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Louisiana Morbidity Report

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David L. Ramse
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Medicare Pays for Screening Mammograms

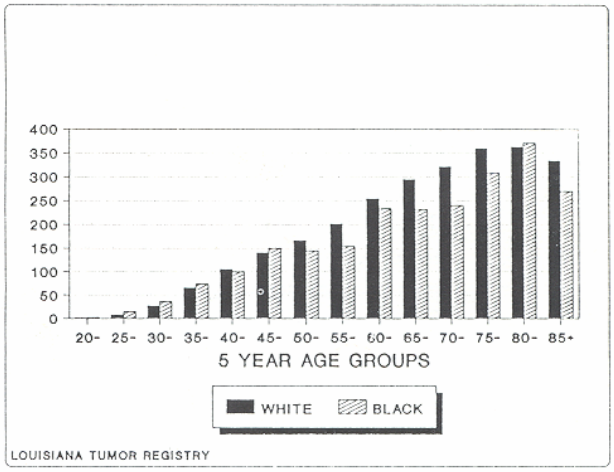
Recognizing that breast cancer is one of the leading causes of cancer deaths among women, the Medicare program began providing reimbursement for screening mammograms for women in January, 1991. Breast cancer is increasingly common as women become older, and it is hoped that this program will encourage older women and their physicians to make greater use of screening mammography to detect early-stage breast tumors.

The two main risk factors for getting breast cancer are being female and increased age. Eighty percent of the women diagnosed with breast cancer have no other risk factor, such as a family history of the disease. Figure 1 illustrates the increased risk of breast cancer with age among women in Louisiana. Black women in the state experience a lower risk of breast cancer than white women, however their mortality rates are similar to or higher than those of whites, probably due to late stage at diagnosis.

In Louisiana breast cancer kills more black women than any other cancer and it is the second leading cause of cancer deaths in white women. The American Cancer Society estimates that 2,400 Louisiana women will be diagnosed with breast cancer in 1991 and 600 will die. These women will lose an average of 19 years of potential life according to the National Cancer Institute.

Contents

Figure 1: Female Breast Cancer Incidence Rates (Per 100,000)
Southern Louisiana, 1983-1986



Mammograms can detect tumors two years before they are large enough to be felt as shown in Figure 2 (page 2). Ninety percent of these early stage breast cancers can be cured. Experts believe that the routine use of screening mammography for asymptomatic women would reduce the breast cancer death rate by more than 30%.

Despite evidence that mammography is the most effective method for detecting early stage breast cancer, use of this technique has been low. National studies have shown that the two main reasons given by women for not obtaining mammograms are perceived no need and lack of physician order. Breast cancer control programs have focused on promoting insurance coverage of screening mammography and on education of women and physicians about the importance of breast cancer screening.

The new Medicare reimbursement program is limited to biennial screening for most elderly beneficiaries and annual screening for certain disabled beneficiaries. Medicare reimbursement for mammography is limited to $44.00 (80% of $55.00).

