County of Los Angeles
Department of Health Services
Public Health

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

Volume 1 • Number 3 October 2001

Revised Guidelines for Latent TB Treatment

The Centers for Disease Control and Prevention (CDC) and American Thoracic Society (ATS) have issued revised treatment guidelines for latent tuberculosis infection (LTBI). The CDC has investigated reports of twenty-one patients who were hospitalized because of severe liver injury associated with a two-month treatment regimen of rifampin and pyrazinamide (RIF-PZA) for LTBI. Sixteen of the patients survived and five died. These findings were published in the August 31 edition of CDC's *Morbidity and Mortality Weekly Report*.[1]

The CDC and ATS are issuing revised treatment guidelines for latent TB infection (LTBI).

To date no deaths or severe liver injuries resulting in hospitalization have occurred in Los Angeles County. The Los Angeles County TB Control Program has received reports of liver enzyme elevations in a few patients who have received the RIF-PZA regimen.

CDC officials have prepared revised guidelines limiting the use of the RIF-PZA regimen including more frequent monitoring of liver functions.[1] For most individuals with LTBI, the new guidelines recommend the nine-month regimen of daily INH as the preferred treatment. Individuals taking INH should be monitored as recommended.[2] These revised recommendations for LTBI treatment do not affect patients currently being treated for active TB.

The CDC and ATS original guidelines emphasize TB testing and treatment for people at high risk.[2] Those at

Continued on page 3

Immunizations: Minimizing Pain and Maximizing Comfort

Throughout the years, more and more vaccines have been added to the recommended childhood immunization schedule. While these new vaccines are a valuable weapon against debilitating, sometimes fatal, childhood diseases, administering injections is often a source of anxiety for patients, parents, and providers alike, especially considering that many young patients may receive multiple injections during a single visit. While multiple immunizations may cause some pain, there is no known increased risk of side effects and no loss of efficacy when routine childhood vaccines are administered simultaneously.

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The vaccine administration technique of the provider is important to reduce the pain, swelling, and redness that sometimes accompany immunizations. Proper administration technique involves choosing the correct anatomic site, needle length and gauge, and angle of needle insertion. Use separate extremities for injections, if possible, when administering more than one. Multiple injections given in the same extremity should be separated by 1 to 2 inches so that local reactions are unlikely to overlap.

Proper administration of vaccines is also affected by the way the child is held. The proper hold depends on the age and activity level of the child, the vaccine site, and preferences of the parent and the provider. Active infants may require the "hold position" indicated for toddlers.

Infants: Sitting position

- Parent holds infant on lap, with infant facing same direction as parent. Parent crosses arms around infant, holding firmly onto infant's arms (parent's right hand on infant's left arm).
- Infant also may straddle the parent's lap and face the parent. Parent crosses arms around the baby's back.
- Infant may also sit in a carrier; infant's arms and legs should be restrained.

Toddlers: Lap position

- Parent holds child "sideways" on lap and restrains the child's legs between parent's legs. The child's arm closest to the parent's body is placed under the parent's arm and behind the parent's back.

Providers have found that the more accepting parents are about immunizations, the less anxiety and tears for the child. Parental acceptance is promoted by the provider explaining

Continued on page 6

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Calming Concerns Regarding West Nile Virus

Several highly publicized cases of West Nile virus (WNV) disease, including the recent death of an elderly woman in Atlanta, Georgia, have prompted concerns regarding the likelihood of contracting this disease in Los Angeles County. The first case of WNV encephalitis in the Western Hemisphere was reported in the New York area in 1999, and WNV has been attributed to 82 encephalitis cases and 9 deaths in New York and New Jersey. A total of 15 cases have been reported in the United States during 2001, though not all cases have been confirmed. To date, the virus has been detected in animals as far west as Wisconsin, Illinois, Michigan and Indiana. Surveillance efforts in Los Angeles County have not detected the virus in this area and there is no current evidence that the virus is in the western United States.

