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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Important Changes in Reportable Diseases

Several important changes recently have been incorporated into the Los Angeles County list of reportable diseases. For all healthcare providers, four changes have been made to the list: 1) suspected SARS cases are reportable immediately by telephone, 2) West Nile virus infections are reportable within 1 day of identification, 3) Lyme disease is reportable within 7 days, and 4) pediatric intensive care cases or deaths with evidence of influenza infection are reportable within 7 days. While these diseases have just been specifically added to state regulations, all have been reportable prior to this modification. Regulations for laboratories have also been revised. Positive tests for West Nile virus and Lyme are both reportable within 1 day.

Regardless of the many specific diseases itemized on the list, **any** suspected unusual disease and **any** suspected evidence of an outbreak of disease warrants an immediate call to Acute Communicable Disease Control (213-240-7941). Similarly, there are several diseases associated with potential bioterrorist activity that also warrant an immediate call if infection is suspected—these include anthrax, botulism, brucellosis, plague, smallpox, tularemia, and the viral hemorrhagic fevers. Primary healthcare providers are frequently the first to recognize unusual occurrences or patterns of disease. As such, it is critical that healthcare providers be alert and quick to report all reportable diseases as well as any unusual occurrences. Moreover, it is also important that these high priority diseases be reported immediately to **local** public health authorities, and not state or national authorities (e.g., CDC). In Los Angeles county, Acute Communicable Disease Control (213-240-7941) should be the first public health authority notified in cases of suspected bioterrorist activity or unusual disease to facilitate a timely and organized response. The office can readily and immediately provide guidance for testing, treatment and prophylaxis. Posters of the full list of reportable diseases have been included in this issue and may be pulled out for display.

For questions about reporting or to request additional poters, please call Acute Communicable Disease Control (213-240-7941).

Annual Influenza Campaign Targets the Highest Risk Groups

Influenza is a common illness causing an average of over 200,000 hospitalizations and approximately 36,000 deaths in the United States each year. The risk for complications, hospitalizations, and deaths from influenza is higher among persons aged ≥65 years, young children, and persons of any age with certain underlying medical conditions than among healthy older children and younger adults.

Vaccination is the primary method for preventing influenza. For the 2005-06 influenza seasons, four manufacturers are expected to provide influenza vaccine to the U.S. population. Three manufacturers will provide trivalent inactivated influenza vaccine (TIV): Sanofi Pasteur, Inc.; GlaxoSmithKline, Inc.; and Chiron Corporation. The fourth manufacturer, MedImmune Vaccines, Inc., will provide Flu Mist®, a nasal-spray vaccine which contains live attenuated influenza vaccine (LAIV).

Because of uncertainties regarding production of influenza vaccine, the exact number of available doses and timing of vaccine distribution for the 2005-06 influenza seasons remain unknown at this time. As a result, CDC recommends that only the following priority groups receive TIV before October 24, 2005:

- Persons aged ≥65 years;
- Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions;
- Persons aged 2–64 years with chronic heart or lung conditions, including asthma (hypertension is not considered a high-risk condition);
- Persons aged 2–64 years with metabolic disease (e.g., diabetes), chronic kidney disease, or weakened immune systems (including disease caused by medications or by infection with human immunodeficiency virus [HIV/AIDS]);

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Screening Children for Lead Poisoning: What Every Health Care Provider Should Know

Background

Lead poisoning continues to be one of the major environmental health threats to children in Los Angeles County. Since 1991, more than 12,000 children in the county (under six years of age) have been identified with elevated blood Lead levels.

Sources of Lead

Housing

For most of these children, the source of Lead has been disrupted Lead-based paint found in the older homes that comprise much of the housing stock in Los Angeles County. Lead can also be found in Lead-contaminated house dust and soil.

Candies

Lead can be found in imported items such as candy and folk medicines. Many of these candies are imported from various Latin and Asian countries and are commonly found in California and adjacent states.

Other sources

Other sources of Lead include, but are not limited to canned food with soldered seams, ceramic dishes and cookware with Lead contaminated paints and glazes.

Harmful Lead levels

The national blood Lead level of concern, designated by U.S. Centers for Disease Control and Prevention (CDC), is 10mcg/dL. Nonetheless, studies have shown that exposure to lower levels of Lead can also be harmful.