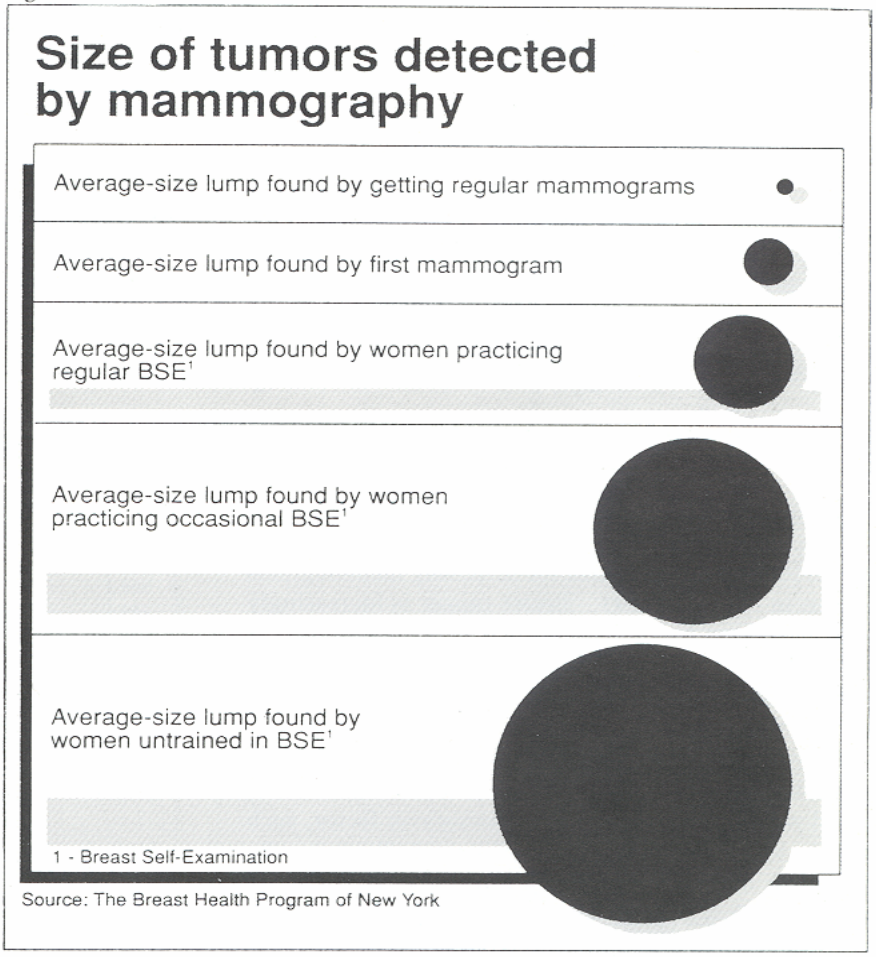
With funding from the National Cancer Institute, the Office of Public Health and YWCA will be piloting an educational campaign to encourage the use of screening mammography in the Shreveport area this year. That area was targeted as it has higher mortality rates for breast cancer than both the state and national averages. Encouraging expansion

of the popular low-cost mammogram annual campaign and advocacy for Medicaid coverage of screening mammograms are part of statewide efforts to encourage early detection of breast cancer.

Many women with chronic diseases use specialists as their primary physicians and are not under the care of internists or general practitioners. Therefore, all physicians are encouraged to follow the schedule recommended by a consensus conference of the American Cancer Society, the National Cancer Institute and nine other medical organizations: obtain a baseline mammogram at age 35, an annual or biannual mammogram from 40 to 50, and one annually after age 50.

Physicians are urged to refer women over the age of 40 for screening mammograms. It is hoped that Medicare reimbursement will encourage older women to obtain screening mammograms.

Figure 2



HIB Vaccine Given at Age 2 Months

OPH parish health units are now providing Hemophilus influenza type B (HIB) conjugate vaccine to children beginning at age 2 months, as recently recommended by the American Academy of Pediatrics and the Centers for Disease Control. The HibTITER vaccine from Lederle/Praxis (designated HbOC) will be used for a three-dose primary series given at ages 2, 4 and 6 months. Children 15 months of age will be given a booster of either the HbOC vaccine or the ProHIBit vaccine from Connaught (designated PRP-D).

Because the different HIB conjugate vaccines now available, health care providers are asked to clearly indicate on all vaccination records which brand of vaccine was administered, using the following CDC-recommended designations:

HbOC for HibTITER from Lederle/Praxis
PRP-OMP for ProHIBit from Connaught
PRP-D for PedvaxHIB from Merck

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Immunization Survey Shows Decline in Coverage

