

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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May 2003

Los Angeles County SARS Update

It is essential that all health professionals in Los Angeles County be capable of identifying and reporting any suspect case of SARS.

After more than eight weeks of surveillance and in spite of a very broad case definition, the number of SARS cases identified in Los Angeles County has remained low. Only 14 cases have been reported to date; of these, 8 are suspect cases and 6 are probable cases (see the current case definition on page 3). Convalescent serologic results have been received for 5 cases (1 suspect and 4 probable cases), and all are negative for coronavirus antibodies. There are no reports of illness among any healthcare workers who have treated the 14 cases, and no evidence of community transmission. There have been no SARS deaths either locally or nationwide. The medical community is advised to continue active screening for possible SARS cases and to implement appropriate infection control practices when indicated.

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Any possible case of SARS should be reported immediately to Acute Communicable Disease Control 213-240-7941 (7:30am - 5:00pm), 213-974-1234 (after hours, emergency operator).

Pediatric MRSA Interim Reporting

In response to the notable increase in community-associated methicillin-resistant *Staphylococcus aureus* (CAMRSA) occurring in Los Angeles County, the Department of Health Services has added skin, soft

tissue and invasive MRSA infections to the list of local reportable diseases. This new reporting requirement will be limited to infections among hospitalized children (<18 years) and excluding those with nosocomial (healthcare associated) infections, unless as part

Reporting will be limited to cases occurring within a six-month period, beginning May 5 and ending November 7, 2003.

of an outbreak. Reporting will be limited to cases occurring within a six-month period, beginning May 5 and ending November 7, 2003. The MRSA isolate and antibiogram will also have to be submitted.

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West Nile Virus 2003: Infections in Los Angeles County are imminent

The diagnosis of the first and only California case of West Nile Virus (WNV) infection occurred last summer in a Los Angeles County resident. This marked the advent of WNV to the West Coast and raised alarm bells among public health officials that additional cases were imminent. This first case prompted extensive investigation by our local vector control districts to search for evidence of WNV infection in mosquitoes and birds. Surveillance included chicken sero-surveillance among sentinel flocks located throughout the county, as well as mosquito pool testing and dead bird testing. None of these well-established surveillance tools for detecting arboviral encephalitis viruses revealed any evidence of WNV. Nonetheless, common bird migration patterns combined with the presence of mosquitoes capable of transmitting the virus bolster the prediction that additional human cases will occur in our county.

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May is Hepatitis Awareness Month:

Prevent the Transmission of Hepatitis B Virus in Adolescents 15-18 Years Old

Many adolescents between the ages of 15-18 years old missed out on hepatitis B immunizations as infants and were again exempt from California's state-mandated hepatitis B immunizations for school entry. Despite hepatitis B immunization coverage estimates of more than 60% among middle school kids, many 15-18 year olds have not completed the hepatitis B immunization series, leaving them unprotected and thus vulnerable to acute and/or chronic infection.

Doctors and health care workers can be instrumental in preventing hepatitis B transmission in 15-18 year olds:

- Routinely review and maintain the immunization record of adolescent patients between the ages of 15-18 years;
- If hepatitis B immunization has not been started, begin the three-dose series. The usual schedule for adolescents is two doses (0.5ml) separated by no less than 4 weeks, and a third dose 4-6 months after the second dose. If the accelerated schedule is needed to ensure that the series is completed soon, the minimum interval between the first two doses is 4 weeks, and the minimum interval between the second and third doses is 8 weeks. However, the first and third doses must be separated by 4 months.
- 11-15 year old may receive the two 10 mcg doses of RecombivaxHB, separated by 4-6 months apart.
- If a patient started but did not complete the hepatitis B three dose series, **DO NOT START THE SERIES AGAIN**. Instead, resume vaccination until the required three doses are completed.
- Remind/Recall patients periodically to return to the clinic to finish the recommended doses in order to satisfy the immunization series.
- Enroll as a **Vaccines for Children Provider (VFC)**, a federally-funded, state-operated vaccine supply program that helps offset the costs of the vaccine to the patient and medical provider.

Taking a careful immunization history of adolescents 15-18 years old can prevent future cases of hepatitis B and its life-threatening sequelae. Don't miss this opportunity to save lives; be sure to vaccinate your adolescent patients.

