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MONTHLY MORBIDITY REPORT
EPIDEMIOLOGY
PUBLIC HEALTH STATISTICS

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF PREVENTIVE AND PUBLIC HEALTH SERVICES
DIVISION OF RECORDS AND STATISTICS
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PENICILLINASE PRODUCING NEISSERIA GONORRHOEAE (PPNG) OUTBREAK IN LOUISIANA

An outbreak of PPNG in south Louisiana has steadily grown more serious with each passing week in 1986. In the most recent week, July 14 through July 20, there were 12 cases reported to the Venereal Disease Control Section in the Office of Preventive and Public Health Services (OPPHS). There have been 148 cases of resistant gonorrhea since the beginning of 1986 compared to only 24 cases in all of 1985, a six fold increase. Among the 148 cases, 122 have been penicillinase producing, 15 were identified as chromosomally mediated resistant, and 11 were tetracycline resistant. During the first three months of the year 44 cases were reported. From April 1 through July 20, there have been 104 cases reported; 27 of these 104 were since July 1. The New Orleans area has accounted for 93 (63%) of the 1986 cases and in the Baton Rouge area 23 (16%) cases have been identified. Isolated cases have been reported in other areas of the state, but sustained pockets of resistant gonorrhea infections have not been identified in these locations.

Containment efforts have taken a three pronged approach:

1. The state health department laboratory is currently testing all positive cultures for resistant gonorrhea strains.
2. The OPPHS sexually transmitted disease clinics in New Orleans and Baton Rouge are treating all gonorrhea cases or suspected cases with a treatment regimen effective for PPNG, either spectinomycin or ceftriaxone. Practitioners are encouraged to use one of these drugs in treating gonorrhea or suspected gonorrhea cases until the epidemic subsides. Spectinomycin (Trobicin) is usually given as a single intramuscular 2 gm dose in the gluteus muscle. Ceftriaxone (Rocephin) is also given as a single dose, 250 mg in the deltoid muscle.
3. Comprehensive disease intervention activities (i.e. in-depth interview and contact tracing, culture testing in high risk groups, and tests for cure after therapy for infected patients) are the top priority for the control effort by the VD Control Section of OPPHS.

All laboratories, private as well as public, are encouraged to routinely test all positive gonorrhea specimens for resistant gonorrhea strains and report positive findings to the VD Control Section on the "Report of Positive Test for Venereal Disease (form No. VD-17)" or preferably by calling results directly to (504) 568-5275.

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Physicians treating a resistant gonorrhea case are encouraged to call the above number to report the case and to request disease intervention assistance. Prompt identification and treatment with spectinomycin or ceftriaxone of all contacts of patients with proven penicillin resistant gonococcal infections is of critical importance in controlling this epidemic. Treatment of contacts should be done at the time of the initial evaluaton rather than waiting for culture results. All sexually transmitted diseases should be reported either by telephoning (504) 568-5275 or by using the "Confidential Report of Sexually Transmitted Disease", form No. STD-43 (Rev. 12/84).

Containment of the outbreak of resistant gonorrhea in the state will require a concerted effort by all medical and health providers. Medical assistance and advice for managing STD cases is available by telephoning Dr. David Martin, VD Control Section Medical Consultant at (504) 568-5030 and for disease intervention assistance by calling (504) 568-5275.

✱Recommended Infection-Control Practices for Dentistry

Dental personnel may be exposed to a wide variety of microorganisms in the blood and saliva of patients they treat in the dental operatory. These include *Mycobacterium tuberculosis*, hepatitis B virus, staphylococci, streptococci, cytomegalovirus, herpes simplex virus types I and II, human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), and a number of viruses that infect the upper respiratory tract. Infections may be transmitted in dental practice by blood or saliva through direct contact, droplets, or aerosols. Although not documented, indirect contact transmission of infection by contaminated instruments is possible. Patients and dental health-care workers (DHCWs) have the potential of transmitting infections to each other (*1*).

A common set of infection-control strategies should be effective for preventing hepatitis B, acquired immunodeficiency syndrome, and other infectious diseases caused by bloodborne viruses (*2-4*). The ability of hepatitis B virus to survive in the environment (*5*) and the high titers of virus in blood (*6*) make this virus a good model for infection-control practices to prevent transmission of a large number of other infectious agents by blood or saliva. Because all infected patients cannot be identified by history, physical examination, or readily available laboratory tests (*3*), the following recommendations should be used routinely in the care of all patients in dental practices.

