

Louisiana Morbidity Report

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

September-October 1998

Volume 9 Number 5

Neonatal Mortality of Very Low Birth Weight Infants

Although the infant mortality rate in Louisiana has decreased, Louisiana still has one of the highest infant mortality rates in the nation. Two-thirds of the infant deaths occur in the neonatal period (birth through 28 days of age). The primary factor associated with death in the neonatal period is low birth weight. However, the likelihood of survival for low birth weight infants can be influenced by the quality of neonatal care received after birth. For this reason, it is recommended that pregnant women at high risk for delivery of a low birth weight infant be transferred to hospitals with high levels of neonatal care for labor and delivery.

In 1994, the Louisiana Commission on the Perinatal Care established standards for neonatal care in the state based on type of patients, staffing, and availability of specialists. Level I neonatal units provide care for healthy newborns and stabilization of unexpectedly small or sick newborns before transfer to a hospital with a higher level of neonatal service. Level II neonatal units provide management of small, sick neonates with a moderate degree of illness. Level III neonatal units provide comprehensive care of all high-risk neonates. Of the 73 hospitals that deliver infants in Louisiana, 29 hospitals have Level III neonatal units, including six hospitals designated as Level III regional centers.

To begin to understand the effectiveness of higher-level neonatal care in Louisiana, the Maternal and Child Health

Section analyzed a linked live birth/infant death file for 1991-1996 to determine the birth weight-specific neonatal mortality rates for Level I, Level II and Level III neonatal units. Special emphasis was placed on the outcome of infants of very low birth weight (500 - 1,500 grams).

During this time period, 1.7% (7,039/416,302) of infants were of very low birth weight (VLBW). Infants were more likely to be VLBW if their mothers were black (2.7%), under 20 years of age (2.1%), unmarried (2.4%), or had no prenatal care (6.8%; Table 1). Of the 7,039 infants with VLBW, 69.5% were born at Level III hospitals, 3.0% were born at Level II hospitals, and 27.5% were born at Level I hospitals.

Table 1: Very low birth weight infants born in Louisiana, 1991-1996

Risk Marker		Total births	VLBW births	Percent VLBW
Mother's race	White	236,068	2,322	1.0%
	Black	171,950	4,646	2.7%
	Other	8,284	71	0.9%
Mother's age	< 20 yrs	76,688	1,638	2.1%
	20-34 yrs	307,253	4,800	1.6%
	35+ yrs	32,308	598	1.9%
	Unknown	53	3	5.7%
Marital status	Married	244,856	2,877	1.2%
	Unmarried	170,630	4,132	2.4%
	Unknown	816	30	3.7%
Prenatal care begun	1st trimester	324,258	5,086	1.6%
	2nd trimester	69,473	1,134	1.6%
	3rd trimester	12,060	100	0.8%
	Never/unknown	10,511	719	6.8%
TOTAL		416,302	7,039	1.7%

Overall, the neonatal mortality rate for VLBW infants was 149 per 1,000 live births. This risk increased dramatically for infants of lower birth weight within the VLBW category (Table 2). VLBW infants delivered outside of Level III hospitals had significantly higher mortality than those delivered at Level III hospitals (190.3 vs. 130.7 per 1,000 live births, relative risk [RR] adjusted for birth weight = (Continue on next page)

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1.45). This discrepancy in mortality by level of neonatal care was found for each weight category within VLBW infants.

In the future, the Maternal and Child Health Section will be looking at additional information on neonatal mortality with regards to the categorization of Level hospital, the number of very low birth weight deliveries and Regional Center status. Based on current data, however, it appears that improvements in neonatal mortality can be achieved if high-risk women can be better identified and referred so that a greater proportion of VLBW infants are delivered at Level III hospitals.

