



Edwin W. Edwards  
GOVERNOR

# Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section  
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J. Christopher Pili  
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## Large Hepatitis A Outbreak in Monroe Area

On June 15, 1992, the Epidemiology Section was notified of five patients that had been reported with a presumptive diagnosis of hepatitis A.

Further investigation identified 72 cases of hepatitis A (Figure 1). Of these, 49 (70%) reported having eaten at restaurant X during April 27 and May 12, 1992. The owner of restaurant X phoned the OPH on the second day of the

investigation to report an employee that had been ill one month before with a presumptive diagnosis of hepatitis A.

A case-control study was conducted that included all identified persons with presumptive or confirmed hepatitis A who had eaten at restaurant X between April 27 and May 12, 1992. Controls were selected from healthy persons who had eaten at the restaurant during the same period as cases. Names of controls were obtained from cases and from rosters of people seeking immunoglobulin shots at the Ouachita and Lincoln Parish Health Units after exposure. Forty-nine case-patients and fifty-one controls were asked about food consumption at the restaurant.

Case-patients were more likely than controls to have eaten cold meat sandwiches (30/18 vs. 22/28, OR = 2.10, P=0.06, Table 1). No single food item was statistically significantly associated with illness. However, the trend toward an association with illness was present for almost all cold sandwiches and cold meat salads.

Several potential cofactors associated with the likelihood of disease transmission were analyzed (Table 2). Individuals that took antacids following their meal were almost twice as likely to become ill as individuals who did not (10/38 vs. 6/44, OR=1.9, P=0.36), but this correlation was not statistically significant. By contrast, customers that took an analgesic on the day of their meal were significantly less likely to become ill than those people who did not take an analgesic (9/36 vs. 22/26, OR=0.3, P-value=0.01).

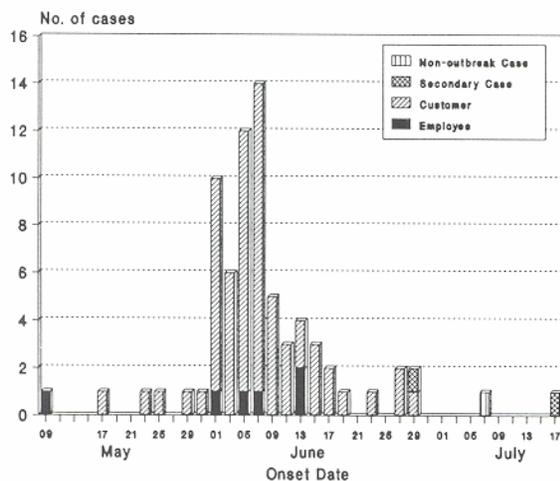
A single grill cook prepared all sandwiches to be served. Sandwiches were either hot, warm or cold and were served open face with trimmings on the side. There were seven people working at the restaurant when the outbreak occurred, six staff and the owner/manager.

The grill cook admitted having symptoms of back pain, nausea, vomiting, fever, and general malaise on April 9, 1992. He eventually developed jaundice. He did not admit to having loose stools. He continued to work on April 11 but he did not return to work on the following day and was off work for a month. In the grill cook's absence, the assistant cook began to prepare sandwiches. She developed symptoms similar to the grill cook with onset on June 6, 1992.

Blood samples from six (75%) of the eight employees were positive for IgM anti-HAV. One of the remaining two employees was positive to IgG anti-HAV and the other was non-reactive.

(Continued on page 2)

Figure: Hepatitis A outbreak at restaurant X, May 9-June 29, 1992



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Hepatitis A Outbreak in Monroe-West Monroe (Cont.)

Given the number of people who ate at restaurant X, the OPH personnel felt that the situation warranted appropriate precautions to prevent further spread of the outbreak. Customers who had eaten at the restaurant in the two weeks prior to the outbreak, were advised to seek immunoglobulin shots from their private practitioner or from the local parish health unit. A press release broadcasted by local T. V. and radio and newspaper articles reported the outbreak. Ouachita Parish Health Unit gave approximately 1,500 immunoglobulin shots to customers of restaurant X following the press release. This very large and effective operation could not have taken place without the effort of Ms. Billie Strickland, Region VII administrator, Dr. Shelley Jones, Ouachita Parish Health Unit Director, and many nurses and administrative personnel.

