Louisiana Morbidity Report

Office of Public Health - Infectious Disease Epidemiology Section
P.O. Box 60630, New Orleans, LA 70160 - Phone: (504) 568-8313
www.ldh.louisiana.gov/LMR

Infectious Disease Epidemiology Main Webpage
www.infectiousdisease.dhh.louisiana.gov

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD MPH
SECRETARY

March-April, 2018 **Volume 29, Number 2**

Active Surveillance Cultures for Antibiotic Resistant Organisms: Louisiana, 2016-2017

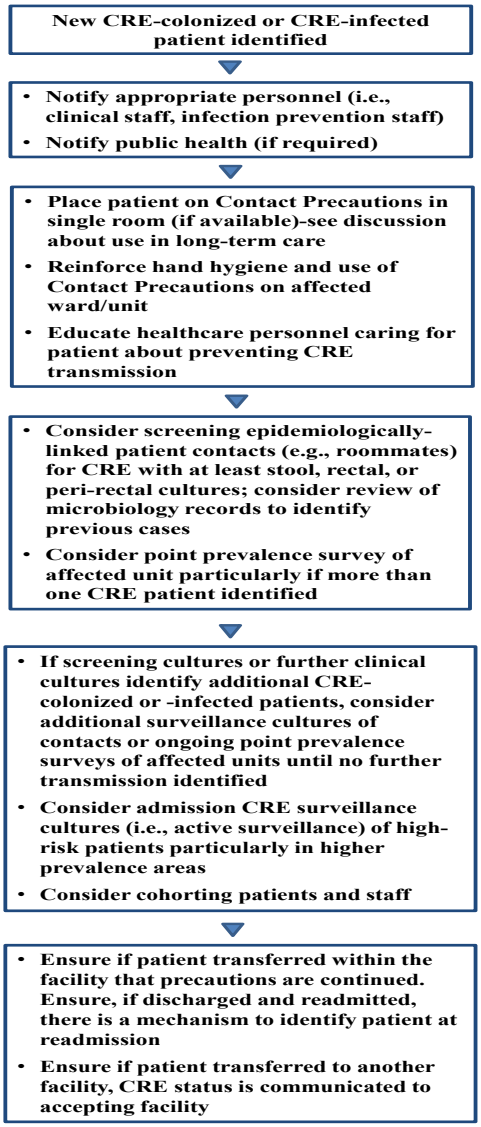
Erica Washington, MPH, CPH, CIC, CPHQ

Antibiotic resistant organisms pose challenging containment and treatment options when presented into healthcare settings. While facilities are able to effectively contain these organisms through infection control measures, active surveillance cultures (ASC) are useful for identifying intra-facility transmission that may have occurred. Active surveillance cultures are targeted laboratory screenings on inpatients healthcare facilities. This practice was first introduced approximately ten years ago to combat methicillin-resistant *Staphylococcus aureus* (MRSA) in hospitals. It has since expanded to other infectious agents such as Carbapenem-resistant *Enterobacteriaceae* (CRE).

Pathogens that are novel to individual healthcare facilities, Louisiana, and the broader geographic region should have ASC performed for hospitalized contacts of index cases. Organisms for which ASC are indicated include: CRE (particularly those with novel resistance mechanisms such as New Delhi Metallo-beta-lactamase production); Vancomycin Resistant *S. aureus* (VRSA); and pan-resistant organisms. The purpose of conducting ASC for contacts (e.g., roommates, patients housed on the same unit) is to determine if intra-facility transmission has occurred.

Laboratory results are an essential component for healthcare-associated infections (HAI) surveillance. The protocol for CRE ASC includes collecting perirectal swabs for epidemiologically-linked contacts of confirmed cases. The Centers for Disease Control and Prevention (CDC) further described containment and response to CRE in the 2015 *Facility Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE)*. This approach to evaluating newly identified CRE colonized or infected patients is described in Figure 1.

Figure 1: Facility Approach to Evaluation of Newly Recognized CRE Colonized or Infected Patients



Extremely drug resistant organisms (XDRO) are tracked in the CDC National Healthcare Safety Network (NHSN) by infectious outcome type. From July 1, 2016 to June 30, 2017, 172 HAI events in Louisiana were identified with XDROs (Figure 2).

(continued on page 6)

Inside

Motor Vehicle Crash Deaths: Louisiana vs. United States, 2013

In 2013, nearly 750 people in Louisiana were killed in motor vehicle crashes. Motor vehicle crashes are a top ten cause of death among people aged from one to 54 years of age. For the United States, crash deaths resulted in $44 billion in medical and work loss costs (Figures 1 and 2, and Table).

