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 2 September 2001

Protecting Your Patients Against Influenza: Vaccine Update, 2001 - 2002

With autumn comes preparations for the influenza (flu) season. Last year there was a nationwide delay in vaccine delivery. In Los Angeles County, this delay caused a great deal of frustration for both the public and health care providers. Luckily, the flu season was mild; influenza B, which results in milder illness, made up more than half of all isolates reported by local laboratories participating in the flu surveillance network. There is a projected vaccine delivery delay again this year, however, it is not expected to impact distribution to the same extent as it did last year. The Centers for Disease Control and Prevention (CDC) estimates that approximately 60% of all doses of flu vaccine produced this year will be distributed by the end of October. While there is no way to know how severe the coming flu season will be, providers should have ample time to vaccinate those at high risk for flu complications prior to the onset of peak influenza activity.

Highest risk for complications

Persons at high risk for flu complications are those ≥65 years and those aged <65 years who have certain underlying medical conditions or chronic illnesses (see table on page 3). Health care providers can protect their high-risk patients from the complications of flu, which include pneumonia, hospitalization and death:

1. When the first shipments of flu vaccine are received, begin immunizing all persons who are at increased

Continued on page 3

MANAGEMENT OF ANIMAL BITES FROM RABIES-PRONE ANIMALS

Animal bites can cause serious injury, bacterial and viral infections, physical and psychological trauma, and even death. The number of animal bites can be reduced by responsible pet ownership, prevention and education to control stray animals, and enforcement of animal control laws and ordinances. This article describes how to report animal bites and how to obtain rabies post-exposure prophylaxis (PEP) when treatment is warranted.

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Reasons for Reporting Animal Bites

Animal bite reporting laws have two purposes: 1) to identify vicious domestic animals and wild animals that may need to be detained or destroyed for the public good; 2) to prevent human rabies by identifying bites by animals prone to rabies so that appropriate treatment may be offered to bite victims.

Bite Reporting Process

Animal bites should be reported to the Los Angeles County Department of Health Services' Veterinary Public Health and Rabies Control Program (VPH-RCP) either by phone (877-747-2243/Rabies Hotline) or by fax (323-735-2085). Reporting forms can be obtained by calling the hotline. Once a report is received, VPH-RCP personnel will either quarantine the biting animal or perform rabies testing. The majority of biting dogs and cats are quarantined at the owner's home. Persons bitten by a stray animal should contact their local Animal Control Agency (Table 1) to ensure that the animal is captured, impounded, and quarantined at a shelter. Biting wildlife are euthanized and tested for rabies immediately.

Treatment Services Provided by the Health Department

When the bite report indicates possible rabies exposure, the caller is referred to Acute Communicable Disease Control (ACDC); a doctor in the unit will speak to the victims or their physician about the need for PEP treatment. ACDC provides consultation to decide if PEP is warranted and to determine the appropriate treatment. The health department provides PEP treatment of uninsured bite victims and those whose health insurance does not include medication coverage. Care is delivered at a Department of Health Services facility under

Continued on page 5

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CONTRIBUTORS TO THIS ISSUE:

Elizabeth Bancroft, MD, SM
Medical Epidemiologist, Acute Communicable Disease Control

Diana Lynn Barnes, PsyD, MFT
Founder, The Center for Postpartum Health

David E. Dassey, MD, MPH
Deputy Chief, Acute Communicable Disease Control

Cheri Todoroff, MPH
Director, Immunization Program

More than Baby Blues:
Postpartum Depression

For most women, the birth of a baby brings feelings of exhilaration and the anticipation of joyous beginnings. But for more than 40,000 women in this country each year, childbirth is nothing short of a nightmare as confusion, disorientation, memory impairment, agitation and anxiety threaten their stamina during the already stressful postpartum adjustment to motherhood.

A time of crisis and enormous change for the family, new mothers are vulnerable to depression anytime within the first year after delivery. In particular, the tremendous hormonal shifts associated with the return of the menses and with weaning, predispose a woman to postpartum illness.

Fortunately, psychosis, an extreme form of postpartum depression affects only one or two mothers in every thousand births. The symptoms are critical enough, however, to warrant immediate emergency medical treatment to maintain the safety of both mother and infant and to prevent its devastating consequences – suicide and/or infanticide. Other symptoms that require emergency treatment include rapid weight loss without intentional dieting, sleep deprivation of more than 48 hours duration, delusions, hallucinations, extreme disorientation, and confusion. A hallmark characteristic of postpartum depression is the mother's detachment and emotional disconnections from her infant. Many mothers describe the experience as "not being able to engage with my baby" or a feeling like "I'm just going through the motions."

