



THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

Volume 7 • Number 2

February 2007

New State Law Underscores The Importance Of Oral Health

February is National Children's Dental Health Month.



California health professionals have a reason to celebrate the implementation of AB 1433 – a new law effective January 2007 requiring that every child have an oral health assessment (dental check-up) by either kindergarten or first grade, whichever is his or her first year in public school.

This law is important because it recognizes the importance of good oral health in school readiness. Although the law does not provide additional resources for dental care and does not address barriers to care, it is still a significant milestone. For the first time, a child's oral health status must be documented before he or she registers for school. This raises public awareness of oral health and its importance in a child's general health.

Tooth decay is an infection that does not heal without treatment. If cavities are not treated, children can develop infections severe enough to require emergency room treatment, and their adult teeth may be permanently damaged. We hope this new law will create momentum to mobilize our communities towards better oral health.

Since the requirements of AB 1433 will affect every child starting school, it is important that all health professionals become familiar with the requirements of the new law so they can assist parents and guardians with fulfilling its requirements.

Requirements

According to the California Dental Association summary, the new law requires the following:

- Schools must notify parents or guardians about the new requirement when their children are registered for school, and must provide information on the importance of oral health to overall health and school readiness. Schools are required to provide enrollment information for government benefit programs such as Medi-Cal and Healthy Families (required forms available at www.cde.ca.gov/).
- Children entering public school for the first time, in kindergarten or first grade, are to have a dental check-up by May 31st of the first school year. The evaluation must be completed by a licensed dental professional. Oral health

Dental problems are the number one cause of children missing school in Los Angeles Unified School District.

evaluations that occurred within the 12 months prior to school entry also meet this requirement.

- Parents may obtain a waiver of this requirement if they cannot find a dental office that takes their child's insurance, cannot afford to pay for it, or the parents choose not to have their child's oral health evaluated.
- Schools must collect and aggregate specified data and school districts must forward specified data by December 31 of each year to their County Office of Education. All required forms will be provided to schools by the California Department of Education. It is anticipated these forms will be available on the DPH web site at www.cde.ca.gov/ by January 1, 2007.

Resources

The following resources will help parents and other interested individuals find a dentist and complete this requirement

1. Medi-Cal/Denti-Cal's toll-free number or Web site can help you to find a dentist who takes Denti-Cal: 1-800-322-6384; <http://www.denti-cal.ca.gov>. For help enrolling your child in Medi-Cal/Denti-Cal, contact your local social service agency at (fill in appropriate local contact information, available at <http://www.dhs.ca.gov/mcs/medi-Calhome/CountyListing1.htm>).
2. Healthy Families' toll-free number or Web site can help you to find a dentist who takes Healthy Families insurance or to find out if your child can enroll in the program: 1-800-880-5305 or <http://www.healthyfamilies.ca.gov/hfhome.asp>.
3. For additional resources that may be helpful, contact the local public health department at (fill in appropriate local contact information, available at <http://www.dhs.ca.gov/mcs/medi-Calhome/CountyListing1.htm>)

By: Maritza Cabezas DDS, MPH and Timothy Collins DDS, MPH

THE PUBLIC'S HEALTH



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Employee Wellness: Walking the Walk

To address the epidemic of obesity in the county, DPH's Service Planning Areas ("SPA") 3 and 4 embarked on a worksite wellness challenge last year. All employees within the two SPA's were invited to participate.

Many health centers and employee groups within DPH have attempted similar interventions, however, this effort differed in that it was offered as a challenge of SPA vs. SPA. Moreover, incentives and awards were offered in an attempt to target all classes of individuals from the most sedentary to the most motivated.



This event included multiple components, such as nutrition education and counseling, physical and group activities, and training in and development of behavioral skills. Participants obtained free pedometers with daily logging instructions and nutritional education.

