Spanish version; EV68 Patient Summary Form (LA); Ebola Virus Disease; Evaluating Patients for Possible Ebola Virus Disease (CDC); Lab Form 96A (LA); Laboratory Specimen Information (LA); Picornavirus Laboratory Instructions (CDC); What Obstetrician-Gynecologists Should Know About Ebola (ACOG)

HAI: CRE Surveillance Worksheet; Infections by Bio-aerosols (Under Resources for Infection)

Influenza: Enterovirus D-68 CDC Health Advisory 9/26/14; Influenza Surveillance Handbook 2014-2015 Season; Fax Report Form 2014-15 Season; Recommendations of the ACIP 2014-15 Influenza Season (MMWR 8/15/14); Virologic Surveillance Handbook 2014-15 Season; Weekly Report

Reportable Disease Surveillance: Pregnancy Testing and Reporting Guidelines

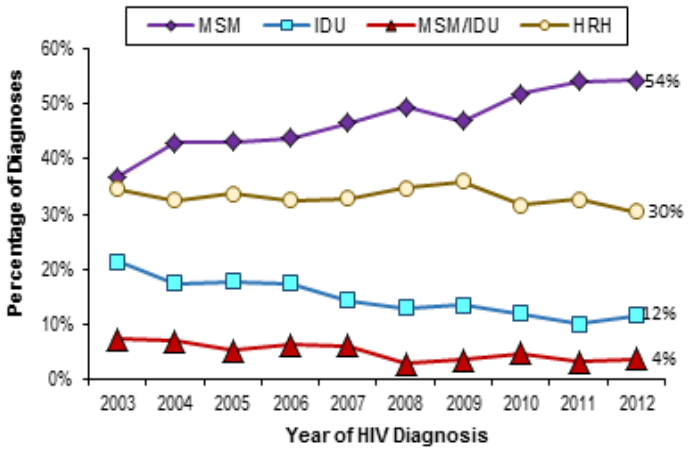
West Nile Virus: Weekly Report

(HIV/AIDS... *continued from page 3)*

Although African Americans make up only 32% of the state's population, 74% of new HIV diagnoses and 79% of new AIDS diagnoses were among African Americans in 2012.

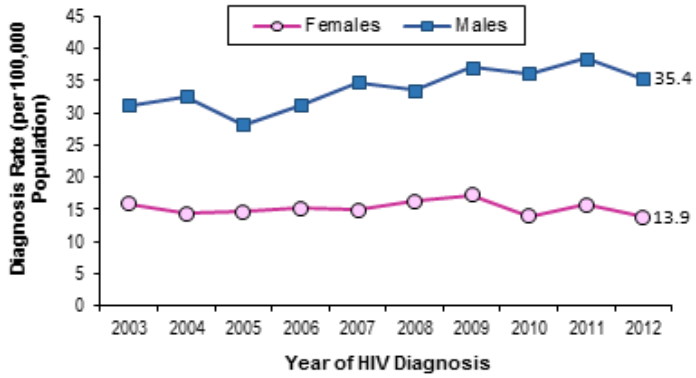
Over the past 10 years, the proportion of adult HIV diagnoses attributed to male-to-male sexual contact (MSM) has increased from 37% in 2003 to 54% in 2012. The proportion of diagnoses associated with injection drug use (IDU) has declined since 2003 and the proportion of diagnoses associated with high-risk heterosexual contact (HRH) has decreased slightly since 2003 (Figure 3).

Figure 3: Trends in HIV Diagnoses by Risk - Louisiana, 2003-2012



Women made up 30% of the new HIV diagnoses and 29% of new AIDS diagnoses in 2012. The HIV rate among women has remained relatively stable over the past 10 years. The HIV rate for men is two-and-a-half times higher than it is for women (Figure 4).

Figure 4: Trends in HIV Rates by Sex - Louisiana, 2003-2012



The SHP office regularly reports and publishes data on websites *www.hiv.dhh.louisiana.gov* and *www.HIV411.org*. SHP produces quarterly reports, an Annual Report and numerous fact sheets that are available on both websites. For more information, please contact Jessica Fridge at (504) 568-5566 or email *jessica.fridge@la.gov.*

Louisiana Fact

Laboratory - Office of Public Health

The Office of Public Health (OPH) Laboratory occupied the seventh and eighth floors at 325 Loyola Avenue, New Orleans from 1957 until Hurricane Katrina destroyed the building (Figures 1 and 2).

Fhoto 1: Front of 325 Loyola Avenue, New Orleans - Louisiana

Fhoto 2: Hay Storage Room 804, 325 Loyola Avenue, New Orleans - Louisiana

Animals that were housed on the 8th floor included sheep (for making blood agar plates), and rabbits (for pregnancy tests). By 1973, only mice and chickens were maintained by the laboratory. In 1978, there were no animals kept in the laboratory; the pens they used to keep the animals in, with drains in the floor, were "unoccupied."