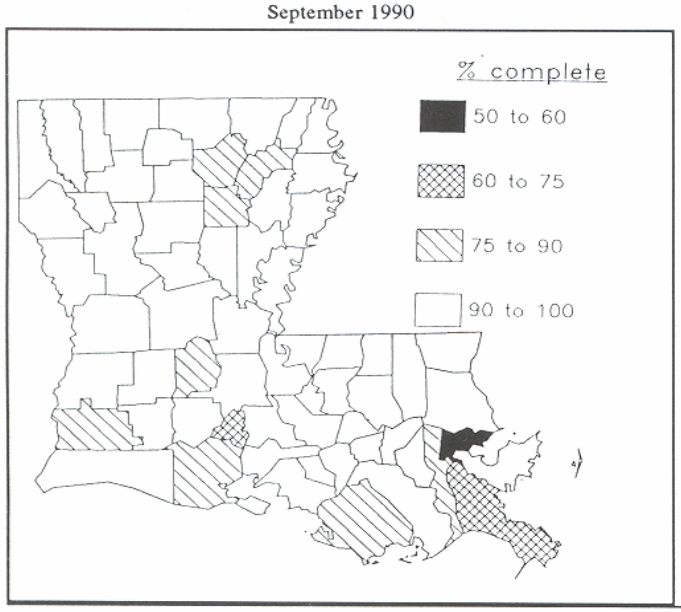
Records of children entering public schools for the first time last fall showed a decrease in immunization coverage when compared to the two previous years. The results point to the need for increased emphasis of primary immunization of children, especially in certain areas.

Each year the Immunization Section conducts surveys of all elementary schools in Louisiana to determine the percentage of children entering school who have received recommended immunizations. Schools are asked to report the number of children entering for the first time and the number of these that at the time of registration have received four doses of DPT vaccine, three doses of polio vaccine, and one dose of MMR vaccine. Children are only counted as immunized if their parents can provide documentation that the vaccines have been given. An initial survey done in September assesses the immunization status at the time of entry, and a follow-up survey done in the winter assesses the success of the schools in locating vaccination records and in ensuring that delinquent children are vaccinated.

In the fall of 1990, 88% of children entering public schools provided documentation of full immunization, as compared to 90% in the fall of 1989 and 93% in the fall of 1988. Among children entering private schools the coverage rate was 92%, a slight increase from previous years. The decrease in immunization rates in public schools was concentrated in certain parishes (figure). The greatest decreases between 1988 and 1990 were found in Orleans Parish (from 88% to 58%) and Lafayette Parish (from 87% to 72%).

The low coverage rate in the public schools is probably an underestimate of the true rate, since some children counted as unimmunized have been vaccinated but lacked documentation of vaccination at the time of school entry. In the public schools in the last two years, the vaccination rate increased 1%-5% in the follow-up surveys when compared to the initial surveys; the increase was 15%-20% in Lafayette and Orleans between the fall of 1989 and the winter of 1990. Nonetheless, the decrease in coverage in the initial surveys suggests a decline in the emphasis on vaccination - a trend that could ultimately lead to increased rates of vaccine-preventable diseases. The Immunization Section is working with school officials and health care providers in areas with low coverage rates to try to improve record-keeping and ensure adequate immunization of all children.

Figure: Immunization coverage rates among first time school enterers September 1990



Home Health Care for HIV\AIDS Clients

Persons with AIDS or HIV infection who require home health care can now receive that care through a new program administered by the AIDS section of OPH. The program will provide services to those persons who neither have private health insurance nor qualify for Medicaid insurance.

The health care services most often needed by persons infected with HIV are intravenous drug therapy, home oxygen, and personal care. Currently, there are an estimated 800 persons living with AIDS in Louisiana; of these, perhaps 20% will need home care at some time during the year. Medicaid and many private health insurance plans pay for the cost of these services, but only about half of the persons in need may be covered by these insurance plans. Previously, patients with AIDS who did not have insurance in Louisiana received funding for home health care through a grant from the Robert Wood Johnson Foundation, but this grant ended in October 1990. Because of this gap in coverage, the AIDS program was awarded a grant from the federal Health Resources and Services Adminstration to provide home health care beginning in 1991.

Persons eligible for this program are persons with AIDS or symptomatic HIV infection who have neither Medicaid nor private insurance; some clinical and income restrictions also apply. Those qualifying will receive medications, supplies, and the services of nurses, home health aides, and personal care attendants provided by private home health agencies through contracts with OPH. Hospice care will also be provided under this program.