Challenge guidelines

Challenge participants as a criteria needed to have a body mass index (BMI) of 27 or greater. They also submitted to daily pedometer logs, and bi-weekly measurements of weight, BMI, waist-to-hip ratio, and blood pressure readings. The SPA with the greatest combined weight and BMI loss per participant received special recognition and awards. All employees with BMI's under 27 were encouraged to maintain pedometer logs to support the challenge participants and to experience first-hand their level of physical activity.

The event began with 41 employees; after two months, 25 individuals actually completed the challenge. Pre- and post-challenge surveys evaluated the event. Although two months seemed too brief a time to achieve significant results, most desired to carry on the program and continue to be measured on a bi-monthly basis throughout the year.

Our 25 challenge participants lost thirty pounds over the two month period with a decrease in BMI of approximately 0.21 per participant. There was an overall Waist-to-Hip measurement decrease of over 0.6 per participant over the two month period.

Defining effective wellness programs

Effectiveness of worksite wellness programs has been defined as weight loss of greater than four pounds over a six month period by the National Center for Chronic Disease Prevention and Health Promotion, CDC. The waist-to-hip ratio is three times stronger than BMI in predicting risk for myocardial infarction by an analysis of data from the INTERHEART study (published in *Lancet* 2005;366:1640-49. Yusuf et al).

A waist-to-hip ratio of 0.85 or higher for women, and 0.90 and higher for men, constitutes an additional risk factor for heart disease.

Congratulations to all our employees, who are on target for completing an effective and enlightening worksite wellness program. Please continue to Walk the Walk.

By: Mitchell S. Kushner, MD, MPH
Area Medical Director SPA 3

Updated STD Treatment Guidelines Released

CDC's STD treatment guidelines, last presented in 2002, have been updated and available online and in print.

The 2006 guidelines include:

- expanded strategies for diagnosis of cervicitis and trichomoniasis;
- new recommendations for trichomoniasis treatment;
- data on the use of azithromycin for chlamydia during pregnancy;
- information on emerging azithromycin-resistant *Treponema pallidum*;
- update on the emergence of lymphogranuloma venereum proctocolitis among men who have sex with men (MSM);
- discussions of *Mycoplasma genitalium* and trichomoniasis' roles in urethritis/cervicitis;
- the use of spinal fluid to evaluate for neurosyphilis;
- increasing prevalence of quinolone-resistant *Neisseria gonorrhoeae* in MSM;
- revised discussion concerning the sexual transmission of hepatitis C;
- the use of postexposure prophylaxis after sexual assault; and,
- an expanded discussion of STD prevention approaches.

To download the documents or request a hard copy, visit <http://www.cdc.gov/std/treatment/>.

On-line Survey Request * On-line Survey Request *On-line Survey Request

TPH Survey

THE PUBLIC'S HEALTH is published by the Department of Public Health for all licensed physicians within Los Angeles County, other community healthcare providers and interested individuals.

The publication provides the latest information from the many programs within the department, including Acute Communicable Disease Control, Environmental Health Services, Injury and Violence Prevention, Immunizations, and Chronic Disease Prevention. Our goal is to keep health professionals abreast of the latest data and information on county health issues.

We have created this survey to learn how our readership regards TPH and as a needs assessment to learn how we can better meet our readers' needs and improve this important news vehicle.

The survey can be accessed at <https://lacws.co.la.ca.us/dhs/tphsurvey.htm>.

Please take a few moments to complete the survey. Your opinion is very important to us.

If you prefer, you may print out the survey, complete it and mail it back to: Sheree R. Poitier, MD, Editor, *The Public's Health*. 313 N. Figueroa St. Ste. 227. LA, CA, 90012

On-line Survey Request * On-line Survey Request *On-line Survey Request

Respiratory Hygiene Educational Materials Available

The importance of effective respiratory hygiene to reduce the spread of disease and illness cannot be overstated – especially during cold and flu season. Simple steps such as washing your hands and covering your mouth when you cough or sneeze yield enormous benefits in the fight against many illnesses.

Free materials are available to educate residents on the simple steps they can take to avoid spreading diseases.

