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Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section
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AZT Found Protective in Needlesticks

Since early in the HIV epidemic, it has been known that the virus can be transmitted through needlestick injuries. It is estimated that the risk of HIV infection after a needlestick injury from HIV-infected blood is approximately 0.3%. To prevent HIV infection in persons exposed in this way, some health authorities have recommended use of post-exposure zidovudine (AZT); however, the benefits and long-term risks of AZT use in this situation are unknown, and in 1990 the Public Health Service concluded that it could recommend neither for nor against post-exposure AZT use.

The Centers for Disease Control and Prevention (CDC) has now published a report of a retrospective case control study of the risk of HIV infection after needlesticks. In this study, factors that increased the risk of HIV infection were a deep injury, visible blood on the needle, a procedure involving the needle being placed directly in a vein or artery, and terminal illness in the source patient. After controlling for these factors, persons who took post-exposure AZT were 79% less likely to become infected with HIV than persons who did not take AZT.

This study design is not optimal to assess the effectiveness of AZT for prevention after needlesticks, nonetheless, the large reduction in risk found by the study suggests that the AZT recommendations need to be reevaluated. The Public Health Service is considering revising its recommendations, and the Office of Public Health will circulate new

recommendations when they are made. In the meantime, health care workers who are stuck with needles contaminated with HIV-infected blood and persons advising them should seriously consider use of AZT after exposure. The potential benefits (decreased risk of HIV infection) and risks (possible carcinogenicity of AZT) should be considered, as should the severity of the injury and disease status of the source patient. If a decision is made to use AZT after prophylaxis, it should be started as soon as possible (within hours). Recommended dosing schedules vary, but the National Institutes of Health uses 200 mg every four hours (six times daily) for 6 weeks.

Requests for the CDC report and questions regarding this study and AZT use after needlestick injuries should be directed to the Epidemiology Section at (504) 568-5005.

Louisiana's Influenza Surveillance Program

The Office of Public Health Influenza Surveillance Program, with the cooperation of some forty volunteer hospitals, physicians and schools that serve as sentinels, annually monitors influenza and influenza-like symptoms throughout the state. This surveillance network is part of a national effort to determine the prevalence of influenza, detect circulating virus strains, and provide information necessary for future vaccine formulation. Data collected also allows estimation of the impact of influenza on morbidity, mortality and economic loss, as well as, assisting disease control through rapid preventive action such as chemoprophylaxis of unvaccinated high risk patients.

On November 6, 1995, a six month old black female from Jefferson Parish was seen at an area hospital emergency room and both clinically diagnosed and laboratory confirmed with influenza type A. Since this first case, sporadic cases of influenza type A have been diagnosed and confirmed. In January, a case of type B was reported in a 22 day old from Baton Rouge. The Influenza Surveillance Program has detected increased activity as of December 24th, 1995 and is reporting regional outbreaks to the Centers for Disease Control & Prevention.

Vaccination is recommended annually for all susceptible individuals, especially high risk groups. Influenza strains contained in this year's vaccine are A/Texas/36/91 (H1N1), A/Johannesburg/33/94-like (H3N2), and B/Harbin/07/94.

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Car Safety Seats Used Improperly

The leading cause of death among U.S. children aged 1-4 years is from motor vehicle accidents. These injuries account for the largest number of years of potential life lost before age 65 (YPLL).

When involved in a serious motor vehicle crash, unrestrained children have a higher proportion of injuries, are more severely injured, have longer hospital stays, and are more likely to be discharged with an impairment when compared with restrained children.

Louisiana law has required child seat use since 1984. In 1990, the Disability Prevention Program established several programs to encourage the use of child safety restraints, including a carseat loaner program.

In 1991 a study conducted at three public health clinics in southern Louisiana estimated overall carseat usage for children under 5 years old to be 29%. A follow-up study was again conducted in 1992-93 and found that overall child safety seat usage had increased to 43%, and that of the children restrained, only 46% were restrained properly.

In December of 1993, the carseat loaner program was discontinued, due to cost and liability pressures. Education and training about car safety seat use was continued, however. Parents were also referred to other agencies near their homes for low-cost or loaner car seats.

