

# THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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## *Influenza Update*

Influenza has arrived in Los Angeles County. On November 1, the first confirmed case of influenza (type B) was identified in a man who resides in the western county. He was not hospitalized and has recovered with no complications. Two important factors associated with this case:

- Since the spread of illness was limited, this suggests that infection was not due to a novel viral strain, although further subtyping is still pending; and,
- This demonstrates the importance of accurately diagnosing influenza when prescribing antiviral treatment since some medications are only effective against type A strains.

Information about antivirals for influenza chemoprophylaxis and treatment is available at: [www.cdc.gov/flu/professionals/treatment](http://www.cdc.gov/flu/professionals/treatment). Guidelines for the accurate diagnosis of influenza are provided on page 3.

The timing of this case is not unusual; the first confirmed case of influenza in our county typically is identified in October or early November. This case cannot tell us whether it will be a severe or mild season—it's still too early to know. In the county, influenza usually peaks just before the New Year (late December), earlier than the rest of the nation. Last year was unusual in that influenza peaked earlier than expected and peaked across the nation almost simultaneously.

While this year's influenza vaccine shortage has caused concern, vaccine shortages and delays alone do not guarantee a severe flu season—there are many other

See Respiratory Etiquette Poster information  
on page 8

**Influenza vaccination for children aged 6 months through 18 years is available during weekdays at Public Health clinics throughout our county. Vaccination will be restricted to:**

- Infants aged 6-23 months,
- Children 6 months through 18 years of age on chronic aspirin therapy, and
- Children 2 through 18 years of age with underlying chronic medical conditions.

**For information on vaccination locations for children, visit:**  
[www.lapublichealth.org/ip/flu/2004-2005/clinics\\_children.pdf](http://www.lapublichealth.org/ip/flu/2004-2005/clinics_children.pdf)

factors involved, especially the types of viral strains in circulation. Based on cases already identified in the U.S., Australia and New Zealand, it is expected that the same viral strain (A/Fujian) prevalent last season will also be the primary strain circulating this season. If that is the case, this season might be mild because there is a lot of natural immunity carried over from last season. In addition, the A/Fujian strain is contained in this year's vaccine and should provide good protection.

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Information on clinic dates and locations is available by calling 1-800-427-8700 and at:

[www.lapublichealth.org/ip/flu/2004-2005/clinics\\_adults.pdf](http://www.lapublichealth.org/ip/flu/2004-2005/clinics_adults.pdf)

# THE PUBLIC'S HEALTH

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## *Influenza Update from page 1*

### **Vaccination clinics**

Influenza vaccination clinics were held in multiple sites on November 13 and 20. These clinics were restricted to individuals in priority categories as issued by the CDC (i.e., persons 65 years of age and older and other high-risk categories such as individuals with chronic medical conditions). Since children and infants have special needs regarding influenza vaccination, parents were encouraged to not bring their children to these clinics. Instead, children in high-risk categories and infants aged 6-23 months may be vaccinated at public health clinics throughout the county.

While the quantity of vaccine distributed was similar to what was provided last season, because of an expected significant increase in demand, vaccine was not available for all who needed it. DHS continues to work hard to obtain additional vaccine. ☞

## **Guidelines for the Accurate Diagnosis of Influenza**

In light of the extra attention influenza has received this season, many doctors have inquired about methods to appropriately diagnose influenza. In addition, many doctors have inappropriately relied on serologic specimens which are not viable for immediate diagnosis of influenza, and without comparison convalescent specimens, do not adequately reflect recent infection (see Table on page 3).

### **Clinical information**

Influenza illness is usually abrupt in onset and can include any or all of these symptoms: fever, muscle aches, headache, lack of energy, dry cough, sore throat, and possibly runny nose. The fever and body aches can last 3-5 days and the cough and lack of energy may last for 2 or more weeks. Influenza can be difficult to diagnose based on clinical symptoms alone because the initial symptoms of influenza can be similar to those caused by many other infectious agents including, but not limited to, Mycoplasma pneumoniae, adenovirus, respiratory syncytial virus, rhinovirus, parainfluenza viruses, and Legionella spp.

