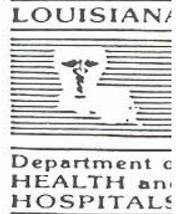




Murphy J. "Mike" Foster, Jr.
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Louisiana Morbidity Report

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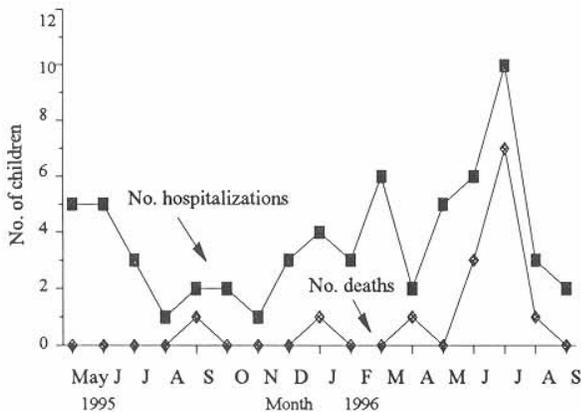
September-October 1996

Volume 7 Number 5

Adenovirus Type 7 Outbreak in a Long-Term Care Facility

On July 8, 1996 the Office of Public Health was contacted by a physician because of an increase in the number of pneumonias in children in a long term care facility with an apparent increase in the number of hospitalizations and deaths (Figure 1). The facility contained 198 beds; 28 beds were for children. Most of the children had severe neurologic and pulmonary impairment. Three were ventilator-dependent and 17 had tracheostomies.

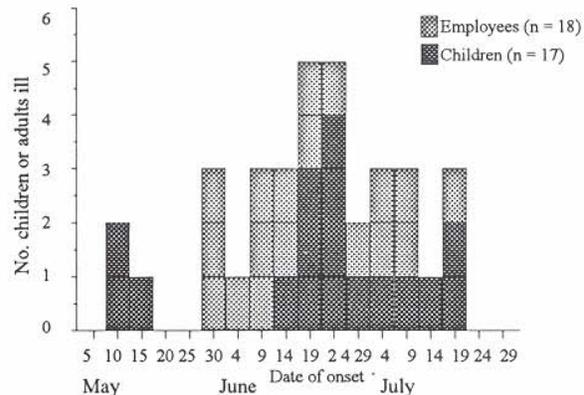
Figure 1: Number of hospitalizations and deaths on children's unit, May 1995-September 1996 (average monthly census 13-23)



The number of hospitalizations and deaths on the children's unit was obtained from medical records between May 1995 and September 1996. Children in the facility and employees were tested for viral infections with viral cultures and serologic tests.

Overall 10 of the 23 children present in the facility during this period were found to have culture-confirmed infection with Adenovirus Type 7 and an additional seven had pneumonia without laboratory confirmation (considered probable cases). The most common clinical finding was fever (100%) followed by increase in oxygen requirements (76%), new infiltrates on chest x-ray (59%), a change in sputum quality (47%), and conjunctivitis (29%). The mean duration of illness was 12.3 days with a range of 4 - 24 days. Seventy-one percent (12/17) of children required hospitalization; ten of whom were in the ICU. Ten of 17 (59%) died.

Figure 2: Adenovirus-like illness in children and employees, May-July 1996



The epidemic curve (Figure 2) shows 10 laboratory-confirmed and 7 probable cases beginning May 10 and continuing through July 23, 1996. Two clusters occurred. The first cluster, consisting of one confirmed and two probable cases, began May 10 and extended through May 19. All three cases came from the same room. The second cluster peaked between June 24-28, 1996. Males were twice as likely to become infected as females (11/11 vs. 6/12; relative risk 2.0, $p < .01$). No differences in attack rates were seen by underlying diagnoses or ambulatory status.

