

Aftershocks

When Hurricane Katrina hit, my wife and I responded in a fashion common to many New Orleans residents: we “vertically evacuated” to the lower floors of one of the city’s larger hotels. This had been a successful routine for many years. But when the storm blew out the windows in our hotel room, we were obliged to take up residence in an exhibit hall, along with more than 1000 other people, and to live there without power, air conditioning, and water for the next six days.

There, I witnessed some stressful medical situations. Elderly patients from nursing homes with physical illnesses and disabilities, including Alzheimer’s disease, as well as patients with emotional problems, had been evacuated to the same large exhibit hall. There were patients with cardiac disease and patients who had long required hemodialysis. There were two families with two-month-old babies. It was difficult, if not impossible, to obtain necessary medications — as I discovered firsthand when I tried unsuccessfully to get an ophthalmic steroid for my corneal grafts.

Eventually, most of the nursing home residents and patients with Alzheimer’s were transferred to relatively unaffected nursing homes.

Several patients were transferred to our hospital’s dialysis center, which could address their medical needs, if not the stress that arose from the lack of availability of their personal physicians and dialysis technicians.

The rest of us remained in the hotel, trapped by the flooding caused by the rupture of levees and by the rioting that spread from the nearby Superdome to the hotel and many areas in the city’s business district. Fortunately, the police protected the hotel from the rioting, but as the evacuees were brought through the ground floor from the Superdome to waiting buses, many relieved themselves on the floor, further fouling the environment.

Having experienced the trauma of this event myself, I am certain that social and behavioral problems will emerge in many victims of Katrina — owing to the displacement of families, the loss of family members and friends, the devastation of homes, the separation of people from their culture, the loss of income, and the disruption of community and social networks.

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tions caused by *Vibrio vulnificus*, and wounds sustained during such disasters can result in infections that appear in the early days of shelter living.⁴ In the United States, tetanus is primarily a disease of the nonimmune elderly, so supplies for tetanus prophylaxis should always be kept on hand.

As shelters become stabilized and consolidated, surveillance based on syndromic case definitions should be implemented to identify potential disease transmission and to follow disease and injury trends. All data, whether collected by the Centers for Disease Control and Prevention (CDC), the state departments of health, the American Red Cross, or other nongovernmental organizations that sponsor shelters, must be coordinated if they are to be as useful as possible. Shelters are critical surveillance sites; however, since shelters are not staffed by physicians or public health experts, a simple, easy-to-use reporting mechanism that identifies sentinel symptoms (such as diarrhea, fever, acute respiratory infection, and hemoptysis) should be implemented as quickly as possible. In Mississippi, within 14 days after Katrina hit, the Red Cross and the state health department provided simple case definitions and set up a toll-free number for shelter staff members to report illnesses. As of September 22, 2005, only isolated cases of presumed chicken pox (in Mississippi), gastroenteritis (in Mississippi and Louisiana), and lice and scabies (in Louisiana) have been identified, but the threat of transmission is ever present.

Immunizations for vaccine-preventable diseases are re-

