



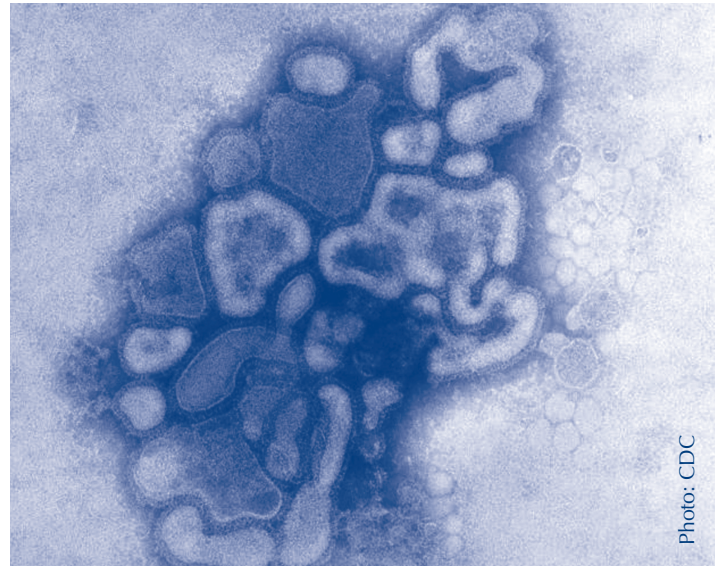
THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County
Volume 9 • Number 5
May 2009

Influenza A (H1N1) Information for Local Clinicians

The influenza A (H1N1) virus, “swine flu,” is a new variant of the influenza virus. It was first confirmed in patients in Mexico, and its current mutation contains a combination of genetic material from avian and pig viruses as well as human influenza virus.

Continued on page 2



Working to Improve Women's Health

Editor's Note: This edition of The Public's Health spotlights women's health issues and coincides with National Women's Health Week, which begins on Mother's Day every year. One of the goals of the Office of Women's Health, a program of the Los Angeles County Department of Public Health, is to help women learn how to achieve longer, healthier, and safer lives. We celebrate this special week while working toward this goal throughout the year.

Los Angeles is a county of stark economic, social, and health disparities. It is home to many diverse cultures and ethnicities, bringing a unique richness to the region. At the same time, many ethnic and racial groups are disproportionately poor, facing language and cultural barriers to health care and experiencing environmental degradation and community violence that impact their overall physical and mental health. Low-income women are the most vulnerable in this population. Health disparities in heart disease, breast cancer, cervical cancer, and overall health status impact their ability to lead productive and successful lives.

The Office of Women's Health (OWH) is a catalyst for change, serving as a focal point for strategic planning

and advocating for comprehensive and effective approaches to improving women's health in Los Angeles. Utilizing a gender lens, the OWH facilitates collaborations to address women's health needs between the Departments of Public Health (DPH) and Health Services (DHS), as well as with the community.

Continued on page 5



THE PUBLIC'S HEALTH



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

The Public's Health can be automatically e-mailed to you (as a PDF document) each month. To subscribe, please visit <http://lapublichealth.org/phcommon/public/listserv/index.cfm?ou=ph> and enter your e-mail address. Select "Department Newsletters" and then "**The Public's Health**." You are welcome to make copies of this newsletter. To view this publication online – and obtain a variety of public health information and data – visit our website: publichealth.lacounty.gov



LOS ANGELES COUNTY
BOARD OF SUPERVISORS

Gloria Molina, *First District*
Mark Ridley-Thomas, *Second District*
Zev Yaroslavsky, *Third District*
Don Knabe, *Fourth District*
Michael D. Antonovich, *Fifth District*

DEPARTMENT OF PUBLIC HEALTH

Jonathan E. Fielding, MD, MPH
Director and Health Officer
Jonathan Freedman, MS
Chief Deputy, Public Health
Jeff Gunzenhauser, MD, MPH
Medical Director of Public Health
Robert Kim-Farley, MD, MPH
Director, Communicable Disease Control and Prevention
Laurene Mascola, MD, MPH
Chief, Acute Communicable Disease Control

