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Louisiana Morbidity Report

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A Pseudo-Outbreak of Legionnaires' Disease

On April 3, 1995 the Office of Public Health was notified about 11 persons who had become ill from January 2 to March 18, 1995 and had acute antibody titers of $>1:256$ to *Legionella pneumophila*. All of these persons had been hospitalized at a hospital in rural southeastern Louisiana, and one had died.

The Centers for Disease Control surveillance case definition for probable Legionnaires' disease includes an antibody titer of $= \geq 256$ together with a clinically compatible illness (fever, cough, and x-ray proven pneumonia). Further investigation of the cases revealed that although all of these persons had pulmonary disease, only 5 (45%) had pneumonia. Ages of these persons ranged from 16 to 83 years, 8 (73%) were older than age 65. The residences of these individuals were scattered over four adjacent towns. When these persons were interviewed, no common exposure (typically a water or aerosol source) was found to explain the outbreak.

Because this outbreak did not have an apparent source, we looked more closely at whether or not the diagnosis of Legionnaires' disease was accurate. Although there are six known serotypes of *L. pneumophila*, serotype 1 is the one associated with most outbreaks of Legionnaires' disease. It is also the only serotype for which well-standardized reagents are available. The serum samples from the

Louisiana "cases" had been tested by a reference laboratory using a commercially available test kit which uses antigens representing all six serotypes. The results of retesting of nine of these serum samples at the Louisiana State Laboratory and at the Centers for Disease Control using several different commercially available test kits are shown in Table 1. Elevated titers were obtained in only five of nine cases, and only when the test kit used by the original laboratory was used at the CDC. Paired acute and convalescent samples were tested at CDC using this kit in five cases, and none showed fourfold titer rises.

Table: Titers to *Legionella pneumophila* for case-patients, by laboratory

Laboratory	Total samples tested	Samples with titers > 256
Original Lab (6 serotypes)		11
Louisiana Lab (6 serotypes, different test kit from original lab)	9	0 (0%)
CDC Lab (LP1 only)	9	0 (0%)
CDC Lab (6 serotypes, same test kit as original lab)	9	5 (55%)

A review of records from two hospitals in the area for January 1 - April 1, 1995 found an increase in admissions for pneumonia during February and early March. However, none of 21 pneumonia patients tested from this group had elevated convalescent titers to *L. pneumophila*, but 14/17 (82%) and 11/17 (65%) had elevated convalescent titers to influenza type A and type B, respectively.

Of note, as our investigation proceeded we became aware of three other states who had investigated similar pseudo-outbreaks which involved testing by the same reference laboratory.

We concluded that this "outbreak" was in fact an artifact of the testing procedure. The positive test results may have been due to laboratory error at the reference laboratory, or due to problems inherent in the particular test kit involved. It is important to remember, however, that *Legionella* (Continued on page two)

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A Pseudo-Outbreak of Legionnaires' Disease (Cont.)

antibody testing in general is not well-standardized and so results, especially single titers, can easily be misinterpreted.

Because of difficulties in the interpretation of serologic tests for Legionnaires disease, we recommend that physicians who wish to test patients for Legionnaires disease not use single titers. Instead, they should test for Legionella antigen itself, using direct fluorescent antibody testing for sputum or radioimmunoassay testing for urine, or should send blood for both acute and convalescent titers, in which case the disease can only be diagnosed after treatment decisions have been made.

Hospital Hepatitis B Immunization Survey

In February, the Immunization Section conducted a survey of the seventy-one (71) hospitals that provided Labor and Delivery Services to assess their practices regarding immunization of infants against hepatitis B.

Eighty-seven percent (87%; 62/71) of the hospitals routinely administer the first dose of hepatitis B vaccine to infants before discharge. Four of the hospitals also have standing policies which assures that all infants receive the first dose before discharge. Seven percent (7%; 5/71) of the hospitals provide the first dose of vaccine after discharge at the two week followup visit. Thus 94% of the hospitals are providing the first dose of hepatitis B vaccine to all infants within the first two weeks of life.

