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# Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section  
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## Update: Syphilis Epidemic

In 1990 and 1991, Louisiana's syphilis epidemic continued and spread further into rural areas of the state. In 1990, 2701 cases of primary and secondary (P&S) syphilis were reported, a 67% increase compared to 1989, and in the first six months of 1991, 1393 cases were reported, a 14% increase from the same period in 1990 (Figure 1). The overall case rate for P&S syphilis was 62 per 100,000 in 1990, three times

that of the United States as a whole and the second highest rate among the 50 states. Case rates continued to be far higher in blacks (197 per 100,000) than whites (4 per 100,000). Among black women from 1987 to 1991, the case rates increased most rapidly in younger age groups (especially ages 10-24; Figure 2). In contrast, among black men, the case rates increased most rapidly in the older age groups (Figure 3).

In 1989 and the early part of 1990, a syphilis increase was seen primarily in urban parishes (those with over 90,000

Figure 1: Cases of primary and secondary syphilis by quarter, 1987-1991

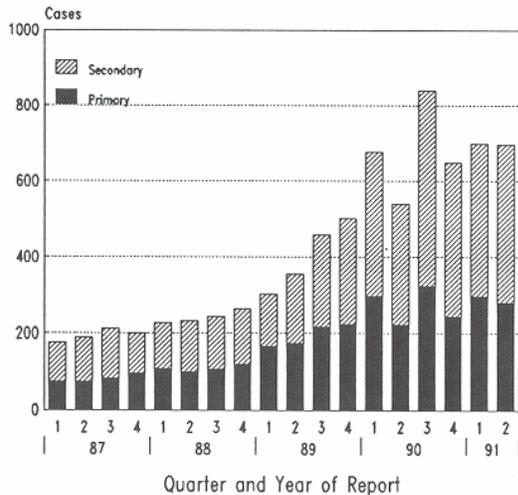


Figure 2: Rates of primary and secondary syphilis among black females by age, 1987-1990

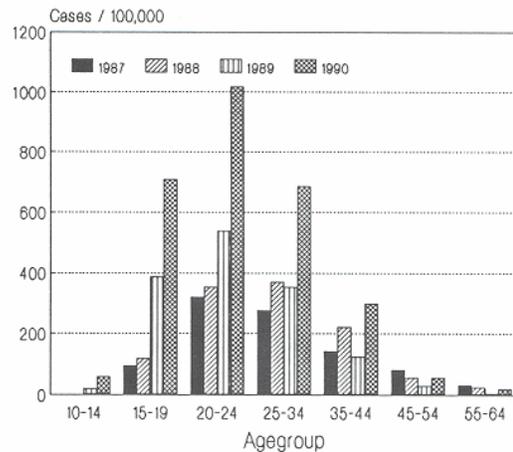
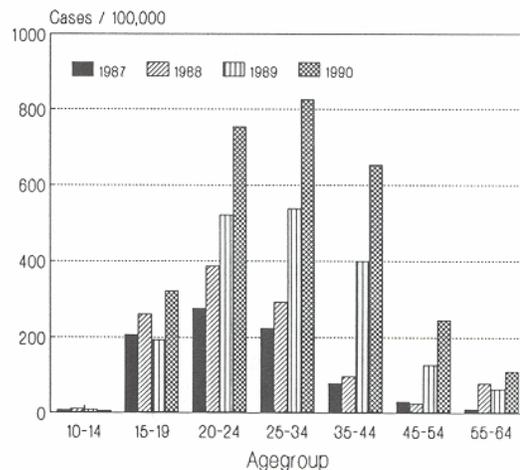


Figure 3: Rates of primary and secondary syphilis among black males by age, 1987-1990



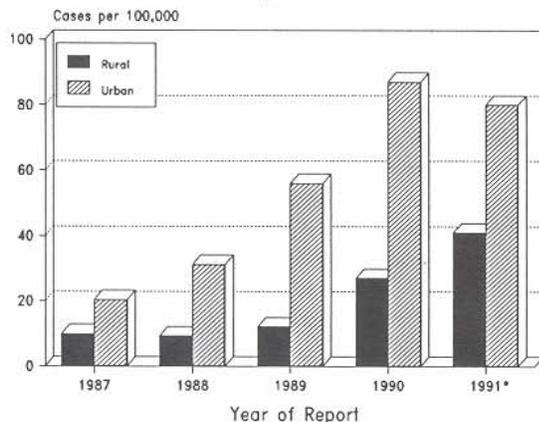
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population) such as Orleans, Jefferson, and East Baton Rouge. However, in the first six months of 1991, there was an increase in case rates in rural parishes, and a small decrease in cases in urban parishes (Figure 4). As shown in Figure 5, while urban parishes still have very high case rates, many rural parishes now have rates nearly as high.