### **Diagnostic tests**

A number of tests can help in the diagnosis of influenza (see Table) but, tests do not need to be done on all patients. Once influenza activity has been established in the community, a patient may be diagnosed clinically without need for laboratory confirmation. For individual patients, tests are most useful when they are likely to give a doctor results that will help with diagnosis and treatment decisions. Additionally, during a respiratory illness outbreak, testing for influenza can be very helpful in determining if influenza is the cause of the outbreak.

Continued on page 3

## Diagnosis of Influenza from page 2

Appropriate samples for influenza testing can include a nasopharyngeal or throat swab, nasal wash, or nasal aspirates, depending on which type of test is used (see Table). Samples should be collected within the first 4 days of illness. Rapid influenza tests provide results within 24 hours; viral culture provides results in 3-10 days.

Most of the rapid tests that can be done in a physician's office are approximately >70% sensitive for detecting influenza and approximately >90% specific. Thus, as many as 30% of samples that would be positive for influenza by viral culture may give a negative rapid test result. And, some rapid test results may indicate influenza when a person is not infected with influenza.

Serum samples also can be tested for influenza antibody to diagnose recent infections—however, this procedure requires two samples collected per person: one sample within the first week of illness and a second sample 2-4 weeks later. If antibody levels increase from the first to the second sample, influenza infection likely occurred. Because of the length of time needed for a diagnosis of influenza by serologic testing, other diagnostic testing should be used if a more rapid diagnosis is needed.

***Serologic tests of influenza require comparison of acute and convalescent specimens. As such, other methods are more viable for rapid diagnosis of recent influenza infection.***

During outbreaks of respiratory illness when influenza is suspected, some samples should be tested by both rapid tests and viral culture. The collection of some samples for viral culture is essential for determining the influenza subtypes and strains causing illness, and for surveillance of new strains that may need to be included in the next year's influenza vaccine. During outbreaks of influenza-like illness, viral culture also can help identify other causes of illness when influenza is not the cause. §

## Influenza is NOT a reportable disease in Los Angeles County

Individual cases of influenza should not be reported to the health department. Exceptions include:

- Influenza and respiratory illness outbreaks should be reported immediately by phone. Morbidity Unit 888-397-3993
- Influenza-related pediatric ICU cases and pediatric deaths should be reported by phone, as soon as possible after laboratory confirmation of influenza.

**Acute Communicable Disease Control**  
213-240-7941 M-F 8am-5pm

**For information on antivirals for treatment and chemoprophylaxis of influenza, visit: [www.cdc.gov/flu/professionals/treatment](http://www.cdc.gov/flu/professionals/treatment)**

