County of Los Angeles
Department of Health Services
Public Health

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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New Law Mandates Varicella Immunization for Children

As of July 1, 2001, all students entering kindergarten in both public and private schools, as well as children 18 months or older who are attending day care in a home, child care center, or nursery school, are required by law to present documentation of varicella (chickenpox) immunization or immunity. The new law (Senate Bill 741) was signed by Governor Gray Davis in October 1999.

Children and adolescents under 18 years of age entering California schools for the first time after July 1, 2001, are required to show proof of varicella immunization. Students already in school at the kindergarten level or above before July 1, 2001, are exempt from the requirement.

The varicella vaccine was licensed for use in 1995 and added to the Recommended Childhood Immunization Schedule in 1996. Recommended at 12-18 months of age, varicella immunization coverage for 2-year-olds in 1999 was 76% in Los Angeles County; coverage has been steadily increasing over the last few years.

To comply with the new law, health care providers will need to ensure that children who are about to enter school have had a varicella shot or have chickenpox disease immunity. A history of chickenpox disease will meet the requirement but it must be documented by the provider.

The State of California Department of Health Services, Immunization Branch offers the following as documentation of disease immunity:

- Immunization Record showing month/day/year of varicella immunization on or after the 1st birthday.
- Health care provider's written indication that the child had a disease that the provider had clinically diagnosed as varicella (chickenpox) at the time of acute infection.
- Health care provider's written indication that the child has adequate clinical history of varicella based on taking a history from the parent/guardian and as a result, the

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Patient-Delivered Therapy for Chlamydia

A Coup for California

A new law – enacted earlier this year – provides physicians an important option to combat chlamydia, the most frequently reported infectious disease in the United States. Senate Bill 648 (Ortiz, Chapter 835) allows physicians to prescribe – and nurse practitioners, physician assistants and certified nurse-midwives to dispense – antibiotic therapy for the sex partners of individuals infected with genital *Chlamydia trachomatis*, even if they have not been able to perform an exam of the patient's partner(s).

It is estimated that 600,000 Californians may become infected with chlamydia each year, with rates of 5 to 10% among adolescent women.

In California alone, more than 85,000 cases of chlamydia were reported in 1999. This figure is just a fraction of the cases estimated in the state. Because the majority of infections are asymptomatic and go undiagnosed, and because of underreporting, it is estimated that 600,000 Californians may become infected each year, with rates of 5 to 10% among adolescent women.

A recent multi-site randomized controlled trial of patient-delivered therapy (PDT) funded by the CDC demonstrated that PDT reduced re-infection rates 20%.

In California, physicians are still required by law to:

- Investigate the source of infection, as well as any sexual or other intimate contact that the patient made while in the communicable stage of the disease
- Make an effort, through the cooperation of the patient, to bring these persons in for examination and treatment (Title 17, California Code of Regulations A7 2636)

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To our Readers —

The Public's Health *is a new monthly publication replacing: The Public Health Letter, Immunization Exchange, STD Examiner and TB Times.*

The Public's Health *will continue to provide the epidemiologic information you expected from these publications – including information on disease outbreaks and reporting issues – and keep you abreast of the latest data and information on county health issues.*

We are committed to being a valuable resource to you and want this publication to be of maximum benefit to you as a health care provider. We welcome your comments and suggestions.

If you prefer to receive **The Public's Health** *via e-mail, contact us at tph@lapublichealth.org.*

You may view this publication – and obtain a variety of public health information and data – by visiting our website: www.lapublichealth.org.

Sincerely,

Jonathan E. Fielding, MD, MPH
Director of Public Health and County Health Officer

Reporting TB Cases

All health care providers (including administration of health facilities and clinics) attending to patients suspected of having or diagnosed with active tuberculosis (TB) must report this fact to the Los Angeles County Tuberculosis Control Program within one working day from the time of identification. Directors of any clinical lab must also report laboratory evidence of TB on the same day the physician submitting the specimen is notified.

Why report?

Reporting is mandated by the State Health and Safety Codes (Section 120130 and 121362) and Administrative Codes, (Title 17, Chapter 4, Section 2500) and must be done within one working day of diagnosis. These laws also mandate that prior to discharge, all TB suspects and cases in hospitals and prisons must have an individualized, written discharge plan approved by the TB Control Program.