Figure 1: Total Costs of Crash Deaths per State – United States, 2013*

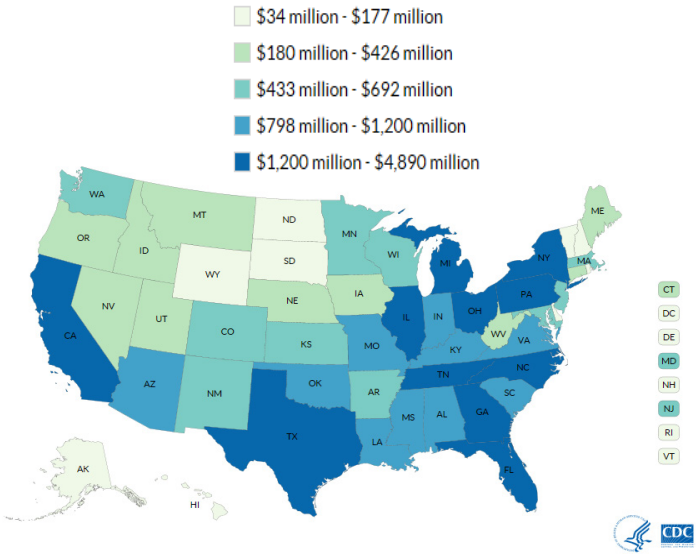
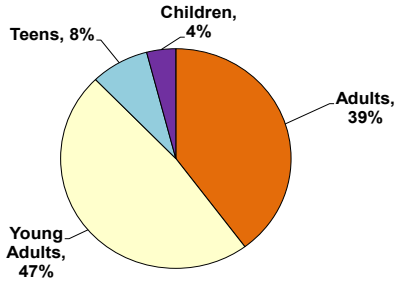


Table: Total Costs of Crash Deaths per Region - Louisiana and Bordering States, 2013*

	Total Population in 2013	Crash-related Death Costs in 2013	Crash-related Death Cost per Person
New Mexico	2.1 Million	$433 Million	$206.19
Arkansas	3.0 Million	$683 Million	$227.67
Oklahoma	3.9 Million	$902 Million	$231.28
Louisiana	**4.6 Million**	**$1.01 Billion****	**$219.57**
Texas	26.4 Million	$4.89 Billion	$185.23

** The cost figures presented in Figure 1 and Table are based on information collected by each individual state. As a result, there are differences between states in the way they collect and categorize these data.*
*** $8 million in medical costs + $998 million in work loss costs; 767 deaths*

Figiure 2: Crash-related Deaths by Age Group - Louisiana, 2013***



**** Children: 0–14, Teens: 15–19, Young Adults: 20–34, Adults: 35–64, Older Adults: 65+*

Ways to prevent crashes include the following:
- graduated driver licensing systems
- sobriety checkpoints
- ignition interlocks for those convicted of driving while intoxicated
- car seat and booster seat use through distribution plus education programs
- car seat and booster seat use through updated laws that require car seat or booster seat use for children eight years of age and younger
- seat belt use through primary seat belt laws for all seating positions.

For more information, go to *https://www.cdc.gov/motorvehicle-safety/pdf/statecosts/la-2015costofcrashdeaths-a.pdf*.

Announcements

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

Annual: Creutzfeldt-Jakob Disease (CJD); Eosinophilic Meningitis; Hepatitis A; Meningococcal Infections

Arboviral: Arboviral Shipping Instructions; Lyme Disease Case Investigation Form (LDH)

Epi Manual: Legionnaires' Disease; Leptospirosis Case Report Form (CDC); Mumps Patient Information Form; Norovirus-Long-term Care Facility

Influenza: Weekly Report

Veterinary: Rabies Testing Form and Case Investigation Worksheet

National Infant Immunization Week
April 26-May 3, 2018

For Louisiana vaccination information, please go to webpage *Healthy Babies* or *http://ldh.la.gov/index.cfm/page/3015*.

Hepatitis Awareness Month
May, 2018

HIV Testing Day
June 27, 2018

Louisiana Morbidity Report
Volume 28, Number 2 March - April, 2018

The Louisiana Morbidity Report is published bimonthly by the LDH, OPH Infectious Disease Epidemiology Section 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, P.O. Box 60630, New Orleans, LA 70160.

Assistant Secretary OPH — *Parham Jaberi, MD, MPH*

State Epidemiologist — *Raoult Ratard, MD, MPH*

Editors — *Theresa Sokol, MPH*, *Julie Hand, MSPH*, *Rosemarie Robertson, BS, MT(C), CNMT*

Updated Recommendations on Hepatitis B for Obstetricians and Pediatricians

Lyndsey Kirchner, MPH

The Centers for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommend that, as part of the comprehensive strategy to eliminate hepatitis B, health professionals follow these guidelines: 1) universal screening of all women during each pregnancy for HBsAg (hepatitis B surface antigen) and prophylaxis for infants born to HBsAg-positive mothers; and 2) universal vaccination of infants starting at birth.

