



Edwin W. Edwards
 GOVERNOR

Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section
 P.O. Box 60630, New Orleans, LA 70160 (504) 568-5005

Happy Holidays

November-December 1995

Volume 6 Number 6

Prevention of Perinatal HIV Transmission

Most cases of HIV infection in infants can be prevented by treatment of infected mothers during pregnancy and delivery. To assess the degree to which national recommendations for screening and treatment of pregnant women have been implemented, the Office of Public Health (OPH) conducted a statewide survey of hospitals and obstetricians in August, 1995.

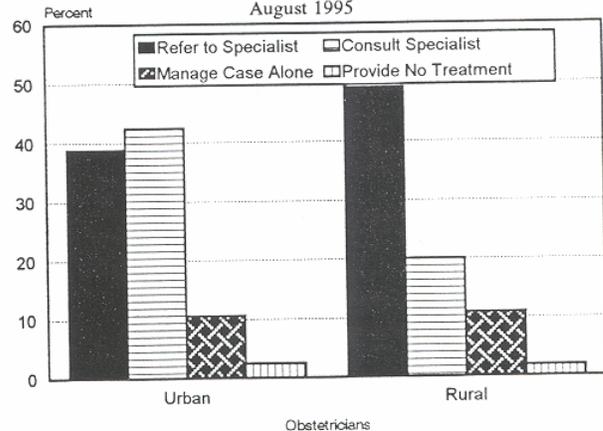
A total of 167 randomly selected obstetricians (including all rural obstetricians and 25% of urban obstetricians) were mailed surveys and 140 (84%) returned them. Sixty-nine percent (58/84) of urban and 70% (39/56) of rural obstetricians routinely test pregnant women for HIV infection (Table). When pregnant women are found to be HIV infected, 38% (32/84) of urban obstetricians and 49% (27/56) of rural obstetricians refer their patients for management; the remainder manage these patients on their own or with consultant advice from a specialist (Figure).

A total of 68 hospitals that provide labor and delivery services were mailed questionnaires, and 67 (99%) responded. Fifty-seven percent of the hospitals responding do not test pregnant women for HIV antibodies at the time of delivery if their HIV status is unknown, while the remaining 43% do test them. Labor/delivery staff at hospitals were asked to estimate the percentage of mothers for whom HIV status is known at the time of delivery: 21% (14/67) of

Table: Estimates regarding HIV testing of women during pregnancy and at time of delivery in Louisiana, August 1995

Survey	Question	Percent		
		Urban	Rural	Total
Obstetrician	Obstetricians conducting routine HIV testing during pregnancy	70%	69%	70%
Hospital	Women HIV tested when coming into Labor and Delivery (estimate)	71%	52%	68%
Hospital	Hospitals testing women at delivery if HIV status is unknown	41%	45%	43%

Figure: Management of HIV-infected women by obstetricians, Louisiana, August 1995



hospitals estimated that this was true for less than 20% of women and only 18% (12/67) of hospitals estimated that over 95% of women were tested. Based on the number of deliveries at the hospitals surveyed, we estimate that as of August 1995, 68% of pregnant women had their status known at the time of delivery (Table).

Forty-six percent of hospitals (31/67) do not have a protocol regarding treatment of HIV positive pregnant women during delivery because they have had none or very few HIV positive pregnant patients. Of the 27 hospitals who have had HIV positive women and answered this question, only 13 (48%) had a policy of routine treatment with AZT during delivery.

This survey indicates that a large percentage of pregnant women are not tested for HIV antibodies either during prenatal
(Continued on page two)

Contents

Louisiana Safe Kids Coalition.....	2
Tuberculosis Clinical Materials Available.....	2
Correction: Flu Program Recommendations.....	2
Drug Resistant Streptococcus Pneumoniae.....	3
Clinic Accessibility and Delays in Seeking STD Care.....	4
Expanded Hepatitis B Vaccination Strategy.....	4
AIDS Update.....	5
Annual Summary: Meningococcal Infection, 1994.....	7

Prevention of Perinatal HIV Transmission (Cont.)

care or at delivery. Because this means that HIV-infected women are not being identified, there are currently missed opportunities to prevent HIV infection in infants. The Centers for Disease Control, the American Academy of Pediatrics and the American College of Obstetrics and Gynecology (ACOG) all recommend routine voluntary HIV testing of pregnant women with appropriate follow-up of infected women. Obstetricians are recommended by OPH to implement these recommendations, and hospital labor/delivery staff are recommended to establish routine voluntary HIV counseling and testing of women who have not been tested during prenatal care. All labor and delivery areas should have protocols established for treatment of HIV-infected women with AZT during delivery.

