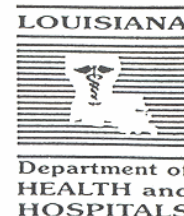




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Louisiana Morbidity Report

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Rose V. Forrest
SECRETARY

Seasons Greetings

November-December 1994

Volume 5 Number 6

Enterotoxigenic *E. coli* Gastroenteritis From a Church Supper

On August 17, 1994 OPH received a call from the Infection Control Officer at a hospital in Baton Rouge about an outbreak of gastroenteritis among hospital staff who had purchased boxed dinners prepared by a local church.

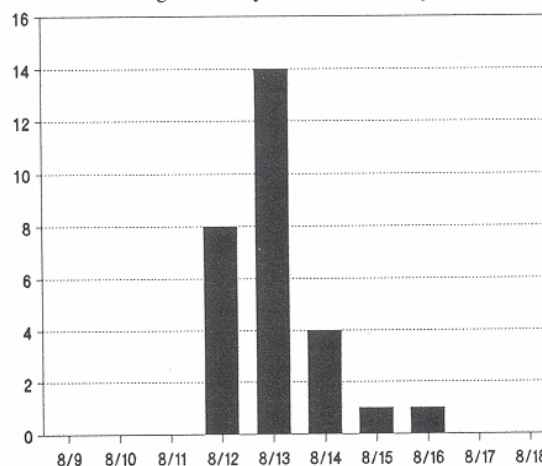
Of the estimated 200 persons who had bought dinners, we were able to contact 54 (approximately 25%) in 5 groups: hospital staff and their relatives (33/45, 73%), staff of a state agency and their relatives (11/11, 100%), family A (4/4, 100%), family B (5/5, 100%), and food handlers not belonging to any of the above groups (1/4, 25%).

Overall there were 28 persons with diarrhea, for an overall attack rate of 52% (28/54). This included cases reported in 26 (78%) of 33 persons in the hospital group, and in 2 (18%) of 11 persons in the state agency group; no cases were reported in the other groups. Symptoms reported by ill persons included: cramps (82%), nausea (50%), headache (21%), fever (14%), and vomiting (11%). No bloody stools were reported. Ill persons reported from two to 10 stools per day. Three ill persons sought medical attention for this illness, and none were hospitalized or died.

An epidemic curve for the outbreak is shown in Figure 1.

1. The median incubation time was 21 hours (range two

Figure: Cases of gastroenteritis associated with a church supper in East Baton Rouge Parish by date of onset, August 1994



to 79 hours). The median duration of illness was four days (range 12 hours to 14 days).

Illness was most strongly associated with consumption of cornbread dressing (RR=2.7), although seven ill people did not report eating this food. There was also a higher attack rate among persons who ate potato salad (RR=1.4), although this RR was not statistically significant. Ten persons in the hospital group did not eat cornbread dressing. All 10 reported eating potato salad. The attack rate in this group was 7/10 (70%). No other common meals were reported by ill persons.

Meals were sold to the hospital group by one of five cooks (Cook A), who also prepared the potato salad and the cornbread dressing sold to the hospital group. Cook A's potato salad was also served to other groups. Both the potato salad and the cornbread dressing were kept unrefrigerated or warm after preparation long enough for bacterial growth to occur. Cook A reported that she dished out her potato salad and cornbread dressing for the plates sold to the hospital group.

Stool samples were collected from 11 ill persons. None of the stools cultured in the State Laboratory were positive for *Salmonella*, *Shigella*, *Campylobacter*, or *Vibrio* species, but seven grew *E. coli*, later identified as *E. coli* serotype 0153 H45, resistant to multiple antibiotics, and possessing the gene for heat stable toxin production.

(Continued on page two)

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Enterotoxigenic E. Coli Gastroenteritis (Cont.)

Thus, this outbreak was apparently caused by Enterotoxigenic *E. coli* (ETEC). Although we could not verify the full extent of the outbreak, illness was concentrated in the hospital group. The vehicle for this bacteria was most likely the cornbread dressing which was made by Cook A and served only to the hospital group (with the exception of one person in another group who did not become ill); potato salad prepared by the same cook may also have been contaminated.

The source of the bacteria in this outbreak is not clear. ETEC is an important cause of diarrhea in the developing world, but is not thought to be a common pathogen in the US. Although Cook A denied ever having travelled outside the US, it is possible that some of the ingredients (especially the produce) purchased by Cook A came from outside the US; further investigation on this point is underway. Other outbreaks of ETEC diarrhea in persons who have not travelled out of the US have been reported.

Since, as in this outbreak, diarrhea is the most common symptom in ETEC infection, and since ETEC is not identified by routine stool culture methods, illness caused by ETEC may be attributed incorrectly to a viral etiology. In outbreak situations, the Health Department can arrange for *E. coli* isolates to be tested for the ability to produce heat-stable enterotoxin; such testing is not routinely available for clinical use, however. Thus, ETEC should be on the list of causes of non-bloody diarrhea which would not be detected by routinely available stool cultures.