MEDICAL HISTORY

Always obtain a thorough medical history. Include specific questions about medications, current illnesses, hepatitis, recurrent illnesses, unintentional weight loss, lymphadenopathy, oral soft tissue lesions, or other infections. Medical consultation may be indicated when a history of active infection or systemic disease is elicited.

USE OF PROTECTIVE ATTIRE AND BARRIER TECHNIQUES

1. For protection of personnel and patients, gloves must always be worn when touching blood, saliva, or mucous membranes (*7-10*). Gloves must be worn by DHCWs when touching blood-soiled items, body fluids, or secretions, as well as surfaces contaminated with them. Gloves must be worn when examining all oral lesions. All work must be completed on one patient, where possible, and the hands must be washed and regloved before performing procedures on another patient. Repeated use of a single pair of gloves is not recommended, since such use is likely to produce defects in the glove material, which will diminish its value as an effective barrier.

2. Surgical masks and protective eyewear or chin-length plastic face shields must be worn when splashing or spattering of blood or other body fluids is likely, as is common in dentistry (*11,12*).

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✱ Reprint from MMWR, Centers for Disease Control, April 18, 1986, Vol. 35, No. 15, pp 237-242

3. Reusable or disposable gowns, laboratory coats, or uniforms must be worn when clothing is likely to be soiled with blood or other body fluids. If reusable gowns are worn, they may be washed, using a normal laundry cycle. Gowns should be changed at least daily or when visibly soiled with blood (*13*).

4. Impervious-backed paper, aluminum foil, or clear plastic wrap may be used to cover surfaces (e.g., light handles or x-ray unit heads) that may be contaminated by blood or saliva and that are difficult or impossible to disinfect. The coverings should be removed (while DHCWs are gloved), discarded, and then replaced (after ungloving) with clean material between patients.

5. All procedures and manipulations of potentially infective materials should be performed carefully to minimize the formation of droplets, spatters, and aerosols, where possible. Use of rubber dams, where appropriate, high-speed evacuation, and proper patient positioning should facilitate this process.

HANDWASHING AND CARE OF HANDS

Hands must always be washed between patient treatment contacts (following removal of gloves), after touching inanimate objects likely to be contaminated by blood or saliva from other patients, and before leaving the operatory. The rationale for handwashing after gloves have been worn is that gloves become perforated, knowingly or unknowingly, during use and allow bacteria to enter beneath the glove material and multiply rapidly. For many routine dental procedures, such as examinations and nonsurgical techniques, handwashing with plain soap appears to be adequate, since soap and water will remove transient microorganisms acquired directly or indirectly from patient contact (*13*). For surgical procedures, an antimicrobial surgical handscrub should be used (*14*). Extraordinary care must be used to avoid hand injuries during procedures. However, when gloves are torn, cut, or punctured, they must be removed immediately, hands thoroughly washed, and regloving accomplished before completion of the dental procedure. DHCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling dental patient-care equipment until the condition resolves (*15*).

USE AND CARE OF SHARP INSTRUMENTS AND NEEDLES

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and must be handled with extraordinary care to prevent unintentional injuries.

2. Disposable syringes and needles, scalpel blades, and other sharp items must be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, disposable needles should not be recapped; purposefully bent or broken; removed from disposable syringes; or otherwise manipulated by hand after use.

3. Recapping of a needle increases the risk of unintentional needlestick injury. There is no evidence to suggest that reusable aspirating-type syringes used in dentistry should be handled differently from other syringes. Needles of these devices should not be recapped, bent, or broken before disposal.

4. Because certain dental procedures on an individual patient may require multiple injections of anesthetic or other medications from a single syringe, it would be more prudent to place the unsheathed needle into a "sterile field" between injections rather than to recap the needle between injections. A new (sterile) syringe and a fresh solution should be used for each patient.

INDICATIONS FOR HIGH-LEVEL DISINFECTION OR STERILIZATION OF INSTRUMENTS

Surgical and other instruments that normally penetrate soft tissue and/or bone (e.g., forceps, scalpels, bone chisels, scalers, and surgical burs) should be sterilized after each use. Instruments that are not intended to penetrate oral soft tissues or bone (e.g., amalgam condensers, plastic instruments, and burs) but that may come into contact with oral tissues should also be sterilized after each use, if possible; however, if sterilization is not feasible, the latter instruments should receive high-level disinfection (*3,13,16*).