EDITORIAL BOARD

Melanie Barr, RN, MSN
Trista Bingham, MPH, PhD
James DeCarli, MPH, MPA, CHES
Kevin Donovan, MPH
Marsha Epstein, MD, MPH
Kim Harrison Eowan, MPH, CHES
Julia Heinzerling, MPH
David Meyer, MPH
Sadina Reynaldo, PhD
Ben Techagaiciyawanis, MPH, CHES

Sheree Poitier, MD, *Editor in Chief*
Summer Nagano, *Managing Editor*
Alan Albert, *Design & Production*
Mary Louise Garcia, *Administration*

Influenza A (H1N1)...from page 1

As of press time, there were 286 laboratory-confirmed cases of A (H1N1) in the United States—30 in California and 3 in Los Angeles County. Based on the human-to-human spread of the virus in at least two countries in one region of the World Health Organization, the agency raised its pandemic alert level to Phase 5 (out of 6).

The Los Angeles County Department of Public Health is working with the California Department of Public Health, the Centers for Disease Control and Prevention, and other county health departments to increase surveillance activities and response capabilities.

This includes the following activities:

- Alerting local physicians to report suspected cases of A (H1N1)
- Alerting hospital laboratories to send isolates of influenza type A to the LA County Public Health Laboratory for further confirmation
- Requesting schools to report increased absenteeism or clusters of respiratory illness
- Undertaking epidemiological investigation of any respiratory disease outbreaks and possible cases to determine whether they are caused by A (H1N1).

Guidelines for **case reporting** and **specimen submittal** may change as this outbreak evolves. Los Angeles County physicians and public health professionals can access the most recent guidelines and forms, as well as other relevant information, through our website at www.publichealth.lacounty.gov > Information for Local Clinicians.

Resources

Centers for Disease Control and Prevention
<http://www.cdc.gov/swineflu/guidance/>

World Health Organization
<http://www.who.int/csr/disease/swineflu/en/index.html>

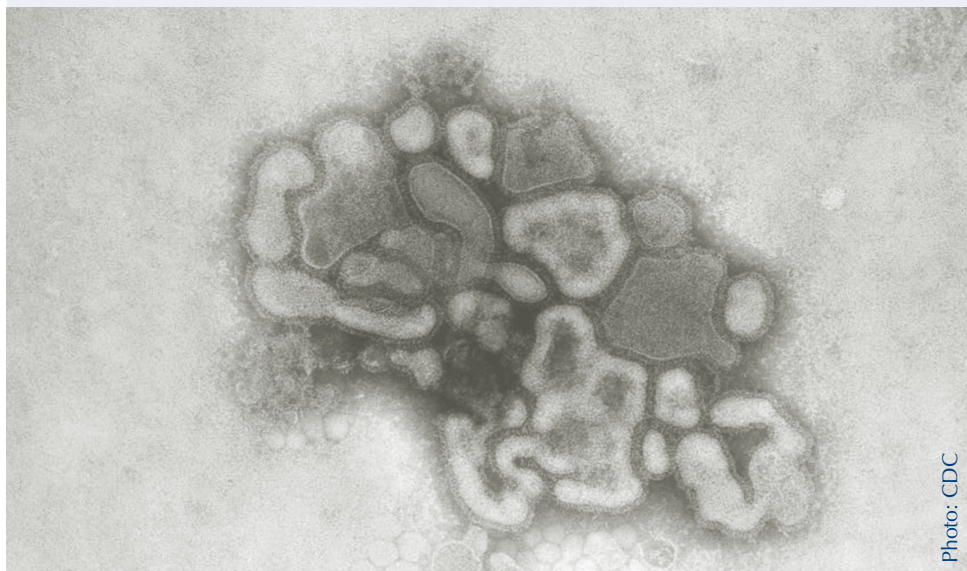


Photo: CDC

Role of Vitamin D in the Health of Women

It has been estimated that one billion people in the world have vitamin D deficiency or insufficiency. Deficiency is particularly widespread among women. Pregnant women, the elderly, obese individuals, non-Hispanic blacks, and Mexican Americans are most at risk.¹ Specifically, studies find African-American women to be 10 times more likely to be vitamin D deficient compared to white women.²

There are limited nutritional sources of vitamin D, so sun exposure becomes one of the most important sources of the vitamin. Factors such as geographical location, darker skin color, and shielding of skin from the sun are important risk factors for vitamin D deficiency.