(Continued on next page)

Contents

Preventing Neural Tube Defects.....	2
Influenza Immunization Program, 1996-97.....	3
Immunization Assessments.....	4
Tetanus-Diphtheria Combination Recommended.....	4
AIDS Update.....	5
Annual Summary: Meningococcal Infections, 1995.....	7

Adenovirus Type 7 Outbreak (Cont.)

Ninety-three employees filled out questionnaires about job responsibilities, and signs and symptoms of an adenovirus respiratory infection. Evidence of an adenovirus infection in employees was defined as the presence of conjunctivitis or two of the following three symptoms: cough, fever, or sore throat, between May 1 - July 31, 1996. Of 93 employees, 22 (24%) met the clinical case definition. In addition, four employees had fourfold rises in antibody titers to adenovirus and one asymptomatic employee had a positive throat culture for Adenovirus Type 7. Dates of onset were known for 18 employees (Figure 2). Environment cultures of air vents, air conditioners, and water used in respiratory devices were negative.

Adenoviruses are a large group of agents that have been associated with respiratory infections in humans. At least 44 types of adenovirus have been identified. Type 7 Adenovirus has been associated with sore throat, conjunctivitis, fever, bronchitis and pneumonia. Type 7 is of particular concern because of its association with fatal pneumonias in children and its propensity for causing epidemics. To date, no therapy exists for adenovirus infections.

In this outbreak, although eight of the children who died had a positive adenovirus culture during the course of their illness, it is unclear to what extent adenovirus attributed to their demise.

The shape of the epidemic curve and the two month period over which this outbreak ensued, suggest that the virus was transmitted either child-to-child or child-to-staff-to-child.

The main preventive measures in such outbreaks center around enhancing infection control practices and compliance, isolating any patient with fever until the infection is ruled out, cohorting staff by unit, and barring all new admissions until the outbreak is over.

Preventing Neural Tube Defects

Recently the Office of Public Health responded to a report of a cluster of four neural tube defects (NTD); three spina bifida and one anencephaly, occurring between June 1, 1995 and July 1, 1996, in the Eunice area. The CDC assisted the Office of Public Health in this investigation to find additional cases, determine rates, and identify possible risk factors. One additional case of anencephaly was identified in the investigation. The NTD rate was much higher than those of a comparison population in metropolitan Atlanta; 78.2/10,000 vs 7.4/10,000, relative risk 10.3 (95% CI, 4.3-24.5.), Table 1. Although no single risk factor was identified only one mother took folic acid supplementation, all had diets with a low consumption of folate (vegetables), and none received prenatal alpha-feto-protein screening for early NTD diagnosis. These occurrences and findings underscore the need for increased efforts to inform health professionals and women of

reproductive age of the need and benefits of folic acid supplementation.

Each year 2500 to 3000 infants are born with spina bifida or anencephaly, NTD caused by incomplete closure of the spine. Between 1990 and 1995, 188 cases were reported in Louisiana, for a rate of 4.8/10,000 pregnancies greater than 20 gestational weeks. These reports underestimate the exact number of affected pregnancies since birth defects surveillance does not include gestations of less than 20 weeks. Rates in Louisiana do not vary substantially by age or race of mother, or by region of the state (Figure 1 and Table 2.)

Table 1: Number, location and rates/10,000 live births of neural tube defects in three neighboring Louisiana towns and metropolitan Atlanta, 1995-1996

Neural Tube Defect	Cases in Eunice, Chataignier, Opelousas		Cases in Atlanta ¹	
	Number	Rate	Number	Rate
Anencephaly	2	31.3 (3.8-112.6)	39	2.0 (1.4-2.7)
Spina Bifida	3	46.9 (9.7-136.5)	71	3.7 (2.9-4.6)
Total	5	78.2 (25.5 -181.6)	110	5.7 (4.7-6.8)
Adjusted	NA	NA	143	7.4 (6.2-8.7)

¹ 1990-1994

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Annual medical and surgical costs for persons in the United States with spina bifida exceed \$200 million per year, and it is estimated that Louisiana's annual cost is more than \$13 million per year, or \$330,000 per case.