Table 2: Mortality rate of VLBW infants by birth weight and level of hospital of birth

<u>Birth weight</u>	Number births	Number deaths	Mortality rate*	Level 1+2 mortality*	Level 3 mortality*	Relative Risk
500-749 g	1499	662	442	509.5	410.3	1.24 (1.11,1.39)**
750-999 g	1643	203	124	182.4	98.7	1.85 (1.43,2.39)**
1,000-1249 g	1897	110	58	80.3	48.3	1.66 (1.15,2.39)**
1,250-1,499 g	2000	73	37	52.5	29.5	1.78 (1.13,2.80)**
Total 500-1,499	7039	1048	149	190.3	130.7	1.45 (1.29,1.62)**

* Neonatal deaths per 1,000 births

**p<0.05

State to Become a Regional Reference Laboratory

The Division of Laboratories, in conjunction with the Epidemiology Section, is developing the capacity to serve as a Regional Reference Laboratory for selected testing in Louisiana and surrounding states. The following services will be available: influenza culturing and subtyping, pulsed field gel electrophoresis (PFGE), and selected polymerase chain reaction (PCR) testing. The Microbiology Section will perform tests for *Campylobacter*, *Bacillus cereus*, *Clostridium perfringens*, and *E. coli* O157:H7 isolation and identification from food and stool. The Virology Section will be able to detect noncultivable pathogens such as Norwalk virus, rapidly diagnose/confirm human infections with hepatitis C, arboviruses, enteroviruses, and rabies. The cost of the testing is the responsibility of the state submitting the specimen. These services are also available, on a limited basis, to providers within the state. Please call the Epidemiology Section (504 568-5005) prior to submitting a specimen for testing to expedite the approval process.

1998-1999 Influenza Immunization Update

Due to unavoidable delays in vaccine production, the influenza immunization kick-off has been postponed from the week of October 12, 1998 to the week of November 2, 1998. Parish health unit clinics throughout the state will begin the Influenza Immunization Program the week of November 2-7, 1998 to individuals who are at high risk of serious illness or death from influenza infection. For information on time and days of the clinics, please contact your local parish health unit. For additional information, call the Immunization Program at (504) 483-1900.

BULLETIN

Revision to Louisiana Morbidity Report's Provisional Data Table

Beginning with the September/October, 1998 issue of the *Louisiana Morbidity Report*, *H. influenzae* will be reported in two distinct areas of the Provisional Data Table: *H. influenzae* (type B) will be reported under the "Vaccine-preventable" category, and *H. influenzae* (other) will be reported under the "Other" category. Previous issues incorrectly listed all serotypes under the "Vaccine-preventable" category. We regret the error.

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- | | |
|--------------------------|---|
| Assistant Secretary, OPH | Jimmy Guidry, MD |
| State Epidemiologist | Louise McFarland, DrPH |
| Editors | Thomas Farley, MD MPH
Karen Kelso, RNC MS |
| Associate Editor | Barbara Trahan, MPH |
| Production Manager | Ethel Davis, CST |
| Contributors | Nilong Vyas, MPH
Mami Shields, MD PhD
Jean Takenaka, MD MPH
Diane Praytor-Cartwright, MPH
Megan Davies, MD
Charles Myers, MSW
Stephanie Posner, MPH |

Deaths from Injuries, 1995-1996

The United States Public Health Service, working with many other individuals and organizations, defines objectives for high priority health events, behaviors, and interventions. *Healthy People 2000 National Health Promotion and Disease Prevention Objective* (HP 2000) is the book that lists the ten-year health objectives for the nation. The Injury Research and Prevention Section evaluated Louisiana's progress toward HP 2000 goals for injury mortality.

Louisiana's performance in the area of Violent and Abusive Behavior Objectives was notable for homicide rates more than two and one half times the target rate (Table, Figure). Homicide rates for black men 15-34 years old and firearm-related mortality rates were also more than double the HP 2000 targets. Suicide mortality rates were better, although even these were 12-38% above target.

For unintentional injuries, the mortality rate in Louisiana was 27% higher than the HP 2000 goal. Since motor vehicle crashes are the most frequent cause of unintentional injury deaths, accounting for 50% of unintentional injury deaths, the high rate of unintentional injury deaths overall is largely due to the high rate of motor vehicle crash deaths.

Drowning also contributed to the elevated unintentional injury mortality rate in the state. Drowning mortality rates were far above HP 2000 targets for all subgroups, particularly for males 15-34 (over three times the HP 2000 targets) and for black males (more than twice the HP 2000 target).