Not only is TB reportable for legal reasons—this information is critical to maintaining an effective public health surveillance system to protect the general public.

How to report?

Submit a completed Confidential Morbidity Report of TB Cases or Suspects (CMR) to the TB Control Program by fax (213-749-0926) or phone (213-744-6271). A CMR can be obtained by phone or via the internet at www.lapublichealth.org/tb. For reporting after hours, providers can leave their name, phone or pager number, date of birth, and medical record number on TB Control's voicemail or call the County Operator at (213-974-1234) and ask to be referred to Medical Officer of the Day.

Delay or failure to report

Delay or failure to report communicable disease can have serious consequences for the public's health. Under the California Code of Regulations, (Title 16, Division 13, Chapter 2, Article 6, section 1364.10) failure to report a communicable disease is a misdemeanor punished by a fine of $100 to 2,500, or by imprisonment for a term of one to 90 days or both. Each day the violation is continued is an offense.

Reportable Diseases: ***A list of all diseases that providers are required to report to the health department can be found on our web site at:***
www.lapublichealth.org/acd/news/phl01/acdn2301.htm

Understanding *E. coli* O157:H7

As outdoor cookouts and barbecued burgers become more common during these summer months, health professionals should be extra vigilant for enteric infections, *Escherichia coli* O157:H7 in particular. Among the various strains of pathogenic *E. coli*, O157:H7 is the most common and its increasing prevalence is a cause for concern. *E. coli* O157:H7 was first identified as an enteric pathogen in 1982 during outbreak investigations of hemorrhagic colitis in Michigan and Oregon. It is shed in the feces of healthy cattle, as such, transmission is most commonly due to ingestion of contaminated undercooked ground beef, but outbreaks have also been linked to many other sources.

Each year, this pathogen accounts for approximately 73,000 cases of infection, 2,200 hospitalizations and 61 deaths in the U.S. The Los Angeles County Department of Health Services started active surveillance for *E. coli* O157:H7 in late 1995 and it has been a State reportable condition since 1996. In recent years, the number of *E. coli* O157:H7 cases reported in the county have remained relatively low and no outbreaks were identified. The reason for the county's low incidence is unknown.

Diagnosis of *E. coli* O157:H7 – The significance of bloody diarrhea

Illness caused by *E. coli* O157:H7 occurs in a two-step process. The first phase is characterized by secretory diarrhea which can be critical for early identification. In fact, a recent study identified enteric pathogens in a substantial number of cases presenting with bloody diarrhea. In light of the serious nature of the illness associated with *E. coli*, the authors recommended that all bloody stools be tested for *E. coli* O157:H7 (Talan, et al. Clin Infect Dis 2000;32:573-80). In addition, the seasonal trends for bloody diarrhea identified by the study (peaking in summer and fall months) parallel seasonal trends also seen in the Los Angeles County.

Diarrhea is sometimes followed by the second phase, the production of potentially fatal cytotoxins called Shiga toxins. In approximately 2-7% of all cases, especially among children and the elderly, the action of Shiga toxin results in hemorrhagic colitis with toxin circulation in the bloodstream. These toxins are responsible for the most serious sequela of *E. coli* O157:H7, hemolytic uremic syndrome (HUS). HUS is diagnosed when hemolytic anemia, thrombocytopenia, and acute renal dysfunction occurs up to two weeks after onset of diarrhea. In the U.S., HUS is the principal cause of acute kidney failure in children and most cases of HUS are caused by *E. coli* O157:H7.

When a patient presents with bloody diarrhea, think of and test for enteric pathogens including E. coli O157:H7.

Transmission and prevention of *E. coli* O157:H7 infections

There have been many outbreaks of *E. coli* worldwide. Among various food sources, undercooked ground beef has been implicated repeatedly. Since tests have shown *E. coli* bacteria to be pervasive among U.S. cattle, thoroughly cooking beef products is strongly recommended. Raw milk and other unpasteurized products (e.g., juice) are also potential sources of infection. In addition, several water sources including swimming pool and lake water have been implicated. To avoid infection, it is recommended to only drink water that has been treated with disinfectants and to avoid swallowing water while swimming.

