County of Los Angeles Public Health

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

Volume 8 • Number 2 February 2008

It's not too late to vaccinate!

Continuing influenza vaccination is important to public health.

We're into the New Year, the holidays are over, and decorations are packed away. However, don't put away your influenza (flu) vaccine just yet—there are many important reasons why influenza vaccination should continue into spring.

Influenza can extend well beyond winter.

While flu is typically associated with cold winter months, and the introduction of seasonal flu vaccine in the fall fosters the impression that vaccination is only effective if done before the New Year—however, flu often continues to circulate and can cause significant illness during spring. In fact, in several recent years, flu didn't reach peak activity until the spring; during the 2001-02 and 2004-05 seasons, peak levels of flu illness in Los Angeles County, including hospital admissions and deaths, occurred in March.

Continued on page 4

Flu continues to circulate and can cause significant illness in the spring.

Addressing Disparities in Heart Disease among Women in Los Angeles County

Disparities in Heart Disease

Cardiovascular disease (CVD) is the leading cause of death among women in the United States. Although rates of CVD are decreasing, close to a half million women die of CVD each year, more than the number of women who die of the next five leading causes of death combined.[1] This translates into approximately one death every minute. Cardiovascular diseases include coronary heart disease, stroke, high blood pressure, heart failure and several other conditions including arrhythmias, atrial fibrillation, cardiomyopathy and peripheral arterial disease.

Of these, coronary heart disease (CHD) accounts for the majority of CVD deaths in women and disproportionately affects racial and ethnic minorities.[1]

In Los Angeles County, mortality rates from CHD and stroke among women are higher than national rates and they are disproportionately higher among African American women compared to other ethnic groups.

In addition, 52% of African American women, 38% of Latinas and 35% of white women in LA County were found to be at risk for heart disease, defined as having two or more of the following risk factors: cigarette smoking, physical inactivity, obesity, diabetes, hypertension, and high blood cholesterol.[2]

Continued on page 3

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Recommended Childhood and Adolescent Immunization Schedule, 2008

In January 2008, the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention, in collaboration with the American Academy of Pediatrics, and the American Academy of Family Physicians, released the updated recommended immunization schedules for persons 0 through 18 years of age — United States, 2008 (MMWR January 11, 2008 / 57[No. 1]; Q1-Q4). Changes in the schedule this year are as follows:

- The pneumococcal conjugate vaccine (PCV) footnote has been updated for incompletely vaccinated children aged 24-59 months, including those with underlying medical conditions. Healthy children 24-59 months who are incompletely vaccinated should receive 1 dose of PCV. Incompletely vaccinated children 24-59 months of age with an underlying medical condition should receive 2 doses of PCV at least 8 weeks apart if they previously received less than 3 doses, or 1 dose if they previously received 3 doses.

- The influenza vaccine footnotes have been updated. Live attenuated influenza vaccine (LAIV) can now be used for healthy children as young as 2 years old. Children under age 5 years with a history of recurrent wheezing should not receive LAIV. Children aged <9 years who are receiving any influenza vaccine for the first time or who were vaccinated for the first time last season, but only received 1 dose, should have 2 doses of vaccine, at least 4 weeks apart.

- The Recommended Immunization Schedule for Persons 7-18 years has been updated to show that meningococcal conjugate vaccine (MCV4) is now recommended as catch-up for all adolescents aged 13-18 years who were not vaccinated at 11-12 years of age. Also MCV4 is now preferred to meningococcal polysaccharide vaccine (MPSV4) for children 2-10 years of age who are at increased risk for meningococcal disease.

- The tetanus and diphtheria toxoids/tetanus and diphtheria toxoids and acellular pertussis vaccine (Td/Tdap) catch-up schedule for persons aged 7-18 years has been updated. Persons who received their first dose of a tetanus-containing vaccine before age 12 months should receive a total of 4 doses, with at least 4 weeks (not 8 weeks) between doses 2 and 3.

- The catch-up bars for hepatitis B and Haemophilus influenzae type b (Hib) conjugate vaccine have been deleted on the routine schedule for persons aged 0-6 years. The schedule refers providers to the catch-up immunization schedule (see MMWR referenced above) for patients who fall behind or start late with vaccinations. Regarding Hib vaccine, providers are reminded of the national shortage and are requested to use CDC's interim recommendations for use of Hib vaccine (published in MMWR Dispatch December 19, 2007/ 56, and also published in the January edition of TPH) until the shortage has been resolved.