Lead poisoning can affect a child's neuro-developmental processing. While many Lead-poisoned children may not have obvious symptoms at presentation or that parents can be readily detect, numerous studies indicate that elevated blood Lead levels (EBLLs) are associated with adverse outcomes on measures of intellectual functioning and social-behavior.

For example, early childhood Lead exposure has been linked to a drop in IQ scores, short attention span, and the increasing presence of certain types of behavioral problems.

The Role of the Primary-Care Providers

Screening

Until now, the true incidence of Lead poisoning in the county has been unknown because the majority of low Lead level tests were not reported to the Health Department.

However, a new law which has gone into effect, Senate Bill 460, requires laboratories to report the results of all blood Lead tests.

Further, the California Code of Regulations (Title 17, Division 1, Chapter 9 Screening for Childhood Lead Poisoning) requires pediatric and family practice health care providers to screen children receiving services from publicly funded programs. Such publicly funded programs include Medi-Cal, Child Health and Disability Prevention Program (CHDP), Healthy Families and Women and Infants and Children (WIC). A health care provider who fails to comply with this standard of care may be subject to the disciplinary provision (Article 12 of Chapter 5 of Division 2 of the Business and Professions Code).

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INFLUENZA CAMPAIGN...from page 1

- Persons aged 2–64 years who have any condition (such as neurological or muscular diseases) that can compromise respiratory function or increase the risk of aspiration.
- Children and adolescents (6 months–18 years) on long-term aspirin therapy;
- Children aged 6–23 months;
- Women who will be pregnant during the flu season;
- Health-care personnel who provide direct patient care (vaccination not only protects health-care personnel, it prevents them from exposing high-risk patients to influenza);
- Household contacts and out-of-home caregivers of children aged <6 months of age.

On September 6, 2005, CDC issued interim vaccination recommendations for persons displaced by Hurricane Katrina. In addition to the above-mentioned groups, priority for influenza vaccination should be extended to include hurricane displaced persons aged ≥6 months living in crowded group settings.

Beginning October 24, 2005, influenza vaccine should be made available to all persons. Healthy persons aged 5-49 years who are not pregnant, including health-care workers who are not caring for severely immunocompromised patients in special-care units, can receive LAIV at any time.

Although influenza vaccination can be given at any time during the fall or winter, it is best when given before the flu season begins. Children younger than 9 years and who are getting influenza vaccine for the first time should be administered 2 doses, at least 1 month apart.

For additional information regarding influenza please visit: http://www.cdc.gov/flu or call the Los Angeles County Immunization Program at (213) 351-7800.

References:

1. Update: Influenza Activity – United States and Worldwide, May 22 – September 3, 2005, and 2005 – 06 Season Vaccination Recommendations. MMWR September 16, 2005.
2. CDC. ACIP Prevention and Control of Influenza Recommendations. MMWR July 29, 2005.

Controlling Antibiotic Resistance: Your prescribing habits and patient education drive appropriate use of antibiotics.

Antibiotic-resistant organisms and infections—linked to the heavy use of antibiotics—are well known in hospital settings. However, there has been an increase of antibiotic resistant infections in the outpatient setting as well.

Antibiotics considered first-line in many situations are no longer effective.

For example, in Los Angeles County, the proportion of *Streptococcus pneumoniae* isolates from sterile sites that are resistant to penicillin increased from 18% in 2003 to 23% in 2004.[1] In addition, the spread of methicillin-resistant Staphylococcus aureus and increasing fluoroquinolone resistance in gonorrhea in California has changed prescribing guidelines.

To add to the growing antibiotic usage crisis, pharmaceutical companies are cutting back on producing new antibiotics. Only 5 of 506 drugs that are currently in research and development by drug companies are antibiotics.[2] Now, more than ever, clinicians and patients need to learn how to use antibiotics appropriately to keep them effective.

There is a pervasive public misconception that antibiotics are effective against viral illnesses and this drives public demand for there use. Results from the 2002-2003 Los Angeles County Health Survey show that only 32% of adults correctly reported that antibiotics are used for bacterial infections and nearly half of adults (46%) reported that they call their doctor for antibiotics when they have a cold or the flu.[3]

Fortunately, increased knowledge of antibiotics is associated with appropriate antibiotic usage. In the same survey, adults who correctly responded that antibiotics are effective for bacterial infections were more likely to finish prescribed antibiotics (63%) and not obtain antibiotics from friends and family members (84%) than those with incorrect responses (48% and 67% respectively).

