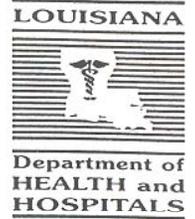




Edwin W. Edwards  
GOVERNOR

# Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section  
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SECRETARY

May-June 1995

Volume 6 Number 3

## The Health Effects of the Flood

On May 8 and 9 southeastern Louisiana experienced severe rains and repeated flooding. Subsequently, 12 parishes were declared federal disaster areas. To assess the possible health effects of the flood, on May 15 the Office of Public Health (OPH) began emergency department (ED) surveillance of all injuries and illnesses in disaster area parishes. ED nurses, infection control nurses and safety personnel were contacted and requested to supply aggregate daily patient data by type of illness or injury for the month of May.

By June 9, of the 37 hospitals with EDs in the disaster area, 17 had responded with information for each day of the month of May. Although 30 hospitals provided information for at least one day in May, only twenty five hospitals had near complete data for May 1 through May 16. Public health officials made over 150 telephone calls to hospitals to obtain this information.

ED surveillance data from the 25 hospitals with nearly complete data for May 1 through May 16 do not show a substantial change in total numbers of patient visits for any illness or injury. There were an average of 1111 visits per day in the 7 days before the storm, 1035 visits per day during the 2 days of the storm, and 1179 visits per day in the 7 days after the storm (Table 1). With the exception of 10 drowning/submersion injuries on the days of the flooding, there were no apparent changes in the type of

injuries/illness during or after the flooding. Figure 1 shows the contribution of selected injuries and illnesses to total visits for each of the first 16 days of May. These results may change when data have been collected from all hospitals.

Hospitals were also asked to complete a survey regarding hospital operations during the storm. Of the 28 hospitals reporting this information, most (at least 90%) were able to continue normal operation of emergency room, internal medicine, ICU, surgery and laboratory departments during the storm. Almost half, however, (44%) did not offer elective procedures. Two hospitals (7%) turned patients away during the storm and 7 (25%) sustained building damage. Seven hospitals (25%) had a shortage of physicians, 9 (32%) had a shortage of nurses and 3 (11%) had additional nurses on duty. Five hospitals (18%) had sewage problems and 4 (14%) used bottled and boiled water. Two hospitals (7%) experienced medical supply shortages and one (4%) experienced food shortages. The routes to 19 hospitals (68%) were blocked due to flooding, downed trees and power lines.

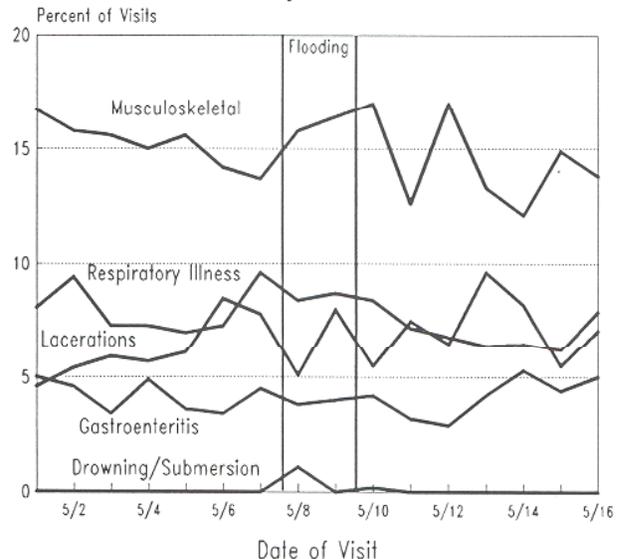
Overall, the surveillance data do not appear to show an increase in injuries and illnesses occurring after the flood.

Many hospitals, however, were impacted by the storm. Obtaining this information is essential for allocating resources, conducting control programs and keeping the public  
*(Continued on page two)*

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Figure: Percentage of Emergency Department visits due to selected injuries and illnesses



## The Health Effects of the Flood (Cont.)

informed in a timely fashion. In the future, OPH plans to collect this information via computers and modems using the Emergency Public Health Information Surveillance System (EPHISS). Until that time, however, OPH will continue to ask for cooperation from hospitals in providing such data over fax machines and the telephone.