The importance of vitamin D in bone health along the lifecycle has been well-established. Deficiency can lead to growth retardation in utero, rickets in childhood, osteomalacia in adulthood, and osteoporosis with fractures in the elderly. However, more recently it has been discovered that vitamin D plays an important role in the health and function of many additional tissues and cells of the body. In fact, vitamin D has now been linked to several chronic conditions, such as common cancers, autoimmune diseases, musculoskeletal conditions and cardiovascular disease.³ Here we discuss the role of vitamin D in some of these conditions.

Cancer

Similar to bone tissue, cells in the prostate, breast, and colon tissues have been found to respond to the active form of vitamin D. This, along with ecological correlation studies that document a higher incidence of cancer in people living at higher latitudes (less sun exposure), were the first clues that vitamin D plays an important role in the development of cancer of the breast, prostate, and colon. Additional epidemiological studies have provided evidence that the link is real. A 30%-50% increased risk of colon, prostate, and breast cancers were found among people with low levels of active vitamin D.³

Cardiovascular Disease

Hypertension, congestive heart failure, stroke, and cardiovascular disease have been linked to vitamin D deficiency. In a study from the Framingham Heart Study Group, it was found that low levels of active vitamin D were associated with increased cardiovascular risk, above and beyond established cardiovascular risk factors.⁴ In fact, individuals with hypertension and low vitamin D levels had two times the risk of a first cardiovascular event than individuals with hypertension but higher levels of vitamin D.

Muscle Weakness and Falls

Basic muscle functions such as performance speed and muscle strength have been positively linked to active vitamin D levels. This translates to an important role of vitamin D in fall prevention. A meta-analysis of five studies found that the risk of falls was reduced by 22% among those who increased their vitamin D intake. Another study done among nursing home residents found a 72% reduction in falls for individuals taking vitamin D plus calcium compared to the placebo group.⁵

Where Do We Go Now?

Although several studies have documented the link between vitamin D deficiency and chronic conditions, and evidence suggests that vitamin D intake above current recommendations may be associated with better health outcomes, additional studies are needed to demonstrate the effectiveness of vitamin D supplementation in reducing mortality and disease rates from these conditions.

Further, as evidence of the causal link between vitamin D and these conditions strengthens, it is necessary to define optimal levels of active vitamin D for disease prevention. Experts in the field have begun to push for a review of the Dietary Reference Intakes for vitamin D, with a possible revision in the adequate vitamin D intake for adults from 400 IU to at least 1000 IU.⁶

Women are particularly at risk for vitamin D deficiency. Therefore, news of the role of vitamin D in preventing many chronic illnesses provides a significant opportunity for public health promotion through education of women on the importance of adequate vitamin D supplementation and/or sun exposure.

Rita Singhal, MD, MPH

Medical Director

Office of Women's Health

Los Angeles County Department of Public Health



References

1. Yetley, E.A., Assessing the vitamin D status of the US population. *Am J Clin Nutr*, 2008. 88(2): p. 558S-564.
2. Nesby-O'Dell, S., et al., Hypovitaminosis D prevalence and determinants among African American and white women of reproductive age: third National Health and Nutrition Examination Survey, 1988-1994. *Am J Clin Nutr*, 2002. 76(1): p. 187-192.
3. Holick, M.F., Vitamin D Deficiency. *N Engl J Med*, 2007. 357(3): p. 266-281.
4. Wang, T.J., et al., Vitamin D Deficiency and Risk of Cardiovascular Disease. *Circulation*, 2008. 117(4): p. 503-511.
5. Bischoff-Ferrari, H.A., et al., Estimation of optimal serum concentrations of 25-hydroxyvitamin D for multiple health outcomes. *Am J Clin Nutr*, 2006. 84(1): p. 18-28.
6. Yetley, E.A., et al., Dietary Reference Intakes for vitamin D: justification for a review of the 1997 values. *Am J Clin Nutr*, 2009. 89(3): p. 719-727.