Posters – available in Spanish, Cambodian, Chinese, Russian, Korean, Tagalog, Farsi, Vietnamese, and Armenian, in addition to English. These colorful posters are 11” X 17” and ideal for waiting rooms, restrooms, cafeterias and other locations where individuals gather.

Self-sticking static cling signs – ideal for posting on smooth surfaces such as windows and mirrors. These signs are 5 1/2” X 8 1/2” and available in English and Spanish. Multiple languages (Cambodian, Chinese, Russian, Korean, Tagalog, Farsi, Vietnamese, Armenian, Thai and Arabic) indicate “wash your hands” on both English and Spanish versions.

Stickers – to promote hand washing and respiratory hygiene. There are 500 stickers per roll with six different designs available in English.

Please contact the Acute Communicable Disease Control Program for your free materials 213-240-7941.

Or visit, www.lapublichealth.org/acd/respiratoryhygiene.htm



Preteen Vaccines

It is important for pre-teens to visit their health care provider to help them stay healthy and safe as they approach adolescence. During the preteen health care visit, young people are able to receive catch-up vaccine doses for vaccine series they may not have completed, including varicella, hepatitis A, and hepatitis B. Equally important, they are also able to receive newer vaccines that will protect them against pertussis (Tdap vaccine), meningococcal disease (MCV4 vaccine), and for females, cervical cancer (HPV vaccine).

Following is a brief summary of the vaccines of particular importance to preteens and adolescents.

- **Tetanus-Diphtheria-Pertussis Vaccine (Tdap).** To protect against tetanus, diphtheria, and pertussis the new Tdap vaccine is recommended as a single booster dose at age 11 to 12 years. (Tdap is also recommended for adolescents 13-18 years who missed the 11-12 year Td/Tdap booster dose.)
- **Meningococcal Conjugate Vaccine (MCV4).** A single dose is recommended at age 11-12 years for protection against invasive meningococcal disease. (Vaccination is also recommended for adolescents at high school entry [approximately age 15 years] and for college freshmen living in dormitories if not previously vaccinated; in addition, vaccination is recommended for certain high risk groups.)
- **Human Papillomavirus Vaccine (HPV).** Girls age 11-12 years need 3 doses of this new vaccine given over a six-month period for protection against human papillomavirus, the primary cause of cervical cancer. (HPV vaccine is also recommended for young women 13 - 26 years of age who have not previously received the new vaccine.)
- **Varicella Vaccine (VZV).** New recommendations advise 2 doses of varicella vaccine for all persons receiving the vaccine and not just for persons age 13 years and older. Preteens (and other children under 13 years of age) should receive another dose of vaccine if previously vaccinated with one dose, or two doses if not previously vaccinated and there is no evidence of immunity.
- **Hepatitis A Vaccine (HAV).** Two vaccine doses separated by 6 months are recommended for all previously unvaccinated children through 18 years of age living in states with increased rates of hepatitis A disease, which includes California.

During the week of January 21-27, 2007, DPH promoted the observance of "Preteen Vaccine Week." Special efforts were made throughout the State of California to increase public awareness of the importance of preteen vaccines to protect children, especially those 11-12 years of age, against serious vaccine preventable diseases.



- **Hepatitis B Vaccine (HBV).** If not previously vaccinated, administer the 3 dose series over 6 months to preteens and other adolescents. Persons that have previously received 1 or 2 doses need to finish the series. (There is a 2-dose series of Recombivax HB®, [adult formulation] licensed for children aged 11-15 years.) Hepatitis B vaccine is required for 7th grade entry under the California School Immunization Law.

Health care providers are urged to remember the vaccine needs of children as they make the transition into adolescence. It is suggested that when possible, health care providers "recall" their 11-12 year old patients, as they will be in need of these important vaccines.

For additional information about "Preteen Vaccines," visit the Immunization Program at: <http://lapublichealth.org/ip>, or call 213-351-7800 during regular business hours.

