

# Louisiana Morbidity Report

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

March-April 2000

Volume 11 Number 2

## Cardiovascular Disease in Louisiana

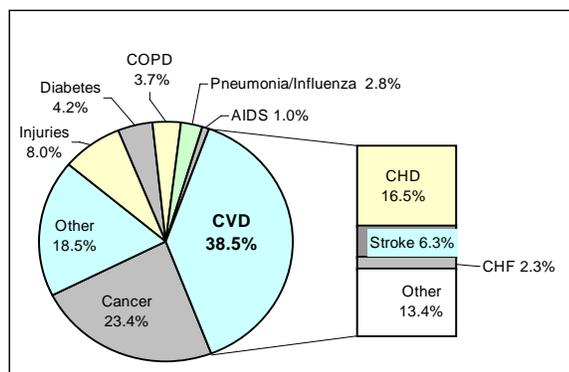
Cardiovascular disease (CVD), including heart disease and stroke, was the leading cause of death in Louisiana in 1997. Almost 40 percent (38.5%) of all deaths were due to CVD (Figure 1). More Louisianians die each year from CVD than from all forms of cancer, AIDS, suicides, and traffic accidents combined.

Cardiovascular disease age-adjusted death rates have declined in both Louisiana and the U.S. over the past 17 years (Figure 2). The decline in CVD deaths is presumably due to improvements in medical care and to healthier lifestyles. However, according to the American Heart Association, Louisiana has the fourth highest car-

diovascular age-adjusted death rate in the nation. Although the Louisiana CVD age-adjusted death rate continues to decline, the rate of decline is slowing. From 1985-1992, the CVD age-adjusted death rate declined by an average of 2.8% per year. By 1992-1997, the rate of decline had slowed to only 1.4% per year.

CVD is not just a disease of old age. Even though the process of arterial narrowing begins in the teenage years, the age at which blocked arteries actually kill varies greatly and death often occurs

Figure 1: Leading causes of death in Louisiana, 1997



COPD = chronic obstructive pulmonary disease  
CVD = cardiovascular disease  
CHD = coronary heart disease  
CHF = congestive heart failure

Figure 2: Age-adjusted cardiovascular disease death rates in Louisiana & US, 1985-1997

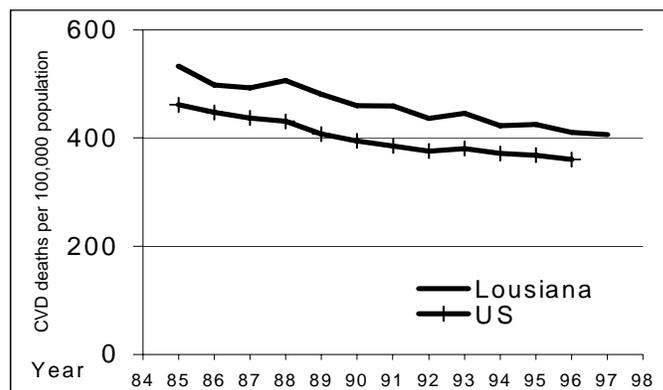
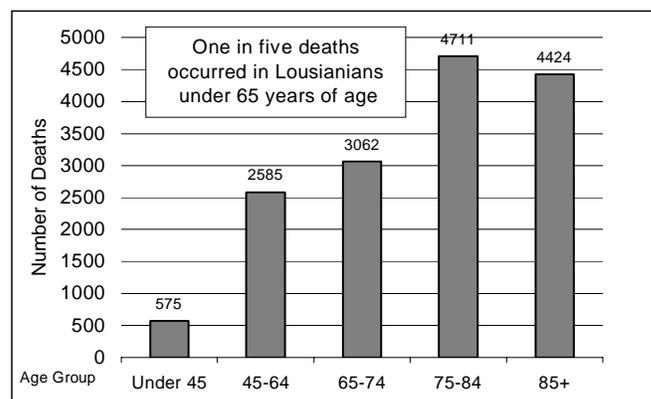


Figure 3: Age-adjusted cardiovascular disease death by age, Louisiana, 1997



before old age. One in five (20.6%) Louisianians who died of CVD in 1996 was in a person younger than 65 years of age (Figure 3).

CVD death rates differ by gender and race. Men have higher age-adjusted rates than women, and blacks have higher age-adjusted rates than whites (Figure 4). However, more women die from CVD than any other cause. These patterns are consistent with national CVD age-adjusted death rates.