The Socioeconomics of Breast Cancer

Women living in the United States have the highest incidence of breast cancer in the world, 101.1 per 100,000 women in 2004.¹ Two unexpected risk factors contributing to this high rate are living in a Western, industrialized country, and being of higher socioeconomic class.

Canada, Europe, and Australia are also among the countries with the highest breast cancer incidence. Most of the countries in the lowest-risk group, China, Zimbabwe, India, and Brazil are developing countries with large rural populations. Disparities in breast cancer rates in developing nations may be due to underreporting or increased accidental deaths and lower percentage of women over 65 years. Recent immigrants living in the U.S. usually mimic their country of origin's lower breast cancer risk, but over successive generations, the daughters and granddaughters of immigrants take on a higher risk, more similar to that in this country.²

In Los Angeles County, the incidence rates of breast cancer between 1998 and 2002 clearly show the risk for invasive breast cancer is directly related to socioeconomic status (SES). Women living at the highest quintile of SES have the highest rate of breast cancer. The rate decreases as SES decreases. This relationship remains true when looking at rates by SES within race/ethnic groups (See Table 1).³

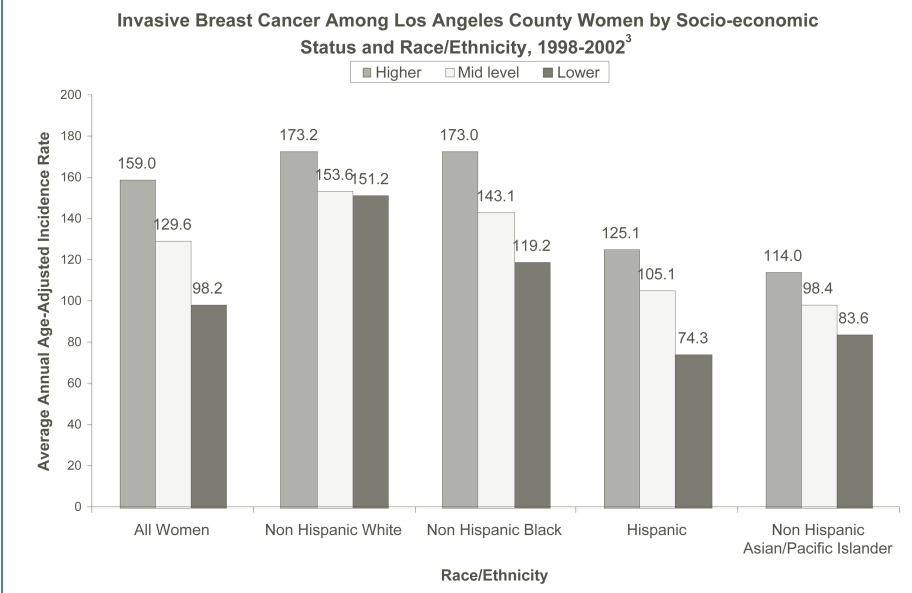
The reasons for these differences may include factors such as diet, alcohol intake, childbirth, and breastfeeding patterns. As a culture is westernized, the women become more sedentary, gain weight, tend to have fewer children, and may take hormone replacement therapy—all of which are risk factors for breast cancer. The basis of each of these risk factors is believed to be an increase in circulating estrogen levels.²

Diet

Differences in cultural dietary patterns may play a significant role in moderating estrogen levels and breast cancer risk. In a study of dietary patterns in Japanese women, increased consumption of milk and green leafy vegetables correlated with a reduction in breast cancer risk.⁴ Women in Western industrialized nations are more likely to consume meats and sources of prefabricated, saturated fat and fewer fresh vegetables.

