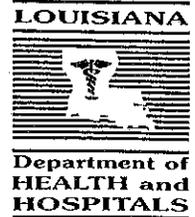




# Louisiana Morbidity Report

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



Edwin W. Edwards  
 GOVERNOR

Rose V. Forrest  
 SECRETARY

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## Vibrio Vulnificus Infection 1985-1994

Recently there have been discussions at the federal level about restricting the sale of raw oysters to prevent infection with *Vibrio vulnificus*. As Louisiana has probably the most complete data about infection with this organism, we reviewed the case reports over the last 10 years.

*Vibrio vulnificus* is an organism that lives in seawater and causes occasionally life-threatening infections. From 1985-1994, 91 cases of infection due to this organism were reported to the Office of Public Health. Reported cases have gradually increased during this 10-year-period (Figure 1), which may reflect an actual increase in disease or simply an increase in recognition of the organism. Of the 91 cases, 23 (25%) persons died of the infection, for a mean of 2.3 deaths per year (Figure 1). Infections were far more common in the summer and early fall months than at other times of the year (Figure 2).

*V. vulnificus* has a predilection for causing infection in males, in elderly persons, and in persons with underlying medical conditions. Of 90 cases of known gender, 79 (88%) were male. Of the 87 cases of known age, 34 (39%) were over 65, and 52 (60%) were over 55 years of age (Figure 3).

Of persons for whom the information was available, 75 (86%) had underlying medical conditions, and 48 (65%) were taking medications that predisposed them to *V.*

Figure 1: Cases of *V. vulnificus* infection reported by year, 1985-1994

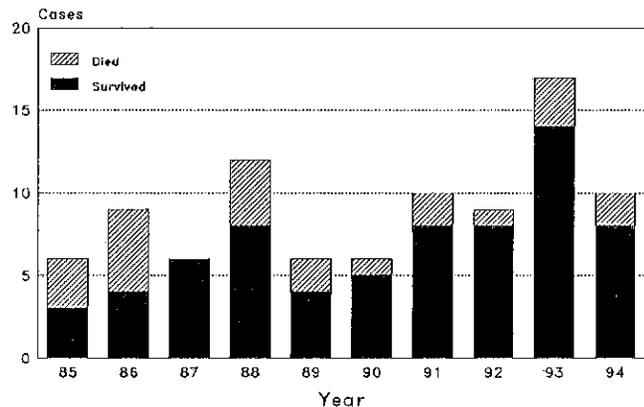


Figure 2: Cases of *V. vulnificus* infection by month of onset, 1985-1994

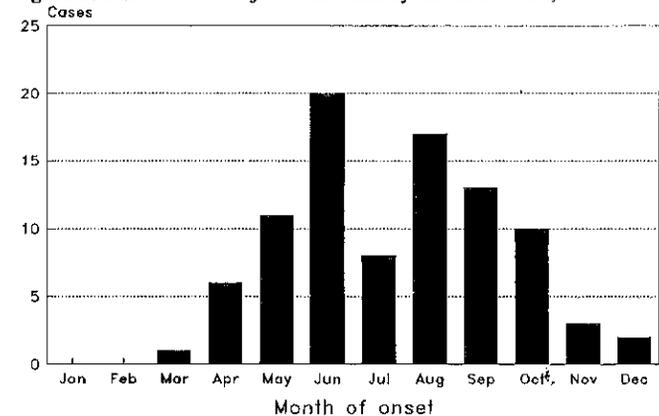
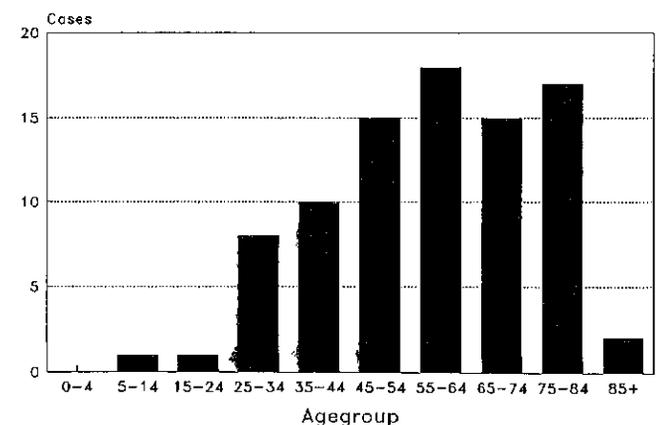