The program has been operating in the metropolitan New Orleans area since January 1,1991, and should be operating statewide by April 1, 1991. Questions about this program can be answered by Avis Gray, AIDS Section at (504) 568-5505.

Church Programs Attack High Blood Pressure

Cardiovascular diseases are the leading cause of death in Louisiana and the fourth leading cause of Years of Potential Life Lost.

Risk factors for cardiovascular diseases include high blood pressure, hypercholesteremia, and smoking. Statistics from the 1989 Louisiana Current Population Survey (CPS) indicate that at least one of these risk behaviors/factors is present in one-fifth to one-third of citizens (Figures 1-3).

Figure 1: Percentage of adults who smoke, 1989

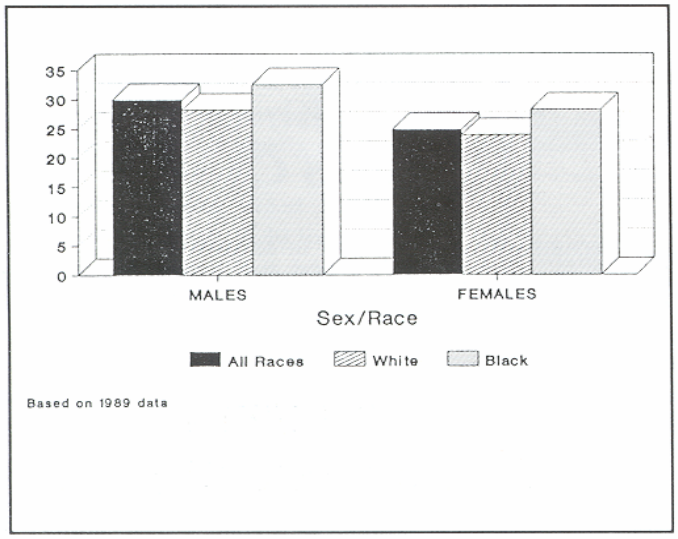
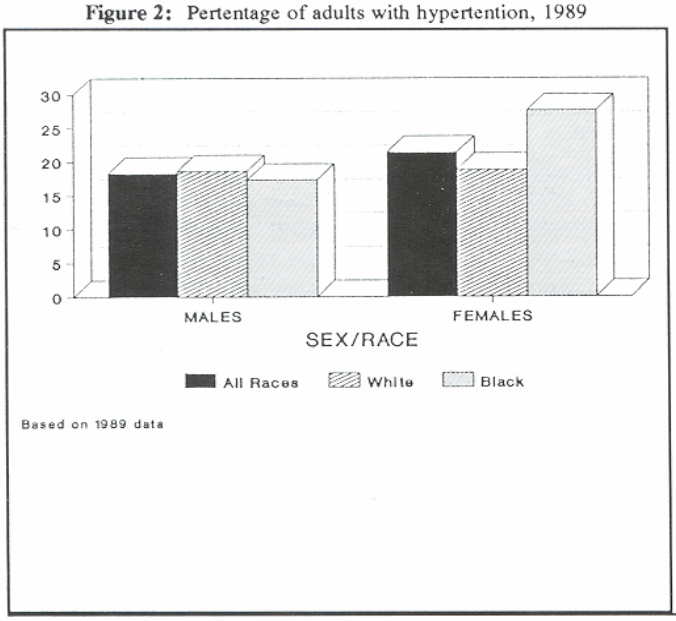