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WNV is transmitted by mosquitoes, although not everyone who is bitten by an infected mosquito will become ill; most suffer only mild or no symptoms. Symptoms usually occur within 5 - 15 days and range from mild "flu-like" symptoms to fever, headache, muscle aches, swollen lymph nodes and rash. More severe illness is rare but may include confusion or disorientation (indicating brain swelling), severe muscle weakness and paralysis.

While WNV has not been identified in Los Angeles County, bird migration patterns and the presence of competent vector mosquitoes able to transmit the virus may allow the virus to eventually spread to this state. In addition, WNV can spread by travel of infected individuals from endemic areas or importation of infected wild or domestic animals. The first evidence of WNV in an area is most often a die-off of wild birds, especially crows.

In Los Angeles County, WNV public health surveillance efforts concentrate on identifying and tracking the mosquitoes which transmit the virus and diagnosing sick birds which are potential vectors (e.g., crows and blue jays are of particular interest). In addition, this year, testing for WNV has been added to the mosquito-borne encephalitis surveillance conducted with sentinel chicken flocks which for decades have been used to monitor other mosquito-borne encephalitis viruses.

As with other mosquito-borne viruses, reducing one's risk of being bitten by mosquitoes is the most important prevention measure. Recommendations for reducing exposure to mosquitoes include:

- limiting outdoor activities between dusk and dawn
- wearing long sleeve shirts and pants when outside
- using mosquito repellent
- eliminating sources of stagnant water where mosquitoes might lay eggs (i.e., bird baths, old tires and other containers)
- installing screens over windows and doors

Additional information about Los Angeles County mosquito-borne encephalitis surveillance, submission of specimens and mosquito/vector control is available in the May 2001 issue of the Public Health Letter available at: **www.lapublichealth.org/acd/news/phl01/acdn2305.htm#Mosquito-borne Encephalitis Surveillance – 2001 or from ACDC @ (213) 240-7941.**

Guidelines for Latent TB Treatment (from page 1)

high risk include individuals with LTBI who were recent contacts of someone with active TB, and individuals who are HIV-infected, injection drug users, or residents or employees of high-risk congregate settings including correctional facilities, nursing homes, homeless shelters, hospitals, and other healthcare facilities. Treatment is recommended for foreign-born people with LTBI who have lived in the United States for less than five years and who were born in countries with high rates of TB. After five years, treatment decisions should be made on the same basis as other patients. The Los Angeles County TB Control Program recommends treatment for foreign-born people with LTBI who have lived in the United States for less than three years and who were born in countries with high rates of TB.

The goal of testing people for TB is to find and treat those have LTBI and are at risk of developing active TB disease.

CDC recommends that providers use RIF-PZA with caution, especially in LTBI patients currently taking other medications that have been associated with liver injury, and those with alcoholism even if alcohol usage is discontinued during treatment. Persons being considered for treatment with RIF-PZA should be informed of potential hepatotoxicity and asked whether they have ever had liver disease or adverse effects from INH.

CDC recommends providers use RIF-PZA with caution.

Careful clinical and laboratory monitoring are outlined in the recommendations for the RIF-PZA regimen. No more than a 2-week supply of RIF-PZA (with a PZA dose <20 mg/kg/d and a maximum of 2 gm/d) should be dispensed at a time to facilitate periodic clinical assessments. The Los Angeles County TB Control Program advises use of directly observed therapy (DOT). A health-care provider should reassess patients in person at 2, 4, and 6 weeks of treatment for adherence, tolerance, and adverse effects, and at 8 weeks to document treatment completion. At each visit, health-care providers conversant in the patients' languages should instruct patients to stop taking RIF-PZA immediately and seek medical consultation if abdominal pain, emesis, jaundice, or other hepatitis symptoms develop. Provider continuity is recommended for monitoring. Serum aminotransferase and bilirubin should be measured at baseline and at 2, 4, and 6 weeks of treatment in patients taking RIF-PZA. Because some side effects may occur in the second month of treatment, patients should be monitored throughout the entire course of treatment.