The Recommended Childhood and Adolescent Immunization Schedule, 2008, is on pages 5 and 6 in this issue of TPH.

Addressing Disparities in Heart Disease...*from page 1*

Table: *Mortality rates among Women for Coronary Heart Disease (CHD) and Stroke by Race/Ethnicity, 2004**

Race/Ethnicity	National[1]		Los Angeles County[2]	
	CHD	Stroke	CHD	Stroke
African American	148.7	65.5	219.7	75.0
Asian/Pacific Islander	N/A	38.9	80.7	33.9
Hispanic	N/A	35.4	106.9	36.2
White	114.7	47.2	158.4	45.7

* Data is presented as age-adjusted rates per 100, 000 population. National data covers ages 20 and over. LA County data covers ages 18 and over. N/A – data not available

Awareness and Knowledge about Heart Disease

A national study conducted by the American Heart Association (AHA) in 2006 evaluated trends in women's awareness, knowledge, and perceptions related to CVD since 1997. The survey showed that although awareness of heart disease as the leading cause of death among women rose from 30% in 1997 to 57% in 2006, there still exists a substantial gap in awareness among racial/ethnic minorities. Only 31% of African American women and 29% of Hispanic women compared with 68% of white women reported CVD as the leading cause of death. The study also showed that Hispanic women were more likely than white women to report that there is nothing they can do to keep themselves from getting CVD.[3]

It is important to improve women's awareness of heart disease as a leading cause of death because perceptions of risk for heart disease do positively influence preventive behaviors and actions. Studies such as the one described above relay one key message: Public health initiatives targeting heart disease prevention strategies are needed, especially among high risk racial and ethnic minorities.

Healthy Heart Risk Assessment

The Los Angeles County Department of Public Health, Office of Women's Health offers a multi-lingual heart disease risk assessment for all women who call the toll-free hotline 1-800-793-8090. Women are asked a series of questions to identify their own risk of developing heart disease and are given materials they can use to help reduce their risk. The goal of the Healthy Heart Risk Assessment is to raise awareness, provide education, and assist women who are disproportionately affected with heart disease. Currently, the risk assessment is available in seven languages: English, Spanish, Cantonese, Mandarin, Vietnamese, Korean, and Armenian.

References

1. Rosamond W, Flegal K, Furie K, et al. Heart Disease and Stroke Statistics – 2008 Update. Circulation 2007. Available at: http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.107.187998v1. Accessed on January 22, 2008.

2. Los Angeles County Department of Public Health, Office of Women's Health, Health Indicators for Women in Los Angeles County Highlighting Disparities by Ethnicity and Insurance Status, May 2007.

3. Christian AH, Rosamond W, White AR, Mosca L. Nine-Year Trends and Racial and Ethnic Disparities in Women's Awareness of Heart Disease and Stroke: An American Heart Association National Study. J Women's Health. 2007;16:68-81.

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It's not too late to vaccinate!...*from page 1*

Those at "high risk" are always changing.

Several groups of individuals are at increased risk for severe complications from flu, and therefore especially benefit from the protection afforded from vaccination; these include:

- Infants and children 6 through 59 months of age, and those that care for infants and children. Since children younger than 6 months cannot be vaccinated against flu, it is especially important that their caretakers, family, and others that might spread infection be vaccinated.
- Pregnant women.
- People 50 years of age and older.
- People of any age with chronic medical conditions; especially those who are immunocompromised and those with impaired respiratory ability.
- People who live in nursing homes and other long-term care facilities.
- Household contacts and healthcare providers that may expose those "high risk" individuals as described above.

However, these "high risk" groups are not static. Instead, many people are newly identified as "high risk" throughout the year—and many may then be excluded from the flu vaccination campaigns that focus on those groups when held during the fall. For instance, a woman who has only recently become pregnant or an individual who was just diagnosed with a respiratory condition like asthma both run the risk of being skipped over from vaccination. It is important that healthcare providers are aware of the conditions that increase the need for flu vaccination and that they provide vaccination when these "high risk" individuals are newly diagnosed, even into spring, so that patients are protected.