(Continue on next page)

### Contents

Tuberculosis - Louisiana, 1999 .....	2
Pregnancy-related Hospitalizations .....	3
Hepatitis B Vaccination for Adolescents .....	4
HIV/AIDS Update .....	5
HIV/AIDS Surveillance Epidemiologists in Louisiana .....	5
Annual Summary: Vibrio Infections - 1998 .....	7

## Cardiovascular Disease in Louisiana, 1997 (Cont.)

Figure 5 shows the twenty parishes with the highest cardiovascular disease death rates. The age-adjusted death rates used here were calculated for a three year period. None of the major cities in the state are included in the top twenty parishes. Seven of these parishes are border parishes in the delta region of Louisiana. One possible explanation for the high CVD death rates seen in these parishes may be that people in or near large cities have better access to medical care for CVD. Also, death and disability from CVD are related to a number of modifiable risk factors, including smoking, high blood pressure, high blood cholesterol, sedentary lifestyle, and being overweight. High CVD rates are typically seen in poor, rural, delta areas and are probably linked to these underlying CVD risks and the effects of poverty.

Sustained behavior changes are often difficult to make, even for highly motivated individuals. Therefore, it is crucial for entire communities to work together to change social norms. Community leaders and parents can act as role models; and local environments, such as schools and workplaces, can be changed to facilitate healthy behaviors.

Source: The 1999 Louisiana State of the Heart Report, Louisiana Office of Public Health, Division of Health Protection and Promotion, Chronic Disease Control Section and American Heart Association, December 1999.

Figure 4: Age-adjusted CVD death rates by race and sex, Louisiana, 1997

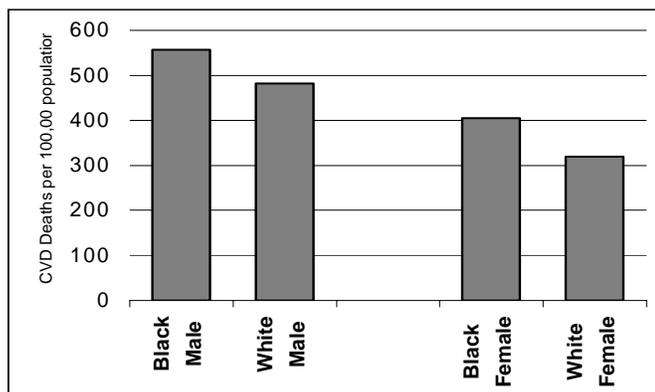
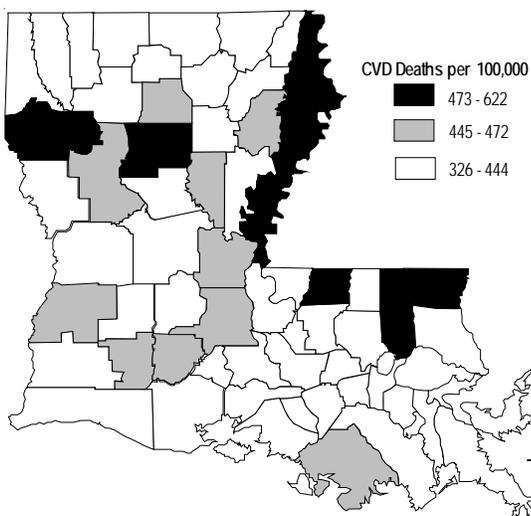


Figure 5: Rates of cardiovascular disease deaths, Louisiana parishes, 1995-1997



## Tuberculosis - Louisiana, 1999

Louisiana reported 357 cases of tuberculosis in 1999, a 6% decrease from the 1998 total of 380. With a 1999 case rate of 8.2 per 100,000, Louisiana exceeds the 1998 national rate of 6.4 per 100,000. In 1998 the CDC ranked Louisiana 8th in the nation in tuberculosis case rates. In general the tuberculosis rates have been decreasing in the southern U.S. in recent years (Figure 1).

Metropolitan New Orleans continues to lead the state in morbidity (Figure 2). Cases of tuberculosis in children (<15 years of age) increased over the past five years from 4 in 1994 to 19 in 1999. The majority of pediatric cases were also reported in the New Orleans region.

Persons of color continue to suffer a disproportionate impact of tuberculosis. Of the 357 cases reported in 1999, 56.3% were found in blacks (17.8 per 100,000) and 5.6% were reported in the Asian/Pacific Islander population (61.8 per 100,000), compared to 37.5% in whites (4.2 per 100,000).

The distribution of cases by gender shows that males outnumber females by more than a 2-1 margin, with 244 (68.3%) of the total cases in 1999. Although the total number of cases declined in 1999, the decrease occurred in all age groups except the 45-64 age group. Fifty-four percent of all persons with tuberculosis in 1999 were unemployed.

The number of tuberculosis cases with HIV infection increased in 1999. A total of 40 (11.2%) HIV infected patients with tuberculosis were identified this year compared to 29 (7.6%) in 1998. The majority, 23 (57.5%) of HIV infected cases, were reported in the New Orleans region.