**Table 1:** Proportion of ED visits due to selected injuries and illnesses\*

Category	Before Storm May 1-7	During Storm May 8-9	After Storm May 10-16
Patient visits, No.	7775	2069	8252
<b>Injuries</b>			
Drowning/Submersion, %	0%	.5%	0%
Laceration/Puncture, %	6.3%	6.5%	7.1%
Muscular-Skeletal, %	15.2%	16.1%	14.3%
<b>TOTAL INJURIES</b>	<b>35.1%</b>	<b>34.9%</b>	<b>34.9%</b>
<b>Illnesses</b>			
Gastroenteritis, %	4.2%	3.9%	4.2%
Respiratory Illness, %	8.0%	8.6%	7.0%
<b>TOTAL ILLNESSES</b>	<b>64.6%</b>	<b>64.5%</b>	<b>64.9%</b>

\*Total categories contain injuries and illness not listed

## TB Cases Increase in 1994

In 1994, 433 cases of active tuberculosis were reported to the Tuberculosis Control Program, an increase of 18% over the 367 cases reported in 1993. TB Program staff are encouraged by this increase, however, rather than discouraged. A new system of active surveillance for cases was established in 1994, using outreach workers to link with hospitals and major providers and to search for new cases that might not have been reported. Another factor that may have contributed to reporting is increased awareness among health care providers of the need to report TB in a timely manner. Whether some part of this increase may be due to an actual increase in morbidity will become clear over the next 1-2 years as a reporting trend is established.

The 1994 cases averaged 48 years of age and were predominantly male (71%). Co-infection with HIV was established in 14% of the cases. Six percent of the patients were born in other countries, 4% percent reported that they were homeless, and 4% percent were incarcerated at the time they were diagnosed. One indicator that is very important in TB management is the percentage of patients with TB bacteria which are resistant to isoniazid (INH). In 1994, 5.4% of the cases were resistant to INH. In the New Orleans metropolitan area, 7.6% of cases were resistant to INH. Because of these high levels of resistance, the TB Control Program is recommending that individuals suspected of having TB should be started on an initial regimen that includes 4 antibiotics (usually INH, rifampin, pyrazinamide, and ethambutol) until the initial drug susceptibility result can be obtained. Also, it is recommended that all TB suspects and cases be treated using Directly-Observed Therapy (DOT) to ensure that patients take their medication and prevent the development of drug-resistant tuberculosis. *Direct questions to the TB Control Program at (504) 568-5015, or your regional TB Coordinator.*

## Ebola Virus Outbreak

In April and May an outbreak of Ebola virus infection occurred in Zaire, representing the fourth recognized outbreak of this deadly virus in humans. The outbreak began in the city of Kikwit (population 500,000) when a patient who apparently had Ebola virus infection had surgery and members of the surgical team developed a hemorrhagic fever disease. Subsequently other hospital staff members and persons outside the hospital also became ill; as of May 31, there were 205 persons with suspected or confirmed Ebola virus infection, of whom 153 had died.

Ebola virus is a member of the filovirus family which cause hemorrhagic fevers, and it is probably the most rapidly fatal virus. The incubation period for the virus is 2-21 days. Although this family of viruses usually come from rodents or arthropods, the reservoir for the outbreak in Zaire is unknown. Ebola virus can be transmitted from person to person through close personal contact, including sexual contact and contact with secretions. Because of this, health care workers caring for ill patients and family members of ill persons are at greatest risk.

The outbreak in Zaire appears to have been controlled through isolation of ill persons, use of "barrier techniques" by medical staff, careful sterilization of needles and syringes, and proper disposal of waste and corpses. With these fairly simple precautions, it is likely that this outbreak will end soon, and the likelihood that the virus would spread to this country is small.

