



DAVID L. RAMSEY
SECRETARY
(504) 342-6711

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
DIVISION OF DISEASE CONTROL
P.O. BOX 60630
NEW ORLEANS, LOUISIANA 70160

LOUISIANA MORBIDITY REPORT EPIDEMIOLOGY

02 ACIP Issues Two-dose Measles
Vaccine Recommendations
04 Louisiana Hospital Immunity
Survey-1989
04 Eosinophilia-Myalgia Syndrome
(EMS) in L-Tryptophan Users
05 Chronic Fatigue Syndrome
06 Beware of Ticks

March/April 1990

Volume 1, Number 2

MEASLES OUTBREAK (SHREVEPORT)

On September 21, 1989, the Bossier Parish Health Unit received a report from a private physician of a suspected measles case. A two year old un-immunized boy had been clinically diagnosed as having measles. The child attended a day care center in Bossier City.

A total of 54 immunization records were evaluated at the day care center. The findings were as follows:

- (1) 13 children had no records
- (2) 8 children had no MMR.
- (3) 4 after school children had no record of having received MMR.
- (4) 3 children were too young to be immunized

The day care center accepted many "drop-ins" without immunization records. Parents of susceptible children were warned about early symptoms, about keeping their children home and about reporting if such symptoms should occur. Vaccinations were recommended for all children 6 months of age and older, with scheduled re-vaccination at 15 months for children less than 13 months.

The next day a physician called the Caddo Parish Health Unit to report that a 9 year old child with measles had been hospitalized in the Pediatric Intensive Care

Unit at Schumpert Hospital. The investigation revealed that a 19 month old child from California with clinical measles was staying at the Schumpert child's home. This 19 month old girl, a tourist from California, had been left at the same day care center during the prodromal stages as a "drop-in" during the afternoon of 9/7/89. This child had been exposed to measles approximately one to two weeks prior in California. Epidemiological investigation ascertained that she was the index case.

Children who lacked proper immunizations, and had been refused admittance by the initial day care center were being openly accepted by other nearby centers without proof of measles immunizations. This further contributed to the dissemination of the measles virus. As a result, the Office of Public Health issued a recommendation to all day care centers stating that children who were 6 months of age and were enrolled in or considered to be "drop-in" at day care centers or nurseries, in Caddo and Bossier Parishes be immunized against measles. Those children that were 13 months of age should be revaccinated at 15 months. Failure to comply with this recommendation would result in immediate closure of the center by the Office of Public Health.

Spot checks of day care centers, especially those accepting "drop-ins", were conducted to ensure compliance. Parents

were immediately notified to remove those children from the center who were not up to date.

In spite of these and other control measures, the outbreak continued four months. It ultimately involved 11 day care centers, 15 elementary, 6 middle, 7 high schools, 3 colleges, 1 business school, Louisiana Down quarter Horses Race Track which draws people from four surrounding states, 1 institution, and 11 businesses. Nosocomial infections occurred at 8 area hospitals, 12 pediatrician clinics and 4 family practice offices. Approximately 300 cases of suspected measles were investigated and 110 indigenous cases were confirmed. Eleven people were hospitalized, two developed coma, one miscarriage occurred in one of the comatose patients.

Special immunization clinics were held at 20 schools, 2 universities, 1 business college, and 2 private industries. Approximately 21,000 doses of MMR vaccine were administered during the outbreak. Containment efforts involved the entire Louisiana Immunization Communicable Disease staff, Program Managers as well as the staff of the Northwest Regional Office and its ten parish health units.

The cost of the investigation and surveillance activities including the cost of mass immunizations was \$485,764.

ACIP ISSUES TWO-DOSE MEASLES VACCINE RECOMMENDATIONS

As a result of the outbreak described above, the Office of Public Health (OPH) in 1989 received reports of 119 measles cases, the largest measles case count in Louisiana in ten years. The Centers for Disease Control reported 15,050 cases for the United States as a whole for the same year; this also was the largest number since 1978. Not only has the goal of eradication of measles escaped us, but measles appears to be making a strong comeback.

Measles has persisted in part because of failure to vaccinate all children according to the recommended schedule. However, in the first six months of 1989, school-age children

(5-19 years of age) accounted for 51.1% of the cases nationwide; and the vast majority of these children were vaccinated. In response to this problem of primary vaccine failures, a two-dose measles vaccination schedule has been suggested.