A hallmark characteristic of postpartum depression is the mother's detachment and emotional disconnections from her infant.

The following are additional common signs of postpartum depression:

- Excessive mood shifts
- Inability to cope
- Feelings of inadequacy
- Rage
- Fear of being alone
- Withdrawal and social isolation

Since there are a number of risk factors that increase a woman's vulnerability to postpartum depression, prenatal assessment and early diagnosis are extremely important for its prevention and treatment. A multi-faceted treatment approach that addresses the use of medications along with exploration of psychological and environmental stresses is crucial to restoring a biochemical balance and sustaining the healing process.

For more information, please contact Robert Bragonier, MD, PhD, Director, Maternal Health and Family Planning Programs at (213) 639-6415. Dr. Bragonier serves as the health department representative for the countywide Maternal Depression Workgroup.

The Edinburgh Postnatal Depression scale is a self-assessment tool developed to help primary care providers detect postpartum depression. For more information, log on to www.wellmother.com/articles/edinburgh.htm

Vaccine Update (from page 1)

risk for complications from the flu. Implement reminder/recall systems that facilitate the immunization of these high-risk individuals. Information about establishing such systems can be obtained at: **www.cdc.gov/nip/flu/provider.htm**

2. Starting in November, as more vaccine is available, begin offering vaccine to contacts of high-risk persons (e.g., medical staff and family members of high risk persons), healthy persons aged 50-64, and any other persons wanting to reduce their risk for influenza. Do not neglect high-risk persons who could not be vaccinated earlier in the fall.

3. Continue immunizing persons at high risk, as well as other target groups noted who have not yet received the vaccine, throughout December and thereafter, as long as there is flu activity and the vaccine is available. Since influenza viruses continue to circulate into the spring, vaccination is still the most important preventive measure.

The total amount of flu vaccine to be produced this year will be almost 9 million doses more than what was produced last year, for a total of 79.1 million doses. The only change in composition of this year's vaccine pertains to the B component, which was changed to get a better match with the strain of influenza B that is expected to circulate during the upcoming flu season. This year's flu vaccine will be composed of the following strains: A/Moscow/10/99 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Sichuan/379/99-like.

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Four antiviral agents are available in the U. S. for treatment, and in some instances, prophylaxis of influenza. These agents, however, are not a substitute for vaccination and their use should only be considered an adjunct to the use of influenza vaccine. Amantadine and rimantadine have only shown effectiveness against influenza A, whereas the neuraminidase-inhibitors zanamivir and oseltamivir have shown efficacy against both influenza A and B. Health care providers can learn more about the current indications for the use of these agents by consulting the MMWR April 20, 2001 issue [50(RR04); 1-46] available at **www.cdc.gov/mmwr/preview/mmwrhtml/rr5004a1.htm**

During the fall and early winter, there will be several information campaigns to inform the community about the value of influenza vaccine in preventing or significantly reducing the severity of the flu. In response to these campaigns, health care providers may receive requests for information about the influenza vaccine. Providers will need to be prepared to help their patients understand their risks for complications from the flu and the benefits of immunization to themselves as well as their families.

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Finally, many health care organizations will be assessing their providers' flu vaccine use this year and providing feedback to providers regarding vaccine coverage levels for persons aged 65 and over. This is part of the national effort to achieve flu vaccination coverage rates of 90% by the year 2010, for this age group.

Please consult the following CDC web site regularly to obtain the latest information about influenza this year: **www.cdc.gov/nip/flu**

Persons at Increased Risk for Complications from Influenza

- Persons aged ≥ 65 years
- Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions
- Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma
- Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies (such as sickle cell), or immunosuppression (including immunosuppression caused by medications or HIV)
- Children and teenagers (aged 6 months to 18 years) who are receiving long-term aspirin therapy and, therefore, might be at risk for developing Reye syndrome after influenza infection
- Women who will be in the second or third trimester of pregnancy during the influenza season

Los Angeles County Health Survey: Briefs

The Los Angeles County Health Survey is a biennial population-based telephone survey of approximately 8,000 households in the county, examining health and health-related issues for adults and children. The Field Research Corporation first conducted the survey for the Los Angeles County Department of Health Services in 1997 and again between September 1999 and April 2000. The health department obtained funding to support the 1999 survey from the California Department of Health Services, the Los Angeles County Department of Public Social Services, and the federal Medicaid Demonstration Project.