Figure 2: Pertentage of adults with hypertention, 1989



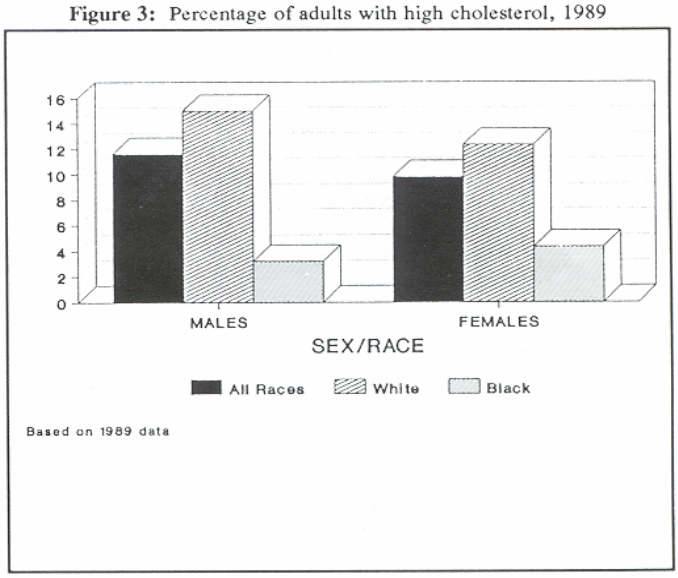
In an effort to address these factors, the Louisiana Office of Public Health has supported the Church-Based High Blood Pressure Control Program since April 1989. The goals of the program are outreach, referral, monitoring known hypertensives, and education. The blood pressure monitors are certified through the American Red Cross course, How to Measure Blood Pressure. These monitors have ongoing contact with the church members and their families which provide unique opportunities for effective intervention.

To promote heart-healthy eating and food preparation, special soul-food cooking workshops have been designed by health department professionals and church members. Other activities promoted within the churches include: health fairs; group walking and aerobic exercise classes to gospel music; smoking cessation classes; and medication seminars presented by pharmacists.

Inspired by the success of the pilot programs at the Shiloh and True Vine Baptist Churches of Westwego, Louisiana, several Louisiana associations are now forming a coalition to coordinate the program at the statewide level. The coalition leaders are: the Louisiana Primary Care Association, the Louisiana Medical Association, and the Louisiana Office of Public Health.

To date eight churches in Louisiana have begun the formation of these programs. Information on resources and program design are available by writing the High Blood Pressure Control Program, Louisiana Office of Public Health, P.O. Box 60630, New Orleans, Louisiana 70160.

Figure 3: Percentage of adults with high cholesterol, 1989



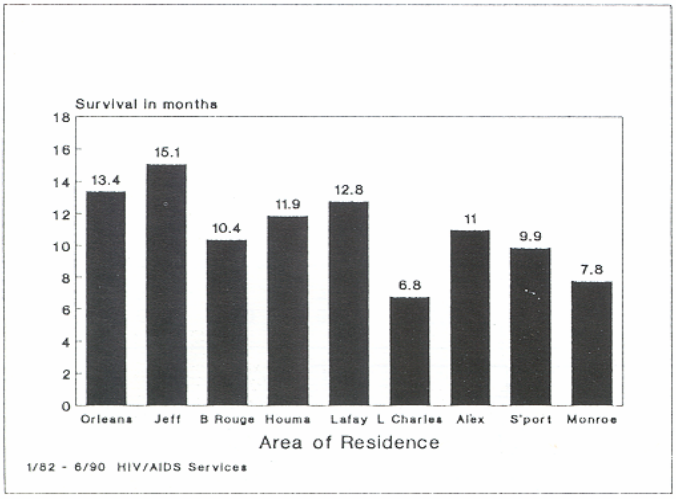
AIDS Update: Survival Time

The AIDS surveillance system in Louisiana routinely collects information about survival of persons with AIDS. Median survival time from the diagnosis of AIDS has been shown elsewhere to vary by sex, age, and risk group; to an extent, AIDS survival time is also an indicator of the quality of medical care services AIDS patients receive.

In September 1990, the AIDS Section performed its first analysis of patients with AIDS in Louisiana. These analyses included 1980 patients diagnosed between January 1982 and June 1990.

The overall estimated median survival time was 12.7 months. Survival time was not significantly different between males (12.7 months) and females (12.4 months; Table). White patients survived significantly longer than black or Hispanic patients. Survival was longest for patients under age 20 and decreased with increasing age. Within the major transmission risk groups, survival was longest for heterosexuals (15.3 months) and shortest for persons infected through transfusions (7.7 months).