There were two areas in which Louisiana stood out for having rates below the HP 2000 target. The mortality rate from motorcycle crashes in Louisiana was two-thirds of the HP 2000 target. These low rates were consistent over both years examined, which gives them credibility. Louisiana's motorcycle helmet law may have contributed to this low rate. The other area in which the average mortality rate was low was drowning in children 4 years old and under. Unfortunately, here the rates for 1995 and 1996 varied widely, suggesting that chance variation may account for the low rate.

Overall, in 37% of injury objectives, Louisiana's rates were 30% farther from the HP 2000 target than the US rates for 1995. This implies that Louisiana's rates are truly high when compared with the national rates, rather than artifactually high because of unrealistic targets.

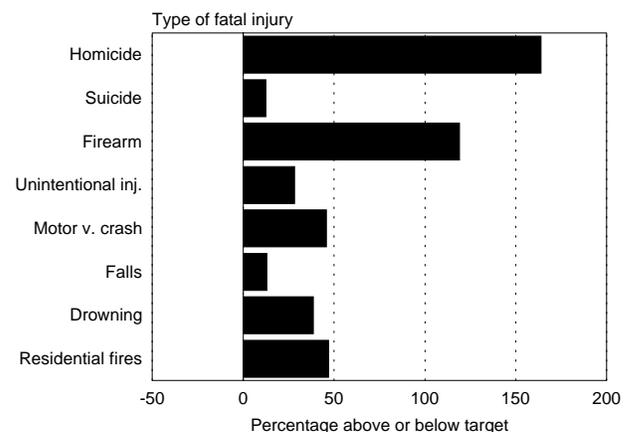
Public health efforts should focus on the health priorities in which rates are far above the HP 2000 objectives. Ongoing tracking of the injuries targeted by HP 2000 can be used to help evaluate the effectiveness of those efforts.

Table: Comparison of Louisiana average mortality rates for 1995-1996 and USA mortality rates for 1995 with Healthy People 2000 injury mortality targets

Goal	HP 2000	USA 1995	Av. LA '95-'96
HOMICIDE	7.2	9.2	19
Children ≤ 3	3.1	.	4.8
Black males 15-34	72.4	114.6	170.2
Black females 15-34	16	18.5	23.2
SUICIDE	10.5	11.2	11.8
Adolescents 15-19	8.2	10.5	11.3
Males 20-34	21.4	26.3	28.4
White males ≥ 65	39.2	38.7	43.8
FIREARM	11.6	13.9	25.4
Blacks	30	30.3	44
UNINTENTIONAL INJURY	29.3	30.5	37.6
Black males	51.9	57.6	64.4
White males	42.9	43	47.4
MOTOR VEHICLE CRASH	14.2	15.9	20.7
Children ≤ 14	4.4	4.8	7.4
People 15-24	26.8	29.6	34.2
People ≥ 70	20	23.3	26.6
Motorcyclists	0.9	0.9	0.6
Pedestrians	2	2.1	3
FALL	2.3	2.6	2.6
People 65-84	14.4	18.5	22.1
People ≥ 85	105	152	135.2
Black males 30-69	5.6	.	6
DROWNING	1.3	1.7	3.1
Children ≤ 4	2.3	3.7	3
Males 15-34	2.5	4.6	7.4
Black males	3.6	4.1	7.8
RESIDENTIAL FIRE	1.2	1.2	1.8
Children ≤ 4	3.3	2.6	2
People ≥ 65	3.3	3.6	7.4
Black males	4.3	4.2	5.2
Black females	2.6	2.4	3

Note: All rates age adjusted with the exception of motor vehicle crash mortality.

Figure: Percentage of Louisiana's injury mortality rates above or below HP 2000 target, for intentional and unintentional injuries for 1995-96