Influenza Diagnostic Table*				
Procedure	Influenza Types Detected	Acceptable Specimens	Time for Results	Rapid Result Available
Viral Culture	A and B	NP swab, <sup>2</sup> throat swab, nasal wash, bronchial wash, nasal aspirate, sputum	5-10 days <sup>3</sup>	No
Immunofluorescence DFA Antibody Staining	A and B	NP swab, <sup>2</sup> nasal wash, bronchial wash, nasal aspirate, sputum	2-4 hours	No
RT-PCR <sup>5</sup>	A and B	NP swab, <sup>2</sup> throat swab, nasal wash, bronchial wash, nasal aspirate, sputum	1-2 days	No
Serology	A and B	paired acute and convalescent serum samples <sup>6</sup>	>2 weeks	No
Enzyme Immuno Assay (EIA)	A and B	NP swab, <sup>2</sup> throat swab, nasal wash, bronchial wash	2 hours	No
Rapid Diagnostic Tests				
Directigen Flu A <sup>7</sup> (Becton-Dickinson)	A	NP swab, <sup>2</sup> throat swab, nasal wash, nasal aspirate	<30 minutes	Yes
Directigen Flu A+B <sup>7,9</sup> (Becton-Dickinson)	A and B	NP swab, <sup>2</sup> throat swab, nasal wash, nasal aspirate	<30 minutes	Yes
FLU OIA <sup>7</sup> (Thermo Electron)	A and B <sup>4</sup>	NP swab, <sup>2</sup> throat swab, nasal aspirate, sputum	<30 minutes	Yes
FLU OIA A/B <sup>7,9</sup> (Thermo Electron)	A and B	NP swab, <sup>2</sup> throat swab, nasal aspirate, sputum	<30 minutes	Yes
XPECT Flu A/B <sup>7,9</sup> (Remel)	A and B	Nasal wash, NP swab, <sup>2</sup> throat swab	<30 minutes	Yes
NOW Flu A Test <sup>7,9</sup>	A	Nasal wash, NP swab <sup>2</sup>	<30 minutes	Yes
NOW Flu B Test <sup>7,9</sup> (Binax)	B	Nasal wash, NP swab <sup>2</sup>	<30 minutes	Yes
QuickVue Influenza Test <sup>8</sup> (Quidel)	A and B <sup>4</sup>	NP swab, <sup>2</sup> nasal wash, nasal aspirate	<30 minutes	Yes
QuickVue Influenza A+B Test <sup>8</sup> (Quidel)	A and B <sup>9</sup>	NP swab, <sup>2</sup> nasal wash, nasal aspirate	<30 minutes	Yes
SAS Influenza A Test <sup>7,9</sup>	A	NP wash, <sup>2</sup> NP aspirate <sup>2</sup>	<30 minutes	Yes
SAS Influenza B Test <sup>7,9</sup>	B	NP wash, <sup>2</sup> NP aspirate <sup>2</sup>	<30 minutes	Yes
ZstatFlu <sup>9</sup> (ZymeTx)	A and B <sup>4</sup>	throat swab	<30 minutes	Yes

1. List may not include all test kits approved by the U.S. Food and Drug Administration  
2. NP = nasopharyngeal  
3. Shell vial culture, if available, may reduce time for results to 2 days.  
4. Does not distinguish between influenza A and B virus infections.  
5. RT-PCR = reverse transcriptase polymerase chain reaction  
6. A fourfold or greater rise in antibody titer from the acute- (collected within the 1st week of illness) to the convalescent-phase (collected 2-4 weeks after the acute sample) sample is indicative of recent infection.  
7. Moderately complex test—requires specific laboratory certification.  
8. CLIA-waived test. Can be used in any office setting. Requires a certificate of waiver or higher laboratory certification.  
9. Distinguishes between influenza A and B virus infections.

\* Disclaimer: Use of trade names or commercial sources is for identification only and does not imply endorsement by the Centers for Disease Control and Prevention or the Department of Health Services.  
Table from CDC available at: [www.cdc.gov/flu/professionals/labdiagnosis.htm#table#table](http://www.cdc.gov/flu/professionals/labdiagnosis.htm#table#table)



# *An Overview of the TB Burden in Los Angeles County*

Tuberculosis (TB), once known as Consumption, the White Plague, and the Captain of all the Men of Death, no longer kills one fourth of the U.S. population as it did at the turn of the 19th century. Successful public health efforts and strategies to identify and diagnose new cases of TB, locate contacts to those contagious cases, and treat latent TB infection and active disease, have reduced the number of cases in the county steadily since 1992. Targeted TB testing, contact investigation, directly observed therapy, and aggressive management of TB are among the many approaches used successfully to control TB.

Despite this reduction, it would be shortsighted to believe TB is close to eradication. While the county's case load has dropped over the past 12 years, the burden of TB globally has increased. Local success can result in complacency and resurgence of disease if aggressive public health efforts to detect and treat TB in population sub-groups are not maintained.

Everyday, more than 20,000 people worldwide develop active TB and 5,000 die from the disease. The global TB epidemic continues to increase 3% every year and 10% annually in sub-Saharan Africa.<sup>1</sup>

During 2003, a total of 14,871 TB cases (5.1 cases per 100,000 population) were reported in the U.S., representing a 1.4% decrease in cases and a 1.9% decline in the rate from 2002. This decline is the smallest since 1992, when TB incidence peaked after a 7 year resurgence.<sup>2</sup>

The Los Angeles County TB Control Program, in partnership with the Community Health Care Service, California Department of Health Services, and the CDC, continues to advance effective strategies to identify and treat high-risk population groups, including homeless individuals, foreign-born, and persons infected with HIV.