To determine whether car safety seat usage had changed since the discontinuance of the carseat loaner program, the Injury Research and Prevention Section of OPH conducted a follow-up study this past fall of child safety seat usage among the clients at the three public health units where prior studies had been done. As had been done in previous surveys, staff stood at the entrances of three health unit parking lots in south Louisiana and counted the number of restrained and unrestrained children in each car, and whether restrained children were restrained properly (i.e., age-appropriate carseat used, carseat buckled in, and carseat harness buckled).

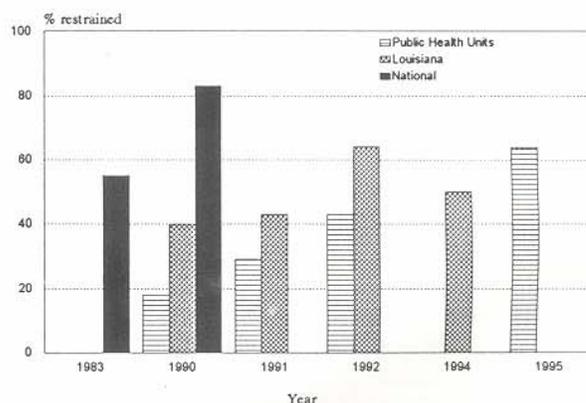
In this recent study, overall restraint usage was 64%, but only 58% of restrained children were properly restrained. As in prior surveys, infants were more likely than older children to be both restrained and properly restrained. In addition, children in cars in which drivers were unrestrained were 3.3 times more likely to be unrestrained.

These data demonstrate that, despite discontinuation of the carseat loaner program, carseat use among parish health unit clients continues to rise. In fact, the percentage of health unit clients in 1995 using carseats surpassed the percentage of the general public in Louisiana using carseats in 1994 (Figure 1). This suggests that the program of carseat education and referral currently in use at health units has been successful and should be continued. Of note, the percentage of both Louisianians and health unit clients using carseats is still far below

national estimates of carseat use of 83% (Figure).

The high frequency of improper carseat use among health unit clients is of concern, and suggests some changes in our carseat education and training program. Other studies have shown that improper use of a car safety seat may place a child at higher risk of injury than not using a carseat at all, and also make the carseat a projectile which can injure other occupants of the vehicle. These data make clear that nurses, health educators and other health unit staff need to emphasize training in proper carseat use in the future. The Office of Public Health has received a grant from the National Highway Traffic Safety Administration to study ways to increase the proportion of properly restrained infants and children.

Figure: Percentage of children restrained in car safety seats in public health units, Louisiana and nationally, 1983-1995



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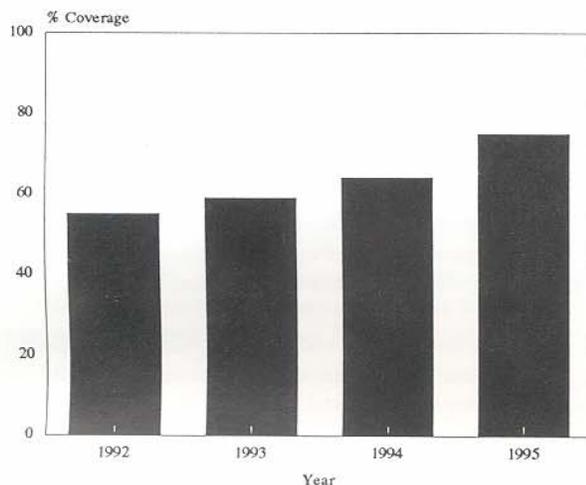
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Improvement in Infant Immunization Rates

The goal of Louisiana's "Shots for Tots" program is to improve the immunization coverage of infants. To assess the progress of the program covering the 70% of infants immunized in public clinics, annual audits of immunization records are conducted each fall in all parish health units. In 1994, 64% of children evaluated had received all required doses. In 1995, 75% were complete (Figure 1). Improvement has been steady in most regions of the state (figure 2; region 9 is a new region.)