PRESSURE TO PRESCRIBE

According to physicians, parental pressure for a prescription antibiotic is a common factor in influencing their decision to prescribe. As stated in the 2002-2003 Los Angeles County Health Survey, 46% of patients reported asking physicians to prescribe antibiotics for their cold or flu symptoms. Although this pressure can be difficult to ignore, physicians must resist writing a prescription for antibiotics.

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Additionally, when parents do not ask for an antibiotic prescription, physicians should not assume that they expect one.

Studies have shown that communication by the physician influences patient satisfaction more than the receipt of an antibiotic, particularly when patients are told to contact the physician if symptoms do not improve.[4,5] If physicians can clearly explain diagnoses and appropriate treatment to patients and parents, inappropriate antibiotic prescriptions can be prevented.

All of these measures can have a positive impact on appropriate prescribing as evidenced by the promising new reports on antibiotic use in children. New studies are showing that the rate of antibiotic use among children has started to decline.[6,7] Parents and physicians alike may be getting the message that appropriate antibiotic use is in everyone's best interest.

STEMMING ANTIBIOTIC RESISTANCE

All physicians can take a leading role to control antibiotic resistance by changing their prescribing behaviors and conducting patient education with the following strategies:

Prescribe appropriately – Always conduct a complete evaluation of the patient before prescribing antibiotics. For example, the majority of cases of acute pharyngitis are caused by viruses with less than 20% of these cases are caused by group A streptococcal infection.[8] Following clinical practice guidelines and using appropriate supportive laboratory data can guide your management in these cases. Reducing antibiotic prescriptions for viral upper respiratory tract infections has been shown to reduce rates of penicillin-resistant pneumococci colonization in children.[9]

The Centers for Disease Control and Prevention (CDC) provides clinical practice guidelines for otitis media, rhinitis, sinusitis, pharyngitis, and cough illness/bronchitis online at http://www.cdc.gov/drugresistance/community/technical.htm. The California Medical Association Foundation also provides a compendium of guidelines for acute respiratory tract infections online at http://www.aware.md/clinical/clinical_guide.asp.

Offer alternatives - Recommend alternatives (fluids, anti-pyretics, anti-histamines) to alleviate symptoms for viral illnesses such as cold and flu. The CDC has developed a "prescription pad" that physicians can use to explain why an antibiotic is not being prescribed and to recommend symptomatic treatments.

Explain why - Give patients a clear explanation of their diagnosis and the rationale for the use or non-use of antibiotics. The above prescription pad should help. Patients should be educated that antibiotics do not work for cold, flu, or pain. In addition, patients should be educated that taking unnecessary antibiotics puts them at risk for side effects, allergies and acquiring an antibiotic resistant infection in the future.

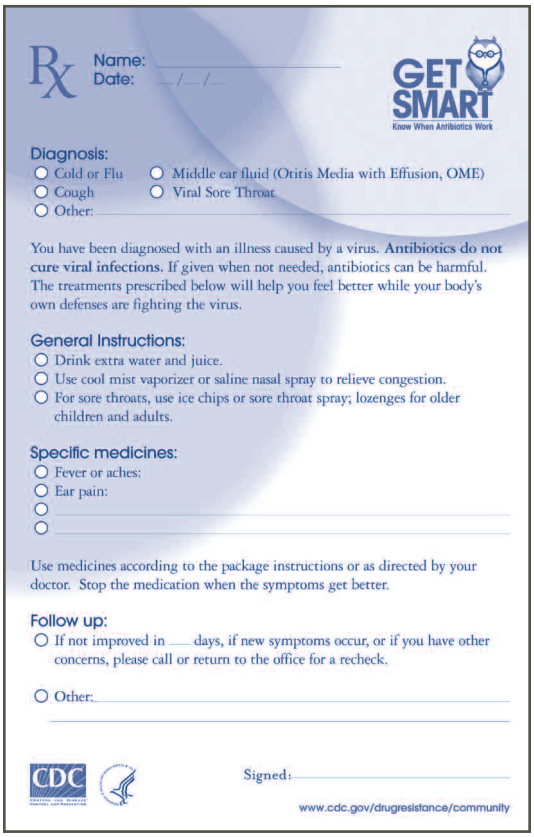

Figure 1: CDC Prescription Pad
Source: Centers for Disease Control and Prevention
Download and photocopy at
http://www.cdc.gov/drugresistance/community//files/RX_form_4c.pdf
Order bulk quantities at http://bookstore.phf.org/subprod326.htm

Promote prevention - Patients should be reminded that hand washing, disinfecting areas at home and work and good respiratory hygiene all help to prevent the spread of disease. Physicians should ensure patients keep their immunizations current, including the influenza and pneumococcal vaccines.