In Louisiana, a total of 772 perinatal hepatitis B exposures were identified from 2006 to 2015, accounting for approximately 30% of the projected case estimate. The number of perinatal hepatitis B exposures continues to increase each year. Of the identified births, five infants became hepatitis B positive and three of those infants did not receive proper prophylaxis at delivery. Preventing perinatal transmission is essential to the comprehensive strategy to eliminate hepatitis B in the United States.

Protocol for obstetricians:

• Routine testing for all women during each pregnancy for HBsAg (hepatitis B surface antigen), even if they have been previously vaccinated or tested.

• A copy of the original laboratory report indicating HBsAg status should be provided to the birthing facility to ensure proper prophylaxis for infant at delivery (administration of hepatitis B vaccine and hepatitis B immune globulin (HBIG) within 12 hours of birth).

• Refer all HBsAg-positive pregnant women to the Louisiana Perinatal Hepatitis B Prevention Program for case management to ensure that the infants receive appropriate prophylaxis and follow up (*http://ldh.louisiana.gov/index.cfm/page/1002*).

Protocol for pediatricians:

• Timely hepatitis B vaccination for all infants. Recommended interval: 1st dose at birth; second dose at one to two months of age; third dose no sooner than six months of age

• Infants born to HBsAg-positive women and women of unknown hepatitis B status, receive HBIG and first dose within 12 hours of birth (Table).

• For infants born to HBsAg-positive women, post-vaccination serologic testing, hepatitis B surface antigen (HBsAg) AND hepatitis B surface antibody (HBsAb or anti-HBs), at nine to 12 months of age.

New and updated strategies to further reduce and eliminate the transmission of hepatitis B include the following:

• Universal hepatitis B vaccination for all medically stable infants (weighing more than or equal to 2,000 grams) within 24 hours of birth to provide a critical safeguard and prevent infection among infants born to HBsAg-positive mothers not identified prenatally

• Testing HBsAg-positive pregnant women for hepatitis B virus deoxyribonucleic acid (HBV DNA) to identify infants at greatest risk for infection and guide the use of maternal antiviral therapy to further reduce perinatal HBV infection (when HBV DNA is greater than 200,000 IU/mL)

• Post-vaccination serologic testing for infants whose mother's HBsAg status remains unknown indefinitely (e.g. when a parent or person with lawful custody surrenders an infant confidentially shortly after birth)

• Single-dose revaccination for infants born to HBsAg-positive women not responding to the initial vaccine series

• Removal of permissive language for delaying the birth dose until after hospital discharge.

For references and more information, please contact Ms. Kirchner at (504) 568-5300 or *lyndsey.kirchner@la.gov*.

Table: Guidance for Infants Born to Hepatitis B Infected Mothers or Mothers Whose Status Remains Unknown

Age	Single-antigen Hepatitis B Vaccine (Engerix-B® or Recombivax HB®)	Combination Hepatitis B Vaccine (Pediarix®)
Birth* (within 12 hours)	Hepatitis B immune globulin (HBIG) AND Hepatitis B vaccine dose #1	Not approved, only single-antigen vaccine used for the birth dose
1-2 months**	Hepatitis B vaccine dose #2	Hepatitis B vaccine dose #2
4 months	No vaccine administered	Hepatitis B vaccine dose #3
6 months	Hepatitis B vaccine dose #3	Hepatitis B vaccine dose #4
9-12 months¶	Post-vaccination serologic testing Hepatitis B Surface Antigen (HBsAg) Hepatitis B Surface Antibody (HBsAb or anti-HBs)	Post-vaccination serologic testing Hepatitis B Surface Antigen (HBsAg) Hepatitis B Surface Antibody (HBsAb or anti-HBs)

Abbreviations: HBIG = hepatitis B immune globulin

** HepB vaccine and HBIG should be administered within 12 hours of birth. However, HBIG can be administered up to 7 days after birth if mother's HBsAg laboratory result is not available at delivery.*

*** Infant weighing less than 2,000 grams or 4.4 pounds should receive 4 total doses of hepatitis B vaccine. The schedule is: HBIG & single-antigen hepB vaccine within 12 hours of birth, hepB vaccine at 1 month, 2 month, and 6 months of age. The Pediarix schedule is: HBIG and single-antigen hepB vaccine within 12 hours of birth, Pediarix doses at 2 months, 4 months, and 6 months of age. Pediarix should not be administered before age 6 weeks.*

¶ Testing should not be completed before 9 months of age AND must be drawn a minimum of 30 days after the final dose of hepB vaccine is given, if the vaccine series has been delayed.

