

Louisiana Morbidity Report



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January-February, 2018

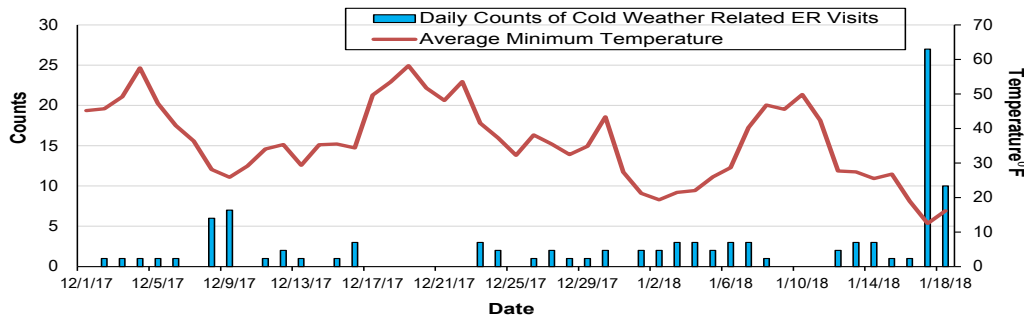
Volume 29, Number 1

Use of the Louisiana Early Event Detection System to Follow the Impact of Cold Weather: December 1, 2017 - January 18, 2018

Dayaamayi Kurimella, MPH

The Louisiana Early Event Detection System (LEEDS) uses emergency department (ER) data to track infectious disease and defined personal injury syndromes. LEEDS was used for situational awareness during the recent uncharacteristic winter weather Louisiana experienced on December 8, 2017 and January 16-18, 2018. The figure illustrates that winter weather related incidents increased with colder temperatures.

Figure: Daily Counts of Winter Weather Related Emergency Department Visits Louisiana, December 1, 2017- January 18, 2018



The events captured through this surveillance were primarily related to hypothermia and injuries from slipping on ice. The ability of LEEDS to capture this data shows the system's utility in situational awareness, particularly in weather related events. For more information on LEEDS, please go to website <http://www.dhh.la.gov/LEEDS>, or contact Dayaamayi Kurimella at (504) 568-3182 or dayaamayi.kurimella@la.gov.

NHSN Standardized Utilization Ratio Demonstrates Exposure Risks to Patients on Devices: Louisiana, January 8, 2018

Erica Washington, MPH, CPH, CIC, CPHQ

The Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) allows settings across the provider spectrum to log healthcare-associated infections. The Patient Safety Component of NHSN tracks infection outcomes related to

indwelling devices such as central lines and urinary catheters which add an additional risk of infection acquisition for patients.

Central lines are intravenous catheters that terminate at or near the heart, or through one of the major vessels. Central lines are used for infusion, withdrawal of blood, or for hemodynamic monitoring. Bloodstream infections that are attributed to central lines are termed central line-associated bloodstream infections (CLABSI). CLABSIs are serious infections that generally prolong hospitalization and increase morbidity, mortality, and healthcare costs.

Urinary catheters (also called "Foleys") are tubes that are inserted into the bladder through the urethra to drain urine. Urinary tract infections involve any part of the urinary system including the urethra, bladder, ureters, and kidney. Catheter-associated urinary tract infections (CAUTI) are urinary tract infections that are attrib-

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The Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS): Response Rates on the Rise

Rosaria Trichilo, MPH

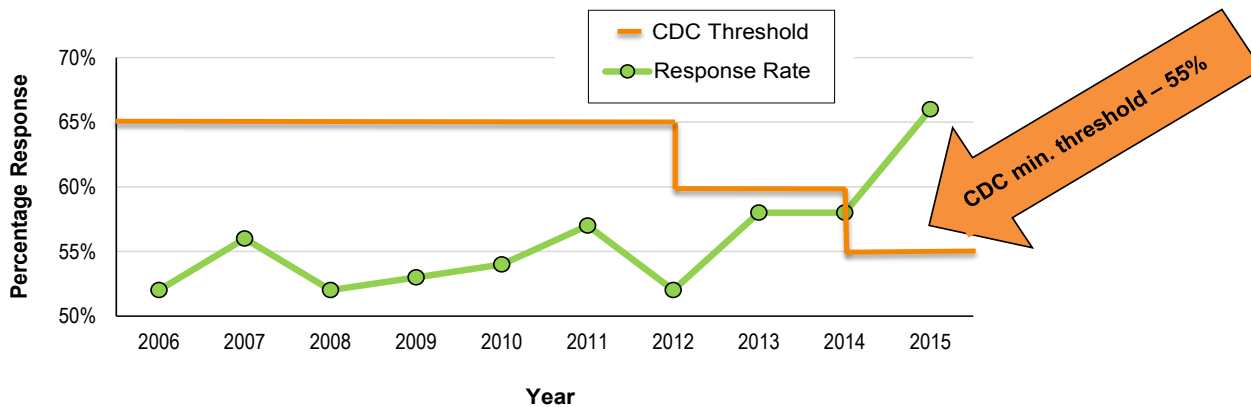
The Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) is a national surveillance project conducted jointly by the Centers for Disease Control and Prevention (CDC) and the Louisiana Department of Health (LDH), and managed by the Bureau of Family Health (BFH), Office of Public Health (OPH). Since 1997, Louisiana has participated in PRAMS and collected population-based survey data on women’s behaviors and experiences before, during and after pregnancy.

