



# Louisiana Morbidity Report

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



M. J. "Mike" Foster, Jr.  
GOVERNOR

David W. Hood  
SECRETARY

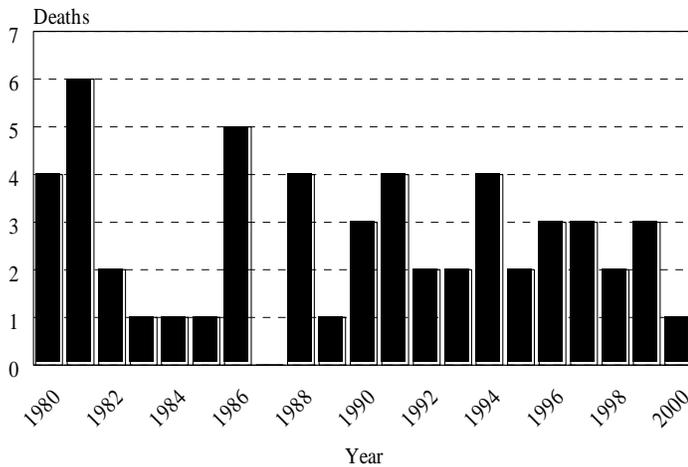
January-February 2001

Volume 12 Number 1

## Creutzfeldt-Jakob Disease in Louisiana

Surveillance for CJD is primarily based on a review of death certificate data since the disease is fatal within a few months. Between 1980 and 2000 there were 57 deaths in LA attributed to CJD, only eight confirmed by an autopsy (Figure 1). However, given the characteristic clinical picture, an ante-mortem clinical diagnosis would be reliable. In 44 (71%) of the cases, CJD was listed as the primary cause of death.

Figure 1: Number of CJD deaths per year in Louisiana, 1980-2000



The cases ranged in age from 34 to 88 with an average age of 67. The number of cases increased with age until the 7<sup>th</sup> decade and then dropped (Figure 2). Males and females were almost equally affected (44% male, 56% female). The overall mortality rate was 0.60 per million (average of 2.7 cases per year) for the 21 year period.

### Contents

Creutzfeldt-Jakob Disease in Louisiana .....	1
BRFSS: Health Insurance, Louisiana, 1991-1999 .....	2
Personal Flotation Device Usage .....	3
Louisiana STD Trends .....	4
Access to Sterile Needles Among Young IVDUs in N.O. ....	4
HIV/AIDS Trends .....	5
Annual Summary: Hepatitis A - 1999 .....	7

Figure 3 represents a spot map of CJD deaths reported in the state. East Baton Rouge, Jefferson, Lafayette, and Orleans parishes reported 7, 8, 7, and 5 deaths respectively.

The age rates and rural/urban distribution patterns of CJD in Louisiana fell within the U.S. range. Therefore it is reasonable to conclude that the surveillance based on death certificates accurately represents the pattern of CJD in the state.

Figure 2: Number of CJD deaths per per age group in Louisiana, 1980-2000

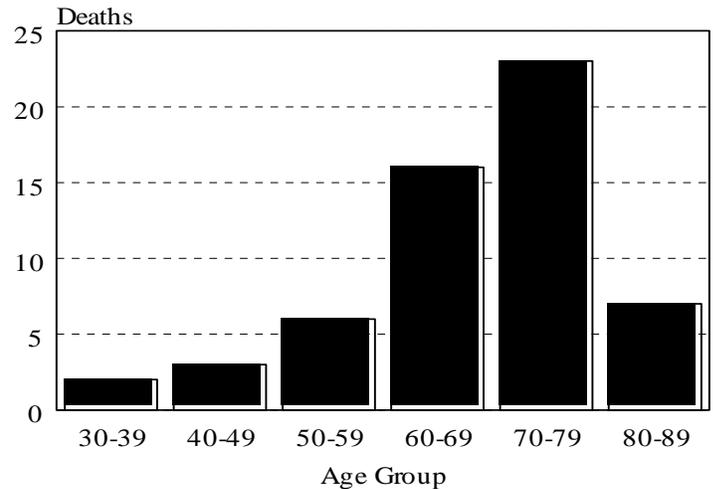
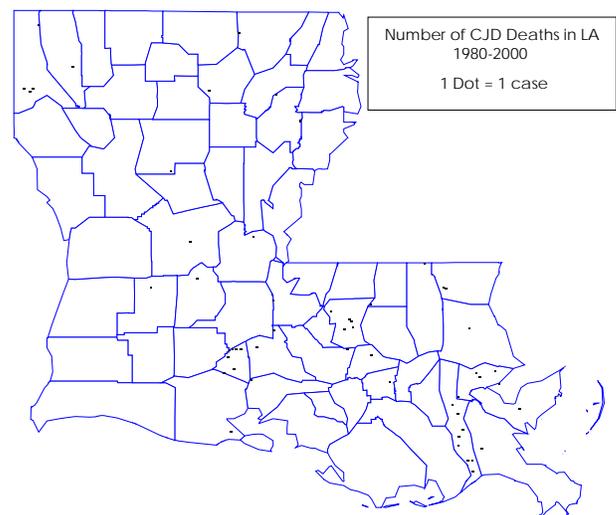


Figure 3: Number of CJD deaths by parish in Louisiana, 1980-2000



(Continue on next page)

**Comment:**

Creutzfeldt-Jakob disease (CJD) was first described by Creutzfeldt and Jakob in the early 1920s. This disease occurs worldwide at a very low rate. In the mid 1980s, an epidemic of bovine spongiform encephalopathy (BSE) resulted in the slaughter of nearly 200,000 heads of cattle in Great Britain. An encephalopathy resembling CJD, named new variant CJD or nv-CJD, appeared in the early 1990s in Great Britain. This new disease killed 80 Britons. Although there is no definite proof that BSE caused the nvCJD cases, most scientists think the two "epidemics" are related. The US has been spared because a ban was placed on importation of British sheep and goats in the early 1950s and on British cattle in the late 1980s. There is no nv-CJD in the USA.

