

LOUISIANA MONTHLY MORBIDITY

DISEASES REPORTED DURING MONTH OF MAY, 1968

BY PARISH OF RESIDENCE

RECOMMENDATION OF THE PUBLIC HEALTH SERVICE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

(See Page 3)

DIVISION OF PUBLIC HEALTH STATISTICS -

- LOUISIANA STATE DEPARTMENT OF HEALTH

RELEASED June 10, 1968	ASEPTIC MENINGITIS	DIPHThERIA	ENCEPHALITIS	ENCEPHALITIS, POST INFECTIONOUS	INFECTIONOUS AND SERUM HEPATITIS	MEASLES	MENINGOCOCCAL INFECTIONS	PERTUSSIS	POLIOMYELITIS, PARALYTIC	RABIES IN ANIMALS	RHEUMATIC FEVER	STREPTOCOCCAL INFECTIONS	SHIGELLOSIS	TYPHOID FEVER	OTHER SALMONELLOSIS	TETANUS	TUBERCULOSIS, PULMONARY	GONORRHEA	SYPHILIS
TOTAL TO DATE 19 67	13	4	13	7	197	136	69	40	0	30	4	44	36	11	72	1	425	2688	954
TOTAL TO DATE 19 68	17	7	12	6	288	2	67	3	0	24	9	141	26	1	51	4	441	3281	1036
TOTAL THIS MONTH	14	1	5	4	64	0	6	1	0	3	3	71	14	0	14	0	98	754	252
ACADIA																	2	4	1
ALLEN																		2	1
ASCENSION					2								1						1
ASSUMPTION													1						6
AVOYELLES																			
BEAUREGARD																			
BIENVILLE																			2
BOSSIER				1						1							1	12	1
CADDO				1	5												9	159	32
CALCASIEU					1										2		4	22	2
CALDWELL					1														
CAMERON																			
CATAHOULA					1												1		
CLAIBORNE																			1
CONCORDIA							1												3
DESOTO																	1	3	1
EAST BATON ROUGE															5		8	41	19
EAST CARROLL																			
EAST FELICIANA																	1		
EVANGELINE																	1		5
FRANKLIN					5												1		2
GRANT					1														6
IBERIA					1													2	3
IBERVILLE																	1		1

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- LOUISIANA STATE DEPARTMENT OF HEALTH

RELEASED June 10, 1968	ASEPTIC MENINGITIS	DIPHtheria	ENCEPHALITIS	ENCEPHALITIS, POST INFECTION	INFECTIOUS AND SERUM HEPATITIS	MEASLES	MENINGOCOCCAL INFECTIONS	PERTUSSIS	POLIOMYELITIS, PARALYTIC	RABIES IN ANIMALS	RHEUMATIC FEVER	STREPTOCOCCAL INFECTIONS	SHIGELLOSIS	TYPHOID FEVER	OTHER SALMONELLOSIS	TETANUS	TUBERCULOSIS, PULMONARY	GONORRHEA	SYPHILIS
JACKSON										1								1	
JEFFERSON	4				1		1					4					3	43	12
JEFFERSON DAVIS													1		2		3	6	
LAFAYETTE					1												3	8	1
LAFOURCHE					1							1						2	5
LASALLE																			
LINCOLN					1												1	12	2
LIVINGSTON																			
MADISON																		1	
MOREHOUSE																		3	
NATCHITOCHE					1												1	1	1
ORLEANS	6	1	2		16			1			2	62	10		5		31	228	94
OUACHITA					4												5	48	
PLAQUEMINES																			
POINTE COUPEE					3		1											3	
RAPIDES							2										2	4	8
RED RIVER																			
RICHLAND					2												1	1	
SABINE													1					2	
ST. BERNARD																	1	4	1
ST. CHARLES	1										1								1
ST. HELENA																	1		
ST. JAMES																		1	
ST. JOHN																		1	5
ST. LANDRY																	7	10	6
ST. MARTIN							1										1	3	
ST. MARY	1		1									1					2	3	3
ST. TAMMANY					3							1						13	4
TANGIPAHOA	1		1		1													12	5
TENSAS																			
TERREBONNE			1	1	5												1	4	2
UNION					3													2	1
VERMILION																	1		
VERNON					2													77	1
WASHINGTON					1												1	8	6
WEBSTER				1	2					1		2					2	2	
WEST BATON ROUGE																		4	2
WEST CARROLL																			
WEST FELICIANA	1																		5
WINN																	1	2	
OUT OF STATE																			

From January 1 through May 31 of 1968, the following cases were also reported: 11 Malaria (contracted outside U.S.A.), 1 Tularemia.