*By: Alvin Nelson, MD, MPH
Medical Director, Immunization Program*

Clinician's Role in Syphilis Control

Syphilis remains a significant public health problem in the county. Because one-half of the county's early syphilis cases are reported from private practice and health management organizations, clinicians play an important role to stop the spread of this serious sexually transmitted disease.

While most early syphilis cases continue to be among men who have sex with men (MSM) and men who have sex with men and women (MSM/W), there has recently been a troubling rise in early syphilis cases among females. Increasing rates of early syphilis among women of reproductive age may lead to a rise in congenital syphilis cases.

Syphilis is a systemic infection that facilitates HIV transmission and causes devastating disease or death in neonates.

Early syphilis, defined as primary, secondary or early latent syphilis, is of particular clinical and public health importance as it represents all infectious syphilis.

Providers can help stop the spread of syphilis by taking the following steps:

- Watch for symptoms of primary and secondary syphilis
- Treat patients and their partners promptly and correctly
- Report all suspected and confirmed syphilis cases to the county's STD Program within 24 hours.

Detecting patients with syphilis

Since many stages of syphilis are asymptomatic and the signs and symptoms of syphilis are similar to other diseases, the diagnosis is often missed. Patients at risk for syphilis should be screened using a non-treponemal test (Rapid Plasma Reagin [RPR] or Venereal Disease Research Laboratory [VDRL]).

Positive tests should be confirmed with treponemal antibody tests (Treponema pallidum Particle Agglutination

[TPPA] or Fluorescent treponemal antibody absorption [FTA-ABS]).

All patients who present with a new onset genital (or oral) lesion should have a sexual history taken and be evaluated for primary syphilis. An RPR or VDRL should be obtained, though these tests may not be positive in about 25 % of patients with primary syphilis. In the RPR/VDRL-negative individual, the test should be repeated 2-4 weeks later.

If suspicion for syphilis is high, patients should be treated immediately, before laboratory results are available. Secondary syphilis should be considered for patients presenting with any kind of new rash or wart-like lesions and an RPR/VDRL should be obtained. At this stage of syphilis, the RPR/VDRL should be positive as long as the prozone phenomenon (false-negative result with very high antibody titers) has been ruled out.

Patients with no current signs or symptoms of syphilis (and no history of treated syphilis) but a positive RPR/VDRL and TPPA/FTA-ABS have latent syphilis.

Latent syphilis is divided into early latent (acquired within the past year) and late latent (> 1 year in duration). Approximately 25% of patients with early latent disease have relapses of secondary disease.

Correct staging of syphilis is important because it determines the treatment duration as well as the likely period of infectiousness. A patient should not be staged as a primary or secondary case unless there is clinical evidence of syphilis infection.

To be staged as an early latent case, there should be evidence of infection within the past year. Sexual transmission of syphilis can occur only through the mucocutaneous syphilitic lesions of primary or secondary stages.

Table 1. Populations for which syphilis screening is recommended:

- Pregnant women*
- MSM and MSM/W
- Incarcerated persons
- Sexually active HIV positive persons
- Those who exchange sex for drugs or money
- Those with a currently diagnosed STD
- Sex partners of cases with infectious syphilis

* It is recommended that pregnant women be screened at the first prenatal visit, during the third trimester, and at delivery.

Table 2. Signs and symptoms of early syphilis by stage of infection:

• **Primary**

Classic: chancre (painless, clean-based, indurated ulcer) with painless adenopathy. Atypical: can mimic herpes and other genital ulcer disease.

• **Secondary**

Rash: most common feature (25-90%--can be macular, papular, squamous (scaly) pustular (rare) vesicular (very rare) or a combination. May involve palms and soles (60%). Generalized lymphadenopathy (70-90%). Constitutional symptoms (50-80%). Mucous patches (5-30%): flat grey-white patches in mouth and genital area. Condyloma lata: (10-15%) moist, heaped, wart-like lesions in genital, perirectal and rectal areas. Alopecia (10-15%). Neurosyphilis (<2%)

• **Early latent**

No current symptoms or signs. Within the past year: a documented seroconversion or fourfold increase in titer of RPR/VDRL; unequivocal symptoms of primary or secondary syphilis; a sex partner documented to have primary, secondary, or early latent syphilis; or the only possible exposure occurred within the previous year.