Obesity is a known risk factor for breast cancer, with the U.S. leading the world in an obesity epidemic. Fat cells are believed to convert adrenal androgens to estrogens, thereby increasing a woman's lifetime estrogen exposure. Higher body mass index and obesity have been found to correlate with earlier age of menarche and later age of menopause. African-American women have higher rates of obesity and are experiencing earlier sexual maturation and menarche and a higher incidence of breast cancer under age 40 than their white counterparts.⁵

TABLE 1.



Obesity is a known risk factor for breast cancer, with the U.S. leading the world in an obesity epidemic. Fat cells are believed to convert adrenal androgens to estrogens, thereby increasing a woman's lifetime estrogen exposure.

Environmental Factors

Several studies have been done recently exploring the correlation and role of environmental factors in the cause and possible prevention of breast cancer. It has been suggested that disparities of breast cancer incidence may be linked to exogenous estrogens in the environment. Topically applied estrogen or placenta-containing products have been shown to result in premature sexual development in infants or toddlers. Man-made estrogenic compounds, such as organochlorine compounds in pesticide residues and hydroxylated PCBs, and some hair products containing placenta may be contributing to women's lifetime exposure to estrogen.⁵ Environmental exposure to such compounds are higher in industrialized countries, perhaps contributing to higher breast cancer incidence.

Conclusion

The greater incidence of breast cancer in women from affluent backgrounds is, however, outweighed by their lower mortality. Women from lower socioeconomic backgrounds often present with more advanced, more deadly disease due to lower access to screening services and possibly less awareness of the disease. Even

Continued on page 5

The Socioeconomics of Breast Cancer...from page 4

with the highest breast cancer incidence in the world, the breast cancer mortality rate in the U.S. is close to the world average.

The best advice for Americans to offset the effects of industrialization is to maintain a healthy lifestyle by being physically active, eating healthy by decreasing intake of fat and increasing intake of fruits and vegetables, and avoiding cigarette smoke. All women are advised to get annual mammograms after the age of 40. Women with a family history of breast cancer should begin breast cancer screening five years prior to the family member's age at diagnosis.

Breast cancer continues to be an important cause of premature mortality among women in LA County and the U.S. It is vital that health care professionals promote healthy lifestyles among women and address the social and physical environmental factors that are contributing to the rise in breast cancer incidence among acculturated women.

Elizabeth Stillwell, RN

Office of Women's Health

Los Angeles County Department of Public Health

Rita Singhal MD, MPH

Medical Director

Office of Women's Health

Los Angeles County Department of Public Health

References

1. J. Ferlay, F. Bray, P. Pisani and D.M. Parkin GLOBOCAN 2002. "Cancer Incidence, Mortality and Prevalence Worldwide". IARC CancerBase No. 5, version 2.0. IARC Press, Lyon, 2004, 27, Jan. 2009 <<http://www.imaginis.com/breasthealth/statistics.asp>>
2. F. Bray, P. McCarron and D.M. Parkin "The changing global patterns of female breast cancer incidence and mortality," *Journal of Hematology and Oncology*, Breast Cancer Research, 26, Aug. 2004, 27, Jan. 2009 <<http://breast-cancer-research.com/content/6/6/229>>
3. California Cancer Registry (www.ccrca.org), California Department of Public Health, Cancer Surveillance and Research Branch. "SEER*Stat Database: Incidence - California, October 2006, (1998-2002), released November, 2006. 2000 Census Bureau population counts by SES at Census tract level.
4. Hirose K, Takezaki T, Hamajima N, Miura S, Tajima K. "Dietary factors protective against breast cancer in Japanese premenopausal and postmenopausal women" *International Journal of Cancer*, 2003, 27, Jan 2009 <<http://www3.interscience.wiley.com/journal/104547180/abstract> >
5. Maryann Donovan, Chandra M. Tiwary, Deborah Axelrod, Annie J. Sasco, Lovell, Jones, Richard Hajek, Erin Sauber, Jean Kuo and Devra L. Davis, "Personal care products that contain estrogens or xenoestrogens may, increase breast cancer risk", University of Pittsburgh Cancer Institute, Center for Environmental Oncology, 26, Nov. 2006, 27, Jan, 2009 <<http://www.environmentaloncology.org/files/file/Publications/Scientific%20Pubs/MedicalHypothesesWeb.pdf>>

Working to Improve Women's Health...from page 1

The OWH works collaboratively to develop policy and advocacy strategies, foster community collaborations, promote multilingual provider and community health education, implement a seven-language hotline, and provide direct health screenings through its mobile clinic.

