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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Avian Influenza: Heightened Awareness and Surveillance is Critical

In light of the Lunar New Year in February, many residents of Los Angeles County may have recently traveled to Asian counties—including countries where avian influenza is of concern. As such, healthcare professionals should be especially vigilant in identifying potential cases of avian influenza.

It is important to note that person-to-person transmission of avian influenza is atypical and has only been documented in two cases. Instead, a key factor in disease transmission is a history of direct contact with infected poultry (i.e., from raising poultry or visiting a poultry farm or bird market). Thus it is critical that a complete case history be considered when assessing patents for possible avian influenza infection.

Since the epidemiologic factors that increase risk for influenza A (H5N1) are frequently changing, consultation with Acute Communicable Disease Control is essential to provide advice on diagnostic testing and specimen collection.

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Provider Alert: Lymphogranuloma Venereum Infections in California

Lymphogranuloma venereum (LGV) is a sexually transmitted disease caused by one variety of the bacterium, Chlamydia trachomatis. Rare in the U.S., LGV is highly prevalent in parts of Africa, Latin America, and Asia. In 2003 and 2004, the Netherlands reported a large outbreak of LGV (92 confirmed cases) among men who have sex with men (MSM); normally, the country sees an average of five cases per year.

In the U.S., public health officials in San Francisco and New York have recently identified new cases of LGV, also among MSM. Based on these reports and the potential for LGV to emerge in Los Angeles County, medical providers should be alert for LGV infections, particularly among MSM who engage in unprotected anal intercourse, and become informed about how to detect, treat, and report suspected cases to the county health department.

Description of LGV

LGV is an invasive form of Chlamydia trachomatis caused by Chlamydia trachomatis serovars L1 to L3. During primary infection, the patient may develop a small, painless lesion, which may ulcerate after an incubation period of 3-30 days. This lesion can remain undetected within the urethra, vaginal vault, or rectum.

More common symptoms include tender inguinal and/or femoral lymphadenopathy (genital exposure), or hemorrhagic proctitis or proctocolitis (anal exposure).

Because of the ulcerative nature of LGV, patients may be at increased risk for transmitting and acquiring HIV and other STDs.

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Provider Alert: (from page 1)

Diagnosis of LGV

The CDC advises clinicians who care for MSM to consider LGV in the diagnosis of compatible syndromes (e.g., proctitis and proctocolitis). Diagnosis may be based on clinical findings, direct identification of C. trachomatis from a lesion via culture, or by serological testing, including a microimmunofluorescence (MIF) test titer >1:256.

Currently, the county's STD Program recommends healthcare providers submit to the Los Angeles County Public Health Laboratory (PHL) serum specimens for MIF titers, as well as culture swabs of sites (e.g. rectum or genital ulcers/lymph nodes) as indicated by symptoms or exam. To order these laboratory tests, a completed *PHL Test Requisition Form must accompany the specimens.

Treatment of LGV

CDC recommends treatment for LGV with **doxycycline, 100 mg PO bid x 21 days, OR erythromycin base, 500 mg PO qid x 21 days.** Treatment should be started pending the return of laboratory test results. If the laboratory test returns negative, therapy can be discontinued.

Medical providers should discuss LGV with patients who practice unprotected anal intercourse and inform them of symptoms, prevention methods, and the need to seek early medical care. Sex partners who had contact with the patient within 60 days of the patient's onset of symptoms should be evaluated; in the absence of symptoms, they should be treated with either 1 g of azithromycin in a single dose, or 100 mg of doxycycline, twice a day for 7 days. Public Health Investigators can help with identification and treatment of partners.

Reporting Requirements

In addition to reporting positive chlamydia diagnostic tests, suspected LGV cases should be reported to the county's STD Program within 24 hours using the *Suspected LGV Case Report Form.

**Further information and resources regarding LGV, including lab and reporting forms, can be found at www.lapublichealth.org/std/lgv.htm.*

For questions and concerns, please contact/email Dr. Christine Wigen at the county's STD Program at (213) 744-3092, cwigen@ladhs.org.

Avian Influenza (from page 1)

For more information on avian influenza visit: www.who.int/csr/disease/avian_influenza/en/

Suspected cases should have:

1. Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, AND
2. A history of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans. Current countries of concern include: Thailand, Vietnam, Malaysia, Korea, Indonesia, Cambodia, China and Japan.