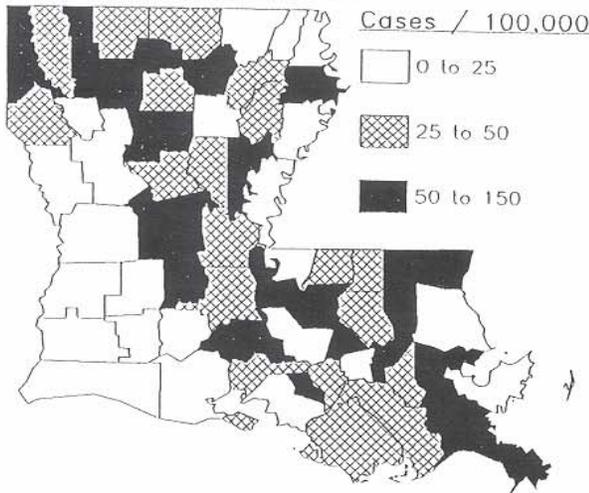
In recent years, large increases in syphilis have been seen in states in all regions of the United States. Louisiana began the current epidemic with higher case rates than other states, and the epidemic has been particularly widespread. It is clear that syphilis is common among sexually active adults of all ages and in all areas of the state. Case workers throughout Louisiana report that the syphilis problem is centered around crack users (particularly young females) and their sex partners, a population that is particularly difficult to reach with prevention efforts. Control of syphilis must rely on improved efforts to locate sex partners of infected persons and screening programs established in jails, emergency rooms, and other settings in which drug users are seen.

Figure 4: Rate of primary and secondary syphilis in urban vs. rural parishes, 1987-1991



\* First six months, annualized

Figure 5: Annualized rates of syphilis for the first six months of 1991



## Influenza High Risk Immunization Program 1991-92

On October 21, 1991 the Office of Public Health will begin influenza immunization of the elderly and those individuals who are at high risk of serious illness or death from influenza. High risk individuals include: persons over 65 years of age and those of any age with chronic cardiac, respiratory, or kidney disease, those with diabetes and those whose immune system has been compromised (such as persons with AIDS and cancer patients receiving chemotherapy).

Groups potentially capable of nosocomial transmission of influenza to high risk persons (e.g., physicians, nurses, and other persons who have extensive contact with high risk patients) are encouraged to see their own physicians or to organize their own immunization programs.

Influenza strains anticipated to be prevalent this flu season will be closely related to A/Taiwan/1/86 (H1N1), A/Beijing/353/89 (H3N2), and B/Panama/45/90. These strains are included in this year's vaccine.

One 0.5ml dose of whole or split virus vaccine is required for persons over 12 years of age. Children 6 months to 9 years of age who have not received influenza vaccine previously should receive two doses of split virus vaccine. If vaccine has been administered previously, one dose is sufficient. The dosage of split virus vaccine for children is 0.25ml for those 6 to 35 months of age, 0.5ml for those 3 to 8 years of age, 0.5 ml for those 9 years and older.

For information on time and days of the clinics, please contact your local parish health unit.

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## Excluding Sick Children from Day Care Centers

Because day care centers are known to be ideal settings for transmission of infectious diseases, directors of these centers need guidance on when to exclude ill children. The Epidemiology Section has worked in conjunction with the Department of Social Services, Health Standards Section, to develop guidelines on exclusion policies for day care centers. These guidelines are now part of the standards required of day care centers for licensure.