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Antibiotic Resistance...from page 4

As the potential for unnecessary antibiotic prescribing and use for viral illnesses is at its greatest during cold and flu season, physicians should also educate patients that antibiotics neither prevent nor treat colds and flu nor prevent secondary complications from colds or flu.

For more information and resources visit online at lapublichealth.org/acd/antibio.htm.

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2. Spellberg B, Powers JH, Brass EP, Miller LG, Edwards JE Jr. Trends in antimicrobial drug development: implications for the future. Clin Infect Dis. 2004;38(9):1279-86.
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PERTUSSIS AT HISTORICALLY HIGH LEVELS IN LOS ANGELES COUNTY

Los Angeles County (LAC) is currently experiencing a significant increase in the number of reported cases of pertussis, with a similar trend evidenced throughout California and the United States. From January 1 - August 31, 2005, 178 pertussis cases have been reported to the LAC Immunization Program, which is nearly a three-fold increase in the number of cases reported during the same time period of the previous 5 years and exceeds the total number of cases reported during the entire year of 2004. Not since the 1970s has LAC experienced this magnitude of pertussis morbidity during this specified time period. Of these 178 cases, 43.3% are less than one year of age, 23.6% are children ages 1-14, and 33.1% are over 15 years of age. Less than half of the cases (n=80) were laboratory-confirmed with culture or PCR, the only two tests that are currently accepted for the laboratory diagnosis of pertussis.

Adolescents and adults continue to be the primary reservoir for transmission to infants who are too young to have received at least 3 doses of a pertussis-containing vaccine. Historically during the fall, winter, and early spring seasons in LAC, a high number of pertussis cases among adolescents and adults are identified, followed by a higher number of cases reported among infants beginning in the late spring and through the summer months than any other time of the year. The need to protect infants from pertussis infection is underscored by the fact that to date, there have been two pertussis-related deaths among infants less than 2 months of age in LAC.

Therefore, it is extremely important that health care providers in LAC heighten their clinical suspicion for pertussis in individuals of all ages and order appropriate laboratory tests (refer to the pertussis fact sheet www.lapublichealth.org/ip/vpds/pertussis.pdf). Consider pertussis in any child, adolescent, or adult that presents with a persistent cough illness of 2 weeks or more whether or not it is associated with coughing paroxysms or whoop. Consider pertussis in infants experiencing a cough illness of any duration. Do not wait for culture or PCR confirmation before reporting a suspected case of pertussis to the LAC Morbidity Central Reporting Unit at 888-397-3993 (phone) or 888-397-3778 (fax).

New TdaP Vaccines Approved for Adolescents

Adolescents and adults are susceptible to pertussis yet are not eligible for childhood DTaP vaccines. The FDA recently licensed two new tetanus-diphtheria-acellular pertussis (TdaP) vaccines for use in adolescents in the US, one for persons aged 10-18 years (BOOSTRIX®, GlaxoSmithKline) and the other for persons aged 11-64 years (ADACEL™, Sanofi Pasteur). These new vaccines should protect adolescents and adults as well as protect infants from exposure to pertussis. The vaccines are expected to become available to California VFC providers in September or October and are expected to replace Td booster doses in adolescent populations.

For additional information about pertussis, refer to the pertussis fact sheet (www.lapublichealth.org/ip/vpds/pertussis.pdf) or visit the Los Angeles County Immunization Program website at http://lapublichealth.org/ip/index.htm or call 213-351-7800.

Africanized Honey Bee Risks: What Physicians Can Do

Background

Honeybees are not native to the Western Hemisphere. They were brought to the New World by the early European settlers. In 1956, Brazilian scientists attempted to breed bees that would produce more honey , but African bees brought in for the experiment escaped. The escaped bees formed the nucleus of a wild population that has since spread 200 to 300 miles per year through Latin America and into the United States

Since the first reported colony of Africanized honey bees (AHB) were discovered in Hidalgo, Texas in October of 1990, AHB swarms have spread at a rate of 600km (375mi) per year, extending throughout the western United States. In April 1999, the Los Angeles County Agricultural Commissioner/Weights and Measures Department declared Los Angeles County completely colonized by the AHB.