### Louisiana Morbidity Report

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**EPIDEMIOLOGY'S NEW  
FAX NUMBER****504-568-5006  
or  
Linc 621-5006****Newly Licensed Varicella  
Virus Vaccine**

Varivax, a varicella virus vaccine was recently licensed by the Food and Drug Administration. The vaccine is indicated for vaccination against chickenpox in individuals 12 months of age and older. The American Academy of Pediatrics recommends the varicella vaccine for all children, adolescents, and young adults who have not already been infected with chickenpox. The Advisory Committee on Immunization Practices (ACIP) is expected to publish their recommendations this summer. It is expected that the vaccine will become part of the routine childhood immunization program.

Varivax is a live attenuated virus vaccine. Because individuals vaccinated with Varivax may potentially be capable of transmitting the vaccine virus to close contacts, these individuals should avoid close association with susceptible high risk individuals (e.g., newborns, pregnant women, immunocompromised persons). Vaccine recipients should avoid use of salicylates for 6 weeks after vaccination. Varivax can be administered concomitantly with MMR vaccine.

Children 12 months to 12 years of age should receive a single 0.5ml dose administered subcutaneously. Adolescents and adults 13 years of age and older should receive two 0.5ml doses administered subcutaneously 4-8 weeks apart.

Varivax must be kept frozen until used. It is recommended that the vaccine be administered immediately after reconstitution and discarded if reconstituted vaccine is not used within 30 minutes.

Private physicians can purchase and begin using the vaccine now. The Office of Public Health has not been given federal or state funds to purchase Varivax, so public health clinics will not be offering the vaccine at this time. Additional information regarding ACIP and OPH recommendations and availability of varicella vaccine in public clinics will be provided as it becomes available.

**Survey of Childbearing  
Women Suspended**

In late April, the Centers for Disease Control abruptly announced that it was suspending the HIV Survey of Childbearing Women, which is a major national surveillance system to monitor trends in the HIV epidemic. In the Survey of Childbearing Women, leftover dried blood spots taken from newborns for biochemical testing are tested in a blinded fashion to measure the prevalence of HIV antibodies in their mothers. Because this testing is blinded, no test result can be linked to an individual mother by anyone (including the health department); the survey provides only statistical information which is very useful in tracking the epidemic. Furthermore, since the testing is carried out on blood samples that have already been taken for another purpose, the survey does not pose any additional risk or burden to anyone. The Office of Public Health has used the results of this survey extensively, including presenting results of it in the last issue of the Morbidity Report.

In the last year, health officials in Louisiana and the rest of the U.S. have been putting in place programs to routinely test pregnant women for HIV infection in the first trimester, so that they can receive AZT and help prevent transmission of the HIV virus to their children. It appears that this testing has been confused with the Survey of Childbearing Women: several legislators have proposed bills in other states and in Washington that would require the blood testing on infants in SCW to be "unblinded" so that mothers could find out their HIV status at this time. The problems with this proposal are that: 1) the testing could only be done on infants whose mothers provide written informed consent, which would cause a statistical bias large enough to invalidate the results, and 2) the testing is done after it is too late for AZT to have any benefit in preventing transmission. The interests of prevention and surveillance can both be served if all women are tested early in pregnancy *and* the SCW continues as before.

Nonetheless, CDC has suspended the Survey of Childbearing Women in response to this proposed legislation, and it will convene a panel of experts to review the issue. In the meantime, OPH is looking for ways to replace the important information obtained from this surveillance system.

## Pneumococcal Resistance in Day Care

Recently, a study was conducted by Drs. Patrick Unkel and Bertrand Foch on pneumococcal resistance in day care centers in Lake Charles/Sulphur in order to determine the prevalence and antimicrobial susceptibility patterns of *Streptococcus pneumoniae* in children in day care centers in Lake Charles. The study was funded by a grant from Bristol-Meyers Squibb. Nasopharyngeal cultures were obtained from 267 children on eleven different occasions at ten day care centers between February and May 1995. *S. pneumoniae* isolates were tested for susceptibility to penicillin and cefotaxime. Of the 267 children in the study, 118 were females and 149 were males with 54 black and 213 white children.