Figure 1: Immunization coverage in public clinics weighted average by year 1992-1995

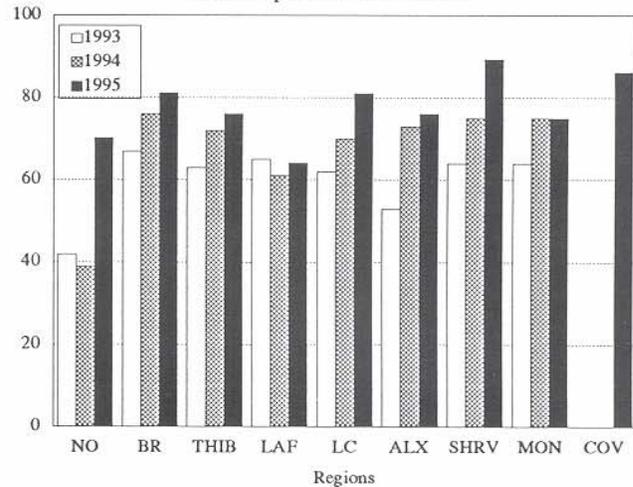


A study of barriers to infant immunization as perceived by parents that was carried out in 1992 found that the major barriers were related to the convenience of vaccination, rather than lack of appreciation of the importance of immunization or fear of adverse consequences of vaccines. The study estimated that 25% of the problem of incompletely-vaccinated 2-year-olds could be attributed to long clinic waiting times and 12% could be attributed to limited days of clinic availability.

Program staff attribute the increase in coverage in 1995 to several factors. Increased priority was given to immunizations in many health units and immunizations were more accessible through extended clinic hours and outreach to alternate sites. Parents are also reminded if their children are due or overdue for immunizations. In addition, the annual clinic audits have given clinics a tool to gauge the success of their efforts, and have provided diagnostic information to improve problem areas. CDC's clinic review software, CASA, has allowed clinics to evaluate their overall coverage, and has also allowed more detailed evaluation of specific problem areas, such as non-simultaneous administration of vaccines, failure of initial recruitment (late starters), loss of clients (drop-off after several visits), and poor record-keeping. This

software is available free-of-charge for any provider who would like to evaluate his own immunization coverage levels. Contact the Office of Public Health's Immunization Program at (504) 483-1900 for more information.

Figure 2: Immunization coverage by region Percent up-to-date at 24 months



CDC Immunization Course by Satellite

Immunization providers will have another opportunity to attend the CDC's excellent course "Epidemiology and Prevention of Vaccine-Preventable Diseases" in February and March at satellite downlink sites throughout the state. Dr. Bill Atkinson will provide an immunization update. The course will be offered in four segments on February 9, 16, 23 and March 1 from 11:00 a.m. to 2:30 p.m. For information about the available sites in your area and registration, call the Immunization Program at 504-483-1900.

New Masks Approved for Tuberculosis Protection

A new class of personal respirators has been approved for use to prevent transmission of tuberculosis in health care settings. The new masks, called N-95 because they filter more than 95% of 0.3 micron particles, have been approved for use in clinical settings. Prior to the approval of the N-95 masks, hospital workers were required to use HEPA masks in rooms where patients with active TB or possible TB were treated or isolated. HEPA masks are relatively expensive (\$6-8 per mask) and uncomfortable to wear for an extended period. The new masks are cheaper (approximately \$1 per mask) and more comfortable. Many companies are already producing the new masks, including those that also make HEPA masks.

Injuries From Electric Heating Pads

The Injury Research and Prevention Section of the Office of Public Health recently received a Health Advisory from the Food and Drug Administration/Consumer Products Safety Commission (CPSC) about health hazards associated with the use of electric heating pads. This advisory is summarized below.

Every year on the average, the CPSC receives eight death reports associated with the use of heating pads. Most deaths are caused by heating pad fires, which occur when broken or worn insulation of the electric wires in the heating pad or its electrical cord cause the pad to ignite. In addition to deaths, CPSC estimates that more than 1600 heating pad burns are treated each year in emergency rooms. Most of these injuries are thermal burns not caused by fire.

Individuals who are at particular risk for injuries and death associated with the use of electric heating pads include infants, since the pad covers a large area of their body and since they may be unable to move when burned, and persons who may be unable to feel pain to the skin because of advanced age, diabetes, spinal cord injury or medication.