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METHODS FOR HIGH-LEVEL DISINFECTION OR STERILIZATION

Before high-level disinfection or sterilization, instruments should be cleaned to remove debris. Cleaning may be accomplished by a thorough scrubbing with soap and water or a detergent, or by using a mechanical device (e.g., an ultrasonic cleaner). Persons involved in cleaning and decontaminating instruments should wear heavy-duty rubber gloves to prevent hand injuries. Metal and heat-stable dental instruments should be routinely sterilized between use by steam under pressure (autoclaving), dry heat, or chemical vapor. The adequacy of sterilization cycles should be verified by the periodic use of spore-testing devices (e.g., weekly for most dental practices) (*13*). Heat- and steam-sensitive chemical indicators may be used on the outside of each pack to assure it has been exposed to a sterilizing cycle. Heat-sensitive instruments may require up to 10 hours' exposure in a liquid chemical agent registered by the U.S. Environmental Protection Agency (EPA) as a disinfectant/sterilant; this should be followed by rinsing with sterile water. High-level disinfection may be accomplished by immersion in either boiling water for at least 10 minutes or an EPA-registered disinfectant/sterilant chemical for the exposure time recommended by the chemical's manufacturer.

DECONTAMINATION OF ENVIRONMENTAL SURFACES

At the completion of work activities, countertops and surfaces that may have become contaminated with blood or saliva should be wiped with absorbent toweling to remove extraneous organic material, then disinfected with a suitable chemical germicide. A solution of sodium hypochlorite (household bleach) prepared fresh daily is an inexpensive and very effective germicide. Concentrations ranging from 5,000 ppm (a 1:10 dilution of household bleach) to 500 ppm (a 1:100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucus, etc.) present on the surface to be cleaned and disinfected. Caution should be exercised, since sodium hypochlorite is corrosive to metals, especially aluminum.

DECONTAMINATION OF LABORATORY SUPPLIES AND MATERIALS

Blood and saliva should be thoroughly and carefully cleaned from laboratory supplies and materials that have been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Materials, impressions, and intra-oral appliances should be cleaned and disinfected before being handled, adjusted, or sent to a dental laboratory (*17*). These items should also be cleaned and disinfected when returned from the dental laboratory and before placement in the patient's mouth. *Because of the ever-increasing variety of dental materials used intra-orally, DHCWs are advised to consult with manufacturers as to the stability of specific materials relative to disinfection procedures.* A chemical germicide that is registered with the EPA as a "hospital disinfectant" and that has a label claim for mycobactericidal (e.g., tuberculocidal) activity is preferred, because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens (*15*). Communication between a dental office and a dental laboratory with regard to handling and decontamination of supplies and materials is of the utmost importance.

USE AND CARE OF ULTRASONIC SCALERS, HANDPIECES, AND DENTAL UNITS

1. Routine sterilization of handpieces between patients is desirable; however, not all handpieces can be sterilized. The present physical configurations of most handpieces do not readily lend them to high-level disinfection of both external and internal surfaces (see 2 below); therefore, when using handpieces that cannot be sterilized, the following cleaning and disinfection procedures should be completed between each patient: After use, the handpiece should be flushed (see 2 below), then thoroughly scrubbed with a detergent and water to remove adherent material. It should then be thoroughly wiped with absorbent material saturated with a chemical germicide that is registered with the EPA as a "hospital disinfectant" and is mycobactericidal at use-dilution (*15*). The disinfecting solution should remain in contact with the handpiece for a time specified by the disinfectant's manufacturer. Ultrasonic scalers and air/water syringes should be treated in a similar manner between patients. Following disinfection, any chemical residue should be removed by rinsing with sterile water.

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2. Because water retraction valves within the dental units may aspirate infective materials back into the handpiece and water line, check valves should be installed to reduce the risk of transfer of infective material (*18*). While the magnitude of this risk is not known, it is prudent for water-cooled handpieces to be run and to discharge water into a sink or container for 20-30 seconds after completing care on each patient. This is intended to physically flush out patient material that may have been aspirated into the handpiece or water line. Additionally, there is some evidence that overnight bacterial accumulation can be significantly reduced by allowing water-cooled handpieces to run and to discharge water into a sink or container for several minutes at the beginning of the clinic day (*19*). Sterile saline or sterile water should be used as a coolant/irrigator when performing surgical procedures involving the cutting of soft tissue or bone.