Dr. George Hauser was director of the laboratory during this time period. In 1939, he was responsible for unifying and standarizing Louisiana's laboratory system into six laboratory districts: Monroe, Shreveport, Alexandria, Jennings, Franklin and New Orleans.The central laboratory in New Orleans served the other five by performing additional functions, some of them that required animials at the time. Dr. Hauser became Assistant Bacteriologist in 1917 and then head of the Bacteriology Lab in 1938. He became the first OPH Laboratory director when the chemical and bacteriology labs were merged in 1957 and served until just before his death in 1977.

GUIDELINES FOR TESTING

INFECTIOUS DISEASES IN PREGNANCY

Office of Public Health, Louisiana Department of Health & Hospitals

TIMING	PROCEDURE	INDICATION
1st Prenatal Visit Of Pregnancy	Offer Syphilis testing	REQUIRED by Louisiana Law[1] See CDC STD Treatment guidelines[3]
	Offer HIV testing/HIV counseling	REQUIRED by Louisiana Law[1]
	HBsAg	RECOMMENDED by CDC and ACOG[3,4]
	Rubella IgG - Antibody test	RECOMMENDED by ACOG[4]
	Gonorrhea/Chlamydia testing	RECOMMENDED by CDC and ACOG[3,4]
	Urine culture/screen	RECOMMENDED by ACOG[4]
	Hepatitis C - Antibody test	RECOMMENDED for women at risk for infection by CDC and ACOG[3,4]
	Genital Herpes - Elicit history for possible exposure	RECOMMENDED by CDC and ACOG[3,4]
	Varicella - Determine immune status; history or testing	RECOMMENDED by ACOG[4]
1st Prenatal Visit of Third Trimester	Offer Syphilis testing	Repeat testing REQUIRED by Louisiana Law[1] See CDC STD Treatment guidelines[3]
	Offer HIV testing/HIV counseling	Repeat testing REQUIRED by Louisiana Law[1]
	Gonorrhea/Chlamydia testing	Repeat testing RECOMMENDED for women < 26 years of age or at high risk of infection by CDC and ACOG[3,4]
35 - 37 Weeks Gestation	GBS culture (rectovaginal)	RECOMMENDED for all pregnant women by CDC and ACOG[4,5,6]
Labor and Delivery	Offer Syphilis testing	RECOMMENDED for all women at continued risk by ACOG[4] See CDC STD Treatment guidelines[3]
	Offer HIV testing/HIV counseling	Recommended for women not previously screened or if status is unknown/undocumented by CDC and ACOG.[1,8] Physicians may test a newborn without maternal consent whose mothers present for delivery without an HIV test on record.[2]
	HBsAg	RECOMMENDED for women not previously screened or if status is unknown/undocumented by CDC and ACOG[3,4] Repeat testing RECOMMMENDED for all women at high risk of infection by CDC[7]
	Genital Herpes - Obtain history and examine genitalia for herpetic lesions	RECOMMENDED by CDC and ACOG[3,4]

1. La. Rev. Stat. § 40:1091; 2014 La. Acts No. 459
2. La. Rev. Stat. § 40:1300.13
3. CDC. Sexually transmitted diseases treatment guidelines, 2010. MMWR, December 17, 2010/59(No. RR-12).
4. American College of Obstetricians and Gynecologists (ACOG); American Academy of Pediatrics. Guidelines for perinatal care. October 2012.
5. CDC. Prevention of Perinatal Group B Streptococcal Disease, Revised Guidelines from CDC, 2010. MMWR, Nov. 19, 2010/59(No. RR-10).
6. ACOG. Prevention of early-onset group B streptococcal disease in newborns. Committee Opinion No. 485. Obstet Gynecol 2011;117.
7. CDC. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infections in the United States. MMWR, Dec. 23, 2005/ 54 (No. RR-16) for management of positive results.
8. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55(No. RR-14):1–17.

Pregnancy Guidelines for Testing and Reporting can be found at http://dhh.louisiana.gov/index.cfm/page/1013. These documents support the elimination of mother-to-child infection of several diseases including Hepatitis B, HIV, and syphilis. In addition to noting the required and recommended tests for infectious diseases during the first prenatal care visit, these guidelines highlight the recently passed Louisiana Act 459 which requires every physician attending any pregnant woman offer a syphilis and HIV test to the woman at the first examination during the third trimester (full text available at: http://www.legis.la.gov). For more information about the guidelines contact Elliott Brannon at (504)568-5133 or email elliott.brannon@la.gov. Also available 'What Obstetrician-Gynecologists Should Know About Ebola' at http://dhh.louisiana.gov/assets/oph/Center-PHCH/Center-CH/infectious-epi/EpiManual/ObstetricsEbola.pdf.