Basic bee biology

Bees are robust hairy insects with four wings. They are usually dark with some coloring such as yellow. Bees swarm in the spring and fall to make new hives. When threatened, bees emit iso-pentyl acetate, a pheromone that is deposited with the stinger at the sting site. This acts as an airborne chemical to alarm other bees to attack in increasing numbers. When domesticated, bees serve an important role in nature and are commercially important. For example, bees provide eighty percent of the pollination required by agricultural crops as well as provide honey for consumers.

What does the AHB mean to citizens of Los Angeles County?

Both AHB and European honey bees (EHB) share many behavioral and biological similarities. For example, both types pollinate flowers, produce honey, sting only once in defense and die, carry nearly the same type and amount of venom, and look the same. However, the significant difference between the two types of bees is that AHB are extremely aggressive when defending their colony. AHB's will:

- Respond to vibrations, such as lawn mowers, leaf blowers, other power equipment, passing vehicles, and even foot traffic;
- Sense threats by people or animals within 50 feet or more from their nest;
- Sense threats by vibration from power equipment within 100 or more from their nest;
- Guard a larger area around their hives than EHB;
- Respond in larger swarms than EHB;
- Respond quickly and in large numbers to pursue an enemy one fourth to one half mile or more from their hive; and
- Remain agitated for 24 hours.

Generally speaking, five hundred or more stings can be life threatening to a healthy adult, with 150 stings being equivalent to a rattlesnake bite (Nineteen stings per 1kg (2.2lb) of human victim body weight is the predicted median lethal dose). AHB's are known to attack in larger swarms. For example, AHB victims generally receive 1,000 or more stings in one attack. This increase in overall volume of bee venom leads to an increased risk of end organ damage (such as the liver and kidney's) for the survivors.

Prevention:

In many AHB fatal attack cases, spectators simply did not know what to do. Common responses include running to help a victim, only to get attacked themselves; jumping into water, only to discover bees still ready for attack up to 24 hours or more later, or rolling on the ground, while being sprayed with water, only have the helper get attacked as well.

Physicians can help reduce the risk of death and injury by providing patients with the following prevention efforts:

Bee-Proof around your property:

- Seal all cracks and holes larger than 1/8 inch that may lead to an attic, sub-wall, crawl space, etc. Sealing can be done with various types of colored caulking and can be purchased at local hardware stores.
- Vent screens: Install a 1/8 inch mesh hardware cloth behind vent screens.
- AHB prefer places left quiet during the summer, such as wood piles, junk piles or unused pots or boxes, cans, buckets, old tires, infrequently used vehicles, holes and cavities in fences, trees or ground, sheds, garages, under decks, attics, utility meter boxes, etc. Be sure to clear these locations and check for cracks and openings each spring.
- If you see bees in a flight pattern in these areas or if you observe a hive call the Los Angeles County Agricultural Commissioner/ Weights & Measures Department at 1-800-BEE-WARY (1-800-233-9279).

If attacked:

- Run away in a straight line as fast as possible. Get into a vehicle or building if possible
- If you are not near a building or vehicle, run as fast as you can. AHB's will chase up to 1/4 mile.
- Cover your face and head while running
- Once in a safe place away from the bees:
    - o Call 911
    - o Start to remove stingers from skin by scraping or using sticky tape.
- Wash sting area with soap and water
- Apply ice pack for a few minutes to relieve pain and swelling
- ALWAYS seek medical attention if 1) you are having breathing problems, 2) if been stung numerous times, or 3) you are allergic to bee stings
- NEVER jump into the water, as AHB's remain aggressive for up to 24hours.
- NEVER squeeze the stinger, as this will release more venom

Screening Children for Lead Poisoning...from page 2

It is recommended that primary care providers screen children at ages 12 and 24 months, and children between 24-72 months and older who were not previously tested or who missed the 24 month test.

Children who are not be recipients of publicly funded health services should not be excluded if they have not been tested for Lead in the past or have been recently exposed. If a child does not receive public assistance, the following risk assessment question should be asked by providers:
Does your child live in or spend a lot of time in a place built before **1978** that:

1. Has peeling or chipped paint, or
2. Has been recently renovated?

If the response to the question is "Yes" or "Don't Known" a blood Lead screening test should be ordered.