Thirty-seven percent (100/267) of the children cultured demonstrated *S. pneumoniae* nasopharyngeal carriage (Table 1). Carriage rates were twice as high for children under 24 months of age (66% versus 33%, RR=2.0, p<.001), and four times as high for children spending more than 20 hours per week in day care (41% versus 10%, RR=4.1, p<.001). Resistance rates for the strains cultured were strikingly high. Forty (40%) of the 100 were resistant to penicillin and 24 (24%) were resistant to cefotaxime (Table 2). Penicillin resistance rates were somewhat higher in children under 24 months of age (57% versus 35%, RR=1.6, p=.06).

These study results demonstrate penicillin-resistant *S. pneumoniae* is prevalent in children in day care centers in

Table 1: *S. pneumoniae* carriage among day care center attendees

Age	Tested	Positive	% Positive	Penicillin Resistant	Percent Resistant
< 24 mons	35	23	66%	13/23	57%
>= 24 mons	232	77	33%	27/77	35%
<b># Hours</b>					
< 20 hours	30	3	10%	1/3	33%
>= 20 hrs	237	97	41%	39/97	40%
Total	267	100	37%	40/100	40%

Table 2: Antimicrobial susceptibility patterns of *Streptococcus pneumoniae*

	No. cultures	No. resistant	%
Penicillin	100	40	40%
Cefotaxime	100	24	24%

Lake Charles, especially in those attending day care greater than twenty hours per week, and with age less than two years. Physicians should consider this in determining antibiotics to use when treating invasive infections caused by known or suspected *S. pneumoniae*.

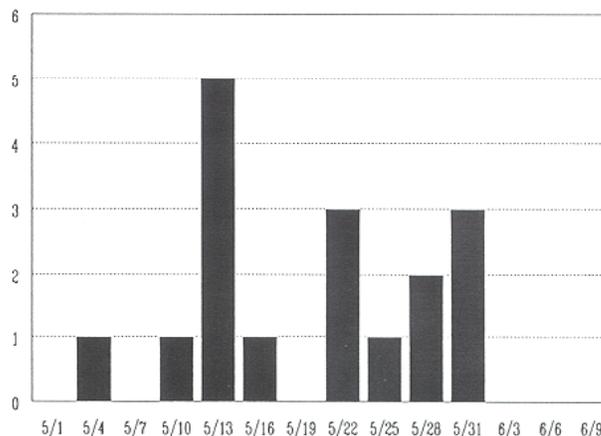
## Measles Outbreak in Jefferson Parish

The Office of Public Health identified an outbreak of measles associated with a daycare center on the westbank of Jefferson Parish. The first cases involved children less than 1 year of age. As of June 20, 1995, a total of 17 cases of measles had been confirmed, including 3 cases in adults. Three daycare centers, 2 hospitals, and several physician's offices have had cases and confirm the spread of disease. Seven of the 17 cases (41%) have occurred in children less than one year of age who are not routinely vaccinated against measles.

The Immunization Program recommends that children in affected daycare centers who are 6-12 months of age receive measles vaccine (either single antigen or as MMR). Preschool children in the New Orleans metropolitan area over 12 months of age should receive their first MMR and if they have had an MMR more than 30 days ago, should receive a second MMR. Vaccinations are free at City of New Orleans health units and will be given free at other parish health units if the child has been exposed to measles. There will be no need to repeat the MMR after the fourth birthday if the child received 2 MMR's more than 30 days apart after the first birthday.

Please report any suspected cases of measles to the Immunization Program for investigation as quickly as possible, so that rapid action can be taken to decrease spread to exposed individuals. The phone number to report a suspected case is (504) 483-1900.