The Office of Women's Health initiated a community-wide collaboration to bring together community leaders, educators, researchers, advocates, and medical professionals to develop and implement concrete strategies to improve women's health. Beginning with the 2007 Women's Health Summit, *Building Multi-Cultural Women's Health: Setting an Agenda for Los Angeles*, the Office of Women's Health and its community, DPH, and DHS partners have developed more than 40 recommendations for reducing health disparities for women whose health needs are most often marginalized. These women include low-income women; women of color; immigrant women; lesbian, bisexual, and transgender women; and women with disabilities. The OWH has convened a Summit Leadership Task Force and working groups to implement the recommendations.

The health and well-being of women is essential to the well-being of their families and their communities. Creating awareness of the impact of health inequities on women, their families and

their communities, and then devising strategies to begin closing those gaps for low-income women and low-income women of color has been a major focus of the Office of Women's Health since its inception.

For further information regarding the Office of Women's Health and/or the Summit Implementation Task Force, please call (626) 569-3850 or visit www.lapublichealth.org/owh.

Susan Berke Fogel, JD

Office of Women's Health

Los Angeles County Department of Public Health

Ellen Eidem, MS

Director

Office of Women's Health

Los Angeles County Department of Public Health

Preteen Vaccine Spotlight: The Facts about HPV Immunizations



This year in California, about 1,400 women will be diagnosed with cervical cancer and 400 will die from it. National Women's Health Week provides an opportunity to encourage females to take an important action that can prevent 7 out of 10 cases of cervical cancer: get a human papillomavirus (HPV) vaccination.

HPV vaccine is recommended for girls who are 11 to 12 years of age and for young women through age 26 who have not been previously vaccinated. This vaccine protects preteens, adolescents, and young women for years to come against cervical cancer and genital warts.

Effectiveness of the HPV Vaccine

Up to 80% of sexually active women will be infected with genital HPV, the most common sexually transmitted infection in the U.S., by the time they turn 50 years of age. HPV is often harmless but it can cause cervical and other cancers, as well as genital warts. The good news is that the HPV vaccine can prevent up to 70% of cervical cancer cases and 90% of genital warts.

Immunization Timing

The preteen health visit is an ideal time to vaccinate against HPV. The Centers for Disease Control and Prevention (CDC) and its Advisory Committee on Immunization Practices, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians, and the American Cancer Society recommend three doses of vaccine to protect against HPV infection. Vaccination is recommended for girls who are 11 to 12 years of age to help ensure they are protected prior to becoming sexually active and because the vaccine works best at this age. However, it's not too late to vaccinate females 13 to 26 years of age. While it's best to get the vaccine before having sex, it can also benefit those who are sexually active. HPV vaccine is not recommended for males because it is not yet confirmed that it is effective for them.

Safety of the HPV Vaccine

Some have expressed concern about vaccine side effects. Those recommending and receiving the HPV vaccine can be confident that it is safe. The HPV vaccine was tested extensively in the U.S. and globally before it was licensed. As with all vaccines, its safety continues to be monitored post-licensure.

Most side effects are minor and temporary, such as pain at the injection site and fever. The CDC and Federal Drug Administration investigated claims that the vaccine caused side effects, such as muscle

weakness and blood clots, and found no evidence that these were caused by the vaccine. Finally, the vaccine does not cause HPV infection.

Other Preventive Strategies

In addition to getting vaccinated, girls and women can take additional steps to prevent and detect cervical cancer. The surest way to prevent HPV is to avoid sexual contact, but other recommendations include limiting the number of sexual partners, using a condom, and getting regular Pap tests. Smoking increases cervical cancer risk. Finally, obese women and those with diets low in fruits and vegetables may be at increased risk for cervical cancer.