Chronic Wasting Disease (CWD) Update: Louisiana, 2018

José Antonio Serrano, MPH

There has been a growing concern in the potential for chronic wasting disease (a prion disease in deer, elk, moose) to cause disease in humans. Though there has not been any scientific evidence to support a claim of zoonotic transmission to humans, recent laboratory evidence of neurologic disease in non-human primates exposed to tissues from infected wild ruminants has caused concern within the public health community. Surveillance efforts have been ramped up in response.

CWD was first identified in captive deer in the late 1960s in Colorado and in wild deer in 1981.By the 1990s, the disease had been reported in surrounding areas in northern Colorado and southern Wyoming. Since 2000, the area known to be affected by CWD in free-ranging animals has increased to include states in the Midwest, Southwest, and limited areas on the East Coast. It is possible that CWD may also occur in other states without strong animal surveillance systems, where cases haven't been detected yet. Once CWD is established in an area, the risk can remain for a long time in the environment. The affected areas are likely to continue to expand.

Nationwide, the overall occurrence of CWD in free-ranging deer and elk is relatively low. However, in several locations where the disease is established, infection rates may exceed 10%, and localized infection rates of more than 25% have been reported. The infection rates among some captive deer can be much higher, with a rate of 79% reported from at least one captive herd.

As of January 2018, CWD in free-ranging deer, elk and/or moose has been reported in at least 22 states in the continental United States, as well as two provinces in Canada. In addition, CWD has been reported in reindeer and moose in Norway, and a small number of imported cases have been reported in South Korea. The disease has also been found in farmed deer and elk.

The Infectious Disease Epidemiology (IDEpi) Section, Office of Public Health (OPH), Louisiana Department of Health (LDH) was recently informed of the discovery of a deer in the state of Mississippi that was confirmed to be infected with CWD. The area in which the affected deer was found borders the Mississippi River and some parts of Northeastern Louisiana. This has naturally become a cause of concern for hunters in this region.

IDEpi recommends that hunters exercise common sense precautions when hunting deer in Louisiana. Hunters should refrain from shooting, handling, or consuming meat from deer that have a sickly appearance or that seem to be acting erratically. Additionally, deer found dead should never be handled or eaten. When dressing harvested animals or handling deer meat, hunters should wear latex, nitrile, or rubber gloves. Hunters should also minimize contact with the organs of the animal, especially the brain and spinal cord. As a reminder, household knives or other kitchen utensils should never be used for field dressing. Prions are not inactivated by dishwashing or other common methods of disinfection.

The Louisiana Department of Wildlife and Fisheries (LDWF) has been monitoring Louisiana deer for cases of CWD in recent years and will continue in this endeavor. OPH asks that anyone who observes a deer showing the following symptoms contact LDWF regarding possible testing of the animal:

- low body weight or emaciation
- stumbling
- tremors
- lack of coordination
- depression
- blank facial expression
- excessive salivation or drooling
- loss of appetite
- excessive thirst and urination
- listlessness
- teeth grinding
- abnormal head posture
- drooping ears

Hunters should call their LDWF regional office if they observe a sick or emaciated deer, especially in Madison, East Carroll, and Tensas Parishes. After hours, the public can call the LDWF Operation Game Thief Hotline at (800) 442-2511. It is important to remember that these signs do not necessarily mean that the deer is infected with CWD, as other diseases may cause these manifestations.

OPH has been informed and updated by LDWF on the wildlife agency's program for surveillance of CWD, a program that complies with U.S. Department of Agriculture-Animal and Plant Inspection Service, and the Centers for Disease Control and Prevention guidelines. Should LDWF discover the disease in deer in Louisiana, OPH will be notified immediately. OPH will continue to monitor all reports of prion diseases.

For more information please contact José Antonio Serrano at (504) 568-8292 or *jose.serrano@la.gov*.

Photo: Courtesy of the CDC

Save the Date!

Field Epidemiology Training -2018

Lake Charles - July 17
New Orleans - August 22
Natchitoches - September 19

For more information go to *http://ldh.la.gov/index.cfm/page/1816*

Hospital Emergency Department Syndromic Surveillance Mardi Gras - Louisiana, 2018

Dayaamayi Kurimella, MPH

The Infectious Disease Epidemiology Section (IDEpi), Office of Public Health, Louisiana Department of Health, conducted syndromic surveillance in Regions 1, 3, 4 and 9* during 2018 Mardi Gras activities. The Louisiana Early Event Detection System (LEEDS), IDEpi's syndromic surveillance system, conducts surveillance of emergency department (ED) data by using chief complaint, admit reason, and discharge diagnosis to tag records to syndromes defined in LEEDS. IDEpi monitored infectious disease and injury syndromes during the 2018 festival season. Mardi Gras fell on February 13, 2018; the period of enhanced surveillance took place from January 1, 2018 through February 23, 2018.