(Enterovrus ... continued from page 1)

half of the children children had EV-D68 in their nose secretions. We do not yet know whether these respiratory infections are linked to their muscle weakness. If a patient presents meeting the following case definition with all four criteria, please contact the Infectious Disease Epidemiology Section, Department of Health and Hospitals at (800) 256-2748:

- Patient less than or equal to 21 years of age, AND
- Acute onset of focal limb weakness, AND
- Onset on or after August 1, 2014, AND
- An MRI showing spinal cord lesion largely restricted to gray matter.

For more information, go to http://dhh.louisiana.gov/index.cfm/page/531.

Table: Communicable Disease Surveillance, Incidence by Region and Time Period, July-August, 2014

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Jul-Aug 2014	Jul-Aug 2013	Jan-Dec Cum 2014	Jan-Dec Cum 2013	Jan-Dec % Chg*
Vaccine-preventable															
Hepatitis B	Cases	1	3	1	2	1	0	1	2	3	14	20	50	47	NA*
	Rate[1]	0.1	0.5	0.3	0.4	0.4	0	0.2	0.6	0.8	0.3	0.5	1.2	1.1	NA*
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Mumps		0	0	0	0	0	0	0	0	0	0	0	0	1	NA*
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		5	1	1	4	0	3	4	2	5	25	53	63	131	-51.9
Sexually-transmitted															
HIV/AIDS	Cases[2]	72	60	6	26	5	9	17	11	16	224	247	998	877	13.8
	Rate[1]	7.2	10.4	1.6	4.8	1.8	3.0	3.4	3.1	3.7	5.1	5.6	22.8	20.1	NA*
Chlamydia	Cases[1,3]	68	110	45	169	40	50	105	154	31	772	4,355	10,663	16,920	-37.0
	Rate[1]	7.8	16.4	11.1	28.6	13.6	16.1	19.1	43.2	5.6	16.8	94.6	231.7	367.7	NA*
Gonorrhea	Cases[1,3]	76	55	35	78	20	33	57	88	17	459	1,372	4,131	5,020	-17.7
	Rate[1]	8.8	8.2	8.6	13.2	6.8	10.6	10.3	24.7	3.1	10.0	29.8	89.8	109.1	NA*
Syphilis (P&S)	Cases[1,3]	41	9	12	3	0	1	14	11	4	95	68	325	238	36.6
	Rate[1]	4.7	1.3	3.0	0.5	0.0	0.3	2.5	3.1	0.7	2.1	1.5	7.1	5.2	NA*
Enteric															
Campylobacter	Cases	2	7	1	11	7	11	10	14	7	70	60	179	182	NA*
Hepatitis A	Cases	0	0	0	1	0	1	0	0	0	2	1	6	6	NA*
	Rate[1]	0	0	0	0.2	0	0.3	0	0	0	0	0	0.1	0.1	NA*
Salmonella	Cases	35	38	23	50	21	18	36	45	57	323	335	732	796	-8.0
	Rate[1]	3.4	6.7	6.1	9.7	7.8	5.9	7.1	12.8	14.8	7.5	7.8	17.0	18.4	NA*
Shigella	Cases	6	8	1	1	0	1	0	3	4	24	104	107	249	-57.0
	Rate[1]	0.6	1.4	0.3	0.2	0	0.3	0	0.9	1.0	0.6	2.4	2.5	5.8	NA*
Vibrio, cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Vibrio, other	Cases	1	0	3	3	1	0	1	1	1	11	9	34	29	NA*
Other															
H. influenzae (other)		1	1	1	0	0	0	0	1	0	4	7	35	43	-18.6
N. Meningitidis		1	1	0	0	0	0	0	0	0	2	0	6	6	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] = Prelminary data.

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

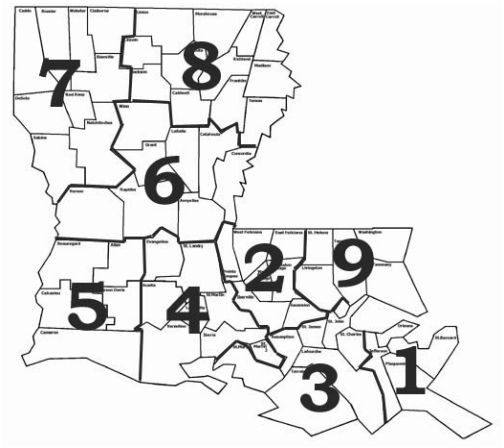
Table 2. Diseases of Low Frequency, January-December, 2014

Disease	Total to Date
Legionellosis	23
Lyme Disease	0
Malaria	5
Rabies, animal	2
Varicella	21

Table 3. Animal Rabies, July-August, 2014

Parish	No. Cases	Species
Washington	1	Cat

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.