Figure: Measles cases, May-June 1995



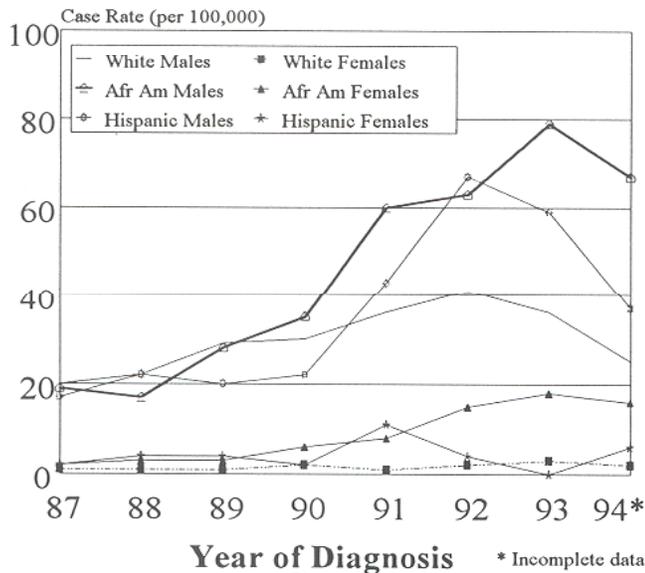
## AIDS UPDATE

### The Profile of Reported AIDS Cases through 1994

The 1,161 AIDS cases reported to the Louisiana AIDS surveillance system during 1994 raised the state's ranking from 16th to 11th highest nationwide in AIDS *case rates* and from 19th to 12th highest for *number* of cases. This brings the cumulative total to 6,894 AIDS cases diagnosed in Louisiana through 1994 and reported to OPH by February 1995. Among these cases, 914 were diagnosed in 1994; however, this number is expected to increase as additional cases are reported at a later date.

This past year, 1994, is first year where the number of diagnosed cases in African-American men exceeded the number of diagnosed cases in white men. Since 1991, the case rates for minority populations in general have been disproportionately high (Figure 1). This is especially the case for the Baton Rouge and Monroe regions, where approximately three quarters of the AIDS cases diagnosed in 1994 were in African-Americans. The case rate in the Baton Rouge Region is almost twice that of the rest of the state.

Figure 1: Trends in AIDS rates by ethnicity and gender

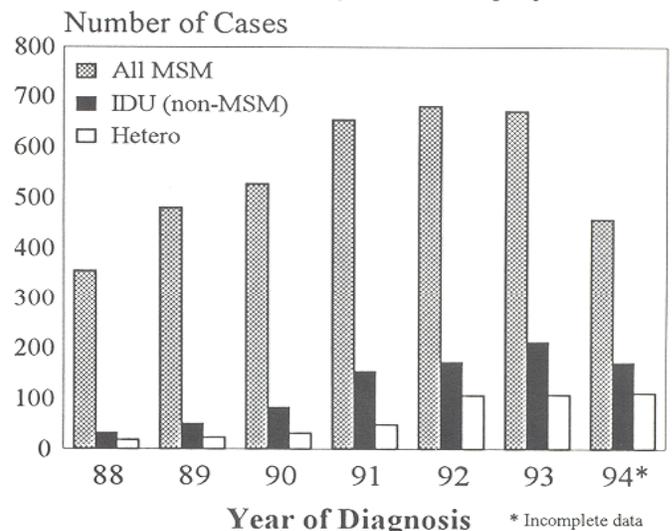


Women represent steadily increasing proportions of persons with AIDS. In 1994, 15% of the cases were in women. As for men ages 25-44, AIDS was the second leading cause of death during 1993. The 25-44 age group has the highest case rate, about five times higher than the rate of all other ages. Statewide, 30% of cumulative cases are between the ages of 30 and 35 at AIDS diagnosis.