Louisiana PRAMS has long served as a unique and vital source of information used by program planners, healthcare providers, policy makers and public health leaders to design, implement, evaluate and allocate resources for programs and services relevant to the health of women and infants in Louisiana. Topics collected by PRAMS include, but are not limited to, preconception health, pregnancy intention and family planning, Medicaid and WIC participation, breastfeeding, prenatal care, infant sleep environment, maternal stressors, maternal substance use, and experiences of discrimination.

Per CDC protocol, data collection is conducted through both mail and phone surveys, with a required response rate of at least 55% to ensure data best represents the experiences of the majority of Louisiana women. After a decade of declining response rates and inability to reach the CDC-required threshold, Louisiana PRAMS took active steps to improve response rates through a combination of operational and outreach projects, including: materials redesign, improved phone number search protocol, more efficient mail packet preparation, increased gift card reward amount, increased time for phone survey interviews and utilization of partner relationships for targeted outreach.

When examining the weighted response rates over the last decade, there is a substantial increase in response rate (Figure 1).

Figure 1: PRAMS Annual Weighted Response Rates - Louisiana, 2006-2015



Louisiana’s weighted response rate increased from 52% in 2012 to 66% in 2015. The rate moves from being below the CDC response rate threshold to meeting and exceeding the threshold. This ensures that the responses received are more representative of Louisiana women, and thus results are generalizable to the state. Louisiana PRAMS has also been exploring methods of monitoring response rates on the regional level (unweighted) as shown through ArcGIS (Geographic Information System) mapping to understand fluctuation in our unweighted mail, phone and overall response rates at a more detailed level. Results from a separately conducted analysis show no regions meeting the threshold in 2011, while all nine regions met the 55% threshold in 2015 (Figures 2 and 3).

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SAVE the DATE

One-Day Long-term Care Training Workshops

Wednesday, March 21 or Thursday, March 22, 2018
New Orleans

APIC EPI® Intensive Workshop

April 3-6, 2018
New Orleans

For information on either workshop, please go to website

<http://ldh.louisiana.gov/index.cfm/page/824>

Louisiana Morbidity Report	
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Overview: 65 Years of Outbreak Investigations Louisiana, 1950-2016

The Louisiana Department of Health, Office of Public Health’s Infectious Disease Epidemiology Section (IDEpi) is responsible for conducting surveillance and outbreak investigations for all communicable diseases of public health importance (with the exceptions of sexually transmitted infections, tuberculosis and HIV/AIDS which are managed by separate programs).

A few definitions (from *Last J 2008. A dictionary of Epidemiology. Oxford 5th Edition*) are useful:

A **cluster** is a an aggregation of relatively uncommon events or diseases in space or time in frequencies that are believed or per-

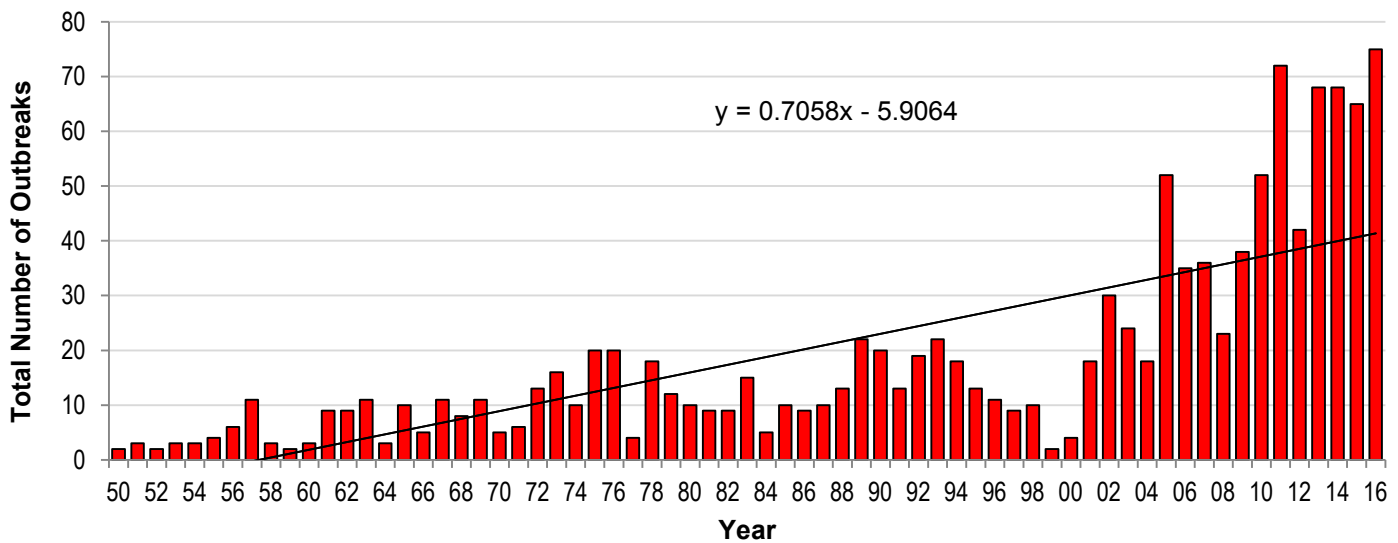
ceived to be greater than could be expected by chance.

An **outbreak** is an epidemic limited to localized increase in the incidence of a disease e.g. in a village, town, or closed institution; *upsurge* is sometimes used as an euphemism for outbreak.

An **epidemic** is the occurrence in a community or region of cases of an illness , specific health behavior, or other health related event clearly in excess of expectancy.