Testing for influenza A (H5N1) will be considered on a case-by-case basis for cases for hospitalized or ambulatory patients with:

1. Documented temperature of >38° C (>100.4°F), AND
2. One or more of the following: cough, sore throat, shortness of breath, AND
3. A history of contact with poultry (e.g., visited a poultry farm or bird market, household raising poultry, etc.) OR
4. A history of contact with a known or suspected human case of influenza A (H5N1) within 10 days of symptom onset.

Any suspected case of avian influenza should be reported immediately to Acute Communicable Disease Control 213-240-7941

Rabies Death in Los Angeles County

First Human Case in 30 Years

On January 21, 2005, the Acute Communicable Disease Control Program (ACDC) received a call from the coroner to report pathology findings highly suspicious for rabies. The decedent, a 22-year-old man born in El Salvador, had been in Los Angeles for 15 months. Additional specimens for rabies testing were sent to the CDC who subsequently confirmed the rabies diagnosis.

On January 27, the CDC reported that the rabies variant is one not present in the U.S., but is a canine variant from El Salvador. Interviews with local household contacts and family members in El Salvador revealed no history of animal bites or exposures—however, canine rabies is endemic in El Salvador, Guatemala, and Mexico. As of February 15, contact tracing has identified at least 30 friends and family members whom rabies post-exposure prophylaxis is highly recommended. In addition, 9 of 76 healthcare workers at risk were identified to receive post-exposure prophylaxis.

California law mandates that rabies cases, including suspected cases, be reported immediately by telephone to the local health officer (California Code of Regulations, Title 17, Section 2500). In Los Angeles County, any healthcare provider suspecting a case of rabies should immediately contact the Communicable Disease Reporting System (888-397-3993) or ACDC (213-240-7941). Had this rabies case been recognized and reported, the Los Angeles County health department could have assisted in the diagnosis, and numerous individuals would have likely avoided exposure, injury and prophylaxis.

Case history

Prior to his death last October, the decedent was seen at three separate Los Angeles County healthcare facilities that same month. On October 19, he was seen at a clinic complaining of nausea, vomiting, and

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Rabies Death in Los Angeles County (from page 3)

right lower back pain—a urinary tract infection was diagnosed and given antibiotics and pain medication.

On October 20, he returned to the clinic; kidney stones were diagnosed and he was again given pain medication. Later that day he presented to a hospital emergency department with continued right-side flank pain. He was afebrile; records note he also complained of throat tightness. Evaluation was found to be consistent with kidney stones and he was discharged.

That evening, according to household members, he became agitated and confused, and had increased salivation. The following day, the decedent was admitted to a second hospital with lower back pain and evaluated for kidney stones.

Information about rabies, animal bites and the reporting of animal bites is available at: www.lapublichealth.org/vet

Records show that throughout the course of hospitalization he was combative, confused, agitated, and displayed excessive salivation. Computerized tomography showed evidence of kidney stones. Records also indicate he had fevers and elevated peripheral white blood cell count. In addition, the decedent became increasingly violent—at one point biting a friend on the wrist and scratching a nurse.

A review of the medical records at the second hospital indicates that the infectious disease physician who evaluated the patient on October 26 included rabies in the differential diagnosis—but the health department was never notified. The patient's clinical status rapidly declined and he was evaluated for a possible surgical emergency. On October 26, the patient went into cardiopulmonary arrest and died. Specimens for rabies testing and encephalitis work up were ordered, but could not be completed due to his sudden cardiopulmonary arrest. The Los Angeles County Coroner subsequently assumed responsibility for this case.

Rabies in L.A. County

This case illustrates the importance of considering the complete patient history, especially country of origin and travel history, during diagnosis. While human rabies is very rare in the U.S., it is more common in other countries—and in particular, in countries whose citizens frequently immigrate to Los Angeles.

The last confirmed human death due to rabies in the county, in 1975, was 16-year-old girl from Mexico who had been living in Los Angeles for eight months—she was bitten by a dog while in Mexico. California is home to the largest number of legal immigrants nationwide, and over one-third of these immigrants settle in Los Angeles County.

In a 1999 Los Angeles County Health Survey, almost one-third of respondents stated they were born outside of the U.S. In addition, travel and foreign visitors are very common in the county. In air travel alone, almost 55 million travelers come through the Los Angeles International Airport every year making it the nation's third busiest airport. Moreover, many serious diseases (e.g., SARS, avian influenza) have nonspecific presentation that can easily be misdiagnosed—but it is the epidemiologic factors (i.e., exposure and travel history) that are critical for accurate diagnosis.