For the full article *Adolescent Hepatitis B Immunizations: Missed Opportunities for Kids 15-18 Years Old*, visit www.lapublichealth.org/wwwfiles/ph/ph/TPHMarApr2003.pdf.

SARS: (from page 1)

SARS case definition (as of 5-23-03):

There have been several changes to the CDC's SARS case definition since the initiation of SARS case surveillance. First, the CDC has refined its definition to distinguish probable from suspect cases. Probable cases present with similar basic symptoms as suspect cases (i.e., fever and signs of respiratory illness) as well as at least one risk factor for SARS illness (i.e., travel to a SARS-afflicted area or contact with a suspected SARS case). However, probable cases also have radiographic evidence of pneumonia or respiratory distress syndrome. Preliminary CDC findings based on serologic samples of SARS cases suggests that probable cases are more likely to have evidence of coronavirus infection.

To date, Los Angeles County has identified 6 probable cases and 8 suspect cases, none laboratory confirmed as SARS cases. California continues to have the highest state total of SARS cases (table 1). In California, only one case has been laboratory confirmed with SARS-associated coronavirus infection. Nationwide, 353 cases have been identified, 19% of which are classified as probable cases. The full list of state totals is available on the CDC web site at: www.cdc.gov/od/oc/media/sars.htm.

The CDC continues to modify its list of areas considered to be high risk for SARS infection due to suspected or documented community transmission. It is important to note that these areas do not necessarily correspond to areas that have health alerts and/or advisories regarding travel – the most current CDC update regarding travel to areas associated with SARS is available at: www.cdc.gov/ncidod/sars/travel.htm). As of May 20, the CDC defines travel to six areas as qualifying risk factors for SARS case diagnosis: China; Hong Kong, Singapore; Taiwan; Toronto, Canada; and Hanoi, Vietnam. The latest case definition is available at: www.cdc.gov/ncidod/sars/casedefinition.htm.

SARS definition for case identification (as of 5-23-03)

- Fever ($\geq 38^{\circ}$ C or 100.5° F);
 - AND one or more signs of respiratory illness (e.g., cough, shortness of breath, abnormal chest x-ray);
 - AND either of the following:
 - History of travel (including stop-overs) to: China; Hong Kong, Singapore; Taiwan; Toronto, Canada; or Hanoi, Vietnam*
- OR
- Close contact with persons known to have SARS. Close contact includes having cared for, lived with or experienced direct contact with respiratory secretions and bodily fluids of a person with SARS.

*Travel restrictions have been terminated for Hanoi. To check the current case definition visit: www.cdc.gov/ncidod/sars/casedefinition.htm

Los Angeles County Cases:

All but one of the 14 Los Angeles cases (the child of another case) qualified as a SARS case due to travel to a SARS-associated area. Among the cases, nearly half (43%) reported travel to mainland China. The average age of cases is 36 years (range 2-78 years) and most are male (79%). Nine of the cases were hospitalized and discharged after short stays (average duration of hospitalization 1.5 days). Cases reside in areas throughout the county, and none of them works in sensitive settings (e.g., healthcare, schools, restaurants or markets).

Race of U.S. SARS cases: Perhaps because of the numerous media reports of the SARS epidemic in Asian countries, there is an erroneous belief that there is a preponderance of SARS cases in the U.S. among Asian Americans. This is not true. Across California and nationwide, equal proportions of cases are White and Asian/Pacific Islanders (for a full summary of U.S. cases see MMWR, May 16, 2003 available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm5219a2.htm).

TABLE 1: SARS Cases Total* (5-23-03)

Continued on page 4

LOCATION	SUSPECT CASES	PROBABLE CASES	TOTAL CASES
LA County	8	6	14
California	45	24	69
New York	30	8	38
Washington	26	2	28
United States	286	67	353

* All totals except L.A. County from CDC at: www.cdc.gov/od/oc/media/sars.htm

SARS (from page 3)

Isolation of visitors from SARS-associated areas:

The CDC presently does not require quarantine of individuals returning or visiting from SARS-associated areas. These individuals are advised to monitor for symptoms (e.g., fever, cough, etc.) and to contact their local health agency should symptoms develop. If only one of the two requisite symptoms for SARS case identification develop (i.e., fever or respiratory illness), the individual should self-isolate for 72 hours and immediately report any important health changes. Should the single symptom persist beyond 72 hours, the individual is advised to remain isolated for an additional 72 hours. Further information regarding of isolation and quarantine procedures and recommendations is available at: www.cdc.gov/ncidod/sars/