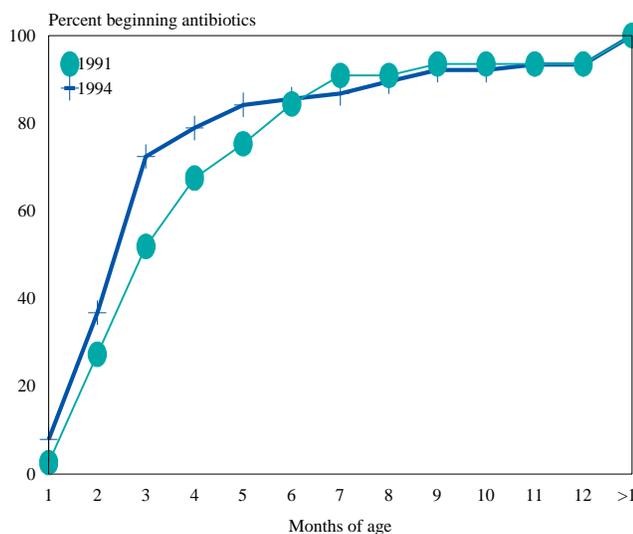


Evaluation of Newborn Sickle Cell Screening

Early diagnosis of sickle cell anemia and initiation of penicillin prophylaxis significantly reduces mortality from bacterial infection for children with this disease. In 1987, the National Institutes of Health recommended that newborn genetic screening programs add universal screening for sickle cell disorders to screening for PKU and hypothyroidism. In 1988, the Office of Public Health was one of a number of southern states given a federal grant to develop a statewide newborn screening sickle cell program. The state health departments in Louisiana, Mississippi and Georgia are now participating in a retrospective study to evaluate the impact of this newborn sickle cell screening. The study compares the morbidity and mortality during the first three years of life in infants with sickle cell disorders born in 1991 with those born in 1994.

Louisiana's data for this study has identified 79 patients in the 1991 cohort and 76 in the 1994 cohort. Approximately 40% of the children were from New Orleans, Baton Rouge, or Shreveport. The program has clearly been successful in early identification of infants with sickle cell disease, as over 90% of infants were diagnosed within the first month of life and over 95% were diagnosed in the first three months for both cohorts. Of the 1991 cohort, 68% were receiving penicillin by four months of age; this proportion increased to 79% in the 1994 cohort (Figure). However, it is now recommended to have a child on penicillin prophylaxis no later than two months of age.

Figure: Percent of infants with sickle cell disease initiating prophylactic penicillin, by month of age, Louisiana, 1991 and 1994



There was one death (1.3%) among the 79 patients in the 1991 cohort and there were two deaths (2.6%) in the 1994 cohort before three years of age. These mortality rates are consistent with those of other states in this study and are a large improvement when compared to the accepted case fatality rate of 16% for the first year of life prior to the advent of newborn screening and the new standards of specialized care. These preliminary results of the evaluation show that newborn screening for sickle cell disorders established in Louisiana in the early 1990's has ensured early detection and the provision of appropriate care.

It is recommended that treating physicians start infants with sickle cell disease on oral penicillin as soon as possible but no later than two months of age. Children with sickle cell disease need to be under the care of a local primary care physician. They also need specialized supervision and evaluation from a pediatric hematologist at a sickle cell clinic. For further information call the Genetic Diseases Program at (504) 568-5070.

Influenza Surveillance Enhancement

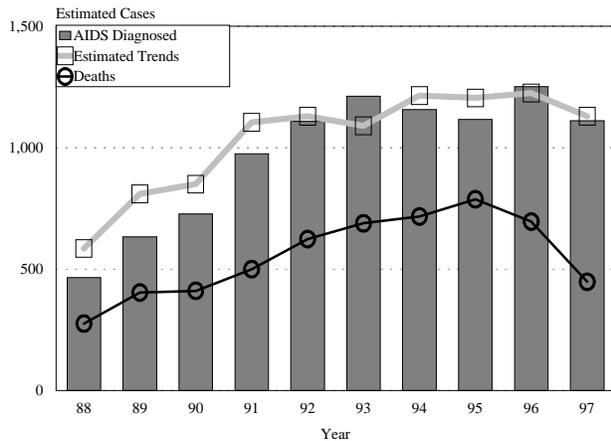
The Immunization Program, in conjunction with the Epidemiology Section, will enhance the current sentinel influenza surveillance system. Selected physicians around the state, called sentinel physicians, participate in this active influenza surveillance system by collecting relevant influenza data. The number of sentinel physicians will be doubled (to allow approximately one sentinel physician for every 225,000 Louisiana residents). The surveillance data (the number of flu-like-illnesses diagnosed) will be collected weekly from October through May. Participating sentinel physicians can use CDC's newly developed electronic data collection system or receive weekly telephone calls from the coordinator. The CDC system will allow physicians to transmit their data via the telephone directly to a computer, which in turn will immediately post the data on a webpage. (Only aggregate influenza data will be available on the webpage available to the general public.) In addition to the sentinel system, any physician who diagnoses flu-like-illness in his/her patients is encouraged to report these findings to the Influenza Surveillance Coordinator or the local parish health unit. All physicians are strongly encouraged to submit influenza cultures in the beginning of the influenza season, at the midpoint of the season, during outbreaks, and from any unusual or severe cases occurring towards the end of the season. Please contact the Influenza Surveillance Coordinator, Cathy Scott (318) 345-1700, for more information, culture kits, or to report flu-like-illnesses.