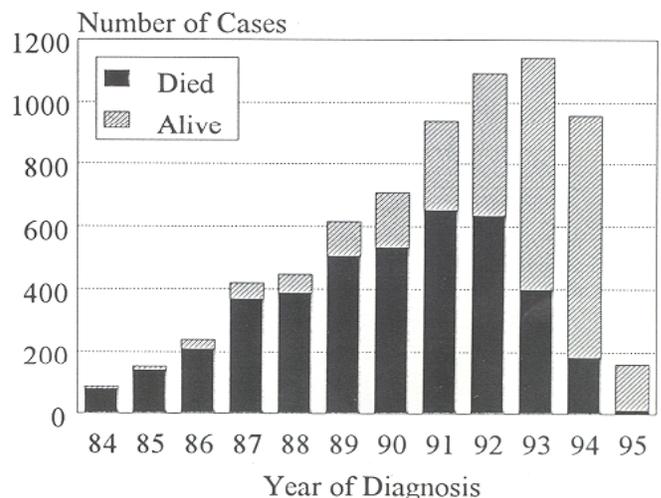
Men who have sex with men (MSM) still remains the leading mode of transmission among persons with AIDS across the state, although the number of new cases in this risk category may have stabilized over the last few years (see Figure 2). Transmissions by injection drug use (among MSM as well as non-MSM) and by heterosexual sex are increasing steadily. In the Baton Rouge Region, injection drug use accounted for 45% of all new cases, more than three times that for the rest of the state.

Aside from regional variations, the epidemiological trends are continuing on a course similar to those over the past three years. Prevention efforts should target men who have sex with men, drug users, and their sex partners, particularly in minority populations. For annual or regional reports, please call (504) 568-7524.

Figure 2: Trends in major transmission groups



### AIDS Case Trends (Reported through May 1995)



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE ,  
MAR - APR, 1995  
PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD				% Chg
	1	2	3	4	5	6	7	8	9	Mar-Apr 1995	Mar-Apr 1994	Cum 1995	Cum 1994	
<u>Vaccine-preventable</u>														
Measles	0	0	0	0	0	0	0	0	0	0	1	0	1	-
Mumps	1	1	0	0	1	1	0	0	1	5	8	6	10	-40
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	0	0	0	0	0	0	0	1	0	1	3	1	4	-75
<u>Sexually-transmitted</u>														
AIDS Cases Rate <sup>1</sup>	16 1.4	1 0.2	2 0.5	3 0.6	3 1.1	8 2.3	7 1.4	1 0.3	2 0.6	43 1.0	173 4.0	137 3.2	356 8.3	-62
Gonorrhea Cases Rate <sup>2</sup>	718 1.4	125 2.3	78 2.2	118 2.4	55 2.1	86 2.8	365 7.2	99 2.9	91 2.6	1735 4.1	1984 4.7	3681 6.4	3809 9.0	-29
Syphilis(P&S) Cases Rate <sup>2</sup>	59 0.1	24 0.4	17 0.5	28 0.6	2 0.1	5 0.2	39 0.8	26 0.8	2 0.1	202 0.5	297 0.7	376 0.9	616 1.5	-40
<u>Enteric</u>														
Campylobacter	7	4	2	3	2	0	0	1	4	23	15	38	21	+81
Hepatitis A Cases Rate <sup>1</sup>	9 0.9	3 0.5	0 -	1 0.2	0 -	0 -	0 -	6 1.7	3 0.8	22 0.5	39 0.9	35 0.8	55 1.3	-36
Salmonella Cases Rate <sup>1</sup>	3 0.3	2 0.4	1 0.3	6 1.2	1 0.4	0 -	6 1.2	0 -	3 0.8	22 0.5	74 1.8	42 1.0	86 2.0	-51
Shigella Cases Rate <sup>1</sup>	6 0.6	6 1.1	0 -	2 0.4	1 0.4	0 -	2 0.4	33 9.4	1 0.3	51 1.2	60 1.4	76 1.8	73 1.7	+1
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Vibrio, other	0	0	0	0	0	0	0	0	0	0	2	1	3	-67
<u>Other</u>														
Hepatitis B Cases Rate <sup>1</sup>	17 1.6	6 1.1	0 -	0 -	1 0.4	1 0.3	8 1.6	5 1.4	1 0.3	40 0.9	43 1.0	69 1.6	55 1.3	+25
Meningitis/Bacteremia														
H. influenzae	0	1	0	0	0	0	0	0	0	1	0	1	2	-50
N. meningitidis	3	2	1	0	0	0	1	2	3	12	12	24	19	+26
Tuberculosis Cases Rate <sup>1</sup>	- -	- -	- -	- -	- -	- -	- -	- -	- -	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A