With rabies, another important factor that must be considered is the importation of infected animals. While rabies is uncommon among domestic animals in the county, in 2004, Public Health investigated two separate incidents—both resulted from the importation of suspected rabies infected dogs. In both instances many individuals were potentially and unwittingly exposed to a deadly disease. Rabies, therefore, should not be excluded from differential diagnosis simply because we live in Los Angeles County. Moreover, all cases suspicious for rabies should be reported immediately to the health department.

For additional questions regarding the diagnosis and reporting of rabies, contact ACDC at 213-240-7941.

The full list of reportable diseases and conditions in the county is available at:www.lapublichealth.org/acd/reports/diseasepluscmr.pdf

Perinatal Hepatitis B: *Vaccine Recommendations*

Hepatitis B virus (HBV) infection is a serious, yet preventable, health problem in the U.S. It is estimated that between 4,000 and 5,000 deaths occur annually from HBV-related chronic liver disease and that HBV infection is a leading cause of liver cancer in the U.S.

The greatest risk of chronic infection and death from HBV-related chronic liver disease occurs from the transmission of HBV from mother to infant during the perinatal period. Within Los Angeles County, it is estimated that 1,000 hepatitis B infected women give birth each year and that up to 90% of the infants born to these women would become infected without prophylaxis. Ninety percent of infants who become infected develop chronic lifelong infection. Chronically infected persons pose a lifelong threat of infection to their sexual partners, children, and other close household contacts. Yet the vast majority (90–95%) of these potential infections may be avoided through appropriate maternal screening and infant immunoprophylaxis.

California state law has required HBsAg serological screening of pregnant women since 1991. In addition, physicians, laboratories, hospitals, and other health care professionals are required by law to report HBsAg-positive persons to the local health department. HBsAg-positive cases in the county are reported by mail, phone or fax to the Morbidity Central Reporting Unit. Prompt health care provider reporting of HBsAg positive women is critical because the health care provider can provide the patient's pregnancy status and diagnosis thereby helping to ensure prompt follow-up. Confidential Morbidity Report forms can be obtained from any local health center registrar, from the Morbidity Central Reporting Unit or the department's web site at www.lapublichealth.org/acd/reports/acdcmr.pdf. Hospitals report births to HBsAg-positive mothers directly to the department's Immunization Program's Perinatal Hepatitis B Prevention Program by mail, phone or fax. Hospitals and birth centers can obtain the Hospital Report-Perinatal hepatitis B reporting form by calling the program or from the web site www.lapublichealth.org/ip/vpds/phB_hospreport.pdf .

In 2003, 696 births to HBsAg-positive women were reported to the program, but it is estimated that the program only receives an estimated 70% of expected reports of births to HBsAg-positive mothers. Reporting increases the likelihood that perinatally HBV-exposed infants and their families will receive needed prophylaxis, immunizations, and follow-up. Once notified, the program's case managers contact the pregnant woman and provide linguistically and culturally appropriate health education on the virus, its transmission, and prevention. The case manager follows the family to ensure that the infant is immunized on time and receives post-vaccination serological screening to verify immunity. The case manager also ensures that household members are referred for serological screening and immunization, if susceptible.

Recommendations

The HBsAg status of pregnant women must be reviewed at the time of admission for delivery. Women whose HBsAg status is unknown need to have a stat HBsAg done to properly manage the infant's care. The vaccination schedule reviews the CDC's Advisory Committee on Immunization Practices (ACIP) recommendations for immunoprophylaxis of infants born to mothers whose HBsAg status is positive, unknown, or negative at the time of delivery.

The ACIP, the American Academy of Pediatrics, and American Academy of Family Physicians recommend health care providers routinely administer the first dose of Hepatitis B vaccine (HepB) to all infants soon after birth and before hospital discharge. Hepatitis B vaccine administered before hospital discharge should minimize the risk of infection due to errors in maternal HBsAg testing or reporting, or from exposure to persons with chronic HBV infection in the household, and can increase the likelihood of completing the vaccine series.