The most striking feature is the rapid increase in outbreak investigations starting in 2001(Figure).

Figure: Summary of Total Recorded Outbreaks - Louisiana, 1950-2016



Until 2001 surveillance of reportable communicable diseases was the focus of the IDEpi section. It was decided that outbreak investigations were another important source of information and it would be beneficial to emphasize this component. The factors that contributed to the increase were:

- 1- The development of Rapid Response Teams integrating epidemiologists, lab technicians, nurses, sanitarians and support staff.
- 2- Field Epidemiology Training for medical providers partnering with IDEpi in these investigations.

3- The development of protocols and manuals for different outbreak investigations.

4- An increased use of laboratory testing with emphasis on rapid collection of specimens and rapid techniques

5- Systematic feedback to the medical providers involved is proving to be extremely useful to motivate reporting in the future.

A detailed description of these outbreaks can be found at website http://new.dhh.louisiana.gov/assets/oph/Center-PHCH/Center-CH/infectious-epi/Annuals/Outbreaks_LaIDAnnual.pdf.

Announcements

Updates: Infectious Disease Epidemiology (IDEpi) Webpages
www.infectiousdisease.dhh.louisiana.gov

Annual: Lyme Disease; Outbreak Investigations; Rabies; Rocky Mountain Spotted Fever; Several Year Comparison Report; Staphylococcal Invasive Disease (MRSA); Tularemia; Varicella

Arboviral: Jamestown Canyon Virus Public Information

Epi Manual: Jamestown Canyon Virus Public Information; Mumps Patient Information Form; Mumps Specimen Collection (LDH)

HAI: APIC EPI® Intensive Workshop; Nursing Home January 2018 Newsletter; One-Day Long-term Care Training Workshops Flyer, Agenda and Registration

Influenza: Influenza Guidance-December 2017; Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities (CDC); Seasonal Influenza A (H3N2) Activity & Antiviral Treatment of Patients with Influenza (CDC); Weekly Report

Parasitic Vector-borne Diseases: Chagas Testing Guidelines; Diagnosis & Treatment of Leishmaniasis: Clinical Practice Guidelines (IDSA & ASTMH)

(NHSN Standardized ... continued from page 1)

ed to catheter use. Approximately 15%-25% of hospitalized patients receive urinary catheters during their hospital stay.

NHSN released Standardized Utilization Ratio (SUR) analysis reports within the Patient Safety Component in 2017. SURs are used to compare number of observed device days to number of predicted device days. This estimate is useful for facilities to compare their respective device usage to other NHSN reporters whereby the SUR provides a benchmark to assess risk to which patients are exposed to device-associated infections. Values less than 1.0 are considered better than expected, and values greater than 1.0 demonstrate excess usage. All SUR are considered statistically significant at the 95% confidence level.

The Healthcare-Associated Infections and Antibiotic Resistance Program (HAI/AR) of the Office of Public Health, Louisiana Department of Health, accesses data that Louisiana healthcare providers submit to NHSN through an agreement with the CDC's Division of Healthcare Quality Promotion. SUR were generated in half-year increments and analyzed for statistical significance. For central lines used in adult critical care units, each time period from January 1, 2015 to June 30, 2017 demonstrated statistical significance for SUR greater than 1.0 (Table 1).

Table 1. Adult Critical Care Central Line (CL) Standard Utilization Ratios (SUR) - January 1, 2015 - June 30, 2017

Period*	Observed CL Days	Predicted Days	SUR	95% C.I.
2015H1	83,240	81,569.860	†1.020	1.014, 1.027
2015H2	81,235	77,697.891	†1.046	1.038, 1.053
2016H1	81,479	78,647.729	†1.036	1.029, 1.043
2016H2	75,041	74,464.621	†1.008	1.001, 1.015
2017H1	77,887	77,125.259	†1.010	1.003, 1.017

*H1 – first half of year/ H2 – second half of year

† Statistically significant at the 95% confidence level

Conversely, urinary catheter utilization was significantly less than 1.0 for each time period with the exception of the second half of 2016 (SUR=1.032, p=0.0001), (Table 2).

Table 2. Neonatal Critical Care Central Line (CL) Standard Utilization Ratios (SUR) - January 1, 2015 - June 30, 2017

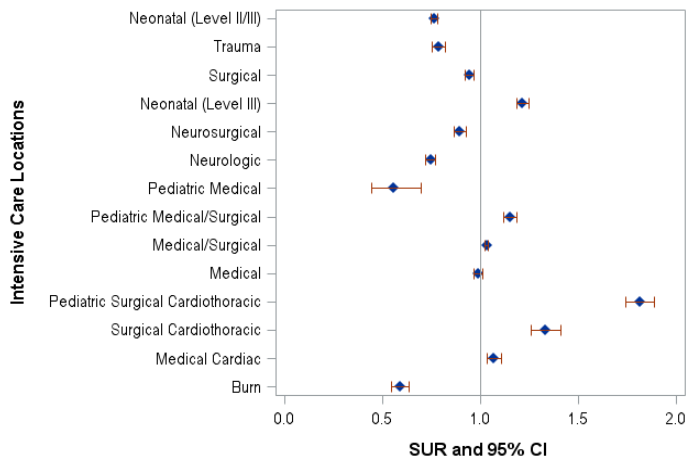
Period	Observed CL Days	Predicted Days	SUR	95% C.I.
2015H1	12,260	14,230.455	‡0.862	0.846, 0.877
2015H2	14,612	15,865.300	‡0.921	0.906, 0.936
2016H1	12,803	14,429.916	‡0.887	0.872, 0.903
2016H2	16,449	15,937.578	†1.032	1.016, 1.048
2017H1	14,393	15,702.018	‡0.917	0.902, 0.932