Reports of products making erroneous claims to cure SARS:

The FDA and the Federal Trade Commission are warning website operators, e-mail solicitors, manufacturers and distributors who suggest that their products will protect against, treat, or cure SARS that they must remove these deceptive claims from the Internet. The two agencies have targeted sites promising SARS protection through products such as air purifiers, sprays, dietary supplements, and masks since there is no known scientific proof for such claims. For more information, visit: www.fda.gov/bbs/topics/NEWS/2003/NEW00904.html. ¶

MRSA (from page 1)

As described in a previous issue of **The Public's Health** (February 2003, available at: www.lapublichealth.org/wwwfiles/ph/ph/ph/TPH0203.pdf), MRSA infection, once limited primarily to hospital and healthcare settings, is now occurring with alarming frequency among individuals without these traditional risk factors. CAMRSA generally has a genotype that is distinct from nosocomial MRSA and has a predilection for skin and soft-tissue infections. Certain virulence factors may also be associated with CAMRSA. Outbreaks of CAMRSA have been noted in correctional facilities, schools, athletic teams, among men who have sex with men, and in other communities, but cases have been reported in a wide range of individuals.

Enhanced reporting will allow for a timelier appraisal of transmission patterns and community-associated risk factors. These data may be useful in developing prevention and control strategies necessary to decrease the incidence of this disease. The new interim reporting

requirement focuses on hospitalized cases in children, who are less likely to have the chronic medical problems associated with nosocomial MRSA carriage. Submission of the isolates will facilitate understanding of the spread of CAMRSA and virulence factors. Following the six-month reporting period, reporting of MRSA will be re-evaluated.

Additional information about MRSA infection and guidelines for patients and healthcare providers regarding the diagnosis, prevention and treatment of community acquired MRSA is available at: www.lapublichealth.org/acd/MRSA.htm. ¶

Identification errors: It is important to note that MRSA infection has been frequently and erroneously identified as spider or bug bites. This misdiagnosis has impeded appropriate treatment and has contributed to the spread of disease. This further underscores the need for enhanced reporting of this disease.

Reporting pediatric MRSA cases:

Cases should be reported using a standard Confidential Morbidity Report (CMR) form (available at: www.lapublichealth.org/acd/reports/diseasePLUScmr.pdf) or may be reported directly to the Morbidity Unit of the LACDHS (213-240-7821 telephone, 888-397-3778 facsimile). The antibiogram of the MRSA isolate should be submitted with the CMR and the isolate should be sent to the Public Health Laboratory (313 North Figueroa, Los Angeles, CA 90012). Questions regarding this new reporting requirement can be addressed by calling Acute Communicable Disease Control (213-240-7941).

Community-Associated Methicillin-Resistant *Staphylococcus aureus* Skin Infections: FACT SHEET FOR HEALTH CARE PROVIDERS

Staphylococcus aureus is a common etiologic organism in soft tissue infections, and may be found on normal skin in nearly 20% of healthy people. Over the past several decades, infections with **methicillin-resistant *Staphylococcus aureus* (MRSA)** among hospitalized patients have become common. Recently, MRSA skin infections that are community-associated have been increasingly reported nationally, including fatalities. In 2002, the Los Angeles County Department of Health Services (LACDHS) received a substantial number of reports of community-associated MRSA skin infections occurring in patients of all ages without traditional risk factors for MRSA (e.g. significant exposure to health care or antibiotics). This fact sheet is meant to improve awareness among health care providers that MRSA has emerged as an important etiologic organism in community-associated soft tissue infections.