Figure: Survival time of patients with AIDS by area of residence 1982-1990



The data were also analyzed by region of the state. Patients residing in the Jefferson Parish region had the longest survival time (15.1 months), followed by the Orleans region (13.4 months). Monroe and Lake Charles regions had the shortest survival times (7.8 and 6.8 months, respectively).

Louisiana's estimated median survival time of 12.7 months is consistent with those found in San Francisco and Houston. The differences in survival time by race and region emphasize the need for increased targeted education and health services outreach to minority communities and in rural areas of the state.

Table: Survival time in patients with AIDS by demographic group and transmission category, 1982-1990

Group	Median Survival Time (Months)
Sex	
Male	12.4
Female	12.7
Race/Ethnicity	
Black	8.9
Hispanic	8.9
White	13.8
Age	
< 20	28.1
20-29	13.3
30-39	13.5
40-49	12.6
50-59	9.3
60-69	3.7
Transmission Category	
Homo/Bisexual	12.6
IVDU	12.8
HB/IVDU	15.3
Transfusion	7.7

BULLETIN
Medical Waste Disposal

In our September/October, 1990 issue of the Louisiana Morbidity Report, information was included on the new infectious waste disposal regulations. As a reminder, on July 1, 1991, the portion of the regulations that apply to households and all other small generators of infectious waste will go into effect. A small generator is a person (or persons) who disposes of less than 50 pounds of such waste per month at the same site.

This will affect most medical offices, free-standing emergency clinics, dentists offices; as well as individuals with insulin-dependent diabetes mellitus who use and dispose of hypodermic syringes.

Sharps must be placed in non-breakable, puncture-resistant containers and rendered unrecognizable. These are called Sharps Containers and should be available at local medical supply dealers. For persons in the New Orleans area, the Orleans Parish Sanitarian Services (504-568-7970) has compiled a list of places where the containers can be purchased. Doctors are encouraged to discuss the new waste disposal law with their patients.

For a copy of the regulations or for further information contact Mr. Charles Anderson at 504-568-5139.

COMMUNICABLE DISEASE SURVEILLANCE, January-February 1991
PROVISIONAL DATA

Table 1. Selected diseases by region

DISEASE		HEALTH DEPARTMENT REGION 1	2	3	4	5	6	7	8	9	Jan-Feb 1991	Jan-Feb 1990	Cum 1991	Cum 1990	%Change
Vaccine-preventable															
Measles	Cases	0	0	0	0	0	0	0	0	0	0	1	0	1	-
Mumps	Cases	1	1	0	5	0	0	0	0	0	7	34	7	34	-79
Rubella	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	Cases	0	1	0	0	0	0	0	0	1	2	0	2	0	+
Sexually-transmitted															
Gonorrhea	Cases	841	250	93	68	58	72	218	200	133	1933	2210	1933	2210	-13
	Rate**	10.8	3.2	3.0	1.2	2.2	2.2	3.7	6.3	2.9	4.4	5.0	4.4	5.0	
Syphilis	Cases	120	71	11	32	6	25	46	28	19	358	334	358	334	+7
	Rate**	1.5	0.9	0.4	0.6	0.2	0.8	0.8	0.9	0.4	0.8	0.8	0.8	0.8	
Enteric															
Campylobacter	Cases	0	0	0	1	0	0	0	0	0	1	13	1	13	-93
Hepatitis A	Cases	5	0	1	0	0	0	5	0	6	20	16	20	16	+25
	Rate*	0.6	0.3	0.3	0	0	0	0.9	0	1.3	0.5	0.4	0.5	0.4	
Salmonella	Cases	6	1	0	3	3	0	2	12	0	12	108	12	108	-75
	Rate*	0.8	0.1	0	0.5	1.1	0	0.3	3.8	0	0.6	2.5	0.6	2.5	
Shigella	Cases	5	2	0	2	0	0	0	5	1	15	34	15	34	-58
	Rate	0.6	0.3	0	0.4	0	0	0	1.6	0.2	0.3	0.8	0.3	0.8	
Vibrio Cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Vibrio, other	Cases	0	0	0	1	0	0	0	0	0	2	2	2	2	0
Other															
Hepatitis B	Cases	7	7	0	2	2	0	1	0	1	20	37	20	37	-47
	Rate*	0.9	0.9	0	0.4	0.8	0	0.2	0	0.2	0.5	0.8	0.5	0.8	
Meningitis/Bacteremia		0	2	0	2	1	0	0	0	0	6	17	6	17	
H. Influenza	Cases	0	0.3	0	0.4	0.4	0	0	0	0	0.1	0.4	0.1	0.4	-65
N. Mening.	Cases	2	0	0	1	0	0	0	1	0	4	9	4	9	-56
Tuberculosis	Cases	3	3	1	2	1	4	1	5	0	20	44	20	44	-55
	Rate*	0.4	0.4	0.3	0.4	0.4	1.2	0.2	1.6	0	0.5	1.0	0.5	1.0	