*H1 – first half of year/ H2 – second half of year

† Statistically significant at the 95% confidence level

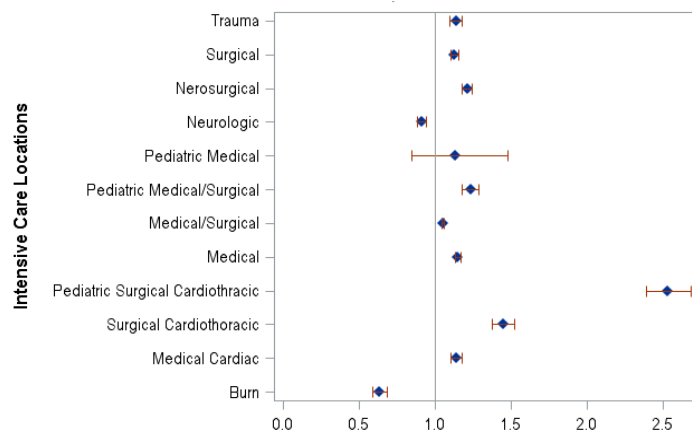
NHSN also allows device utilization to be analyzed by unit type. From January 1, 2017 to June 30, 2017, central lines were most utilized in pediatric surgical cardiothoracic units (SUR=1.812, p<0.0001). Other units (adult surgical cardiothoracic, neonatal level III, pediatric medical/surgical, medical cardiac, and medical/surgical) were on both sides of a SUR of 1.0 (Figure 1).

Figure 1. Central Line Standard Utilization Ratios by Location Type January 1, 2017 - June 30, 2017



Burn and Neurologic intensive care locations were the only unit types that experienced less urinary catheter utilization with SUR=0.637 (p<0.0001) and SUR=0.913 (p<0.0001), respectively. Pediatric medical intensive care was the only unit that was non-significant for urinary catheter usage (Figure 2).

Figure 2. Urinary Catheter Standard Utilization Ratios by Location Type January 1, 2017 - June 30, 2017



Although 95% confidence intervals that do not include 1.0 connotes statistical significance, SURs reported here only marginally exceed 1.0. This is a nuance of statistics that provide point estimates for large values such as the central line days utilized by patients.

Acute care hospitals that report device-associated infections into NHSN may review their device utilization by accessing the Analysis Reports function of the Patient Safety Component. It is recommended that data be generated in half-year increments. The HAI/AR Program will begin to send facility-level reports to NHSN reporters this spring. Questions about this report may be sent to erica.washington@la.gov. Additional information about the HAI/AR Program may be accessed at www.ldh.la.gov/HAI.

Five Tips on Zika for Pediatricians

Julius Tonzel, MPH; John Chiosi, MD

1. Screen All Mothers of Newborns for Possible Zika Exposures.

Newborns of mothers who have traveled to or lived in an area with Zika, or have had sexual contact with a partner who traveled to or lived in an area with Zika, during the mother’s pregnancy or periconceptional period are at an increased risk of Zika infection. The periconceptional period is the eight weeks prior to conception or the six weeks before the last menstrual period. A two-question travel screen can determine a newborn’s risk for Zika (Figure 1). A “yes” response to either question requires further investigation into whether the newborn and mother need to be tested for Zika.

Figure 1: Zika Travel Screen Questions

1. Did you travel to or live in an area of Zika risk during your pregnancy or eight weeks before conception?
2. Did you have unprotected sex with a male partner who traveled to or lived in an area of Zika risk during your pregnancy or eight weeks before conception?

As of August 30, 2017, there are no areas within the U.S. with local transmission of Zika. There is a Zika risk for the U.S. territories of Puerto Rico and the U.S. Virgin Islands. Please go to website <https://wwwnc.cdc.gov/travel/page/zika-travel-information> for an updated list and searchable map of areas with a Zika risk.

2. Identify Newborns with Zika-related Birth Defects

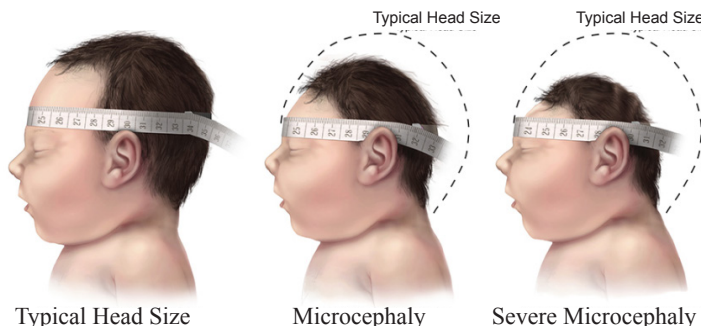
Zika infection during pregnancy can cause serious birth defects, including microcephaly. However, newborns can be infected with Zika and have other congenital defects without microcephaly. Newborns infected with Zika may also have a normal head circumference at birth and develop microcephaly after birth. Therefore, it is important to recognize all congenital birth defects associated with Zika (Figure 2).