The Louisiana SAFE KIDS Coalition

In 1993, 191 Louisiana children from birth to 14 years died as a result of unintentional injuries. Each year, more children die from injuries than from all childhood diseases combined. It is estimated that for each injury death, seven children suffer permanent disabilities, forty children are hospitalized, and 1,100 are treated in emergency rooms. Thus, we can estimate that in 1993 in Louisiana, 1,337 suffered permanent disabilities, 7,640 children were hospitalized, and 210,100 were treated in emergency rooms.

Given the high costs of injuries, injury prevention is likely to be cost-effective. Injuries are the leading cause of medical spending for children ages 5-14.¹ The injuries that occur to children in Louisiana each year will lead to medical and lost productivity costs of \$2.8 billion over their lifetimes. In a recent one-year study of children aged birth to five years, the direct medical costs to treat Medicaid eligible victims of motor vehicle crashes exceeded \$1.7 million in acute costs at one small hospital alone. This exceeds the cost of purchasing and distributing car safety seats for every Medicaid-eligible child born in Louisiana in one year (about \$900,000).

The phrase "accidents will happen" is misleading because injuries are largely preventable. The Louisiana SAFE KIDS Coalition, a joint project of the Louisiana Office of Public Health and Children's Hospital, is dedicated to helping local communities organize to keep their children safe. Examples of recent projects include bicycle helmet, car safety seat, and smoke detector promotions. Chapters have formed in Baton Rouge, Bossier City, Covington-Mandeville, Lafayette, Lake Charles, Shreveport and Slidell. For more information about the Coalition, about how to form a local chapter, or about what you can do to keep our children safer, please call the Louisiana SAFE KIDS Coalition at (504) 568-2509.

¹ CSN Economics and Insurance Resource Center, Childhood Injury: Cost & Prevention Facts

Tuberculosis Clinical Materials Available

The Centers for Disease Control, Division of Tuberculosis Elimination has recently revised the "Core Curriculum on Tuberculosis," an excellent guide for the clinician concerning TB diagnosis, treatment, and control. They have also revised the booklet entitled "Improving Patient Adherence to Tuberculosis Treatment." Several new publications have been developed, including the "TB Care Guide" which is a pocket-sized booklet containing highlights from the Core Curriculum (with dosage charts and regimen option charts); as well as, a new patient education booklet, "Questions and Answers About TB" with simple explanations and colorful illustrations.

All of these publications are available free through the TB Control Program. Interested individuals should call (504) 568-5015 to receive copies of any or all of these new publications.

Correction - Flu Program Recommendations

The following sentence should read "Because influenza vaccine can cause fever when administered to young children, DTaP may be preferable in those children 15 months of age or older who are receiving the fourth or fifth dose of pertussis vaccine."

Louisiana Morbidity Report	
Volume 6 Number 6	November-December 1995
The Louisiana Morbidity Report is published bimonthly by the Epidemiology Section of the Louisiana Office of Public Health to inform physicians, nurses, and public health professionals about disease trends and patterns in Louisiana. Address correspondence to Louisiana Morbidity Report, Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.	
Assistant Secretary, OPH	Eric Baumgartner, MD MPH
State Epidemiologist	Louise McFarland, DrPH
Editors	Thomas Farley, MD MPH Karen Kelso, RNC MS
Production Manager	Ethel Davis, CST
Contributors	Susan Wilson, BSN Ronald Silberman, PhD Donald Thompson, MD MPH Kerry Chausmer, MSW MPH Meg Lawrence, MD Ruth Bessinger, MPH Maria Toledo, MPH

Drug Resistant *Streptococcus pneumoniae* Report from Shreveport

In the year prior to November 1, 1994, the Louisiana State University Medical Center, University Hospital Laboratory (UHL) in Shreveport found 146 out of 154 (95%) *Streptococcus pneumoniae* (STPN) isolates to be susceptible to penicillin. In order to investigate the incidence of increased resistance to penicillin in the patient population, and to perfect the performance of the E test (a proprietary method for determining STPN minimal inhibitory concentration [MIC]), laboratory personnel performed sensitivity testing on all STPN isolated in the laboratory between February 1, 1995 and August 17, 1995. Ninety-eight different patient isolates were evaluated for sensitivity to selected antibiotics using the NCCLS disk diffusion method and the E test for MIC determination.

