



MONTHLY MORBIDITY REPORT

Provisional Statistics

FROM THE

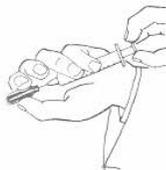
OFFICE OF PUBLIC HEALTH STATISTICS

Reported Morbidity
May, 1976

On June 10, 1976, an Ad Hoc Committee of the Louisiana State Medical Society recommended endorsement of the Division of Health plans for a statewide "swine influenza" vaccination program. The committee recommended that local medical societies participate in the planning of local programs, and that volunteer physicians provide coverage for mass immunization clinics.

All physicians, clinics, hospitals, etc. should immediately start evaluating their needs. Two "swine" vaccines will be available - a monovalent "swine" antigen product for the general public and a bivalent "swine" and A/Victoria product for the medical-at-risk population. These vaccines will be issued by parish health units only. Procedures for obtaining the vaccine will be issued as soon as all guidelines are finalized.

THE "SWINE FLU" IMMUNIZATION PROGRAM GENERAL INFORMATION



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HOW DO YOU IMMUNIZE 213 MILLION AMERICANS?

The goal is to immunize the elderly and the chronically ill beginning in late July and the general population, September through November 30. Obviously, a program of this scope and intensity will require a major effort by both public and private sectors. The Federal government will provide purchasing power, technical leadership, and coordination through the Center

for Disease Control (CDC). State health agencies will be counted on for their experience in conducting systematic immunization programs; and the private health care sector for its extensive medical and other health-related resources. The strategy is to use mass immunization techniques where appropriate, but also delivery points already in place, such as physicians' offices, public health clinics, community health centers, hospitals, and industrial clinics.

TWO VACCINES

Two types of killed-virus vaccine are being made by four FDA licensed manufacturers. One is monovalent vaccine intended for use for the general population. The other is a bivalent vaccine for persons 65 years and older and those with a chronic, debilitating illness. Both vaccines will be available only through local health units.

The monovalent vaccine contains antigens from influenza A/New Jersey, a swine-like influenza strain which caused an outbreak at Fort Dix, New Jersey in February, 1976. The bivalent vaccine contains antigens from influenza A/New Jersey plus influenza A/Victoria, the prevalent strain in the winter and spring of 1975-76. The bivalent vaccine is being produced so that persons at the greatest risk of death from any kind of influenza can receive protection not only against influenza A/New Jersey, (the swine flu) but also against influenza A/Victoria, the strain which caused most illnesses in 1976.

GREATEST RISK GROUP

Persons who have an illness which makes them unusually susceptible to stress on the cardiac, pulmonary, or immune systems are at greatest risk of death from influenza and its complications. These persons should receive the bivalent vaccine. Recognizing that the severity of the illness or condition is directly related to the risk of complications (i.e., a person with a mild scoliosis has no increased risk as opposed to the person with severe kyphoscoliosis who may be at significant risk) we offer a list of conditions which we feel increase the risk of death due to influenza and its complications. The list is not exhaustive. The results of special vaccine trials currently in progress and the availability of vaccine may require revision in the list.

1. Persons with congenital or rheumatic heart disease, especially those with mitral stenosis.
2. Persons with frank or incipient congestive heart failure due to any cause (coronary artery disease, myocardopathy, etc.)
3. Persons with significant pulmonary

abnormalities, for example:

- a. emphysema
 - b. chronic bronchitis
 - c. asthma
 - d. bronchiectasis
 - e. tuberculosis
 - f. cystic fibrosis
 - g. quadraplegia
 - h. amyotrophic lateral sclerosis
 - i. myasthenia gravis
 - j. severe kyphoscoliosis
4. Persons with miscellaneous compromising illnesses or conditions such as:
 - a. diabetes
 - b. Addison's disease
 - c. multiple sclerosis
 - d. chronic renal failure
 - e. chronic liver failure
 5. Persons receiving steroids or anti-metabolic drugs.
 6. All persons 65 years or older.