Everyone can benefit from flu vaccination.

During the fall flu vaccine push, the focus is typically on those most vulnerable. But the best protection doesn't stop there. It is also important to vaccinate those people around them, those likely to infect these vulnerable individuals, like their friends and family—people who may have been overlooked for vaccination earlier in the season.

For information on the availability of influenza vaccination at LA County Public Health clinics, please call the LA County information line at 211or visit: http://lapublichealth.org/ip/index.htm.

Expanding your scope of vaccination helps everyone. The Centers for Disease Control and Prevention (CDC) and the Los Angeles County Department of Public Health recommend that anyone 6 months of age and older who wants to decrease their risk of getting flu, and that does not have a contraindication for receipt of the vaccine, be vaccinated against flu—not just for their own protection, but to protect vulnerable individuals that they may expose, and to reduce the overall burden of disease in our communities.

And flu vaccination may have even wider reaching benefits. Research is only now noting the role influenza infection may play in exacerbating other illnesses and fatal conditions. For instance, new evidence shows flu can trigger heart attacks and strokes; vaccination may promote public health in ways we are only now beginning to realize. In addition, while research is still ongoing, ordinary seasonal flu vaccination may provide some protection against bird flu (highly pathogenic avian influenza A H5N1).

The best protection against flu is vaccination. The Los Angeles County Department of Public Health urges you to continue to offer and encourage flu vaccination to your patients.

For more information on influenza vaccination visit: http://www.cdc.gov/flu/protect/keyfacts.htm.

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Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2008

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		*see footnote 1*	HepB						
Rotavirus[2]			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	*see footnote 3*	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR					MMR
Varicella[8]						Varicella					Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MCV4	

Range of recommended ages

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 0 through 6 years. Additional information is available at **www.cdc.gov/vaccines/recs/schedules**. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. **Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high risk conditions: http://www.cdc.gov/vaccines/pubs/ACIP-list.htm**. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete VAERS form is available at **www.vaers.hhs.gov** or by telephone, **800-822-7967**.

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

At birth:

- Administer monovalent HepB to all newborns prior to hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can be delayed, **in rare cases,** with a provider's order and a **copy of the mother's** negative HBsAg laboratory report in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered no earlier than age 24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of at least 3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*

- Administer the first dose at age 6–12 weeks.
- Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer any dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHIBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children age 12 months or older.

5. Pneumococcal vaccine. *(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])*

- Administer one dose of PCV to all healthy children aged 24–59 months having any incomplete schedule.
- Administer PPV to children aged 2 years and older with underlying medical conditions.

6. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])*

- Administer annually to children aged 6–59 months and to all close contacts of children aged 0–59 months.
- Administer annually to children 5 years of age and older with certain risk factors, to other persons (including household members) in close contact with persons in groups at higher risk, and to any child whose parents request vaccination.
- For healthy nonpregnant persons (those who do not have underlying medical conditions that predispose them to influenza complications) ages 2–49 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if age 6-35 mos or 0.5 mL if age 3 years or older.
- Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season, but only received one dose.

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided 4 weeks or more have elapsed since the first dose.

8. Varicella vaccine. *(Minimum age: 12 months)*

- Administer second dose at age 4–6 years; may be administered 3 months or more after first dose.
- Don't repeat second dose if administered 28 days or more after first dose.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*

- HepA is recommended for all children aged 1 yr (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.

10. Meningococcal vaccine. *(Minimum age: 2 years for meningococcal conjugate vaccine (MCV4) and for meningococcal polysaccharide vaccine (MPSV4))*

- MCV4 is recommended for children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. Use of MPSV4 is also acceptable.
- Persons who received MPSV4 3 or more years prior and remain at increased risk for meningococcal disease should be vaccinated with MCV4.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2008

For those who fall behind or start late, see the green bars and the catch-up schedule