Direct, person-to-person transmission has occurred in household, day-care and nursing home settings since bacteria in diarrheal stools of patients can be passed if handwashing habits are inadequate. This is particularly likely among toddlers who are not toilet trained; family members and playmates of these children are at high risk of infection. And recently, the CDC reported the first outbreaks in the U.S. due to contact with farm animals. These outbreaks were the result of children having direct contact with farm animals (on farms and at petting zoos) and then eating without proper handwashing.

E. coli O157:H7 – Characteristics

- **Agent:** gram-negative bacillus
- **Major reservoir:** healthy cattle
- **Transmission:** ingestion of contaminated food or drink, person-to-person (low infective dose, < 100 organisms)
- **Symptoms:** diarrhea, bloody diarrhea, abdominal cramps, fever.
- **Mean incubation:** 3-4 days, usual duration of illness is 5-10 days.
- **Complications:** Young children and elderly are at higher risk for severe illness or death. About 5% of Shiga toxin producing *E. coli* infections progress to hemolytic uremic syndrome, occurring usually within one week after diarrhea onset. Secondary attack rate is high (especially in day-care settings).
- **Treatment:** Supportive care is recommended. The use of antibiotics to treat *E. coli* O157:H7 infection are often of little benefit and may increase the risk of hemolytic uremic syndrome.
- **Differential diagnoses for *E. coli* O157:H7:**
  - ischemic colitis*
  - intussusception*
  - inflammatory bowel disease*

(*Note: these conditions may also be exacerbated by *E. coli* O157:H7)

- **Laboratory identification:** *E. coli* O157:H7 tests need to be ordered, in addition to any routine enteric stool cultures, to assure plating on the appropriate media. Shiga toxin can be tested for in stool.

E. coli O157:H7 online:

- Foodborne and Diarrheal Diseases Branch: www.cdc.gov/ncidod/dbmd/foodborn.htm
- Outbreak Response and Surveillance Unit: www.cdc.gov/ncidod/dbmd/outbreak
- Center for Food Safety and Applied Nutrition: vm.cfsan.fda.gov/list.html
- Government Food Safety Information: www.FoodSafety.gov

New Study Reveals Startling Picture of County Health Status

Pioneering Methodology Gauges More Reliable Statistics on Premature Death and Disability

Most counties and states rely primarily on mortality statistics to measure and track the health of a population. But mortality statistics do not account for many of the devastating chronic health conditions that individuals live with and that can markedly impact their quality of life. Now, using a pioneering new method, the Los Angeles County Department of Health Services and the University of California, Los Angeles School of Public Health have detailed a more accurate picture of Los Angeles County residents' health status to determine the leading causes of premature death and disability (also referred to as "years of healthy life lost").

What they found is surprising – but the results also afford health care providers and community stakeholders a blueprint for interventions and programs that may be more successful at changing behaviors and influencing outcomes.

For example, while heart disease ranks as the leading cause of premature death and disability, alcohol and substance abuse, depression and arthritis rank high on the list for both men and women. Broken down by location, alcohol dependence outpaces heart disease as the leading cause of years of healthy life lost for residents of the Antelope Valley. Homicide/violence is not among the top ten causes of healthy life lost in the Antelope Valley, while countywide, homicide/violence is ranked second.

"This is a major breakthrough because it takes into consideration the many diseases that cause substantial disabilities but do not show up in death statistics," said Jonathan E. Fielding, MD, MPH, Health Officer and Director of Public Health.

The study uses a measurement called Disability-Adjusted Life Years (DALYs), which provides a more accurate picture of the relative importance of various diseases. It combines the number of years lost when a person dies prematurely and the years of life lost due to temporary or permanent disability.

The DALYs measure was developed by the Harvard School of Public Health and the World Health Organization in the early 1990s to measure the burden of disease and injury in various countries around the world. DHS is the first health department in the country to be able to use the DALYs to measure the health status of a local population. The department is on the cutting edge of a new movement that uses evidence-based planning and programming for its residents.

"The information helps us, policy makers and community groups make better decisions to plan and allocate resources," said Paul Simon, MD, MPH, Director of Health Assessment and Epidemiology and a co-author of the study. "The data will also educate the general public on the conditions that most significantly impair life and cause premature death."