Detailed summaries of these topics may be found on Public Health's web site at: **www.lapublichealth.org/ha/haprog.htm**

Health-Related Quality of Life Lower in Los Angeles County than Nationally

The first-ever report on health-related quality of life in Los Angeles County indicates that, during 1999, county adults reported more days of poor health and more days of limited activities (such as work and recreation) because of poor physical and mental health than adults throughout California and the United States. According to the report, county residents reported an average of 6.4 days of poor health (referred to as "unhealthy days") and 2.4 days of limited activity because of poor health (referred to as "activity limitation days") in the past month. The county figures were higher than those for California (5.9 days and 2.1 days, respectively) and the nation (5.5 days and 1.9 days, respectively).

Using measures developed by the CDC,[1] the 1999 – 2000 Los Angeles County Health Survey asked the nearly 8400 respondents a set of quality of life questions. The CDC has encouraged local and state health departments to adopt these measures. Los Angeles is the first county in the nation to examine this issue.

County residents reported an average of 6.4 days of poor health and 2.4 days of limited activity because of poor health in the past month.

Other findings include:

- Persons living below the federal poverty level reported one and one half times more unhealthy days and nearly double the number of activity limitation days in the past month than did those living above 300% of the federal poverty level.
- Persons living below poverty were also more than four times as likely to report their health as only poor or fair (42%) than those living above 300% of poverty (9%).
- Persons who had been diagnosed with depression reported three times as many unhealthy days and four times as many activity-limitation days as those individuals not diagnosed with depression. Similar trends were also found for heart disease, diabetes, arthritis and asthma. The findings are consistent with another recent county study that found these chronic diseases among the leading causes of premature death and disability in the county population. (See August 2001 issue of The Public's Health at **www.lapublichealth.org/wwwfiles/ph/ph/ph/TPH_August_2001.pdf**

Diabetes Rates High for County Residents; Obesity Blamed

Seven percent of Los Angeles County adults (age 18 years or older) have been diagnosed with diabetes. Type I diabetes (insulin-dependent) accounts for 5 – 10% of those with diabetes and most often occurs in childhood or adolescence. Type II diabetes (non-insuling dependent) is more common (affecting 90 – 95% of diabetes cases) and usually occurs in adulthood, although it is being seen with increasing frequency among adolescents. In addition, many more residents are believed to be living with diabetes but are unaware of their condition. Death certificate records indicate that the disease is the seventh leading cause of death (12.9 deaths per 100,000 population in 1997) in the county population.

Seven percent of Los Angeles County adults (age 18 years or older) have been diagnosed with diabetes....25% of adults with diabetes are not currently receiving medical care for their condition.

The major risk factor for Type II diabetes (non-insulin dependent) is obesity; diet, lack of physical activity and older age are also associated with the disease. Findings for Los Angeles County show that the prevalence of diabetes increases with body weight; the prevalence is 4% among individuals of normal weight and 21% among extremely obese individuals.

Regular exercise is important not only for the prevention of diabetes, but also to manage the condition. The survey found that 61% of adults with diabetes are sedentary compared to 40% of adults who do not have diabetes.

According to the survey, 25% of adults with diabetes are not currently receiving medical care for their condition. Health insurance coverage greatly influences receipt of care for those with diabetes; twice as many (51%) uninsured people with diabetes are not receiving care as those with insurance (20%).

These statistics are consistent with several recently published studies, one conducted by the National Institutes of Health and one by the Centers for Disease Control and Prevention (CDC), which found that the rate of diabetes has increased six-fold in the U.S. population since 1960.

Reference:

1. CDC. Health-related quality of life – Los Angeles County, California, 1999. MMWR 2001;50(26):556. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm5026a2.htm

Animal Bites (from page 1)

the direction of the District Medical Director, with case management by a public health nurse.

Persons in need of rabies PEP who have medical insurance are expected to obtain treatment through their regular medical provider. Most primary care physicians are fully capable of providing rabies PEP. In some cases initial care may be better managed in the emergency department, such as when the bite has caused serious injuries in need of irrigation and closure, or if the bite was to a delicate structure like the face or hand that might need reconstructive work. Complete recommendations for rabies PEP are available on the Internet at www.cdc.gov/ncidod/dvrd/rabies/Professional/ACIP/rr4801.pdf

Sources of Rabies Vaccine and RIG

RIG and the first vaccine dose are administered on day 0. Four additional doses of rabies vaccine are administered on days 3, 7, 14, and 28 after the start of treatment. There are three makers of rabies vaccine and two companies providing RIG in the United States (Table 2). The vaccines are considered equivalent for post-exposure administration. The two available RIG products, BayRab™ and Imogam® Rabies-HT, are an antirabies immunoglobulin (IgG) preparation standardized at a concentration of 150 IU per mL, supplied in 2-mL (300 IU) vials for pediatric use and 10-mL (1,500 IU) vials for adult use; the recommended dose is 20 IU/kg body weight.