HIV/AIDS UPDATE

Profile of the Epidemic, 1997

In Louisiana and across the rest of the nation, there was a substantial drop in the number of AIDS cases diagnosed and reported in 1997. Similarly, there has been a dramatic drop in the number of deaths due to AIDS (Fig. 1), such that AIDS dropped to the second leading cause of death among men age 25-44 during 1996. These drops are in large part due to the availability of more effective treatment regimens.

Figure 1: AIDS case trends, 1988-1997



Although the largest exposure group for persons with AIDS is men who have sex with men (MSM), the number of AIDS cases in this group has been steadily declining. This decrease appears to be limited to white men who have sex with men (Fig. 2); among African-Americans, new cases in MSM may not be declining. The increases in AIDS cases attributed to injection drug use (IDU) and high risk heterosexual contact (HRH) have been substantial among African-Americans, such that the numbers of new cases among the three risk groups is estimated to be equal (Fig. 3).

Figure 2: Trends in exposure category for AIDS cases among Whites, 1988-1997

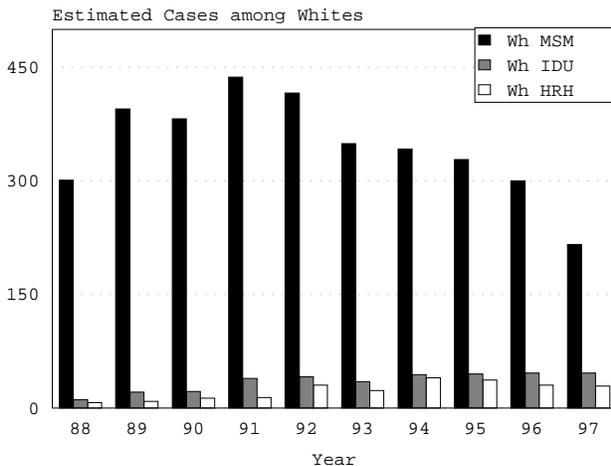
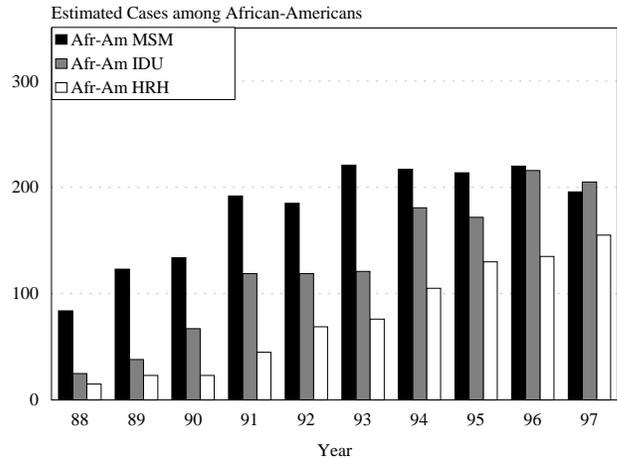