There are very few illnesses for which children need to be excluded from day care. Bearing that in mind, the following are the recommended guidelines based on the potential contagiousness of the disease:

Illness/Symptoms	Exclude Until
Meningococcal disease	Well & also completed 2 day course of Rifampin
Haemophilus influenzae disease	Well & also completed 4 day course of Rifampin
Diarrhea	Diarrhea resolved or cleared by child's physician/health department
Fever of unknown origin	Fever resolved or cleared by child's physician/health department
Chickenpox	Skin lesions (blisters) scabbed over
Hepatitis A	One week after illness started and fever resolved
AIDS (or HIV infection)	Until his/her health, neurologic development, behavior, and immune status are deemed appropriate (on a case-by-case basis) by qualified persons, including the child's physician.*
Undiagnosed generalized rash	Well or cleared by child's physician
Sudden onset of vomiting, irritability or excessive sleepiness	Evaluated and cleared by child's physician

For most other conditions, either a child has already exposed others before becoming obviously ill (e.g. colds) or is not contagious after beginning treatment (e.g. strep throat, conjunctivitis, impetigo, ringworm, parasites, head lice, and scabies).

Children who are carriers of some viral illnesses, such as cytomegalovirus and herpes can be admitted to day care

without posing a significant threat to the health of others.

Ideally day care centers should have a written health policy, which includes procedures regarding:

1. Health appraisal at the time of admission.
2. Responsibilities for ongoing medical care.
3. Management of acute illnesses, including the admissions or exclusion of the child who is ill, provisions for the child who becomes ill during the day, and notification of the parent of the ill child.
4. Management of accidents.
5. Continuing health screening and supervision.
6. Education of staff, parents, and children about infectious illnesses, techniques to prevent their spread, and proper care of ill children.

\*These qualified persons should be able to evaluate whether the child will receive optimal care in the specific program being considered and whether an HIV-infected child poses a potential threat to others.

## Testing for Atypical Mycobacteria Available

The OPH central laboratory will now identify all mycobacteria species, including atypical mycobacteria, through use of a new rapid test developed at the Centers for Disease Control. The test uses high pressure liquid chromatography to identify unique components of the mycobacterial cell wall. The laboratory will accept both clinical specimens (sputum, bronchial washings, etc.) and pure cultures referred from other laboratories. Final identification of clinical specimen isolates will take three to six weeks; identification of pure cultures will take five working days. Antimicrobial susceptibility testing will be performed on all isolates of *M. tuberculosis*, and after November 1, on most isolates of clinically significant atypical mycobacteria. For more information, call (504) 568-7682.

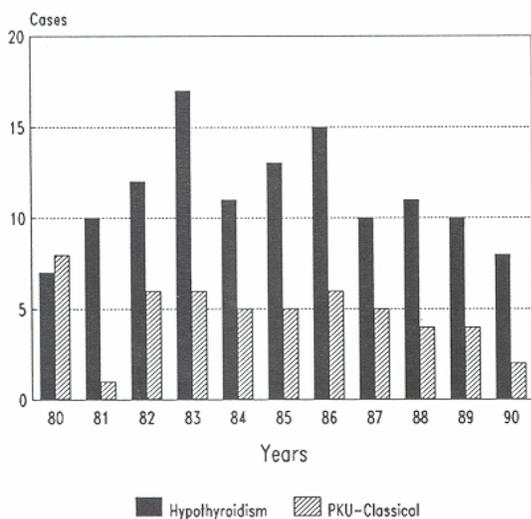
## Neonatal Screening Program Results

In the last eleven years, Louisiana's newborn genetic screening program has identified 124 cases of congenital hypothyroidism and 47 cases of phenylketonuria (PKU). Thus, this program has prevented some 171 cases of mental retardation since 1980.

Newborn genetic screening is carried out on heelstick blood collected on filter paper shortly after birth. Nearly all testing in Louisiana is carried out at the OPH state laboratory.

Congenital hypothyroidism is expected to occur in 1:3,600 - 1:5,000 white infants and 1:10,000 - 1:17,000 black infants. During 1980-1989, Louisiana's hypothyroidism screening program found 79 white infants (1:5990) and 37 black infants (1:8636) with this disease. PKU is expected to occur in

Figure: Conditions found on neonatal screening



1:10,000 - 1:25,000 white infants and is rare in black infants. From 1980 to 1989 the program identified 45 white infants (1:10,517) and 2 black infants (1:159,762) with PKU.

