

Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
 P.O. Box 60630, New Orleans, LA 70160 (504) 568-5005

March-April 1999

Volume 10 Number 2

Brain Injuries and Motorcycle Helmets

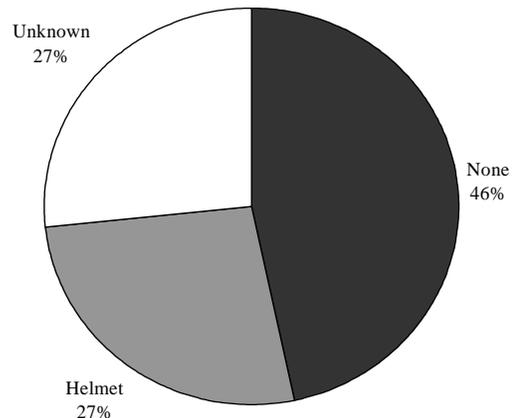
Traumatic brain injuries (TBI) are extremely expensive injuries in terms of both financial cost and human suffering. TBI can lead to premature death or to injuries with severe sequelae requiring multiple hospitalizations, long-term care, and rehabilitation. Vehicle crashes, including motorcycles, account for more than 50% of all TBIs nationally. TBIs are the leading cause of death in motorcycle crashes.

Motorcycle helmets are 67% effective in preventing all TBIs. In addition, motorcycle helmets are 29% effective in preventing fatal TBIs. Riders not wearing helmets are more than twice as likely as helmeted riders to incur a TBI.

Reporting of TBIs has been legislatively mandated in Louisiana since 1990; reports come from hospitals and death certificates. There were 40 motorcycle crash-related TBIs reported to the Injury Section for 1996. However, only 76% of TBIs reported contain information on the cause of the TBI. Applying the frequency of motorcycle crash-related deaths for which information on cause was available to the case reports of TBI for which no cause information was available, the Injury Section estimates that there were a total of 52 motorcycle crash-related TBIs in Louisiana in 1996.

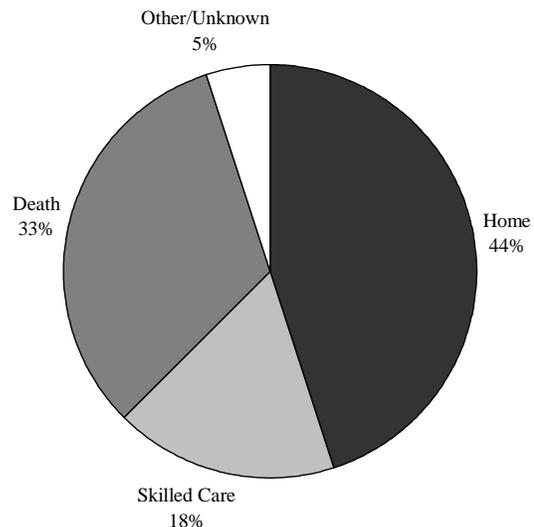
Just more than one third of those who sustained a motorcycle crash-related TBI and for whom information about helmet use was known were wearing a helmet at the time of the crash (Figure 1).

Figure 1: Use of helmets by persons with motorcycle crash - related traumatic brain injuries, Louisiana, 1996



Nearly one third of persons with a motorcycle crash-related TBI in Louisiana in 1996 died as a result of their TBI. Approximately another 18% required rehabilitative care at a skilled care facility or were transferred to another acute care facility, such as a trauma center (Figure 2).

Figure 2: Discharge disposition of persons with motorcycle crash - related traumatic brain injuries, Louisiana, 1996



(Continue on next page)

Contents

Tuberculosis in Louisiana - 1998.....	2
Sub-typing of Influenzae Isolates	3
Confidential Disease Case Report	3
Diabetes in Louisiana	4
STD Projects Funded	4
HIV/AIDS Update	5
Annual Summary: Shigellosis 1997.....	7

Brain Injuries and Motorcycle Helmets (Cont.)

The majority of the motorcycle-related TBI hospitalization costs were covered by private insurance (54%), however one-third of all hospitalization costs were uncompensated.