Five Notable Results From This Study

1. **For the entire L.A. County population heart disease was the leading cause of premature death and disability followed by alcohol dependence, homicide and violence, depression, diabetes, osteoarthritis, stroke, lung cancer, emphysema, and motor vehicle crashes.**
2. **Residents of the South Service Planning Area (SPA 6) have the highest rate of premature death and disability followed by Antelope Valley (SPA 1).**
3. **Premature death is higher in men than women.**
4. **Among ethnic groups, African Americans and American Indians/Alaska Natives have the highest rate of premature death and disability in the County. Asian/Pacific Islanders and Latinos have the most favorable picture of health of any ethnic group in the County.**
5. **Heart disease was the leading cause of premature death and disability in all SPAs except Antelope Valley (SPA 1) and South (SPA 6), where alcohol dependence and homicide/violence top the list, respectively.**

Gerald K. Kominski, PhD, Jeffery Luck, PhD, Yee-Wei Lim, MD, from the UCLA Center for Health Policy Research collaborated on this study.

Los Angeles County Service Planning Area (SPA)

1 Antelope Valley (SPA 1) *is the northernmost SPA in the County. It stretches all the way to the Kern County border on the north, and south to the mountains in the Angeles National forest. SPA 1 encompasses the Antelope health district.*

2 San Fernando Valley (SPA2) *serves residents living between Westlake Village and Calabasas in the west to Glendale and La Cañada-Flintridge in the east, the Santa Monica Mountains in the south, and Castaic in the north. SPA 2 encompasses the four health districts of West Valley, San Fernando, East Valley, and Glendale.*

3 San Gabriel (SPA3) *serves residents in the San Gabriel and Pomona Valleys. SPA 3 encompasses the five health districts of Alhambra, El Monte, Foothill, Pasadena*, and Pomona.*

4 Metro (SPA 4) *serves residents in downtown Los Angeles and several surrounding communities. SPA 4 encompasses the three health districts of Central, Hollywood-Wilshire, and Northeast.*

5 West (SPA 5) *serves residents living in West Los Angeles, Beverly Hills, Malibu, Marina del Rey and all communities in between. SPA 5 encompasses the West health district.*

6 South (SPA 6) *serves residents living in the cities of Compton, Lynwood, Paramount and the Leimert Park, Watts, Hyde Park, Adams, Jefferson Park, south Vermont and Crenshaw District communities of Los Angeles. SPA 6 encompasses the health districts of Compton, South, Southeast, and Southwest.*

7 East (SPA 7) *encompasses the four health districts of Bellflower, East Los Angeles, San Antonio, and Whittier.*

8 South Bay (SPA 8) *is the southernmost SPA in the County. SPA 8 encompasses the four health districts of Harbor, Inglewood, Long Beach* and Torrance.*

**Long Beach City and Pasadena City health districts are independent health jurisdictions operating within the geographic boundaries of Los Angeles County.*

Shortage of Combined Tetanus and Diphtheria Toxoids

Most health care providers are aware of the national shortage of combined tetanus and diphtheria toxoids adsorbed for adult use (Td) that has existed for the past several months. This shortage resulted when one of the two manufacturers of Td vaccine in the US ceased production. The remaining sole producer of the vaccine has been unable to meet the current demand and does not expect to be able to do so until 2002.

Because of the shortage, in November of last year the CDC issued guidelines detailing which priority groups should be allowed to receive the Td vaccine.[1] Because the shortage has continued, in May of this year the CDC released updated guidelines for use of Td.[2] These new guidelines recommend that all routine booster Td doses in adolescents and adults be delayed until the year 2002. Providers are encouraged to keep appropriate records so that these individuals can be contacted to receive their booster when the shortage has abated. Because California law does **not** require a Td booster for middle school entry, this recommendation should have no impact on California school students.

These new guidelines recommend that all routine booster Td doses in adolescents and adults be delayed until the year 2002.

Delaying administering routine Td boosters will insure that vaccine is available for CDC's high priority groups. These groups include persons aged 7 years and above who: 1) intend to travel to a country where the risk for diphtheria is high, 2) require tetanus vaccination for prophylaxis in wound management, 3) have received less than three (total) doses of any vaccine containing tetanus toxoid, and 4) are pregnant and have not been vaccinated with Td during the previous ten years. Current Los Angeles County Department of Health Services guidelines do **not** allow use of Td vaccine if foreign travel is the only indication for patients presenting to clinics of the Department of Health Services. A list of Travel Medicine Clinics in Los Angeles County is available on the Immunization Program web site at www.lapublichealth.org/ip/clinics/travelIZ.htm. Countries of concern are listed below.