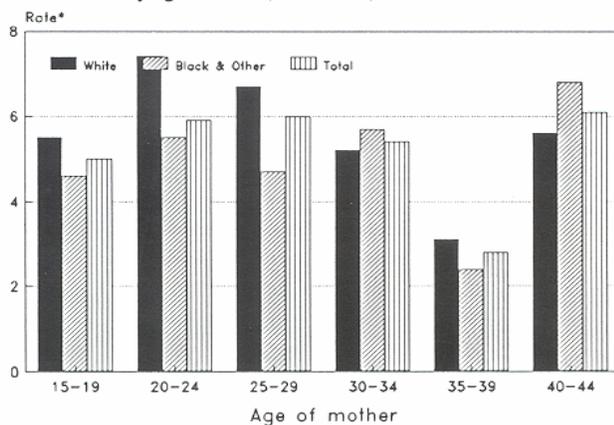
Spina bifida, the leading cause of childhood disability, results from failure of the spinal column to close between the 3rd and 4th week of pregnancy. Although children survive into adulthood, most will suffer from varying degrees of lower limb paralysis and bladder and bowel control. More severe cases are affected with hydrocephaly and mental retardation. Anencephaly is characterized by incomplete development of the skull and an absence of the brain. Most of these pregnancies spontaneously terminate early or result in stillbirths or infants who die within the first days of life. Although all women of childbearing age are at some risk of having children with NTD, rates of occurrence have been observed to be higher among Hispanics, those with previous children with NTD, and women with exposure to valproic acid, diabetes mellitus, fever during pregnancy, malnutri-

tion, or poverty.

Since 1992, solid evidence has shown that 50% of cases of NTD can be prevented with daily consumption of 400 micrograms of folic acid, a B vitamin, by women of reproductive age. For women who have had previous children with NTD, consumption of 4 milligrams of folic acid for one month before conception and during the first 3 months of pregnancy, reduces recurrent NTD by 86%.

This year the Maternal Child Health and Family Planning Divisions have begun an intensive effort to educate all women of this opportunity to decrease birth defects. This includes voluntary maternal serum alpha-feto-protein screening in the parish maternity clinics for clients between their 15th to 20th week of gestation, educational programs, and pre-conceptual counseling on the need for folic acid supplementation by all women of reproductive age in the parish family planning clinics. In addition, educational information will be made available to health professionals on birth defects risk factors and identification, minimizing that risk, surveillance procedures, and the promotion of folic acid supplementation by all women of reproductive age.

Figure 1: Cumulative incidence of Anencephaly & Spina Bifida by age and race, Louisiana, 1990-1995



* Cumulative incidence / 10,000 births

Table 2: Number of and rates per 10,000 live births of neural tube defects in Louisiana by region, 1990-1995

Region	Anencephaly Cases	Spina Bifida Cases	Total	Rate
Orleans	6	42	48	3.7
Baton Rouge	4	9	13	1.7
Houma/Thibodeaux	4	12	16	3.9
Lafayette	9	18	27	3.3
Lake Charles	4	6	10	2.4
Alexandria	3	4	7	1.4
Shreveport	4	17	21	3.5
Monroe	7	21	28	3.4
Slidell/St. Tammany	2	14	16	3.5
Out of state	0	2	2	

Influenza Immunization Program, 1996-97

Beginning the week of 10/21/96-10/25/96, parish health unit 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. Those that are considered to be at high risk are the same as those identified in previous years (i.e., persons over 65 years of age and those of any age with chronic cardiac, respiratory, or kidney diseases, those with diabetes, those whose immune system has been compromised, and children/teenagers receiving long-term aspirin therapy).

Groups potentially capable of nosocomial transmission of influenza to high risk persons (e.g., physicians, nurses, and others with extensive contact with high risk patients) are encouraged to see their own physicians and/or organize their own immunization programs.