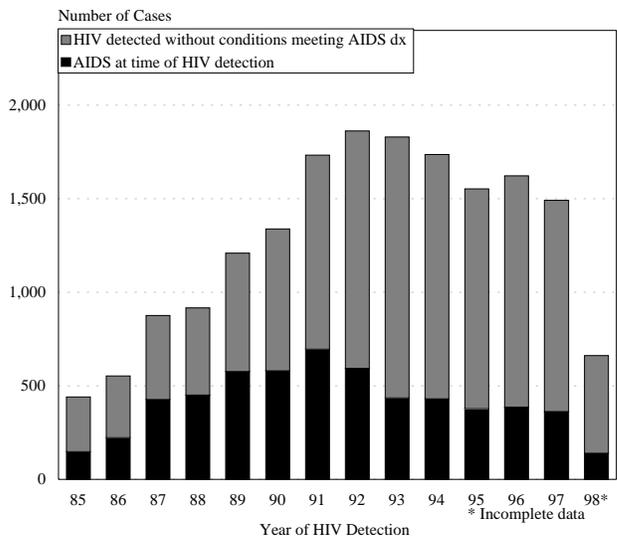
Figure 3: Trends in exposure category for AIDS cases among African-American, 1988-1997



Because AIDS incidence declines with the new effective treatments, OPH will increasingly be monitoring the epidemic by following reports of HIV infection (rather than full-blown AIDS). Overall, the number of new HIV infections reported has been declining slowly since its peak in 1992 (Fig. 4). During 1997, over a quarter of new cases had progressed to AIDS at the time of HIV detection and over 70% of new cases were among African-Americans. For several years, the HIV detection rates among African-Americans have been disproportionately high, especially among African-American men where the rate is four times that of white men.

Trends in HIV infection data must be interpreted with caution since persons may be detected with HIV at any point in their disease progression and therefore do not necessarily represent a recent infection. With the new effective treatments available, offering testing to persons at high risk and promptly providing access to appropriate treatments may reduce the spread of HIV to other persons at risk for HIV.

Figure 4: HIV/AIDS case trends, 1985-1997



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
Sept - Oct 1998
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	September October 1998	September October 1997	Cum 1998	Cum 1997	% Chg
Vaccine-preventable														
<i>H. influenzae</i> (type B)	0	0	0	0	0	0	0	0	0	0	-	0	-	-
Hepatitis B	17	2	0	1	2	3	4	5	4	38	37	151	154	-2
Rate ¹	1.6	0.4	-	0.2	0.7	1.0	0.8	1.4	1.0	0.9	0.9	3.5	3.6	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	0	0	0	0	0	0	3	8	15	-47
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	0	0	0	0	0	0	0	0	0	0	2	11	20	-45
Sexually-transmitted														
HIV/AIDS	57	47	7	7	13	11	4	18	6	170	296	1095	1310	-17
Rate ¹	5.3	8.5	1.9	1.4	5.0	3.5	0.8	5.2	1.7	3.9	6.9	25.4	30.4	
Gonorrhea	484	237	107	233	92	72	451	309	172	2157	2230	10431	8813	+18
Rate ¹	46.6	41.7	28.4	45.2	34.3	23.6	89.1	88.0	44.7	51.1	52.8	247.2	208.8	
Syphilis(P&S)	17	7	29	23	4	4	2	4	1	91	61	369	313	+18
Rate ¹	1.6	1.2	7.7	4.5	1.5	1.3	0.4	1.1	0.3	2.2	1.4	8.7	7.4	
Enteric														
Campylobacter	7	5	0	1	0	1	1	1	4	20	23	100	141	-29
Hepatitis A	11	2	0	2	1	4	0	3	0	23	48	107	219	-51
Rate ¹	1.1	0.4	-	0.4	0.4	1.3	-	0.9	-	0.5	1.1	2.5	5.1	
Salmonella	29	19	23	16	11	16	16	17	24	175	140	567	477	+19
Rate ¹	2.8	3.3	6.1	3.1	4.1	5.2	3.2	4.8	6.2	4.1	3.2	13.1	11.1	
Shigella	13	5	1	2	0	5	13	14	2	55	23	254	115	+121
Rate ¹	1.3	0.9	0.3	0.4	-	1.6	2.6	4.0	0.5	1.3	0.5	5.9	2.7	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	2	0	-
Vibrio, other	3	1	3	1	0	0	0	0	1	10	6	43	29	+48
Other														
<i>H. influenzae</i> (other)	1	0	0	0	0	0	0	0	0	1	1	23	13	+77
<i>N. Meningitidis</i>	0	1	0	0	1	0	0	0	2	4	1	58	47	+23
Tuberculosis	14	3	4	4	5	2	1	7	3	43	76	308	230	+34