PKU screening has been in place since 1964, so there are now a number of women of childbearing age with this condition. Many of these women no longer continue the restrictive diet used to treat PKU in childhood. It is imperative that PKU women resume the diet before conception in order to prevent damage to the developing fetus from her uncontrolled phenylalanine levels. Otherwise, PKU induced mental retardation will simply be postponed from one generation to the next.

## BULLETINS AIDS Helpline for Health Professionals

Health care professionals with a question about HIV/AIDS now have a toll-free number to call: 1-800-548-4659. Specialists at the Helpline can provide the following types of help:

- Current HIV/AIDS information
- Customized literature searches
- Clinical consultations
- Educational information
- Surveillance data
- Journal articles updates
- Specialized bibliographies

The AIDS Helpline, a free service of the Delta Region AIDS Education and Training Center (ETC), is available to all health professionals in Louisiana, Mississippi and Arkansas, including nurses, physicians, dentists, social workers, psychologists, infection control specialists, and health administrators.

## Single Dose Quadrivalent Meningococcal Vaccine Available

The Food and Drug Administration (FDA) has approved a single-dose vial of quadrivalent polysaccharide vaccine against *Neisseria meningitidis* serogroups A, C, Y, and W135. The single-dose vial replaces the previously available ten-dose vial, which once reconstituted, had a five-day shelf life. No vaccine is yet available to offer protection against serogroup B.

Vaccine is indicated for travelers to countries recognized as having epidemic meningococcal disease. Duration of immunity is unknown, but appears to be at least 3 years in those 4 years of age or older. Revaccination after 2 or 3 years should be considered for children first vaccinated at less than 4 years of age who continue to be at high risk.

The vaccine is available from Connaught Laboratories, Inc., at 1-800-822-2463.

Cases of suspected or confirmed meningococcal disease should be reported promptly to the Epidemiology Section at 504-568-5005 or toll free at 1-800-256-2748.

## AIDS Update

### Regional Shifts in AIDS Cases

AIDS cases have been reported from every city and most rural areas of Louisiana and the U.S. as a whole. At the start of the epidemic, the majority of AIDS cases in Louisiana were reported from the metropolitan New Orleans area (Orleans, Jefferson, Plaquemines, St. Bernard, and St. Tammany Parishes). However, in the last six years, AIDS surveillance data have documented a shift from metropolitan New Orleans to other areas of the state. This shift has been accompanied by changes in the characteristics of the persons identified with AIDS.

From 1985 to 1990 the percentage of cases that lived outside of the New Orleans area increased from 28% (39/137) to 45% (255/567; Table 1).

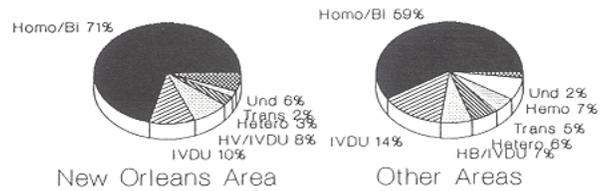
**Table 1.** Cases of AIDS by year of diagnosis and area of residence, 1985-1990

Year	Metropolitan New Orleans		Other Areas	
	N	%	N	%
1985	98	72	39	28
1986	161	69	71	31
1987	278	69	123	31
1988	254	61	165	39
1989	347	61	220	39
1990	312	55	255	45

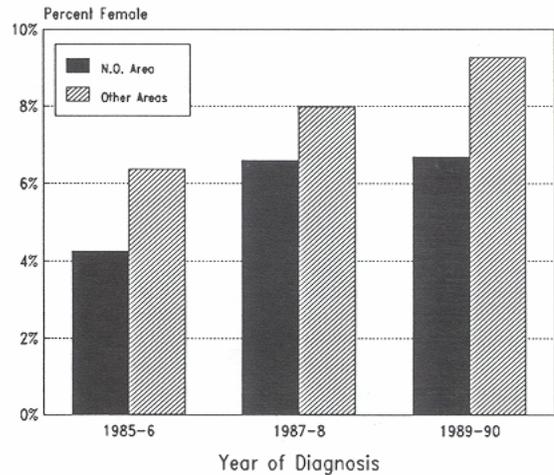
The distribution of the exposure category of AIDS cases differs by place of residence (Figure 1). In 1990, homosexual activity accounted for 71% of cases diagnosed in the New Orleans area and only 59% of cases diagnosed in other parts of the state. Cases were more likely to be associated with intravenous drug use and heterosexual activity in other areas of the state than in the New Orleans area.