Figure 3: Cases of *V. vulnificus* infection by age, 1985-1994



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*Vibrio vulnificus* Infection (Cont.)

*vulnificus* infection. Medical conditions most commonly associated with infection were liver disease (40%) and alcohol abuse (29%), and medications most commonly reported were steroids (14%), antacids (11%) and H2-blockers (11%; Table).

**Table:** underlying medical conditions and medications taken by persons with *V. vulnificus* infections

	N	% *
Medical Conditions	75	86%
Liver disease	35	40%
Alcohol abuse	25	29%
Heart disease	24	28%
Diabetes	20	23%
Peptic ulcer disease	13	15%
Malignancy	10	11%
Immune deficiency	7	8%
Gastric surgery	6	7%
Renal disease	5	6%
Hematologic disease	3	3%
Other	40	46%
Medications	48	65%
Steroids	10	14%
Antacids	8	11%
H2-blockers	8	11%
Chemotherapy	3	4%
Antibiotics	3	4%

\*percent among persons with medical information available

*V. vulnificus* infection can be acquired by consuming shellfish or by percutaneous exposure to the organism through contact with seawater, fish or shellfish. Because persons may report both types of exposure before becoming ill, it is often difficult to determine the actual route of infection in an individual case. In addition, information about reported exposures is incomplete. Among those for whom this information is known, 57% (36/63) had eaten shellfish in the 7 days before illness and 71% (52/73) had a skin or wound exposure to seawater or fish. The 36 persons who ate shellfish most frequently reported eating oysters (n=21, 20 of whom ate raw oysters), shrimp (n=16), crabs (n=14).

Among the 23 persons who died of the infection, 21 (91%) were reported to have an underlying medical condition. Food histories were available for 12 persons who died, of whom 11 (92%) were known to have eaten shellfish, including raw oysters (n=9), crabs (n=5), and shrimp (n=4); skin exposure histories were available for 11, of whom five (45%) had a skin or wound exposure to seawater or fish.

Although it is difficult to establish whether individual deaths due to *V. vulnificus* infection are related to raw oyster consumption or other routes of exposure, it is clear that raw

oyster consumption is related to *V. vulnificus* deaths in some persons with underlying medical conditions. Physicians, restaurant owners, and seafood distributors should educate persons with underlying medical conditions about the risks of raw oyster consumption. As regulatory agencies discuss possible restrictions on oyster sales, further research needs to be done on the ecology of *V. vulnificus* in oysters and the ways to prevent illness in persons eating oysters.

## Dengue Fever Update

Recently there have been reports of widespread epidemics of dengue fever in Mexico, which have raised concern about possible spread of dengue into Texas and Louisiana.

Dengue is a disease caused by a virus which is transmitted by certain mosquitos. The disease occurs in a mild form called dengue fever and the more severe forms of dengue hemorrhagic fever and dengue shock syndrome. Dengue fever is characterized by an abrupt onset of high fever, headache, myalgias, and a rash over the chest and upper limbs. The hemorrhagic form is accompanied by skin bruising and bleeding from nose, mouth and gums, and the shock syndrome is associated with hypotension.

The dengue virus is in the flavivirus family of arboviruses (arthropod-borne viruses). Throughout the world, it is most commonly transmitted by the mosquito *Aedes aegypti*, although in some areas of Asia it is transmitted by *Aedes albopictus* (the Asian tiger mosquito). For practical purposes, humans are the only reservoir host.