Free or Low-Cost Immunizations

LA County residents are encouraged to contact their regular health care provider for recommended vaccinations. Individuals through 18 years of age who qualify can receive no-cost immunizations through a clinic or medical office participating in the Vaccines for Children (VFC) program. Most health insurers also cover HPV vaccine for those meeting the criteria. Those with no vaccine insurance coverage may be eligible for reduced-cost or no-cost vaccinations. Families without a regular health care provider can dial 2-1-1 or visit www.publichealth.lacounty.gov/ip for referrals to providers offering immunizations at no charge or at a reduced charge.

To learn more and download educational materials, visit www.publichealth.lacounty.gov/ip or www.cdc.gov/vaccines/spec-grps/preteens-adol.htm or www.HpvVaccineCa.org.

Julia Heinzerling, MPH

Immunization Program

Los Angeles County Department of Public Health

Important Preteen Vaccines

A growing regimen of safe and effective preteen vaccines is recommended to extend the protection of infant and childhood immunizations and prevent diseases, such as whooping cough, during adolescence and beyond. The CDC, the Society for Adolescent Medicine, and the AAP recommend that 11-12 year-olds receive

- The meningococcal vaccine (MCV4) to protect against certain serious types of bacterial meningitis and related infections.
- A Tdap booster to prevent tetanus, diphtheria, and pertussis.
- A second chickenpox vaccine, unless they have received 2 doses as a child or have had chickenpox.
- An annual flu vaccine.
- HPV vaccine series to protect girls against cervical cancer.

Preteen visits at 11-12 years of age offer an opportunity to reconnect adolescents with a regular health care provider, provide recommended immunizations, and promote other healthy practices such as healthy eating.

West Nile Virus Update for 2009

With West Nile virus (WNV) now enzootic among birds and mosquitoes in Los Angeles County, cases can be expected to occur as summer approaches. The number of cases that will occur in the 2009 season, however, will be difficult to predict, as it has varied markedly each year since WNV arrived in LA County in 2003 with a single case.

In 2008, the County experienced nearly a four-fold increase in infections from the previous year, with 170 reported cases (including asymptomatic blood donors) and six deaths. In contrast, cases of WNV infection declined to a low of 16 cases in 2006 after a peak of 309 cases in 2004.

While WNV human cases typically do not occur in LA County until June, now is the time to prepare. Animal and vector surveillance efforts have already detected positive sentinel chickens this year in South Los Angeles and the South Bay. Indications of WNV in dead birds and mosquito pools have also been found in other areas of the state, including the nearby counties of Orange and San Diego. Providers should be aware of proper diagnostic procedures, understand the importance of prompt reporting, and educate their patients on how to protect themselves against infection.

WNV Serological Screening Tests

WNV screening tests are recommended only for patients with signs or symptoms compatible with West Nile fever, aseptic meningitis, encephalitis, or acute flaccid paralysis (see Diagnostic Testing Guidelines for WNV). Specimens positive for acute WNV infection from commercial labs generally do not require confirmation by the LA County Public Health Laboratory. Excellent correlation has been found between WNV positive tests from the majority of commercial labs and subsequent confirmation at reference public health laboratories. The County Public Health Lab will continue to be available for initial screening diagnostics and confirmation of ambiguous results.

Reporting of Human WNV Cases

The LA County Department of Public Health conducts surveillance on human WNV infections by tracking occurrences of West Nile fever, neuroinvasive disease, and asymptomatic donors. WNV infection has been reportable in California since July 2004.

Diagnostic Testing Guidelines for West Nile Virus Los Angeles County Public Health Laboratory

1. WNV testing is available at the Public Health Laboratory for individuals with the following signs or symptoms:
 - a. Encephalitis
 - b. Aseptic meningitis (individuals 18 years of age or older)
 - c. Acute flaccid paralysis or atypical Guillain-Barré syndrome
 - d. Febrile illness compatible with West Nile fever syndrome
 - Case must be evaluated by a health care provider.
 - Symptoms associated with West Nile fever syndrome can be variable and often include headache, fever (>38°C), and muscle weakness, rash, swollen lymph nodes, eye pain, nausea, or vomiting.