IDEpi monitored six syndromes related to infectious disease: fever, gastrointestinal complaints (GI), influenza-like illness (ILI), lower respiratory tract infections (LRTI), skin and soft tissue infections (SSTI), and upper respiratory tract infections (URTI). The data was monitored for spikes and increases in percentage of ED visits associated with each syndrome (Figures 1-4).

The enhanced surveillance did not show any significant spikes in the percentage of emergency department visits for any syndrome, nor were any sustained increases in the trends for the syndromes of interest identified, though a slight decrease in URTI, ILI, and fever was noted.

For more information, please contact Ms. Kurimella at (504) 568-3182 or dayaamayi.kurimella@la.gov.

* *Map of Regions on Page 7*

Figure 1: Daily Summaries of ED Visits Related to Infectious Disease Syndromes - Region 1: Louisiana, January 1 - February 23, 2018

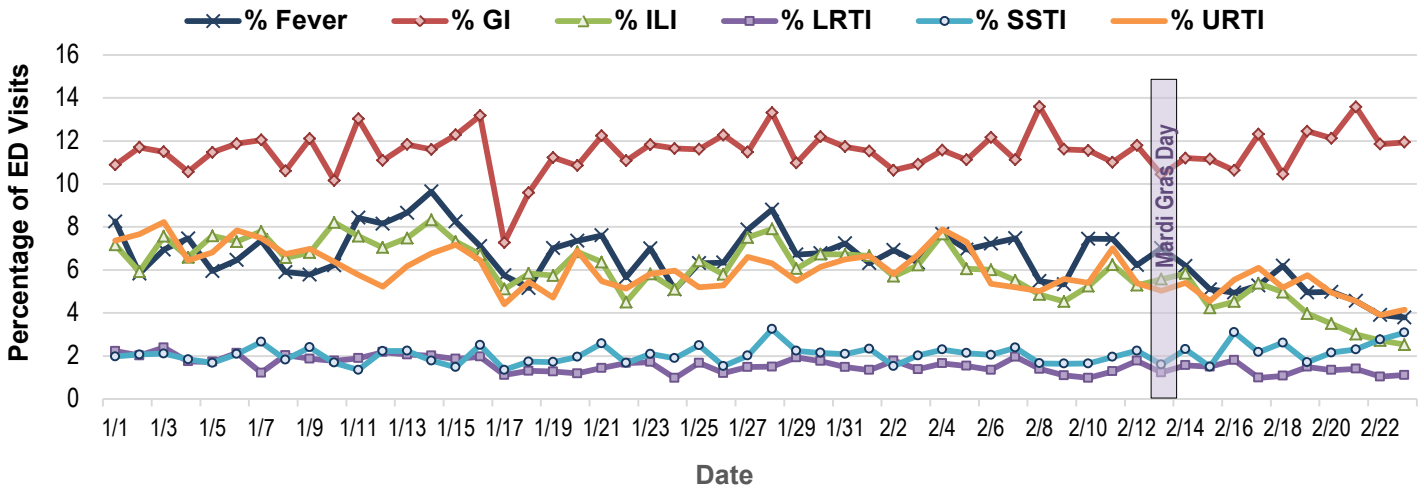
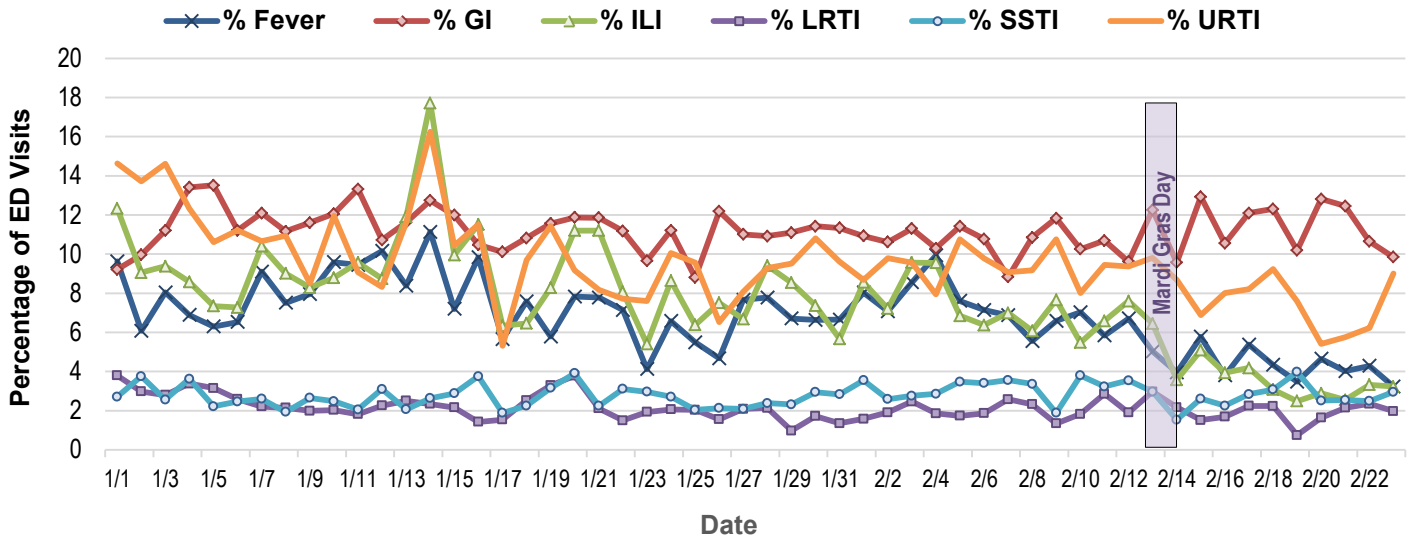