An additional difference is that a greater percentage of cases diagnosed outside of the New Orleans area were female. From 1985 to 1990, 6.2% (90/1450) of cases in the metropolitan area were females, as compared to 8.5% (74/873) of cases in other areas of the state. In addition, in all areas of the state, the percentage of cases that were female increased steadily over this period (Figure 2).

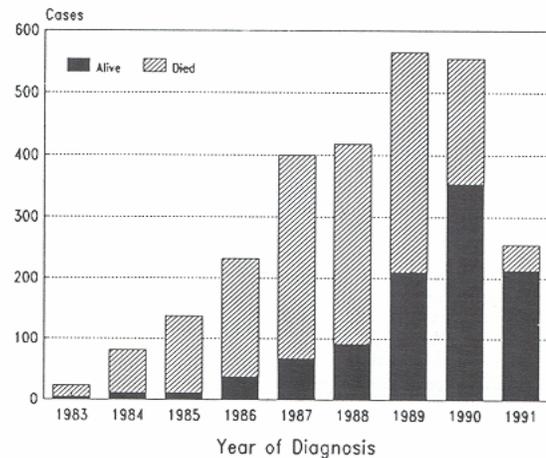
**Figure 1:** Exposure category among persons with AIDS by region of residence, 1990



**Figure 2:** AIDS cases in females, New Orleans vs other areas, 1985-1990



**AIDS Case Trends**



COMMUNICABLE DISEASE SURVEILLANCE, July-August, 1991  
PROVISIONAL DATA

Table 1. Selected diseases by region

DISEASE	HEALTH DEPARTMENT REGION										July-Aug 1991	July-Aug 1990	Cum 1991	Cum 1990	%Change
	1	2	3	4	5	6	7	8	9						
<b>Vaccine-preventable</b>															
Measles	Cases	0	0	0	0	0	0	0	0	0	0	0	0	10	-
Mumps	Cases	1	1	0	1	0	0	0	0	0	3	15	20	93	-78
Rubella	Cases	0	0	0	0	0	0	0	0	0	0	0	0	-	
Pertussis	Cases	0	0	0	0	0	1	0	2	0	4	13	8	24	-67
<b>Sexually-transmitted</b>															
Gonorrhea	Cases	1218	355	90	197	90	200	237	139	199	2725	1642	10306	9226	+12
	Rate**	16.4	2.1	3.0	3.5	3.5	6.4	4.3	4.6	4.4	6.5	3.7	24.4	26.1	
Syphilis (P&S)	Cases	124	149	41	79	4	14	71	37	34	553	428	1937	1641	+18
	Rate**	1.7	2.0	1.4	1.4	0.2	0.4	1.3	1.2	0.8	1.3	1.0	4.6	3.7	
<b>Enteric</b>															
Campylobacter	Cases	4	3	3	3	0	1	0	0	3	19	27	53	85	-38
Hepatitis A	Cases	2	2	0	1	0	2	1	0	1	9	41	79	130	-39
	Rate*	0.3	0.3	0	0.2	0	0.6	0.2	0	0.2	0.2	0.9	1.8	3.0	
Salmonella	Cases	20	13	10	29	4	4	16	5	11	112	134	331	382	-13
	Rate*	2.6	1.7	3.2	5.1	1.5	1.2	2.7	1.6	2.4	2.6	3.1	7.6	8.7	
Shigella	Cases	11	2	1	22	1	0	4	4	2	47	72	124	193	-36
	Rate*	1.4	0.3	0.3	3.9	0.4	0	0.7	1.3	0.4	1.1	1.6	2.8	4.4	
Vibrio Cholera	Cases	0	0	0	0	0	0	0	0	0	0	1	0	2	-
Vibrio, other	Cases	1	0	0	0	0	0	0	0	1	3	5	33	21	+57
<b>Other</b>															
Hepatitis B	Cases	21	12	2	7	0	2	4	1	1	50	64	182	210	-13
	Rate*	2.7	1.6	0.6	1.2	0	0.6	0.7	0.3	0.2	1.1	1.5	4.1	4.8	
Meningitis/Bacteremia	Cases	0	0	0	1	0	0	0	0	0	1	14	16	52	-69
H. Influenza	Cases	0	0	0	1	0	0	0	0	0	1	14	16	52	-69
N. Mening.	Cases	0	0	0	2	0	0	0	0	0	2	2	19	27	-30
Tuberculosis	Cases	25	8	6	9	2	3	10	3	9	75	49	184	198	-7
	Rate*	3.2	1.0	1.9	1.6	0.8	0.9	1.7	0.9	1.9	1.7	1.1	4.2	4.5	