PREGNANCY AND CANCER NOT HIGH RISK

Many chronic illnesses are not associated with an increased risk of influenza and its complications. For example, persons with hypertension or peptic ulcer disease do not seem to be at increased risk of death and should receive the monovalent rather than the bivalent vaccine. Although pregnancy has been considered a high risk condition in the past,¹ more recent studies have not shown any increased maternal mortality during influenza epidemics.² Therefore, the Public Health Service Advisory Committee on Immunization Practices stated in 1975 that "Pregnancy is not an indication for or against influenza vaccination."³ Presumably, this recommendation will be altered to suggest that pregnant women should receive the monovalent vaccine with the general population in 1976.

Recent studies have found persons with cancer (all types considered together) to be at no increased risk of death⁴ and at a small but significant increased risk of death during epidemics of influenza A.² At the present time we recommend persons with cancer receive the bivalent vaccine only if they fulfill one of the above criteria. All other persons with cancer should receive the monovalent vaccine.

2,000 CHILDREN TESTED

The recommendations concerning the use of the swine-influenza vaccine in children will depend on the results of the vaccine trials now underway. A decision on the minimum age and other recommendations for mass immunization of children is expected in late June.

The testing of 2,000 children 3 to 11 years of age with reduced-strength doses began in May at a dozen medical centers throughout the United States. Reports from the first tests on 155 adult volunteers in Washington, D.C. showed no serious side effects associated with the vaccine and no work-loss time. The largest group testing began May 3 in Atlanta with 1,000 volunteers including some CDC staff members.

THREE DOSAGE LEVELS

During clinical tests, three dosage levels of the vaccine are being tested. Vaccines will contain either 200, 400, or 800 CCA (Chick Cell Agglutination) units of the vaccine. Some volunteers received a placebo rather than the vaccine. The study will be doubleblind in that neither the volunteer nor the doctor administering the inoculation will know the preparation given to any individual. After clinical trials have been completed and antibody tests performed, results with each vaccine dosage will be determined. After analyzing these results plus data from other clinical trials, FDA will determine the correct dosage for use in the national immunization program.

PURPOSE OF TRIALS

The purpose of clinical trials is to determine the minimum effective dose and to gauge the anticipated adverse effects of the vaccines before they are made available to the public. Small amounts of blood are drawn from volunteers before they are inoculated. Blood samples will again be taken three to four weeks later to measure the antibodies in the blood. These antibodies indicate the extent of immunity and provide the information needed to determine the minimum effective dose.

The volunteers will be observed for 48 hours

after inoculation to determine the extent of side effects. Side effects used to be a major problem with the flu vaccine. However, over the decade new techniques have been developed that allow for a more potent and purier product. Recent vaccines have not caused a large incidence of reactions; about 1 percent of people inoculated run temperatures over 100°F and in 20 to 40 percent there is swelling, redness, and tenderness in the arm. These reactions are rarely severe. Moreover, the flu vaccine contains a dead virus. The vaccine stimulates the production of antibodies in the person without reproducing the flu itself. Thus, no one will get the flu from taking the vaccine.

EFFECTIVENESS OF VACCINE

Vaccines against the flu generally are 70 to 90 percent effective. The degree of effectiveness depends to a large extent on how closely the virus used to make the vaccine matches the virus that causes the illness in the fall or winter. At this point no one can predict with certainty how effective this vaccine will be.

REFERENCES

1. Eickhoff, T.C. et al.: Observations on excess mortality associated with epidemic influenza. *Journal of the American Medical Association* 176:104-110, 1961.
2. Housworth, J. and Langmuir, A.D.: Excess mortality from epidemic influenza, 1957-1966. *American Journal of Epidemiology* 100:40-48, 1974.
3. Center for Disease Control: Recommendations of the Public Health Service Advisory Committee on Immunization Practices. *Morbidity and Mortality Weekly Report*, 24:197, 1975.
4. Regot, E. et al.: Daily variation in USA mortality. *American Journal of Epidemiology* 103:198-211, 1976.
5. Center for Disease Control: Fact sheet on swine influenza.