- Acute Flaccid Paralysis
- Anthrax
- Avian or novel strain Influenza A (initial detection)
- Botulism
- Brucellosis
- Cholera
- *Clostridium perfringens* (foodborne infection)
- Diphtheria
- Fish/Shellfish Poisoning (Domoic Acid, neurotoxic, Cigueatera, paralytic, Scombroid)
- Foodborne Infection
- *Haemophilus influenzae* (invasive disease)
- Influenza-associated Mortality
- Measles (Rubeola imported or indigenous)
- *Neisseria meningitidis* (invasive infection)
- Outbreaks of Any Infectious Disease
- Pertussis
- Plague (*Yersinia pestis*)
- Poliomyelitis (paralytic & non-paralytic)
- Q Fever (*Coxiella burnetii)*
- Rabies (animal and human)
- Ricin Poisoning
- Rubella (congenital syndrome)
- Rubella (German Measles)
- Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)
- Smallpox
- *Staphylococcus aureus*, Vancomycin Intermediate or Resistant (VISA/VRSA)
- Staphylococcal Enterotoxin B (SEB) Pulmonary Poisoning
- Tularemia (*Francisella tularensis*)
- Viral Hemorrhagic Fever
- Yellow Fever

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.

- Amoeba (free living infection: *Acanthamoeba, Naegleria, Balamuthia,* others)
- Anaplasmosis
- Arthropod-Borne Neuroinvasive Disease (West Nile, St, Louis, California, Eastern Equine, Western Equine, others)
- Aseptic Meningitis
- Babesiosis
- Chagas Disease
- Chancroid
- Dengue Fever
- *Escherichia coli*, Shig-toxin producing (STEC), including *E. coli* 0157:H7
- Granuloma Inguinale
- Hantavirus (infection or Pulmonary Syndrome)
- Hemolytic-Uremic Syndrome
- Hepatitis A (acute disease)
- Hepatitis B (acute illness and carriage in pregnancy)
- Hepatitis B (perinatal infection)
- Hepatitis E
- Herpes (neonatal)
- Human Immunodeficiency Virus[2] [(HIV), infection in pregnancy]
- Human Immunodeficiency Virus[2] [(HIV), perinatal exposure]
- Legionellosis (acute disease)
- Malaria
- Mumps
- Salmonellosis
- Shigellosis
- Syphilis[1]
- Tetanus
- Tuberculosis[3] (*M. tuberculosis, M. bovis, M. africanum*)
- 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[3] (AIDS)
- Anaplasma Phagocytophilum
- Blastomycosis
- Campylobacteriosis
- Chlamydial infection[1]
- Coccidioidomycosis
- Cryptococcosis
- Cryptosporidiosis
- Cyclosporiasis
- Ehrlichiosis (human granulocytic and monocytic, *Ehrlichia chaffeensis)*
- Enterococcus, Vancomycin Resistant [(VRE), invasive disease]
- Giardia
- Glanders
- Gonorrhea[1] (genital, oral, ophthalmic, pelvic inflammatory disease, rectal)
- Hansen's Disease (leprosy)
- Hepatitis B (carriage, other than in pregnancy)
- Hepatitis C (acute illness)
- Hepatitis C (past or present infection)
- Human Immunodeficiency Virus[2] (HIV (infection other than as in Class B)
- Human T Lymphocyte Virus (HTLV I and II infection)
- Leptospiriosis
- Listeria
- Lyme Disease
- Lymphogranuloma Venereum[1]
- Meliodosis (*Burkholderia pseudomallei)*
- Meningitis, Eosinophilic
- Nipah Virus Infection
- Psittacosis
- Spotted Fevers [Rickettsia species including Rocky Mountain Spotted Fever (RMSF)]
- *Staphylococcus aureus*,(MRSA) invasive infection
- Staphylococcal Toxic Shock Syndrome
- Streptococcal Disease, Group A (invasive disease)
- Streptococcal Disease, Group B (invasive disease)
- Streptococcal Toxic Shock Syndrome
- *Streptococcus pneumoniae*, invasive disease
- Transmissible Spongiform Encephalopathies (Creutzfeldt-Jacob Disease & variants)
- Trichinosis
- Varicella (chickenpox)
- Vibrio Infections (other than cholera)
- Yersiniosis

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

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

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

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

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

[3]Report on CDC72.5 (f.5.2431) card

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

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