In conclusion, in this outbreak of hepatitis A, the customers and employees became ill primarily by consuming uncooked foods contaminated during the preparation by an infected foodhandler. It is probable that several food items, particularly sandwiches, were contaminated during the two week period between April 27th through May 12th, 1992. Taking an analgesic may have served as a protectant to infection for some of the individuals exposed.

**Table 1:** Association between illness and consumption of categories of food at restaurant X during April 27-May 12, 1992

	Case		Control		O.R. <sup>1</sup>	P-value
	Ate	DNE <sup>2</sup>	Ate	DNE		
Cold meat salad	5	42	1	49	5.8	0.08
Cold sandwich	30	18	22	28	2.1	0.06
Warm sandwich	14	34	13	37	1.2	0.72
Vegetable salad	10	38	10	40	1.1	0.91
Hot sandwich	2	46	11	39	0.2	0.02

1 O.R. = Odds Ratio  
2 DNE = Did Not Eat

**Table 2:** Relationship between illness and potential cofactors

	Case		Control		O.R.	P-value
	Yes	No	Yes	No		
Antacids	10	38	6	44	1.9	0.36
Exercise	30	19	28	23	1.3	0.66
Hot sauce added to food	2	46	2	49	1.1	0.66
Smoking	10	39	10	41	1.1	0.88
Pre-existing illness	3	46	3	48	1.0	0.64
Usage of illicit drugs	3	46	3	48	1.0	0.64
Antibiotics	5	43	5	44	1.0	0.61
Alcoholic beverage with meal	6	41	7	44	0.9	0.72
Weekly alcohol consumption	30	17	39	17	0.9	0.91
Analgesics	9	36	22	26	0.3	0.01

## Pilot Blood Lead Screening Program Begins

In response to the October 1991 CDC Lead Poisoning Prevention Guidelines (see Louisiana Morbidity Report, Vol. 3, No. 1, p. 3), the Louisiana Lead Poisoning Prevention Program has begun efforts to determine the extent of low-level lead poisoning in Louisiana's children.

A pilot study will be conducted in Lafourche parish in which all children between 1 and 6 years of age currently receiving child-health services in the public health unit will have capillary blood lead levels done. Venous confirmations of elevated initial levels will be done to eliminate any false positive results.

Lafourche Parish was selected as the study site because of patient load and health unit staffing considerations. Screening will be done on an estimated 500 children between September 1992 and early Spring 1993.

For further information, contact the Louisiana Lead Poisoning Prevention Program at 568-5070.



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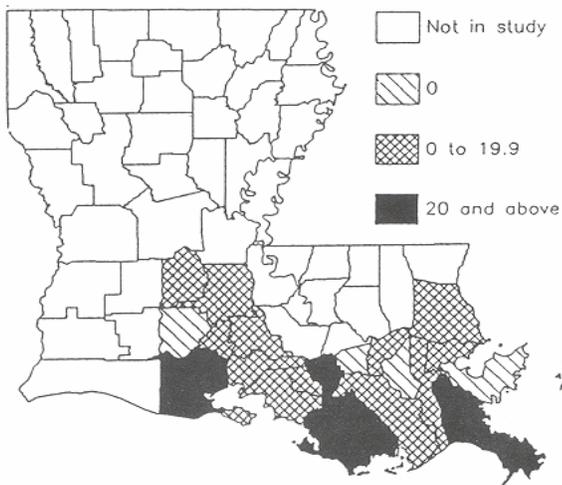
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# Campylobacteriosis in Southeastern Louisiana