HANDLING OF BIOPSY SPECIMENS

In general, each specimen should be put in a sturdy container with a secure lid to prevent leaking during transport. Care should be taken when collecting specimens to avoid contamination of the outside of the container. If the outside of the container is visibly contaminated, it should be cleaned and disinfected, or placed in an impervious bag (*20*).

DISPOSAL OF WASTE MATERIALS

All sharp items (especially needles), tissues, or blood should be considered potentially infective and should be handled and disposed of with special precautions. Disposable needles, scalpels, or other sharp items should be placed intact into puncture-resistant containers before disposal. Blood, suctioned fluids, or other liquid waste may be carefully poured into a drain connected to a sanitary sewer system. Other solid waste contaminated with blood or other body fluids should be placed in sealed, sturdy impervious bags to prevent leakage of the contained items. Such contained solid wastes can then be disposed of according to requirements established by local or state environmental regulatory agencies and published recommendations (*13,20*).

Developed by Dental Disease Prevention Activity, Center for Prevention Svcs, Hospital Infections Program, Center for Infectious Diseases, CDC.

Editorial Note: All DHCWs must be made aware of sources and methods of transmission of infectious diseases. The above recommendations for infection control in dental practices incorporate procedures that should be effective in preventing the transmission of infectious agents from dental patients to DHCWs and vice versa. Assessment of quantifiable risks to dental personnel and patients for specific diseases requires further research. There is no current documentation of patient-to-patient blood- or saliva-borne disease transmission from procedures performed in dental practice. While few in number, reported outbreaks of dentist-to-patient transmission of hepatitis B have resulted in serious and even fatal consequences (*9*). Herpes simplex virus has been transmitted to over 20 patients from the fingers of a DHCW (*10*). Serologic markers for hepatitis B in dentists have increased dramatically in the United States over the past several years, which suggests current infection-control practices have been insufficient to prevent the transmission of this infectious agent in the dental operatory. While vaccination for hepatitis B is strongly recommended for dental personnel (*21*), vaccination alone is not cause for relaxation of strict adherence to accepted methods of asepsis, disinfection, and sterilization.

Various infection-control guidelines exist for hospitals and other clinical settings. Dental facilities located in hospitals and other institutional settings have generally utilized existing guidelines for institutional practice. These recommendations are offered as guidance to DHCWs in noninstitutional settings for enhancing infection-control practices in dentistry; they may be useful in institutional settings also.

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LOUISIANA AIDS UPDATE

	CASES	DEATHS	PERCENT
JAN - JUNE, 1986	57	18	32
TOTAL, ALL YEARS (as of 6/30/86)	262	171	65

LOUISIANA'S AIDS EDUCATION AND RISK REDUCTION PROGRAM

Department of Health and Human Resources's Office of Preventive and Public Health Services will receive $296,000 in assistance for its AIDS Education and Risk Reduction Program during the first year of a new cooperative agreement with the United States Public Health Service's Centers for Disease Control. During this time of sharp budget cuts in our state's public service programs, this will provide us with urgently needed resources to support appropriate public health responses to the AIDS epidemic.

Up to the end of 1984, there had been 98 cases of AIDS diagnosed in Louisiana. During 1985, another 107 cases were seen, for a total of 205 cases. By the end of 1986, we expect to reach a total of 400 cases, and by the end of 1987, between 700 and 800 cases. Depending on how the epidemic develops, we could see between 1,500 and 2,400 cases by the end of 1989. There is every indication that this deadly disease will be with us for a long time; it is urgent that we utilize all available means to limit spread of the human immunodeficiency virus (HIV) that causes AIDS. There is also a great need for appropriate education regarding AIDS and HIV infection, in order to allay unwarranted fears, reduce inappropriate responses, and promote appropriate responses to the AIDS/HIV epidemic.

With the routine testing of all donor blood, the risk of virus transmission by transfusion has been largely eliminated. All other methods for control of transmission depend on reducing the occurrence of high risk behaviors. The goals of the AIDS Education and Risk Reduction Program are to make appropriate AIDS education, risk reduction counselling, and antibody testing available to high risk persons; to make appropriate AIDS education and risk reduction counselling available to adolescents and young adults, who are forming the lifestyles that will determine their long-term risk of acquiring the disease; and to make sound AIDS information effectively available to the public.