Obtaining rabies immune globulin and rabies vaccine sometimes presents a challenge to an independent physician's office. The best alternative is to order these medications from the hospital pharmacy, emergency department, or pharmacy purchasing representative; generally, the products can be delivered in 24 hours.

To obtain assistance with rabies treatment decisions or to refer an uninsured patient for treatment, call ACDC at 213-240-7941.

TABLE 1. Animal Control Agencies in Los Angeles County

City	Telephone
Avalon, City Hall	(310) 510-0174
Bellflower City Animal Control	(562) 803-3301
Burbank Animal Control	(818) 238-3340
Commerce City Animal Control	(323) 722-4805
Covina/West Covina City Animal Control	(626) 962-3577
Duarte City Animal Control	(626) 357-7938
Glendale Humane Society	(626) 242-1128
Glendora Police Department	(626) 914-8275
Hermosa Beach Animal Control	(310) 376-6984
Huntington Park City Animal Control	(562) 582-6161
Inland Valley Humane Society	(909) 623-9777
Lawndale, City of	(310) 970-2129
Long Beach Animal Control	(562) 570-3073
Los Angeles City	see below*
Los Angeles County, other areas not included elsewhere	see below**
Manhattan Beach Animal Control	(310) 545-5621
Monterey Park Animal Control	(626) 307-1217
Pasadena Humane Society (PH)	(626) 792-7151
Redondo Beach City Animal Control	(310) 318-0611
San Gabriel Human Society	(626) 286-1159
Santa Monica Animal Control	(310) 450-6179
Southeast Area Animal Control	(562) 803-3301
Temple City Animal Control	(626) 285-7187
***City of Los Angeles, Department of Animal Regulation**	
Administrative Offices	(213) 473-8253
North Central Animal Shelter (northwest, downtown, Hollywood)	(888) 452-7381
South Central Animal Shelter (southern and western areas)	(888) 452-7381
Harbor Animal Shelter (San Pedro area)	(888) 452-7381
East San Fernando Valley Animal Shelter	(888) 452-7381
West San Fernando Valley Animal Shelter	(888) 452-7381
West Los Angeles Animal Shelter	(888) 452-7381
****County of Los Angeles, Department of Animal Care and Control**	
Shelter No. 1 (southeast county)	(562) 940-6898
Shelter No. 3 (southwest county)	(310) 523-9566
Shelter No. 4 (eastern county)	(626) 962-3577
Shelter No. 5 (Antelope Valley)	(661) 940-4191
Shelter No. 6 (northern San Fernando Valley)	(661) 257-3191
Shelter No. 7 (west San Fernando Valley)	(818) 991-0071

TABLE 2. Rabies Biologics — United States, 1999

Type	Product name	Manufacturer
Human rabies vaccine		
Human diploid cell vaccine (HDCV)		
· Intramuscular	Imovax® Rabies	Pasteur-Merieux Serum et Vaccins, Connaught Laboratories, Inc.
· Intradermal (*not for postexposure*)	Imovax® Rabies I.D.	(800) 822-2463
Rabies vaccine adsorbed (RVA)		
· Intramuscular	Rabies Vaccine Adsorbed (RVA)	BioPort Corporation (517) 335-8120
Purified chick embryo cell vaccine (PCEC)		
· Intramuscular	RabAvert®	Chiron Corporation (800) 244-7668
Rabies immune globulin (RIG)		
	Imogam® Rabies-HT	Pasteur-Merieux Serum et Vaccins, Connaught Laboratories, Inc. (800) 822-2463
	BayRab™	Bayer Corporation Pharmaceutical Div. (800) 288-8370

Outbreak of Norwalk-like Virus Associated with Foodhandlers:
Evidence of Prolonged Viral Shedding

Norwalk-like viruses (NLV) are the most common cause of foodborne illness in the U.S., accounting for an estimated 23 million cases each year. Symptoms of NLV infection start 1-2 days after exposure and include nausea, vomiting and diarrhea that usually last 24-48 hours. The most common modes of transmission are ingestion of contaminated food or water and contact with an infected person. While rare, airborne spread via aerosolized vomitus also has been reported. Foodhandlers can be associated with NLV outbreaks and transmission has been documented from foodhandlers both prior to symptom onset and after recovery.