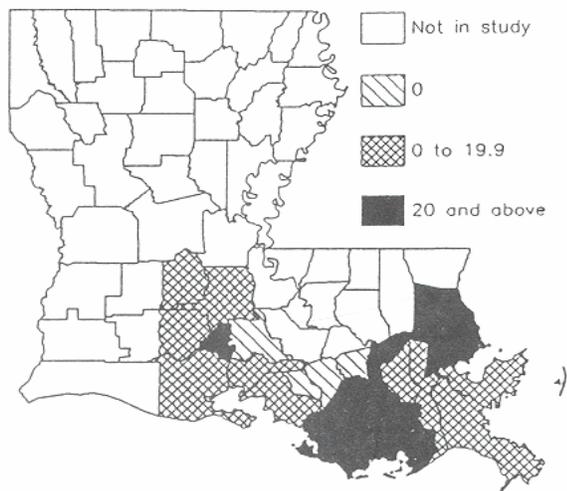
Data from an ongoing study of bacterial enteric infections show that campylobacteriosis is relatively common in southeastern Louisiana. The Office of Public Health, in active surveillance of 19 southeastern parishes, ascertained 98 cases between March 1st and July 31st of this year, compared with 151 cases of salmonellosis during the same period.

Rates of campylobacteriosis to date have been highest in coastal parishes (Figure 1). High rates of salmonellosis are more evenly distributed among coastal and inland parishes (Figure 2).

**Figure 1:** Incidence of campylobacter infection per 100,000 population by parish



**Figure 2:** Incidence of salmonella infection per 100,000 population by parish



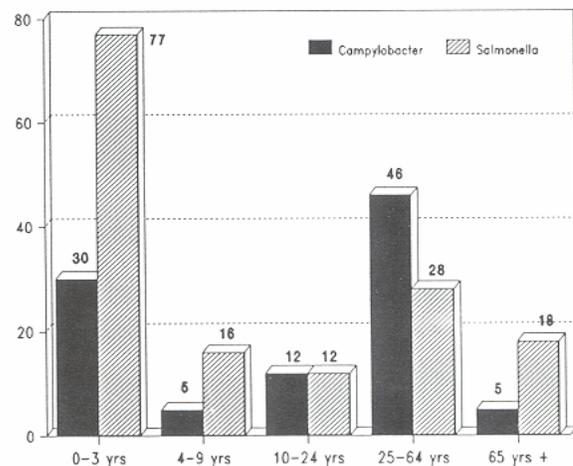
Males and females as well as blacks and whites have nearly identical incidence rates of salmonellosis, but campylobacteriosis is higher among males and among whites (Table 1).

**Table 1:** Incidence rates of campylobacter and salmonella infections per 100,000 population, by gender and race

	Campylobacter		Salmonella	
	Cases	Rate	Cases	Rate
Females	45	10	78	17
Males	53	12	73	17
Blacks	21	8	44	17
Whites	70	12	92	16
Other/Unk.	7	-	15	-

The age distribution of cases differs substantially for these two organisms. About half of salmonella cases (51%) are babies and pre-schoolers, while about one fifth (19%) are working age adults. Among campylobacter cases however, only one third (31%) are babies and pre-schoolers and nearly half (47%) are working age adults (Figure 3).

**Figure 3:** Age distribution of persons with campylobacter and salmonella infections



As part of the study, the Epidemiology Office has interviewed in detail 75 persons with campylobacteriosis and 59 persons with salmonellosis as of August 1st. Of the 75 campylobacter isolates, 63 have been received and speciated by the State laboratory; there were 55 *C. jejuni*, five *C. coli*, two *C. fetus* and one *C. laridis* isolates.

The same percentage (11%) of campylobacter and salmonella infections were outbreak-associated (based on the patients report of at least one other ill person in his/her immediate environment). The clinical features of the two illnesses were very similar (Table 2).

(Continued on page 4)

*Campylobacteriosis in Southeastern Louisiana (Cont.)***Table 2:** Clinical features of campylobacter and salmonella infections

	Campylobacter Total = 75		Salmonella Total = 59	
Diarrhea	75	100%	59	100%
Mean duration of diarrhea	6.4 days		7.3 days	
Fever	61	81%	48	81%
Stomach cramps	54	72%	34	58%
Nausea	44	59%	29	49%
Headache	35	47%	18	31%
Bloody stools	40	53%	32	54%
Vomiting	37	49%	32	54%
Antibiotic therapy	51	68%	31	53%
Hospitalization	16	21%	15	25%

The public health and financial impact of these infections can be partially inferred from the percentage of persons who missed work due to their illness: 42% of persons with campylobacter infections and 14% with salmonella infections missed at least one day of work; also, for 26% of persons with campylobacter infections and 24% with salmonella infections another person missed work in order to care for the patient. These differences highlight the fact that campylobacteriosis is found mainly among working age adults.