Since almost two-thirds of those whose helmet use status was known were not wearing helmets, there were approximately 34 TBIs in which helmets were not worn. Based on this and the known protective effectiveness of helmets, the Injury Section estimates that 23 of the motorcycle crash-related TBIs in Louisiana in 1996 could have been prevented simply by riders wearing helmets consistently. Efforts are needed to increase helmet use in Louisiana.

Legislatively mandating the wearing of motorcycle helmets has been controversial. While just having a law does not result in 100% helmet use, motorcycle helmet laws have been shown to increase motorcycle helmet use. Data has shown that without such laws only 40-60% of riders wear helmets, while after enactment of such laws 90-100% of riders wear helmets. In Louisiana a motorcycle helmet law was repealed from 1976 to 1981. When the law was reinstated in 1982 the average cost per motorcycle crash-related injury decreased almost 50%. Repealing or limiting the motorcycle helmet law in Louisiana would almost certainly increase the financial and human costs of motorcycle crash-related TBIs in Louisiana.

Tuberculosis in Louisiana - 1998

Louisiana reported 380 cases of tuberculosis in 1998, a 6.4% (decrease) from the 1997 total of 406. With a 1998 case rate of 8.7 per 100,000, Louisiana exceeds the 1997 national rate of 7.4 per 100,000. In 1997, The Centers for Disease Control and Prevention (CDC) ranked Louisiana 8th in the nation according to tuberculosis case rate. A comparison of tuberculosis cases and case rates for bordering states is shown in the Table.

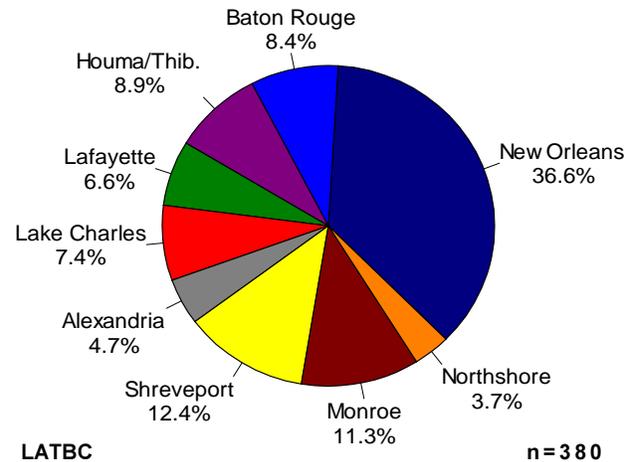
The regional distribution of cases within Louisiana is illustrated in Figure 1, and metropolitan New Orleans continues to lead the state in morbidity. Cases of tuberculosis in children (<15 years of age) increased over the past four years from 4 in 1994 to 20 in 1998. The majority of pediatric cases were also reported in the New Orleans region.

Table: Cases and rates of tuberculosis in Louisiana and surrounding states, 1998

States	Cases	Rates / 100,000
TX	1820	9.3
LA	380	8.7
MS	225	not available
AR	171	7

LATBC

Figure: Cases of tuberculosis by region, 1998



Persons of color continue to suffer a disproportionate impact of tuberculosis. Of the 380 cases reported in 1998, 61.3% were found in blacks (a case rate of 17.9 per 100,000) and 6.9% were reported in the Asian/Pacific Islander population (case rate of 63.5 per 100,000), compared to 28.9% in whites (case rate of 3.9 per 100,000).

Distribution by gender shows that males outnumber females by more than a 2-1 margin, with 266 (70%) of the total cases in 1998. Although the total number of cases declined in 1998, the decrease occurred in the age groups of 45-64 and 0-14, while the number of new tuberculosis cases in persons 65 and over increased. Fifty-four percent of all persons with tuberculosis in 1998 were unemployed.

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The number of tuberculosis cases with HIV infection decreased in 1998. A total of 29 (7.6%) HIV infected patients with tuberculosis were identified this year compared to 40 (9.8%) in 1997. The majority, 17 (59%) of HIV infected cases, were reported in the New Orleans region.