Figure 2: Congenital Zika Syndrome

1. Severe microcephaly in which the skull has partially collapsed
2. Decreased brain tissue with a specific pattern of brain damage, including subcortical calcifications
3. Damage to the back of the eye, including macular scarring and focal pigmentary retinal mottling
4. Congenital contractures, such as clubfoot or arthrogryposis
5. Hypertonia restricting body movement soon after birth

Birth defects associated with congenital Zika syndrome include head/brain defects (microcephaly, anencephaly, hydrocephaly, spina bifida), eye defects (coloboma, cataract), ear malformations, congenital hip deformities, talipes equinovarus, and clubfoot (Figure 3).

Figure 3: Normal Infant Head Size and Microcephaly Examples



Other causes of birth defects should also be investigated along with suspected Zika exposure. For additional information on how to care for infants and children with a possible congenital Zika syndrome, please visit website <https://www.cdc.gov/pregnancy/zika/testing-follow-up/infants-children.html>.

3. Contact the Office of Public Health If There Is a Concern About a Newborn with Possible Zika Risk.

For more information regarding newborns possibly exposed to Zika, contact the Infectious Disease Epidemiology Section, Office of Public Health, Louisiana Department of Health at website <http://new.dhh.louisiana.gov/index.cfm/page/2554> or (800) 256-2748, or the Louisiana Birth Defects Monitoring Network at <http://new.dhh.louisiana.gov/index.cfm/page/771> or (225)342-2017.

4. Test Newborns for Zika.

Newborns that are suspected to be congenitally infected with Zika should be routinely tested at birth, preferably within two days of delivery. There is limited data on the persistence of the virus or Zika-specific antibodies in newborns that are infected in utero. As a result, molecular and serologic testing should happen concurrently when attempting to diagnose a newborn with a congenital Zika infection. It is important to remember that a negative test does not rule out a congenital Zika infection. A negative test could mean that the newborn was tested at the wrong time and could potentially acquire Zika-associated birth defects later in life. Monitoring the newborn for birth defects during infancy is vital. Infants that test positive for Zika should have repeat neutralizing antibody testing performed at 18 months to determine if the antibodies detected at birth belong to the mother or the infant.

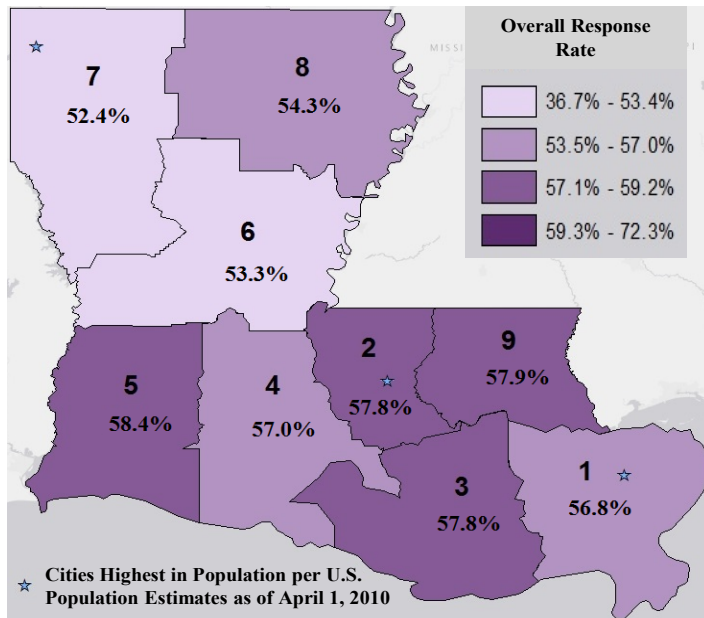
The placenta and fetal tissues can be tested at the CDC for Zika virus. The Infectious Disease Epidemiology Section will request preapproval from the CDC to test the tissues; all specimens should be forwarded to the Louisiana Office of Public Health Laboratory. For more information about placenta and fetal tissue collection, please visit website <https://www.cdc.gov/zika/laboratories/test-specimens-tissues.html>.

5. Protect Children and Families Against Zika.

Pregnant women and couples attempting to become pregnant (continued on page 6)

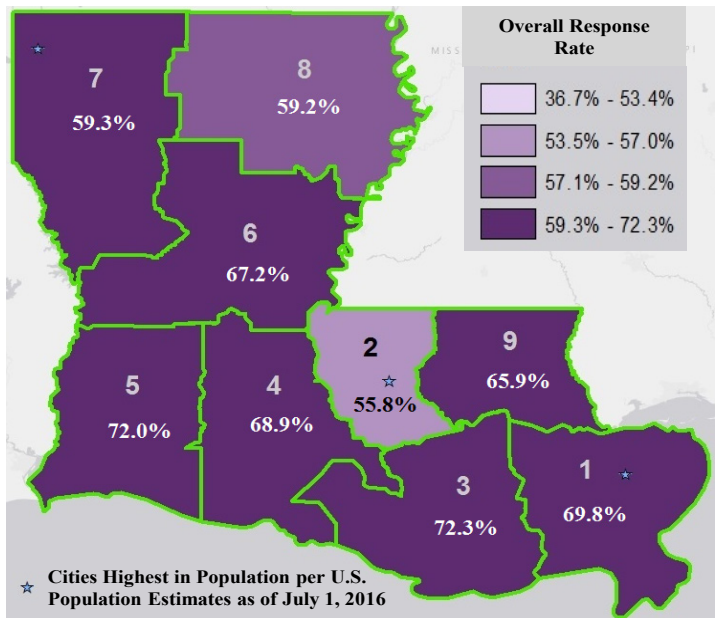
(LA PRAMS ... continued from page 2)

Figure 2: PRAMS Unweighted Response Rate by OPH Region Louisiana, 2011



Areas Outlined in Green Meet the CDC's Annual Response Rate Threshold of 65% for 2011

Figure 3 PRAMS Unweighted Response Rate by OPH Region Louisiana, 2015



Areas Outlined in Green Meet the CDC's Annual Response Rate Threshold of 55% for 2015

The comprehensive improvement efforts made by the Louisiana PRAMS team contributed to increased overall weighted response rates, as well as unweighted regional response rates. While a separate analysis showed that efforts to improve response rates through increased rewards alone did not affect overall rates, a combination of targeting operational inefficiencies, redesigning materials and outreach have resulted in increased rates. Most notably is the increase in phone response rates.