Definition Community-associated MRSA infections are distinguished from hospital-acquired MRSA infections by using the following criteria:

- Diagnosis of MRSA was made in the outpatient setting or by a culture positive for MRSA within 48 hours after admission to the hospital.
- The patient has no past medical history of MRSA infection.
- The patient has no past medical history in the past 1 year of:
 - Hospitalization
 - Admission to a nursing home, skilled nursing facility, or hospice
 - Dialysis
 - Surgery
 - Permanent indwelling catheters or percutaneous medical devices

Clinical Presentation MRSA skin infections may present in a number of forms:

- **Cellulitis:** Inflammation of skin
- **Impetigo:** Bullous (blistered) lesions or abraded skin with honey-colored crust
- **Folliculitis:** Infection of hair follicle (like a pimple)
- **Furunculosis:** Deeper infection below hair follicle
- **Carbuncle:** Multiple adjacent hair follicles and substructures are affected
- **Abscess:** Pus-filled mass below skin structures
- **Infected Laceration:** Pre-existing cut that has become infected

Other manifestations (i.e. blood or joint infections) have been less common, but some patients have required hospitalization for debridement or intravenous antibiotics. Some MRSA skin lesions have been initially misdiagnosed as “spider bites.”

Diagnosis Culture of skin lesions is especially useful in recurrent or persistent cases of skin infection, in cases of antibiotic failure, and in cases that present with advanced or aggressive infections. When antibiotics are necessary, LACDHS encourages the use of microbiologic culture to guide appropriate antibiotic selection. In the absence of symptomatic infection, culture for MRSA colonization is generally not necessary.

Treatment The first line of treatment for soft tissue infections is incision, drainage, and local care, rather than antibiotic treatment.

- Health care providers should continue prudent management of skin lesions and selective use of antibiotics, as inappropriate antibiotic use has been associated with the development of MRSA infection.
- At this time, LACDHS has no basis to recommend a change from standard practice in the empiric antibiotic treatment of soft tissue infections. The predominant strain of MRSA found in this investigation is resistant to β -lactam antibiotics, erythromycin, and fluoroquinolones. It is not clear whether resistance patterns vary by subpopulations within Los Angeles County.
- If antibiotics are indicated, use culture to select an antibiotic the organism is susceptible to. The predominant strain in this outbreak has been susceptible to TMP/SMX (Bactrim or Septra), clindamycin, gentamicin,

and rifampin. Dual antibiotic therapy (i.e., TMP/SMX plus rifampin) might be considered. According to laboratory tests by CDC, the predominant MRSA strain in this outbreak has not exhibited inducible clindamycin resistance.

- The role of MRSA decolonization with mupirocin (Bactroban), especially in the community setting, is not yet known. However, there have been reports of mupirocin resistance in the setting of widespread mupirocin use.
- At this time, expert consensus recommendations for the management of community-associated MRSA infections are not yet available; this fact sheet has been developed as interim guidance.

Prevention Skin infections with MRSA are thought to be transmitted by close skin to skin contact with another person infected with MRSA or by contact with a fomite or surface contaminated with MRSA.

Risk factors for MRSA skin infection might include exposure to health care settings, jails or prisons; occupations or recreational activities with regular skin to skin contact (i.e. wrestling); exposure to someone with MRSA; exposure to antibiotics; severe illness; advanced age; and immune suppression.

- Use Standard Precautions to help prevent the spread of MRSA in a health care setting;
- Between patients, wash hands regularly with soap and warm water. When hands are not visibly soiled, alcohol-based hand rubs are effective and have high compliance rates in health care settings.
- Wear gloves when managing wounds. After removing gloves, wash hands with soap and water or use alcohol or antibacterial hand rub.
- Carefully dispose of dressings and other materials that come into contact with blood, nasal discharge, urine, or pus from patients infected with MRSA.
- Clean surfaces of exam rooms with commercial disinfectant or a 1:100 solution of diluted bleach (1 tablespoon bleach in 1 quart water).
- Launder any linens that come into patient contact in hot water (>160°F) and bleach. The heat of commercial dryers improves bacterial killing.

The CDC website provides additional details on hand hygiene and environmental control in the health care setting:

- www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm
- www.cdc.gov/ncidod/hip/GUIDE/handwash_pre.htm

Surveillance In addition to the pediatric reporting requirement, health care providers should report to LACDHS unusual clusters of patients with MRSA infections. Otherwise, health care providers can track the characteristics of skin lesions seen in their own practices to identify patterns of antibiotic resistance, which can help identify unusual trends and guide appropriate treatment decisions. Please contact LACDHS if you have questions about instituting surveillance for MRSA within your medical practice. 

West Nile Virus (from page 1)

The first human and bird cases of WNV encephalitis in the western hemisphere were reported in the New York City area in 1999. A total of 83 human cases were identified in the U.S. during 1999–2000, and 58 cases in 2001. In 2002, WNV caused the largest arboviral encephalitis epidemic known in the western hemisphere; more than 4,100 cases with 284 deaths from 39 states and the District of Columbia.