The incidence of drug-resistant tuberculosis declined slightly in 1998 with an initial INH resistance rate of 6.2% statewide. Nearly 94% of all culture positive tuberculosis cases in Louisiana had initial drug susceptibility tests performed. These susceptibility studies provide meaningful surveillance regarding the incidence of drug resistant disease and provide guidance in the establishment and maintenance of appropriate tuberculosis treatment regimens. The CDC defines multi-drug resistance (MDR) tuberculosis as those cases which exhibit resistance to at least Isoniazid and Rifampin. Although Louisiana reported one case of MDR in 1998, a total of 19 cases were identified with resistance to at least one anti-tuberculosis drug. Of those resistant cases, 8 (42%) were identified in the New Orleans region. The Lafayette region accounted for 7 (39%) cases resistant to at least one anti-tuberculosis drug.

The Louisiana Office of Public Health, Tuberculosis Control Program, provides diagnostic, treatment, and prevention services through regional chest clinics and parish health units. Services include provision of case management such as directly observed therapy for persons with disease, and epidemiologic investigations to determine the potential for transmission of tuberculosis in the community.

Recommendations, based on current epidemiologic data, include continuation of an initial four-drug regimen statewide in the treatment of tuberculosis, and application of directly observed therapy where resources allow.

Sub-Typing of Influenzae Isolates

The OPH Laboratory now has the capability of sub-typing influenza isolates. The first step in sub-typing is to grow the influenza virus in tissue culture then proceed to sub-typing. This year it has been difficult to grow a sufficient amount of the virus for the sub-typing to be accomplished. Several different types of cells have been used in this procedure but to date none have been successful. The OPH virologist has consulted with the Centers for Disease Control (CDC) influenza laboratory only to find that CDC is having the same problem. For those of you who have called for information on sub-typing of Louisiana influenza cases, please know that we will get the information to you as soon as the lab is able to solve the problem of producing enough virus for the sub-typing procedure.

CONFIDENTIAL DISEASE CASE REPORT

All diseases and conditions on the list of reportable diseases (see the back of this report) should be reported on an EPI-2430 card (below), or on other forms as stated. Please print out this form and forward reports by fax or mail to either the local parish health unit or to the Infectious Disease Epidemiology Section, Department of Health & Hospitals, Office of Public Health, P.O. Box 60630, New Orleans, LA 70160. The phone numbers are 504-568-5005 or 1-800-256-2748 or FAX 504-568-5006. All facsimile transmissions are considered part of the confidential disease case report, and as such, are not subject to disclosure. Xerox additional copies as needed. Your support in disease reporting will enhance disease surveillance activities.

DISEASE/CONDITION		DATE OF REPORT		DATE OF ONSET	
PATIENT'S NAME		RACE*	ETHNIC**	SEX	DATE OF BIRTH
ADDRESS	STREET NO. (R.F.D. If rural)			ZIP CODE	
	CITY		PARISH		
HEAD OF HOUSEHOLD			PHONE NO.		
DAY CARE CENTER ASSOCIATED: YES ___ NO ___		DATE		SPECIMEN TYPE	
NAME OF DCC:					
LAB RESULTS					
COMMENTS:					
PHYSICIAN/HOSPITAL			PHONE NUMBER		

*Wh = White, not of Hispanic origin, Bl = Black, Pac Is/Asi = Pacific islander or Asian, Am Ind/AI = American Indian or Alaskan Native

** Hisp/Non-Hispanic

Diabetes in Louisiana

Diabetes affects about 16 million or 6% of Americans. In 1994, Louisiana ranked second in the U.S. in self-reported prevalence of diagnosed diabetes. In 1993, diabetes resulted in an estimated 276 new cases of blindness, 1,162 lower extremity amputations, 417 new cases of end-stage kidney disease and 66,965 diabetes-related hospitalizations. The annual direct and indirect costs from diabetes in Louisiana exceed \$2 billion dollars.

The Chronic Disease Section used data from the Behavioral Risk Factor Surveillance System (BRFSS) aggregated for the years 1994-97 to estimate the percent of adults 20 years of age and older with self-reported diagnosed diabetes. BRFSS is an annual telephone survey of a random sample of population. To estimate cases of undiagnosed diabetes, they applied rates from the Third National Health and Nutrition Examination Survey (1988-1994) to the Louisiana population.