For HIV-negative individuals with LTBI, the new guidelines recommend the nine-month regimen of daily INH as the standard treatment. Patients co-infected with HIV and LTBI are at increased risk for developing active TB disease. While available data do not suggest excessive risk of severe side effects associated with RIF-PZA among HIV-positive individuals, providers should consider the use of INH when completion of this longer regimen can be assured.

CDC is collecting reports of severe liver injury (i.e., leading to hospital admission or death) in persons receiving any regimen for LTBI. Reports are being analyzed to assess contributing factors. ***Report possible cases to the Division of TB Elimination; telephone (404) 639-8116.***

The Los Angeles County TB Control Program is reviewing the CDC recommendations and is preparing a revision of the previously published standards for treating LTBI in Los Angeles County facilities. A copy of the revision can be obtained by calling 213-744-6160 or visiting the TB Control Web site www.lapublichealth.org/tb/tbtreat.htm

References:

1. CDC. Update: Fatal and severe liver injuries associated with rifampin and pyrazinamide for latent tuberculosis infection, and revisions in American Thoracic Society/CDC recommendations — United States, 2001. MMWR 2001; 50(34):733. Available at www.cdc.gov/mmwr/PDF/wk/mm5034.pdf
2. CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection.MMWR 2000;49(RR-6). Available at www.cdc.gov/mmwr/PDF/rr/rr4906.pdf

LEGIONELLOSIS: Taking The Mystery Out of Laboratory Diagnosis

Twenty-five years have passed since Legionnaires' disease was first recognized after an outbreak of a mysterious respiratory illness among attendees of the 1976 American Legion convention in Philadelphia. Yet legionellosis is still poorly understood by the general public and many in the medical community. While most physicians know how to treat Legionnaires' disease, clinical and laboratory diagnosis remains problematic. The escalating trend towards empirical treatment of community-acquired pneumonia without diagnostic testing results in underdiagnosis of legionellosis. But perhaps an equally worrisome trend is the reliance of healthcare providers on a single elevated antibody titer (serology) for diagnosis. This test lacks specificity (as many as 20% of the healthy adult population will have false-positive tests due to cross-reactivity with other bacteria or because of prior infection) and is rarely helpful in diagnosing either acute or prior legionellosis, especially in persons without a compatible clinical illness.

A single elevated antibody titer does not confirm a case of Legionnaires' disease.

Legionellosis is associated with two clinically and epidemiologically distinct illnesses: Legionnaires' disease and Pontiac fever. Legionnaires' disease is a pneumonia caused by *Legionella* species with a broad spectrum of clinical manifestations. Pontiac fever is a self-limited, flu-like illness without pneumonia that has been primarily recognized in outbreak settings.

Legionella species are gram-negative bacilli that are ubiquitous in a variety of aquatic environments, both natural and man-made. They thrive in warm (25-42^0 C) stagnant water, living in the biofilm that lines water-containing pipes and tanks. Transmission occurs through inhalation of aerosols containing the bacteria or by aspiration of contaminated water; there is no documented person-to-person transmission. While a number of species and serogroups have been implicated in human disease, *Legionella pneumophila*, particularly serogroup-1, accounts for more than 90% of Legionnaires' disease cases. Legionnaires' disease is a well-recognized cause of sporadic community-acquired and nosocomial pneumonia. Middle-aged to elderly persons, especially those who are cigarette smokers, have chronic lung or heart disease, or are immunocompromised, constitute the majority of patients with Legionnaires' disease, although cases in infants and adolescents also have been described. Outbreaks have been associated primarily with contamination of man-made aquatic environments, including air conditioning cooling towers, evaporative condensers, humidifiers, whirlpool spas, decorative fountains, and hot water in potable water systems. During outbreaks of Legionnaires' disease, attack rates are generally less than 5%.

The clinical manifestations of *Legionella* pneumonia are difficult, if not impossible, to distinguish from those of other bacterial pneumonias; they range from mild cough and slight fever to prostration, respiratory failure, multiorgan system failure, and death. The incubation period is usually 2-10 days. In the early stages, symptoms are often non-specific, including fever (often exceeding 104^0 F), malaise, myalgia, and headache. Cough is initially mild and nonproductive. Chest pain, occasionally pleuritic, may be present. Gastrointestinal symptoms (including nausea, vomiting, and abdominal pain) are often prominent; diarrhea is seen in 25-50% of cases.