In summary, campylobacteriosis is not a rare condition, and its manifestations are highly similar to those of salmonellosis. However, the affected population is considerably different, and the financial and public health impact are not inconsequential. Physicians should consider campylobacter infection when evaluating persons with diarrhea, and laboratories should test stool cultures for campylobacter if they are not already doing so.

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## Cholera in Vermilion Parish

A 64-year-old Black female was hospitalized for gastroenteritis on August 29, 1992. Symptoms had started the morning of the day she was hospitalized.

*V. cholerae inaba* hemolytic subgroup 01 was cultured from the patient's stool. This is a different strain from the one causing the current cholera epidemic in Latin America.

Exposure may have occurred by cross-contamination of poultry prepared in a kitchen area where contaminated seafood was handled by patient prior to freezing. Thawing process due to electrical power failure following Hurricane Andrew may have contributed to the cross-contamination. The fish and shrimp came from an area in Louisiana's coast that has been an endemic site for previous cholera cases. Frozen shrimp, fish and poultry are being tested at Louisiana Central Laboratory.

## Influenza High Risk Immunization Program 1992-93

On November 2, 1992 health clinics throughout the state will begin to administer influenza immunizations to individuals who are at high risk of serious illness or death from influenza infection. High risk individuals include:

- Persons 65 or older
- residents of nursing homes and other chronic-care facilities
- adults and children with chronic disorders of the pulmonary or cardiovascular systems, including children with asthma
- adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, or immunosuppression (such as persons with AIDS and cancer patients receiving chemotherapy)
- children and teenagers receiving long-term aspirin therapy, who therefore may be at risk of developing Reye syndrome after influenza.

Physicians, nurses and other personnel capable of nosocomial transmission of influenza to high risk individuals are encouraged to see their own physicians or to organize their own immunization programs.

This year's trivalent influenza vaccine will contain A/Texas/36/91 (H1N1), A/Beijing/353/89 (H3N2), and B/Panama/45/90 viruses. Although the current influenza vaccine can contain one or more antigens administered in previous years, annual vaccination using the current vaccine is necessary because immunity for a person declines in the year following vaccination. Because the 1992-93 vaccine differs from the 1991-92 vaccine, supplies of 1991-92 vaccine should not be administered to provide protection for the 1992-93 influenza season.

Previously unvaccinated children 6 months to 9 years who are in risk groups should receive two doses of split virus vaccine. The dosage of split virus vaccine for children is 0.25 ml for those 6 to 35 months of age, 0.5 ml for those 3 to 8 years of age, and 0.5 ml for those 9 years of age and older. Persons older than 12 years of age may receive either split or whole virus vaccine.

Children at high risk for influenza-related complications may receive influenza vaccine at the same time as MMR, Hib, pneumococcal, and oral polio vaccines. Vaccines should be administered at different sites on the body. Influenza vaccine should not be administered within 3 days of vaccination with pertussis vaccine.

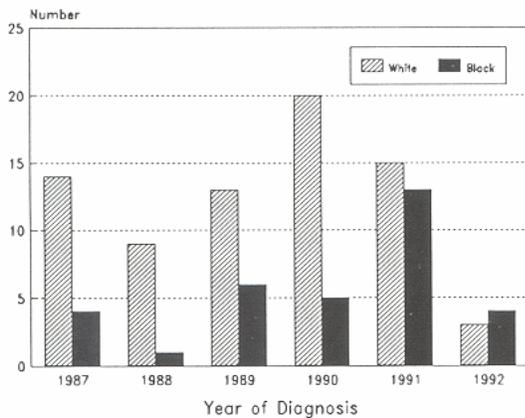
Questions regarding the influenza immunization program may be directed to the respective parish health unit or to the Immunization Section at (504) 568-5007.