An estimated 350,000 or 8.5% (5.8% diagnosed and 2.7% undiagnosed diabetes) of Louisiana residents 20 years and older had diabetes in 1997; 32% or 112,000 of the diabetics were undiagnosed or unaware that they have diabetes. Over a million additional persons may be at increased risk for diabetes because of the risk factors of age, obesity and sedentary lifestyle. Of the persons with diabetes, 55% were females, 84% were over 44 years of age (mean age of 61 years), 56% were white, 33% had a household income of less than 15,000 dollars, 33% were employed and 41% were retired. Moreover, 51% were found to be overweight based on body mass index, 29% were self-reported to be current smokers, 50% were told they have high blood pressure, and 38% to have high cholesterol. In addition, 68% reported no leisure time physical activity and 76% reported of not consuming the recommended five servings of fruit and vegetables a day.

Table 1 lists the prevalence by age, gender, race and income of self-reported diagnosed diabetes. There was no statistically significant difference between females and males or among regions in Louisiana in self-reported risk of being diagnosed with diabetes. However, persons older than 44 years of age (RR = 7.4, p<0.05), African Americans (RR = 1.8, p<0.05) and individuals with household income of <15,000 dollars (RR = 2.3, p<0.05) were at higher risk of having diagnosed diabetes as compared to persons younger than 44 years of age, Whites and individuals with household incomes ≥15,000 respectively.

The prevalence of diabetes will continue to increase if the following trends continue: prevalence of obesity increases, population ages, and the socioeconomic gap persists.

Much of the diabetes burden, however, can be prevented with adherence to proper nutrition and regular physical activity, better education for self-management, and improved clinical preventive services including blood glucose control and regular foot and eye exams. Diabetes surveillance should identify high-risk groups, monitor health outcomes and indi-

cators of quality of care and evaluate progress in diabetes prevention and control. Finally, there is a need to develop new and strengthen existing partnerships among private health care providers, employers, payers and governmental, voluntary, professional, and academic institutions to combat the disease.

Table 1: Percentage and number of Louisiana residents aged 18 and over who have been told by a health professional that they have diabetes by age, gender, race and household income

Category		Percent (95% CI)
Total		5.8(5.1,6.4)
Gender	Female	6.0(5.2,6.9)
	Male	5.5(4.5,6.5)
Age	18-44	1.6(1.0,2.2)
	45-64	8.9(7.4,10.4)
	65-74	15.7(12.8,18.5)
	75+	16.3(12.5,20.1)
Race	Whites	4.6(4.0,5.3)
	African Americans	8.4(6.9,10.0)
Income	<15,000	10.8(8.6,12.9)
	15,000-35,000	5.3(4.3,6.2)
	>35,000	3.3(2.5,4.1)

**NATIONAL INFANT IMMUNIZATION WEEK
APRIL 18-24, 1999**



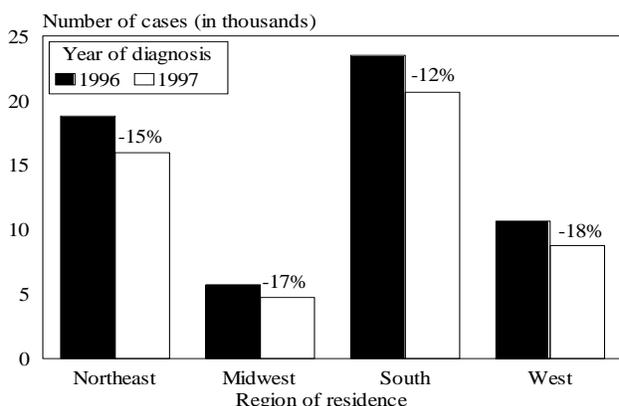
HIV/AIDS UPDATE

The HIV/AIDS Epidemic in the U.S.

The CDC has recently released two reports which use data from HIV and AIDS case surveillance and prevalence surveys to highlight the current status of the HIV/AIDS epidemic across the nation. These reports note a disproportionate impact of the epidemic on racial/ethnic minority populations and on women and youth. Also, despite a growing heterosexual epidemic, young men who have sex with men (MSM) remain a population at high risk for HIV infection.

Overall, the incidence of AIDS in the U.S. is declining. From 1996 to 1997, the AIDS incidence decreased in all regions, racial/ethnic groups, and exposure groups (Figures 1, 2 and 3). These declines in AIDS incidence are partly caused by the success of new treatment regimens. The various groups, however, have experienced different levels of decrease in AIDS incidence, which mainly reflects differences in the underlying pattern of HIV incidence. The groups that have experienced the smallest declines in AIDS incidence are those which have seen the most recent increases in HIV infection.

