

DATA SOURCES

Data on occurrence of communicable diseases in Los Angeles County (LAC) were obtained through passive and/or active surveillance. Passive surveillance relies on physicians, laboratories, and other health-care providers to report diseases of their own accord to the Department of Health Services (DHS) using the Confidential Morbidity Report (CMR) card, Acquired Immunodeficiency Syndrome (AIDS) Adult Confidential Case Report form, the Sexually Transmitted Disease Confidential Morbidity Report (STD CMR) form, or electronically by telephone or facsimile.

During active surveillance, Disease Control or special project staff contact hospitals, laboratories and physicians regularly in an effort to identify all cases of a given disease. In 1997, active surveillance was employed for the following diseases or syndromes:

- Acquired Immunodeficiency Syndrome (adult and pediatric cases)
- Cryptosporidiosis
- Escherichia coli* O157:H7
- Group A Streptococcal Invasive Disease
- Haemophilus influenzae* Invasive Disease
- Hemolytic Uremic Syndrome
- Listeriosis (perinatal and nonperinatal)
- Meningococcal Invasive Disease
- Pneumococcal Invasive Disease
- Streptococcal Necrotizing Fasciitis
- Streptococcal Toxic Shock Syndrome

In addition, Disease Control staff contact schools, hospitals, nursing homes, student health centers and sentinel physicians to collect reports of vaccine-preventable diseases and to investigate outbreaks of any kind.

DATA LIMITATIONS

This report should be interpreted in light of the following notable limitations:

1. Problems with cases reporting

The proportion of cases that are not reported varies for each disease. Evidence indicates that the proportion of the cases that are not reported for some diseases may be as high as 95%.

2. Fatality rates

Some deaths from communicable diseases may not appear on LAC=s Vital Records computer files. Deaths are filed with only underlying cause of death indicated. Any contributing or otherwise significant conditions, including communicable diseases, are not indicated in the computer record. Also, case-fatality rates (except for acquired immunodeficiency syndrome [AIDS]) are based on deaths that occurred in 1997 regardless of year of disease onset; therefore, fatality rates should be interpreted with caution.

3. Case definitions

To standardize surveillance, A Case Definitions for Infectious Conditions under Public Health Surveillance, @ *MMWR* 1997;46(RR-10):1-57 is used. Since verification by a laboratory test is required for the diagnosis of some diseases, cases reported without such verification may not be true cases. Therefore, an association between a communicable disease and a death or an outbreak possibly may not be identified.

4. Onset date versus report date

Some cases of disease occurring in 1997 were not reported until after this annual report was completed. Slight differences in the number of cases and rates of disease for 1997 may be observed in subsequent annual reports. Any such disparities are likely to be small.

5. Population estimates

Estimates of the LAC population are subject to error. Population estimates for the years 1980 and 1990 were obtained from census data. Excluding those years, population data for the years 1981 through 1992 were estimated from 1980 census by simple proportional increases between census years. Population data for 1993 through 1997 were estimated from 1990 census through a more sophisticated technique. Population of LAC is in constant flux. Though not accounted for in census data, visitors and other non-residents will have an effect on disease occurrences.

6. Place of acquisition of infections

Some cases of diseases reported in LAC may have been acquired outside of the county. This may be especially true for many of the diseases common among the Hispanic and Asian populations. Certain disease rates may reflect the place of diagnosis, rather than the location where an infection was acquired.

7. Health District boundaries changes

In 1994, the following health district boundaries changed: Central, Compton, Glendale, Inglewood, Northeast, San Fernando, West, and Torrance. San Fernando Health District was split into Antelope Valley and San Fernando Health Districts. These health district boundaries were used for most diseases in the 1997 annual report, with the exception of genital chlamydial infection, gonorrhea, and syphilis. Each district health officer oversees from one to three health districts and the disease control activities therein. For this report these groupings are termed A health officer jurisdictions. @ Previous affiliations with DHS Personal Health Services networks are no longer valid and do not represent the pattern of public health services delivery.

8. Race/Ethnicity category changes

In 1994, the racial group designation of "Other" was separated from the Asian racial group, and is now designated as ANative American @ (including American Indian, Alaskan

Native, Aleut, and Eskimo). Thus, the five major racial categories and their definitions as used in this report are as follows:

Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands.
Black	A person having origins in any of the black racial groups of Africa.
Hispanic	A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
Native American	A person having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.
White	A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

STANDARD REPORT FORMAT

CRUDE DATA

Number of Cases: For most diseases, this number reflects new cases of the disease with an onset in 1997. If the onset was unknown, the date of diagnosis was used. For sexually transmitted diseases and tuberculosis, this number reflects cases reported and confirmed in 1997.

Annual Incidence Rates in Los Angeles County: Number of new cases in 1997 divided by 1997 county population estimate (9,051,337) multiplied by 100,000.

Annual Incidence Rates in the US and California: 1997 incidence rates for the US and California were taken from the previously cited *Morbidity and Mortality Weekly Report*. The *MMWR* records diseases by date of report rather than date of onset.

Mean Age at Onset: Arithmetic average age of all cases.

Median Age at Onset: The age that represents the midpoint of the sequence of all case ages.

Range of Ages at Onset: Ages of the youngest and oldest cases in 1997. For cases under one year of age, less than one (<1) was used.

Case Fatality: Number of deaths in 1997 due to disease (when data were available) divided by the number of new cases of the disease in 1997, expressed as a percentage. Note that deaths may be due to infections acquired prior to 1997.

ETIOLOGY: The causative agent(s).

DISEASE ABSTRACT: A synopsis of the disease activity in 1997.

STRATIFIED DATA

Trends: Any trends in case characteristics during recent years.

Seasonality: Number of cases that occurred during each month of 1997.

Age: Annual rate of disease for individual age groups. Race-adjusted rates are presented for some diseases.

Sex: Male-to-female rate ratio of cases.

Race/Ethnicity: Annual rate of disease for the five major racial groups. Cases of unknown race are excluded; thus, race-specific rates may be underestimates. Age-adjusted rates are presented for some diseases.

Location: Location presented most often is the health district of residence of cases. Note that "location" rarely refers to the site of disease acquisition. Age-adjusted rates by location are presented for some diseases.

PREVENTION: A description of county programs that address the disease, as well as personal control actions.

COMMENTS: Miscellaneous information not pertaining directly to any of the above items.