The incidence of drug-resistant tuberculosis declined slightly in 1999 with an initial rate of resistance to isoniazid (INH) of 2.9% statewide. Ninety-eight percent of culture-positive tuberculosis cases in Louisiana had initial drug susceptibility tests per-

### Louisiana Morbidity Report

Volume 11 Number 2

March-April 2000

The Louisiana Morbidity Report is published bimonthly by the Infectious Disease 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, Infectious Disease Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.

Assistant Secretary, OPH

Madeline McAndrew

State Epidemiologist

Louise McFarland, DrPH

Editors

Thomas Farley, MD MPH  
Karen Kelso, RNC MS  
Barbara Trahan, MPH

Layout & Design

Ethel Davis, CST

#### Contributors

Susan Wilson, MSN

Charles DeGraw

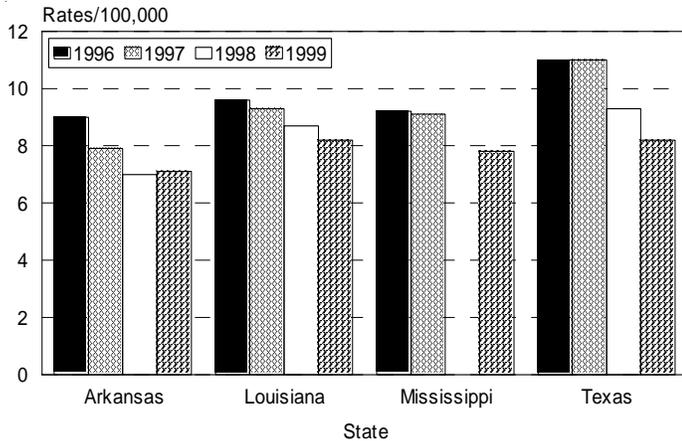
Tim Church, MD

Kathleen Welch, PhD

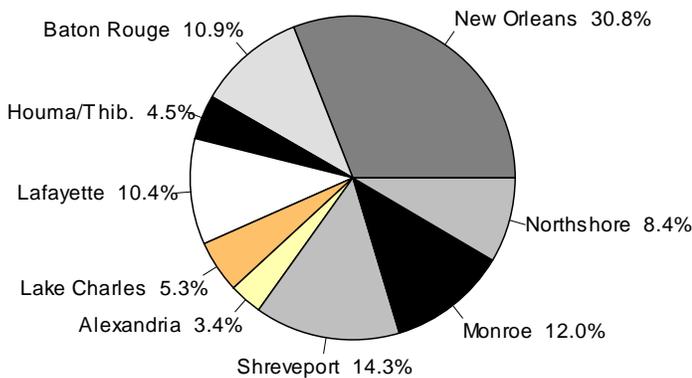
Rebecca Meriwether, MD MPH

Suzanne Kim, MPH

**Figure 1:** Tuberculosis rates in Louisiana and surrounding states, 1996-1999



**Figure 2:** Cases of tuberculosis by region, 1999  
n=357



formed. These susceptibility studies provide meaningful surveillance regarding the incidence of drug resistant disease and provide guidance in the establishment and maintenance of appropriate tuberculosis treatment regimens. The CDC defines multi-drug resistant (MDR) tuberculosis as those cases which exhibit resistance to at least Isoniazid and Rifampin. Although Louisiana reported one case of MDR in 1999, a total of 15 cases were identified with resistance to at least one anti-tuberculosis drug. Of those resistant cases, 7 (46%) were identified in the New Orleans region.

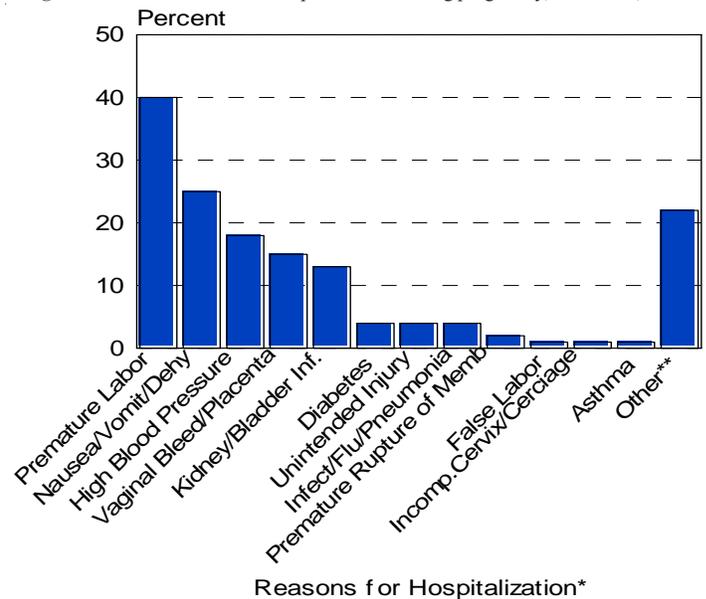
The Tuberculosis Control Program, provides diagnostic, treatment, and prevention services through regional chest clinics and parish health units. Services include provision of case management such as directly observed therapy for persons with disease, and epidemiologic investigations to determine the potential for transmission of tuberculosis in the community. Based on current epidemiologic data, the Tuberculosis Control Program recommends continuing an initial four-drug regimen in the treatment of tuberculosis statewide, and application of directly observed therapy where resources allow.