To better understand the epidemiology of this disease, this article presents an overview of TB in the county and contrasts it with data from California and the United States as a whole.

In 2003, there were 949 confirmed cases of TB in the county, representing a 7.4% decrease from 2002 (1,025 cases) and a 56.8% decrease since 1992 (2,198

***in 2003, the county reported the highest number of TB cases among all jurisdictions in California, accounting for 29.4% of the TB cases in California (3,230 cases) and 6.4% of the TB cases in the U.S. (14,871 cases).***

cases). This is the eleventh consecutive year of decline since the peak in 1992 and marks the first time in the history of the county the number of cases fell below 1,000. However, in 2003, the county reported the highest number of TB cases among all jurisdictions in California, accounting for 29.4% of the TB cases in California (3,230 cases) and 6.4% of the TB cases in the U.S. (14,871 cases).<sup>3</sup> The group with the largest number of reported TB cases was those aged 15-34 years with 246 cases (25.9%), followed by those 65 years or older with 238 cases (25.1%). Those between 0-4 years of age accounted for 21 cases (2.2%) which represented a 31.3% increase from 2002 (16 cases, 1.6%).<sup>3</sup> The occurrence of TB in the very young is significant because it indicates recent TB transmission in the community.

The TB rate among foreign-born individuals remains disproportionately high. In the U.S. in 2002, 51% of TB cases were foreign-born.<sup>4</sup> In contrast, of the 949 total county cases, 749 (78.9%) were foreign-born. Foreign-born TB cases were reported from 48 different countries in 2003. Of the foreign-born cases, 257 (27.1%) were from Mexico, 145 (15.3%) were from the Philippines, 53 (5.6%) were from China, 44 (4.6%) were from South Korea, 41 (4.3%) were from Vietnam and combined accounted for 72.1% of foreign-born TB cases.<sup>3</sup>

In California, Asian/Pacific Islanders and African Americans had the highest case rates among the various ethnic groups, at 29.9 per 100,000 population and 11.6 per 100,000 population respectively.<sup>5</sup> However in the county, Hispanics represent the greatest number and proportion of TB cases (434, 45.7%) compared to other races or ethnic groups such as Asian/Pacific Islanders, which were the second leading racial/ethnic group (346 cases, 36.5%) after Hispanics.<sup>3</sup>

**Continued on page 5**

## **An Overview of the TB Burden from page 4**

In the U.S. during 2002, of the 14,715 TB cases with information on homeless status, 6.0% (883 cases) were homeless.<sup>7</sup> In California, in the year 2002, of the 3,132 TB cases with information on homeless status, 6.4% were homeless.<sup>7</sup> Of the 949 TB cases reported in county, 7.8% (74 cases) were homeless. This represents a 3.9% decrease in the number of homeless cases from the year 2002 (77 cases).<sup>3</sup>

In 1987, the county piloted the use of incentives and enablers (I&E) as a strategy to improve treatment completion rates among homeless TB patients. The I&E included housing and food vouchers, grocery coupons, and transportation tokens. Prior to the pilot project, approximately 53% of the homeless TB patients completed treatment, increasing the risk of TB transmission among the homeless population in Los Angeles. The pilot was so successful reducing costs associated with increasing rates of treatment of homeless TB patients that the I&E program was expanded to cover all eligible patients in the county including the non-homeless. The I&E program continues to receive funding each year. For the cohort of patients starting treatment in 2002 who received I&E, the treatment completion rate within 12 months was 82.6%.