Figure 1: Estimated AIDS incidence, by region of residence and year of diagnosis, 1996 and 1997, U.S.



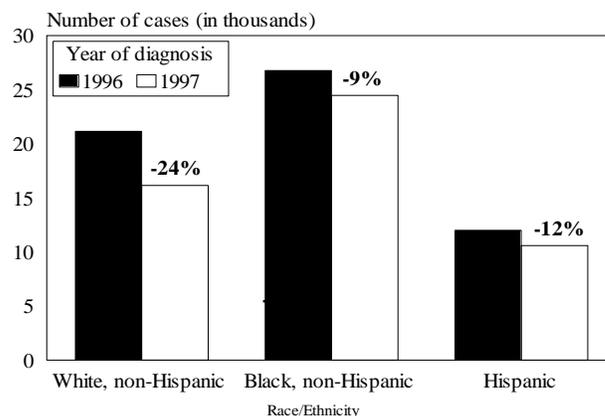
Adapted from CDC HIV/AIDS Surveillance Report, 1998 Midyear Edition

Among regions of residence, the South has experienced the smallest decline (12%) in numbers of new AIDS cases (Figure 1); Louisiana has observed only a 7% decline in this same time period. Among racial/ethnic groups, the decrease is smaller in blacks (9%) than in whites or Hispanics (Figure 2). Additionally, data from prevalence surveys show a higher prevalence of HIV in non-Hispanic blacks than in other racial/ethnic groups in most populations surveyed.

Among exposure groups, men who have sex with men (MSM) continue to comprise the largest proportion of new AIDS cases (Figure 3). Although MSM have seen the sharpest declines in AIDS incidence (19%), MSM attending STD clinics still experience the highest HIV prevalence rates among populations at risk for HIV nationwide. AIDS incidence is declining most slowly among persons infected through heterosexual contact (3% in males and 6% in females).

AIDS incidence reflects infection that occurred on aver-

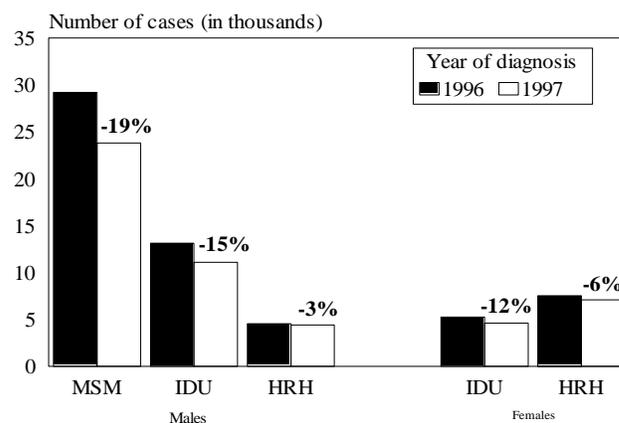
Figure 2: Estimated AIDS incidence, by race/ethnicity and year of diagnosis, 1996 and 1997, U.S.



Adapted from CDC HIV/AIDS Surveillance Report, 1998 Midyear Edition

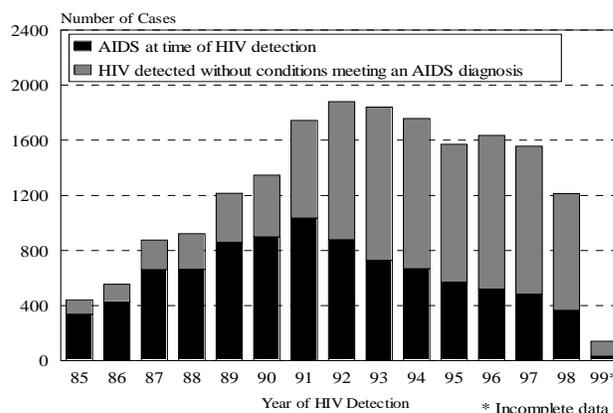
age 10 years earlier. These data show the continuing trend in HIV infection toward minority heterosexuals. While prevention programs must continue and be refocused in MSM (particularly younger MSM), efforts must clearly be expanded to prevent HIV infection in minority heterosexuals.