While experimental studies have documented NLV shedding in stool up to 13 days after exposure, the duration of shedding after resolution of gastrointestinal symptoms has not been adequately documented. A recent investigation by the Acute Communicable Disease Control Unit (ACDC) of a restaurant-associated outbreak of NLV provided data on this important issue, which has implications regarding the duration ill foodhandlers should be restricted from work

NLV restaurant-associated investigation:

During March 2000, ACDC received several reports of illness linked to a restaurant in Los Angeles County . Interviews with restaurant patrons and employees revealed symptoms consistent with NLV disease. Given the high risk of NLV transmission by foodhandlers, the restaurant was closed and all employees (N=71) needed clearance by the health department before returning to work (i.e., had no gastrointestinal symptoms for at least 2 days). Laboratory investigations consisted of testing stool samples from restaurant patrons and employees for the presence of NLV by reverse transcriptase-polymerase chain reaction (RT-PCR). RNA from selected positive samples was sequenced. The purpose of the investigation was to confirm the etiology of the outbreak, to determine the incidence of gastroenteritis among the employees and to calculate the length of NLV shedding in stool after resolution of gastrointestinal symptoms.

Laboratory results confirmed NLV as the etiology of the outbreak. A substantial proportion of employees (39%, n=28) met the case definition of acute gastroenteritis (vomiting or diarrhea at least three times in a 24-hour period); another 10% (n=7) were possible cases. Half of the employees for whom information was available admitted working while ill. The majority of employees who met the case definition and who submitted stool samples (n=12, 57%) tested positive for NLV by RT-PCR. In addition, one possible case and 20% of the 20 asymptomatic employees who submitted stool samples also tested positive for NLV. Three isolates (from a cook, a waitress, and a patron) were submitted for RNA sequencing and all were identical.

The majority of cases continued to shed NLV 3-11 days after the resolution of symptoms.

Surprisingly, a substantial proportion of cases (n=10, 77%) continued to shed NLV in their stool well beyond two days after resolution of their gastrointestinal symptoms – one case was still shedding at 11 days. Moreover, since stool samples were only taken at one point in time, the estimate of the duration of shedding is a minimum since employees may have continued to shed after sample collection. Similarly, because employees submitted a single stool sample, the number of employees infected with NLV is probably underestimated since they may have stopped shedding before the samples were collected.

Conclusion and recommendations:

Current Centers for Disease Control and Prevention (CDC) recommendations suggest stool specimens be collected within the first 48-72 hours after patients become ill, and from patients with watery or unformed stool. However, we found that persons who had vomiting without diarrhea were as likely to have a positive stool result as persons who had diarrhea, and that RT-PCR was sensitive enough to detect NLV up to 11 days after resolution of symptoms. These findings should encourage public health investigators to collect stool samples for NLV testing longer than previously thought, and from a wider variety of patients.

Continued on page 7

NLV (from page 6)

To decide how long foodhandlers should be restricted from preparing food, additional studies are needed to further assess the risk of shedding NLV and transmission of the virus. Recommendations for preventing the transmission of NLV by foodhandlers vary considerably. In 1990, the CDC recommended restricting foodhandlers from preparing food for at least 2 days after resolution of gastrointestinal illness. In 2001, the CDC issued new guidelines which stated that foodhandlers should maintain strict personal hygiene at all times, but did not specify for how long ill foodhandlers should be removed from work. The Food and Drug Administration (FDA) 1999 Food Code recommends restricting foodhandlers from preparing food only while symptomatic with vomiting or diarrhea; the National Restaurant Association and many state departments of health use this guideline as a model.

Since half of the employees surveyed admitted to working while ill, stricter enforcement of foodhandler guidelines may have prevented this NLV outbreak.

Given that half of the employees surveyed in this investigation admitted to working while ill, this study supports the stricter CDC recommendations to restrict foodhandlers for at least 2 days after gastrointestinal symptoms resolve. If the foodhandler no longer has diarrhea, and adheres to adequate handwashing and gloving, as called for in the FDA Food Code, then there may be no need to restrict the foodhandler from work for longer than 48 hours. In order to recommend that ill foodhandlers be kept from work for longer than 48 hours, further studies are needed: 1) to identify the likelihood of NLV transmission among post-symptomatic foodhandlers, and 2) to quantify the decrease in NLV shedding which occurs over time. An additional factor to consider is that paid sick leave is not routinely offered to hourly employees in the restaurant industry. Policies and benefits which accommodate sick leave for restaurant employees may have prevented this outbreak.