Dementia (memory loss, mood changes, judgment errors) is always present and is often the first manifestation of the disease. Patients lose interest, become apathetic or irritable, experience sleep disorders, intellectual decline and disorientation. They may also have tremors, disturbances of gait, stance and loss of motor control. As the disease progresses, the patient may experience hallucinations, delusional ideas and confusion. In some patients the cerebellar and visual abnormalities (even cortical blindness) predominate. At the end, patients are mute, stuporous, spastic and rigid. The disease rapidly progresses to death in 6 months. Less than 10% have an illness that lasts up to 3 years. The generalized slowing of EEG waves observed at the beginning is replaced by distinctive repetitive sharp waves that become bilateral and synchronous. The regular rate found in CJD is not observed in dementia due to other causes such as Alzheimer or other sub-cortical encephalopathy. The CT scan is usually normal at onset. As the disease progresses, CT scan and MRI show rapid development of bilateral cortical atrophy.

CJD may be mistaken for Alzheimer with myoclonus, multi-infarct dementia, alcoholic or nutritional deficiency syndromes or brain tumors. But the presence of cerebellar involvement, typical EEG changes and rapid deterioration over a few months secures the diagnosis. Confirmation is based on the typical histologic pattern of spongiform encephalopathy.

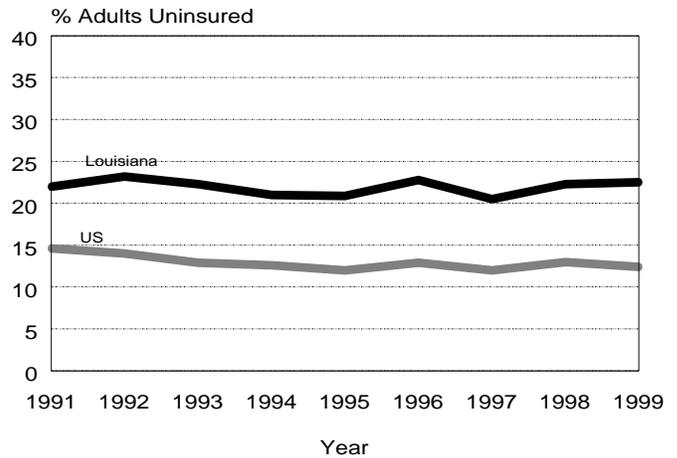
Some populations seem to have a higher incidence of CJD than others. Incidence rates calculated in a few countries show a range from 0.3 to 1 million /year, with an average of 0.5 per million. Nv-CJD is limited to Great Britain and a few other European countries.

## BRFSS: Health Insurance, Louisiana, 1991-1999

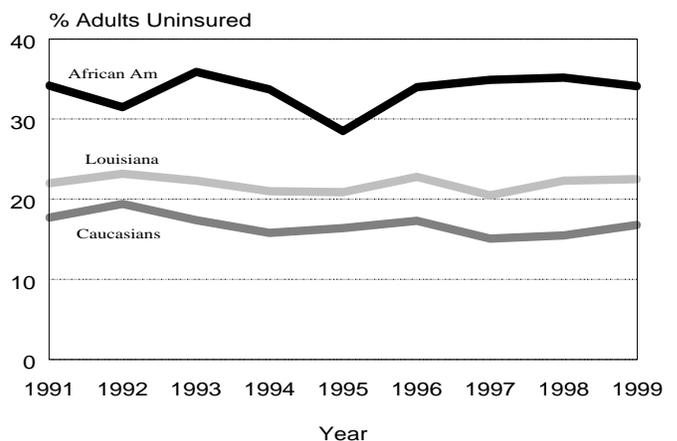
Between 1991-1999, the overall percent of uninsured adults in Louisiana remained stable - around 22% (Figure 1). However, this is significantly higher than the national average of 13% for the same time period. The percent of under-insured adults in Louisiana steadily decreased from 10.1% in 1991 to 4.3% in 1999, possibly indicating more affordable health care, once insurance is obtained.

While there is no difference in insurance status between adult men and women in Louisiana, serious racial disparities do exist. The rate of uninsured African Americans is nearly twice that of Caucasians (33.6% vs 16.8%; Figure 2).

**Figure 1:** Adults who are uninsured, Louisiana vs US, BRFSS, 1991-1999



**Figure 2:** Adults who are uninsured by race, BRFSS, 1991-1999



**Louisiana Morbidity Report**  
Volume 12 Number 1 January-February 2001

The Louisiana Morbidity Report is published bimonthly by the Infectious Disease Epidemiology Section of the Louisiana Office of Public Health to inform physicians, nurses, and public health professionals about disease trends and patterns in Louisiana. Address correspondence to Louisiana Morbidity Report, Infectious Disease Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.