The chest radiograph shows pneumonia. Laboratory findings may include abnormal liver function tests, hematuria, hypophosphatemia, and thrombocytopenia. Hyponatremia is common. Sputum gram stain shows many neutrophils, but few, if any, bacteria. Erythromycin remains the treatment agent of choice. Rifampin used in conjunction with erythromycin has been shown in several studies to provide superior results, especially in severely ill patients. For patients unable to tolerate erythromycin, other drugs such as the fluoroquinolones should be considered. Penicillin, cephalosporins, and aminoglycosides are ineffective. Failure of a pneumonia case to respond to beta-lactam antibiotics should raise the possibility of legionellosis.

Laboratory diagnosis

The diagnosis of legionellosis in a patient with a compatible clinical illness may be confirmed by any of the following:[1]

- Culture isolation of *Legionella* from respiratory secretions or tissues
  - Note that *Legionella* will not grow on standard laboratory media. In most laboratories, clinicians must specifically request culture for *Legionella* so that specimens will be plated on appropriate selective media.
- Microscopic visualization of *Legionella* in respiratory secretions or tissue by immunofluorescent microscopy
- Detection of *L. pneumophila* serogroup-1 antigens in urine by enzyme immunoassay or immunochromatography
- Observation of a four-fold or greater rise in *L. pneumophila* serogroup-1 antibody titer to >128 in paired acute and convalescent serum specimens by use of an indirect immunofluorescent antibody test (IFA).
  - A single elevated antibody titer **does not** confirm a case of Legionnaires' disease because IFA titers of

Continued on page 5

Legionellosis (from page 4)

1:256 or greater are found in up to 20% of healthy adults.
- Antibody tests to serogroups and species other than *L. pneumophila* serogroup-1 have not been standardized, are difficult to interpret, and are not FDA-approved.

Culture remains the gold standard, but is underutilized, probably because of cost and other issues. Urinary antigen detection by radioimmunoassay or enzyme-linked immunosorbent assay is a convenient, rapid, sensitive, and highly specific method for diagnosing infection caused by *Legionella pneumophila* serogroup-1 (LP SG-1). Bacterial antigenuria can be detected in the first week of illness and for days to weeks following initiation of specific antibiotic therapy. The test is available in most reference and many smaller laboratories. Direct fluorescent antibody (DFA) testing of respiratory secretions or other clinical specimens is highly specific but not very sensitive. Nucleic acid detection (DNA probe) and PCR testing are promising but not readily available.

Urinary antigen detection by radioimmunoassay or enzyme-linked immunosorbent assay is a convenient, rapid, sensitive, and highly specific method for diagnosing infection caused by Legionella pneumophila serogroup-1 (LP SG-1).

Legionellosis has been a reportable disease in California since 1985. The CDC estimates that *Legionella* causes 1-5% of community-acquired pneumonia in adults, and has a case-fatality rate of 5-30%. The number of reported cases in Los Angeles County has ranged from 3 in 1987 to 18 in 1991. In 2000, only 14 cases met the CDC public health surveillance case definition for legionellosis; an equal number of reported suspect cases were not confirmable because of inappropriate laboratory testing (single elevated antibody titer, only).

Public health surveillance for legionellosis is important in order to monitor disease incidence and to identify outbreaks and factors amenable to intervention. This requires both accurate diagnosis and prompt reporting of identified cases. The Acute Communicable Disease Control Unit (ACDC) and the CDC recommend that, along with heightened clinical awareness, testing methods such as (1) culture on selective media, (2) urinary antigen detection, or (3) acute and convalescent titers be used for diagnosing legionellosis.