CPSC therefore recommends that heating pads never be used on infants and on persons whose skin is not sensitive to temperature changes. In addition, the pad and its electrical cord should be inspected before use, and placed on top of, and not underneath, the body part in need of heat. Heating pads should never be used near equipment that stores or emits oxygen, should never be held in place with pins or metallic fasteners, and should never be crushed or folded during storage or use.

Screening for Syphilis in Pregnant Women: Results of a Survey

Congenital syphilis (CS) is preventable with proper syphilis screening and treatment in pregnant women. The risk of CS from untreated primary or secondary syphilis during pregnancy ranges from 70-100%, and the risk of perinatal death approaches 40%. Although the syphilis epidemic is subsiding in Louisiana, the state continues to have rates of early syphilis in adults and congenital syphilis rates in newborns much above the national average.

In 1995, a mail survey from the Office of Public Health regarding syphilis screening and reporting practices was sent to a sample of obstetricians and to all hospitals that have labor and delivery suites. Of 167 randomly selected obstetricians

(including all rural obstetricians and 25% of urban obstetricians), 140 (84%) returned questionnaires. Ninety-nine percent (139/140) of obstetricians report screening for syphilis during the first trimester. However, only 43% (60/140) of obstetricians report screening for syphilis during the third trimester. Screening practices did not vary between urban and rural areas.

A total of 68 hospitals that provide labor and delivery services were mailed questionnaires. Of 65 hospitals responding, only 48 (74%) reported routinely screening pregnant women for syphilis at delivery. Although hospital screening practices did not vary substantially between urban and rural areas (urban 31/43 [72%]; rural 17/22 [77%]; RR=0.9, 95% CI= .7-1.3), public hospitals were more likely to screen than private hospitals (public 7/7 [100%], 41/58 [71%]; RR=1.4, 95% CI= 1.2-1.7). Ninety percent (47/52) of hospitals surveyed said they report suspected cases of CS to the Office of Public Health.

The survey suggests CS may occur due to failure to screen pregnant women adequately for syphilis during the third trimester or at delivery. Failure to follow public health screening and reporting recommendations appears to be more common among private than public hospitals.

Below is a summary of syphilis screening, treatment, and reporting recommendations for pregnant women.

1. *All pregnant women should be screened for syphilis three times during pregnancy.* Screening should occur during her first prenatal visit (which preferably is in the first trimester), during the third trimester at least 30 days before delivery, and at the time of delivery. Testing at delivery should be on the mother since cord or infant blood may give false negative results.
2. *Treatment for pregnant women with syphilis is benzathine penicillin.* There are no proven alternatives to penicillin. Therefore, desensitization may be necessary in penicillin-allergic women. Serologic titers should be checked monthly until adequacy of treatment has been assured. Failure of nontreponemal test titers to decline fourfold, equivalent to a change of two dilutions (e.g., from 1:16 to 1:4 or from 1:8 to 1:32), by three months suggests treatment failure.
3. *Reporting to the Office of Public Health is required* for all positive serologic tests for syphilis (urgency should be given to pregnant women) and any suspected cases of congenital syphilis.

AIDS UPDATE

Counseling of Sex Partners

Sex partners of persons who are HIV positive are themselves at high risk for HIV infection. These persons can benefit from knowledge that they are at high risk so that they can learn their own HIV status and decrease their own risk behavior. Perhaps surprisingly, many partners of HIV-infected persons are unaware of the status of their partners. In an evaluation of an HIV partner notification program in South Carolina, only 9% of partners who were counseled by the health department said that they knew they were having sex with an HIV-positive person before this counseling. Furthermore, 77% said that they appreciated having been notified of this risk by the health department. In view of this, the Office of Public Health offers the service of partner notification to HIV-infected patients identified in public health clinics and state hospitals or referred by private physicians. This service is provided in a way which is confidential - that is, the names of original interviewed patients are not disclosed to the partners when they are counseled.

To evaluate this program we analyzed data from interviews completed by OPH staff in 1995. Information is currently available on 615 persons interviewed, including 383 men and 232 women. Overall, 421 (68%) provided the name of at least one sex partner (Table 1); interviewees as a

whole named 909 partners, for a mean of 1.5 sex partners per case. Women were more likely than men to name partners (78% versus 62%) and among men, those who reported same-sex contact were more likely to name partners than those who reported injecting drug use (67% versus 59%), but these differences were small.