## AIDS Update AIDS in the Elderly

The number of AIDS cases in persons over age 60 has steadily increased. A total of 123 cases have been reported in this age group, representing 3.4% of all AIDS cases. Of this group, 68% are white, 30% are black, and 2% are hispanic. Eighty percent are male and 20% are female. The geographic distribution differs from cases under age 60 in that there is a lower percentage in the New Orleans area and a higher percentage in most other regions of the state.

The characteristics of this group have changed over time. Through 1990, the majority of cases were white. In 1991, an almost equal distribution occurred. Preliminary data for 1992 shows blacks slightly higher than whites (Figure 1). Modes of transmission differ from the cases under age 60, with a lower percentage of sexual transmission and a higher percentage of transfusion-related cases (Figure 2). However, within the elderly group, modes of transmission are changing, with a decreasing percentage of transfusion-related cases (from 61% in 1987 to 14% in 1991) and increasing percentages in other risk categories.

Figure 1: AIDS cases in elderly by race, 1987-1992



AIDS indicator diseases are different in this older age group. Pneumocystis carinii pneumonia is only diagnosed in 40% of persons over age 60. The wasting syndrome and HIV dementia are diagnosed in a higher percentage of persons within this group. Kaposi's sarcoma and Mycobacterium avium occur less frequently (Figure 3). Other diseases occur in less than 5% of the group. Seventy-five percent of the persons over 60 have died, compared to 64% of persons under age 60.

Retrospective chart reviews during surveillance activities suggest that HIV infection may not be adequately diagnosed in older persons. HIV should be considered in the diagnosis of an older person with wasting and recurrent or unusual infections.

Figure 2: AIDS cases by age group and risk category

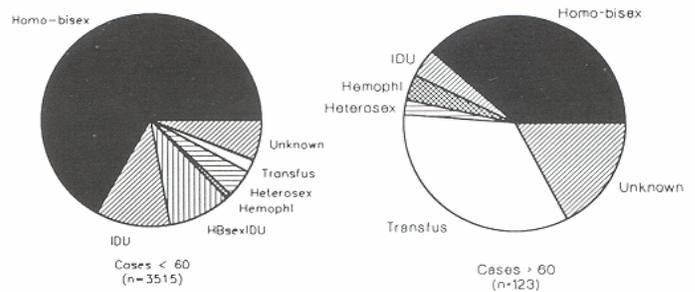
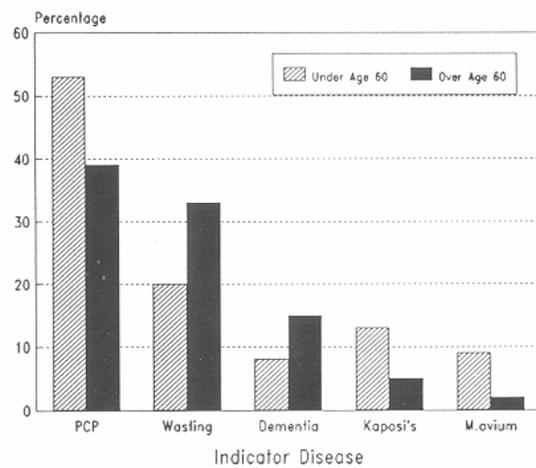
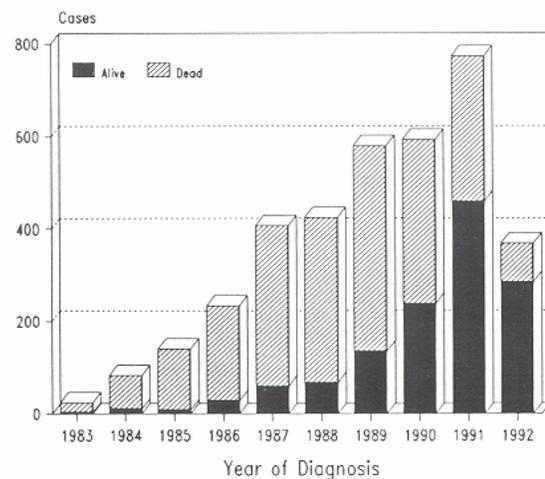