One of the three components of the trivalent influenza vaccine for the 1996-97 season has changed from last year's vaccine as recommended by the Food and Drug Administration Vaccines and Related Biological Products Advisory Committee. The vaccine for this year consists of an inactivated formulation of the three viruses most likely to be prevalent: A/Texas/36/91-like (H1N1), A/Wuhan/359/95-like (H3N2), and B/Beijing/184/93-like. The strains that will be used by U.S. vaccine manufacturers because of their growth properties and induced antibody response and which are antigenically equivalent-strains are: A/Nanchang/933/95 (H3N2) and B/Harbin/07194. Annual vaccination using the currently recommended vaccine is necessary for immunity (Continued on next page)

Influenza High Risk Immunization Program (Cont.)

to the likely infected strains of influenza virus and any remaining supplies from 1995-96 should be discarded.

Children 6 months to 8 years of age who have not received influenza vaccine previously should receive two doses of split virus vaccine at least a month apart. If vaccine has been administered previously, one dose is sufficient. The dosage of split virus vaccine for children is 0.25ml for those 6 to 35 months of age, and 0.5ml for those children 3 years and older. Only one 0.5ml dose of whole or split virus vaccine is required for persons 12 years of age and older.

For information on time and days of the clinics, please contact your local parish health unit.

Immunization Assessments

Ensuring that all children in our state are appropriately immunized is one of the responsibilities of the Louisiana Immunization Program. Ongoing efforts to ensure accomplishment of the Year 2000 objectives have stimulated different assessments and approaches to measure the impact of the Infant Immunization Initiative. Assessments of the immunization status of children in day care are one approach to measure such an impact. In Louisiana, 81,000 children from birth to five years of age are in licensed day care centers. These represent approximately 20% of the children in that age group, but this is a particularly important group because day care settings have been where major measles outbreaks have occurred.

These assessments are important because they help us in six ways: (1) to determine how well children are vaccinated against vaccine-preventable childhood diseases; (2) to identify children that are adequately immunized each year; (3) to identify children that are not optimally immunized; (4) to contact, motivate and bring children to immunization compliance; (5) to identify susceptible individuals during suspected outbreaks in order to take necessary preventive measures to minimize disease transmission; and (6) to maintain an open communication with the day care staff. Although state law requires that day care centers complete and return assessment forms, compliance varies from area to area. In some areas, the Office of Public Health has issued citations to noncompliant day care centers which were referred to adjudication hearings. Such actions have been successful in raising levels of compliance, particularly in New Orleans (Figure).

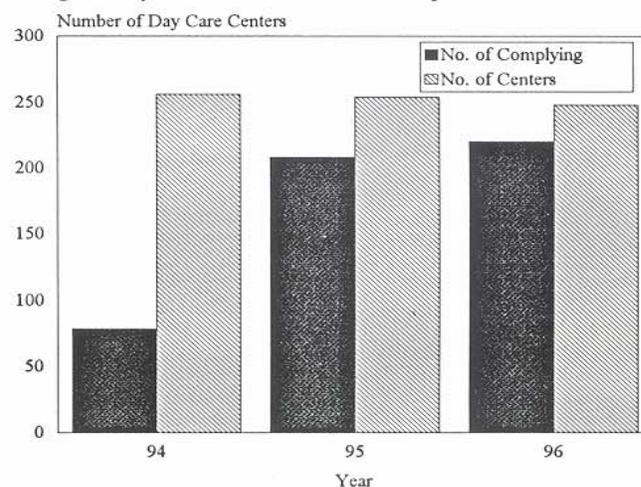
The four major constraints cited for failing to comply were: (1) immunization records were inappropriately completed; (2) the parents/guardians failed to inform and update the child's record at the child care center; (3) the physician failed to provide parents with an updated record of immunization; and (4) failure to understand immunization schedules.