Over the holidays the Centers for Disease Control Advisory Committee on Immunization Practices (ACIP) published its recommendations for the new two-dose measles vaccine schedule. The core of the recommendations is that children should receive MMR for the first time at 15 months and MMR for a second time before entering kindergarten or first grade (age 4-6). In addition, ACIP is recommending a routine second dose of MMR for students entering college and for medical workers, unless they have proof of measles immunity (table 1). Specific recommendations for endemic areas and outbreaks have also been changed (table 1 and table 2).

The timing of the second dose of MMR is based primarily on administrative considerations, since children already visit health care providers at age 4-6 for DPT and OPV. The American Academy of Pediatrics (AAP) has recently issued its own measles vaccine recommendations; the AAP suggests a second dose of MMR be given on entry to middle school or junior high school. The AAP recommendation has the advantage of helping to control school-based outbreaks of measles and mumps in the near future, but has the disadvantage of requiring an additional health visit.

In February, the OPH convened a group of experts to make recommendations for measles policy in Louisiana. The committee endorsed the ACIP recommendations (second dose at age 4-6) for the same administrative reasons cited by the CDC. While this strategy will have the greatest success in vaccinating an entire age cohort, it will not protect the few susceptible children in junior high and high schools for several years, so some continued measles activity in these settings is possible. This policy does not preclude physicians from vaccinating children ages 6-18 on their own if they wish to. Physicians are reminded that mild respiratory illnesses are not a contraindication to vaccination.

TABLE 1. 1989 Recommendations for measles vaccination

| | |
|--|---|
| Routine childhood schedule, United States | |
| Most areas | Two doses*† -first dose at 15 months -second dose at 4-6 years (entry to kindergarten or first grade) [‡] |
| High-risk areas [§] | Two doses*† -first dose at 12 months -second dose at 4-6 years (entry to kindergarten or first grade) [‡] |
| Colleges and other educational institutions post-high school | Documentation of receipt of two doses of measles vaccine after the first birthday [†] or other evidence of measles immunity**. |
| Medical personnel beginning employment | Documentation of receipt of two doses of measles vaccine after the first birthday [†] or other evidence of measles immunity**. |

*Both doses should preferably be given as combined measles, mumps, rubella vaccine (MMR).

†No less than 1 month apart. If no documentation of any dose of vaccine, vaccine should be given at the time of school entry or employment and no less than 1 month later.

‡Some areas may elect to administer the second dose at an older age or to multiple age groups (see "Age at Vaccination").

§A county with more than five cases among preschool-aged children during each of the last 5 years, a county with a recent outbreak among unvaccinated preschool-aged children, or a county with a large inner-city urban population. These recommendations may be applied to an entire county or to identified risk areas within a county.

**Prior physician-diagnosed measles disease, laboratory evidence of measles immunity, or birth before 1957.

TABLE 2. Recommendations for measles outbreak control*

| | |
|--|--|
| Outbreaks in preschool-aged children | Lower age for vaccination to as low as 6 months of age in outbreak area if cases are occurring in children <1 year of age [†] . |
| Outbreaks in institutions: day-care centers, K-12th grades, colleges, and other institutions | Revaccination of all students and their siblings and of school personnel born in or after 1957 who do not have documentation of immunity to measles [‡] . |
| Outbreaks in medical facilities | Revaccination of all medical workers born in or after 1957 who have direct patient contact and who do not have proof of immunity to measles [‡] . Vaccination may also be considered for workers born before 1957. Susceptible personnel who have been exposed should be relieved from direct patient contact from the 5th to the 21st day after exposure (regardless of whether they received measles vaccine or IG) or—if they become ill—for 7 days after they develop rash. |

*Mass revaccination of entire populations is not necessary. Revaccination should be limited to populations at risk, such as students attending institutions where cases occur.

†Children initially vaccinated before the first birthday should be revaccinated at 15 months of age. A second dose should be administered at the time of school entry or according to local policy.

‡Documentation of physician-diagnosed measles disease, serologic evidence of immunity to measles, or documentation of receipt of two doses of measles vaccine on or after the first birthday.

LOUISIANA HOSPITAL IMMUNITY SURVEY - 1989

During the past few years there has been considerable interest in the reduction of vaccine preventable morbidity and associated sequela among Health-care workers. Nosocomial measles transmission has been reported in emergency rooms, and on hospital wards nationwide according to the Centers for Disease Control⁽¹⁾ Louisiana also has experienced several outbreaks of measles that have affected hospitals. Much of the disease in these hospitals could have been prevented, had the hospital employees been properly immunized against this disease. These nosocomial infections occurred in the Washington-St. Tammany outbreak of 1986, as well as in most recent Bossier-Shreveport outbreak of 1989.