Strict adherence to the May CDC guidelines should allow the limited amount of Td vaccine currently available nationwide to be used appropriately in the highest risk situations. Local providers who experience difficulty obtaining Td for patients who meet the priority criteria discussed above (excluding foreign travel) can call the health department's Health Information-line at 1-800-427-8700 to find the nearest health department's immunization clinic. Providers can also obtain this information from the health department's web site (www.ladhs.org) by clicking on "clinics."

References:

1. CDC. Shortage of tetanus and diphtheria toxoids. MMWR 2000;49(45):1029-30. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm4945a3.htm.
2. CDC. Deferral of routine booster doses of tetanus and diphtheria toxoids for adolescents and adults. MMWR 2001;50(20):418, 427. Availableat: www.cdc.gov/mmwr/preview/mmwrhtml/mm5020a8.htm.

Countries with High-risk for *C. diphtheriae* Exposure

Travelers to certain countries may be at substantial risk for exposure to toxigenic strains of *C. diphtheriae*, especially with prolonged travel, extensive contact with children, or exposure to poor hygiene. Based on surveillance data and consultation with the World Health Organization, countries at highest risk are:

- Africa (Algeria, Egypt, and sub-Saharan Africa).
- Americas (Brazil, Dominican Republic, Ecuador, and Haiti).
- Asia/Oceania (Afghanistan, Bangladesh, Cambodia, China, India, Indonesia, Iran, Iraq, Laos, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Syria, Thailand, Turkey, Vietnam, and Yemen).
- Europe (Albania and all countries of the former Soviet Union).

Guide to Tetanus Prophylaxis in Routine Wound Management

History of Adsorbed Tetanus Toxoid (Doses)	Clean, Minor Wounds Td†	Clean, Minor Wounds TIG‡	All other Wounds* Td†	All other Wounds* TIG‡
Unknown or less than 3	Yes	No	Yes	Yes
3 or more§	No‖	No	No¶	No

* Such as, but not limited to, wounds contaminated with dirt, feces, soil, and saliva; puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns, and frostbite.

† For children younger than 7 years of age, diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) is recommended; if pertussis vaccine is contraindicated, DT is given. For persons 7 years of age or older, Td is recommended. Td indicates adult-type diphtheria and tetanus toxoids.

‡ TIG, tetanus immune globulin (human); equine tetanus antitoxin should be used when TIG is not available.

§ If only 3 doses of fluid toxoid have been received, a fourth dose of toxoid, preferably an adsorbed toxoid, should be given. Although licensed, fluid tetanus toxoid is rarely used.

‖ Yes, if more than 10 years since last dose.

¶ Yes, if more than 5 years since last dose. More frequent boosters are not needed and can accentuate adverse effects.

Table adapted from Red Book 2000 Report of the Committee on Infection Diseases

Antepartum Fetal Surveillance

Public Education Campaign Encourages "Kicks"

Fetal death is a tragedy for mother, family and obstetrician. Fetal activity is an indirect measure of fetal central nervous system integrity and function, and an active fetus is reassuring to both the woman and her obstetrician[1]. Recording of fetal motion by an expectant mother is the oldest technique for assessing fetal well-being. Since a decrease in the mother's perception of fetal movement often precedes fetal death, in some cases by several days, it becomes imperative that obstetrical providers and practitioners educate pregnant women in fetal movement assessment, commonly referred to as kick count.

Several different counting protocols have been reported and validated; however, no single protocol has proven to be the best. One commonly used protocol is one in which the preterm woman lies on her side, preferably after a meal, and counts distinct fetal movements. Her perception of ten distinct movements in a period of up to two hours is considered to be reassuring. Once she has felt the ten movements ("kicks"), counting can be discontinued; she need not persist for the full two-hour period. Failure to feel 10 moves within two hours should be reported immediately to the health care provider.

Recording of fetal motion by an expectant mother is the oldest technique for assessing fetal well-being. Failure to feel 10 moves within two hours should be reported immediately to the health care provider.