Of those with HIV, almost 10% will develop active TB every year and it will be the principle cause of death globally in up to one-third of people with HIV. HIV infection is the most rapidly increasing threat to TB control worldwide; among all the AIDS-associated infections, TB is the only one readily transmitted to HIV-negative as well as HIV-positive individuals. TB and HIV are synergistic infections. HIV increases the rate of activation of latent TB and speeds progression of TB disease. TB accelerates the progression of AIDS by increasing the rate of HIV replication. HIV-infected individuals often present with atypical clinical and x-ray findings for TB and have an increased frequency of sputum smear-negative pulmonary tuberculosis, making the diagnosis of TB more difficult.<sup>6</sup>

In California, of the 3,331 TB cases, 149 had a diagnosis of AIDS in 2001. Of these 149, most were Hispanics (79 cases), followed by African Americans (33 cases), Whites (25 cases), and Asian/Pacific

Islanders (11 cases).<sup>7</sup> Of the 949 TB cases reported in the county, 656 (69.1%) were tested for HIV and 75 (7.9%) were co-infected with HIV.<sup>3</sup>

Overall, groups at high risk for TB include: those with HIV infection, those in close contact with infectious TB cases, and those with medical conditions that suppress the body's immune system (for example, diabetes, cancer, long-term use of corticosteroids). Other high-risk groups include: foreign-born individuals from countries with high rates of TB, certain racial or ethnic minorities, people who work in or are residents of long-term care facilities or congregate settings (nursing homes, prisons, and migrant farm worker camps), health care workers, and those who are malnourished, alcoholics and IV drug users.

Targeted interventions for these at-risk populations, continued collaborative efforts toward the global and local fight against TB, and adequate resources are essential to eliminate TB. The CDC continues to work with partners to develop strategies to eliminate existing TB. Finally, international partners, such as the World Health Organization are essential to defeating this persistent plague. ¶

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## County Sees Possible Downward Trend in Early Syphilis

After a dramatic increase which began in early 2000, the number of early syphilis cases may have reached a plateau and begun to decline in 2004. According to surveillance reports published by the STD Program, between January and July of corresponding year, early syphilis cases increased from 256 in 2000 to 535 in 2003, and then decreased to 407 in 2004. A similar trend can be observed for primary and secondary (P&S) syphilis; between January and July of corresponding year, P&S syphilis cases increased from 95 in 2000 to 291 in 2003, and then decreased to 222 in 2004.<sup>1</sup>

Significantly, a decline has also been observed among men who have sex with men (MSM) in 2004; between January and July of the following year, early syphilis cases among MSM increased from 93 in 2000 to 364 in 2003, and then decreased to 254 in 2004. This shift is encouraging because new syphilis cases primarily occur among MSM; however, health department officials caution that it is still too soon to let our guard down.

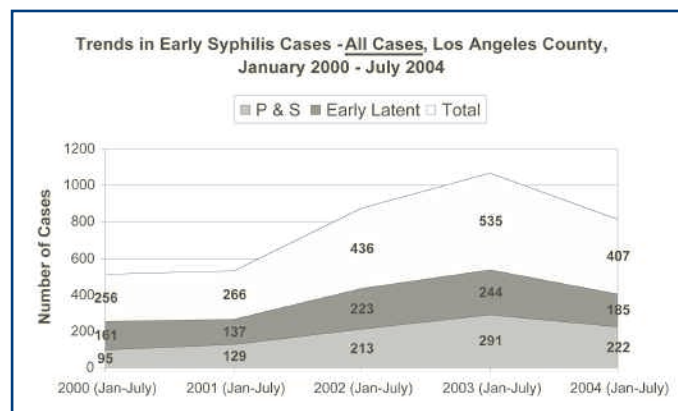
“Healthcare providers who see syphilis patients should continue to report new cases immediately to the health department, so that we can closely monitor this epidemic and target our efforts where they are most needed,” says Dr. Peter Kerndt, Director, Los Angeles County STD Program.

Currently, the health department maintains several critical ongoing activities to address the local syphilis epidemic and believes these activities have contributed to the recent downward trends:

- Traditional disease investigation efforts conducted by Public Health Investigators (PHIs). PHIs interview patients diagnosed with an STD (including HIV) in order to identify and notify any partners who may have been exposed. PHIs receive comprehensive training in disease control, investigative techniques, law enforcement, and interviewing.
- Partner counseling and referral services. These services are intended to assist patients who have been diagnosed with an STD or HIV with informing their sex and/or needle-sharing partners of their potential exposure to STDs/HIV.

In addition, these services are free, voluntary, client-centered, and confidential.