Figure 3: Estimated adult/adolescent AIDS incidence by gender, exposure category, and year of diagnosis, 1996 and 1997, U.S.



Adapted from CDC HIV/AIDS Surveillance Report, 1998 Midyear Edition

LOUISIANA HIV/AIDS CASE TRENDS



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
January - February 1999
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	Jan.-Feb. 1999	Jan.-Feb. 1998	Jan.-Feb. Cum 1999	Jan.-Feb. Cum 1998	% Chg
	Vaccine-preventable													
<i>H. influenzae (type B)</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	1	0	0	2	1	1	0	0	0	5	2	5	2	+150
Rate ¹	0.1	-	-	0.4	0.4	0.3	-	-	-	0.1	0.04	0.1	0.04	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	0	0	1	0	0	0	0	0	0	1	0	1	0	-
Sexually-transmitted														
HIV/AIDS Cases ²	81	27	7	6	12	8	11	1	4	157	213	157	213	-26.3
Rate ¹	7.5	4.9	1.9	1.2	4.6	2.5	2.2	0.3	1.1	3.6	4.9	3.6	4.9	
Gonorrhea Cases	563	220	117	204	94	55	456	253	150	2112	1885	2112	1885	+12
Rate ¹	54.2	38.7	31	39.5	35.1	18	90.1	72.1	39	50	44.7	50	44.7	
Syphilis (P&S) Cases	10	3	7	5	7	0	3	0	1	36	60	36	60	-40
Rate ¹	1	0.5	1.9	1	2.6	-	0.6	-	0.3	0.9	1.4	0.9	1.4	
Enteric														
Campylobacter	1	0	0	0	1	2	0	1	0	5	14	5	14	-64.3
Hepatitis A Cases	1	0	0	5	5	2	1	2	0	16	4	16	4	+300
Rate ¹	0.1	-	-	1	1.9	0.7	0.2	0.6	-	0.4	0.1	0.4	0.1	
Salmonella Cases	4	0	2	9	5	4	7	3	6	40	12	40	12	+233
Rate ¹	0.4	-	0.5	1.7	1.9	1.3	1.4	0.9	1.6	0.9	0.3	0.9	0.3	
Shigella Cases	4	0	0	3	0	3	2	1	1	14	16	14	16	-12.5
Rate ¹	0.4	-	-	0.6	-	1	0.4	0.3	0.3	0.3	0.4	0.3	0.4	
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	1	0	1	-
Other														
<i>H. influenzae (other)</i>	2	0	0	0	0	0	1	0	0	3	8	3	8	-62.5
N. Meningitidis	0	0	0	0	0	0	0	0	0	0	9	0	9	-
Tuberculosis	16	1	4	7	1	1	2	5	4	41	46	41	46	-11

1 = Cases Per 100,000

2 = These totals reflect cumulative totals of HIV+ and AIDS cases.

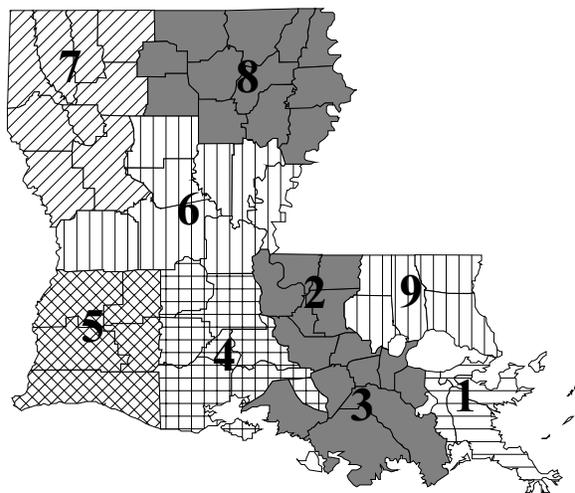
Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	1
E. coli O157:H7	1
Histoplasmosis	1
Lead Toxicity	9
Varicella	0
Rocky Mountain Spotted Fever	1
Legionellosis	1
Lyme Disease	2
Malaria	1
Tetanus	0

Table 3. Animal Rabies (May - June 1999)

Parish	No. Cases	Species
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No rabies reports for this quarter.