Among African-Americans, fetal mortality rates are twice that of other ethnic groups[2]. This summer, the Black Infant Health Program, one of five perinatal programs within the Maternal, Child and Adolescent Health Program, will fund a public education campaign in selected zip codes in SPAs 4 (Metro), 5 (West), 6 (South), 7 (East) and 8 (South Bay) to increase awareness of the importance of monitoring fetal activity. Physicians in these areas will receive a one-page educational tool outlining one method of performing kick counts, with space for the pregnant client to record fetal movements and return the record at her next office visit. The campaign includes working with the news media to educate pregnant

For further information about this campaign, call Beverly Williams, Director of Perinatal Health Programs at (213) 639-6418 or e-mail at bevwilliams@dhs.co.la.ca.us.

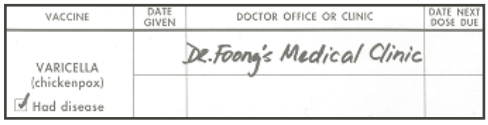
References:

1. Smith CV, Davis SA, Rayburn WF. Patients' acceptance of monitoring fetal movement: A randomized comparison of charting techniques. *Journal of Reproductive Medicine.* 1992;37:144-6.
2. Family Health Outcomes Project, California Department of Health Services, Center for Health Statistics, 1997.

Immunization (from page 1)

provider is reasonably certain the child had chickenpox disease. Only a physician or a registered nurse functioning under the facility's standardized nursing procedure can certify prior varicella disease.

- Health care provider's written indication that the child is sero-positive for varicella.
- When documenting a clinical history of varicella disease, providers must either write "had disease" or check the box marked "Had disease" on the immunization record card, then add the practice's name or rubber stamp (see examples).



The Los Angeles County Immunization Program urges health care providers to prepare for the new immunization requirement. Specifically, providers can alert families of the July 1, 2001 effective date and make an effort to reduce missed opportunities by anticipating which of their patients need the varicella vaccine. Patients should be screened at regular appointments to determine immunization status for varicella and provider offices can conduct chart reviews to identify patients who need the immunization. Making use of every opportunity to appropriately immunize children will result in a smooth transition once the law is in effect.

For more information, visit the Immunization Program website at www.lapublichealth.org/ip/.

Chickenpox is a common childhood disease caused by the varicella zoster virus, which results in a blister-like rash, itching, tiredness and fever. Chickenpox is highly contagious and spreads from person to person by direct contact or through the air. Although rare, children can die from chickenpox if they develop pneumonia and/or secondary bacterial infections.

The most prominent features of varicella in children:

- *Varicella is more common mid-winter through spring, although it can occur anytime*
- *The illness lasts about 5-7 days*
- *The rash consists of crops of red spots and vesicles progressing rapidly to crusted lesions ("scabs"), sometimes so quickly that the parent doesn't notice macules or vesicles*
- *Pruritic rash, vesicles, or scabs*
- *Fever, usually low-grade in infants and young children*
- *Contact with other chickenpox cases around that time*

Chlamydia (from page 1)

•Report to local health officers (Title 17, California Code of Regulations § 2500).

While the option of PDT for chlamydia should not be the first-line method of providing services, it can serve as a useful alternative when the partner is unlikely to seek care or cannot easily get an evaluation or diagnosis in the community.

Recommended treatment

All sexual contacts within the past 60 days from the onset of symptoms or diagnostic test results need to be treated. The medication recommended for patient-delivered therapy is single dose azithromycin tablets (1 gram orally once). As compared to the azithromycin powder (sachet) formulation, tablets are easier to deliver and facilitate compliance. Patients may be provided with the number of doses necessary to treat each of their exposed partners. Providers should encourage the patient to deliver both the medication and accompanying educational information to the partner. This method of therapy has been supported by STD experts since the risk of re-infection and severe complications to the female patient is greater than the risk of one dose of azithromycin to the male partner. For female partners, providers should make an extra effort to refer them for timely clinical evaluation.

Chlamydia's complications

Chlamydia is a leading cause of pelvic inflammatory disease (PID), ectopic pregnancy and preventable infertility in sexually active women. Patients with chlamydia are also at increased risk of sexual transmission of HIV. Partner treatment is critical since repeat infections in women, the majority of which are caused by male partners going untreated, are much more likely to cause serious complications.