Table 1 shows the cumulative penicillin susceptibility results for two time periods, November 1, 1993 through October 31, 1994 and the study period, February 1, 1995 through August 17, 1995. A dramatic decrease in susceptibility was shown. The data was also examined with respect to specimen source (Table 2). With one exception, all of the resistant isolates were obtained from blood or respiratory sources.

This data was submitted by LSUMC, UHL with the hope that others will both collect and present their data. Only recently has *Streptococcus pneumoniae*, drug resistant been included as one of the infectious diseases designated as notifiable at the national level. Clinical laboratories should at a minimum utilize the disk diffusion method and include an oxacillin disk in order to screen for penicillin susceptibility. When an isolate fails the screen, a decision must be made as to how to obtain MIC results and report the MIC for PE to the clinician. Sending the organism off to a reference laboratory delays reporting because the isolates must be first subcultured before performing MIC testing. Patients presenting with bacteremia, meningitis, treatment failure and other life threatening infections must have appropriate therapy instituted as soon as possible. The E test has proven easy to use at the UHL and has provided valuable information regarding STPN antibiotic susceptibility. Some resistance to the third generation cephalosporins, ceftriaxone and cefotaxime has also been noted using the E test. For questions regarding the results or testing methods, contact Dr. Ronald Silberman at 318-675-5867.

Table 1: *Streptococcus pneumoniae* penicillin susceptibility by time period

Dates Reviewed	Number of Isolates - Percent of Total		
	Susceptible	Intermediate	Resistant
Total - 154 Isolates 11/1/93 - 10/31/94	146 - 95%	8 - 5%	0 - 0%
52 Isolates 2/1/95 - 4/17/95	40 - 77%	9 - 17%	3 - 6%
46 Isolates 4/18/95 - 8/17/95	29 - 63%	13 - 28%	4 - 9%
Total - 98 Isolates 2/1/95 - 8/17/95	69 - 79%	22 - 23%	7 - 7%

Table 2: *Streptococcus pneumoniae* penicillin susceptibility by source

Source	Isolates* Obtained 2/1/95 - 8/17/95					
	Blood	Resp.**	Eye	Ear	CSF***	Abscess
Number of Patients	30	40	28	3	2	3
Interpretation****	S-I-R	S-I-R	S-I-R	S-I-R	S-I-R	S-I-R
# for Interpretation	24-4-2	24-12-4	21-7-0	3-0-0	2-0-0	2-0-1

* Results of all isolates (106) including those from multiple sources from the same patient.

** Sputum, bronchoalveolar lavage, endotracheal, and nasopharyngeal specimens.

*** Cerebrospinal fluid.

**** = Sensitive, I = intermediate, R = resistant

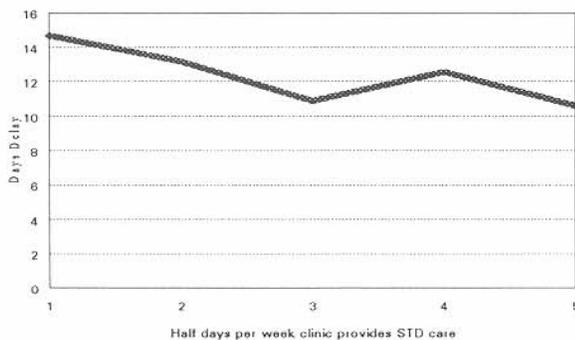
Clinic Accessibility and Delays in Seeking STD Care

Delayed treatment for sexually transmitted diseases is associated with increased illness severity, increased health care costs for treatment, and increased opportunities for spread of the infection. Clinic accessibility is a major factor in prompt treatment for STDs. The availability of "walk-in" care is particularly important, since a significant number of infected persons will not seek care if they have to schedule an appointment in advance.