All hospital employees that have patient contact are at risk for exposure to and possible transmission of vaccine preventable diseases. ⁽²⁾ Hospitals and health care facilities should know the immunity status of their employees and ensure that anyone deficient is brought up-to-date. This is an essential part of any prevention and control program. It is to this aim that the advocacy proof of immunization requirement prior to employment and post employment is directed. A proof-of-immunization requirement reduces the problem of having susceptible health care workers in the hospital and reduces the risk of disease infection to other workers and patients.

In the summer of 1989 the Office of Public Health conducted a survey of 135 hospitals in Louisiana. One hundred and twenty-eight (95%) responded. The survey showed that 53 hospitals (41%) had an immunization policy at their institution; while 75 hospitals (59%) had no immunization requirement at all for employment. Hospitals with no requirement were further asked if they would consider establishing an immunization requirement in the future. Twenty-eight (37.3%) responded positively; while, 47 (62.7%) were against establishing such a requirement. It should be noted that of those hospitals with immunization requirements, 47 said that the requirement was a part of their pre-employment policy.

Close examination of the respondents showed that of those institutions with immunity requirements, only nine (17.0%) required proof of measles immunization while 50 (94.3%) had a rubella requirement and 21 (39.6%) had a Td requirement for their employees.

This survey shows that much work must be done to convince health care facilities of the importance of a comprehensive immunization policy.

The Centers for Disease Control has developed immunization recommendations for health-care workers that provide direct patient care or contact. Please refer to reference number two for specific information. For copies please write to Technical Information Services, Center for Prevention Services, Centers for Disease Control, Atlanta, GA 30333.

References

1. MMWR 1989; 38:49-52, 57-59
2. "Immunization Recommendations for Health-Care Workers;" U.S. Department of Health and Human Services, Center for Disease Control, April 1989

EOSINOPHILIA-MYALGIA SYNDROME (EMS) IN L-TRYPTOPHAN USERS

In November 1989, the New Mexico Department of Health notified other health departments of a newly identified syndrome occurring in users of L-tryptophan, an over-the-counter amino acid supplement. After the publicity about this problem other patients with this syndrome were found in other states. As of February 2, 1990, a total of 1,321 patients were reported, including 1 from Louisiana, 9 from Mississippi, 11 from Alabama, and 68 from Texas.

For the purposes of reporting, a case of EMS has been defined as a patient with 1) an absolute eosinophil count of 1000 cells per cubic mm, 2) generalized myalgia (at some point during the course of illness) of severity sufficient to affect the patient's ability to pursue his or her usual daily

activities, and 3) absence of any infection or neoplasm that could account for 1 or 2 above.

Besides eosinophilia and myalgia, some patients with EMS have had shortness of breath, peripheral edema, and a maculopapular, vesicular, or urticarial rash. The syndrome develops over several weeks. Most patients improve after L-tryptophan is discontinued, but for some patients the disease persists. A summary of current

knowledge about EMS was published in the January 15 issue of *Annals of Internal Medicine*.

The Food and Drug Administration (FDA) has issued a nationwide recall of all over-the-counter dietary supplements in capsule or tablet form providing 100 mg or more of L-tryptophan in a daily dose. Studies are underway to determine if a specific manufacturer, brand, supplier, or lot number is particularly associated with EMS. Although it is possible that a contaminant in these preparations is responsible for causing EMS, none has been found so far.

Physicians are encouraged to report suspected cases of EMS to the Epidemiology Section of the Office of Public Health (504) 568-5005.

CHRONIC FATIGUE SYNDROME*

The last decade has been a disturbing one for the American medical community. AIDS emerged as a merciless killer of young men and little children. People thought recovered from poliomyelitis a generation ago found themselves losing motor function and suffering disabling myalgias-- the post-polio syndrome. Measles, almost forgotten, found a receptive new home on college campuses.

Most recently, a baffling disorder dubbed chronic fatigue syndrome (CFS) has been described. It interrupts education and employment, extracts the enjoyment from life, and causes the accumulation of tremendous medical expenses. Its ultimate outcome is unknown.