Although mail is the preferred method of response due to cost effectiveness (less staff time and resources), as compared to phone surveys, Louisiana recognizes the difficulty in mail surveillance, especially in a state with reoccurring natural disasters leading to household displacement.

Louisiana attributes the increase in phone rates to concentrated efforts in operational improvement, which allowed for more personnel time to conduct phone interviews. Increased response rates help ensure high quality and generalizable data across the state with fewer underrepresented areas. Utilizing ArcGIS analysis allows for geographical depiction of where Louisiana women who complete the survey live, thus highlighting overarching trends in regional needs to improve program planning and resource allocation.

In an environment of national declines in survey participation and limited funding, Louisiana PRAMS is continuously considering strategic ways of analyzing changes in response rates to better target populations through partnerships and outreach. By participating in future targeted outreach, especially on a regional level, Louisiana PRAMS hopes to continue to maintain high response rates, while also increasing partner engagement and providing timely availability of surveillance data to assist partners with programs to best address the needs of pregnant women and new mothers.

For more information about Louisiana PRAMS, or to sign up to receive our quarterly newsletter, please contact Rosaria Trichilo,

Louisiana PRAMS Coordinator at rosaria.trichilo@la.gov or at (504)568-3504. For more PRAMS data and our annual reports, please visit <https://1800251baby.org/provider/data/#louisiana-prams-reports>.

(Five Tips ... continued from page 5)

should avoid traveling to areas with a Zika risk. The CDC website, <https://wwwnc.cdc.gov/travel/page/zika-travel-information> has the most up-to-date information about travel advisories for areas with a Zika risk.

If in a Zika-affected area, couples should prevent mosquito bites and practice safe sex. Mosquito bite prevention includes using insect repellent, treating clothes and gear with permethrin, and mosquito-proofing the home. Please refer to the following CDC handout at <https://www.cdc.gov/zika/pdfs/MosqPrevInUS.pdf> for additional tips on mosquito prevention. Remember to avoid using insect repellent on infants younger than two months of age. Zika can also be sexually transmitted, so if in an area with Zika, use condoms or abstain from sex. Sexual intercourse includes vaginal, anal, and oral sex, and the sharing of sex toys.

Zika transmission has not been linked to breastfeeding. Mothers exposed to Zika should continue to breastfeed. There is limited information on long-term outcomes for infants and children exposed to Zika after birth (mainly through mosquito bites). Most are asymptomatic or may have mild illness similar to adults. Treatment for symptomatic patients include rest and fluids.

For additional information on Zika, refer to <http://new.dhh.louisiana.gov/index.cfm/page/2554> and <https://www.cdc.gov/zika/> or contact Julius Tonzel at (504) 568-8296 or email julius.tonzel@la.gov.

Table 1: Communicable Disease Surveillance, Incidence by Region and Time Period, November-December, 2017

DISEASE	HEALTH REGION									TIME PERIOD					
	1	2	3	4	5	6	7	8	9	Nov-Dec 2017	Nov-Dec 2016	Jan-Dec Cum 2017	Jan-Dec Cum 2016	Jan-Dec % Chg*	
Vaccine-preventable															
Hepatitis B	Cases	2	3	1	0	0	1	1	1	0	9	16	87	59	47.5
	Rate ¹	0.2	0.5	0.3	0	0	0.3	0.2	0.3	0	0.2	0.4	2.0	1.4	NA*
Measles		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Mumps		0	0	1	0	0	0	0	0	0	1	0	54	1	5300.0
Rubella		0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis		4	0	0	1	0	1	1	0	7	14	4	68	50	36.0
Sexually-transmitted															
HIV/AIDS	Cases ²	62	29	5	15	7	10	7	6	5	146	183	1155	1129	2.3
	Rate ¹	6.9	4.2	1.2	2.5	2.3	3.3	1.3	1.7	0.9	3.1	3.9	24.7	24.2	NA*
Chlamydia	Cases ^{1,3}	698	374	195	283	97	195	349	254	254	2,747	4,612	31,748	31,490	0.8
	Rate ¹	77.8	54.6	48.2	46.5	32.2	63.8	64.2	71.7	43.7	58.7	98.5	678.1	672.6	NA*
Gonorrhea	Cases ^{1,3}	255	125	54	101	29	59	133	80	74	917	1,574	10,866	10,715	1.4
	Rate ¹	28.4	18.3	13.4	16.6	9.6	19.3	24.5	22.6	12.7	19.6	33.6	232.1	228.9	NA*
Syphilis (P&S)	Cases ^{1,3}	11	9	5	6	6	4	3	14	1	59	123	622	748	-16.8
	Rate ¹	1.2	1.3	1.2	1.0	2.0	1.3	0.6	3.9	0.2	1.3	2.6	13.3	16.0	NA*
Enteric															
Campylobacter	Cases	1	5	0	7	1	7	6	0	6	33	47	337	278	21.2
Hepatitis A	Cases	0	0	0	0	0	0	0	0	0	0	0	8	11	NA*
	Rate ¹	0	0	0	0	0	0	0	0	0	0	0	0.2	0.3	NA*
Salmonella	Cases	10	9	20	19	10	8	6	9	18	109	177	976	1355	-28.0
	Rate ¹	1.0	1.6	5.3	3.7	3.7	2.6	1.2	2.6	4.7	2.5	4.1	22.6	31.4	NA*
Shigella	Cases	0	5	0	3	11	0	1	2	1	23	68	173	389	-55.5
	Rate ¹	0	0.9	0	0.6	4.1	0	0.2	0.6	0.3	0.5	1.6	4.0	9.0	NA*
Vibrio, cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	1	0	NA*
Vibrio, other	Cases	1	0	1	1	1	0	0	0	0	4	5	59	48	22.9
Other															
<i>H. influenzae (other)</i>		2	1	0	1	2	0	2	0	2	10	12	59	57	NA*
<i>N. Meningitidis</i>		0	0	0	0	0	0	0	0	0	0	0	5	2	NA*