The remaining four hospitals (6%) provide hepatitis B vaccine to infants born to hepatitis B positive mothers only. The reason most often given for not providing universal immunization of all infants against hepatitis B is lack of insurance or the insurance is not willing to cover the cost of the immunization. These hospitals refer their patients to the local parish health unit for immunizations. Another reason cited is that the physicians preferred to provide the immunization in their offices.

The survey showed that universal immunization of all infants against the hepatitis B virus is currently a standard of care for most hospitals in Louisiana. There is some concern as to whether initiation of the first dose may be impacted by the trend toward early discharge of mothers and babies. Health care providers should be aware that the first dose of hepatitis B vaccine can be administered within the first 12 hours of life, so vaccination can take place even with early discharge.

An Outbreak of Tuberculosis Among Workers on a Group of River Barges

In May 1994, OPH was notified that a group of Louisianians living and working on a group of six barges operated on the Mississippi River by the US Army Corps of Engineers were possibly exposed to a fellow worker with active tuberculosis (TB). In December 1993 this worker reported a three-month history of cough that did not respond to several courses of antibiotics. PPD testing showed 22 mm. of induration, a chest x-ray showed bilateral upper lobe cavitory disease, numerous acid-fast bacilli were found in his sputum smear, and sputum culture grew *M. tuberculosis*. Because this man had been living and working on the barges in cramped and poorly-ventilated conditions while symptomatic, a contact investigation was begun by the Mississippi and Louisiana Health Departments. Pre-employment TB testing was not routine on these barges.

Of 429 potentially exposed employees, 393 (92%) were traced and skin tested, and 287 (67%) interviewed. Eight other cases of TB were identified: three culture-confirmed cases, all with isolates identical to the source case, and five clinical cases (negative cultures, but clinical or radiographic evidence of infection, and improvement on anti-TB chemotherapy). None of the cases were HIV positive. Four of the

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cases, including the index case, lived on the same barge. None of the cases reported a close relationship with the index case, either during work hours or off-duty. All cases were treated with standard four-drug anti-TB chemotherapy given under direct supervision. Of the 393 employees, 128 (33%) were PPD positive, including 40 known converters (of 229 with documented prior negative PPD). The highest rates of PPD-positivity (57%) and PPD-conversion (38%) were found on the barge where the index case lived. Risk factors for PPD-positivity were black race (Relative Risk [RR] = 2.6), living on the same barge as the index case (RR=1.9), use of the back mess hall (RR=2.5), and use of any lounge facilities (RR=3.0). The same four risk factors were also statistically significant risk factors for PPD conversion. In multivariate analyses, only lounge use (OR=2.9) remained a statistically significant risk factor for PPD-positivity. All PPD-positive workers who did not have active disease were treated with Isoniazid prophylaxis given under direct supervision.

Widespread transmission of TB appears to have occurred throughout these barges, favored by cramped, poorly ventilated living conditions. In this and similar settings, where the workforce is drawn from a population at high risk for TB and where transmission of TB would be promoted by working and living conditions, pre-employment PPD testing is critical to help prevent outbreaks like this one. In addition, health care practitioners treating these workers need to have a high index of suspicion for TB disease so that prompt identification, isolation and treatment of TB cases can be accomplished.

Immunization Course for Physicians

A Vaccine-Preventable Diseases Update for physicians, physician assistants, and nurse practitioners will be offered on September 7, 1995 from 11:00am to 1:30pm through a satellite downlink from the Centers for Disease Control and Prevention (CDC). Interested persons should call the Immunization Program office at (504) 483-1900 for details about sites in each region of the state. Continuing education credits (3 CME's or .25 CEU's) will be awarded to successfully complete the course.

BULLETIN

The National Adult Immunization Week is the week of October 22-28, 1995. The Office of Public Health, Immunization Program plans to initiate the Influenza High Risk Immunization Program as of October 24, 1995.