Vaccine ▼ Age ▶	7-10 years	11-12 years	13-18 years
Diphtheria, Tetanus, Pertussis[1]	*see footnote 1*	Tdap	Tdap
Human Papillomavirus[2]	*see footnote 2*	HPV (3 doses)	HPV Series
Meningococcal[3]	MCV4	MCV4	MCV4
Pneumococcal[4]	PPV		
Influenza[5]	Influenza (Yearly)		
Hepatitis A[6]	HepA Series		
Hepatitis B[7]	HepB Series		
Inactivated Poliovirus[8]	IPV Series		
Measles, Mumps, Rubella[9]	MMR Series		
Varicella[10]	Varicella Series		

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 7–18 years. Additional information is available at **www.cdc.gov/vaccines/recs/schedules**. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. **Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high risk conditions: http://www.cdc.gov/vaccines/pubs/ACIP-list.htm.** Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete VAERS form is available at **www.vaers.hhs.gov** or by telephone, **800-822-7967**.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). *(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)*
- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids (Td) booster dose.
- 13–18 year olds who missed the 11–12 year Tdap or received Td only, are encouraged to receive one dose of Tdap 5 years after the last Td/DTaP dose.

2. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine.
- Administer MCV4 at age 11–12 years and at age 13–18 years if not previously vaccinated. MPSV4 is an acceptable alternative.
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories.
- MCV4 is recommended for children aged 2-10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups.
- Persons who received MPSV4 3 or more years prior and remain at increased risk for meningococcal disease should be vaccinated with MCV4.

4. Pneumococcal polysaccharide vaccine (PPV).
- Administer PPV to certain high-risk groups.

5. Influenza vaccine.
- Administer annually to all close contacts of children aged 0–59 months.
- Administer annually to persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at higher risk.
- Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season, but only received one dose.
- For healthy nonpregnant persons (those who do not have underlying medical conditions that predispose them to influenza complications) ages 2–49 years, either LAIV or TIV may be used.

6. Hepatitis A vaccine (HepA).
- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.

7. Hepatitis B vaccine (HepB).
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV).
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).
- If not previously vaccinated, administer 2 doses of MMR during any visit, with 4 or more weeks between the doses.

10. Varicella vaccine.
- Administer 2 doses of varicella vaccine to persons younger than 13 years of age at least 3 months apart. Do not repeat the second dose, if administered 28 or more days following the first dose.
- Administer 2 doses of varicella vaccine to persons aged 13 years or older at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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Human Rabies

Human rabies is extremely rare in the United States. The most likely potential vector of rabies in Los Angeles County is bats. In 2007, 25 rabies-infected bats were identified by the Los Angeles County Public Health Laboratory. In recent years, bats have accounted for the majority of human rabies cases in the United States and California. Rabies virus transmission can occur from a very minor or even unrecognized bite—bat bites may not leave any evident mark and a limited recall of exposure can inhibit proper diagnosis of bat-based rabies exposure. As such, healthcare providers should discourage all human contact with bats. Because domestic dogs and cats may come upon ill bats, it is critical that these pets be immunized against rabies and that documentation is retained in the event that the pets are involved in a biting incident.

Rabies Biologics- United States

Type Human Rabies Vaccine	Product Name	Manufacturer
Human diploid cell vaccine (HDCV)-Intramuscular (intradermal for pre-exposure ONLY)	Imovax® Rabies	Sanofi Pasteur, Inc. (800) 822-2463 www.vaccineplace.com/products/
Purified Chick Embryo Cell Culture (PCEC)- Intramuscular (not approved for intradermal)	RabAvert® Rabipar®	Novartis Vaccines and Diagnostics (800) 244-7668 www.rabavert.com
(Both types of vaccine are considered equally efficacious and safe when used as indicated.)		
Human Rabies Immune Globulin (HRIG)		
	HyperRab™ S/D	Talecris Biotherapeutics (800) 243-4153 www.talecris-pi.info
	Imogram® Rabies-HT	Sanofi Pasteur, Inc. (800) 822-2463 www.vaccineplace.com/products/
(Both types of vaccine are considered equally efficacious and safe when used as indicated.)		

Rabies is enzootic in many countries (e.g., El Salvador, Guatemala, Mexico, Philippines, India) whose citizens frequently visit or immigrate to the Los Angeles area. The first Los Angeles County human rabies case in 30 years occurred in 2004; he likely contracted rabies in El Salvador. Similarly, potentially infected animals may also be imported both legally and illegally. In 2004, there were two incidents involving the importation of pets with possible or confirmed rabies infection.