In 1993-1995, the Office of Public Health conducted annual surveys concerning delay in seeking health care among STD clinic patients. In each year, patients in eleven large public STD clinics were surveyed by a self-administered questionnaire during a two week period. During these three years, clinics have been made more accessible, with clinics offering walk-in care more days per week for patients with STD symptoms. Overall, the mean delay between the onset of symptoms and the clinic visit decreased from 14.7 days in 1993 to 11.5 days in 1994 and to 11.1 days in 1995. Females had a longer mean delay than males (14.1 days vs. 11.3 days, $p < .0001$), whites had a longer delay than blacks (15.7 days vs. 11.9 days, $p = .0006$), and persons less than 20 years old had a longer delay than those in their 30s (12.7 days vs. 10.7 days, $p = .02$). Patients who came for a urethral or vaginal discharge had a shorter delay than all other patients (9.9 days vs. 14.1 days, $p < .0001$). The number of half-days per week that the clinic was open for STD treatment was associated with decreased delay in seeking care (Figure 1). As many patients with STDs remain sexually active, these reductions in delays in treatment should result in decreased spread of disease to others.

As clinic accessibility is increased, the number of patients seen for STD care will initially increase. With time, however, as the community burden for disease is reduced, both numbers and severity of disease should decrease. Public and private health care providers are encouraged to improve the accessibility of medical care for patients who may have STDs.

Figure: Mean delay in seeking health care



Expanded Hepatitis B Vaccination Strategy

The Advisory Committee on Immunization Practices (ACIP) has recommended expanding vaccination against Hepatitis B to include all 11-12 year old children. In addition, the ACIP now recommends targeted vaccination of all unvaccinated children less than 11 years of age who are Pacific Islanders or reside in households of first-generation immigrants from countries where hepatitis B is of high or intermediate endemicity. Countries with high or intermediate endemicity include China, Southeast Asia, most of Africa, most Pacific Islands, parts of the Middle East, and the Amazon Basin.

Pre-adolescent children are a high priority group for vaccination because the predominant route of transmission of hepatitis B in the U.S. is by sexual contact. This recommendation will supplement the current recommendation of vaccinating all newborns against Hepatitis B and should only be necessary until the current group of vaccinated newborns reaches adolescence. Hepatitis B immunization will be one part of a newly recommended pre-adolescent medical visit, at which health care providers can also give a second dose of MMR (if not already given), and a booster dose of tetanus and diphtheria, assess varicella immunity, and provide health education for drug abuse prevention and prevention of sexually-transmitted diseases.

Pacific Islanders and household members of immigrants are high priority groups because studies have shown that children living in households with a Hepatitis B chronic carrier show a steady rise in markers of infection throughout childhood. This suggests that continuing transmission is occurring in these households. In the countries listed with high or intermediate endemicity above, 8-15% of the population are chronic carriers and the lifetime risk of infection is more than 60%.

The Immunization Program of the Office of Public Health convened an advisory group in July to discuss expanded Hepatitis B immunization, among other topics. This ad-hoc advisory committee recommended that hepatitis B vaccine be offered through public clinics in Louisiana to 10 year old children rather than 11-12 year old children. This decision was based primarily on cost differential, since the cost of vaccination doubles after the 11th birthday with the larger adult dosage. This recommendation is preliminary at this time and an expanded program will require further development before it can be implemented.

AIDS UPDATE Use of PCP Prophylaxis

Pneumocystis Carinii Pneumonia (PCP) is the most common pneumonia associated with HIV. There are several agents that are effective in preventing PCP including trimethoprim-sulfamethoxazole (TMP-SMX), pentamidine, and dapson. In 1989, the U.S. Public Health Service recommended that HIV-infected patients with a CD4 count < 200 or a percent CD4 < 20 initiate prophylaxis. Although prophylaxis has been shown to significantly decrease the morbidity, mortality and cost attributed to PCP, not all patients eligible for prophylaxis actually receive it. An analysis of data in the CDC funded Adult Spectrum of Disease Database (ASD) from January 1990 to June 1995 was undertaken to describe the use of PCP prophylaxis in the HIV infected population in New Orleans.

Using both CD4 count and CD4 percent as the criteria, approximately 62% of the persons per year enrolled in the database were eligible for prophylaxis. However, only 60% of the persons per year who were eligible actually received prophylaxis for PCP. Prophylaxis varied by several demographic characteristics; African-Americans and older patients were slightly more likely to have been on prophylaxis whereas gay/bisexual men were less likely to have taken prophylaxis. Prophylaxis use was also related to immunosuppression; use of prophylaxis increased as CD4 cell count decreased. Seventy-nine percent of those with a CD4 count < 50 were on prophylaxis as compared to 68% of those with a CD4 count of 50-200, and 36% of those with a CD4 count > 200. Use of prophylaxis also showed a decreasing trend over time. In 1990, 72% of those eligible were on prophylaxis whereas only 56% of those eligible in 1994 were taking prophylaxis drugs. Patients accessing care as hospital inpa-

tients or at an HIV outpatient program were much more likely to be on prophylaxis than patients attending early intervention or prenatal clinics. This may be due to the fact that the patients at early intervention and prenatal clinics are earlier on in the disease process and thus have higher CD4 cell counts.