¹ = Cases Per 100,000

² = These totals reflect cumulative totals of HIV+ and AIDS cases.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	4
<i>E. coli</i> 0157:H7	5
Histoplasmosis	1
Lead Toxicity	41
Varicella	173
Rocky Mountain Spotted Fever	2
Legionellosis	4
Lyme Disease	5
Malaria	13
Tetanus	1

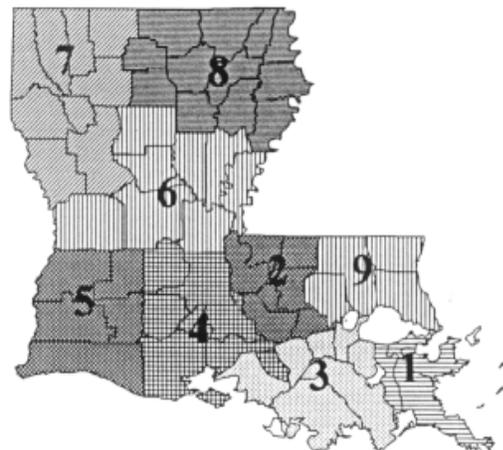


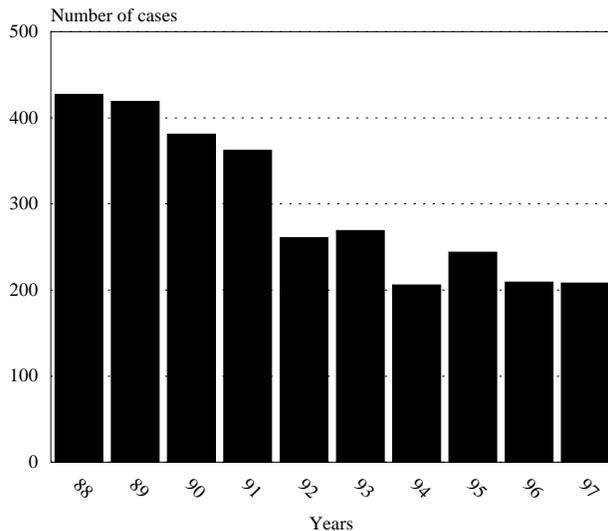
Table 3. Animal Rabies (September - October, 1998)

Parish	No. Cases	Species
No rabies reports for this quarter.		

Annual Summary Hepatitis B - 1997

In 1997 the number of hepatitis B cases reported to the Epidemiology Section was 208, which is essentially unchanged from 1996 and a decrease of 15% from 1995 (Figure 1). The overall state case rate for 1997 is 4.8 per 100,000. Sex-specific rates continue to be higher for males than females (5.2 vs 4.5 per 100,000). Race-specific rates were over three times higher in African-Americans than for whites (7 vs 2.2 per 100,000). Cases by age groups and sex peak in age groups 20-54 for males and 15-44 for females (Figure 2). Of the 208 cases reported, 46 case reports were available with information regarding drug use. Of these 46 cases, 2 (4%) cases reportedly used IV drugs during the 6 weeks to 6 months prior to illness. One of 63 case reports (2%) and 2 of 42 case reports (5%) were either attendees of day care settings or contacts of day care attendees, respectively. Thirty-five out of 208 cases (17%) provided information about their hepatitis contacts. Two (6%) of these cases reported contact with a known hepatitis B case. Five (2%), however, provided information on the types of hepatitis B contact. Three (60%) were sexual contacts and 2 (40%) were household contacts. Of the 40 (19%) that answered about their sexual preference, 32 (80%) were heterosexual, 18% homosexual, and 3% bisexual. Two (33%) of 6 cases indicated having a blood transfusion during the 6 weeks to 6 months prior to illness. No cases were associated with dialysis patients. One (2%) of 41 indicated a history of tattoo. Parishes reporting the highest case rates per 100,000 include: Red River (21), W. Feliciana (15), Tangipahoa (14), and Grant (11).