Of the 909 partners named, we currently have information on 512, of whom 441 (86%) were located and counseled and 382 (75%) had their HIV antibody status determined at the time of the counseling. Of these, 110 (29%) already knew they were HIV infected, 205 (54%) were found to be HIV negative, and 67 (18%) were found to be HIV positive (Table 2). The percentage of partners newly recognized as HIV positive did not vary by the gender of the interviewed patient, but was greater in sex partners of women who reported using injecting drugs (30%) or who had at least one sex partner who used injecting drugs (40%).

This program has been successful in identifying a substantial number of HIV infected persons who can be referred into medical care and an even larger number of uninfected persons for whom infection can be prevented. The HIV/STD program views the program as important to prevention of AIDS in Louisiana and plans to expand this partner counseling program to the extent that staff time allows. Physicians who are interested in providing this service to their patients and their sex partners should contact their regional STD clinic or the STD Program in the central office at (504) 568-5275.

Table 1. Number of partners named by HIV-positive persons interviewed, 1995

Gender/Risk factor	No.	Named partners	
		No. (%)	Partners per patient
Male	383	239 (62%)	1.3
Sex with men	131	88 (67%)	1.7
Injecting drug use	61	36 (59%)	0.9
Female	232	182 (78%)	1.7
Injecting drug use	33	27 (82%)	1.8
Sex partner of IDU	20	17 (85%)	1.9
Total	615	421 (68%)	1.5

Table 2. HIV status of partners counseled, 1995

Patient gender/risk factor	Partners tested	HIV antibody status		
		Prev. Pos (%)	New Pos. (%)	Neg. (%)
Male	206	70 (34%)	35 (17%)	101 (49%)
Sex with men	80	32 (40%)	13 (16%)	35 (44%)
Injecting drug use	33	8 (24%)	7 (21%)	18 (55%)
Female	176	40 (23%)	32 (18%)	104 (59%)
Injecting drug use	33	5 (15%)	10 (30%)	18 (55%)
Sex partner of IDU	15	2 (13%)	6 (40%)	7 (47%)
Total	382	110 (29%)	67 (18%)	205 (54%)

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

NOVEMBER - DECEMBER, 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	Nov-Dec 1995	Nov-Dec 1994	Cum 1995	Cum 1994	% Chg	
<u>Vaccine-preventable</u>															
Measles	0	0	0	0	0	0	0	0	0	0	0	18	1	+170	
Mumps	0	0	0	0	0	0	0	0	2	2	5	14	35	-60	
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-	
Pertussis	3	0	0	0	0	0	0	0	1	4	3	21	14	+50	
<u>Sexually-transmitted</u>															
AIDS	Cases	19	3	0	1	0	0	2	1	26	160	690	1028	-33	
	Rate ¹	1.8	0.5	0	0.2	0	0	0.6	0.3	0.6	3.7	16.0	23.8		
Gonorrhea	Cases	515	163	53	109	29	89	153	118	1312	2060	10611	12288	-14	
	Rate ²	5.0	2.9	1.4	2.1	1.1	2.9	3.0	3.4	3.1	4.9	25.1	29.1		
Syphilis(P&S)	Cases	30	34	12	14	1	5	15	6	121	185	997	1645	-39	
	Rate ²	0.3	0.6	0.3	0.3	0.04	0.2	0.3	0.2	0.3	0.4	2.4	3.9		
<u>Enteric</u>															
<i>Campylobacter</i>		0	2	3	0	1	1	0	3	1	23	34	198	153	+29
Hepatitis A	Cases	4	2	1	1	0	1	3	37	0	49	14	175	161	+9
	Rate ¹	0.4	0.4	0.3	0.2	-	0.3	0.6	10.5	-	1.1	0.3	4.0	3.8	
<i>Salmonella</i>	Cases	10	3	2	3	2	0	3	4	8	110	145	567	548	+3
	Rate ¹	1.0	0.5	0.5	0.6	0.7	-	0.6	1.1	2.1	2.5	3.4	13.1	13.0	
<i>Shigella</i>	Cases	65	2	3	1	0	0	2	0	9	169	25	505	458	+10
	Rate ¹	6.3	0.4	0.8	0.2	-	-	0.4	-	2.3	3.9	0.6	11.7	10.9	
<i>Vibrio cholera</i>		0	0	0	0	0	0	0	0	0	0	0	0	-	
<i>Vibrio, other</i>		2	0	1	0	0	0	0	0	0	3	7	43	50	-14
<u>Other</u>															
Hepatitis B	Cases	8	1	0	2	0	3	2	1	3	20	18	225	188	+20
	Rate ¹	0.8	0.2	-	0.4	-	1.0	0.4	0.3	0.8	0.5	0.4	5.2	4.5	
<u>Meningitis/Bacteremia</u>															
<i>H. influenzae</i>		0	0	0	0	0	0	0	0	0	0	1	6	-83	
<i>N. meningitidis</i>		4	1	1	5	0	1	0	0	0	12	6	59	41	+44
Tuberculosis ³	Cases	147	45	39	44	29	19	88	42	23	N/A	N/A	476	443	+7
	Rate ¹	14.1	7.9	10.3	8.5	10.8	6.2	17.4	12.0	6.0	N/A	N/A	11.0	10.3	