CFS is diagnosed on clinical grounds. Patients must fulfill two major criteria, six minor symptom criteria, and two minor physical criteria; or the two major criteria and eight minor symptoms criteria.¹

Major Criteria

The first major criterion is the new onset of persistent or recurrent fatigue. It does not resolve with rest, lasts at least six months, and limits activities to less than 50% of the pre-morbid level.

The second major criterion is that no other cause can be found for fatigue. Among conditions to be considered are viral hepatitis, renal insufficiency, tuberculosis, pregnancy, hypothyroidism, cancer, endogenous depression, pathologic grief reaction, and alcoholism. The diagnostic process must be comprehensive. Once CFS is diagnosed it can, like a diagnosis of multiple sclerosis, explain away almost any subsequent symptoms.

Minor Symptom Criteria

There are 11 minor symptom criteria. They must appear with or after the onset of fatigue, and persist or recur for at least six months. They are:

1. fever of 37. to 38.6 C
2. sore throat
3. painful anterior or posterior cervical or axillary lymph nodes
4. generalized muscle weakness
5. myalgia
6. at least 24 hours of generalized fatigue 0 after exertion that previously would have been well tolerated
7. headaches different from any that might have been experienced in the pre-morbid state
8. miganatory arthralgia without joint swelling or redness
9. one or more of: photophobia, transient scotomata, forgetfulness, irritability, confusion, difficulty thinking, inability to concentrate, depression
10. hypersomnia or insomnia
11. description of the condition as having developed over hours to a few days.

Minor Physical Criteria

Physical criteria must be observed by a physician on at least two occasions at least one month apart. They are:

1. oral temperature of 37.6 to 38.6°C
2. non-exudative pharyngitis
3. palpable or tender anterior or posterior cervical or axillary lymph nodes.

Precautions

Persistent fever in excess of 38.6°C is inconsistent with CFS. If suggests instead an occult infection or neoplasm. Appropriate studies should be ordered.

Non-tender cervical or axillary lymph nodes more than two cm in diameter suggest malignancy. Breast cancer, oropharyngeal neoplasm, and lymphoma should be ruled out. Tender cervical lymph nodes suggest an abscessed oral structure. Dental examination may be indicated.

Treatment

There is no treatment for CFS. There is not even accord whether it is one or many disorders, an illness or a symptom. The development of a treatment is unlikely unless the cause becomes known. The presence of antibodies to Epstein-Barr virus and cytomegalovirus, once felt indicative of the etiology, are now felt to be a result, rather than a cause, of this syndrome. A clinical trial of antiviral therapy in carefully selected CFS patients was unsuccessful.²

Support groups exist for people with CFS. The National Chronic Fatigue Syndrome Association can provide details about local groups, as well as informational literature and announcements of professional and public educational meetings.³ The address is 12106 54th Terrace, Kansas City, MO 64133. Telephone numbers are 816-737-2567 and 913-321-2278.

1. Chronic Fatigue Syndrome: A Working Case Definition. Holmes GP, Kaplan JE, Gantz NM, et al. *Ann Int Med* 1988; 108:387-389.
2. The Chronic Mononucleosis Syndrome. Straus SE. *J Inf Dis* 1988; 157:405-412
3. Chronic Mononucleosis - A legitimate diagnosis. Tobi M, Straus SE. *Postgraduate Med* 1988; 83:69-78.

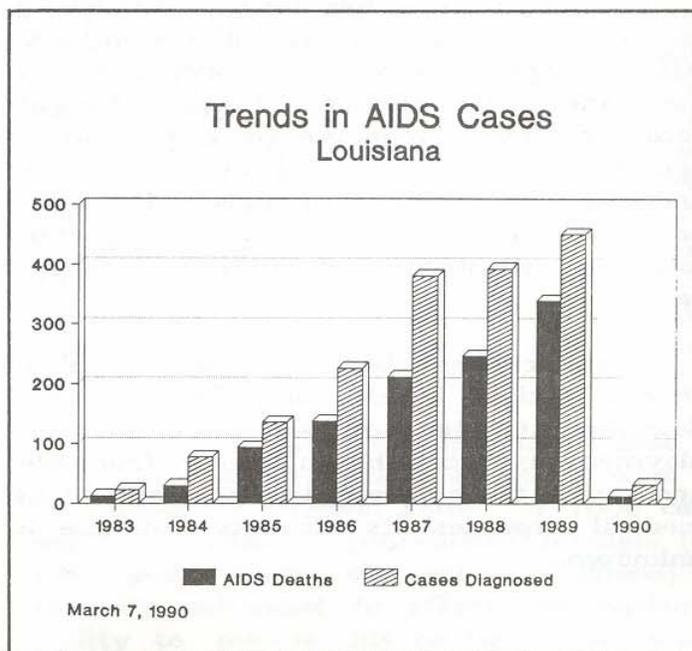
* Copied from Kansas Department of Health and Environment, "Epistat," Volume Two Number Six, June 1989.