Report HBsAg-positive persons to the local health department

HBsAg-positive cases are reported to the Morbidity Central Reporting Unit:

Address: 313 N. Figueroa Rm 117, Los Angeles, CA 90012
Phone: 213-240-7821
Fax: 888-397-3778
Confidential Morbidity Report form:
www.lapublichealth.org/acd/reports/acdcmr.pdf

Births to HBsAg-positive mothers are reported directly to the Immunization Program's Perinatal Hepatitis B Prevention Program (PHBPP):

Address: 3530 Wilshire Blvd Ste 700, Los Angeles, CA 90010
Phone: 213-351-7400
Fax: 213-351-2781
Hospital Report form for Perinatal Hepatitis B:
www.lapublichealth.org/ip/vpds/phB_hospreport.pdf

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Recommended Hepatitis B Vaccination Schedule for Infants and Premature Infants Born to Mothers Whose Hepatitis B Surface Antigen Status is Positive, Unknown, or Negative at the Time of Delivery					
Mother's HBsAg Status	HBIG and Hepatitis B Vaccine Schedule*				
	Hepatitis B Immune Globulin	Hepatitis B vaccine #1	Hepatitis B vaccine #2	Hepatitis B vaccine #3	Hepatitis B vaccine #4
Infant born to HBsAg-positive mother	Within 12 hours of birth	Within 12 hours of birth	1-2 months of age	6 months of age†	
Infant born to mother whose HBsAg status is unknown‡	Within 7 days of birth if mother tests positive	Within 12 hours of birth	1-2 months of age	6 months of age	
Infant born to mothers whose HBsAg status is negative	Not indicated	Soon after birth and before hospital discharge	1- 4 months of age	6 – 18 months of age	
Premature infant weighing <2,000 grams born to HBsAg-positive mother	Within 12 hours of birth	Within 12 hours of birth§	1 month of age	2 months of age	6 months of age†
Premature infant weighing <2,000 grams whose mother's HBsAg status is unknown‡	Within 12 hours of birth**	Within 12 hours of birth §**	1 month of age	2 months of age	6 months of age
Premature infant weighing <2,000 grams born to mothers whose HBsAg status is negative	Not indicated	1 month†† of age	2 – 4 months of age	6 – 18 months of age	

*The routine recommended first dose of HepB should be given soon after birth and before hospital discharge; the first dose also may be given by age 2 months if the infant's mother is HBsAg negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose except for combination vaccines, which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

† Test infants who have completed the hepatitis B series at age 6–8 months for HBsAg and anti-HBs at 9–15 months of age to monitor the success of therapy. If the series is completed at an older age due to the use of Comvax or due to a delayed schedule, the optimal testing time is 1–2 months after the final dose of hepatitis B vaccine. Every effort should be made to ensure that infants of HBsAg-positive mothers are vaccinated on schedule and then tested for immunity.

‡ Mother should have blood drawn for stat HBsAg testing.

§ This initial HepB dose should not be counted towards completion of the HepB series and three additional doses of HepB should be administered beginning when the infant is age 1 month.

**Premature infants weighing less than 2,000 grams at birth who are born to mothers with unknown HBsAg status must receive immunoprophylaxis with hepatitis B vaccine and HBIG ≤12 hours after birth unless mothers' HBsAg test result is available in <12 hours.

†† The optimal timing of the first dose of HepB for premature infants of HBsAg-negative mothers with a birth weight of <2,000 grams has not been determined. However, these infants can receive the first dose of the HepB series at chronological age 1 month. Premature infants discharged from the hospital before chronological age 1 month can also be administered HepB at discharge, if they are medically stable and have gained weight consistently.

Table adapted from: Advisory Committe on Immunization Practices - Vaccine for Children Program Resolution No. 10/03-2

CDC. Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States Through Universal Childhood Vaccination: Recommendations of the ACIP APPENDIX A: Postexposure Prophylaxis for Hepatitis B. MMWR Recommendations and Reports, Nov 22, 1991, Vol. 40, No. RR-13, 21-25. www.cdc.gov/mmwr/preview/mmwrhtml/00033455.htm

CDC. General Recommendations on Immunization. Special Situations: "Vaccination of Premature Infants". MMWR Recommendations and Reports, Feb 8, 2002, Vol. 51, No. RR-2, 18. www.cdc.gov/mmwr/preview/mmwrhtml/rr5102a1.htm

Recommended Childhood and Adolescent Immunization Schedule, United States, July – December 2004.

Vaccine Recommendations (from page 5)

Infants whose mothers are HBsAg-positive should receive HepB and hepatitis B immune globulin (HBIG) within 12 hours of birth. Infants whose mothers' HBsAg status is unknown at birth should receive HepB within 12 hours of birth and if the mother is found to be HBsAg-positive, infants should receive HBIG as soon as possible but not later than 7 days of age. Premature infants weighing less than 2,000 grams at birth whose mothers' HBsAg status is positive or unknown should receive both HepB and HBIG within 12 hours of birth.

For more information on hepatitis B, the Perinatal Hepatitis B Prevention Program, or reporting requirements, contact the Perinatal Hepatitis B Prevention Program at (213) 351-7400.