Figure 2: Daily Summaries of ED Visits Related to Infectious Disease Syndromes - Region 3: Louisiana, January 1 - February 23, 2018



(continued on page 6)

(Hospital Emergency Department ... continued from page 5)

Figure 3: Daily Summaries of ED Visits Related to Infectious Disease Syndromes - Region 4: Louisiana, January 1 - February 23, 2018

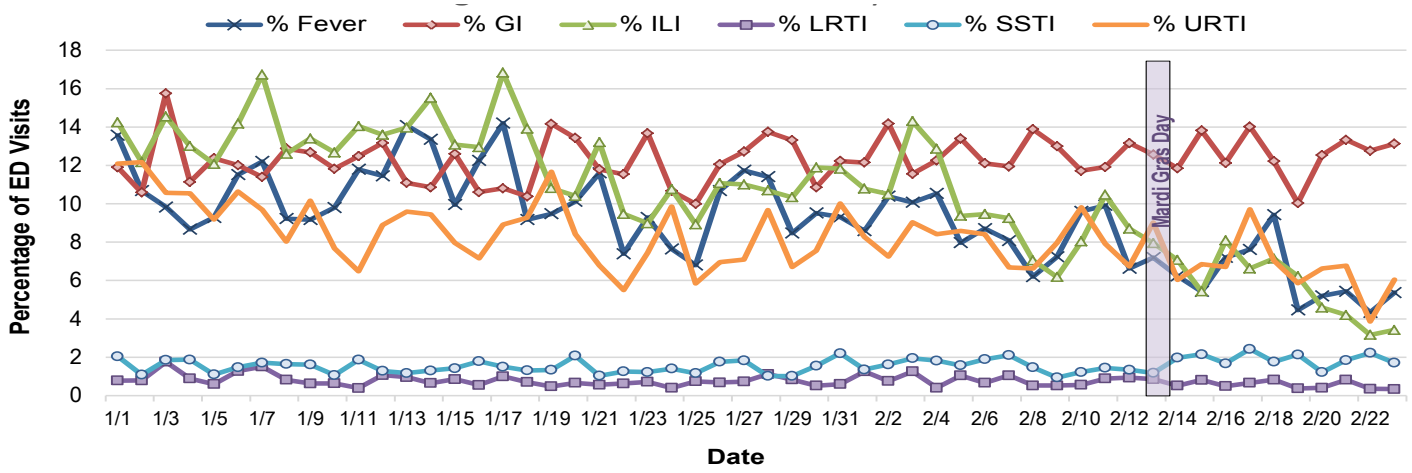
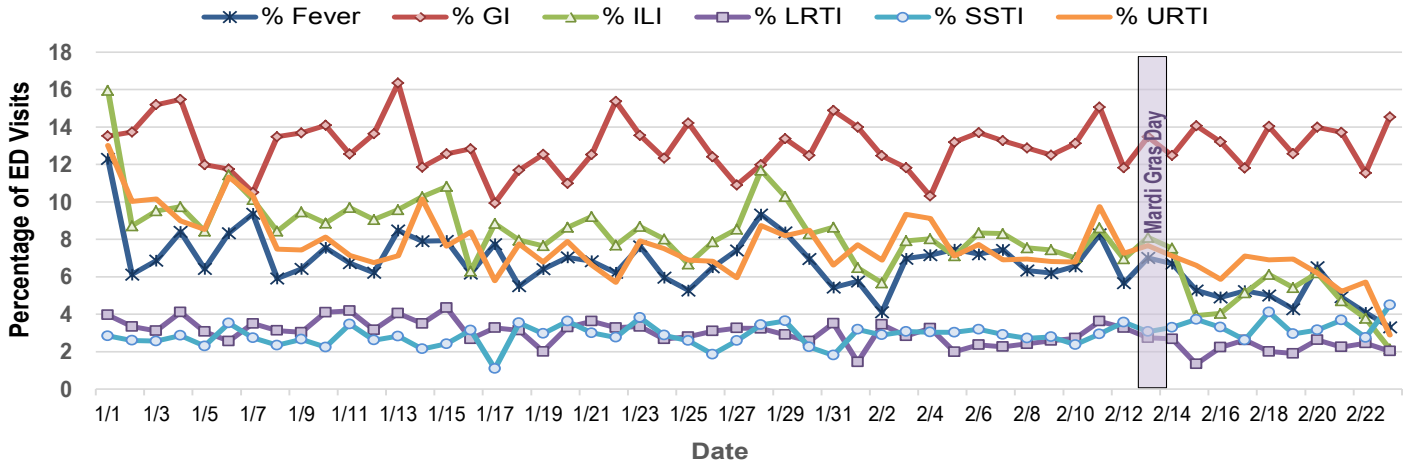
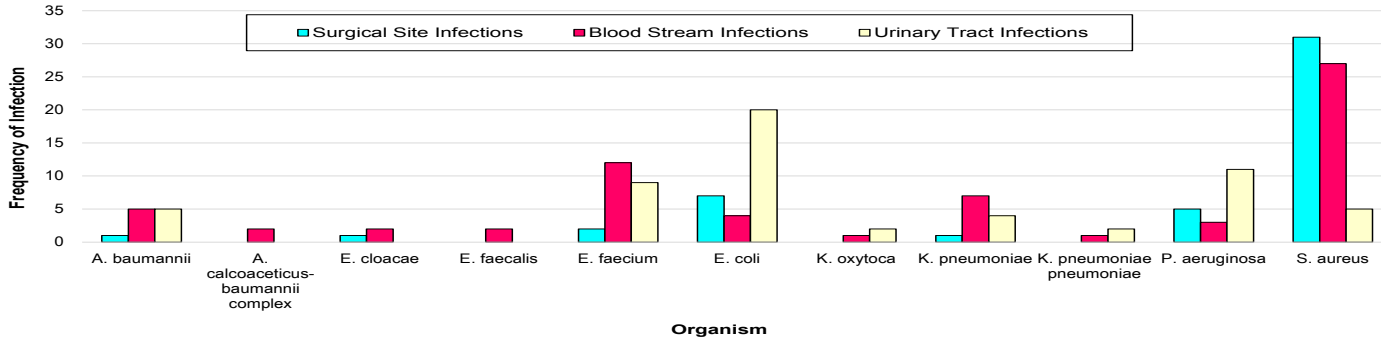