<i>Assistant Secretary, OPH</i>	<i>Madeline McAndrew</i>
<i>State Epidemiologist</i>	<i>Raoult Ratard, MD MPH MS</i>
<i>Editors</i>	<i>Karen Kelso, RNC MS Barbara Trahan, MPH Buddy Bates, MSPH</i>
<i>Layout &amp; Design</i>	<i>Ethel Davis, CST</i>
<i>Contributors</i>	
<i>Susan Wilson, MSN John Clayton, MPH Joy Ewell, BA Jennifer Wood, MPH</i>	<i>Jennifer Wiley, MHSE CHES Jim Scioneaux, BS Rafael Jarpa, MPH</i>

**Table:** Adults 18 years and older who are insured, underinsured, and uninsured, Louisiana, 1999 (N= 1658)

Groups	Insured		Under-insured		Un-insured	
	No.	%	No.	%	No.	%
<b>Total</b>	1236	73.4*	76	4.2*	346	22.4*
<b>Sex</b>						
Male	510	76.3	18	2.3	130	21.4
Female	726	70.8	58	5.9	216	23.3
<b>Age</b>						
18-24	100	58.7	12	6.1	63	35.3
25-44	490	70.0	37	5.2	155	24.8
45--64	353	74.3	17	3.0	106	22.7
65+	285	91.3	10	2.3	20	6.4
<b>Education</b>						
< High School	175	59.2	22	5.9	94	34.9
High School Grad	400	67.7	29	4.8	156	27.6
Some College	305	77.2	13	3.3	66	19.6
College Grad	353	89.2	12	3.0	30	7.8
<b>Income</b>						
<\$15,000	137	53.2	18	6.8	87	40.0
\$15,000-\$24,999	203	58.2	16	5.3	122	36.5
\$25,000-\$49,000	400	80.7	20	4.4	59	14.9
≥\$50,000	331	92.5	7	1.8	21	5.7
<b>Race</b>						
White	885	78.6	54	4.6	172	16.8
African-American	274	62.3	18	3.6	147	34.1
<b>Employment</b>						
Employed	755	75.6	40	4.3	195	20.2
Homemaker	120	61.7	7	3.8	58	34.5
Retired	338	81.5	25	4.2	51	14.3
Unemployed	21	37.8	4	4.9	40	57.3

\* Weighted (adjusted rate)

Table 1 compares insurance status across 5 main demographic categories for 1999: Sex, Age, Education, Income, and Race. As expected, the proportion of respondents with health care coverage increased consistently with increasing age, educational status and income.

As part of the Office of Public Health's Behavioral Risk Factor Surveillance System (BRFSS), respondents are asked their current insurance status and classified as insured, under-insured, or uninsured. Insured is defined as having health care coverage (e.g. private or group health insurance, HMO membership, Medicare, etc.) and able to see a physician during the last 12 months, without regard to cost. Under-insured is defined as having health care coverage but not able to see a physician at a given time in the last 12 months because of cost. Uninsured is defined as having no health care coverage. An average of 1650 adults was interviewed each year.

Adequate health insurance is becoming a necessity as health care and prescription drug costs continue to rise. Lack of a health care plan or inadequate insurance coverage prevents many people from getting needed care because they are financially unable to pay for services without the help of insurance resulting in escalating health care costs. Based on the above data, prevention efforts should be planned which target known health disparities.

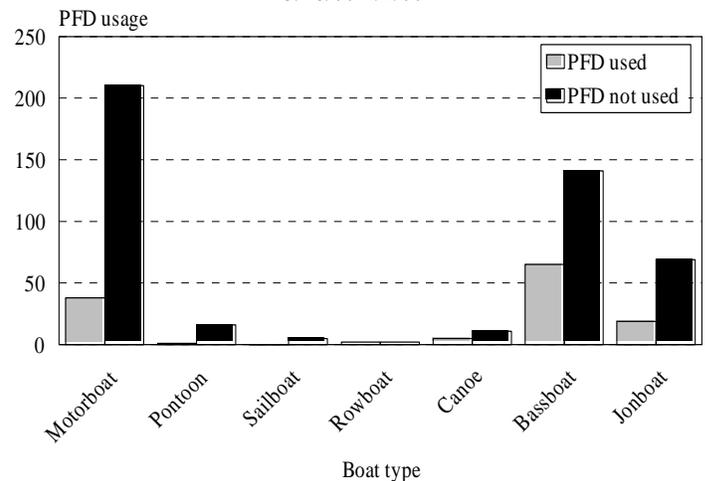
## Personal Flotation Device (PFD) Usage

From March 18 – April 2, 2000, an observational survey was conducted at boat ramps around Lake Pontchartrain and the Greater New Orleans Metropolitan Area to determine the rate of personal flotation device (PFD) usage among boaters using the metro-New Orleans waterways in boats 26 feet or smaller. A bass fishing tournament was observed at one of the sites on March 18, 2000.

Of 586 boaters observed, 11.4% (n=67) were believed to be children (0-12 years of age), and 88.6% (n=519) were believed to be adults (13 years of age and older). The majority (85.5%, n=501) of boaters were male. Race was not recorded.