Legionellosis is reportable to the local health department (California Code of Regulations, Title 17, Section 2500, 1995). **For consultation, please call ACDC at (213) 240-7941.**

Reference:

1. CDC. Case definitions for infectious conditions under public health surveillance. MMWR 1997;46(RR10):1-55. Available at www.cdc.gov/mmwr/preview/mmwrhtml/00047449.htm

Summary of laboratory methods for diagnosis of *Legionella* infection

TEST	SENSITIVITY SPECIFICITY	PROCESSING TIME	ADVANTAGES	DISADVANTAGES
Culture	80% 100%	3-5 days	Provides isolate for environmental comparison	Requires special media and lab expertise
Urinary antigen	80% 95%	hours	Fast, inexpensive, non-invasive, and remains positive for weeks after infection	Relatively specific to LP SG-1
DFA stain	33-70% 95-100%	hours	Remains positive several days after treatment started	Requires special lab expertise
Paired antibody testing	40-60% 95-100%	2-8 weeks	Remains positive despite treatment	Requires collection of 2nd blood sample; only validated for LP SG-1

Immunizations: (from page 1)

what vaccines will be given, discussing the benefits of immunizations and the risks of the diseases, and allowing them to ask any questions. Also, by including parents in the immunization process, providers will ease their concerns and thus help alleviate their child's anxiety before, during, and after the immunization, and when they are at home. These comfort measures include behavioral interventions such as visual distractions and pain management techniques such as holding and cuddling.

While painless shots can't be guaranteed, providers can strive for safe, effective, and caring administration of vaccines. Adherence to the proper technique minimizes patient discomfort and maximizes parental confidence in the safety and value of childhood immunizations.

Vaccine Administration Techniques

VACCINE	Needle size	Needle length	Angle for needle insertion**	Infant and Toddlers (birth to 36 mos.)	Children and Adults (3 yrs. to adult)
INTRAMUSCULAR (IM): Diphtheria-Tetanus-Pertussis (DTaP) Hepatitis A Hepatitis B *H. influenzae* type b (Hib) Influenza (flu) Pneumococcal conjugate (PCV)	23-25 gauge	1″ 11/2″-2″ may be used for large adults	90° Hold needle 1″ from the site and insert with a quick thrust. Inject vaccine using steady pressure; withdraw the needle quickly at angle of insertion.	Anterolateral thigh; the vastus lateralis muscle is on the outside of the leg in the mid- to upper-thigh.	Upper arm; the deltoid muscle is about 3 fingers below the acromion, above the level of the armpit.
SUBCUTANEOUS (SC): Poliovirus vaccine, inactivated (IPV)* Measles-Mumps-Rubella (MMR) Varicella (chickenpox) Pneumococcal polysaccharide* (*can also be given intramuscularly)	23-25 gauge	5/8″	45° Pinch up a bit of subcutaneous tissue with the other hand to help prevent inadvertent intramuscular injection. Hold needle 1″ from the site and insert with a quick thrust. Inject vaccine using steady pressure; withdraw the needle quickly at angle of insertion.	Either in the upper arm or in the fatty area of the thigh. The tissue is pinched up between the thumb and index finger.	Upper arm. The tissue on the back of the upper arm is pinched up between the thumb and index finger.

Table adapted from the poster "Anatomic Sites for Immunization" and video notes for "Immunization Techniques".
** There are no data to document the necessity of aspiration; however, if performed and blood appears after negative pressure, withdraw needle and administer injection at another site (Red Book 2000, American Academy of Pediatrics, pg.18).