- “Stop the Sores” social marketing campaign focusing on syphilis awareness and screening. Funded by the health department and implemented



by a collective of community-based organizations, this media campaign targets MSM to provide education and encourage screening.

- HIV/STD testing targeting high-risk individuals through the STD Program’s Mobile Testing Unit (MTU). The MTU offers free, confidential HIV/STD screening to high-risk groups, such as MSM and commercial sex workers, in venues all over the county.
- HIV/STD screening in correctional facilities. The STD Program provides these services in adult jail facilities, as well as juvenile halls, recognizing that working with the incarcerated population represents an opportunity to test, treat, and educate many high-risk individuals.

In combination, these various strategies, as well as prevention and screening initiatives by numerous community-based organizations, remain essential to combating syphilis. While the outlook may appear to be improving, there is still cause for concern, such as the potential for syphilis to increase among women, although male cases currently predominate.

“These recent trends provide hope, but the health department and community providers still must maintain our efforts to further reduce the number of syphilis cases if we expect to see a clear, substantial victory,” says Kerndt. “We should not think that the epidemic is now over.”

### Reference

<sup>1</sup>These surveillance data should be interpreted with caution, due to the impact of report delay. Report delay is defined as the time interval between the date a syphilis diagnosis was made and the date the case was reported to the Health Department. Currently, the mean reporting delay for early syphilis is 20 days and the 95th percentile is 72 days.<sup>0</sup>



## ANTIBIOTIC RESISTANCE INFORMATION CORNER

During this cold and flu season, the potential for unnecessary antibiotic prescribing for viral illnesses is at its greatest. Due to the flu vaccine shortage this season, this may greatly impact the extent of illness, and as such, the number of people who will erroneously request antibiotics. Despite good intentions, physicians lack knowledge about appropriate antibiotic use even when they are aware that antibiotic resistance is a problem in their own facility. Furthermore, many physicians continue to jeopardize the health of patients by not complying with hand hygiene recommendations—this increases patients' risk to life threatening antibiotic-resistant infections.

### **A Survey of Knowledge, Attitudes, and Beliefs of House Staff Physicians From Various Specialties Concerning Antimicrobial Use and Resistance.**

**Srinivasan A, Song X, Richards A, Sinkowitz-Cochran R, Cardo D, Rand C. *Arch Intern Med.* 2004 Jul 12;164(13):1451-6. Available at:** [www.archinte.ama-assn.org/cgi/content/full/164/13/1451](http://www.archinte.ama-assn.org/cgi/content/full/164/13/1451)

In an effort to improve antimicrobial use and prevent resistance, physicians at a university teaching hospital were surveyed to assess their knowledge, attitudes and behaviors antimicrobial use and resistance. Medical residents were significantly more knowledgeable than other groups. Despite overall low scores, the majority of physicians wanted more education on antimicrobials (90%) and more feedback on antimicrobial selections (67%). Physicians were well aware of the problem of antimicrobial resistance and believed that appropriate antimicrobial use is necessary—88% agreed antibiotics are overused in general and 72% also agreed that this was the case at their institution; 96% agreed that hospitals face serious problems with antibiotic resistance and 93% agreed that their hospital faces these same problems; 97% agreed that better use of antibiotics would reduce resistance. The authors recommend that tailored programs that target different physician specialties may be more effective in supporting antimicrobial education.

The CDC offers important tools for preventing antimicrobial resistance in health care settings, such as hospitals and long-term care facilities. For more information, visit: [www.cdc.gov/drugresistance/healthcare](http://www.cdc.gov/drugresistance/healthcare) 


### **Hand Hygiene among Physicians: Performance, Beliefs, and Perceptions.**

**Pittet D, Simon A, Hugonnet S, Pessoa-Silva CL, Sauvan V, Perneger TV. *Ann Intern Med.* 2004 Jul 6;141(1):1-8.**

Despite the recommendation that hand washing is important to reduce the risk of infection and disease transmission, observational studies continue to show low adherence to this simple practice in health care settings. Physician adherence to hand hygiene practices in a large university hospital averaged 57% overall. Adherence was higher when physicians were aware of being observed (61%; n=117) than when they were not aware of being observed (44%; n=46). Low adherence was associated with busy workloads, performance of activities associated with high risks for cross contamination, and being in technical specialties (such as surgery and anesthesiology). High adherence was associated with easy access to hand-rub solutions, positive attitudes towards hand hygiene after patient contact, and the belief of being a positive role model for other colleagues. The authors support hand hygiene promotion efforts on these factors associated with high adherence, especially towards physicians working in technical specialties.