For patient education materials, the text of revisions to the Health and Safety Code, and information on local chlamydia efforts, visit the California Chlamydia Action Coalition's website at www.ucsf.edu/castd or call the California Department of Health Services' STD Control Branch at (510) 540-2657. Please report any adverse reactions by calling (866) 556-3730 (toll-free). For other questions call Robert Hurd Settlage, MD, MPH, Medical Director, STD Program, at (213) 744-3093.

Medical providers should address three key counseling messages when prescribing patient-delivered therapy:

1. **Patients and partners should abstain from sex for at least seven days after treatment and until seven days after all partners have been treated.**
2. **Partners should seek a complete STD evaluation whenever possible.**
3. **Partners who have allergies to erythromycin, azithromycin or other similar macrolides, have kidney failure, heart disease, or any other serious health problems, should not take the medication and should see a provider. If partners are unsure about any possible medication allergies or other health problems, they should consult a healthcare provider.**

Calendar

Nursing Intensive/ "TB 101"

A one-day course for nurses (PHNs, RNs, NPs, LVNs), either clinic or hospital-based, which reviews TB epidemiology, transmission, pathogenesis, screening, diagnosis, and treatment as well as the protocols and documentation used in working with the TB Control Program. This course fulfills the prerequisite for ERN Training.

Time: 8:00 am –4:30 pm
Place: TB Control Program Headquarters
2615 S. Grand Ave., Room 506A
Los Angeles
Date: August 14
Pre-registration is required. (213) 744-6229.

Pediatric Equipment and Resource Fair

Sponsored by the Los Angeles County, California Children's Services, Medical Therapy Program. Agencies will offer medical, recreational and financial information about children with special health care needs. Features include vendors' display of medical equipment and products for children with special needs; entertainment; free refreshment.

Time: 9:00 a.m. - 3:30 p.m.
Place: Perez Special Education Center
4540 Michigan Ave., Los Angeles.
Date: Wednesday, August 22, 2001
Contact: (323) 869-8136

Satellite Courses:

Immunization Update
Time: 9:00am ~ 12:30pm
Date: September 20

Vaccines for International Travel
Time: 9:00am ~ 12:30pm
Date: December 13

Both courses are open to the public.

DHS Administration Building
313 North Figueroa Street, Auditorium
Los Angeles, CA 90012

For more information, contact Ina Hasley, Immunization Program, at (213) 580-9800

Protecting health, preventing disease, and promoting a healthy Los Angeles County.

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County of Los Angeles
Department of Health Services
Public Health

313 North Figueroa Street, Room 806
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This Issue . . .

Selected Reportable Diseases (Cases) - May 2001

Disease	THIS PERIOD May 2001	SAME PERIOD LAST YEAR May 2000	YEAR TO DATE 2001	YEAR TO DATE 2000	YEAR END TOTALS 2000	YEAR END TOTALS 1999
AIDS	94	116	553	678	1,682	1,892
Amebiasis	10	11	42	45	106	142
Campylobacteriosis	113	120	375	457	1,299	1,100
Chlamydial Infections	2,728	2,726	13,443	12,797	30,947	27,586
Encephalitis	3	0	21	20	46	7
Gonorrhea	616	624	3,153	2,757	7,250	6,054
Hepatitis Type A	54	148	186	473	1,008	1,258
Hepatitis Type B, Acute	11	16	30	97	183	282
Hepatitis Type C, Acute	2	3	5	28	64	696
Measles	1	2	8	2	5	1
Meningitis, viral/aseptic	41	20	179	201	455	390
Meningococcal Infections	3	5	39	35	58	53
Mumps	0	0	1	27	41	22
Non-gonococcal Urethritis (NGU)	107	119	584	642	1,578	1,742
Pertussis	6	8	25	80	145	202
Rubella	0	1	1	1	5	0
Salmonellosis	106	95	278	442	1,092	1,027
Shigellosis	45	49	148	311	839	687
Syphilis, primary & secondary	12	11	58	66	129	84
Syphilis, early latent (<1 yr.)	10	18	76	98	248	334
Tuberculosis	71	101	272	310	1,065	1,170
Typhoid fever, Acute	0	6	6	12	25	16

Data provided by DHS' Public Health programs: Acute Communicable Diseases Control, Data Collection & Analysis, HIV/Epidemiology, Sexually Transmitted Diseases, and Tuberculosis Control.