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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 Melvin Kohn, MD Ruben Tapia, MPH Rebecca Meriweather, MD Lynn Gibbs, MPH Stephanie Posner, MPH

*Dengue Fever Update (Cont.)*

There is no specific curative treatment for persons with dengue fever. Prevention of dengue outbreaks in general rests on control of mosquitos, including eliminating standing water, chemical spraying, and prevention of contact between mosquitos and humans.

The risk of transmission of dengue in Louisiana appears small. The reasons for this are that *Aedes albopictus* (the most common yard mosquito currently in Louisiana) is probably not a very efficient vector for the virus, and that contact between humans and mosquitos in the U.S. is much less than it is in Mexico due to widespread use of screens, mosquito repellants, and chemical spraying. Nonetheless, the Epidemiology Section recommends physicians consider dengue as a possibility in patients with fever and rash. The State Laboratory does not currently have the ability to test sera for dengue antibodies, but it can test serum for antibodies to the St. Louis Encephalitis virus, which cross-reacts strongly with dengue, for a presumptive diagnosis. For questions regarding possible cases of dengue or testing for this disease, contact the Epidemiology Section at (504) 568-5005.

## Breast Cancer: New Preventive Health Program

Breast cancer is the most common cancer diagnosed among women and the second most common cause of cancer deaths in women. It is estimated that one in eight women will develop breast cancer at some time during her life. Every year approximately 680 women die in Louisiana as a result of breast cancer. The incidence of breast cancer is increasing, due in part to increased detection resulting from increased use of mammography.

Nationally and in Louisiana, breast cancer occurs more frequently among white women than among women of color, but African American women who develop this disease are more likely to die. Traditionally, breast cancer incidence has been lower in Louisiana than in the US as a whole. This remains true for white women but by 1992 incidence among African American women in Louisiana had reached national levels. Louisiana women (regardless of race) who develop breast cancer are diagnosed at later stages of disease and are more likely to die than are women in the rest of the country.

Known risk factors for breast cancer account for only 25-30% of all cases. Age, duration of estrogen exposure, and genetics appear to play the most important roles. In Louisiana, incidence is 16 to 20 times higher for women over 50 and 8 to 10 times higher for women in their 40s than for younger women. Factors related to prolonged estrogen exposure include early menarche, late menopause, nulliparity, delay of first childbirth past 30, and failure to breast feed. The most important clinical indication of increased genetic risk is having a first degree relative (mother, sister, or

daughter) with breast cancer.

There are a number of important actions health professionals and women themselves can take to reduce the number of women who die every year from this disease and to improve the lives of breast cancer survivors. Long-term survival is more likely if the tumor is found early. Monthly self-breast exams and regular clinical breast exams are recommended for women 18 and older. Mammography is recommended every one to two years for women 50-75. Mammography reduces the risk of death due to breast cancer by 20 to 40% in this age group. Nationally and in Louisiana, about 60% of women over 50 reported through the Behavioral Risk Factor Surveillance System that they get mammograms at least every two years. Low income women are substantially less likely to be screened than women with higher incomes. Mammography is also recommended for women 40-49 with a personal history or first degree relative with breast cancer.

The Chronic Disease Control Section recently received funding from CDC to begin a Women's Preventive Health Program which provides clinical breast exams, mammograms, pap smears and, for women with abnormal findings, referrals, tracking and follow-up services. Services are provided every two years and also include risk assessments and personalized health guidance to prevent cardiovascular disease, osteoporosis, diabetes, injuries, and other cancers. This new program targets women 50-75 years old, especially women of color and those under 200% of the federal poverty level who do not have the means to obtain these services. A pilot of this new program began in September in Bienville, Claiborne, and Red River Parishes. Expansion to other areas of the state is anticipated in early 1996. In collaboration with other organizations the Program will conduct outreach, public education, and provider education activities at the local and statewide levels.

### Corrections - STD Treatment Guidelines

The following are corrections to the STD Treatment Guidelines chart in the July-August issue.