• Neurosyphilis: *Can occur at any stage of disease.* Visual problems (e.g., uveitis), hearing loss, cranial nerve palsies, signs/symptoms of meningitis

Treating syphilis

The only recommended treatment for syphilis is **penicillin G**.¹ Alternative regimens should be used if contraindications to penicillin exist and with close clinical and serological follow-up.

No alternative regimens exist for penicillin-allergic pregnant women; desensitization is required. Bicillin® L-A, tradename for benzathine penicillin G, should not be confused with Bicillin® C-R.

Bicillin® C-R should NOT be used for syphilis treatment.

Partner management

Treating an infectious patient's partner, an important component of patient management and syphilis control, provides an opportunity to break the cycle of transmission

by preventing patient re-infection and reducing the disease burden in the community. The main goal of partner management is to identify and treat as many partners as possible in a voluntary and confidential manner.

Most partners are unaware of their exposure and need for treatment. County public health investigators or nurses will attempt to contact and counsel all early syphilis cases and all pregnant women with syphilis.

Providers should inform patients with early syphilis that they may be contacted by the health department to ensure adequate follow-up and partner management.

Table 3.

Primary, Secondary, & Early Latent:

Benzathine penicillin G (Bicillin® L-A)** 2.4 million units IM once

Late Latent & Unknown Duration:

Benzathine penicillin G** 7.2 million units total, administered as 3 doses of 2.4 million units IM, at 1-week intervals

Neurosyphilis:

Aqueous Crystalline Penicillin G 18-24 million unit daily, administered as 3-4 million units IV q4 hours for 10-14 days

Epidemiologic Treatment of contacts/sex partners to cases of early syphilis:

Benzathine penicillin G** 2.4 million units IM once

**Benzathine penicillin G (Bicillin® L-A) can be given as one large IM injection of 2.4 MU or 2 smaller injections of 1.2 MU each.

Syphilis Control...from page 7

Patients can also notify their partners directly, and can do so anonymously, using inSPOTLA, the on-line partner notification website (www.inspotla.org).

If a patient reports that he/she was informed of exposure to syphilis, either by a partner or the health department, providers should examine the patient for signs or symptoms of infectious syphilis, obtain an RPR/VDRL for syphilis and treat for incubating syphilis with benzathine penicillin G. All patients with an exposure within the past 3 months should be treated independent of serologic results, as incubating syphilis is often falsely negative.

Reporting syphilis and HIPAA requirements (Health Insurance Portability and Accountability Act)

California health care providers must report all suspected or confirmed cases of syphilis within one working day. Cases should be reported by completing the STD Confidential Morbidity Report (CMR) and returning it via fax or mail to the County STD Program. STD reporting does not require patient consent and is not affected by the Privacy Rule of HIPAA.

Reporting STD morbidity to the Public Health Department does not violate HIPAA requirements.

STD Resources:

- More information on syphilis and other STDs along with downloadable CMR forms can be found on the STD Program website: <http://www.lapublichealth.org/std/>.
- The STD Nursing Unit is available for syphilis case record searches and consultation (213/744-3106). Medical consultation is also available for providers by calling 213/744-3070 and asking for the physician-on-call.

Reference

- 1 CDC. Sexually Transmitted Disease Guidelines 2006. MMWR 2006;55 (No. RR-11).
- 2 CDC. Sexually Transmitted Disease Guidelines 2006. MMWR 2006;55 (No. RR-11).
- 3 Code of Federal Regulations, Title 45, §164.512(a)

*By: Christine Wigen, MD
STD Program*

Sudden Infant Death Syndrome

Introduction

Sudden Infant Death Syndrome (SIDS) remains the leading cause of post-neonatal deaths in the U.S. and the second leading cause of post-neonatal deaths in California. Healthy People 2010 aims to reduce the rate of SIDS to 0.25 deaths per 1000 live births by the year 2010.¹ Although years of public education and risk reduction efforts have significantly reduced the number of infants lost to SIDS, we are still well short of our goal. The rate of SIDS was 0.52 in the country and 0.32 in California in 2003 (per 1000 live births).