Although both CD4 cell count and percent CD4 were used to determine eligibility for PCP prophylaxis, providers often rely only on CD4 count to assess disease progression and susceptibility to infection. Among patients with a CD4 count < 200, 74% were prescribed prophylaxis, leaving still a large number of patients per year who should have been receiving prophylaxis but were not.

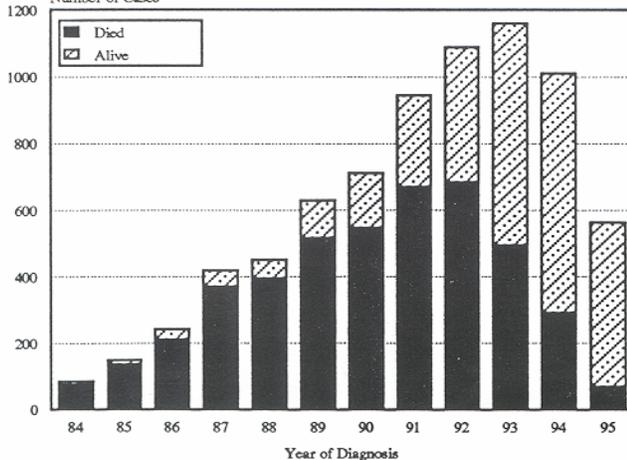
Prophylaxis against PCP is probably the single most effective medical advance in prolonging the life of persons with HIV infection. Health care providers should ensure that all HIV infected patients who are eligible receive this benefit.

Table: Demographic characteristics and CD4 counts of patients taking PCP prophylaxis among those eligible for prophylaxis by both CD4 count and percent CD4 (n = 6198 person-years).

	Total	% on pro.	Chi-square ns
Sex			
Male	5308	(59.3)	
Female	890	(60.1)	
Race			p < .001
White	2679	(54.1)	
Black	3210	(63.9)	
Other	308	(52.6)	
Age			.02
<35	3788	(58.3)	
> 35	2409	(61.1)	
Mode			p = .01
Gay/Bisexual	3269	(59.2)	
IVDU	895	(63.1)	
GAY/IVDU	780	(58.5)	
HeteroOther	139	(61.2)	
No identified risk	454	(54.4)	
CD4 Count			p < .001
< 50	1840	(79.0)	
50-199	2108	(67.6)	
200	2250	(35.7)	
CD4 Percent			p < .001
< 14	4130	(68.0)	
14-19	1860	(39.6)	
20	208	(65.4)	
Year			p < .001
1990	263	(71.9)	
1991	620	(72.3)	
1992	847	(73.7)	
1993	1325	(61.4)	
1994	1631	(56.2)	
1995*	1511	(45.6)	
Catchment Area			p < .001
Inpatient	1218	(69.5)	
HOP	3571	(68.6)	
EIC	1266	(25.4)	
Ob/Gyn	89	(44.9)	
Adolescent	54	(46.3)	
TOTAL	6198	(59.3)	