1. Pelvic inflammatory disease - The dose of Ofloxacin as an alternative treatment should be 400 mg bid for 14 days.

2. Herpes simplex, suppressive therapy - The dose of Acyclovir should be 200 mg 3-5 times a day.

In addition, the guidelines for treatment of recurrent episodes of Herpes simplex were misleading. The CDC treatment guidelines state that "most immunocompetent patients with recurrent disease do not benefit from acyclovir treatment, and it is not generally recommended." The dose given is for the unusual patients for whom treatment may be helpful.

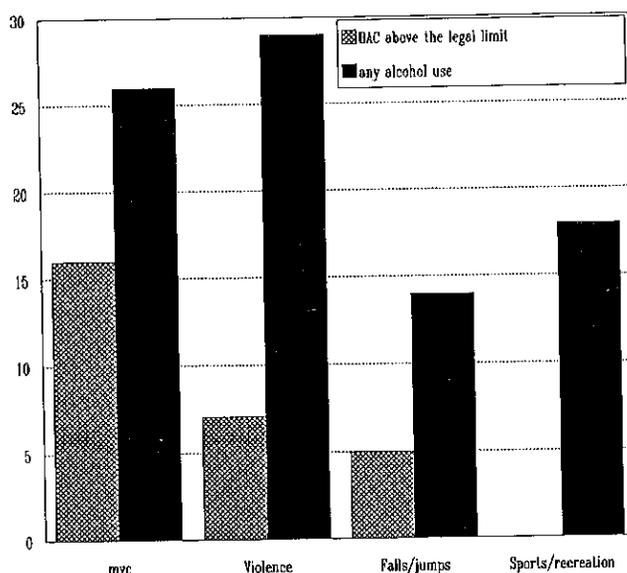
## Alcohol Involvement in Central Nervous System Injuries

The use and abuse of alcoholic beverages increases the risk of virtually all types of injury. Nationally, studies show that 50% or more of the fatally injured have blood alcohol concentrations (BAC) above the legal limit (.10mg/dl). In Louisiana, 28% of the cases of central nervous system injury reported in 1994 had a blood alcohol concentration reported. Of those reported, 41% had a BAC above the legal limit and 21% had a positive BAC but remained under the legal limit. In addition, 13% of those not tested exhibited clinical signs of intoxication.

The percentage of injuries involving alcohol varies by etiology. Motor vehicle crashes had the largest percentage of BACs above the legal limit (16%), followed by violence (7%), and falls/jumps (5%). Injuries caused by sports and recreation had no reported BACs above the legal limit. However, if any alcohol use is considered, not only BACs above the legal limit, the pattern changes. Injuries related to violence had the highest percentage of alcohol use (29%), followed by motor vehicle crashes (26%), sports/recreation (18%), and falls/jumps (14%; Figure). These results reflect only the use of alcohol by the victim. Data on alcohol use by other persons involved in the injury are not available.

Because alcohol decreases reaction time and impairs judgment, it is an important risk factor for injuries. The disinhibitory effects of alcohol, even at levels less than those legally defined as intoxication, are likely to play an important role in the causation of many injuries, especially those related to violence. Therefore, programs aimed at decreasing alcohol use or promoting responsible alcohol use are essential for injury prevention efforts.

Figure: Injuries associated with use of alcohol, 1994



## 1995-1996 Flu Program

Beginning the week of October 22, 1995, parish health units throughout the state will kick off the Annual Influenza Campaign. This start up date will coincide with the National Adult Immunization Awareness Week. This year's campaign goal is to provide protection against influenza, tetanus, and diphtheria to at least 60 percent of our high risk adult population for influenza.

The influenza vaccine is updated annually to include viruses that are antigenically similar to the strains of the three distinct groups of influenza viruses that have been circulating worldwide. Persons at high risk of influenza-related complications and their close contacts and health care providers can best prepare by taking the influenza vaccine.