## Pregnancy-related Hospitalizations

Data on hospitalizations during pregnancy in Louisiana in 1998 indicate that twenty-four percent (24%) of women reported being hospitalized before delivery. Hospitalization during pregnancy is defined as at least one overnight stay in the hospital. The time that the mother went to the hospital to have her baby is not counted. Of those mothers who were hospitalized, 62% were hospitalized once, 20% twice, 9% three times, and 9% four or more times.

The Figure shows the reasons for these pregnancy-related hospitalizations. Among all maternal hospitalizations during pregnancy, premature labor (labor pains at least 3 weeks early) was reported the most (40%), followed by nausea, vomiting, and dehydration (25%), high blood pressure (18%), vaginal bleeding and placenta problems (15%), and kidney and bladder infections (13%). Other causes for hospitalizations with smaller incidence (1- 5%) included diabetes, unintended injury (car accidents, dog bites, and falls), infections/flu/pneumonia, premature rupture of the membranes (leaking bag, ruptured water bag or membranes), false labor (early contractions, and early dilations), incompetent cervix/ cerclage, and asthma.

**Figure:** Reasons for maternal hospitalization during pregnancy, Louisiana, 1998



\* Percents based on all hospitalizations. Multiple reasons could be given for hospitalizations.

\*\* The "other" category contained a large collection of unrelated causes of maternal hospitalizations, for example, abdomen pain, intentional injuries, and decreased fetal activity.

The Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS) is an on-going, population-based risk factor surveillance system that surveys women in Louisiana to determine behaviors and risks associated with pregnancy. Each month, approximately 200 women, who have given birth within Louisiana, are selected at random from birth certificate files. The sample size (Continue on next page)

of 2,421 mothers represents 3.7% of the 65,006 live births reported in the state in 1998.

The sample for the PRAMS Survey is drawn from two strata: rural or urban residence and categories of birth weight (normal birth weight and low birth weight  $\geq$  1500 grams and very low birth weight <1500 grams) as recorded on the birth certificate. All mothers that have delivered a very low birth weight baby are included in the sample.

LaPRAMS is a partnership between the Centers for Disease Control and Prevention (CDC) and the Louisiana Department of Health and Hospitals, Office of Public Health (OPH). The goal is to provide information needed to improve the health of mothers and babies and to reduce the number of infant deaths in Louisiana. Louisiana is one of over 20 states participating in PRAMS.

For further information contact Suzanne Kim at LaPRAMS, (504) 568-7729.

## Hepatitis B Vaccination for Adolescents

The FDA has approved an optional two-dose schedule of Recombivax HB (Merck & Co.) for vaccination of adolescents aged 11-15 years. The Advisory Committee on Immunization Practices

approved the optional two-dose schedule in October 1999. Using the two-dose schedule, the adult dose of Recombivax HB (1.0 mL dose containing 10  $\mu$ g of hepatitis B surface antigen [HbsAG]) is administered to adolescents aged 11-15 years, with the second dose given 4-6 months after the first dose. In immunogenicity studies among adolescents aged 11-15 years, antibody concentrations and end seroprotection rates were similar with the two-dose schedule (1.0 mL dose containing 10  $\mu$ g of HbsAg) and the currently licensed three-dose schedule (0.5mL dose containing 5  $\mu$ g of HbsAg).

The overall frequency of adverse events was similar for the two-dose schedule and the three-dose schedule. Short-term (2-year) follow-up data indicate that the rate of decline in antibody levels for the two-dose schedule was similar to that for the three-dose schedule. No data are available to assess long-term protection (beyond 2 years) or immune memory following vaccination with the two-dose schedule, and it is not known whether booster doses of vaccine will be required. As with other hepatitis B vaccination schedules, if administration of the two-dose schedule is interrupted it is not necessary to restart the series. Children and adolescents who have begun vaccination with a dose of 5  $\mu$ g of Recombivax HB should complete the three-dose series with this dose. If it is not clear which dose an adolescent was administered at the start of a series, the series should be completed with the three-dose schedule. *Source: MMWR, Vol. 49/No. 12.*

---

### CONFIDENTIAL DISEASE CASE REPORT

All diseases and conditions on the list of reportable diseases (see the back of this report) should be reported on an EPI-2430 card (below), or on other forms as stated. Please print out this form and forward reports by fax or mail to either the local parish health unit or to the Infectious Disease Epidemiology Section, Department of Health & Hospitals, Office of Public Health, P.O. Box 60630, New Orleans, LA 70160. The phone numbers are 504-568-5005 or 1-800-256-2748 or FAX 504-568-5006. All facsimile transmissions are considered part of the confidential disease case report, and as such, are not subject to disclosure. Xerox additional copies as needed. Your support in disease reporting will enhance disease surveillance activities.