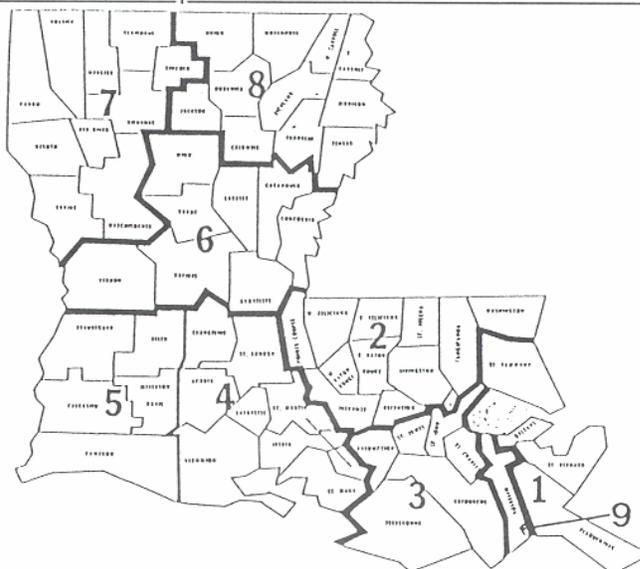
\* Cases per 100,000 population  
\*\* Cases per 10,000 population

Table 2. Diseases of low frequency, 1991

Disease	Total to date
Blastomycosis	4
Brucellosis	0
Histoplasmosis	3
Lead Toxicity	9
Legionellosis	5
Leprosy	1
Leptospirosis	0
Lyme Disease	1
Malaria	13
Rocky Mountain Spotted Fever	0
Tetanus	0
Typhoid	4

Table 3. Animal rabies - July - August, 1991

Parish	Species	No. Cases
No cases for this quarter		



## Annual Summary Salmonellosis

For 1990, 823 cases of salmonellosis were reported to the Epidemiology Section, a 10% increase from 1989. The case rate for Louisiana for 1990 was 19 per 100,000. Incidence rates were highest among children under 5 (89 per 100,000) followed by the 75+ age group (20 per 100,000). Rates were slightly higher for males than females (21 vs. 20 per 100,000) but did not differ for blacks vs whites. Parishes with the highest case rates per 100,000 were: Caddo (45), Terrebonne (38), Allen (37), Rapides (36), Lafayette (30) and Washington (30) (Figure 1).

Two outbreaks of salmonellosis were investigated in 1990. One involved a day care center where 11 cases of *Salmonella javiana* were reported with no identified common source and the second outbreak involved a fund raising shrimp boil in which 10 cases of *Salmonella java* were identified. Cases by month of report are shown in Figure 2.

Salmonellosis is a bacterial infection caused by approximately 2000 identified *Salmonella* serotypes, 200 of which typically occur in the U.S. Twenty nine different serotypes were reported in Louisiana for 1990; the most prevalent were *S. typhimurium*, *S. enteritidis*, and *S. newport* (Table 1). *S. typhimurium* and *S. enteritidis* have consistently been the

most commonly identified serotypes reported in the United States as a whole. Although the association of *S. enteritidis* with contaminated eggs and chicken was initially identified in the northeast U.S., to date this problem has not been reported in Louisiana.

Salmonellosis is one of the most commonly reported enteric infections in Louisiana. Transmission usually occurs through ingestion of contaminated food, although person-to-person transmission can also occur. The most frequent symptoms of salmonellosis include fever, diarrhea, abdominal cramps, headaches, nausea, and vomiting. Treatment for uncomplicated enterocolitis should be aimed at rehydration and electrolyte replacement. Antibiotic therapy should be reserved for those individuals at high risk of invasive disease such as infants, elderly and the debilitated. Otherwise, antibiotics may prolong the period of communicability and lead to resistant strains.