**Who should get influenza vaccine?** Persons 65 years of age or older, residents of long care facilities; adults and children who have a serious long-term health problem or hospitalization during the preceding year because of chronic metabolic disease (including diabetes mellitus), renal dysfunction, or immunosuppression (such as persons with AIDS and cancer patients receiving chemotherapy); children and teenagers (6 months - 18 years of age who are receiving long-term aspirin therapy and therefore may be at risk of developing reye syndrome after influenza).

Physicians, nurses and other personnel capable of nosocomial transmission of influenza to high risk individuals are encouraged to see their own physicians or to organize their own immunization programs.

The vaccine for the 1995-1996 season contains A/Texas/36/91 (H1N1), A/Johannesburg/33/94-like (H3N2), and B/Harbin/07/94. Most of the influenza viruses isolated since March 1995 are antigenically similar to the 1995-1996 influenza vaccine strains.

**Dosage by Group:** Previously unvaccinated children 6 months to 8 years of age who have not received influenza vaccine previously should receive two doses of split virus vaccine at least a month apart. If vaccine has been administered previously, one dose is sufficient. The dosage of split virus vaccine for children is 0.25ml for those 6 to 35 months of age and 0.5ml for those children 3 years and older. Only one 0.5ml dose of whole or split virus vaccine is required for persons over 12 years of age. Please note that children 12 years of age and older can receive split virus.

High risk children may receive influenza vaccine at the same time as they receive other routine vaccinations, including DTP, DTaP, DT, MMR, Hib, OPV, eIPV and Pneumococcal vaccines. Because influenza vaccine can cause fever when administered to young children, DTaP may be preferable in those children < 15 months of age who are receiving the fourth or fifth dose of pertussis vaccine.

Influenza immunization questions may be directed to the respective parish health unit or to the Immunization Program at (504) 483-1900, Fax (504) 483-1909.

## AIDS UPDATE

### The Epidemiology of Recent HIV Infection

Because HIV-infected persons often are not identified until they reach a later stage of disease, it is difficult to assess the current epidemiology of HIV, which is necessary for effective planning and targeting of Early Intervention and prevention programs. However, an analysis of cases who are diagnosed shortly after infection lends insight into the present trends of the epidemic.

Since studies have shown that CD4 counts can serve as markers of the disease progression, "recently infected" cases were defined as subjects whose CD4 counts averaged 800 or greater during the first 18 months since the initial CD4 count after the first positive HIV test. Subjects were identified from the Adult Spectrum of Disease (ASD) study, which follows HIV infected patients (ages 13 and over) attending public and community based sites in New Orleans at six-month intervals. Whereas the proportion of HIV+ cases who are identified as recently infected has remained stable over the last five years (8%), the epidemiology of these reported early-stage cases has changed, especially with respect to ethnicity, gender, and risk group. In both the primary treatment sites and the community-based site, there were increases over time in the percentage of recent cases in blacks (Table 1), and at the primary sites there was a sharp increase in the percentage of early cases in women who were exposed through sexual contact (Table 2).

There are biases in this analysis including the wide variability of CD4 counts and the variations over time among HIV+ persons who enter public medical facilities or early intervention clinics. Nonetheless, these findings are similar to those from AIDS case data indicating a rapidly increasing proportion of HIV infections in African-Americans, continued high rates of infection in MSM and IDU, and an increasing proportion of cases in women having sex with high-risk men.