Education

Families should be educated about unexpected lead exposure risks. The following are some recommendations that can be shared with patients:

1. Parents and guardians should be advised to check their children's candies at Halloween and other holiday occasions. Imported Tamarind, and chili and Lime type candies can be laced with lead and should be removed;

2. Families should be informed that when considering the purchase of ceramic dishes and cookware for daily use, to look for the Proposition 65 warning (a yellow triangle). This warning on the package indicates that the product may be made with materials hazardous to the consumer's health and;

Choice of Sample Collection Method

Providers may choose to have blood samples collected by the venous method or the capillary method. A venous blood draw is considered the method of choice by many providers because of the high level of reliability and accuracy and the smaller risk for specimen contamination. The capillary draw is an alternative method of obtaining a blood Lead specimen, that is done primarily in situations where a missed opportunity to screen a child exists. It must be performed according to the CDC Finger stick protocol. The testing may take place in the office by trained staff or trained off-site phlebotomists in a CHDP-approved or state certified proficiency lab.

Role of the Childhood Lead Poisoning Prevention Program (CLPPP)

CLPPP is responsible for facilitating case management recommendations at the local level, establishing basic screening recommendations, and quality assurance activities with providers and labs.

Quality assurance

False positives Lead levels do occur and the causes need evaluation. Each child that experiences a false positive result is subject to a case review by both the public health nurse (PHN) and the provider training/education coordinator. The coordinator contacts the provider and discusses a plan of action to minimize future occurrence of false positive results. The following are examples of reasons for false positive results:

- Specimen contamination
- Faulty equipment
- Flawed methodology
- Clerical error

In 2003, the CLPPP began reviewing false-positive results by conducting telephone and on-site surveys related to screening practice and sampling collections. Providers are contacted if survey results indicate a need for intervention.

Healthcare Provider Training "Lead Awareness and Finger stick" training sessions are offered to new and existing providers as requested by both CHDP and CLPPP.

Providers who wish to register physicians assistants, certified medical assistants and licensed nursing staff for one of the training sessions or to obtain more information may call: Kathleen Lang, Assistant Program Specialist, Childhood Lead Poisoning Prevention Program, at (323) 869-7185.

Lead Awareness Month

October 23rd to October 29th is Lead awareness week and patients and practitioners alike are encouraged to become knowledgeable about Lead exposure and its risks.

SENTINEL PHYSICIANS NEEDED FOR INFLUENZA SURVEILLANCE

Every year the CDC relies on the assistance of sentinel physicians to help monitor influenza trends by reporting weekly their percentage of patients who present with influenza-like illness. The CDC is attempting to expand the number of participating physicians in Los Angeles County in order to obtain a more accurate picture of local trends and to keep pace with the rapid growth of the population. If you are interested in becoming a sentinel physician or would like more information, please contact:

Dr. Sadina Reynaldo or Dr. David Dassey at: 213-240-7941 or acdc2@ladhs.org

This Issue . . .

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Selected Reportable Diseases (Cases)* - May 2005

Disease	THIS PERIOD May 2005	SAME PERIOD LAST YEAR May 2004	YEAR TO DATE May 2005	YEAR TO DATE May 2004	YEAR END TOTALS 2004	2003	2002
AIDS*	129	133	678	798	2,335	2,532	1,719
Amebiasis	10	8	53	40	98	121	102
Campylobacteriosis	62	67	277	359	915	1,100	1,067
Chlamydial Infections	3,358	3,011	16,827	15,665	38,464	36,555	35,688
Encephalitis	4	4	35	17	137	38	61
Gonorrhea	825	720	4,213	3,794	9,696	8,008	7,800
Hepatitis Type A	6	24	80	136	319	376	438
Hepatitis Type B, Acute	7	6	31	34	71	56	29
Hepatitis Type C, Acute	0	1	0	4	5	0	3
Measles	0	0	0	0	1	0	0
Meningitis, viral/aseptic	42	56	367	182	790	899	466
Meningococcal Infections	3	1	14	8	28	32	46
Mumps	0	0	3	1	2	10	16
Non-gonococcal Urethritis (NGU)	111	133	568	649	1,470	1,393	1,393
Pertussis	42	6	133	51	141	130	170
Rubella	0	0	0	0	0	0	0
Salmonellosis	66	80	253	389	1,185	995	956
Shigellosis	20	39	264	164	550	669	974
Syphilis, primary & secondary	45	33	225	177	459	442	364
Syphilis, early latent (<1 yr.)	38	36	198	159	381	365	353
Tuberculosis	54	77	237	245	856	949	1,025
Typhoid fever, Acute	0	1	4	4	13	16	33

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