TRAINING PROFESSIONALS FOR AIDS EDUCATION AND RISK REDUCTION COUNSELLING

In order to make sound information and risk reduction counselling effectively available to high-risk persons and to adolescents and young adults, we need to provide sound, up-to-date training for AIDS education and risk reduction counselling to those persons who are most likely to stand in a counselling or health advisory role for members of these target groups. By the end of April, 1987, the program is expected to train 1,000 key professionals and paraprofessionals across the state for AIDS education and risk reduction counselling. This training will be available to selected physicians, dentists, nurses, social workers, disease intervention specialists, educators, school counsellors, substance abuse program staff, and staff of correctional institutions. Trainees will receive advance study materials before participation in an intensive one-day workshop on AIDs education and risk reduction counselling, and will be supplied with appropriate, up-to-date reference materials for use in their work.

Training of these 1,000 persons will be a major step toward establishing credible sources of sound information on AIDS and HTLV-III (HIV) infection throughout the state, and they will be expected to serve as resource persons for dissemination of sound information in their own communities. A follow-up program will provide trainees with up-dated information on AIDS and will invite them to keep in touch with the program and to report on their AIDS education and risk reduction counselling activities. Organization of local and regional discussion groups, speakers' bureaus, and community education activities will be encouraged.

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PRODUCTION OF EDUCATIONAL MATERIALS

In order to obtain the fullest benefit from the wider availability of personnel with sound AIDS/HTLV-III information at their fingertips, and to extend the effect of their teaching efforts, we will need to supply appropriate educational materials for their use. To make these materials as effective as possible, they will be adapted to the target groups they must address. Appropriate materials will be located or developed and produced for distribution in the following target groups:

homosexual and bisexual males

health care professionals and para-professionals

clients of VD, family planning, and prenatal clinics

persons who are seropositive for HTLV-III antibodies

drug abusers and staff of drug abuse programs

inmates and staff of correctional institutions

adolescents, and teachers and parents of adolescents

teachers and parents of elementary school children

community organizations and the general public

During the first year of the project, Office of Preventive and Public Health Services plans to produce and distribute some 100,000 items of printed material for education of specific target groups on AIDS and HTLV-III infection.

AIDS EDUCATION, RISK REDUCTION COUNSELLING AND ANTIBODY TESTING IN VD FAMILY PLANNING AND PRENATAL CLINICS

In our VD clinics and our Family Planning clinics, we are in daily contact with a client population expected to have a relatively high proportion of high-risk individuals. This provides us with a unique opportunity and a special obligation to provide them with sound AIDS information and risk reduction counselling. In keeping with current CDC recommendations, and as part of our appropriate services to high-risk individuals, we would offer HTLV-III antibody testing to high-risk persons who request it after appropriate counselling. Such testing can also be a very important source of epidemiologic information on the distribution of the infection in the community and its clinical correlates in individuals. Our role as a primary health care provider to pregnant women in prenatal clinics carries with it the special need to provide the counselling and screening recommended for prevention of perinatal transmission of the AIDS-associated virus.

The top priority facilities for institution of this program are the largest public VD, family planning, and prenatal clinics in the New Orleans area, the area which accounts for the majority of Louisiana's AIDS cases and positive serologies. Accordingly, during the first year of the project, AIDS education, counselling, and testing services will be made available to clients of the Delgado Clinic for venereal disease control, the New Orleans Family Planning Clinic, and the outpatient prenatal clinics of Charity Hospital of New Orleans.

Clients in each of these clinics will be briefly informed of what kinds of risk factors may expose them to HTLV-III infection. Those who request it will then

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be offered in-depth information on AIDS and HTLV-III (HIV) infection, with specific risk reduction counselling as indicated. This information and counselling will be offered in the same facility as the clinic and, whenever possible, during the same clinic visit. Persons who request testing after such information and counselling will be offered a chance to have their blood tested for HTLV-III (HIV) antibodies. Confidentiality of testing will be protected by keeping records of testing separate from other clinic records, in number-coded files which do not contain identifying information. Clients may be tested anonymously if they choose. Those tested will have a post-test counselling session to receive an interpretation of their test results, further risk reduction counselling, and referral for further testing and evaluation as indicated.

AIDS counselling and testing services should begin in Delgado Clinic by early September.