Annual Summary Shigellosis - 1997

One hundred and eighty-two cases of shigellosis were reported in 1997. This was a 68% decrease from 1996 and a 63% decrease from 1995 (Figure 1). Louisiana's case rate is less than half the national rate (4.2 vs 9.8 per 100,000). Sex-race specific rates were highest among Black females and males (3.4 vs 3.2 per 100,000, respectively) compared to White males and females (2.1 vs 1.8; Figure 2). Thirty-four percent of the cases occurred in age groups less than 14 years of age followed by the 25-34 years age group (Figure 3). Of 120 (66%) cases reported with daycare information, 6 (5%) were associated with a daycare; none of these were outbreak related. Cases were reported in all months of the year with most of the cases reported in the fall months (Figure 4). The highest rates per 100,000 were reported in the following parishes: Vermilion (18), Evangeline (15) and Acadia (14). Of the three serotypes reported, *S. sonnei* represented 84% of the cases.

Figure 1: Cases of shigellosis by year, 1988-1997

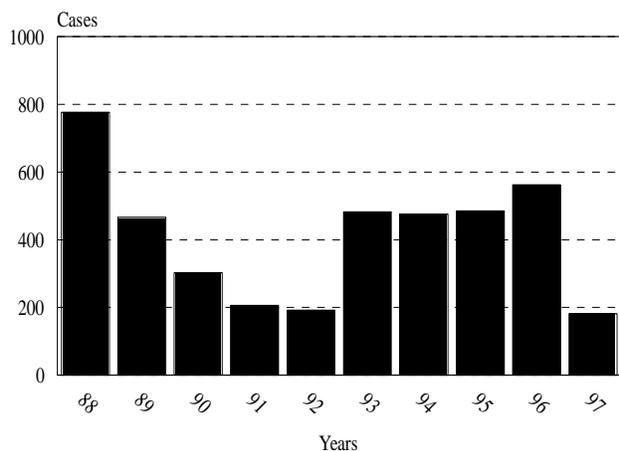
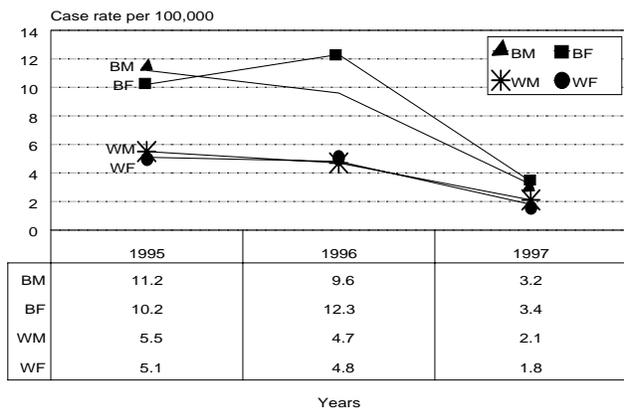


Figure 2: Rates of shigellosis by sex and race, 1995-1997



Comment:

Shigellosis is an acute bacterial disease characterized by watery diarrhea, fever, nausea, vomiting, and in typical cases, blood in the stool. Outbreaks commonly occur in homosexual men, overcrowded conditions, and where personal hygiene is poor. The mode of transmission is mainly direct or indirect fecal-oral transmission. Asymptomatic carriers may transmit infection; rarely, the carrier state may persist for months or longer. Careful handwashing with soap and water is the single most important control measure to decrease transmission in most settings.