Risk Factors

SIDS is the sudden and unexpected death of an infant under one year of age that remains unexplained even after an autopsy, death scene investigation and a thorough medical history review. SIDS deaths usually occur during sleep and peak between 2 and 4 months of age. It is more common in the winter months, in male babies and among African American and American Indian populations.



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Additional important risk factors for SIDS include: 2,3,4

- Prone sleeping
- Low birth weight (less than 2500g)
- Young maternal age (20 years of age or younger)
- Increasing parity (3 or more previous live births)
- Exposure to tobacco smoke (in utero and/or post-partum)

SIDS is a diagnosis of exclusion and is not preventable, but following current risk reduction guidelines can significantly reduce its incidence.

AAP Recommendations

The American Academy of Pediatrics (AAP) revised its recommendations to reduce the risk of SIDS in 2005. Controversial issues addressed in the revisions include bed-sharing and pacifier use.

Summary of current AAP recommendations to reduce the risk of SIDS: 5

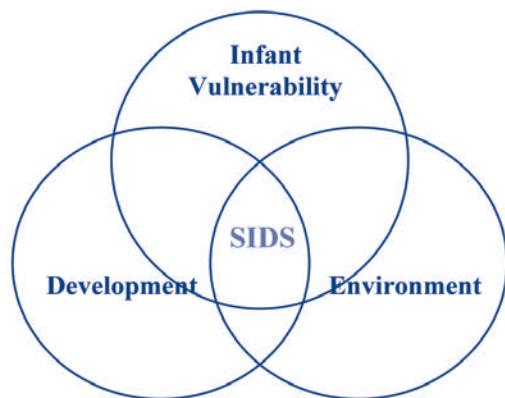
1. Place infants to sleep in a supine (lying on back) position for every sleep. Side sleeping is no longer considered a safe alternative to fully supine sleeping.
2. Use a firm sleep surface: A firm crib mattress, covered by a sheet, is recommended.
3. Keep soft objects and loose bedding out of the crib (pillows, quilts, stuffed toys etc.).
4. Do not smoke during pregnancy. Do not expose infants to secondhand smoke after birth.
5. A separate but proximate sleeping environment is recommended such as a separate crib in the parent's bedroom (room-sharing). Bed-sharing is not recommended.
6. Consider offering a pacifier at nap and bedtime: The pacifier should be used when placing infants down and should not be reinserted once the infant falls asleep. Delay pacifier use until the infant is one month if breastfeeding.
7. Avoid overheating: The infant should be lightly clothed for sleep, and the bedroom temperature should be kept comfortable for a lightly clothed adult.
8. Avoid commercial devices marketed to reduce the risk of SIDS.
9. Do not use home monitors as a strategy to reduce the risk of SIDS.
10. Avoid development of positional plagiocephaly (flat back of head): encourage 'tummy time' when awake. Avoid having infants spend excessive time in car seats and bouncers.
11. Assure that others caring for the infant are aware of these recommendations.



The AAP press release can be viewed at: <http://www.aap.org/ncepr/sids.htm>

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Sudden Infant Death Syndrome...from page 9



SCHEMATIC DIAGRAM OF A SIDS EVENT

Infant death occurs; 911 called
Paramedics/police arrive at the scene and contact the Coroner

Coroner:
Investigates death scene, transports infant for autopsy
Reviews infant medical history
Informs parents of presumptive cause of death
Contacts Department of Public Health within 24 hours

Department of Public Health - Fetal and Infant Health Program:
Confirms presumptive SIDS referral with Coroner
SIDS Program contacts District Public Health Nurse (DPHN)
DPHN contacts family within 3 working days, conducts an assessment, provides SIDS information, counseling & referrals