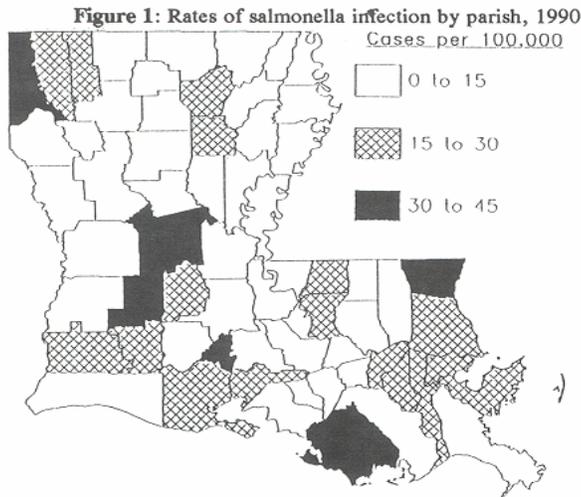


Figure 2: Salmonellosis cases by month of report, 1987-1990

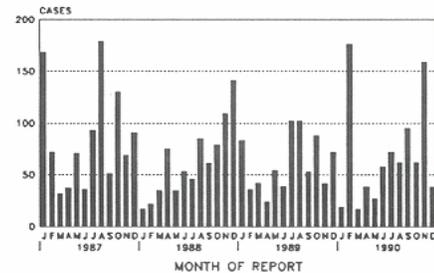


Table 1: Salmonella serotypes identified, 1990

Serotype	# cases
<i>S. typhimurium</i>	67
<i>S. enteritidis</i>	37
<i>S. newport</i>	35
<i>S. javiana</i>	28
<i>S. mississippi</i>	21
<i>S. hadar</i>	16
<i>S. meunchen</i>	11
<i>S. brandederup</i>	9
<i>S. heidelberg</i>	9

### LOUISIANA FACTS

Louisiana's annual morbidity from Diphtheria during the 1930's was approximately 1,000, with a mortality of 100. The city of New Orleans embarked upon an all-out campaign in 1935 to immunize its entire school-age population. By the end of the year, 36,000 New Orleans children had been immunized.

Do you have an interesting fact 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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## LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Gonorrhea**	Plague*	Cancer
Amebiasis	Granuloma Inguinale**	Poliomyelitis	Complications of abortion
Anthrax	Hepatitis, (Specify type)	Psittacosis	Congenital hypothyroidism
Aseptic meningitis	Herpes (genitalis/ neonatal)**	Rabies (animal & man)	Lead poisoning
Blastomycosis	Legionellosis	Rocky Mountain Spotted Fever	Phenylketonuria
Botulism*	Leprosy	Rubella (German measles)*	Reye Syndrome
Brucellosis	Leptospirosis	Rubella (Congenital syndrome)	Severe undernutrition severe anemia, failure to thrive
Campylobacteriosis	Lyme Disease	Salmonellosis	Sickle cell disease (newborns)
Chancroid**	Lymphogranuloma venereum**	Shigellosis	Spinal cord injury
Cholera*	Malaria	Syphilis**	Sudden infant death syndrome (SIDS)
Chlamydial infection**	Measles (rubeola)*	Tetanus	
Diphtheria*	Meningitis, Haemophilus	Trichinosis	
Encephalitis (Specify primary or post-infectious)	Meningococcal Infection (including meningitis)*	Tuberculosis***	
Erythema infectiosum (Fifth Disease)	Mumps	Tularemia	
Foodborne illness*	Mycobacteriosis, atypical***	Typhoid fever	
Genital warts**	Ophthalmia neonatorum*	Typhus fever, murine (fleaborne endemic)	
	Pertussis (whooping cough)	Vibrio infections (excluding cholera)	
		Yellow fever	

Report cases on green EPI-2430 card unless indicated otherwise below.

\*Report suspected cases immediately by telephone. In addition, report all cases of rare or exotic communicable diseases and all outbreaks.

\*\*Report on STD-43 form. Report syphilis cases with active lesions by telephone.

\*\*\*Report on CDC 72.5 (f 5.2431) card

The toll free number for reporting communicable diseases is  
 1-800-256-2748

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