Of all boaters observed, childhood PFD use was high (67.1%) compared to 16.4% of all adults. Fifty percent of the adult bass tournament participants used a PFD. Among adults, bass tournament participants were almost nine times more likely (OR = 8.69, CI: 4.92<OR<15.39) to wear a PFD than adult boaters not participating in the tournament.

Overall, PFD use varied with type of boat and weather conditions. Boaters on motor boats were about half as likely to wear a PFD (OR: 0.48, CI: 0.31 <OR< 0.74) than boaters on other types of boats (e.g., party barge/pontoon, canoe, bass boat, jonboat). Overall, boaters on bass boats were more than two times likely to wear a PFD (OR: 2.24, CI: 1.47 <OR< 3.41) than boaters on other boats (Figure). Both results are probably due in part to the fact that over half the boaters participating in the bass fishing tournament wore PFDs. When bass tournament participants are eliminated from the

**Figure:** PFD usage in metro-New Orleans by boat type, 3/18/00-4/2/00

sample, these results are not statistically significant. Boaters were more than twice as likely to wear a PFD on a significantly overcast day than on a sunny day (OR: 2.20, CI: 1.39 <OR< 2.70). PFD use did not vary with number of persons on a boat, water conditions, wind speed, or day of the week.

**Comment:**

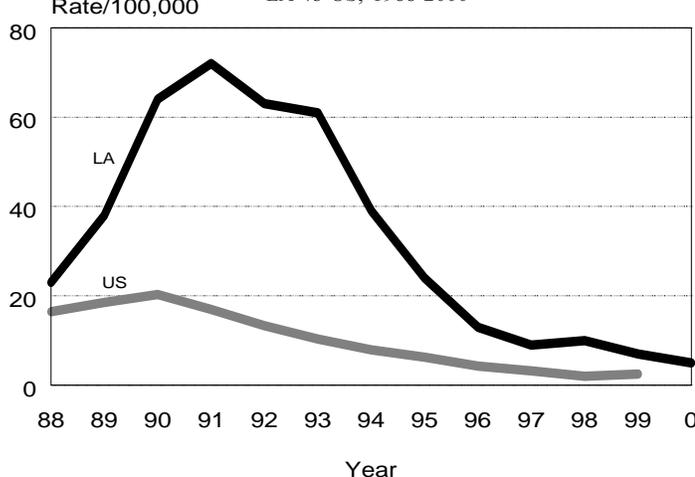
Observations were limited to boats 26' or less because 1) Louisiana children under 13 years old are mandated to wear PFDs on boats of this size, and 2) 85% of boating fatalities nationwide in 1998 occurred on boats 26' or less.

Boating is a recreational sport that requires skill and knowledge. There are many risks associated with boating, the worst of which is drowning. Nationwide, roughly one fifth of all drownings are boating-related. In 1998, 574 boaters drowned. This figure represents 70% of all boating fatalities. According to the U.S. Department of Transportation and the U.S. Coast Guard, the lives of 89% (509/574) of these boaters could have been saved if they had worn a life jacket. Although the prevalence of personal floatation device usage is higher among organized water/sporting event participants, all boat users should be encouraged to use PFDs at all times. For additional information, contact the Office of Public Health, Injury Research & Prevention Section at 504-568-2509.

## Louisiana STD Trends

Louisiana experienced an epidemic of syphilis in the late 1980's and early 1990's, with rates of primary and secondary syphilis peaking at 72 per 100,000 in 1991. Since that time, syphilis rates in the state have dropped steeply (Figure 1). In 1999, there were 304 cases of primary and secondary syphilis reported (709 cases including early latent disease), for a rate of 7 per 100,000. This represented a decrease of 30% in primary and secondary syphilis from 1998, as well as, a 90% decline from the peak of the epidemic in 1991. Annualized rates for 2000 (based on the first six months of reports) have decreased to 4.7 per 100,000. In 1999, rates of early syphilis were far higher in African-Americans than Caucasians (48 vs. 3 per 100,000); however, the African American/Caucasians ratio declined from 20:1 in 1998 to 16:1 in 1999. Primary and secondary syphilis rates were highest in the rural Lake Charles, followed by Houma/Thibodaux

**Figure 1:** Rates of primary and secondary syphilis, LA vs US, 1988-2000\*

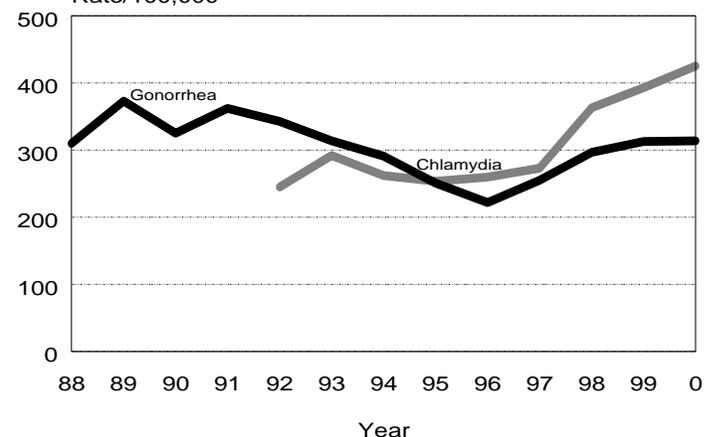


and Lafayette regions (17, 13 & 11 per 100,000 respectively). In 1999, there were 12 cases in newborns meeting the congenital syphilis surveillance definition. This is an increase from 7 in 1998, but a decrease from 31 in 1997.