DISEASE/CONDITION		DATE OF REPORT		DATE OF ONSET	
PATIENT'S NAME		RACE*	ETHNIC**	SEX	DATE OF BIRTH
ADDRESS	STREET NO. (R.F.D. If rural)			ZIP CODE	
	CITY		PARISH		
HEAD OF HOUSEHOLD			PHONE NO.		
DAY CARE CENTER ASSOCIATED: YES ___ NO ___			DATE		SPECIMEN TYPE
NAME OF DCC:					
LAB RESULTS					
COMMENTS:					
PHYSICIAN/HOSPITAL			PHONE NUMBER		

\*Wh = White, not of Hispanic origin, Bl = Black, Pac Is/Asi = Pacific islander or Asian, Am Ind/AI = American indian or Alaskan Native

\*\* Hisp/Non-Hispanic

EPI-2430

Revised 6/98

---

## HIV/AIDS Update

### Alcohol and Drug Use Among HIV + Persons

Injecting drug use accounts for the second highest percentage of AIDS cases diagnosed in the U.S. Non-injecting drug use has also been cited as a risk factor for HIV, due to the exchange of sex for drugs or money and other high-risk sexual behaviors that may result from the use of alcohol or drugs. As a result, alcohol and/or drug (AOD) use and HIV infection are now considered twin epidemics, often coexisting in the same individual. A survey was done of 303 HIV-infected persons at the HIV Outpatient Program in New Orleans to describe the psychosocial factors associated with AOD use.

The majority of respondents were male (64%), African-American (51%), and unemployed (67%). Twelve percent were homeless, 8% percent had been arrested or questioned by the police in the past 6 months, and 50% had associated with others who use drugs. Overall, 22 % of respondents reported using alcohol a few times a week or every day, 15% reported using marijuana a few times a week or every day and 9% reported currently using crack, cocaine, or heroin one or more times in the previous month. Logistic regression showed that associating with others who use drugs and hospitalization for a mental illness were associated with current AOD use (Table). Variables derived from the AIDS Risk Reduction Model that integrates elements of the Health Belief Model, efficacy theory, and social network theory, indicated that 14% of the sample admitted to having an AOD problem. Twenty-six percent of the AOD users reported that they had little social support to help them stop their AOD use. A disturbing finding was that 24% of the AOD users had actively sought help or treatment for their AOD problem and had not been able to find help. These patients differed significantly from the AOD users who could find help in that they were primarily black and 46% had been hospitalized for a mental illness.

This survey showed that drug use continues as a health problem among HIV-infected persons receiving medical care for their HIV infection, which increases the likelihood that they will transmit the infection to others. Health care providers treating HIV-infected patients should screen for substance use among their patients and assist patients in receiving appropriate substance abuse treatment and support services.

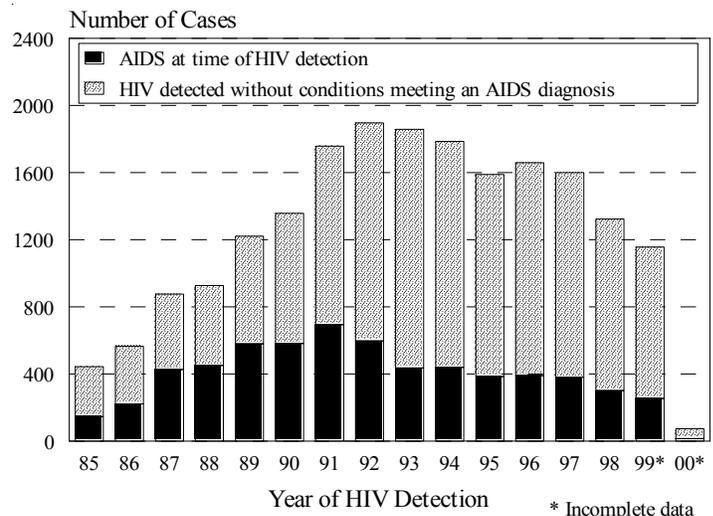
Table: Predictors of alcohol and/or other drug use among HIV-infected persons at the HIV Outpatient Program<sup>1</sup>

	Odds Ratio	95% CI
Age (Age $\geq$ 30 vs. Age <30)	1.48	(0.78, 4.90)
Sex (Male vs. Female)	0.90	(0.37, 2.16)
Race (White vs. Black)	2.01	(0.94, 4.31)
Previous AOD Treatment	1.92	(0.68, 5.42)
Associate with others who use drugs*	10.90	(5.10, 23.34)
Hospitalized for a mental illness*	4.51	(1.54, 13.33)

\* $p < .05$

<sup>1</sup> Current AOD use was defined as alcohol or marijuana use either a few times each week or every day in the past month or crack, cocaine, heroin or speedball one or more times in the past month.