Figure 3: AIDS indicator diseases by age group



### AIDS Case Trends



COMMUNICABLE DISEASE SURVEILLANCE, Jul - Aug, 1992  
PROVISIONAL DATA

Table 1. Selected diseases by region

DISEASE	HEALTH DEPARTMENT REGION										Jul-Aug 1992	Jul-Aug 1991	Cum 1992	Cum 1991	%Change
	1	2	3	4	5	6	7	8	9						
<b>Vaccine-preventable</b>															
Measles	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	Cases	3	0	0	0	0	0	0	0	0	3	3	20	20	0
Rubella	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	Cases	1	0	0	2	0	0	0	0	0	3	4	6	8	-25
<b>Sexually-transmitted</b>															
AIDS	Cases	49	23	2	6	2	5	9	8	10	115	132	512	737	-31
	Rate*	6.7	3.0	0.7	1.1	0.8	1.6	1.7	2.6	2.2	2.7	3.1	12.1	17.5	
Gonorrhea	Cases	927	364	105	182	75	205	355	155	158	2526	2725	9369	10339	-9
	Rate**	12.6	4.8	3.5	3.3	2.9	6.6	6.5	5.1	3.5	6.0	6.5	22.2	24.5	
Syphilis (P&S)	Cases	99	84	61	32	1	28	65	35	33	438	548	1783	1938	-8
	Rate**	1.3	1.1	2.0	0.6	0.04	0.9	1.2	1.1	0.7	1.0	1.3	4.2	4.6	
<b>Enteric</b>															
Campylobacter	Cases	21	6	8	7	1	0	0	0	8	51	19	154	53	+191
Hepatitis A	Cases	15	3	0	1	0	0	1	47	3	72	9	159	79	+101
	Rate*	2.0	0.4	-	0.2	-	-	0.2	15.4	0.7	1.7	0.2	3.8	1.8	
Salmonella	Cases	31	22	11	22	0	3	12	1	11	114	112	294	331	-11
	Rate*	4.2	2.9	3.6	4.0	-	1.0	2.2	0.3	2.5	2.7	2.6	7.0	7.6	
Shigella	Cases	7	4	0	0	0	0	2	0	0	14	47	60	124	-52
	Rate*	1.0	0.5	-	-	-	-	0.4	-	-	0.3	1.1	1.4	2.8	
Vibrio Cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Vibrio, other	Cases	1	2	1	0	0	0	0	0	1	5	3	21	33	-36
<b>Other</b>															
Hepatitis B	Cases	4	3	0	3	1	1	6	0	0	18	50	121	182	-34
	Rate*	0.5	0.4	-	0.5	0.4	0.3	1.1	-	-	0.4	1.1	2.9	4.1	
Meningitis/Bacteremia	Cases	0	0	0	0	0	0	0	0	0	0	1	0	16	-
H. Influenza	Cases	0	0	0	0	0	0	0	0	0	0	1	0	16	-
N. Mening.	Cases	1	0	0	1	0	0	0	0	0	2	2	23	19	+21
Tuberculosis	Cases	13	4	0	5	2	2	6	5	2	39	75	178	184	-3
	Rate*	1.8	0.5	-	0.9	0.8	0.6	1.1	1.6	0.4	0.9	1.7	4.2	4.2	

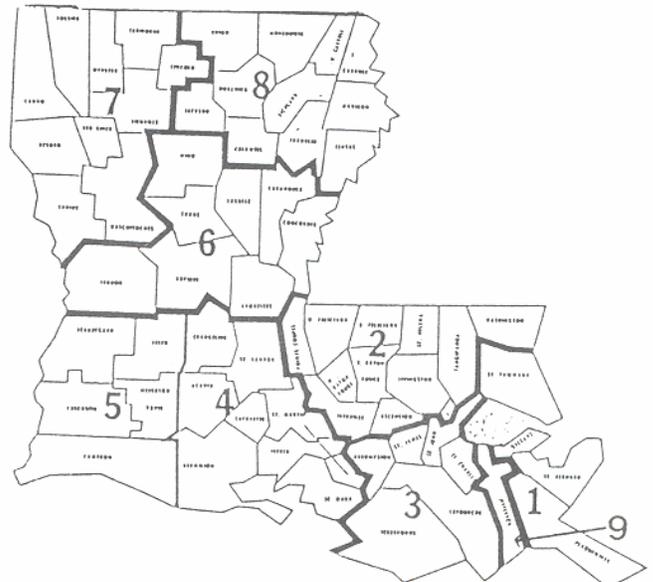
\* Cases per 100,000 population  
\*\* Cases per 10,000 population