E. coli O157:H7 in Louisiana

In recent years, *Escherichia coli* type O157:H7 has increasingly been recognized as an important cause of food-related gastroenteritis and hemolytic uremic syndrome. Earlier this year, the Office of Public Health declared infection due to *E. coli* O157:H7 and hemolytic uremic syndrome to be reportable diseases. In the first six months of 1995, three cases of *E. coli* O157:H7 have been reported to OPH. The three cases were in adults (age range 49-75) in Shreveport, New Orleans, and Lafayette, all of whom had bloody diarrhea. All three were hospitalized, and one died of thrombotic thrombocytopenia purpura (TTP), a syndrome in adults that is very similar to hemolytic-uremic syndrome. Both of the patients who survived reported that before they became ill they ate ground beef; one of the two sampled raw ground beef while preparing a meal and the other shared a cooked hamburger with another person who also developed gastroenteritis but had negative stool cultures.

E. coli O157:H7 is an "enterohemorrhagic" strain of *E. coli* that produces a toxin similar to that produced by *Shigella dysenteriae*. It was first recognized during a multi-state outbreak of hemorrhagic colitis in 1982. *E. coli* O157:H7 infection can cause asymptomatic infection, nonbloody diarrhea or bloody diarrhea. Hemolytic uremic syndrome, which is the leading cause of acute renal failure in children, occurs in approximately 6% of cases. Outbreaks of *E. coli* O157:H7 have been associated with a variety of foods and with person-to-person transmission, but the greatest number of foodborne-related cases have been associated with undercooked ground beef. In 1994, a large outbreak of gastroenteritis caused by this organism occurred in several northwestern states and was linked to undercooked hamburgers served by a fast-food chain. The most effective way to prevent infection is thorough cooking of ground beef.

Most clinical laboratories do not routinely test stool cultures for *E. coli* O157:H7. Because of this, it is likely that most cases of infection from this organism are unrecognized. Clinicians considering this organism as a possible cause of diarrhea should specifically request laboratory testing for *E. coli* O157:H7. Laboratories that do not have the capability of testing specimens for O- and H-typing may send stool or *E. coli* isolates to the OPH state central laboratory for confirmation. We encourage all health care providers to look more carefully for this infection, as it may be an important cause of severe gastroenteritis in the state.

Sexually Transmitted Disease Program, Louisiana Office of Public Health
STD Treatment Guidelines

These guidelines for the treatment of patients with STDs reflect the 1993 CDC STD Treatment Guidelines and recommendations from the The Medical Letter. The focus is primarily on STDs encountered in an office or clinic practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens, and should not be construed as standards or inflexible rules. Advice on treatment of complication of STD infection and inpatient management is available from the STD Program at (504) 568-5275. Cases of gonorrhea, chlamydia infection, NGU, PID, syphilis, chancroid, and HIV infection should be reported to the Office of Public Health. STD Program staff is available to assist health care providers with confidential notification of sexual partners of patient with syphilis or HIV infection.