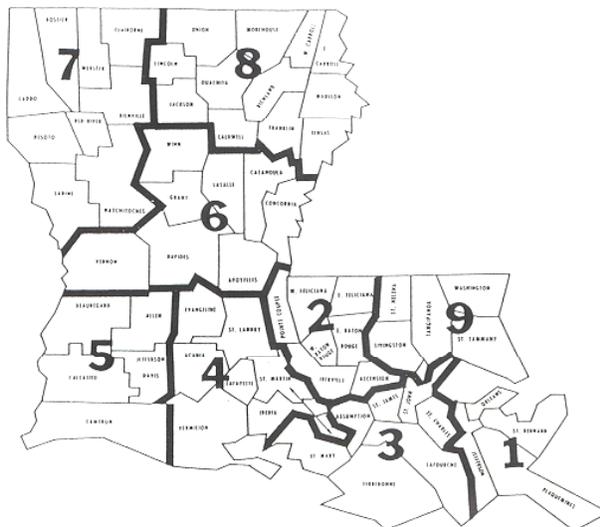
1 = Cases per 100,000  
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	5
Brucellosis	0
Histoplasmosis	1
Lead Toxicity	27
Legionellosis	2
Lyme Disease	0
Malaria	1
Tetanus	0

Table 3. Animal Rabies (Mar-Apr 1995)

Parish	No. Cases	Species
Acadia	2	Skunks
Vermilion	3	Skunks
Lafayette	2	Skunks
Webster	1	Skunk



## Annual Summary Vibrio Infections, 1994

In 1994, 56 cases of vibrio infection were reported to the Epidemiology Section, a 33% increase in comparison to 1993 and representing the most number of cases reported over the last ten years (Figure 1). The overall case rate was 1.3 per 100,000. Sex-specific rates continue to be higher in males than females (1.9 vs 0.7 per 100,000). The case rate among white males is nearly three to four times higher than other race-sex specific groups (Figure 2). Cases ranged in age from 2 to 95 years, a mean age of 46 years. Eight vibrio serotypes were identified. *V. parahaemolyticus* (38%) was most frequently isolated followed by *V. cholera* non-01 (20%) and *V. vulnificus* (18%). Four cases had multiple serotypes isolated from either one or more biologic specimen sources. Of the 54 cases with completed epidemiologic information, 34 cases (63%) had underlying or pre-existing medical conditions prior to vibrio infection. Twenty seven cases (51%) involved shellfish consumption. Of the 10 *V. vulnificus* cases, 7 cases were wound infections associated with exposure to saltwater or raw seafood drippings. Only one *V. vulnificus* case was associated with raw shellfish consumption. Three deaths were reported, two of which were *V. vulnificus* infections. Parishes with the largest number of cases include: Jefferson (11), Orleans (8), St. Bernard and Terrebonne [5 each; Figure 3].