Instructions for Sending Specimens

Required

- **Acute Serum:** 5-10 ml of blood obtained at least 7 days after symptom onset. (Use a red top tube, spun, separated, and refrigerated).
- **Convalescent Serum:** Only if West Nile infection is highly suspected and acute serum is negative, ≥5 ml of blood collected 3-5 days after the acute serum.
- **Cerebral Spinal Fluid:** 1-2 cc stored frozen.

Each specimen should be labeled with date of collection, specimen type, and patient name.

- Specimens should be sent on cold pack using an overnight courier.
- The Los Angeles County Public Health Laboratory requisition form is recommended. The form is available on at <http://publichealth.lacounty.gov/lab/labsamps.htm>.

Send specimens and lab slips to:

LA County Public Health Laboratory, Serology Section
12750 Erickson Ave.
Downey, CA 90242
Phone: (562) 658-1300

Physicians and laboratories are required to report all positive laboratory findings of WNV, whether they are confirmed or not, to the Department of Public Health within one working day.

Timely identification of infections assists in prevention of subsequent cases by enabling local mosquito abatement districts to focus mosquito control and prevention efforts on communities at higher risk. Case information also guides the Department in directing health education efforts towards a target audience via the media and local organizations.

A standard Confidential Morbidity Report can be used to report suspected cases; it may be faxed to the Department of Public Health's Morbidity Unit at (888) 397-3778, or be reported by phone at (888) 397-3993 during normal business hours. We remind clinicians and infection control professionals that under California law, cases of acute encephalitis and meningitis of all etiologies, including viral, bacterial, fungal, and parasitic, are also reportable to the Department of Public Health within one working day.

For more information about West Nile virus, visit the following websites:

<http://publichealth.lacounty.gov/acd/VectorWestNile.htm>
<http://www.westnile.ca.gov/>
<http://www.cdc.gov/ncidod/dvbid/westnile/index.htm>

Rachel Civen, MD, MPH

Van Ngo, MPH

Acute Communicable Disease Control Program

Los Angeles County Department of Public Health

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...

<i>Influenza A (H1N1)</i>	1
<i>Working to Improve Women's Health</i>	1
<i>Role of Vitamin D in the Health of Women</i>	3
<i>The Socioeconomics of Breast Cancer</i>	4
<i>The Facts about HPV Immunizations</i>	6
<i>West Nile Virus Update for 2009</i>	7

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County



COUNTY OF LOS ANGELES

Public Health

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

Selected Reportable Diseases (Cases)¹ — December 2008

Disease	THIS PERIOD DEC 2008	SAME PERIOD LAST YEAR DEC 2007	YEAR TO DATE – DEC		YEAR-END TOTALS		
			2008	2007	2007	2006	2005
AIDS ¹	125	67	1,725	1,406	1,406	1,332	1,497
Amebiasis	7	7	110	120	120	94	114
Campylobacteriosis	72	36	1,056	824	824	775	725
Chlamydial Infections	2,579	3,006	42,337	40,932	40,932	39,876	38,862
Encephalitis	0	2	66	59	59	46	72
Gonorrhea	585	687	8,179	9,313	9,313	10,430	10,494
Hepatitis Type A	3	2	80	77	77	364	480
Hepatitis Type B, acute	2	4	64	55	55	62	57
Hepatitis Type C, acute	1	0	3	2	2	4	3
Measles	0	0	1	0	0	1	0
Meningitis, viral/aseptic	23	28	595	389	389	373	527
Meningococcal Infect.	0	1	30	23	23	46	37
Mumps	0	1	7	5	5	10	10
Pertussis	10	12	79	66	66	150	439
Rubella	0	0	1	0	0	0	1
Salmonellosis	85	60	1,596	1,081	1,081	1,217	1,085
Shigellosis	18	19	493	463	463	524	710
Syphilis (prim. and sec.)	26	48	643	847	847	789	644
Syphilis Early latent	13	58	660	803	803	764	570
Tuberculosis	168	208	792	812	812	885	906
Typhoid fever, Acute	1	1	15	17	17	17	12

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