The Louisiana branch of the Chronic Fatigue Syndrome Association is located at 846 Shadyglen Dr, Baton Rouge, LA 70816 telephone number 504-275-2716. Governor Roemer has declared the week of March 4-10 Chronic Fatigue Syndrome Week.

BEWARE OF TICKS

Late spring and summer are the most likely time of exposure to ticks, blood-sucking arachnids. Ticks are capable of transmitting serious illnesses such as Rocky Mountain Spotted Fever and Lyme disease. It is important for individuals to be instructed on avoiding known tick-infected areas. It is recommended that individuals wear clothing that interferes with tick attachment (long sleeves, socks pulled up over pant's legs). Applying repellents containing diethyltoluamide (Deet) and regular inspection of the body for ticks are also recommended.

Ticks that have been removed from individuals that are symptomatic may be submitted through the mail for identification purposes. Please send the tick in a sealed container of alcohol to Mr. Charles Anderson State Entomologist, Office of Public Health P.O. Box 60630, New Orleans, LA 70160.



BULLETINS

LETTERS TO THE EDITOR

The Louisiana Morbidity Report welcomes letters to the editor. If you have a topic in disease control that you would like to discuss send your comments/letters to Editor, Louisiana Morbidity Report, DHH-OPH, Epidemiology Section, P. O. Box 60630, New Orleans, LA 70160. Due to space limitations, it may not be possible to print every letter.

NEW FORMAT FOR THE LOUISIANA MORBIDITY REPORT

In an effort to produce/print the Louisiana Morbidity Report in a more timely fashion, the format of the report is being changed. Starting with this issue (March-April, 1990), the articles will contain current topics, but the morbidity table will consist of data from the previous two months (e.g. Jan-Feb, 1990). The reports will now be numbered as well as dated for easy reference. The 1990 morbidity reports will begin with Volume One, Number two and proceed accordingly. There will be no January-February issue for 1990.

HEPATITIS B - REGION 4

A significant increase in Hepatitis B activity is occurring in Region 4. Of the 14 total cases (see table 3) reported in the region for January-February 1990, Iberia, Lafayette and St. Landry Parishes equally reported 3 cases whereas Evangeline and St. Mary Parishes accounted for 1 case each. Eight blacks, 5 whites and 1 Pacific Asian were reported; there were 10 males and 4 females. The Epidemiology Section is presently investigating this cluster. Health care providers should be aware of this increase in activity in this Region and are encouraged to report all hepatitis B cases.

LOUISIANA FACTS

Did you know that during the month of August 1853 the mortality from yellow fever was well over five thousand.

DO YOU HAVE ANY INTERESTING FACTS ABOUT LOUISIANA THAT YOU WOULD LIKE TO SEE PUBLISHED THE LOUISIANA MORBIDITY REPORT? SEND FACTS AND SOURCE TO: LOUISIANA FACTS, DHH-OPH-EPIDEMIOLOGY SECTION, P.O. BOX 60630, NEW ORLEANS, LA 70160.