Louisiana is reporting increasing rates of gonorrhea and chlamydia, although it is unclear how much of this might be due to changes in surveillance and testing practices. The number of cases of gonorrhea reported in 1999 was 13,198. Gonorrhea rates increased 5.4% in 1999 compared to 1998 (313 vs. 297 per 100,000), after a 16.4% increase in 1998 compared to 1997 (297 vs. 255 per 100,000). In the middle of 1997, Louisiana changed its surveillance procedures, and for the first time, began to include as cases reports of gonorrhea test from laboratories with no confirmation from physicians. This change in procedures was followed by a sharp increase in cases in the second half of 1997 and 1998. It is possible, however, that some of the increase in 1998 and 1999 is unrelated to the change in surveillance procedures.

The change in surveillance procedures also has been followed by a sharp increase in reports of chlamydia infection. Between 1998 and 1999, rates of reported chlamydia infection rose 8% from 363 to 393 per 100,000 (to 16,573 cases), after a 33% increase from 1997 to 1998 (273 vs. 363 per 100,000, Figure 2).

**Figure 2:** Rates of gonorrhea and chlamydia from 1988-2000\*  
Rate/100,000



\*Projected from first 6 months.

The STD Program continues to work closely with the HIV Prevention Program to reach high-risk populations (youths at high-risk, females at risk, IVDUs, commercial sex workers, and men who have sex with men), with appropriate prevention strategies, as well as the surveillance and treatment of the STDs.

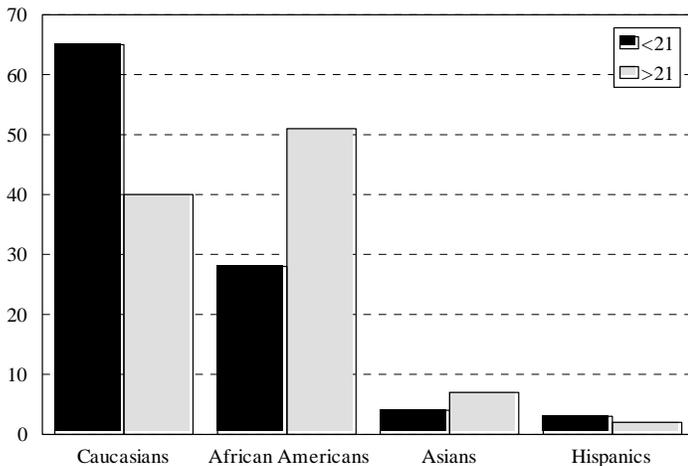
## Access to Sterile Needles Among Young IVDUs in New Orleans

A study to determine where young IVDUs in New Orleans are acquiring their needles and describe the social and demographic characteristics associated with accessing sterile needles from pharmacies and Needle Exchange Programs (NEP) was conducted between September, 1997 and January 1999. In-depth interviews were

conducted with young IDUs (ages 16-30) in five cities (Baltimore, New York, New Orleans, Chicago, and Los Angeles) as part of the Collaborative Injection Drug Users Study II (CIDUS II).\*

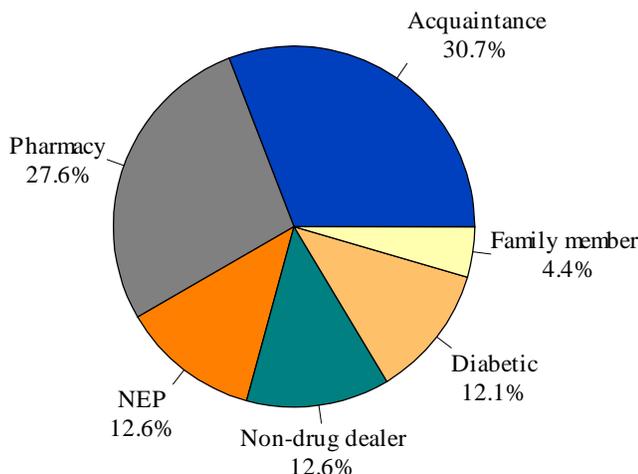
A total of 200 persons completed the interview and were included in the analyses. The majority (72.7%) reported residing in New Orleans during the previous 6 months; 50.0% were >21 years old; 65.2% were male; 53.4% reported being Caucasian, 2.5% Hispanic, 5.4% Asian, Native American, and the remainder (38.7%) reported African American as their race (Figure 1). Few (6.0%) participants were married, and most (72.4%) had less than a high school education. Although almost half (44.8%), of the sample reported having a regular place to stay, two thirds (67.0%) reported being

Figure 1: Number of IVDUs in New Orleans by race and age, 1997-1999



homeless at the same time during the last six months. One third (32.5%) had a regular job, with the remainder of the participants scavenging (35.0%) or obtaining money through illegal activities (32.5%). Most participants (91.1%), had some experience in a correctional facility (jail, juvenile correctional facility or prison) and 53.5% had been arrested for drug related charges. Only 38.6% of the participants reported EVER buying needles from a pharmacy. The majority (28%) of those questioned about where the last needle

Figure 2: Source of needle acquisition by IVDUs in New Orleans, 1997-1999



used was obtained reported access through an acquaintance, followed by pharmacies (25%) and NEPs (11.5%; Figure 2).