### HIV/AIDS TRENDS



## HIV-AIDS Surveillance Epidemiologists in Louisiana

Region I: (New Orleans area)	Cheryl Wheeler, 504-568-7526, Fax 504-568-5760
MCLNO: (New Orleans)	James Hubbard, 504-568-5453, Fax 504-568-5760
Region II: (Baton Rouge area)	Danni Pecue, 225-925-4746, Fax 225-925-7245
Region III: (Houma/Thibodaux area)	vacant*
Region IV/V: (Lafayette/Lake Charles area)	Rosalie Ardoin, 337-262-5321, or Greg Gaines, 337-262-1398, Fax 337-262-5336, (both)
Region VI: ((Alexandria area)	vacant*
Region VII: (Shreveport area)	LaVerne Chance, 318-371-3320, (F) 318-371-3300
Region VIII: (Monroe area)	vacant*

For information or to report HIV or AIDS cases please contact the surveillance epidemiologist in your area.

\*In the meantime, contact Kelly McKinell, 504-568-5200, Fax 504-568-5760

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE  
January - February, 2000  
**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	Jan-Feb 2000	Jan-Feb 1999	Cum 2000	Cum 1999	% Chg
<b>Vaccine-preventable</b>														
<i>H. influenzae</i> (type B)	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	9	0	0	1	0	1	0	1	4	21	5	21	5	+320
Rate <sup>1</sup>	0.9	-	-	0.2	-	0.3	-	0.3	1	0.4	0.1	0.4	0.1	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	1	1	0	0	0	0	0	0	2	0	2	0	-
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	1	0	1	-
<b>Sexually-transmitted</b>														
HIV/AIDS Cases <sup>2</sup>	52	16	0	5	6	3	10	3	0	95	294	95	294	-68
Rate <sup>1</sup>	5.0	2.9	-	1.0	2.3	1.0	2.0	0.9	-	0.4	1.2	0.4	1.2	
Gonorrhea Cases	523	332	126	178	82	110	477	184	118	2130	2112	2130	2112	+0.9
Rate <sup>1</sup>	50.3	58.5	33.4	34.5	30.6	36.1	94.3	52.4	30.6	50.5	50.0	50.5	50.0	
Syphilis (P&S) Cases	4	4	4	15	2	2	0	2	3	36	36	36	36	-
Rate <sup>1</sup>	0.4	0.7	1.1	2.9	0.7	0.7	-	0.6	0.8	0.9	0.9	0.9	0.9	
<b>Enteric</b>														
Campylobacter	2	2	2	4	0	0	0	0	0	12	5	12	5	+140
Hepatitis A Cases	6	0	1	0	0	1	1	0	1	13	16	13	16	-18.8
Rate <sup>1</sup>	0.6	-	0.3	-	-	0.3	0.2	-	0.3	0.2	0.4	0.2	0.4	
Salmonella Cases	9	2	1	2	2	3	4	2	7	33	40	33	40	-17.5
Rate <sup>1</sup>	0.9	0.4	0.3	0.4	0.7	1	0.8	0.6	1.8	0.7	0.9	0.7	0.9	
Shigella Cases	8	5	0	3	0	5	1	4	1	27	14	27	14	+93
Rate <sup>1</sup>	0.8	0.9	-	0.6	-	1.6	0.2	1.1	0.3	0.6	0.3	0.6	0.3	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Vibrio, other	0	0	0	0	0	0	0	0	0	0	0	0	0	-
<b>Other</b>														
<i>H. influenzae</i> (other)	1	1	0	0	1	0	0	0	0	3	3	3	3	-
<i>N. Meningitidis</i>	4	0	4	2	1	1	3	0	1	16	0	16	0	-
Tuberculosis	0	3	3	7	0	2	2	0	2	19	41	19	41	-53.7