TYPHOID FEVER OUTBREAK IN NATCHITOCHES PARISH

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On January 5, 1976, the Natchitoches Parish Health Unit was notified by the Infectious Disease Control Unit at Confederate Memorial Medical Center (CMMC) in Shreveport of three Natchitoches residents with typhoid fever. All had become ill on December 21, 1975 and, after initial examinations by local physicians, had been referred to the CMMC for further evaluation and treatment.

One patient, a 30-year-old male, was hospitalized due to a syncopal episode oc-

curing one week following the onset of bloody stools and abdominal pains. The second patient, a 13-month-old female, was seen at CMMC because of fever and diarrhea for 10 days. The third patient, a 4-year-old male, was referred to CMMC because of fever, diarrhea, vomiting, and lymphadenopathy for 10 days. All three had positive stool cultures for *Salmonella typhi*, phage type D-1.

These cases were all related. Two were of the same household and the third is a fre-

quent visitor. The two children are cousins and the 30-year-old is their uncle. Stool specimens were obtained from all household members and from contacts outside the household. A total of 24 people were cultured. Appraisals of homesites of all persons involved were made. It was found that the drinking water used by all three cases came from a cistern. Cultures taken from this cistern at the time of the investigation were negative for salmonella.

Stool cultures from one asymptomatic contact, the grandmother of the two ill children, grew *Salmonella typhi*, phage type D-1. This woman had recently come to live with the children;

the woman claims that 16 years earlier she had typhoid fever.

EDITORIAL NOTE:

This outbreak again emphasizes that (1) typhoid fever persists despite adequate sanitation because of the carrier state, (2) diagnosis is made by culturing (i.e. diagnosis is not made by febrile agglutination testing), and (3) public health efforts are aimed at locating the carrier and then subsequent surveillance of cases, carrier, and their environment for potential problems.

RECOMMENDATIONS FOR HEALTH DEPARTMENT SUPERVISION OF TUBERCULOSIS PATIENTS

Tuberculosis patients who complete adequate chemotherapy should be considered cured. They have no need for routine lifetime periodic recall for X-ray or examination. Indeed, perpetuating lifetime follow-up of such treated patients diverts clinic personnel and resources from the crucial task of providing services for those who really need them.

Highest priority should be given to prompt and thorough treatment for newly diagnosed patients with tuberculosis. Medical supervision is most important during the early months of outpatient chemotherapy whether treatment begins at home or with a brief period of hospitalization. Patients known to have had tuberculosis without chemotherapy, who are still being followed, should receive preventive treatment. Contacts of patients with newly diagnosed tuberculosis and other high-risk infected persons should be sought and should receive preventive treatment.

Persons who have responded well to treatment and have completed the recommended course of therapy should be told to expect their recovery to be permanent. The diagnosis of treated tuberculosis becomes part of their medical history. These persons should be discharged with instructions not to return unless they develop

symptoms that could be caused by tuberculosis, such as cough of longer than 2 weeks' duration, significant weight loss, persistent fever or prolonged respiratory infection. Persons who have completed preventive therapy should also be discharged with similar instructions to return if they develop symptoms.

If a patient has not responded well to drugs or has had an irregular course of treatment, efforts should be made to complete adequate therapy. Special treatment programs such as directly administered ambulatory therapy, should be considered for such patients. Continuing periodic chest roentgenograms and bacteriologic examinations should be considered only for persons in whom all attempts at therapy have failed. If such persons are in occupations where infectiousness may have serious consequences (such as some school and hospital personnel) they should be examined more than once a year or, if feasible, transferred to areas where there are minimal consequences to contacts if the person becomes infectious.