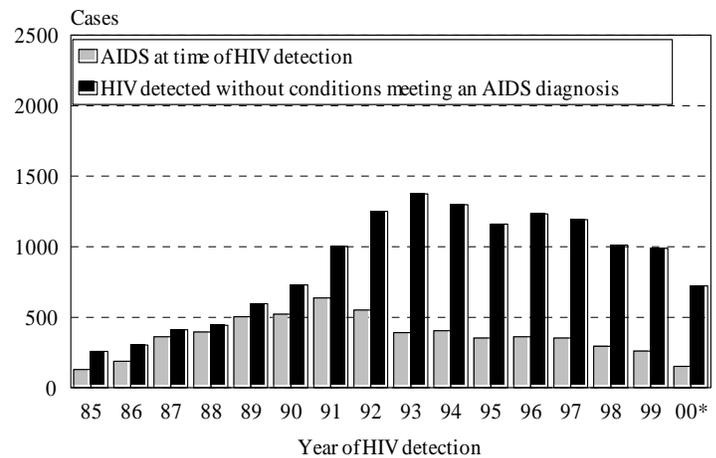
Pharmacies were the most commonly reported usual source of new needles in the last six months (33.2%). When participants were asked how they obtained the needle used the last time they injected, 53.2% reported buying the needle while 44.8% reporting being given (by whom was not specified) the needle for free. When participants were asked where they obtained the needle they used the last time they injected, acquaintances were the most commonly reported source for obtaining the needle used the last time they injected (28.0).

Participants' age (<21 vs >21) and race (African American vs. Caucasian/Other) were associated with accessing needles from pharmacies or NEPs ( $p < 0.05$ ). Caucasians and persons of other races were 3.7 times (95 percent C.I. 1.72-7.99) more likely than African-Americans to access sterile needs from pharmacies or NEPs. Participants <21 years old were 2.4 times (95 percent CI 1.28-4.56) more likely than individuals <21 years old to access sterile needles in the same manner, while participants who injected alone the last time they injected were 2.2 times (95 percent CI 0.99-4.76) more likely.

Pharmacies and needle exchange programs are the only reliable sources of sterile needles in Louisiana (although NEPs are illegal in Louisiana). Improvements in access to sterile needles may reduce risk behavior among IVDUs and is an important component of HIV prevention. The paraphernalia law allows pharmacists to refuse sales to customers suspected of being an IVDU, and Farley et al. have confirmed that only one fourth of pharmacists in Louisiana sell to suspected IVDUs. Taken together, the results from this study and Farley et al.'s suggest that increased access to sterile needles is needed to minimize the spread of blood-borne diseases and would be improved by changes in the paraphernalia laws to allow unrestricted sales of needles to IVDUs.

\*Only the New Orleans data were analyzed for this study.

### HIV/AIDS TRENDS



\*Incomplete data

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE  
November - December, 2000  
**PROVISIONAL DATA**

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD				
	1	2	3	4	5	6	7	8	9	Nov-Dec 2000	Nov-Dec 1999	Jan-Dec Cum 2000	Jan-Dec Cum 1999	% Chg
<b>Vaccine-preventable</b>														
<i>H. influenzae (type B)</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	6	0	1	0	0	0	0	0	0	7	11	135	167	-19.2
Rate <sup>1</sup>	0.6	-	0.3	-	-	-	-	-	-	0.2	0.3	3.1	3.9	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	0	0	0	0	0	0	1	5	11	-54.5
Rubella	0	0	0	0	0	0	0	0	0	0	0	1	0	-
Pertussis	1	0	0	0	0	0	0	1	0	2	0	17	10	+70
<b>Sexually-transmitted</b>														
HIV/AIDS Cases <sup>2</sup>	43	21	2	9	2	9	7	2	6	101	189	1000	1256	-20
Rate <sup>1</sup>	4.1	3.7	0.5	1.7	0.7	2.9	1.4	0.6	1.6	2.3	4.4	23.2	29.1	
Gonorrhea Cases	529	330	92	154	57	39	526	190	101	2018	2073	13265	13209	+0.4
Rate <sup>1</sup>	50.9	58.1	24.4	29.8	21.3	12.8	104	54.1	26.2	47.8	49.1	314.3	313.0	
Syphilis (P&S) Cases	3	6	2	12	0	0	0	0	1	24	46	210	306	-31.4
Rate <sup>1</sup>	0.3	1.1	0.5	2.3	-	-	-	-	0.3	0.6	1.1	5	7.3	
<b>Enteric</b>														
Campylobacter	2	0	0	4	2	0	1	0	2	11	3	135	117	+15.4
Hepatitis A Cases	24	1	2	1	0	0	0	0	0	28	16	104	204	-49
Rate <sup>1</sup>	2.3	0.20	0.5	0.2	-	-	-	-	-	0.6	0.4	2.4	4.7	
Salmonella Cases	10	2	8	17	5	2	3	0	14	62	43	499	536	-6.9
Rate <sup>1</sup>	1	0.4	2.1	3.3	1.9	0.7	0.6	-	3.6	1.4	1	11.6	12.4	
Shigella Cases	13	2	4	0	0	0	1	1	12	33	21	283	165	+71.5
Rate <sup>1</sup>	1.3	0.4	1.1	-	-	-	0.2	0.3	3.1	0.8	0.5	6.6	3.8	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	3	0	-
Vibrio, other	0	0	0	1	0	0	0	0	0	1	1	30	24	+25
<b>Other</b>														
<i>H. influenzae (other)</i>	0	0	0	0	0	0	0	0	0	0	1	14	13	+7.7
<i>N. Meningitidis</i>	1	0	0	1	2	0	0	0	0	4	3	43	58	-25.9
Tuberculosis	60	12	7	15	4	4	7	12	9	130	57	331	357	-7.3