REPORTING: ***Clinicians should report all cases of suspected foodborne illness immediately to the health department, especially when multiple cases have occurred from the same food source. Some foodborne diseases are reportable as single cases because of their public health importance. These include: botulism, illness due to any Vibrio species (e.g., cholera, vulnificus, parahaemolyticus) and ciguatera fish poisoning.***

1-888-397-3993 Morbidity Hotline

Calendar

Managing Medication Errors in Public Health

This 3-hour course reviews medication safety, the prevention of error, and existing medication error reporting systems. The format includes case presentations, review of policies, procedures and forms, and audience discussion. The goal is to take steps toward creating a public health clinic culture that accepts errors as indications for improving the system (not hiding errors as stigmata of personal failure and blame).

Date: Friday, September 21, 2001
Time: 1:00 ~ 4:00 p.m. (Registration at 12:45 p.m.)
Place: 313 N. Figueroa St., DHS Auditorium, Los Angeles, CA 90012
Contact: Kirby Mellinger, STD Program (213) 744-5912
CME Credit: 3.0 hours

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Diagnostic Features of Tuberculosis Obtained From Pulmonary Function Testing

Presented by Richard Casaburi, PhD, MD, Chief, Division of Respiratory & Critical Care Medicine, Harbor/UCLA Medical Center

Date: Friday, October 5, 2001
Time: 9:00 a.m. ~ 10:30 a.m.
Place: Orthopaedic Hospital of Los Angeles (Andrew Norman Hall Auditorium), 2400 So. Flower St. Los Angeles
CME Credit: 1.0 hour
Contact: Robert Miodovski, MPH, TB Control Program (213) 744-6229

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Tuberculosis Case Presentations

Organized by Annette Nitta, MD.

Date: Friday, October 5, 2001
Time: 10:30 a.m. ~ 12 noon
Place: Orthopaedic Hospital of Los Angeles (Andrew Norman Hall Auditorium), 2400 So. Flower St. Los Angeles
CME Credit: 1.0 hour
Contact: Robert Miodovski, MPH, TB Control Program (213) 744-6229

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Satellite Courses:

Vaccines for International Travel
Time: 9:00am ~ 12:30pm
Date: December 13
Place: DHS Administration Building 313 North Figueroa Street, Auditorium Los Angeles, CA 90012
Contact: Ina Hasley, Immunization Program (213) 580-9800
Open to the public

THE PUBLIC'S HEALTH

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INFLUENZA SENTINEL PHYSICIANS NEEDED

Every year the CDC relies on the assistance of sentinel physicians to help monitor influenza trends by reporting their percentage of patients who present with influenza-like illness. Additional physicians are needed to keep pace with the growing LA 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@dhs.co.la.ca.us

This Issue . . .

Selected Reportable Diseases (Cases) - June 2001

Disease	THIS PERIOD June 2001	SAME PERIOD LAST YEAR June 2000	YEAR TO DATE 2001	YEAR TO DATE 2000	YEAR END TOTALS 2000	YEAR END TOTALS 1999
AIDS	79	117	627	795	1,682	1,892
Amebiasis	6	8	48	53	106	142
Campylobacteriosis	108	119	483	576	1,299	1,100
Chlamydial Infections	2,576	2,767	16,365	15,561	30.947	27,586
Encephalitis	3	3	24	23	46	7
Gonorrhea	597	641	3,841	3,399	7,250	6,054
Hepatitis Type A	43	65	229	538	1,008	1,258
Hepatitis Type B, Acute	4	20	34	117	183	282
Hepatitis Type C, Acute	0	16	5	44	64	696
Measles	3	0	11	1	5	1
Meningitis, viral/aseptic	44	10	334	211	455	390
Meningococcal Infections	3	6	42	41	58	53
Mumps	1	1	2	36	41	22
Non-gonococcal Urethritis (NGU)	91	165	693	807	1,578	1,742
Pertussis	4	8	29	88	145	202
Rubella	0	0	1	1	5	0
Salmonellosis	83	76	361	518	1,092	1,027
Shigellosis	46	47	194	358	839	687
Syphilis, primary & secondary	13	12	74	78	129	84
Syphilis, early latent (<1 yr.)	19	16	107	114	248	334
Tuberculosis	72	61	344	371	1,065	1,170
Typhoid fever, Acute	1	4	7	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.