Figure 1: Cases of vibrio infections by year, 1985-1994

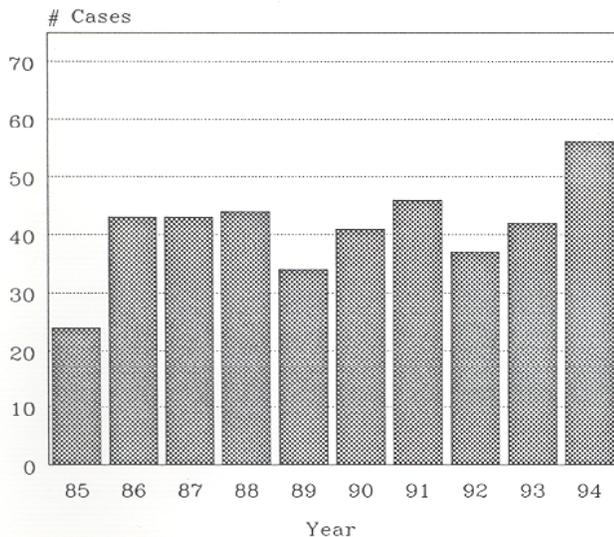


Figure 2: Cases of vibrio infection by race and sex, 1994

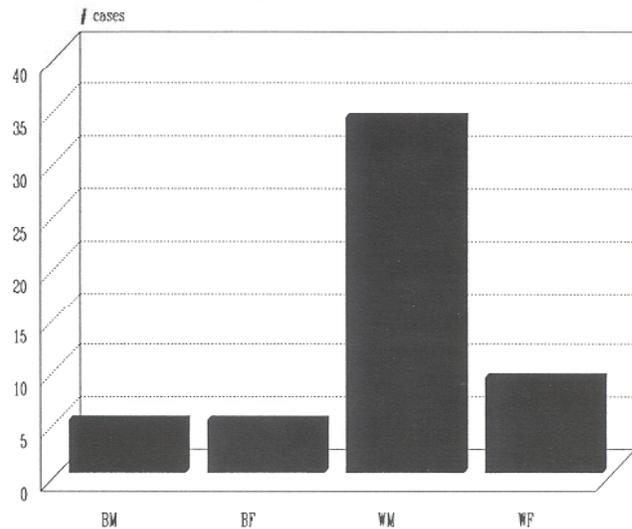


Figure 3: Cases of vibrio infection by parish, 1994



### LOUISIANA FACTS

Did you know that during the period 1928-38 the number of tuberculosis cases reported annually averaged about 2000. The State Board of Health established the Tuberculosis Control Division of the Bureau of Parish Health Administration in 1931. Regular reports from the Division appeared in each Quarterly Bulletin for the remainder of the decade. The first reports gave figures on persons examined, persons placed in institutions, home visits, and tuberculosis tests administered to cattle. Taken from "Progressive Years," by Gordon Gillson

## LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Hemolytic-Uremic Syndrome	Polioomyelitis	Cancer
Amebiasis	Hepatitis, Acute (A, B, C, Other)	Psittacosis	Complications of abortion
Anthrax	Hepatitis B in pregnancy	Rabies (animal & man)	Congenital hypothyroidism
Aseptic meningitis	Herpes (genitalis/neonatal)**	Rocky Mountain Spotted Fever (RMSF)	Galactosemia
Blastomycosis	Human Immunodeficiency Virus (HIV) infection****	Rubella (German measles)	Hemophilia
Botulism*	Legionellosis	Rubella (congenital syndrome)	Lead poisoning
Brucellosis	Leprosy	Salmonellosis	Phenylketonuria
Campylobacteriosis	Leptospirosis	Shigellosis	Reye Syndrome
Chancroid**	Lyme disease	Syphilis**	Severe Traumatic Head Injuries+
Cholera*	Lymphogranuloma venereum**	Tetanus	Severe undernutrition
Chlamydial infection**	Malaria	Trichinosis	severe anemia, failure to thrive
Diphtheria*	Measles (rubeola)*	Tuberculosis***	Sickle cell disease (newborns)
Encephalitis (specify primary or post-infectious)	Meningitis, (Haemophilus)*	Tularemia	Spinal cord injury+
Erythema infectiosum (Fifth Disease)	Meningococcal infection (including meningitis)*	Typhoid fever	Sudden infant death syndrome (SIDS)
Escherichia coli 0157:H7	Mumps	Typhus fever, murine (fleaborne, endemic)	
Foodborne illness*	Mycobacteriosis, atypical***	Vibrio infections (excluding cholera)	
Genital warts**	Ophthalmia neonatorum**	Yellow fever*	
Gonorrhea**	Pertussis		
Granuloma Inguinale**	Plague*		

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 FAX # 504-568-5006