1 = Cases Per 100,000

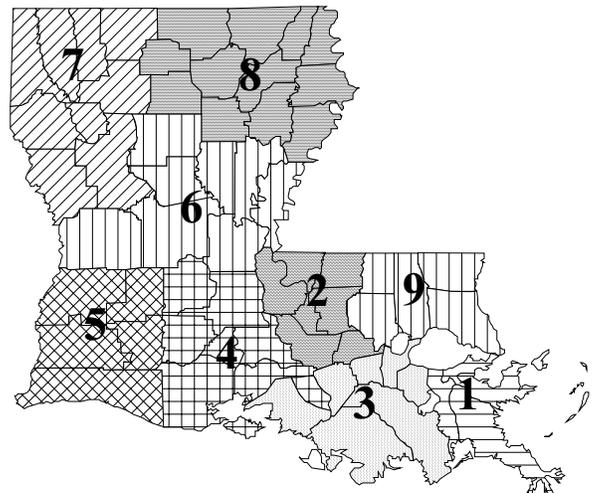
2=These totals reflect persons with HIV infection whose status was first detected during the specified time period. This includes persons who were diagnosed with AIDS at time HIV was first detected.

Table 2. Diseases of Low Frequency

Disease	Total to Date
E.coli O157:H7	13
Legionellosis	7
Lyme Disease	7
Malaria	14
Rabies, animal	2
Varicella	98

Table 3. Animal Rabies (Nov-Dec, 2000)

Parish	No. Cases	Species
Acadia	1	Skunk

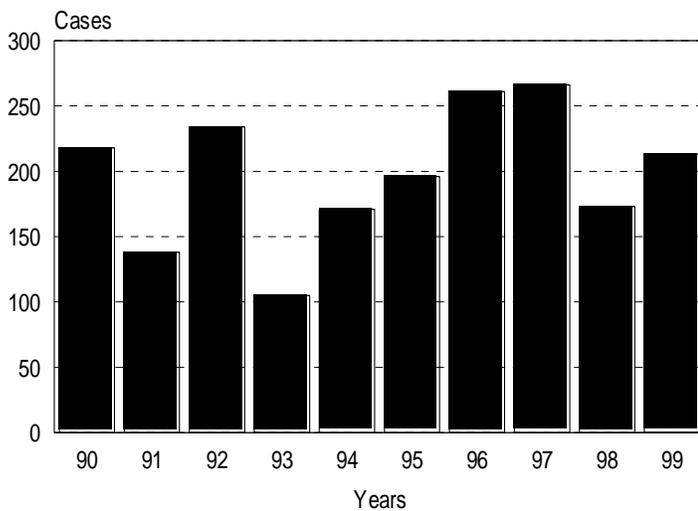


## ANNUAL SUMMARY

### Hepatitis A - 1999

In 1999, 213 hepatitis A cases were reported. This was an increase of 23% from 1998 (Figure 1). Louisiana's case rate (4.9 per 100,000) is approximately half of the national case rate for 1998 (8.6 per 100,000). Sex-race specific rates per 100,000 were highest among white males (5.1) followed by white females (4.3). Overall, Caucasians accounted for 64% of all reported cases. The 35-44 (36), and the 25-34 (34) age groups reported the most cases (Figure 2). One hundred nineteen (56%) cases had complete clinical and risk factor information. Seventy-seven percent (92) experienced jaundice; 26% (31) were hospitalized; 21% (25) reported hepatitis A exposure other than sexual or household; 15% (18) reported household contact with a known hepatitis A case; 13% (16) were reported in either children attending a day care or a day care center attendee; 4%(5) were food handlers and one traveled outside of the United States. There was one reported death, a twenty-one year old, Caucasian male. Parishes reporting the highest case rates per 100,000 include Vermilion (132), West Feliciana (70) and Jefferson Davis (42; Figure 3). The high rate of Hepatitis A in Vermilion parish is attributed to a large-scale propagated outbreak that occurred throughout the year as a result of person-to-person transmission. Fifty-five percent of the cases in Vermilion occurred among individuals between the ages of five and nineteen. This outbreak could account for the slight increase observed among reported cases this year.