* through June 1995

Figure: AIDS Case Trends through Mid-October 1995
Number of Cases



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

SEPTEMBER - OCTOBER, 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	Sept-Oct 1995	Sept-Oct 1994	Cum 1995	Cum 1994	% Chg	
Vaccine-preventable															
Measles	0	0	0	0	0	0	0	0	0	0	0	18	0	-	
Mumps	0	1	0	0	1	0	0	1	0	3	7	12	29	-59	
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-	
Pertussis	1	1	0	0	0	0	0	1	0	3	0	17	10	+70	
Sexually-transmitted															
AIDS Cases	31	8	5	1	2	8	10	12	3	80	155	586	858	-32	
Rate ¹	2.9	1.5	1.3	0.2	0.8	2.5	2.0	3.4	0.8	1.9	3.6	13.6	19.9		
Gonorrhea Cases	849	131	134	106	48	62	157	71	72	1630	1895	10021	10233	-2	
Rate ²	8.2	2.3	3.6	2.1	1.8	2.0	3.1	2.0	1.9	3.8	4.5	23.7	24.3		
Syphilis(P&S) Cases	65	31	2	18	2	3	30	22	11	184	254	957	1461	-34	
Rate ²	0.6	0.5	0.05	0.3	0.7	0.1	0.6	0.6	0.3	0.4	0.6	2.3	3.5		
Enteric															
<i>Campylobacter</i>	13	4	8	0	0	2	1	0	5	40	29	168	117	+44	
Hepatitis A Cases	9	1	2	0	1	0	1	16	2	32	18	124	138	-10	
Rate ¹	0.9	0.2	0.5	-	0.4	-	0.2	4.6	0.5	0.7	0.4	2.9	3.2		
<i>Salmonella</i> Cases	42	17	19	32	7	14	24	13	21	202	73	436	398	+9	
Rate ¹	4.0	3.0	5.0	6.2	2.6	4.6	4.7	3.7	5.5	4.7	1.7	10.1	9.4		
<i>Shigella</i> Cases	43	10	6	4	2	0	10	6	0	87	142	329	425	-23	
Rate ¹	4.1	1.8	1.6	0.8	0.7	-	2.0	1.7	-	2.0	3.4	7.6	10.1		
<i>Vibrio cholera</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-	
<i>Vibrio, other</i>	7	0	1	0	0	0	0	0	2	11	9	40	42	-5	
Other															
Hepatitis B Cases	5	1	0	3	0	0	2	3	2	31	26	195	153	+27	
Rate ¹	0.5	0.2	-	0.6	-	-	0.4	0.9	0.5	0.7	0.6	4.5	3.6		
Meningitis/Bacteremia															
<i>H. influenzae</i>	0	0	0	0	0	0	0	0	0	0	1	1	5	-80	
<i>N. meningitidis</i>	4	1	0	0	0	0	2	0	0	7	7	47	35	+34	
Tuberculosis Cases	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A	
Rate ¹	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A	

1 = Cases per 100,000

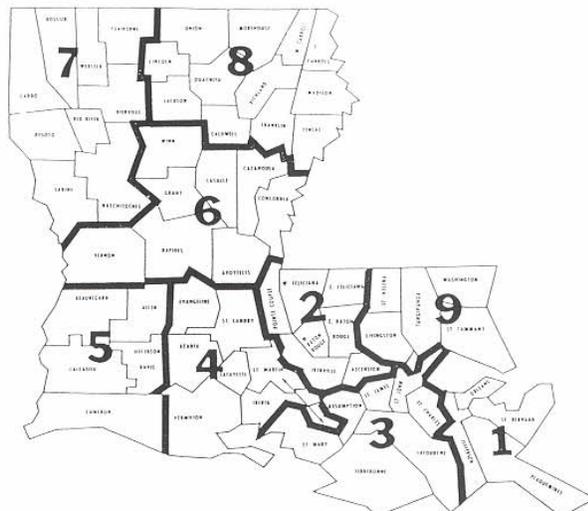
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	6
Legionellosis	3
Lyme Disease	6
Malaria	5
Rocky Mountain Spotted Fever	1
Tetanus	2

Table 3. Animal Rabies (Sept-Oct 1995)

Parish	No. Cases	Species
Caddo	4	Bats
Calcasieu	1	Bat
Jefferson	1	Bat
Lafayette	2	Skunks
St. Landry	3	Skunks
Iberia	1	Skunk
East Baton Rouge	1	Raccoon



Annual Summary Meningococcal Infection, 1994

Forty-seven cases of meningococcal infections were reported to the Epidemiology Section in 1994, for a case rate of 1.1 per 100,000. The number of cases reported for 1994 did not significantly differ from 1993. Sex-specific rates were similar for males and females (1.1 per 100,000). Race-specific rates were higher for blacks than whites (1.3 vs 0.9 per 100,000). Even though thirty-three percent of the cases were less than 10 years of age, an increasing number of cases are occurring among the adolescent and young adult age groups (Figure 1). Of 25 isolates serotyped, 5 were group B, 15 were C, 3 were group Y and 2 were not groupable. Five deaths were reported. Forty-five percent of the cases occurred in the first three months of 1994 (Figure 2). No outbreaks were identified except for one family cluster. Forty percent (19/47) of the cases resided in Orleans Parish (Figure 3).