For CDC guidelines and materials to promote hand hygiene practices at your health care facility, visit: [www.cdc.gov/handhygiene](http://www.cdc.gov/handhygiene)

### **Clinical practice guidelines and other resources are available online at:**

- Infectious Diseases Society of America — [www.idsociety.org](http://www.idsociety.org)
- Clinical Practice Guidelines — [www.journals.uchicago.edu/IDSA/guidelines/](http://www.journals.uchicago.edu/IDSA/guidelines/)
- California Medical Association (CMA) Foundation - [www.aware.md/resource/index.asp](http://www.aware.md/resource/index.asp)
- Clinical Practice Guidelines Compendium (Pediatric and Adult) - [www.aware.md/clinical/clinical\\_guide.asp](http://www.aware.md/clinical/clinical_guide.asp)
- Centers for Disease Control and Prevention — [www.cdc.gov/drugresistance/community/](http://www.cdc.gov/drugresistance/community/)
- Los Angeles County Department of Health Services Acute Communicable Disease Control Program — [www.lapublichealth.org/acd/antibio.htm](http://www.lapublichealth.org/acd/antibio.htm) 



## Respiratory Hygiene — Contact us for your free posters

Especially during cold and flu season, the importance of effective respiratory hygiene to reduce the spread of disease and illness cannot be overstated. 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. This fall, DHS launched a Respiratory Hygiene Awareness Campaign to educate residents on the simple steps they can take to avoid spreading diseases. This poster was included with your September 2004 issue, however, you may request more by using the following contact information:

Additional posters are available at [www.lapublichealth.org/acd/index.htm](http://www.lapublichealth.org/acd/index.htm) or by calling Acute Communicable Disease Control (213) 240-7941



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COUNTY OF LOS ANGELES  
DEPARTMENT OF HEALTH SERVICES  
**Public Health**

313 North Figueroa Street, Room 212  
Los Angeles, California 90012

### Selected Reportable Diseases (Cases)\* - June -July 2004

Disease	THIS PERIOD June & July 2004	SAME PERIOD LAST YEAR June & July 2003	YEAR to date July		YEAR END TOTALS		
			2004	2003	2003	2002	2001
AIDS*	334	428	1,187	1,392	2,590	1,719	1,354
Amebiasis	24	23	53	71	121	102	139
Campylobacteriosis	175	218	520	610	1,093	1,067	1,141
Chlamydial Infections	6,506	6,179	22,239	21,501	36,555	35,688	32,670
Encephalitis	4	3	23	28	41	61	41
Gonorrhea	1,611	1,414	5,367	4,582	8,008	7,800	7,443
Hepatitis Type A	56	55	204	211	376	438	542
Hepatitis Type B, Acute	8	12	3	8	56	29	44
Hepatitis Type C, Acute	0	0	0	0	0	3	1
Measles	0	0	0	0	0	0	8
Meningitis, viral/aseptic	173	211	311	432	899	466	530
Meningococcal Infections	4	1	19	17	34	46	58
Mumps	1	3	2	9	10	16	17
Non-gonococcal Urethritis (NGU)	240	223	881	830	1,393	1,393	1,429
Pertussis	0	15	52	90	128	170	103
Rubella	0	0	0	0	0	0	0
Salmonellosis	218	185	650	523	996	956	1,006
Shigellosis	71	57	208	404	671	974	684
Syphilis, primary & secondary	77	83	257	273	442	364	188
Syphilis, early latent (<1 yr.)	60	58	233	223	365	353	209
Tuberculosis	159	149	405	418	949	1,021	1,046
Typhoid fever, Acute	6	3	10	9	16	33	17

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