Disease	Recommended RX	Dose/Route	Alternatives
GONORRHEA¹ Urogenital, rectal, pharyngeal	Cefixime (Suprax) or Ofloxacin ² (Floxin)	400 mg po once 400 mg po once	Ceftriaxone (Rocephin) 125 mg IM once Spectinomycin ³ 2 gm IM once
Conjunctivitis ⁴	Ceftriaxone (Rocephin)	1 g IM once	
Children (<45 kg): Urogenital, rectal, pharyngeal	Ceftriaxone (Rocephin)	125 mg IM once	Spectinomycin ³ 40 mg/kg IM once (maximum 2 g)
Neonates: Conjunctivitis ⁴ Infants born to infected mothers	Ceftriaxone (Rocephin) ⁵	25-50 mg/kg/day IV or IM once (maximum 125 mg)	
CHLAMYDIAL INFECTIONS			
Conjunctival, urethral, cervical, rectal	Azithromycin ⁶ (Zithromax) or Doxycycline ⁷	1 g po once 100 mg po bid for 7 days	Ofloxacin ² (Floxin) 300 mg po bid for 7 days Erythromycin ⁸ 500 mg po qid for 7 days ⁹
Children (<45 kg): Urogenital, rectal	Erythromycin	50 mg/kg per day (4 divided doses) 10-14 days	
Neonates: Ophthalmia, pneumonia, infants born to infected mothers	Erythromycin	50 mg/kg per day (4 divided doses) 10-14 days	
NONGONOCOCCAL URETHRITIS	Doxycycline ⁷ or Azithromycin ^{8,10} (Zithromax)	100 mg po bid for 7 days 1 g po once	Erythromycin ⁸ 500 mg po qid for 7 days ⁹
EPIDIDYMITIS¹¹	Ceftriaxone (Rocephin) plus Doxycycline	250 mg IM once plus 100 mg po bid for 10 days	Ofloxacin ² (Floxin) 300 mg po bid for 10 days
PELVIC INFLAMMATORY DISEASE (Outpatient management)	Ceftriaxone (Rocephin) plus Doxycycline ⁷	250 mg IM once plus 100 mg po bid for 14 days	Ofloxacin ² (Floxin) mg po bid for 14 days plus either: Metronidazole ¹² 500 mg po bid for 14 days or Clindamycin ¹³ 450 mg qid for 14 days
SYPHILIS			
Early - primary, secondary or latent < 1 year	Benzathine penicillin G	2.4 million U IM once	Doxycycline ⁷ 100 mg po bid for 14 days ¹⁴
Latent > 1 year, latent of unknown duration, late (cardiovascular, gumma)	Benzathine penicillin G	2.4 million U IM for 3 doses at 1 week intervals	Doxycycline ⁷ 100 mg po bid for 4 weeks ¹⁴
Neurosyphilis	Aqueous crystalline penicillin G	2 to 4 MU IV q4h for 10-14 days	Procaine penicillin G 2.4 MU IM daily, plus Probenecid 500 mg po qid, both for 10-14 days
Congenital Syphilis	Procaine penicillin G	50,000 u/kg IM daily 10-14 days	Aqueous crystalline penicillin G 100,000- 150,000 u/kg/day in doses of 50,000 U/kg IV q12h for 7 days then q8h for 3-7 days
Children: early - primary, secondary or latent < 1 year	Benzathine penicillin G	50,000 U/kg IM once (maximum 2.4 MU)	
Children: latent > 1 year, late syphilis or unknown duration	Benzathine penicillin G	50,000 u/kg IM for 3 doses at 1 week intervals (maximum total 7.2 MU)	