1 = Cases per 100,000 3. Cumulative for 1995

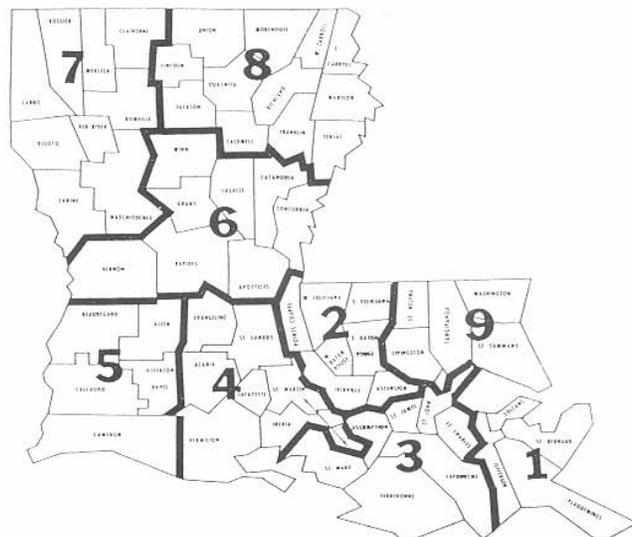
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	7
Histoplasmosis	4
Legionellosis	3
Lyme Disease	8
Malaria	6
Rocky Mountain Spotted Fever	2
Tetanus	2
Typhoid	1
Lead Toxicity	175

Table 3. Animal Rabies (Nov-Dec 1995)

Parish	No. Cases	Species
Acadia	1	Skunk
Caddo	1	Cat
Caddo	1	Bat
Lafayette	4	Skunks
St. Landry	3	Skunks
St. Landry	1	Bat



Annual Summary Hepatitis B, 1994

Two hundred six cases of hepatitis B were reported to the Epidemiology Section in 1994, for an overall state case rate of 4.8 per 100,000. Hepatitis B case reports decreased 24% from 1993 and 21% from 1992. There has been a consistent decline in reported cases of hepatitis B since 1987 (Figure 1). Sex-specific rates continue to be higher among males than females (5.5 vs 4.0 per 100,000), while race-specific rates have been consistently higher among blacks than whites (8.0 vs 2.4 per 100,000). The age-specific rate pattern has been similar to previous years with 76% of the cases within the 15 - 44 year age groups (Figure 2). Twenty-one (33%) parishes exceeded the overall state case rate. Parishes reporting the highest case rates per 100,000 include: St. Helena (20), Plaquemines (16), Tangipahoa and Sabine (13 each), and St. Martin and Claiborne (11 each, Figure 3).

One of the difficulties in interpreting hepatitis B surveillance data is determining the actual rate of newly infected cases. With many laboratory markers available for determining HBV status, the Louisiana Sanitary Code has been amended to require reporting of acute HBV cases only, in which those individuals have positive laboratory markers for HBsAg and Anti-HBc IgM. In addition, hepatitis B carriage in pregnancy is required to be reported.