After Autopsy:
Coroner's Investigator determines final cause of death and notifies parents/guardian

Coroner's Office:

LA County Department of Coroner
1104 N. Mission Road,
Los Angeles, CA 90033
Tel: (323)-343-0512
<http://coroner.co.la.ca.us>

LAC Department of Public Health – Fetal and Infant Health Program:

SIDS Program
Maternal, Child and Adolescent Health
600 S. Commonwealth Ave, Suite 800
Los Angeles, CA 90005
Tel: (213)-639-6457
<http://www.lapublichealth.org>

Etiology

Currently there is no known cause, but several suspected pathways for SIDS. Some researchers and professionals view the triple-risk model as a possible explanation for SIDS. According to this model, infants who die of SIDS are born with vulnerabilities that increase their risk of sudden infant death when exposed to certain internal or external stressors.⁶ These innate vulnerabilities, combined with developmental changes that occur in the homeostatic control mechanisms of infants during their first six months of life, make these infants more susceptible to SIDS when exposed to outside stressors such as overheating, prone sleeping or exposure to tobacco smoke.

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All three components - infant vulnerability, critical developmental period, and outside stressors must interact for a sudden infant death to occur, according to this model.

A SIDS death not only affects parents and caregivers, but also siblings, providers, the health community and the larger society. By working together, the number of babies lost to SIDS can be decreased significantly. Consistently following AAP guidelines and disseminating information about SIDS to others are easy first steps that may allow babies to take their first steps and more.

For further information on SIDS or SIDS training sessions for your workplace contact DPH's Fetal and Infant Health Program 213-639-6457.

*By: Bhavna Sivanand, B.S.
Maternal Child and Adolescent
Health Programs*

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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 emailed updates alerting you to the latest significant local public health information as well as emerging threats like pandemic influenza and possible bioterrorist activity. Membership is free and all physician information will remain private and will not be distributed to other agencies or used for commercial purposes.

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

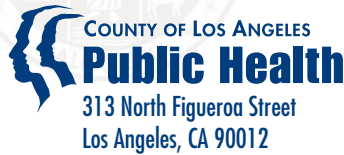
Be alert to Public Health emergencies! Enroll now!

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THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County



Selected Reportable Diseases (Cases)¹ — August/September 2006

Disease	THIS PERIOD AUG/SEPT2006	SAME PERIOD LAST YEAR AUG/SEPT2005	YEAR TO DATE –SEPT		YEAR END TOTALS		
			2006	2005	2005	2004	2003
AIDS ¹	238	233	1001	1140	1,519	2,211	2,440
Amebiasis	15	19	73	93	114	114	121
Campylobacteriosis	175	144	574	555	725	884	1,100
Chlamydial Infections	7,002	6,714	31,117	29,479	38,862	38,464	36,900
Encephalitis	7	5	50	47	57	133	38
Gonorrhea	1,882	1,929	8,255	7,827	10,494	9,696	8,078
Hepatitis Type A	53	20	452	111	480	321	374
Hepatitis Type B, acute	7	3	50	41	57	72	73
Hepatitis Type C, acute	1	0	3	1	3	5	0
Measles	0	0	1	0	0	1	0
Meningitis, viral/aseptic	100	146	276	511	515	807	899
Meningococcal Infect.	4	3	37	30	37	28	32
Mumps	13	2	18	8	8	2	10
NGU	89	154	606	907	1,101	1,470	1,410
Pertussis	39	51	207	232	438	156	130
Rubella	0	0	1	0	1	0	0
Salmonellosis	292	263	799	784	1,085	1,205	995
Shigellosis	145	138	371	454	710	625	669
Syphilis (prim. and sec.)	98	114	529	467	646	470	468
Syphilis early latent	97	106	522	425	571	395	388
Tuberculosis	132	176	477	570	906	930	949
Typhoid fever, Acute	4	3	13	10	12	13	16

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