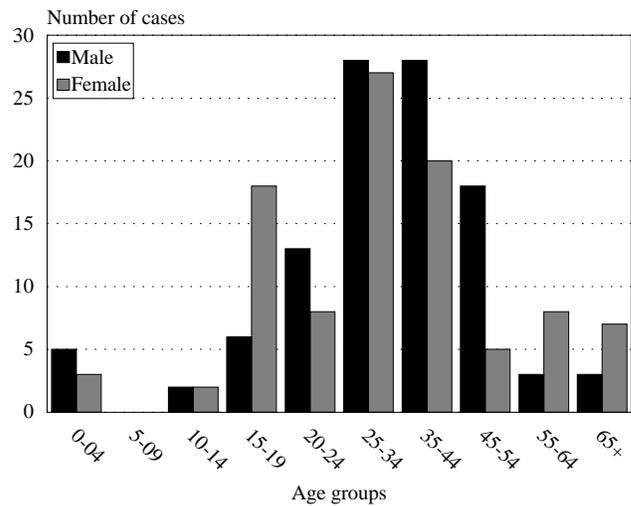
Figure 1: Cases of hepatitis B by year, 1988-1997



Comment:

Analysis of the data suggests that less than 1% of those infected with hepatitis B were employed in the medical field. This is a significant decrease reported in medical workers from 1996 (17%) and may be as a result of stringent needle-stick policies in hospitals and clinics in averting cases. Over the years, the increase in rates within the 0-4 age group may be explained by the increased risk of perinatal transmission. More educational efforts need to be targeted to all high risk groups as well as encourage physicians to follow up with their patients and administer vaccine to those who are identified as high risk.

Figure 2: Cases of hepatitis B by sex and age groups, Louisiana 1997



Louisiana Fact

Did you know that the city of New Orleans more than once established a board of health during the era preceding the State Board's appearance in 1855 and that Shreveport and Baton Rouge had created similar organizations after being so authorized by legislation in 1878? In 1882, the General Assembly enacted Act. No. 92 which empowered municipal authorities in all incorporated towns to constitute themselves boards of health, but the response was less than enthusiastic. "Municipal boards sometimes were created in periods of crisis, and came to be stigmatized for their willingness to adopt or condone vexatious shotgun quarantines. These boards, never very numerous, tended to be characterized by extremely limited programs."

Taken from the Progressive Years by Gordon Gillson (page 285).

LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis, Acute (A, B, C, Other)	Rubella (German measles)	Cancer
Amebiasis	Hepatitis B carriage in pregnancy	Rubella (congenital syndrome)	Complications of abortion
Arthropod-borne encephalitis (Specify type)	Herpes (neonatal)	Salmonellosis	Congenital hypothyroidism*
Blastomycosis	Human Immunodeficiency Virus (HIV) infection ³	Shigellosis	Galactosemia*
Botulism ¹	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Hemophilia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Lead Poisoning
Chancroid ²	Lymphogranuloma venereum ²	Syphilis ²	Phenylketonuria*
Chlamydial infection ²	Malaria	Tetanus	Reye' Syndrome
Cholera ¹	Measles (rubeola) ¹	Tuberculosis ⁴	Severe traumatic head injury**
Cryptosporidiosis	Meningitis, other bacterial or fungal	Typhoid fever	Severe under nutrition (severe anemia, failure to thrive)
Diphtheria	Mumps	Varicella (chickenpox)	Sickle cell disease (newborns)*
Enterococcus (infection; resistant to vancomycin)	Mycobacteriosis, atypical ⁴	Vibrio infections (excluding cholera) ¹	Spinal cord injury**
Escherichia coli O157:H7 infection	Neisseria meningitidis infection ¹		Sudden infant death syndrome (SIDS)
Gonorrhea ²	Pertussis		
Haemophilus influenzae infection ¹	Rabies (animal & man)		
Hemolytic-Uremic Syndrome	Rocky Mountain Spotted Fever (RMSF)		

¹ Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.

² Report on STD-43 form. Report cases of syphilis with active lesions by telephone.

³ Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.

⁴ Report on CDC 72.5 (f. 5.2431) card.

*Report to the Louisiana Genetic Diseases Program Office by telephone (504) 568-5070 or FAX (504) 568-7722.

** Report to Injury Research & Prevention Section (504-568-2509).

Numbers for reporting communicable diseases

1-800-256-2748

Local # 568-5005

FAX # 504-568-5006

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

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