1 = Cases Per 100,000

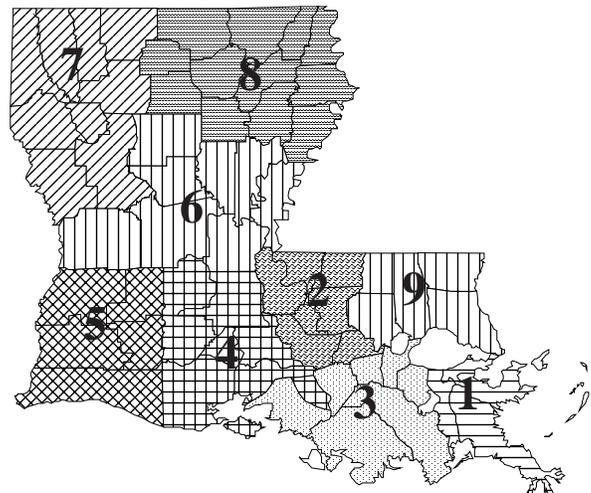
2 = These totals reflect cumulative totals of HIV+ and AIDS cases.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	1
E. coli O157:H7	0
Histoplasmosis	0
Lead Toxicity	0
Legionellosis	2
Lyme Disease	0
Malaria	1
Rocky Mountain Spotted Fever	0
Tetanus	0
Varicella	21

Table 3. Animal Rabies (January-February, 2000)

Parish	No. Cases	Species
Lincoln	1	Skunk
St. Landry	1	Skunk



## ANNUAL SUMMARY

### Vibrio Infections - 1998

Sixty-one cases of vibrio infections were reported in 1998, a 58% increase from 1997 (Figure 1). Sex-specific rates were over twice as high for males than females (1.9 vs 0.8 per 100,000, respectively; Figure 2). Age-specific rates were highest for those 65 years and older (3.5/100,000). The most frequently reported Vibrio serotypes were *V. vulnificus* (35%), *V. parahaemolyticus* (23%) and *V. cholerae*, Non-01 (21%; Table). Vibrio cases occurred most frequently between the months of May and September (Figure 3). Of the reported cases with known exposures (including multiple exposures), 40 cases (75%) were associated with shellfish consumption, while 29 (52%) cases had contact with saltwater or raw seafood drippings. Of the cases with reported underlying conditions, 38 (68%) cases had reported preexisting illnesses with the most frequent conditions being heart disease, diabetes, liver disease and alcoholism.

Figure 1: Cases of vibrio infection in Louisiana by year, 1989-1998

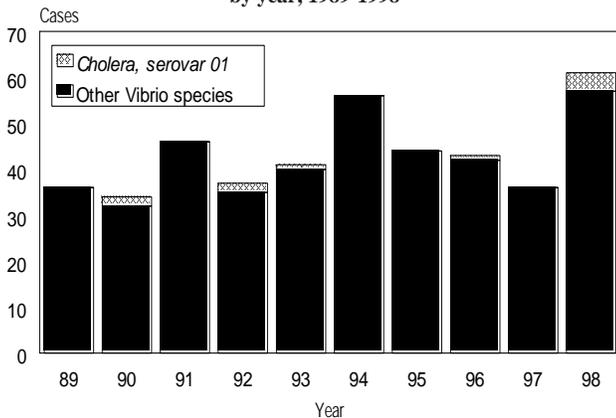
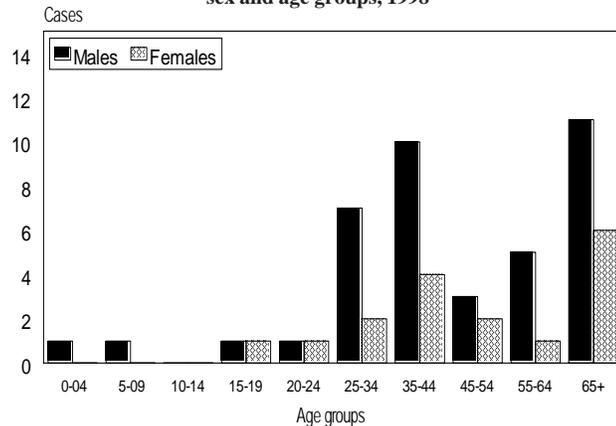


Figure 2: Cases of vibrio infection by sex and age groups, 1998



Twenty (35%) cases were associated with infections due to *V. vulnificus*. Fifty percent of *V. vulnificus* case-patients developed wound infections while 40% of case-patients developed septicemia. Two deaths were reported. Seven out of nine *V. vulnificus* cases reported raw oyster consumption prior to illness onset. Fifteen cases had reported underlying conditions with the most frequent reports of alcoholism, diabetes and liver disease.

Four cases of *V. Cholera 01* were reported and equally divided

between males and females. All cases were white. Two cases were associated with foreign travel while the other two cases were associated with seafood consumption. *Cholera-01* cases were reported from E. Baton Rouge, Lafayette and Rapides parishes. The majority of the other Vibrio cases occurred in the southeastern part of the state, including: Jefferson (11), Terrebonne (11), and Orleans (7).