The marked decline in reported hepatitis B cases could represent a better identification of acute cases (versus chronic cases), a real decrease in acute cases due to use of hepatitis B vaccine, or a real decrease in acute cases due to changes in risk behavior as a result of the AIDS epidemic.

Hepatitis B vaccine is widely available, even though OPH's current provisions are to infants born to carrier mothers, household contacts of prenatal carriers and universal vaccination of infants. Individuals in high risk groups (i.e. drug users, individuals with multiple sexual partners) should

be referred for hepatitis B vaccine even if one needs to obtain the vaccine through private providers. As of this writing, completion of the three dose series is considered adequate for protective immunity and no further recommendations have been made for routine boosters.

Figure 2: Cases of hepatitis B by age and sex, 1994

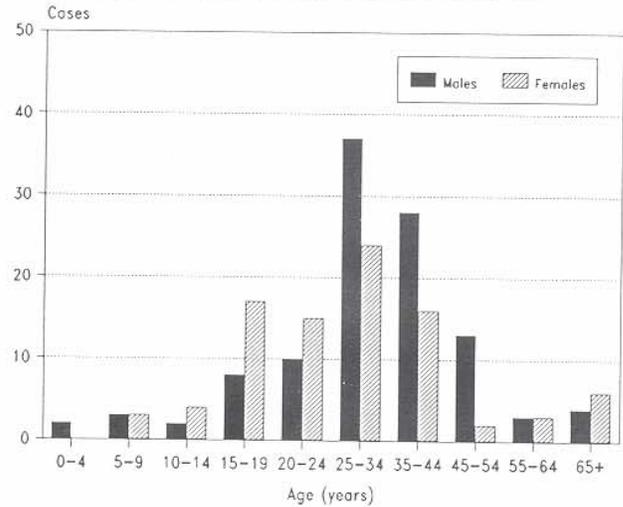


Figure 3: Rates of hepatitis B by parish, 1994

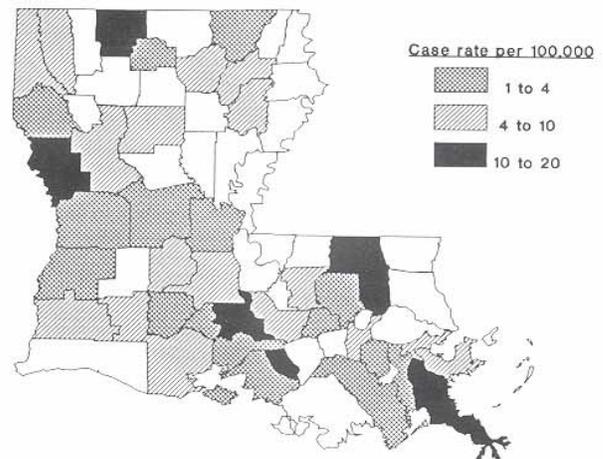
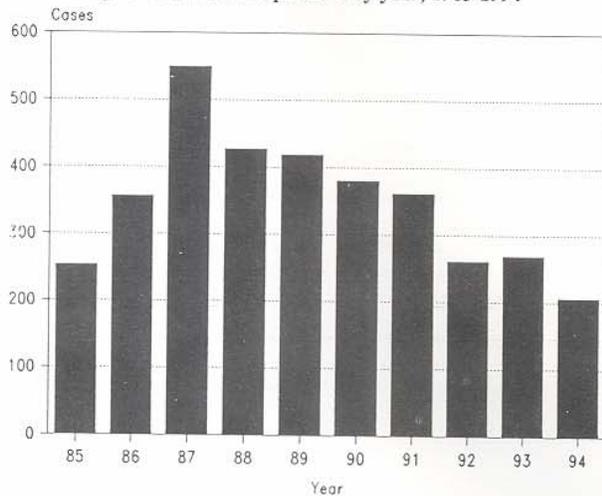


Figure 1: Cases of hepatitis B by year, 1985-1994



LOUISIANA FACTS

The first case of smallpox occurred in Louisiana in 1733. The exact date when vaccination against smallpox was adopted is not known; records indicate it was around 1802-04. The last case of smallpox in Louisiana occurred in 1949.

LIST OF REPORTABLE DISEASES/CONDITIONS

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

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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