Disease	Recommended RX	Dose/Route	Alternatives
CHANCROID	Azithromycin ⁹ (Zithromax) or Ceftriaxone (Rocephin)	1 g po once 250 mg IM once	Erythromycin 500 mg po qid for 7 days Amoxicillin 500 mg po plus Clavulanic acid 125 mg po tid for 7 days
BACTERIAL VAGINOSIS	Metronidazole ¹² (Flagyl)	500 mg po bid for 7 days	Clindamycin cream ¹³ 2%, 1 applicator qhs for 7 days Metronidazole vaginal gel ¹² 0.75%, 1 vag applicator bid for 5 days Clindamycin ¹³ 300 mg po bid for 7 days Metronidazole ¹² 2 g po once
TRICHOMONIASIS	Metronidazole ¹² (Flagyl)	2 grams po once	Metronidazole ¹² (Flagyl) 500 mg po bid for 7 days
VULVOVAGINAL CANDIDIASIS	Terconazole 0.8% cream or Clotrimazole 1% cream or Clotrimazole 100 mg vag tab or Miconazole 2% cream	5 g intravag for 3 days 5 g intravag 7-14 days 2 tabs for 3-7 days 5 g intravag for 7 days	Butoconazole 2 % cream, 5 g intravag for 3 days Fluconazole 150 po once
HERPES SIMPLEX First clinical episode of genital herpes	Acyclovir ¹³	400 mg po tid 7-10 days or clinical resolution	Acyclovir ¹³ 200 mg po 5 times a day for 7-10 days or until clinical resolution
First clinical episode of herpes proctitis	Acyclovir ¹³	800 mg po tid 10 days or clinical resolution	Acyclovir ¹³ 400 mg po 5 times a day for 7-10 days or until clinical resolution
Recurrent episodes	Acyclovir ¹³	400 mg po tid for 5 days	Acyclovir ¹³ 200 mg po 5 times a day for 5 days or 800 mg po bid for 5 days
Suppressive therapy ¹⁵	Acyclovir ¹³	400 mg po bid	Acyclovir ¹³ 20 mg po 3-5 times a day
GENITAL WARTS ¹⁶	Podophyllin ¹⁷ 10-25% or Podofilox ¹⁷ 0.5% or Liquid nitrogen or cryoprobe	Apply weekly for 4-6 wks max, wash off in in 1-4 hrs Apply twice daily for 3 days, rest 4, total 4 cycles max.	Trichloroacetic acid (TCA) ¹³ 80-90%, apply weekly for 6 weeks maximum. Electrodesiccation or electrocautery. Surgical excision.
MOLLUSCUM CONTAGIOSUM	Excisional curettage or Direct pressure to express core of lesion		Liquid nitrogen. Electrodesiccation Trichloroacetic acid ¹³ 80-90%
PEDICULOSIS PUBIS	Permethrin (Rid, Nix, etc.) 1% creme rinse or Pyrethrins with piperonyl butoxide	Apply to affected areas, wash off in 10 min	
SCABIES	Permethrin (Rid, Nix, etc) 5% cream	Apply to all areas of the body; from neck down, wash off after 8-14 hrs	Crotamiton 10%, apply to all areas of body from neck down for 2 consecutive nights, wash off 24 hours after second application

¹ Patients with gonococcal infection should receive co-treatment for chlamydial infection.

² Contraindicated for pregnant or nursing women and children < 18 years of age.

³ For patients who cannot tolerate cephalosporins or quinolones; not effective against pharyngeal gonococcal infection.

⁴ Irrigate with saline as adjunct to antibiotic therapy.

⁵ Use with caution in infants with elevated bilirubin levels, especially premature infants.

⁶ Safety of azithromycin has not been determined during pregnancy nor for children < 16 years of age.

⁷ Doxycycline should not be administered during pregnancy, lactation, or to children < 8 years of age.

⁸ Erythromycin estolate is contraindicated during pregnancy. If patient cannot tolerate high-dose erythromycin, change to 250 mg qid for 14 days.

¹⁰ According to manufacturer's data, effectiveness is equivalent to doxycycline.

¹¹ For patients with sexually transmitted epididymitis.

¹² Contraindicated during first trimester of pregnancy; safety during second and third trimester not established.

¹³ Safety during pregnancy not established.

¹⁴ Pregnant patients allergic to penicillin should be treated with penicillin after desensitization.

¹⁵ Discontinue treatment for 1-2 months after one year to assess frequency for recurrence.

¹⁶ Vaginal, cervical, urethral meatal, oral, and anal warts may require referral to an appropriate specialist.