ASSISTANCE TO NEW ORLEANS AIDS TASK FORCE

The New Orleans/AIDS Task Force operates an AIDS Information Center in a store-front office on Bourbon Street. This is a clean, well-organized, professionally run facility, well-stocked with appropriate educational material. It has been directed by a professional nurse and staffed by trained volunteers who provide information and counselling services by phone and on a walk-in basis. It enjoys high credibility in the New Orleans gay community, as well as the respect and cooperation of city and state health officials. It has been very successful in mobilizing volunteer support, and is by far the most effective means available to us for relating to the gay community in this area and for delivering sound and effective health education messages to homosexual and bisexual males.

Office of Preventive and Public Health Services (OPPHS) staff have provided technical advice on educational materials and assistance with training of volunteers and with educational activities. Several OPPHS staff members have given considerable volunteer time to assist with New Orleans/AIDS Task Force counselling and screening activities. OPPHS has provided contract funding for operation of one of Louisiana's Alternate Testing Sites by the New Orleans/AIDS Task Force, and for support of their educational program.

It is expected that this positive working relationship with the New Orleans/AIDS Task Force will continue, and that they will continue to be our primary channel for educational services and risk reduction counselling for the gay community. The new cooperative agreement with CDC includes financial assistance for the work of the New Orleans/AIDS Task Force's AIDS Information Center.

For more information about Department of Health And Human Resources/Office of Preventive and Public Health Services's AIDS Education and Risk Reduction Program, or about currently available AIDS-related services, call the Office of Preventive and Public Health Services Epidemiology Section at (504) 568-5005 or the New Orleans/AIDs Task Force's AIDS hotline at (504) 522-AIDS.

SELECTED REPORTABLE DISEASES

(By Place of Residence)

STATE AND PARISH TOTALS REPORTED MORBIDITY MAY, 1986	VACCINE PREVENTABLE DISEASES					ASEPTIC MENINGITIS	HEPATITIS A AND UNSPECIFIED	HEPATITIS B	LEGIONELLOSIS	MALARIA	MENINGOCOCCAL INFECTIONS	SHIGELLOSIS	TUBERCULOSIS, PULMONARY	TYPHOID FEVER	OTHER SALMONELLOSIS	UNDERNUTRITION SEVERE	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY	RABIES IN ANIMALS (PARISH TOTALS CUMULATIVE 1986)
	MEASLES	RUBELLA	MUMPS	PERTUSSIS	TETANUS														
TOTAL TO DATE 1985	10	0	2	5	0	18	62	79	1	0	17	12	132	0	51	3	9640	449	8
TOTAL TO DATE 1986	0	0	1	4	0	20	48	77	1	4	15	10	164	0	55	2	7913	372	7
TOTAL THIS MONTH	0	0	1	1	0	6	13	23	1	0	6	6	14	0	14	0	1896	79	1
ACADIA							1								1		5		
ALLEN																	6		
ASCENSION																	12	1	
ASSUMPTION																	2		
AVOYELLES																	7		1
BEAUREGARD																	4		
BIENVILLE																	3		1
BOSSIER												1			1		9	3	3
CADDO								3							1		223	7	
CALCASIEU							1	1									70	1	
CALDWELL																	9		
CAMERON											1						1		
CATAHOULA																	1		
CLAIBORNE																	2		
CONCORDIA																	8	2	
DESOTO																	1		
EAST BATON ROUGE						2											78	7	
EAST CARROLL																	12	1	
EAST FELICIANA																	2	1	
EVANGELINE								1									2		
FRANKLIN																	1	1	
GRANT																			
IBERIA												1					42	3	
IBERVILLE																	10		
JACKSON																	2		
JEFFERSON						1	2	5			4	1	3		1		91	3	
JEFFERSON DAVIS																	3		
LAFAYETTE								1					1				88	6	
LAFOURCHE								2									17		
LASALLE																	3		
LINCOLN																	9		
LIVINGSTON																	2		
MADISON																	8		
MOREHOUSE							1										14	1	
NATCHITOCHES																	6	4	1
ORLEANS						2	2	6	1		1	1	6		5		678	20	
OUACHITA								1									64		
PLAQUEMINES																	4	1	
POINTE COUPEE													1				4		
RAPIDES																	94	4	1
RED RIVER																	1		
RICHLAND																	7		
SABINE																	1	2	
ST. BERNARD			1				2	1							1		2	1	
ST. CHARLES																	3	2	
ST. HELENA																			
ST. JAMES													1				7		
ST. JOHN																	9		
ST. LANDRY							1					1					26		
ST. MARTIN							1										15	1	
ST. MARY																	9		
ST. TAMMANY						1		2							1		33		
TANGIPAHOA													1				22	1	
TENSAS																	6		
TERREBONNE															1		40	1	
UNION																	5		
VERMILION							2					1			1		8		
VERNON																	61	1	
WASHINGTON				1											1		8		
WEBSTER													1				19	3	
WEST BATON ROUGE																	8		
WEST CARROLL																	4		
WEST FELICIANA																		1	
WINN																			
OUT OF STATE																	5		