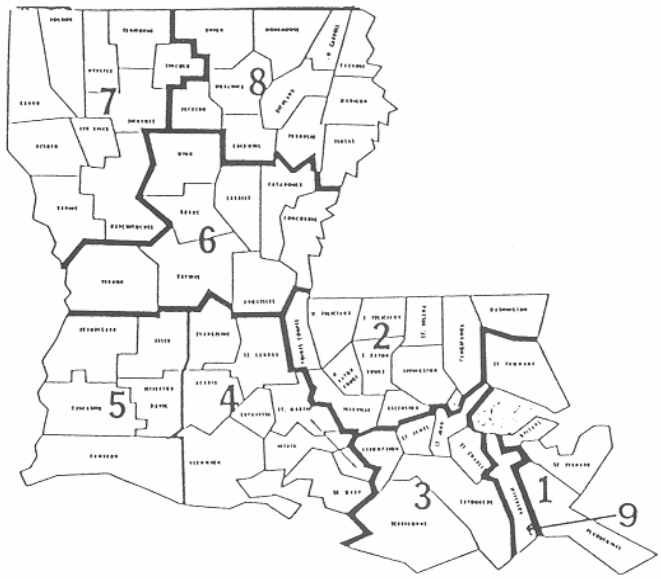
* Cases per 100,000 population
** Cases per 10,000 population

Table 2. Diseases of low frequency, 1991

Disease	Total to date
Blastomycosis	0
Brucellosis	0
Histoplasmosis	0
Lead Toxicity	0
Legionellosis	1
Leprosy	0
Lyme Disease	0
Malaria	1
Rocky Mountain Spotted Fever	0
Tetanus	0
Typhoid	0

Table 3. Animal rabies - January - February 1991

Parish	Species	No. Cases
Lincoln	Skunk	1
Bossier	Skunk	2



Annual Summary Hepatitis A 1990

In 1990, there were 215 cases of Hepatitis A reported to the Epidemiology Section, a 39% decrease from 1989. The case rate for 1990 was 4.9 per 100,000. Race-sex specific rates (per 100,000) were highest for black males (76) and lowest for white males (39). The highest age- specific rates occurred in the 5 - 9 year age group, followed by the 25 - 34 year age group (Figure 1).

Hepatitis A is most common among young children. Even though there were fewer cases reported in 1990 than 1989, the age patterns for the two years were similar. Person-to-person contact and association with a day care center remains the two risk factors most frequently recognized for acquiring Hepatitis A, although drug use may be an increasing risk factor of exposure, especially in young adults.