To help day care center operators understand schedules, the Louisiana Immunization Program has developed a standardized Child Care Preschool Certificate of Immunization, which will enable the day care center operators to determine

whether the child is current with his/her immunizations by just looking at the expiration date of the card.

Estimated vaccination coverage, according to the National Immunization Survey for Orleans Parish conducted in April 1994 through March 1995, was 67% for four doses of Diphtheria/Tetanus Toxoid/Pertussis vaccine, three doses of Polio virus vaccine, and one dose of Measles/Mumps/Rubella vaccine, while the state's estimate was 71%. A recently released quarterly survey indicates that the immunization levels in Orleans Parish have risen to 79%, exceeding the state total by one percent.

Figure: Day care center immunization compliance - Orleans Parish



Tetanus-Diphtheria Combination Recommended

When adolescents and adults present with a dirty wound and require tetanus immunization, or when they are given their routine booster every 10 years, the Louisiana Office of Public Health and the Centers for Disease Control and Prevention recommend that combined tetanus-diphtheria vaccine be used. This will provide protection against both diseases which require regular adult boosters. Diphtheria has become rare in the United States in recent years, but there is a growing epidemic of diphtheria in the countries of the former Soviet Union, as well as in parts of South East Asia. Hundreds of thousands of cases are being reported annually. One traveler from one of the epidemic countries with diphtheria will be sufficient to re-introduce this severe disease to Louisiana. Diphtheria causes a membrane to form over the soft palate and tonsils, causing asphyxiation. It also produces a toxin which affects the heart (leading to arrhythmias), and the motor neurons (leading to paralysis of the affected areas, including the diaphragm). In order to protect our patients from this severe illness, only combined vaccine should be routinely available in emergency rooms and clinics.

AIDS UPDATE

Epidemiologic Profile of Injection Drug Users

Injection drug use is still the second largest exposure category among all AIDS cases. In order to provide information for effective targeting of interventions, the following statistics summarize the current epidemiologic profile of the HIV/AIDS epidemic among injection drug users (IDUs). This summary is based on a collaborative effort to review IDU information from all data sources within HIV/AIDS Services.

In 1995, more than one fourth (237 cases) of all diagnosed cases reported using injected drugs. The Baton Rouge and Alexandria regions have the highest percentage (range 32% - 42% of AIDS cases reported injected drugs). Statewide, the majority of AIDS cases reporting injection drug use are in African-American men. OPH has estimated that one third of all AIDS cases in men and two thirds of all cases in women reported either injecting drugs or being a sex partner of an injecting drug user. In fact, when all AIDS cases that could have been related to injection drug use are considered (by including a portion of those who reported as their only risk factor sex with an HIV-positive person, who could have been an injecting drug user), nearly 40% of cases in men and 80% of cases in women are in this category (Figures 1 and 2). In recent years, the 35-44 age group has the highest percentage of cases related to injection drug use and appears to be increasing. The 15-24 age group has the lowest percentage.

It is approximated that between 2,500 and 5,000 injection drug users (about 5%) are currently infected with HIV in the state of Louisiana. Estimates also show that *each year* one in every hundred uninfected injection drug users becomes infected with HIV. This amounts to 500 new cases of HIV in injection drug users per year. If the lifetime cost for treatment of HIV disease remains around \$100,000 per person, the cost of treating injection drug users infected with HIV within the past year would total \$50 million. Since four out of every five AIDS cases in IDUs were diagnosed in publicly funded facilities this past year, most of the costs must be picked up by the public.

Injection drug use underlies a large and under-recognized proportion of AIDS cases in Louisiana. Cases of AIDS caused directly or indirectly by needle sharing associated with injection drug use can be prevented by either 1) decreasing the amount of injection drug use, which has proven to be very difficult, or 2) providing sterile needles to drug users until they go into treatment.