Immunization Comfort Measures

	INFANTS	TODDLERS
Before shots	• Ask parent to bring child's immunization record. • Suggest to parent to bring along child's favorite toy or blanket. • Give vaccine information statements (VISs) to parent to read. • Answer any questions parent may have. • Reassure parent and encourage to be calm as child picks up on parent's feelings.	**Consider all of the pointers for infants, plus advise parent to:** • Reassure child honestly, "It might sting but it will only last a few seconds." • Never threaten child with shots, "If you are not good, I will have the nurse give you a shot." • Encourage older siblings to reassure and comfort, not to scare toddler.
During shots	To distract and comfort infant, have parent: • Touch soothingly and talk softly. • Make eye contact and smile at infant.	**Have parent:** • Hold child securely onto lap. • Talk to or sing with child. • Tell child a story or have child tell one. • Use a hand puppet. • Point out posters or objects around the room. • Help child take deep breaths and slowly blow out the pain. • Allow child to cry; don't force him/her to be brave.
After shots	**Encourage parent to:** • Hold, cuddle, caress, and/or breastfeed infant. • Talk lovingly and soothingly to child. • Give parent advice on using a non-aspirin pain reliever	**Suggest that parent:** • Give praises and hugs or a surprise. • Reassure child that everything is okay.
At home	**Ask parent to do the following:** • Mark calendar for child's next appointment. • Review vaccine information statements (VISs) for possible reactions. • Observe child for the next few days; parent might see a small rash or notice a fever. Encourage parent to call you if child has any reaction that is of concern to the parent. • Use a cool wet cloth at the injection site to help reduce redness, soreness, and/or swelling. • Give child a sponge bath with lukewarm water to reduce fever. • Give child plenty of fluids; it is normal if child eats less than usual for the next 24 hours.	

Adapted from the poster "Be There for Your Child During Shots (Comfort Measures)."

Continued on page 7

Immunizations: (from page 6)

Limited quantities of these materials are available from the Immunization Program or may be downloaded from the Los Angeles County Immunization Program Web Site: www.lapublichealth.org/ip/

- Poster: Anatomic Sites for Immunization (IMM-685)
  www.lapublichealth.org/ip/immunization/providers/site_anatomic.pdf
- Immunization Site Map for Infant and Toddler Shots (IMM-718)
  www.lapublichealth.org/ip/immunization/providers/site_infant.pdf (Infant)
  www.lapublichealth.org/ip/immunization/providers/site_toddler.pdf (Toddler)
- Skills Checklist for Pediatric Immunization (IMM-694)
  www.lapublichealth.org/ip/immunization/providers/skillscheck.pdf
- Poster: Comfort Measures / Be There for Your Child During Shots (English IMM-674E; Spanish IMM-674S)
  www.lapublichealth.org/ip/immunization/providers/comfort_pE.pdf (English)
  www.lapublichealth.org/ip/immunization/provider/comfort_pS.pdf (Spanish)
- Comfort Measures / Be There for Your Child During Shots (IMM-686 E/S)
  www.lapublichealth.org/ip/immunization/parents/comfort-bethereE.pdf (English)
  www.lapublichealth.org/ip/immunization/parents/comfort-bethereS.pdf (Spanish)
- Video: Immunization Techniques

Posters and videos may be ordered from the California Distance Learning Health Network. Order forms are available at: www.lapublichealth.org/ip/materials/IZtech_order.pdf

Influenza Vaccine Use Among Children

Currently, three influenza vaccines are licensed for use in the United States. Only Flushield™ (Wyeth Laboratories) and Fluzone® split vaccine (Aventis Pasteur) are approved for use among children > 6 months. The third licensed vaccine — Fluvirin® (Evans Vaccines Ltd.) – is labeled for use only among persons > 4 years because its efficacy has not yet been demonstrated among younger children. Dosage recommendations vary according to age group. Among previously unvaccinated children aged <9 years, two doses administered one month apart are recommended for satisfactory antibody responses. Consider prescribing antiviral medications for prophylaxis as necessary with unvaccinated children at high risk of influenza complications.

Consider prescribing antiviral medications for prophylaxis as necessary with unvaccinated children at high risk of influenza complications.

General information about influenza including vaccine, antiviral medications, and prevention information, including the complete Advisory Committee on Immunization Practices 2001 recommendation, is available at: **www.cdc.gov/ncidod/diseases/flu/fluvirus.htm**

Calendar

STD*Casewatch® Training for Physicians - CME Program

At the conclusion of this training session, physicians who attend will be able tosign on to an STD*Casewatch® terminal; review the history of an STD case previously entered into STD* Casewatch®; describe how serological tests can assist in the diagnosis of syphilis, and specify the use of treponemal tests; describe a laboratory approach to a patient who has been treated for gonorrhea with a CDC-recommended drug regimen but who shows no clinical improvement after a week; and describe how the Public Health Laboratory manages first-voided urine specimens in order to minimize cross contamination and false-positive tests.