Figure 4: Daily Summaries of ED Visits Related to Infectious Disease Syndromes - Region 9: Louisiana, January 1 - February 23, 2018



(Active Surveillance ... continued from page 1)

Figure 2: Antimicrobial Resistant Healthcare-Associated Infections in Louisiana, July 1, 2016 - June 30, 2017



The most frequently identified antibiotic resistant organism was *Escherichia coli* in urinary tract infections, followed by *Enterococcus faecium* in bloodstream infections. During this time period, two infections were identified with CRE that were resistant to imipenem, meropenem, and ertapenem. These organisms were cultured from a surgical site and urinary tract. Conducting ASCs when these organisms are identified can assist facilities with identifying breaches in infection control practices.

The HAI/AR Program is collaborating with the CDC's Antibiotic Resistance Laboratory Network (ARLN) for testing the following organisms: suspect and confirmed *Candida auris*; CRE confirmatory testing; CRE ASC colonization testing; Vancomycin-resistant *Enterobacter* (VRE), VRSA; multi drug-resistant (MDR) *Pseudomonas;* MDR *Acinetobacter*; and pan-resistant organisms. When these organisms are identified, facilities should notify the LDH, Office of Public Health's Infectious Disease Epidemiology Section by calling (800) 256-2748 so that the HAI/AR Program may coordinate confirmatory testing with the CDC ARLN.

For more information, contact *Erica.Washington@LA.gov*.

Table 1: Communicable Disease Surveillance, Incidence by Region and Time Period, January-February, 2018