Table 2. Diseases of low frequency, 1992

Disease	Total to date
Blastomycosis	3
Brucellosis	1
Histoplasmosis	0
Lead Toxicity	9
Legionellosis	2
Leprosy	0
Leptospirosis	0
Lyme Disease	5
Malaria	1
Rocky Mountain Spotted Fever	0
Tetanus	0
Typhoid	1

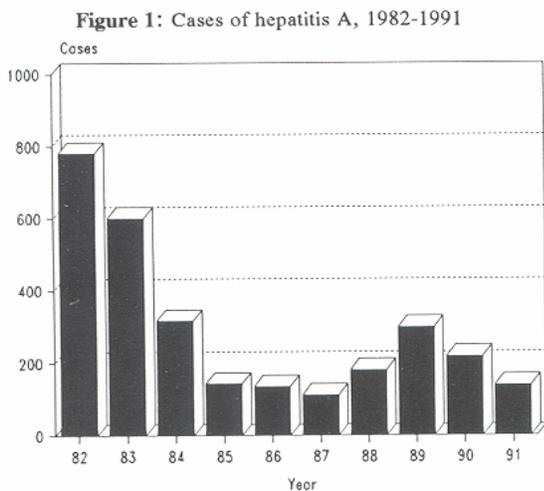
Table 3. Animal rabies - Jul - Aug, 1992

Parish	Species	No. Cases
Grant	Bat	1
Bossier	Skunk	1

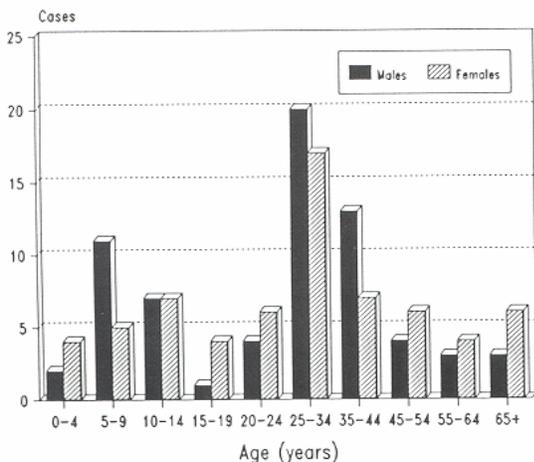


## Annual Summary Hepatitis A 1991

In 1991, 138 cases of hepatitis A were reported to the Epidemiology Section. The overall case rate for 1991 was 3.3 per 100,000. Hepatitis A case reports decreased to their lowest levels since 1987 with a 36% decrease from 1990 and 54% decrease from 1989 (Figure 1). The incidence by age peaks bimodally, first in the 5-9 year age group followed by young adults 25-44 years (Figure 2). Case rates by race were higher for blacks (3.5 per 100,000) than whites (2.7). Five parishes reported at least ten or more cases: Caddo (10), E. Baton Rouge (17), Jefferson (17), Orleans (19), and Plaquemines (16).



**Figure 2: Cases of hepatitis A by age and sex, 1991**



**Comment:**

The incidence of hepatitis A is decreasing, yet historically, the incidence of hepatitis A has had recurring peaks with nationwide epidemics spaced roughly 7 to 10 years apart. Hepatitis A is the predominant type of hepatitis among persons up to 15 years of age. Cases among the youngest age groups are underreported, since many cases in children are asymptomatic. It has been estimated that for every case reported, ten are not recognized or not reported. Risk factors most frequently associated with illness are personal contact, drug use and association with a day care. One of the largest foodborne outbreaks of hepatitis A occurred in 1992 in northeast Louisiana (See article in this issue.)