Communicable Disease Surveillance, January-February 1990

Table 1. Frequent diseases by region

| Disease | Health Department Region | | | | | | | | | Jan-Feb 1990 | Jan-Feb 1989 | Cum. 1990 | Cum. 1989 | % Change | |
|-----------------------------|--------------------------|------|-----|-----|-----|-----|-----|-----|-----|--------------|--------------|-----------|-----------|----------|------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | | | | | |
| VACCINE-PREVENTABLE | | | | | | | | | | | | | | | |
| Measles | Cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | - |
| Mumps | Cases | 3 | 10 | 2 | 9 | 3 | 0 | 0 | 2 | 1 | 30 | 109 | 30 | 109 | -72 |
| | Rate | 0.4 | 1.3 | 0.6 | 1.6 | 1.1 | 0 | 0 | 0.6 | 0.2 | 0.7 | 2.5 | 0.7 | 2.5 | |
| Rubella | Cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 3 | - |
| Pertussis | Cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - |
| SEXUALLY-TRANSMITTED | | | | | | | | | | | | | | | |
| Gonorrhoea | Cases | 993 | 324 | 48 | 108 | 59 | 117 | 329 | 142 | 81 | 2210 | 1922 | 2210 | 1922 | +15 |
| | Rate** | 12.7 | 4.2 | 1.6 | 1.9 | 2.2 | 3.6 | 5.7 | 4.5 | 1.7 | 5.0 | 4.4 | 5.0 | 4.4 | |
| Syphilis | Cases | 196 | 39 | 6 | 10 | 7 | 19 | 12 | 13 | 32 | 334 | 149 | 334 | 149 | +124 |
| | Rate** | 2.5 | 0.5 | 0.2 | 0.2 | 0.3 | 0.6 | 0.2 | 0.4 | 0.7 | 0.8 | 0.3 | 0.8 | 0.3 | |
| ENTERIC | | | | | | | | | | | | | | | |
| Campylobacter | Cases | 0 | 2 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 5 | 6 | 5 | 6 | -17 |
| Hepatitis A | Cases | 2 | 1 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 8 | 52 | 8 | 52 | -85 |
| | Rate* | 0.3 | 0.1 | 0.6 | 0.5 | 0 | 0 | 0 | 0 | 0 | 0.2 | 1.2 | 0.2 | 1.2 | |
| Salmonella | Cases | 6 | 2 | 1 | 3 | 2 | 1 | 2 | 0 | 2 | 19 | 59 | 19 | 59 | -68 |
| | Rate* | 0.8 | 0.3 | 0.3 | 0.5 | 0.8 | 0.3 | 0.3 | 0 | 0.4 | 0.4 | 1.3 | 0.4 | 1.3 | |
| Shigella | Cases | 11 | 0 | 1 | 2 | 0 | 0 | 3 | 0 | 7 | 24 | 81 | 24 | 81 | -70 |
| | Rate* | 1.4 | 0 | 0.3 | 0.4 | 0 | 0 | 0.5 | 0 | 1.5 | 0.5 | 1.8 | 0.5 | 1.8 | |
| Vibrio Cholera | Cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - |
| Vibrio, other | Cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 5 | 1 | 5 | -80 |
| OTHER | | | | | | | | | | | | | | | |
| Hepatitis B | Cases | 5 | 2 | 0 | 14 | 0 | 2 | 1 | 0 | 1 | 25 | 51 | 25 | 51 | -50 |
| | Rate* | 0.6 | 0.3 | 0 | 2.5 | 0 | 0.6 | 0.2 | 0 | 0.2 | 0.6 | 1.2 | 0.6 | 1.2 | |
| Meningitis H. Influenza | Cases | 6 | 1 | 1 | 4 | 0 | 0 | 1 | 0 | 2 | 15 | 18 | 15 | 18 | -17 |
| N. Meningi. | Cases | 3 | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 7 | 12 | 7 | 12 | -42 |
| Tuberculosis | Cases | 16 | 0 | 0 | 4 | 2 | 3 | 8 | 9 | 2 | 44 | 32 | 44 | 32 | +38 |
| | Rate* | 2.1 | 0 | 0 | 0.7 | 0.8 | 0.9 | 1.4 | 2.8 | 0.4 | 1.0 | 0.7 | 1.0 | 0.7 | |

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

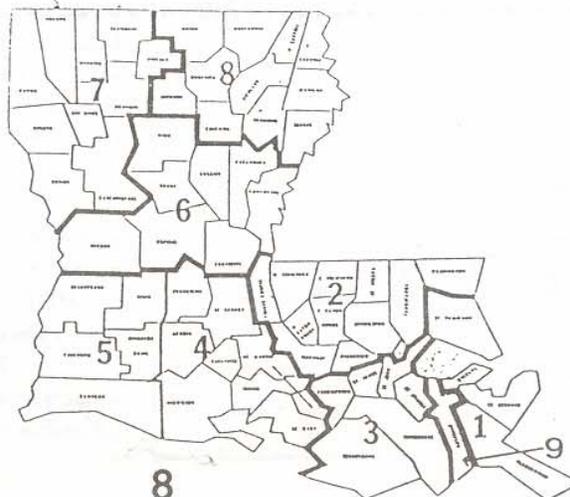


Table 2. Case reports of diseases of low frequency, 1990

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

Table 3. Cases of animal rabies, January - February 1990

| Parish | Species | No. cases |
|-----------|---------|-----------|
| Caddo | Skunk | 1 |
| Avoyelles | Skunk | 1 |

Annual Summary - Hepatitis A

In 1989 there were 310 cases of hepatitis A reported in Louisiana, an increase of 64% from 1988 and 177% from 1987 (see figure). For the United States as a whole hepatitis A reports also increased from 1988 to 1989, but by a smaller amount (30%). The case rate for Louisiana for 1989 was 7.1 cases per 100,000.