From January 1, 1986 - May 31, 1986 the following cases were also reported:
1-Cholera, 1-Typhus Fever, Endemic

* Includes Rubella, Congenital Syndrome.

** Includes 11 cases of Hepatitis Non A, and Non B.

*** Acquired outside United States unless otherwise stated.

SELECTED REPORTABLE DISEASES

(By Place of Residence)

STATE AND PARISH TOTALS REPORTED MORBIDITY MAY, 1986	VACCINE PREVENTABLE DISEASES					ASEPTIC MENINGITIS	HEPATITIS A AND UNSPECIFIED	HEPATITIS B	LEGIONELLOSIS	MALARIA	MENINGOCOCCAL INFECTIONS	SHIGELLOSIS	TUBERCULOSIS, PULMONARY	TYPHOID FEVER	OTHER SALMONELLOSIS	UNDERNUTRITION SEVERE	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY	RABIES IN ANIMALS (PARISH TOTALS CUMULATIVE 1986)
	MEASLES	RUBELLA	MUMPS	PERTUSSIS	TETANUS														
TOTAL TO DATE 1985	10	0	2	5	0	18	62	79	1	0	17	12	132	0	51	3	9640	449	8
TOTAL TO DATE 1986	0	0	1	4	0	20	48	77	1	4	15	10	164	0	55	2	7913	372	7
TOTAL THIS MONTH	0	0	1	1	0	6	13	23	1	0	6	6	14	0	14	0	1896	79	1
ACADIA							1								1		5		
ALLEN																	6		
ASCENSION																	12	1	
ASSUMPTION																	2		
AVOYELLES																	7		1
BEAUREGARD																	4		
BIENVILLE																	3		1
BOSSIER												1			1		9	3	3
CADDO								3							1		223	7	
CALCASIEU							1	1									70	1	
CALDWELL																	9		
CAMERON											1						1		
CATAHOULA																	1		
CLAIBORNE																	2		
CONCORDIA																	8	2	
DESOTO																	1		
EAST BATON ROUGE						2											78	7	
EAST CARROLL																	12	1	
EAST FELICIANA																	2	1	
EVANGELINE								1									2		
FRANKLIN																	1	1	
GRANT																			
IBERIA												1					42	3	
IBERVILLE																	10		
JACKSON																	2		
JEFFERSON						1	2	5			4	1	3		1		91	3	
JEFFERSON DAVIS																	3		
LAFAYETTE								1					1				88	6	
LAFOURCHE								2									17		
LASALLE																	3		
LINCOLN																	9		
LIVINGSTON																	2		
MADISON																	8		
MOREHOUSE							1										14	1	
NATCHITOCHES																	6	4	1
ORLEANS						2	2	6	1		1	1	6		5		678	20	
OUACHITA								1									64		
PLAQUEMINES																	4	1	
POINTE COUPEE													1				4		
RAPIDES																	94	4	1
RED RIVER																	1		
RICHLAND																	7		
SABINE																	1	2	
ST. BERNARD			1				2	1							1		2	1	
ST. CHARLES																	3	2	
ST. HELENA																			
ST. JAMES													1				7		
ST. JOHN																	9		
ST. LANDRY							1					1					26		
ST. MARTIN							1										15	1	
ST. MARY																	9		
ST. TAMMANY						1		2							1		33		
TANGIPAHOA													1				22	1	
TENSAS																	6		
TERREBONNE															1		40	1	
UNION																	5		
VERMILION							2					1			1		8		
VERNON																	61	1	
WASHINGTON				1											1		8		
WEBSTER													1				19	3	
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