Figure 1: Percent of AIDS cases related to injection drug use by ethnicity

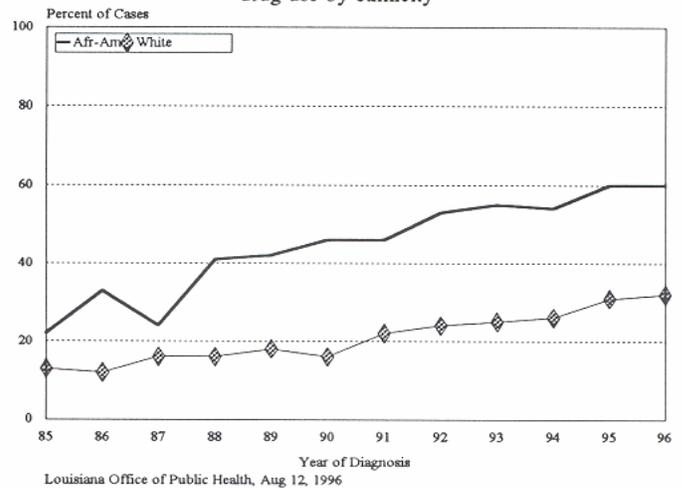
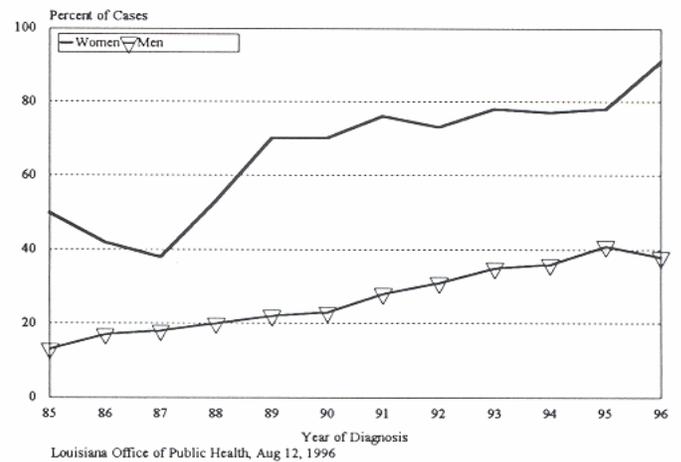
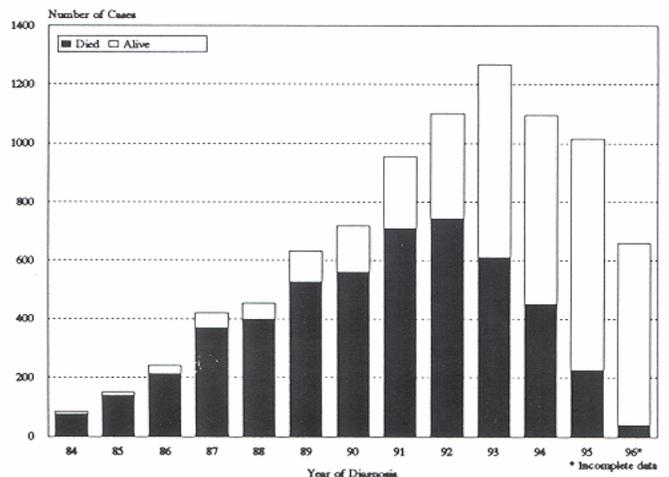