Figure: AIDS Case Trends through Mid-October 1995

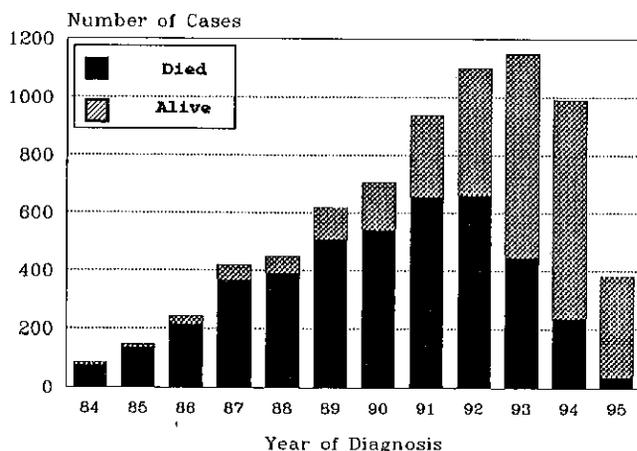


Table 1: Demographic Trends among Recently Infected

Treatment site		Year of HIV Detection							
		1989		89-90		91-92		93-94	
		n	(%)	n	(%)	n	(%)	n	(%)
<b>Primary sites:</b>									
Men	Bl	5	(28)	13	(62)	24	(69)	27	(68)
	Wh	13	(72)	8	(38)	11	(31)	13	(33)
Women	Bl	5	(83)	13	(68)	26	(84)	26	(93)
	Wh	1	(17)	6	(32)	5	(16)	2	(7)
<b>Community-Based Site*:</b>									
Men	Bl	1	(6)	1	(7)	7	(44)	7	(22)
	Wh	15	(94)	14	(93)	9	(56)	25	(78)
<b>TOTAL</b>		40		55		82		100	

\* The population utilizing the community-based site is primarily white men.

Table 2: Risk Groups Trends among Recently Infected

Treatment site		Year of HIV Detection							
		<1989		89-90		91-92		93-94	
		n	(%)	n	(%)	n	(%)	n	(%)
<b>Primary sites:</b>									
Men	MSM	14	(78)	12	(57)	17	(49)	16	(40)
	IDU	3	(17)	3	(14)	11	(31)	14	(35)
	Oth**	1	(6)	6	(27)	7	(20)	10	(25)
Women	IDU	3	(50)	7	(37)	10	(32)	7	(25)
	Oth	3	(50)	12	(63)	21	(68)	21	(75)
<b>Community-Based Site*:</b>									
Men	MSM	15	(94)	14	(93)	12	(75)	29	(91)
	IDU	0	(0)	1	(7)	0	(0)	2	(6)
	Oth	1	(6)	0	(0)	4	(25)	1	(3)
<b>TOTAL</b>		40		55		82		100	

\*\* The "Other" risk category is predominantly hetero-sexual transmission.

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE  
 JULY - AUG, 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	July-Aug 1995	July Aug 1994	Cum 1995	Cum 1994	% Chg	
<b>Vaccine-preventable</b>															
Measles	0	0	0	0	0	0	0	0	0	0	0	18	1	+170	
Mumps	0	0	0	0	0	0	0	0	0	0	4	9	22	-59	
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-	
Pertussis	1	0	1	0	0	0	1	1	0	4	4	14	10	-40	
<b>Sexually-transmitted</b>															
AIDS	Cases	22	3	2	7	2	6	7	4	2	55	162	404	691	-42
	Rate <sup>1</sup>	2.0	0.5	0.5	1.4	0.8	1.9	1.4	1.1	0.6	1.2	3.8	9.4	16.0	
Gonorrhea	Cases	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A
	Rate <sup>2</sup>	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A
Syphilis(P&S)	Cases	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A
	Rate <sup>2</sup>	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A
<b>Enteric</b>															
Campylobacter		8	7	5	6	1	0	2	2	1	38	34	125	87	+44
Hepatitis A	Cases	9	0	0	3	0	0	2	19	0	34	32	86	116	-26
	Rate <sup>1</sup>	0.9	-	-	0.6	-	-	0.4	5.4	-	0.8	0.8	2.0	2.8	
Salmonella	Cases	6	16	8	19	6	1	2	4	11	74	101	212	320	-34
	Rate <sup>1</sup>	0.6	2.8	2.1	3.7	2.2	0.3	0.4	1.1	2.9	1.7	2.4	4.9	7.6	
Shigella	Cases	22	7	2	8	0	0	3	9	3	63	88	231	279	+ (
	Rate <sup>1</sup>	2.1	1.2	0.5	1.6	-	-	0.6	2.6	0.8	1.5	2.1	5.4	6.6	
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	-
Vibrio, other		4	4	1	1	0	0	1	0	1	13	15	27	33	-18
<b>Other</b>															
Hepatitis B	Cases	11	4	2	0	2	0	4	6	4	33	23	146	125	+17
	Rate <sup>1</sup>	1.1	0.7	0.5	-	0.7	-	0.8	1.7	1.0	0.8	0.5	3.4	3.0	
<b>Meningitis/Bacteremia</b>															
H. influenzae		0	0	0	0	0	0	0	0	0	0	1	1	4	-75
N. meningitidis		2	0	0	0	0	1	2	-	0	5	6	39	28	+39
Tuberculosis	Cases	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A
	Rate <sup>1</sup>	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A