**Figure 1:** Cases of hepatitis A in Louisiana by year, 1990-1999



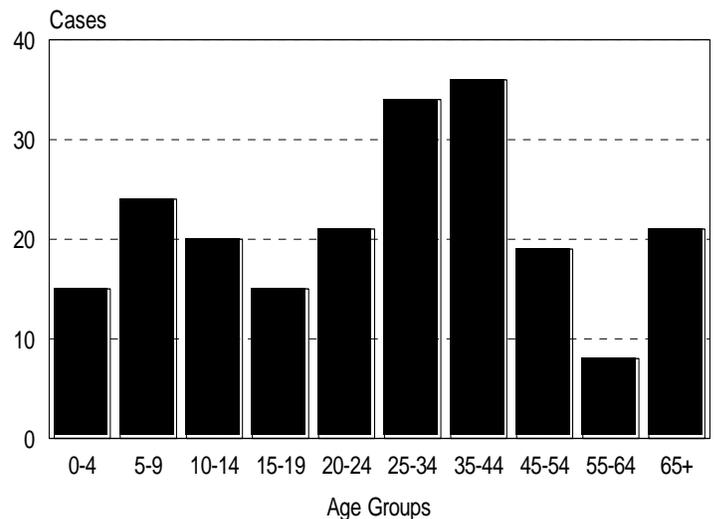
*Comment:*

A case of hepatitis A is identified as an individual who exhibits illness characterized by the discrete onset of jaundice and/or elevated serum ALT levels (at least 2.5 times normal levels) and is laboratory confirmed by the presence of IgM antibodies to hepatitis A in serum (anti-HAV IgM). Household contacts of a confirmed hepatitis A case should receive immune globulin (IG) within 14 days after initial exposure. The hepatitis A outbreak that occurred in Vermilion parish this past year could have been curtailed through early detection of hepatitis A cases and prompt post-exposure prophylaxis of contacts.

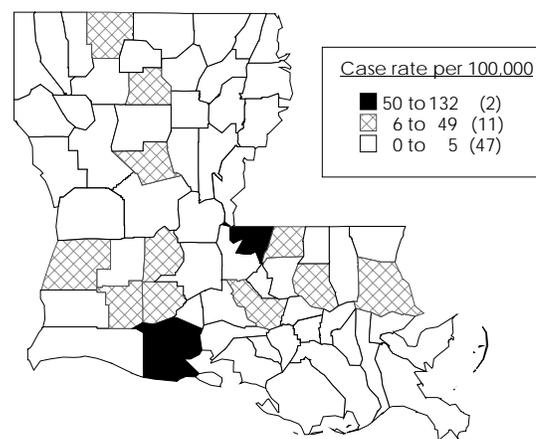
The Infectious Disease Epidemiology Section should be notified immediately of confirmed hepatitis A cases among day care center staff, day care center attendees, and/or food handlers.

Hepatitis A vaccine is available through OPH clinics for those parishes that have exceeded the state case rate for three consecutive years. Primary care physicians should consider administering hepatitis A vaccine to any individual who chooses to reduce the risk of acquiring hepatitis A disease, such as those traveling internationally, child care employees, or those working in food establishments.

**Figure 2:** Cases of hepatitis A by age group, 1999



**Figure 3:** Rates of hepatitis A by parish, 1999



*Louisiana Fact*

*Charity Hospital in New Orleans is the oldest hospital in continuous operation in the United States. On March 10, 1736, Widow Kolly's house on Chartres and Bienville Streets, which had been occupied by the Ursuline Nuns (1727 – 1734) while their convent was under construction, became the first "l'Hospital des pauvres de la Charite".*

# LIST OF REPORTABLE DISEASES/CONDITIONS

## REPORTABLE DISEASES

## OTHER REPORTABLE CONDITIONS

Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis, Acute (A, B, C, Other)	Rubella (German measles)	Cancer
Amebiasis	Hepatitis B carriage in pregnancy	Rubella (congenital syndrome)	Complications of abortion
Arthropod-borne encephalitis (Specify type)	Herpes (neonatal)	Salmonellosis	Congenital hypothyroidism*
Blastomycosis	Human Immunodeficiency Virus (HIV) infection <sup>3</sup>	Shigellosis	Severe traumatic head injury**
Botulism <sup>1</sup>	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Galactosemia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Hemophilia*
Chancroid <sup>2</sup>	Lymphogranuloma venereum <sup>2</sup>	Syphilis <sup>2</sup>	Lead Poisoning
Chlamydial infection <sup>2</sup>	Malaria	Tetanus	Phenylketonuria*
Cholera <sup>1</sup>	Measles (rubeola) <sup>1</sup>	Tuberculosis <sup>4</sup>	Reye's Syndrome
Cryptosporidiosis	Meningitis, other bacterial or fungal	Typhoid fever	Severe under nutrition (severe anemia, failure to thrive)
Diphtheria	Mumps	Varicella (chickenpox)	Sickle cell disease (newborns)*
Enterococcus (infection; resistant to vancomycin)	Mycobacteriosis, atypical <sup>4</sup>	Vibrio infections (excluding cholera) <sup>1</sup>	Spinal cord injury**
Escherichia coli 0157:H7 infection	Neisseria meningitidis infection <sup>1</sup>		Sudden infant death syndrome (SIDS)
Gonorrhea <sup>2</sup>	Pertussis		Traumatic Brain Injury
Haemophilus influenzae infection <sup>1</sup>	Rabies (animal & man)		
Hemolytic-Uremic Syndrome	Rocky Mountain Spotted Fever (RMSF)		

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

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

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

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

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

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

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

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

### Numbers for reporting communicable diseases

**1-800-256-2748**

**Local # 568-5005**

**FAX # 504-568-5006**

**Web site: <http://www.dhh.state.la.us/oph/infectepi/default.htm>**

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

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

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