This information is available on the Immunization Program web site at:
www.lapublichealth.org/ip/vpds/perinatalhepB.pdf.

HIV and High-Risk Groups

In late 2003, the HIV Epidemiology Program conducted the HIV Testing Survey (HITS) among male-to-female transgenders and female sex workers. The CDC-funded HITS was designed to better understand risk behaviors, HIV testing, and the use of prevention services among high-risk groups. Previous research indicated high levels of HIV risk among transgenders and relatively low levels among female sex workers (FSWs); however, little recent data were available on the latter population.

Most HITS 2003 participants were recruited from street locations and clubs; some were recruited from service agencies and social events. Respondents received $25 for completing the survey. Of the 312 potentially eligible people approached, 260 completed surveys (80%). Two hundred twenty-four participants were eligible, including 130 transgenders and 94 females who reported trading sex for money or drugs in the previous 12 months.

Preliminary study findings are reported here.

The sample was predominately African American (30% among transgenders, 50% among FSWs) and Latino (46% among transgenders, 29% among FSWs), young, and of low socioeconomic status. Eighteen to 24 year olds composed more than 20% and 25 to 29 year olds composed one-third of both populations surveyed. Approximately 60% of both groups had monthly incomes of less than $2000, and slightly over 40% had not graduated high school. Furthermore, 39% of transgenders and 31% of FSWs reported being homeless at some point in the past year.

Both groups reported high levels of lifetime HIV testing with 87% of transgenders and 81% of FSWs having testing at least once. Over 67% and 60%, respectively, had tested in the previous 12 months. Among those who had ever tested, 15% of transgenders and 6% of female sex workers reported being diagnosed with HIV infection. Because some respondents had either seroconverted after their last test or tested positive and not reported it, this is an underestimate of the level of HIV infection in both groups. The percentage reporting having tested HIV-antibody positive among FSWs is higher than expected and should be examined further in a larger sample.

Significant proportions of respondents reported receiving prevention services. For example, 75% of transgenders and 61% of FSWs had received free condoms, 48% and 35% respectively had received brochures, and 41% and 19% had talked to an outreach worker about HIV prevention. Smaller proportions reported taking part in more in-depth prevention interventions such as small groups sessions (33% of transgenders and 6% of FSWs) or role-plays to practice condom negotiation (33% of transgenders and 11% of FSWs).

These findings indicate high levels of HIV infection among transgender women and women who participate in exchange sex. They show that local prevention efforts have successfully reached portions of both communities, but underscore the need for increased prevention efforts to address the HIV-risk behaviors and the more basic needs for housing, education, and other services of among male-to-female transgenders and female sex workers.

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This Issue . . .

Selected Reportable Diseases (Cases)* - October 2004

Disease	THIS PERIOD Oct. 2004	SAME PERIOD LAST YEAR Oct. 2004	YEAR to date Oct. 2004	YEAR to date Oct. 2003	YEAR END TOTALS 2003	YEAR END TOTALS 2002	YEAR END TOTALS 2001
AIDS*	120	175	2,331	2,470	2,590	1,719	1,354
Amebiasis	9	16	85	109	121	102	139
Campylobacteriosis	95	140	788	964	1,093	1,067	1,141
Chlamydial Infections	3,320	3,383	32,125	31,118	36,555	35,688	32,670
Encephalitis	52	2	97	37	41	61	41
Gonorrhea	869	741	7,970	6,697	8,008	7,800	7,443
Hepatitis Type A	32	26	278	310	376	438	542
Hepatitis Type B, Acute	6	6	57	57	56	29	44
Hepatitis Type C, Acute	1	0	5	0	0	3	1
Measles	0	0	1	0	0	0	8
Meningitis, viral/aseptic	123	121	687	964	899	466	530
Meningococcal Infections	0	7	32	44	34	46	58
Mumps	0	0	2	10	10	16	17
Non-gonococcal Urethritis (NGU)	101	129	1,232	1,202	1,393	1,393	1,429
Pertussis	0	0	86	97	128	170	103
Rubella	0	0	0	0	0	0	0
Salmonellosis	119	154	977	870	996	956	1,006
Shigellosis	72	106	428	656	671	974	684
Syphilis, primary & secondary	38	33	372	375	442	364	188
Syphilis, early latent (<1 yr.)	25	33	321	311	365	353	209
Tuberculosis	77	106	627	653	949	1,021	1,046
Typhoid fever, Acute	1	0	13	14	16	33	17

* Case totals are provisional and may vary following periodic updates of the database.