¹ = Cases Per 100 000 Population.

² = These totals reflect people with HIV infection whose status was first detected during the specified time period. This includes people who were diagnosed with AIDS at the time HIV first was detected. Because of delays in reporting HIV/AIDS cases, the number of persons reported is a minimal estimate. Data should be considered provisional.

³ = Preliminary data. December change in electronic system may show underestimated counts.

* = Percent change not calculated for rates or count differences less than 5.

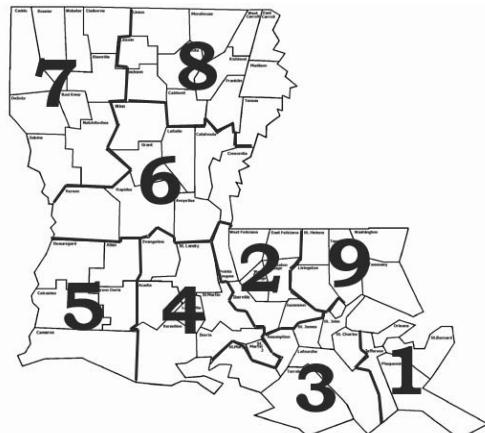
Table 2: Diseases of Low Frequency, January-December, 2017

Disease	Total to Date
Legionellosis	46
Lyme Disease	7
Malaria	9
Rabies, animal	14
Varicella	59

Table 3: Animal Rabies, November - December, 2017

Parish	No. Cases	Species
De Soto	1	Skunk

Figure: Department of Health Regional Map



Sanitary Code - State of Louisiana Part II - The Control of Disease

LAC 51:II.105: The following diseases/conditions are hereby declared reportable with reporting requirements by Class:

Class A Diseases/Conditions - Reporting Required Within 24 Hours

Diseases of major public health concern because of the severity of disease and potential for epidemic spread-report by telephone immediately upon recognition that a case, a suspected case, or a positive laboratory result is known; [in addition, all cases of rare or exotic communicable diseases, unexplained death, unusual cluster of disease and all outbreaks shall be reported.

Acute Flaccid Paralysis	Fish/Shellfish Poisoning (domoic acid, neurotoxic shellfish poisoning, ciguatera, paralytic shellfish poisoning, scombroid)	Plague (<i>Yersinia pestis</i>)	Smallpox
Anthrax	Foodborne Infection	Poliomyelitis (paralytic & non-paralytic)	<i>Staphylococcus aureus</i> , Vancomycin Intermediate or Resistant (VISA/VRSA)
Avian or Novel Strain Influenza A (initial detection)	<i>Haemophilus influenzae</i> (invasive infection)	Q Fever (<i>Coxiella burnetii</i>)	Staphylococcal Enterotoxin B (SEB) Pulmonary Poisoning
Botulism	Influenza-associated Mortality	Rabies (animal and human)	Tularemia (<i>Francisella tularensis</i>)
Brucellosis	Measles (Rubeola imported or indigenous)	Ricin Poisoning	Viral Hemorrhagic Fever (Ebola, Lassa, Marburg, Crimean Congo, etc.)
Cholera	Neisseria meningitidis (invasive infection)	Rubella (congenital syndrome)	Yellow Fever
<i>Clostridium perfringens</i> (foodborne infection)	Outbreaks of Any Infectious Disease	Rubella (German Measles)	
Diphtheria	Pertussis	Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)	

Class B Diseases/Conditions - Reporting Required Within 1 Business Day

Diseases of public health concern needing timely response because of potential of epidemic spread-report by the end of the next business day after the existence of a case, a suspected case, or a positive laboratory result is known.