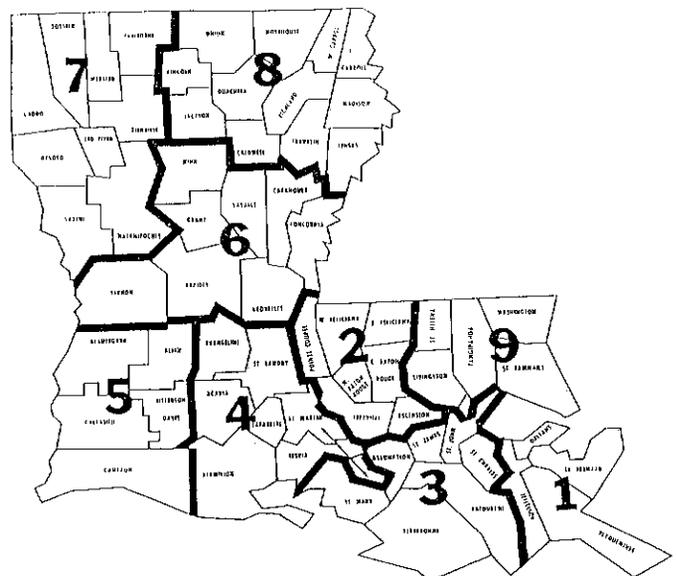
1 = Cases per 100,000  
 2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	6
Brucellosis	0
Histoplasmosis	2
Lead Toxicity	94
Legionellosis	2
Lyme Disease	3
Malaria	4
Tetanus	1

Table 3. Animal Rabies (July-Aug 1995)

Parish	No. Cases	Species
Bossier	1	Bat
Lafayette	3	Skunks
St. Landry	1	Skunk



## Annual Summary Shigellosis, 1994

Four hundred seventy-six cases were reported for 1994, which did not differ significantly from 1993, but was 60% higher than 1992 (Figure 1). The overall state case rate for 1994 was 11.0 per 100,000 and was higher than the five year average case rate of 7.9 per 100,000. Sex-specific rates between males and females were similar (10.6 vs 11.0 per 100,000, respectively). Race-specific rates were nearly twice as high in blacks as whites (6.5 vs 3.6 per 100,000). Sixty six percent of the total cases occurred in persons less than 15 years, which is consistent with previous years (Figure 2).

Of 407 cases, 24 (6%) were associated with day care. Several shigellosis outbreaks occurred during the year. One outbreak involved a day care center in which 14 cases were identified. The other outbreak was a repeat occurrence at the same developmentally disabled institution reported in 1993. Interestingly, two separate cluster outbreaks occurred during March and July, 1994 at this facility. A significant outcome of this institutional outbreak was the emergence of Bactrim-resistant shigella strains, making selection of antimicrobial therapy difficult for the target population involved and affecting the length of time to control the outbreak despite the use of other control measures such as cohorting and supervised handwashing.

Four hundred sixteen shigella isolates were serotyped, in which 86% were reported as *S. sonnei*. Five parishes reported case rates more than double the overall state case rate. They are (per 100,000): Rapides (44), Iberia (28), Orleans (25), Vermilion (24) and Jefferson (23; Figure 3).