Los Angeles County WNV Surveillance – 2003

This year, surveillance for WNV and other more common arboviral encephalitis viruses, such as Saint Louis encephalitis and Western Equine encephalitis, will be increased. Locally, surveillance efforts concentrate on testing sentinel chicken flocks, identifying and tracking the mosquitoes which transmit the virus and diagnosing sick birds which are potential reservoirs. The first evidence of WNV in an area is most often a die-off of wild birds from the corvid family such as crows and jays. When a problem is identified, mosquito abatement efforts can be targeted to the area. Surveillance for human disease is also carried out by investigating all cases of viral encephalitis, aseptic meningitis and acute flaccid paralysis syndrome and by offering serologic testing in our Public Health Laboratory (PHL).

However, both surveillance and future control of WNV depends upon joint cooperation between public health agencies, vector control districts, the medical community and the public at large since it is critical that suspected human cases and dead birds are promptly reported. Public health also relies upon individuals to eliminate water sources which encourage the breeding of mosquitoes.

Diagnosis of WNV

WNV belongs to a group of viruses called flaviviruses which include the viruses that cause Japanese encephalitis, Saint Louis encephalitis, dengue fever and yellow fever. Infection with flaviviruses is usually diagnosed by the presence of IgM in serum and/or CSF, but diagnosis may be difficult in people who have already been infected with one of

The first evidence of West Nile Virus in an area is most often a die-off of wild birds from the corvid family such as crows and jays.

these viruses due to cross-reacting antibodies. The IgM antibody capture enzyme-linked immunosorbent assay (MAC_ELISA) is considered the diagnostic testing method of choice because it is simple, sensitive, and applicable to serum and CSF samples. Diagnostic testing is available free of charge for suspected human WNV cases through the PHL. WNV testing can be arranged by calling the Acute Communicable Disease Control Program at 213-240-7941. Testing will be prioritized for hospitalized individuals where WNV is the suspected etiology for encephalitis, aseptic meningitis, and acute flaccid paralysis syndrome (a condition which has clinical similarities to Guillain-Barré syndrome). WNV testing is also available through a variety of commercial laboratories.

WNV is transmitted by several different species of mosquitoes; more than 30 species infected with WNV have been identified in North America. Most people who are bitten by an infected mosquito experience mild or no symptoms. While the majority of transmission is through infected mosquitoes, the virus can also be transmitted from infected transplanted organs and blood products. CDC investigators have also reported two cases of transmission of WNV to laboratory workers working with WNV-infected animals. Investigations are ongoing concerning possible transmission in breast milk; however, because this method of transmission is especially unlikely and since the benefits of breast feeding are well-established, physicians should continue to strongly encourage breast feeding.

In humans, most persons infected by WNV are asymptomatic. Only one of five will experience a mild illness known as "WNV fever," a self-limited febrile illness indistinguishable from dengue fever and other viral gripes such as influenza. Symptoms usually occur within 5 to 15 days after being bitten and may include fever, headache, muscle aches,

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West Nile Virus (from page 6)

swollen lymph nodes and rash. More severe illness is rare, but may include encephalitis, (indicating brain swelling) which causes lethargy, confusion, disorientation or coma, severe muscle weakness and paralysis. Other CNS manifestations include aseptic meningitis and acute flaccid paralysis syndrome. Treatment for WNV infection is supportive. 

To report dead birds contact:
West Nile Virus Dead Bird Surveillance Program
Division of Communicable Disease Control
California Department of Health Services
toll free hotline 877- WNV-BIRD (877-968-2473)

Additional information about Los Angeles County mosquito-borne encephalitis surveillance, submission of specimens and mosquito control is available by calling Acute Communicable Disease Control 213-240-7941 and at: www.lapublichealth.org/acd/docs/wnvbroch.pdf

For questions about mosquito containment:

Greater Los Angeles County Vector Control District
(562) 944-9656

Los Angeles County West Vector Control District
(310) 915-7370

San Gabriel Valley Mosquito and Vector Control District (626) 814-9466

Antelope Valley Mosquito and Vector Control District (661) 942-2917

Compton Creek Mosquito Abatement District (310) 639-7375

To report suspected human cases of West Nile Virus infection or to arrange testing, call:

Acute Communicable Disease Control

213- 240-7941 (during business hours, 7:30am - 5:00pm)

213-974-1234 (emergency operator, after hours and weekends)



ANTIBIOTIC RESISTANCE INFORMATION CORNER

Changing Use of Antibiotics in Community-Based Outpatient Practice, 1991-1999

Michael A. Steinman, MD, Ralph Gonzales, MD, MSPH, Jeffrey A. Linder, MD, MPH and C. Seth Landefeld, MD
Annals of Internal Medicine 2003;138(7):525-33.
Available at: www.annals.org/issues/v138n7/full/200304010-00008.html

With concern over the connection between inappropriate antibiotic use and increases in antibiotic resistance, nationwide efforts continue to reduce unnecessary antibiotic prescribing. This article presents encouraging news that outpatient antibiotic prescriptions decreased by 17% in the U.S. over the study period (1991-1999). However, prescriptions for broad-spectrum antibiotics (e.g., azithromycin, quinolones, amoxicillin-clavulanate, and second- and third-generation cephalosporins) increased. Adult broad-spectrum prescriptions increased from 24% to 48% ($p < 0.001$) in which 22% of these prescriptions were for conditions where antibiotics are not indicated (e.g., common cold, unspecified respiratory tracts infections, acute bronchitis, and viral conditions). Pediatric broad-spectrum prescriptions increased from 23% to 40% ($p < 0.001$), in which 14% of these prescriptions were used for inappropriate conditions.

The unnecessary and increased use of broad-spectrum antibiotics raises serious concern over losing the effectiveness of these agents to resistance. Efforts among physicians should focus on judicious prescribing and conscientious antibiotic decisions including whether or not to use antibiotics.

The CDC provides clinical practice guidelines for otitis media, rhinitis, sinusitis, and cough illness/bronchitis online at: www.cdc.gov/drugresistance/community/technical.htm and www.cdc.gov/drugresistance/technical/prevention_tools.htm

Other clinical practice guidelines are provided by the Infectious Diseases Society of America at: www.idsociety.org 

SARS INFORMATION HOTLINE

In order to address basic questions about SARS, the Los Angeles County Department of Health Services has established a toll-free hotline to provide information to the public in 7 languages: English, Mandarin, Cantonese, Vietnamese, Thai, Korean, and Spanish. This service provides the latest in CDC guidelines and can explain to your patients what is SARS, its symptoms, how it is spread, and what is recommended for travelers.

SARS Hotline: 1-800-989-5255

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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)¹ - January 2003

Disease	THIS PERIOD Jan 2003	SAME PERIOD LAST YEAR Jan 2002	YEAR END TOTALS				
			2002	2001	2000	1999	1998
AIDS ²	107	111	1,787	1,354	1,648	1,870	2,014
Amebiasis	12	6	109	139	109	134	157
Campylobacteriosis	97	93	1,092	1,141	1,273	1,089	1,217
Chlamydial Infections	2,306	1,050	36,590	32,670	30,546	27,595	24,166
Encephalitis	3	6	63	41	49	39	48
Gonorrhea	489	519	7,985	7,743	7,199	6,061	5,986
Hepatitis Type A	34	40	482	542	839	1,120	940
Hepatitis Type B, Acute	0	2	27	44	65	61	92
Hepatitis Type C, Acute	1	0	3	1	28	21	12
Measles	0	0	0	8	5	1	3
Meningitis, viral/aseptic	41	53	669	530	491	390	626
Meningococcal Infections	4	2	46	58	53	49	50
Mumps	1	1	16	17	29	24	21
Non-gonococcal Urethritis (NGU)	47	57	1,398	1,429	1,576	1,744	N/A ³
Pertussis	4	18	167	103	102	238	77
Rubella	0	0	0	0	3	0	0
Salmonellosis	92	104	990	106	990	1,101	1,253
Shigellosis	105	68	922	684	849	669	784
Syphilis, primary & secondary	35	17	362	199	144	88	120
Syphilis, early latent (<1 yr.)	21	17	341	223	214	328	524
Tuberculosis	15	17	1,025	1,046	1,065	1,170	1,299
Typhoid fever, Acute	1	1	34	17	21	16	17

1. Case totals are provisional and are subject to change following publication.

2. Case totals are interim and may vary following periodic updates of the database.