Date: Friday, October, 19, 2001
Time: 12:45 - 4:15 p.m. (Registration at 12:45)
Place: Computer Training Classroom and STD Conference Room
STD Program Headquarter
2615 S. Grand Ave
Los Angeles, CA 90007
Contact: Kirby Mellinger, STD Program
(213) 744-5912
CME Credits: 3.0 Hours

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Epidemiology and Prevention of Vaccine-Preventable Diseases

This live course is designed to provide updates on immunization schedules, contraindications, standard immunization practices, vaccine-preventable diseases, and vaccine management and safety.

Date: Mon, Nov 5 ~ Tue, Nov 6, 2001
Time: 8:00 a.m. ~ 5:00 p.m.
Place: Norwalk Marriot
13111 Sycamore Drive
Norwalk, CA 90650
Contact: Sandra Jo Hammer
(shammer@dhs.ca.gov), CA IZ Branch
(213) 744-5912
CME Credit: 15.0 hours

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Diabetes Mellitus Type II: The Growing Epidemic

A national live satellite broadcast sponsored by the Office of Organizational Development and Training.

Date: Thursday, November 1, 2001
Time: 12:00 noon ~ 2:00 p.m.
Place: 313 N. Figueroa Street, DHS Auditorium
Los Angeles, CA 90012
Contact: Rosemary Salazar, Public Health Training Unit at (818) 364-4796 or via e-mail at ROSalazar@dhs.co.la.ca.us.

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Satellite Courses:

Vaccines for International Travel

Date: Thursday, December 13, 2001
Time: 9:00 a.m. ~ 12:30 p.m.
Place: 313 N. Figueroa Street, DHS Auditorium
Los Angeles, CA 90012
Contact: Ina Hasley, Immunization Program
(213) 580-9800

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 the percentage of patients who present with influenza-like illness. This year, 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. This expansion is especially important considering the frequent international travel and arrival of international visitors to the Los Angeles area. In addition, in light of current influenza-related events, such as vaccine delays and the rising reliance on antiviral medications, monitoring influenza trends has become more important than ever.

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@dhs.co.la.ca.us

This Issue . . .

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

County of Los Angeles
Department of Health Services
Public Health

313 North Figueroa Street, Room 806
Los Angeles, California 90012

Selected Reportable Diseases (Cases) - July 2001

Disease	THIS PERIOD July 2001	SAME PERIOD LAST YEAR July 2000	YEAR TO DATE 2001	YEAR TO DATE 2000	YEAR END TOTALS 2000	YEAR END TOTALS 1999
AIDS	115	149	739	944	1,682	1,892
Amebiasis	13	4	61	57	106	142
Campylobacteriosis	97	138	580	714	1,299	1,100
Chlamydial Infections	2,642	2,626	19,295	18,189	30,947	27,586
Encephalitis	3	6	27	26	46	7
Gonorrhea	603	634	4,545	4,033	7,250	6,054
Hepatitis Type A	34	61	263	499	1,008	1,258
Hepatitis Type B, Acute	1	10	35	127	183	282
Hepatitis Type C, Acute	1	4	6	48	64	696
Measles	0	1	11	2	5	1
Meningitis, viral/aseptic	73	50	296	261	455	390
Meningococcal Infections	1	2	43	43	58	53
Mumps	1	0	3	36	41	22
Non-gonococcal Urethritis (NGU)	84	137	810	944	1,578	1,742
Pertussis	1	4	30	92	145	202
Rubella	0	1	1	2	5	0
Salmonellosis	63	112	424	630	1,092	1,027
Shigellosis	54	94	248	452	839	687
Syphilis, primary & secondary	16	9	94	88	129	84
Syphilis, early latent (<1 yr.)	16	12	122	126	248	334
Tuberculosis	81	86	422	457	1,065	1,170
Typhoid fever, Acute	0	1	13	16	25	16

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