¹⁷ Should not be used during pregnancy.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE ,
MAY - JUNE, 1995
PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD				
	1	2	3	4	5	6	7	8	9	May-June 1995	May-June 1994	Cum 1995	Cum 1994	Chg
<u>Vaccine-preventable</u>														
Measles	16	0	1	0	0	0	0	0	0	17	0	17	1	1600
Mumps	2	0	0	0	0	0	0	0	0	2	8	8	18	-56
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	1	2	2	0	0	0	1	2	0	8	2	9	6	+50
<u>Sexually-transmitted</u>														
AIDS Cases	28	6	2	10	3	5	3	7	2	66	164	270	527	-49
AIDS Rate ¹	2.6	1.1	0.5	2.0	1.1	1.6	0.6	1.4	0.6	1.5	3.8	6.3	12.2	
Gonorrhea Cases	834	185	162	167	78	101	393	181	101	2202	2333	5872	6142	-4
Gonorrhea Rate ²	8.0	3.4	4.5	3.4	3.0	3.2	7.8	5.2	2.9	5.2	5.5	14.0	14.6	
Syphilis(P&S) Cases	30	10	15	27	2	7	26	32	14	163	299	539	915	-41
Syphilis(P&S) Rate ²	0.3	0.2	0.4	0.5	0.1	0.2	0.5	0.9	0.4	0.4	0.7	1.3	2.2	
<u>Enteric</u>														
<i>Campylobacter</i>	11	5	9	2	0	1	0	3	12	44	30	82	51	+61
Hepatitis A Cases	4	0	1	2	0	0	0	5	2	14	21	49	78	-37
Hepatitis A Rate ¹	0.4	-	0.3	0.4	-	-	-	1.4	0.5	0.3	0.5	1.1	1.9	
<i>Salmonella</i> Cases	11	16	9	9	4	6	25	6	9	95	125	135	212	-36
<i>Salmonella</i> Rate ¹	1.1	2.8	2.4	1.7	1.5	2.0	4.9	1.7	2.3	2.2	3.0	3.1	5.0	
<i>Shigella</i> Cases	27	3	1	10	2	1	4	33	8	91	114	166	188	+8
<i>Shigella</i> Rate ¹	2.6	0.5	0.3	1.9	0.7	0.3	0.8	9.4	2.1	2.1	2.7	3.8	4.5	
<i>Vibrio cholera</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-
<i>Vibrio</i> , other	4	1	2	1	0	0	0	0	2	12	14	13	18	-28
<u>Other</u>														
Hepatitis B Cases	12	3	2	2	1	2	7	3	1	33	34	105	100	+5
Hepatitis B Rate ¹	1.2	0.5	0.5	0.4	0.4	0.7	1.4	0.9	0.3	0.8	0.8	2.4	2.4	
<u>Meningitis/Bacteremia</u>														
<i>H. influenzae</i>	0	0	0	0	0	0	0	0	0	0	1	1	3	-67
<i>N. meningitidis</i>	2	0	2	1	0	0	2	0	0	8	3	33	22	+50
Tuberculosis Cases	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A
Tuberculosis Rate ¹	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A

1 = Cases per 100,000

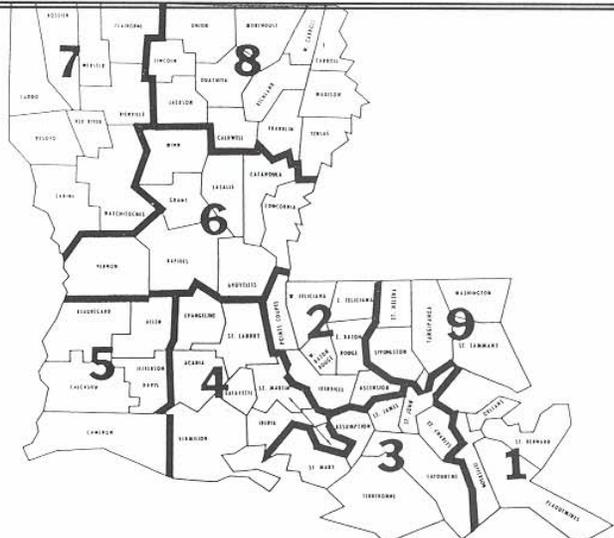
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	5
Histoplasmosis	2
Lead Toxicity	34
Legionellosis	2
Lyme Disease	0
Malaria	1

Table 3. Animal Rabies (May-June 1995)

Parish	No. Cases	Species
Iberia	2	Skunks
Bossier	1	Bat
Lafayette	2	Skunks
Webster	4	Skunks
Sabine	1	Bat
Orleans	1	Bat



LIST OF REPORTABLE DISEASES/CONDITIONS

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

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

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

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

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

**** Report on Lab 94 form (Retrovirus). Name and street address are optional but city and ZIP code must be recorded.

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

**The toll free number for reporting communicable diseases is
1-800-256-2748 FAX # 504-568-5006**

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