### LOUISIANA FACTS

Notice sent by Dr. Edmond Souchon, President, State Board of Health, to housekeepers following the Yellow Fever Epidemic of 1897.

BOARD OF HEALTH STATE OF LOUISIANA.

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NEW ORLEANS, LA., February 23, 1898.

RECOMMENDATIONS TO HOUSEKEEPERS.

The greatest danger of recurrence of disease lies in the houses, and especially in the bedding, clothing, bureaus, trunks, boxes, etc.

It is earnestly hoped that the people in whose houses sickness has, or has not occurred, to apply most rigorously, in spirit and in letter, the following recommendations:

- I. Sanitary Inspectors appointed by the Board of Health will explain to the housekeepers the importance of thorough house sanitation. It is earnestly hoped that the inspectors will be received with the proper spirit, and their instructions complied with.
- They will return to see that these instructions have been followed.
- II. The rooms should be thrown wide open for eight hours, especially on sunny days; also on cold days.  
This should be repeated four or five days or more.
- III. The armchairs, bureaus, boxes, trunks, etc., should be opened and contents spread as much as possible, on these days.
- IV. The bedding, cotton comfort and woolen fabrics should be exposed to the air and to the sun for eight hours, turning them over every two hours.  
This should be repeated four or five days, or more.
- V. The yard must be kept thoroughly clean and drained.
- VI. The garbage must be put out early, in water-tight receptacles. These should be large enough to hold all the garbage easily.
- VII. All obstructions to the free flow of water in the gutters in front of each house should be swept out of the gutter to the edge of the street.  
The mud at the bottom of the gutters should not be disturbed.

EDMOND SOUCHON, M. D.,  
President.

Do you have an interesting fact about Louisiana that you would like to see published in the Louisiana Morbidity Report? Send facts and source to: Louisiana facts, DHH-OPH-Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160.

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## LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Gonorrhea**	Plague*	Cancer
Amebiasis	Granuloma Inguinale**	Poliomyelitis	Complications of abortion
Anthrax	Hepatitis, (Specify type)	Psittacosis	Congenital hypothyroidism
Aseptic meningitis	Herpes (genitalis/ neonatal)**	Rabies (animal & man)	Lead poisoning
Blastomycosis	Legionellosis	Rocky Mountain Spotted Fever	Phenylketonuria
Botulism*	Leprosy	Rubella (German measles)*	Reye Syndrome
Brucellosis	Leptospirosis	Rubella (Congenital syndrome)	Severe Traumatic Head Injuries ■
Campylobacteriosis	Lyme Disease	Salmonellosis	Severe undernutrition
Chancroid**	Lymphogranuloma venereum**	Shigellosis	severe anemia, failure to thrive
Cholera*	Malaria	Syphilis**	Sickle cell
Chlamydial infection**	Measles (rubeola)*	Tetanus	disease (newborns)
Diphtheria*	Meningitis, Haemophilus	Trichinosis	Spinal cord injury ■
Encephalitis (Specify primary or post-infectious)	Meningococcal Infection (including meningitis)*	Tuberculosis***	Sudden infant death syndrome (SIDS)
Erythema infectiosum (Fifth Disease)	Mumps	Tularemia	
Foodborne illness*	Mycobacteriosis, atypical***	Typhoid fever	
Genital warts**	Ophthalmia neonatorum*	Typhus fever, murine (fleaborne endemic)	
	Pertussis (whooping cough)	Vibrio infections (excluding cholera)	
		Yellow fever	

Report cases on green EPI-2430 card unless indicated otherwise below.

\*Report suspected cases immediately by telephone. In addition, report all cases of rare or exotic communicable diseases and all outbreaks.

\*\*Report on STD-43 form. Report syphilis cases with active lesions by telephone.

\*\*\*Report on CDC 72.5 (f 5.2431) card

■ Report on DDP-3 form; preliminary phone report from ER encouraged (568-2509).

The toll free number for reporting communicable diseases is  
 1-800-256-2748

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