Figure 2: Percent of AIDS cases related to injection drug use by gender



AIDS Case Trends



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

July - Aug, 1996
PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD					
	1	2	3	4	5	6	7	8	9	July-Aug 1996	July-Aug 1995	Cum 1996	Cum 1995	% Chg	
Vaccine-preventable															
Measles	0	0	0	0	0	0	0	0	0	0	0	0	18	-	
Mumps	1	0	0	0	0	0	0	1	2	4	0	16	9	+78	
Rubella	0	0	0	0	0	0	0	0	0	0	0	1	0	-	
Pertussis	1	1	0	0	0	0	1	0	0	3	4	8	14	-43	
Sexually-transmitted															
AIDS	Cases Rate ¹	34 3.1	17 3.1	1 0.3	5 1.0	1 0.4	2 0.6	4 0.8	2 0.6	3 0.8	69 1.6	148 3.4	647 15.0	640 14.8	+1.1
Gonorrhoea	Cases Rate ²	606 5.8	143 2.5	101 2.7	133 2.6	85 3.2	45 1.5	217 4.3	68 1.9	98 2.5	1496 3.5	1781 4.2	6211 14.7	7651 18.1	-18.8
Syphilis(P&S)	Cases Rate ²	30 0.29	15 0.26	5 0.13	4 0.07	3 0.11	1 0.03	10 0.20	4 0.11	5 0.13	77 0.18	156 0.37	409 0.97	692 1.64	-40.9
Enteric															
<i>Campylobacter</i>		14	5	5	8	1	5	3	2	0	43	38	107	125	-14
Hepatitis A	Cases Rate ¹	3 0.3	7 1.2	1 0.3	1 0.2	2 0.7	0 -	16 3.2	20 5.7	0 -	51 1.2	34 0.8	138 3.2	86 2.0	+60
<i>Salmonella</i>	Cases Rate ¹	37 3.6	24 4.2	26 6.9	33 6.4	5 1.9	10 3.3	20 4.0	20 5.7	25 6.5	200 4.6	74 1.7	372 8.6	212 4.9	+75
<i>Shigella</i>	Cases Rate ¹	33 3.2	30 5.3	2 0.5	7 1.4	0 -	2 0.7	15 3.0	0 -	4 1.0	93 2.2	63 1.5	465 10.8	231 5.4	+101
Vibrio cholera		0	0	0	0	0	0	0	0	0	0	0	0	0	-
Vibrio, other		7	0	3	0	0	0	0	0	0	11	13	27	27	-0
Other															
Hepatitis B	Cases Rate ¹	2 0.2	2 0.4	0 -	2 0.4	4 1.5	1 0.3	7 1.4	8 2.3	5 1.3	31 0.7	33 0.8	98 2.3	146 3.4	-33
Meningitis/Bacteremia <i>H. influenzae</i>		0	0	0	0	0	0	0	0	1	1	0	3	1	+200
<i>N. meningitidis</i>		6	0	0	2	0	0	0	1	0	9	5	49	39	+26

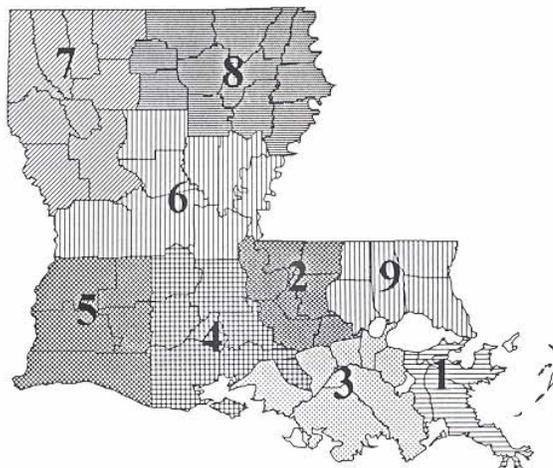
1 = Cases per 100,000
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	3
Histoplasmosis	2
Lead Toxicity	63
Typhoid	1
Rocky Mountain Spotted Fever	2
Legionellosis	1
Lyme Disease	2
Malaria	6
Tetanus	1

Table 3. Animal Rabies (July - Aug, 1996)