Amoeba (free living infection: <i>Acanthamoeba</i> , <i>Naegleria</i> , <i>Balamuthia</i> , others)	Chagas Disease	Hepatitis B (perinatal infection)	Mumps
Anaplasmosis	Chancroid	Hepatitis E	Salmonellosis
Arthropod-Borne Viral Infections (West Nile, Dengue, St. Louis, California, Eastern Equine, Western Equine, Chikungunya, Usutu, and others)	<i>Escherichia coli</i> , Shiga-toxin producing (STEC), including <i>E. coli</i> O157:H7	Herpes (neonatal)	Shigellosis
Aseptic Meningitis	Granuloma Inguinale	Human Immunodeficiency Virus ² [(HIV), infection in pregnancy]	Syphilis ¹
Babesiosis	Hantavirus (infection or Pulmonary Syndrome)	Human Immunodeficiency Virus ² [(HIV), perinatal exposure]	Tetanus
	Hemolytic-Uremic Syndrome	Legionellosis	Tuberculosis ³ (due to <i>M. tuberculosis</i> , <i>M. bovis</i> , or <i>M. africanum</i>)
	Hepatitis A (acute illness)	Malaria	Typhoid Fever
	Hepatitis B (acute illness and carriage in pregnancy)		

Class C Diseases/Conditions - Reporting Required Within 5 Business Days

Diseases of significant public health concern-report by the end of the workweek after the existence of a case, suspected case, or a positive laboratory result is known.

Acquired Immune Deficiency Syndrome ³ (AIDS)	Giardiasis	Listeriosis	Staphylococcal Toxic Shock Syndrome
<i>Anaplasma Phagocytophilum</i>	Glanders (<i>Burkholderia mallei</i>)	Lyme Disease	Streptococcal Disease, Group A (invasive disease)
Blastomycosis	Gonorrhea ¹ (genital, oral, ophthalmic, pelvic inflammatory disease, rectal)	Lymphogranuloma Venereum ¹	Streptococcal Disease, Group B (invasive disease)
Campylobacteriosis	Hansen's Disease (leprosy)	Melioidosis (<i>Burkholderia pseudomallei</i>)	Streptococcal Toxic Shock Syndrome
Chlamydial infection ¹	Hepatitis C (acute illness)	Meningitis, Eosinophilic (including those due to <i>Angiostrongylus</i> infection)	<i>Streptococcus pneumoniae</i> , invasive disease
Coccidioidomycosis	Histoplasmosis	Nipah Virus Infection	Transmissible Spongiform Encephalopathies (Creutzfeldt-Jacob Disease & variants)
Cryptococcosis (<i>C. neoformans</i> and <i>C. gattii</i>)	Human Immunodeficiency Virus ² (HIV) (infection other than as in Class B)	Non-gonococcal Urethritis	Trichinosis
Cryptosporidiosis	Human T Lymphocyte Virus (HTLV I and II infection)	Ophthalmia neonatorum	Varicella (chickenpox)
Cyclosporiasis	Leptospirosis	Psittacosis	<i>Vibrio</i> Infections (other than cholera)
Ehrlichiosis (human granulocytic, human monocytic, <i>E. chaffeensis</i> and <i>E. ewingii</i>)		Spotted Fevers [<i>Rickettsia</i> species including Rocky Mountain Spotted Fever (RMSF)]	Yersiniosis
<i>Enterococcus</i> , Vancomycin Resistant [(VRE), invasive disease]		<i>Staphylococcus aureus</i> (MRSA), invasive infection	

Class D Diseases/Conditions - Reporting Required Within 5 Business Days

Cancer	Heavy Metal (arsenic, cadmium, mercury) Exposure and/or Poisoning (all ages) ⁵	Phenylketonuria ⁴	Severe Traumatic Head Injury
Carbon Monoxide Exposure and/or Poisoning ⁵	Hemophilia ⁴	Pneumoconiosis (asbestosis, berylliosis, silicosis, byssinosis, etc.)	Severe Undernutrition (severe anemia, failure to thrive)
Complications of Abortion	Lead Exposure and/or Poisoning (all ages) ^{4,5}	Radiation Exposure, Over Normal Limits	Sickle Cell Disease ⁴ (newborns)
Congenital Hypothyroidism ⁴	Pesticide-Related Illness or Injury (all ages) ⁵	Reye's Syndrome	Spinal Cord Injury
Galactosemia ⁴			Sudden Infant Death Syndrome (SIDS)

Case reports not requiring special reporting instructions (see below) can be reported by mail or facsimile on Confidential Disease Report forms (2430), facsimile (504) 568-8290, telephone (504) 568-8313, or (800) 256-2748 for forms and instructions.

¹Report on STD-43 form. Report cases of syphilis with active lesions by telephone, within one business day, to (504) 568-8374.

²Report to the Louisiana HIV/AIDS Program: Visit www.hiv.dhh.louisiana.gov or call 504-568-7474 for regional contact information.

³Report on form TB 2431 (8/94). Mail form to TB Control Program, DHH-OPH, P.O. Box 60630, New Orleans, LA. 70160-0630 or fax both sides of the form to (504) 568-5016

⁴Report to the Louisiana Genetic Diseases Program and Louisiana Childhood Lead Poisoning Prevention Programs: www.genetics.dhh.louisiana.gov or facsimile (504) 568-8253, telephone (504) 568-8254, or (800) 242-3112

⁵Report to the Section of Environmental Epidemiology and Toxicology: www.seet.dhh.louisiana.gov or call (225) 342-7136 or (888) 293-7020

All **laboratory facilities** shall, in addition to reporting tests indicative of conditions found in §105, report positive or suggestive results for additional conditions of public health interest. The following findings shall be reported as detected by laboratory facilities: 1. adenoviruses; 2. coronaviruses; 3. enteroviruses; 4. hepatitis B (carriage other than in pregnancy); 5. hepatitis C (past or present infection); 6. human metapneumovirus; 7. parainfluenza viruses; 8. respiratory syncytial virus; and 9. rhinoviruses.