DISEASE		HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Jan-Feb 2018	Jan-Feb 2017	Jan-Dec Cum 2018	Jan-Dec Cum 2017	Jan-Dec % Chg*
Vaccine-preventable															
Hepatitis B Acute	Cases[4]	1	3	1	0	0	2	0	1	1	9	15	9	15	-40.0
	Rate[1]	0.1	0.5	0.3	0	0	0.7	0	0.3	0.3	0.2	0.3	0.2	0.3	NA*
Measles (Rubeola)	Cases[5]	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Mumps	Cases[5]	0	1	0	0	0	0	0	0	0	1	3	1	3	NA*
Rubella	Cases[4]	0	0	0	0	0	0	0	0	0	0	0	0	0	NA*
Pertussis	Cases[5]	9	2	0	1	0	1	0	0	5	18	17	18	17	NA*
Sexually-transmitted															
HIV/AIDS	Cases[2]	52	33	8	24	10	14	13	11	10	175	176	175	176	NA*
	Rate[1]	5.8	4.8	2.0	3.9	3.3	4.6	2.4	3.1	1.7	3.7	3.8	3.7	3.8	NA*
Chlamydia	Cases[1,3]	1,307	930	398	528	294	300	752	625	488	5,653	6,315	5,653	6,315	-10.5
	Rate[1]	145.7	135.9	98.4	86.7	97.5	98.1	138.4	176.3	84.0	120.7	134.9	120.7	134.9	NA*
Gonorrhea	Cases[1,3]	415	225	101	163	75	141	255	178	100	1,671	2,142	1,671	2,412	-30.7
	Rate[1]	46.3	32.9	25.0	26.8	24.9	46.1	46.9	50.2	17.2	35.7	45.8	35.7	45.8	NA*
Syphilis (P&S)	Cases[1,3]	4	8	3	7	0	11	8	6	3	50	124	50	124	-59.7
	Rate[1]	0.4	1.2	0.7	1.1	0	3.6	1.5	1.7	0.5	1.1	2.6	1.1	2.6	NA*
Enteric															
Campylobacter	Cases[5]	4	9	7	39	11	3	5	5	8	91	112	91	112	-18.8
Hepatitis A	Cases[4]	0	0	0	0	1	0	0	0	0	1	2	8	11	NA*
	Rate[1]	0	0	0	0	0.4	0	0	0	0	0	0	0.2	0.3	NA*
Salmonella	Cases[5]	7	18	11	14	8	3	3	8	9	81	99	81	99	-18.2
	Rate[1]	0.7	3.2	2.9	2.7	3.0	1.0	0.6	2.3	2.3	1.9	2.3	1.9	2.3	NA*
Shigella	Cases[5]	1	1	2	4	5	0	1	1	1	16	51	16	51	-68.6
	Rate[1]	0.1	0.2	0.5	0.8	1.9	0	0.2	0.3	0.3	0.4	1.2	0.4	1.2	NA*
Vibrio, Cholera	Cases[4]	0	0	0	0	0	0	0	0	0	0	0	1	0	NA*
Vibrio, Other	Cases[5]	1	2	1	0	2	0	0	0	0	6	6	6	6	NA*
Other															
H. influenzae (invasive) [5]		4	4	5	5	0	2	4	0	1	25	13	25	13	92.3
N. Meningitidis (invasive) [5]		0	0	0	0	0	0	0	0	0	0	2	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] = Prelminary data. December change in electronic system may show underestimated counts.

[4] = Confirmed cases

[5] = Confirmed and Probable cases

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

Figure: Department of Health Regional Map

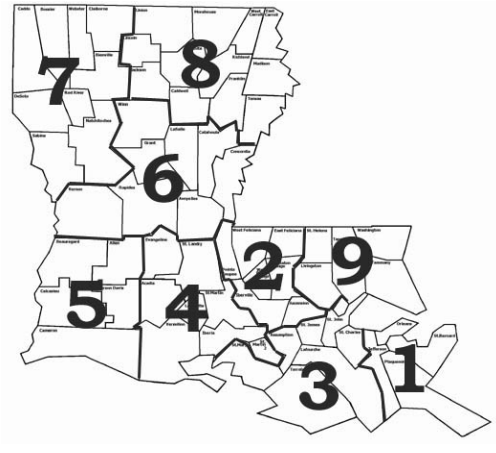


Table 2: Diseases of Low Frequency, January-December, 2018

Disease	Total to Date
Legionellosis	4
Lyme Disease	0
Malaria	2
Rabies, animal	0
Varicella	8

Table 3: Animal Rabies, January - February, 2018

Parish	No. Cases	Species
	0	

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

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

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

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

- Cancer
- Carbon Monoxide Exposure and/or Poisoning[5]
- Complications of Abortion
- Congenital Hypothyroidism[4]
- Galactosemia[4]
- Heavy Metal (arsenic, cadmium, mercury) Exposure and/or Poisoning (all ages)[5]
- Hemophilia[4]
- Lead Exposure and/or Poisoning (all ages)[4, 5]
- Pesticide-Related Illness or Injury (all ages)[5]
- Phenylketonuria[4]
- Pneumoconiosis (asbestosis, berylliosis, silicosis, byssinosis, etc.)
- Radiation Exposure, Over Normal Limits
- Reye's Syndrome
- Severe Traumatic Head Injury
- Severe Undernutrition (severe anemia, failure to thrive)
- Sickle Cell Disease[4] (newborns)
- Spinal Cord Injury
- 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), fascimile (504) 568-8290, telephone (504) 568-8313, or (800) 256-2748 for forms and instructions.

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

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

[3]Report 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

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

[5]Report 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.