The increase from 1987 to 1989 was seen in both males and females and in all agegroups. The rate increased more for non-whites (from 2.5 to 11.5) than for whites (from 3.0 to 7.1). Nearly all regions in the state saw at least a doubling of the reported case rate (see table). The largest increase was seen in region 7, which increased from 1.7 to 12.4 cases per 100,000, the highest regional rate in the state.

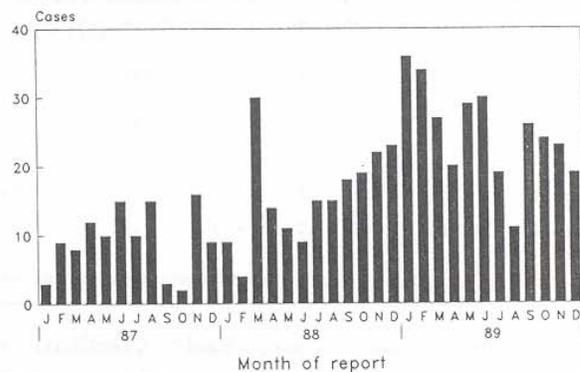
Editorial note:

Hepatitis A is transmitted by the fecal-oral route, usually by close personal contact. Disease spread commonly occurs where children who are not toilet-trained are present, such as households and daycare centers. Recently, an association has been found between hepatitis A and illicit drug use; since hepatitis A is not generally transmitted by needle sharing, the cause for this drug association is not known.

We are uncertain of the cause of the increase in hepatitis A reports in Louisiana. It is unlikely to be due solely to changes in reporting practices, since it was seen in all areas of the state and all demographic groups. We speculate that the increase may be partly related to an increased use of day

care, or an increase in illicit drug use. Health care workers should be aware of this increase and report cases of hepatitis A to the Office of Public Health. The diagnosis of hepatitis A should be considered in persons having home or occupational exposure to children and in users of illicit drugs. If day care staff, attendees, or their household contacts are found to have hepatitis A, immune globulin may be recommended for the entire day care center.

Hepatitis A, Louisiana
1987 - 1989
Cases by month of report



Hepatitis A Cases by Region, 1987-1989

| Region | Central City | 1987 | | 1988 | | 1989 | |
|--------|--------------|-------|------|-------|------|-------|------|
| | | Cases | Rate | Cases | Rate | Cases | Rate |
| 1 | New Orleans | 23 | 3.0 | 50 | 6.2 | 70 | 6.9 |
| 2 | Baton Rouge | 14 | 1.8 | 49 | 6.4 | 53 | 6.9 |
| 3 | Houma | 1 | 0.3 | 14 | 4.5 | 15 | 4.9 |
| 4 | Lafayette | 8 | 1.4 | 6 | 0.9 | 17 | 3.0 |
| 5 | Lake Charles | 18 | 6.8 | 23 | 8.3 | 24 | 9.1 |
| 6 | Alexandria | 6 | 1.9 | 2 | 0.6 | 13 | 4.0 |
| 7 | Shreveport | 10 | 1.7 | 10 | 1.7 | 72 | 12.4 |
| 8 | Monroe | 12 | 3.8 | 2 | 0.6 | 7 | 2.2 |
| 9 | Metairie | 20 | 4.3 | 33 | 6.2 | 38 | 8.2 |

04591R
RAOULT C RATARD MD
4109 CLEVELAND PL
METAIRIE LA 70003-1343

BULK RATE
U.S. POSTAGE
PAID
NEW ORLEANS, LA
PERMIT NO. 471

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

This public document was published at a total cost of \$705.00. Seven thousand five hundred copies of this public document were published in this first printing at a cost of \$705.00. The total cost of all printings of this document including reprints is \$705.00. This document was published by Department of Social Services Printing Facility, 2636 Daisy Street, Baton Rouge, Louisiana 70805, 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 standards for printing by State Agencies established pursuant to R.S. 43:31.