Figure 3: Cases of vibrio infection by month of onset, 1998

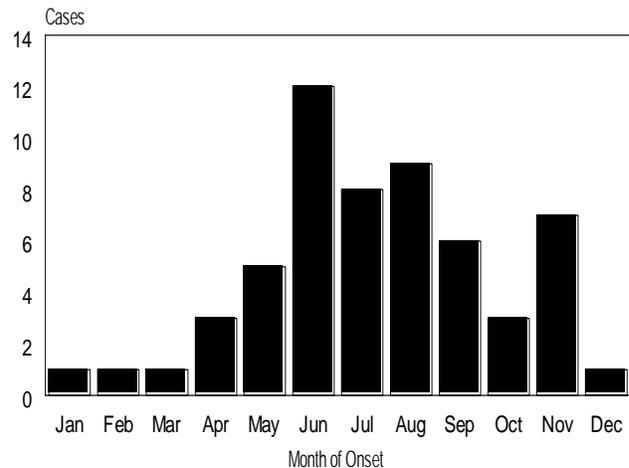


Table: Vibrio species by year, 1996-1998

Species	1996	1997	1998
<i>vulnificus</i>	13	8	20
<i>parahaemolyticus</i>	7	9	14
<i>cholera, Non-01</i>	11	5	12
<i>fluvialis</i>	1	5	4
<i>cholera, 01</i>	11	5	4
<i>mimicus</i>	5	8	3
<i>hollisae</i>	2	1	2
<i>damsela</i>	-	-	2
<i>alginolyticus</i>	1	1	1
TOTAL	42	37*	62*

\* Several cases with multiple serotypes.

#### Louisiana Fact

In the late 1800s The Louisiana State Board of Health began its gradual transformation into an administrative organization which increasingly carried on its program through parish units. By 1900 boards of health existed in 45 municipalities and 31 parishes. Local health officers of each parish health unit were obliged under Act No. 192 of 1898 and the 1899 sanitary code to submit monthly reports (vital statistics). More difficult and costly than providing for local boards of health was the instituting of full-time parish health units. In 1915 Calcasieu parish, through its police jury and school board, employed a full time district health officer in charge of rural sanitation. By 1921, six parishes appropriated sufficient money to commence a credible program. A common annual budget was \$10,000, and permitted employment of a full-time director, a public health nurse, a sanitary inspector, a clerical assistant, and carpenters on a part-time basis to construct sanitary privies. The remaining money was used for transportation and contingencies.

Source: *The Progressive Years* by Gordon E. Gillson.

# 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 <sup>3</sup>	Shigellosis	Severe traumatic head injury**
Botulism <sup>1</sup>	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Galactosemia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Hemophilia*
Chancroid <sup>2</sup>	Lymphogranuloma venereum <sup>2</sup>	Syphilis <sup>2</sup>	Lead Poisoning
Chlamydial infection <sup>2</sup>	Malaria	Tetanus	Phenylketonuria*
Cholera <sup>1</sup>	Measles (rubeola) <sup>1</sup>	Tuberculosis <sup>4</sup>	Reye's Syndrome
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 <sup>4</sup>	Vibrio infections (excluding cholera) <sup>1</sup>	Spinal cord injury**
Escherichia coli 0157:H7 infection	Neisseria meningitidis infection <sup>1</sup>		Sudden infant death syndrome (SIDS)
Gonorrhea <sup>2</sup>	Pertussis		
Haemophilus influenzae infection <sup>1</sup>	Rabies (animal & man)		
Hemolytic-Uremic Syndrome	Rocky Mountain Spotted Fever (RMSF)		

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, phone reports, or electronic transmission.

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

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

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

<sup>4</sup> Report on CDC 72.5 (f. 5.2431) card.

All reportable diseases and conditions other than the venereal diseases, tuberculosis and those conditions with \*'s should be reported on an EPI-2430 card and forwarded to the local parish health unit or the Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160, Phone: 504-568-5005 or 1-800-256-2748 or FAX: 504-568-5006.

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

\*\* Report on DDP-3 form; preliminary phone report from ER encouraged (504-568-2509). Information contained in reports required under this section shall remain confidential in accordance with the law.

## Numbers for reporting communicable diseases

**1-800-256-2748**

**Local # 568-5005**

**FAX # 504-568-5006**

This public health document was published at a total cost of . Seven thousand copies of this public document were published in this first printing at a cost of . The total cost of all printings of this document, including reprints is . This document was published by to inform physicians, hospitals, and the public of current Louisiana morbidity status under authority of R.S. 40:36. This material was printed in accordance with the standards for printing for state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with the provisions of Title 43 of Louisiana Revised Statutes.

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

**BULK RATE  
U.S. POSTAGE  
PAID  
Baton Rouge, LA  
Permit No. 1032**