Figure 1: Cases of meningococcal infection by age and sex, 1994

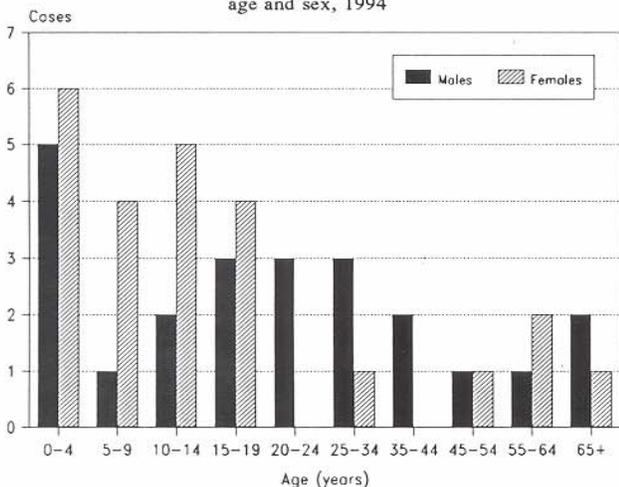


Figure 2: Cases of meningococcal infection by month of report, 1992-1994

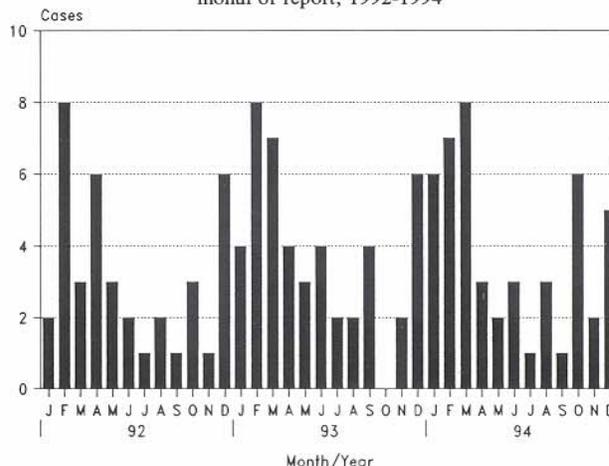


Figure 3: Cases of meningococcal infection by parish, 1994



LOUISIANA FACTS

In the years 1918-19, sanitary inspections were made of premises where a case of communicable disease existed, with the exception of whooping cough, measles, pneumonia, and tuberculosis. The report card used in a sanitary inspection of premises carried the name and address of the case and provided a place for information regarding the sanitary condition of the premises. The name and address of the dairy, grocer, butcher, baker, etc., supplying the household was also included, and any known case of illness among these food handlers was reported on the card. Documentation was also made on the card of any illness at the patient's place of business. A square was outlined on the report card, the streets surrounding the square were written in by the inspector and the house where the case existed was spotted within the square.

Taken from the Report of the Health and Sanitary Survey of the City of New Orleans, 1918-1919.

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES	OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Cancer
Amebiasis	Complications of abortion
Anthrax	Congenital hypothyroidism
Aseptic meningitis	Galactosemia
Blastomycosis	Hemophilia
Botulism*	Lead poisoning
Brucellosis	Phenylketonuria
Campylobacteriosis	Reye Syndrome
Chancroid**	Severe Traumatic Head Injuries+
Cholera*	Severe undernutrition
Chlamydial infection**	severe anemia,
Diphtheria*	failure to thrive
Encephalitis (specify primary or post-infectious)	Sickle cell
Erythema infectiosum (Fifth Disease)	disease (newborns)
Escherichia coli 0157:H7	Spinal cord injury+
Foodborne illness*	Sudden infant death syndrome (SIDS)
Genital warts**	
Gonorrhea**	
Granuloma Inguinale**	
Hemolytic-Uremic Syndrome	
Hepatitis, Acute (A, B, C, Other)	
Hepatitis B in pregnancy	
Herpes (genitalis/neonatal)**	
Human Immunodeficiency Virus (HIV) infection****	
Legionellosis	
Leprosy	
Leptospirosis	
Lyme disease	
Lymphogranuloma venereum**	
Malaria	
Measles (rubeola)*	
Meningitis, (Haemophilus)*	
Meningococcal infection (including meningitis)*	
Mumps	
Mycobacteriosis, atypical***	
Ophthalmia neonatorum**	
Pertussis	
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

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

BULK RATE U.S. POSTAGE P A I D Baton Rouge, LA Permit No. 1032
--