Thus, rabies continues to be a potential risk to humans and animals alike in Los Angeles County. Any suspected human or animal case should be reported immediately to Public Health. Prompt reporting of animal bites is also mandated by law and critical to the control of vicious animals. Veterinary Public Health works with the many animal control agencies countywide to impound animals that have bitten people and observe them for illness. Acute Communicable Disease Control assists with decisions to administer rabies post-exposure prophylaxis (PEP) as well as arranging PEP at a public health clinic for exposed persons who do not have adequate medical insurance. Please contact ACDC at (213)-240-7941 to discuss such unusual exposure situations.

National recommendations for treatment of animal bites at risk of rabies may be found at the CDC's website—Rabies Exposure—What You Need to Know http://www.cdc.gov/rabies/exposure/

Detailed information about rabies immune globulin and rabies vaccine are found at Human Rabies Prevention—United States, 1999 Recommendations of the Advisory Committee on Immunization Practices (ACIP) http://www.cdc.gov/mmwr/PDF/rr/rr4801.pdf

However, the biologics supply information in that report is out of date; current contact information to purchase these products is reproduced in the table to the left.

Recommendations for the control and prevention of rabies in animals can be found in the Compendium of Animal Rabies Prevention and Control, 2007 http://www.cdc.gov/MMWR/PDF/rr/rr5603.pdf, or by calling the LAC Veterinary Public Health at (562)-401-7088.

Reporting Animal Bites

Animal bites can cause serious injury, bacterial and viral infections, physical and psychological trauma, and even death. As such, it is critical to the public's health to obtain accurate reports of all animal bites that occur in our county. Anyone can report animal bites by telephone (877)-747-2243 to the Rabies Hotline; information can also be submitted on-line at www.lapublichealth.org/vet/biteintro.htm.

To obtain medical consultation on rabies treatment decisions or to refer an uninsured patient for treatment consideration, please call: Acute Communicable Disease Control, (213) 240-7941.

David E. Dassey, MD, MPH
Acute Communicable Disease Control Program

Physician Registry

Become a Member of the Health Alert Network

The Los Angeles County Department of Public Health urges all local physicians to register with the Health Alert Network (HAN). By joining, you will receive periodic email updates alerting you to the latest significant local public health information including emerging threats such as pandemic influenza. Membership is free. All physician information remains private and will not be distributed or used for commercial purposes.

Registration can be completed online at www.lahealthalert.org or by calling (323) 890-8377.

Be aware of public health emergencies! Enroll now!

This Issue...

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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Selected Reportable Diseases (Cases)[1] — AUG/SEPT 2007

Disease	THIS PERIOD AUG/SEPT 2007	SAME PERIOD LAST YEAR AUG/SEPT 2006	YEAR TO DATE –AUG/SEPT		YEAR END TOTALS		
			2007	2006	2006	2005	2004
AIDS[1]	275	233	1,126	974	1,390	1,521	2,211
Amebiasis	22	15	91	63	94	114	114
Campylobacteriosis	149	178	685	612	774	725	884
Chlamydial Infections	6,814	6,853	28,248	26,928	39882	38,862	38,464
Encephalitis	14	7	42	40	45	57	133
Gonorrhea	1,623	1,814	6,645	7,134	10,430	10,494	9,696
Hepatitis Type A	14	37	64	335	365	480	321
Hepatitis Type B, acute	12	7	37	49	62	57	72
Hepatitis Type C, acute	0	1	1	4	4	3	5
Measles	0	0	0	1	1	0	1
Meningitis, viral/aseptic	73	82	256	278	369	515	807
Meningococcal Infect.	4	3	21	35	46	37	28
Mumps	0	2	4	6	10	10	5
NGU	78	91	295	558	758	1,101	1,470
Pertussis	10	10	47	113	149	438	156
Rubella	0	0	0	0	0	1	0
Salmonellosis	275	274	856	916	1,216	1,085	1,205
Shigellosis	146	162	363	398	521	710	625
Syphilis (prim. and sec.)	116	126	573	524	789	644	470
Syphilis early latent	140	117	531	464	758	570	395
Tuberculosis	163	129	460	474	885	906	930
Typhoid fever, Acute	1	6	12	15	17	12	13

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