RECOMMENDATION OF THE PUBLIC HEALTH SERVICE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

The Public Health Service Advisory Committee on Immunization Practices meeting on February 15, 1968, issued the following recommendation on cholera vaccine.

CHOLERA VACCINE

CHOLERA

Cholera generally occurs in endemic and epidemic form only in South and Southeast Asia. In recent years, however, it has also been epidemic in certain areas of the Middle East.

Infection is acquired from contaminated water or food. It is believed to result from personal contact only in rare instances.

CHOLERA VACCINE

Various cholera vaccines have been widely used, but until recently their efficacy was unproved. Carefully controlled field studies have now clearly demonstrated the effectiveness of current vaccines against both the classical and El Tor strains of cholera vibrios. However, severe cases of cholera have occurred in vaccinated persons.

The duration of immunity induced by vaccine is relatively brief. Antibody titers reach a peak within 4 weeks of vaccination and are maintained for about 3 months. Protection against disease seems to last no more than 6 months after the primary series or a booster dose.

Vaccine available in the United States is prepared from a combination of inactivated suspensions of classical Inaba and Ogawa strains of cholera vibrios grown on agar or in broth and preserved with phenol.

RECOMMENDATIONS FOR VACCINE USE

A primary vaccination or a booster dose within the previous 6 months is generally required for persons traveling to or from countries with cholera.* Vaccination requirements are published annually by the World Health Organization and summarized by the Public Health Service in its booklet *Immunization Information for International Travel* (PHS Publication No. 384). Because cholera sometimes reappears in countries free of the disease for several years, travelers should seek up-to-date information to determine the need for a valid International Certificate of Vaccination.

Physicians administering vaccine to travelers should emphasize that an International Certificate of Vaccination must be validated for it to be acceptable to quarantine authorities. Validation can be obtained at most city, county, and State health departments. Failure to secure validation can cause travelers to be revaccinated or quarantined during the course of travel. The Certificate remains valid for 6 months.

The traveler's best protection against cholera, as well as against many other enteric diseases, is to avoid po-

*For a current listing, consult the most recent issue of the World Health Organization's *Weekly Epidemiologic Record*.

tentially contaminated food and water. Persons following the usual tourist itinerary through countries reporting cholera and using standard accommodations run virtually no risk of acquiring cholera.

Vaccination Schedule

Injections may be given subcutaneously or intramuscularly.

Primary: For travelers vaccinated in the United States, a single 0.5 ml. dose of cholera vaccine is considered adequate to satisfy the International Sanitary Regulations. The single dose for children is proportionately smaller (see table below).

Two doses of cholera vaccine, 0.5 ml. and 1.0 ml., preferably given a month or more apart, are recommended for adults traveling or working in areas where cholera is epidemic or known to be endemic and living under conditions in which sanitation is less than adequate. The doses for children are suggested in the summary table. A two-dose schedule of vaccination is also advisable for persons working with cholera vibrios in the laboratory.

Boosters: Booster injections should be given every 6 months as long as the likelihood of exposure persists. In areas where cholera only occurs in a two to three month "season", protection is optimal when the booster dose is given at the beginning of the season. The primary series need never be repeated for booster doses to be effective.

Summary: The following table summarizes the recommended doses for primary and booster vaccination:

Dose Number	Age (Years)		
	Under 5	5-10	Over 10
1	0.1 ml.	0.3 ml.	0.5 ml.
2 & Boosters	0.3 ml.	0.5 ml.	1.0 ml.

Reactions

Vaccination often results in discomfort at the site of injection for one or more days. The local reaction may be accompanied by fever, malaise, and headache.

Contraindication

Rarely, several reactions of various kinds follow administration of cholera vaccine. If one experiences such a reaction, revaccination is not advisable. Most governments will permit such an individual to proceed provided he carries a physician's statement of the medical contraindication. However, any inadequately vaccinated traveler coming from an infected area may be quarantined or placed under surveillance for 5 days.