Figure 3: Cases of shigellosis by age group and sex, 1997

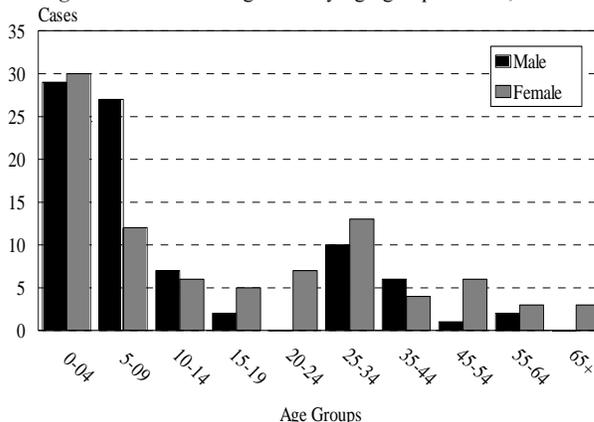
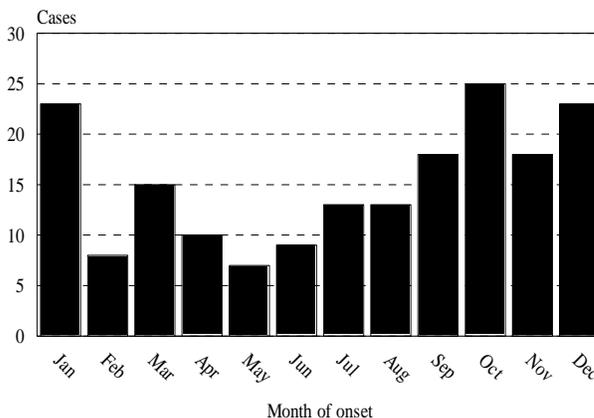


Figure 4: Cases of shigellosis by month of onset, 1997



Louisiana Fact

In 1880, the American Public Health Association was instrumental in the development of a Quarantine Division within the National Board of Health. The National Board of Health had established the Mississippi River Inspection Service and at the American Public Health Association's national conference that year (held in New Orleans), APHA passed two resolutions advocating that the "General Government" should have the direction and control of national and maritime quarantine.

Taken from the Formative Years by Gordon Gillson (pages 215-219).

LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Hepatitis, Acute (A, B, C, Other)	Rubella (German measles)	Cancer
Amebiasis	Hepatitis B carriage in pregnancy	Rubella (congenital syndrome)	Complications of abortion
Arthropod-borne encephalitis (Specify type)	Herpes (neonatal)	Salmonellosis	Congenital hypothyroidism*
Blastomycosis	Human Immunodeficiency Virus (HIV) infection ³	Shigellosis	Severe traumatic head injury**
Botulism ¹	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Galactosemia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Hemophilia*
Chancroid ²	Lymphogranuloma venereum ²	Syphilis ²	Lead Poisoning
Chlamydial infection ²	Malaria	Tetanus	Phenylketonuria*
Cholera ¹	Measles (rubeola) ¹	Tuberculosis ⁴	Reye's Syndrome
Cryptosporidiosis	Meningitis, other bacterial or fungal	Typhoid fever	Severe under nutrition (severe anemia, failure to thrive)
Diphtheria	Mumps	Varicella (chickenpox)	Sickle cell disease (newborns)*
Enterococcus (infection; resistant to vancomycin)	Mycobacteriosis, atypical ⁴	Vibrio infections (excluding cholera) ¹	Spinal cord injury**
Escherichia coli 0157:H7 infection	Neisseria meningitidis infection ¹		Sudden infant death syndrome (SIDS)
Gonorrhea ²	Pertussis		
Haemophilus influenzae infection ¹	Rabies (animal & man)		
Hemolytic-Uremic Syndrome	Rocky Mountain Spotted Fever (RMSF)		

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, phone reports, or electronic transmission.

¹ Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.

² Report on STD-43 form. Report cases of syphilis with active lesions by telephone.

³ Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.

⁴ Report on CDC 72.5 (f. 5.2431) card.

All reportable diseases and conditions other than the venereal diseases, tuberculosis and those conditions with *'s should be reported on an EPI-2430 card and forwarded to the local parish health unit or the Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160, Phone: 504-568-5005 or 1-800-256-2748 or FAX: 504-568-5006.

* Report to the Louisiana Genetic Diseases Program Office by telephone (504) 568-5070 or FAX (504) 568-7722.

** Report on DDP-3 form; preliminary phone report from ER encouraged (504-568-2509). Information contained in reports required under this section shall remain confidential in accordance with the law.

Numbers for reporting communicable diseases

1-800-256-2748

Local # 568-5005

FAX # 504-568-5006

This public health document was published at a total cost of Seven thousand copies of this public document were published in this first printing at a cost of The total cost of all printings of this document, including reprints is This document was published by to inform physicians, hospitals, and the public of current Louisiana morbidity status under authority of R.S. 40:36. This material was printed in accordance with the standards for printing for state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with the provisions of Title 43 of Louisiana Revised Statutes.

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