Figure 1: Hepatitis A case rates (per 100,000) by age, 1990

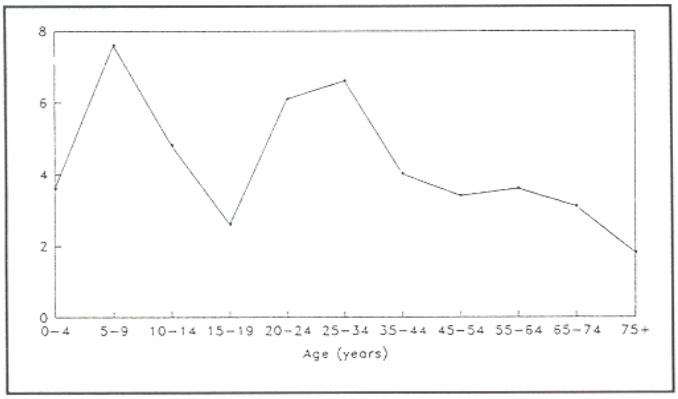


Figure 2: Hepatitis A cases by month of report, 1988-1990

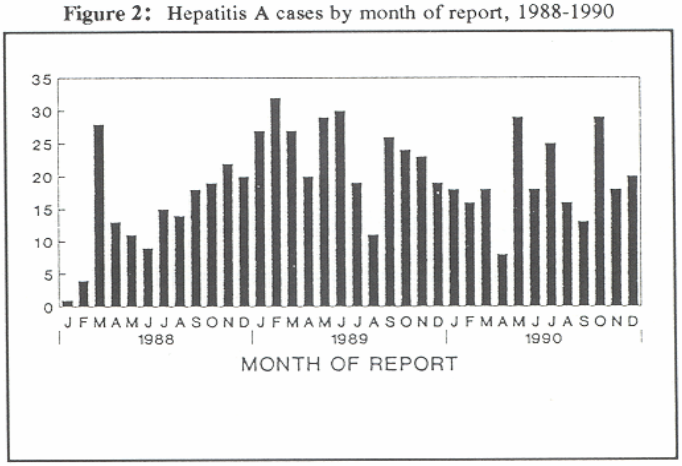
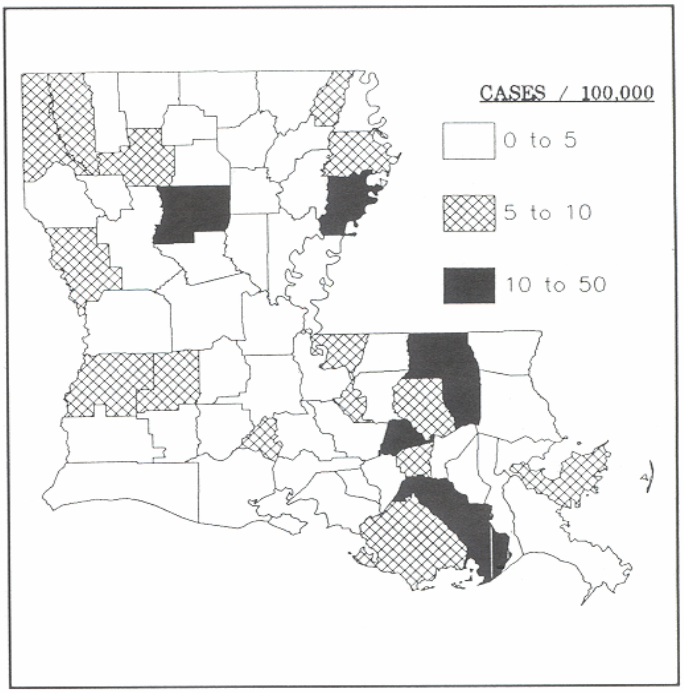


Figure 3: Hepatitis A case rates (per 100,000) by parish, 1990



LOUISIANA FACTS

Did you know that in the 1927 governor's race, Huey P. Long decided to try to personally speak in front of every voter in Louisiana? He traveled the state by automobile, making as many as nine speeches a day. At the end of the campaign he estimated that he had made six hundred speeches and addressed a total of three hundred thousand people.

Do you have any interesting facts about Louisiana that you would like to see published in the Louisiana Morbidity Report? Send facts and source to: Louisiana facts, DHH-OPH-Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160.

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