Parish	No. Cases	Species
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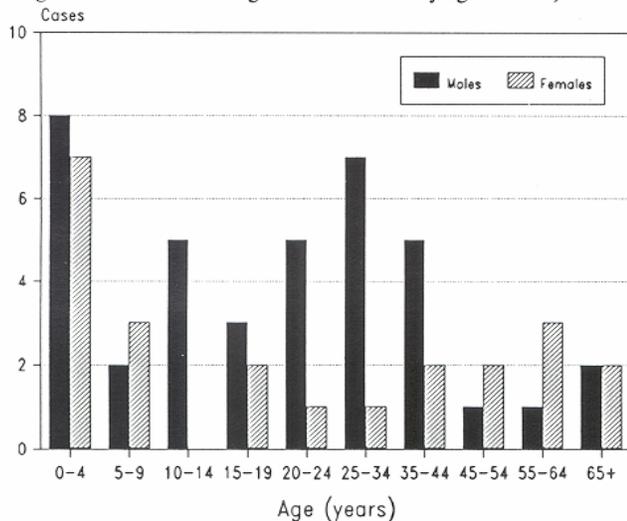


ANNUAL SUMMARY

Meningococcal Infections - 1995

Sixty-two cases of meningococcal infections were reported in Louisiana in 1995, a 32% increase from 1994. The overall state case rate was 1.4 per 100,000. Sixty-three percent of the cases were reported in males. Race-specific rates continue to be higher in blacks than in whites (2.3 vs 1.0 per 100,000). The sex-specific rate in males was almost twice that of females (1.9 vs. 1.0 per 100,000). Twenty-four percent of the cases occurred in the 0-4 age group followed by the 25-34 age group (Figure 1). Forty-four percent of the parishes reported at least one case; three of those parishes reported 42% of the total cases: Orleans (14), Caddo (7), and E. Baton Rouge (5, Figure 2). Of those cases that indicated serotype (n=26), Serogroup C (12) was the most commonly reported of the meningococcal serogroups followed by Y (9), B (4) and A (1). Thirteen deaths (21%) were reported from eight parishes.

Figure 1: Cases of meningococcal infection by age and sex, 1995



Meningococcal disease is a serious bacterial infection in which invasive disease usually manifests itself as meningitis and/or bacteremia. Serogroup identification is the only way to link cases and detect outbreaks. All laboratories that culture meningococcal organisms are encouraged to submit the isolate (free of charge) to the State Lab for serogrouping.

Figure 2: Cases of meningococcal infection by parish, 1995



LOUISIANA FACTS

The precursor of our modern day Sanitarian was known as the Sanitary Police. According to Dr. J.S. Clark's Report of the Sanitary Inspector dated 12/31/1873, their assistance was invaluable. "The experience of each year adds to the efficiency of the corps, and today they are not surpassed by any organization of like purpose. The opposition at first encountered has become changed to positive approval. The frequency of their visits and their unusual consideration and friendly advice to the poorer people, has resulted in almost every instance, in assuring them a pleasant welcome, and with the evil disposed, who are few if judged by their conduct in these matters, the authority conveyed by a Metropolitan uniform is decidedly wholesome. The regular, and re-inspections which immediately follow, and the special and cursory inspections continued throughout the year, together with their visits in cases of small-pox, yellow fever, cholera, and other contagious and infectious diseases, and to premises wherein occur deaths that might have been incidental to local sanitary causes, render the countenance of the Sanitary Police familiar to every household. It is therefore, of the first importance that a class of men be detailed who will command the good opinion of the community, and that changes in this body be as infrequent as possible."

(Taken from Annual Reports, Board of Health, December 31, 1872.)

LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Hemolytic-Uremic Syndrome	Poliomyelitis	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 severe anemia, failure to thrive
Chlamydial infection**	Malaria	Trichinosis	Sickle cell disease (newborns)
Diphtheria*	Measles (rubeola)*	Tuberculosis***	Spinal cord injury+
Encephalitis (specify primary or post-infectious)	Meningitis, (Haemophilus)*	Tularemia	Sudden infant death syndrome (SIDS)
Erythema infectiosum (Fifth Disease)	Meningococcal infection (including meningitis)*	Typhoid fever	
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 Lab 94 form (Retrovirus). Name and street address are optional but city and ZIP code must be recorded.

+ 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**

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