These recommendations are summarized in table 1.
(Reported by the Tuberculosis Control Division, Bureau of State Services, CDC, MMWR 23:8, Feb. 23, 1974)

**Table 1
RECOMMENDATIONS FOR SUPERVISION OF PATIENTS WITH TUBERCULOSIS INFECTION OR DISEASE**

	Recommended Action *		
	Treat	Discharge	Follow
Currently Being Treated	I		
Previous Treatment Incomplete	I		II
Never Treated	I		II
Treatment Completed		I	

* I = Preferred choice

II = Secondary choice

SELECTED REPORTABLE DISEASES

(By Place of Residence)

STATE AND PARISH TOTALS	ASEPTIC MENINGITIS	DIPHTHERIA	ENCEPHALITIS	ENCEPHALITIS POST INFECTION	HEPATITIS A AND UNSPECIFIED	HEPATITIS B	TUBERCULOSIS, PULMONARY	MENINGOCOCCAL INFECTIONS	PERTUSSIS	RABIES IN ANIMALS	RUBELLA*	SEVERE UNDERNUTRITION	SHIGELLOSIS	TYPHOID FEVER	OTHER SALMONELLOSIS	TETANUS	MEASLES	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY
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TOTAL TO DATE 19 75	45	0	10	8	222	82	224	22	14	2	243	9	63	1	54	3	0	9163	215
TOTAL TO DATE 19 76	24	0	5	3	191	54	245	20	1	0	84	7	28	0	34	1	154	7570	242
TOTAL THIS MONTH	7	0	0	0	38	12	61	3	0	0	12	0	10	0	7	0	43	1165	51
ACADIA						1	1											10	
ALLEN																		3	1
ASCENSION																	2	4	
ASSUMPTION																		6	
AVOUELLES																		8	
BEAUREGARD																		7	
BIENVILLE																		2	
BOSSIER																		15	1
CADDO					4	1	7											154	
CALCASIEU						1					1							82	
CALDWELL																			
CAMERON					1														
CATAHOULA																		1	
CLAIBORNE																		6	
CONCORDIA																		2	
DESOTO							1											8	
EAST BATON ROUGE						1	6							1				68	5
EAST CARROLL																		5	
EAST FELICIANA																		1	
EVANGELINE					1														
FRANKLIN																		2	
GRANT							1											3	
IBERIA																		15	
IBERVILLE					1								1	1				10	
JACKSON																		1	
JEFFERSON	1				4	1	3				8		1			22		49	5
JEFFERSON DAVIS					2													5	
LAFAYETTE							1											42	1
LAFOURCHE								1										3	2
LASALLE																			
LINCOLN					1													37	
LIVINGSTON																		3	
MADISON					1													1	
MOREHOUSE																		19	
NATCHITOCHE																		19	
ORLEANS	5				19	6	22	2			3		8	3		17		186	18
OUACHITA							2											59	6
PLAQUEMINES																		3	
POINTE COUPEE																		1	
RAPIDES							2											60	
RED RIVER																			
RICHLAND																		12	
SABINE							2											11	
ST. BERNARD																		1	
ST. CHARLES														1		2		3	
ST. HELENA																		2	
ST. JAMES							1											2	
ST. JOHN																		2	
ST. LANDRY								3										44	
ST. MARTIN					1													13	
ST. MARY	1						1											2	1
ST. TAMMANY							1											25	2
TANGIPAHOA							4											26	2
TENSAS																			
TERREBONNE					1													3	1
UNION																		11	
VERMILION						1												2	
VERNON																		34	3
WASHINGTON																		20	
WEBSTER							2								1			21	
WEST BATON ROUGE							1											5	
WEST CARROLL																		2	2
WEST FELICIANA					2													18	1
WINN																		6	
OUT OF STATE																			

* Includes Rubella, Congenital Syndrome

From January 1 through May 31, the following cases were also reported: 4-Brucellosis; 1-Leptospirosis