Figure 1: Cases of shigellosis by year, 1985-1994

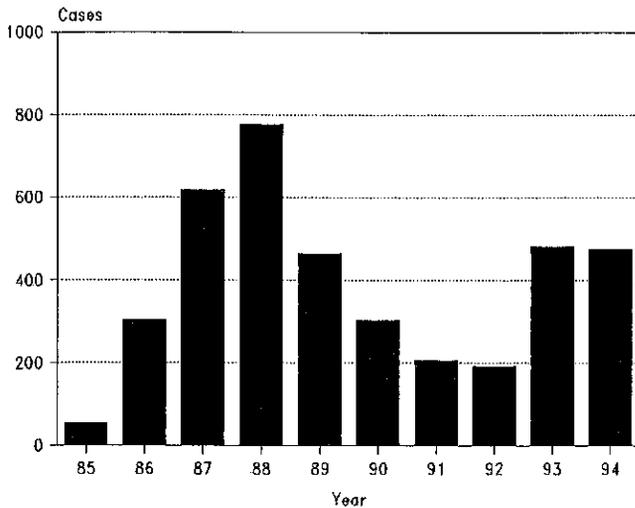


Figure 2: Cases of shigellosis by age and sex, 1994

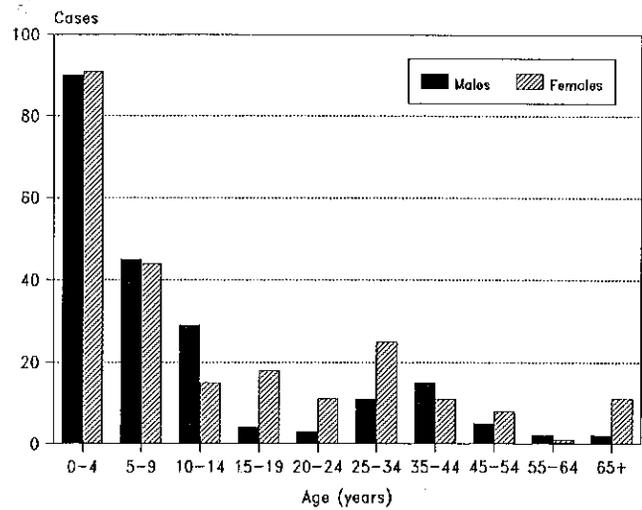
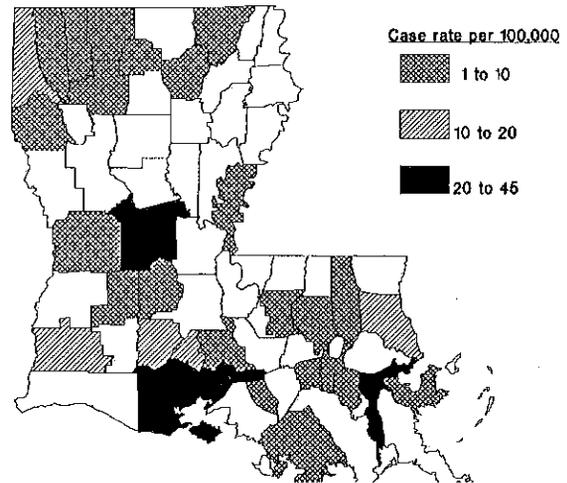


Figure 3: Rates of shigellosis by parish, 1994



### LOUISIANA FACTS

Do you know that Louisiana residents may suffer from "swamp itch?" This can be caused by species of *strongyloides* which normally infect other mammals, such as nutria and raccoons. Unlike *strongyloides* species which normally infect humans, these species cause clinical manifestations limited to the skin, associated with localized rash, erythema, itching and edema. People at risk are those who wade in swamp water.

## LIST OF REPORTABLE DISEASES/CONDITIONS

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

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

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