CDC Vaccine-Preventable Diseases Course

The CDC's outstanding course on Vaccine-Preventable Diseases will be broadcast by satellite as a 4-part series during January, February, and March, 1995. The Office of Public Health has arranged for down-link sites for the course in the following cities: New Orleans, Baton Rouge, Lafayette, Lake Charles, Alexandria, Shreveport and Monroe. The course will be broadcast from 11:00 am to 2:30 pm in 4 parts on the following dates: January 19, February 2, February 16, and March 2. Individuals who register for the course can receive 12 hours of CME or 1.2 CEU credits through the CDC. The course is practical, interesting, and educational for physicians and nurses. The course includes an extensive syllabus that is an excellent, easy-to-use resource for coping with day-to-day questions. Anyone interested in attending should contact their OPH regional Immunization Specialist or Mr. Lynn Carroll at (504) 483-1900.

TB Transmission Guidelines

The Centers for Disease Control and Prevention (CDC) has just released "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities, 1994" (MMWR Vol. 43, No. RR-13, October 28, 1994). These Guidelines are the final version of the draft which was published in the Federal Register on October 12, 1993. The CDC revised some parts of the guidelines based on more than 2,500 responses to the draft. Revisions include the addition of two lower-risk categories in the institutional risk classifications, clarification of requirements for physician and dental offices, and general criteria for the use of respiratory protective devices. These guidelines are expected to be used by the Occupational Safety and Health Administration (OSHA) for institutional reviews. (Copies can be purchased from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325. Telephone: (202) 783-3238.)



Louisiana Morbidity Report

Volume 5 Number 6

November-December 1994

The Louisiana Morbidity Report is published bimonthly by the Epidemiology Section of the Louisiana Office of Public Health to inform physicians, nurses, and public health professionals about disease trends and patterns in Louisiana. Address correspondence to Louisiana Morbidity Report, Epidemiology Section, Louisiana Department of Health and Hospitals, P.O. Box 60630, New Orleans, LA 70160.

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Diseases/Conditions Added to Reportable List

In Louisiana, it is the responsibility of the state health officer to determine which diseases are to be reported to the health department. The state health officer may, at his/her discretion, from time to time, add to or delete from this list. Accordingly, the Office of Public Health has added the following diseases/conditions effective November 20, 1994: *E. coli* 0157:H7, Hemolytic-Uremic Syndrome, Hepatitis B in pregnancy, Hemophilia, and Galactosemia.

Escherichia coli 0157:H7 - a recently-recognized important cause of severe gastroenteritis and of Hemolytic-Uremic Syndrome. Improved epidemiologic information about cases of infection with the organism or cases of the syndrome that it causes can lead to specific measures to prevent contamination of food, and thereby prevent serious illness. Because the organism may no longer be present when hemolytic-uremic syndrome occurs, it is necessary to make both the organism and the disease reportable.

Hepatitis B carriage in pregnant women - Since there is a 70-90% chance infants infected with hepatitis B virus will become carriers with its resultant sequelae, the Office of Public Health tracks pregnant women who carry hepatitis B to be sure that the infant is appropriately immunized. This program relies on the reporting of information about these women.

Hemophilia - a congenital blood disease characterized by severe bleeding which can cause crippling and be life threatening. The requirement of reporting will ensure persons receive proper care, prevent major complications (i.e., HIV, hepatitis B, joint disease), and indicate the prevalence of the disease in the state.

Galactosemia - condition resulting from a genetic inability to metabolize galactose, causing damage to the central nervous system, liver, eyes and kidneys. Early detection and treatment which reportable status should promote can prevent many of the severe acute effects of the debilitating and life threatening disease.

In addition, the reporting of acute hepatitis has been changed to require specification of the virus type. Acute hepatitis can be caused by virus types A,B,C, and others. Previous reportable disease lists have simply listed "hepatitis" as reportable. This list clarifies that the type of hepatitis must be reported, and that only acute hepatitis is reportable. Chronic hepatitis is not reportable with the exception of hepatitis B carriage in pregnant women, as described above.

BULLETIN New Case Definition - Traumatic Brain Injury

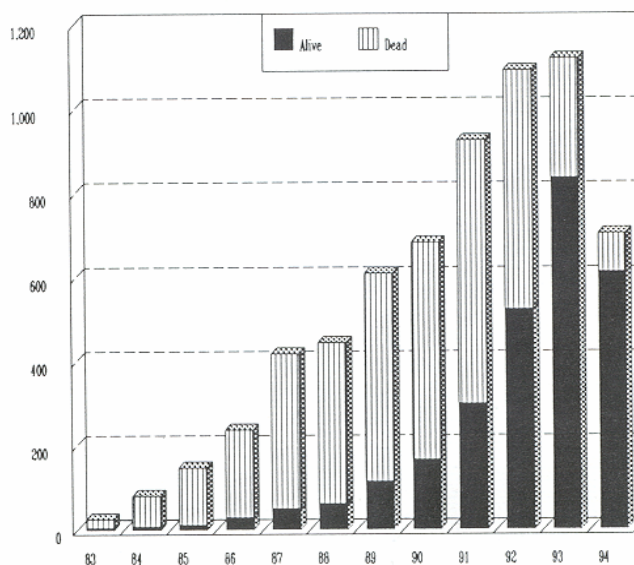
The Disability Prevention Office collects reports of severe traumatic brain injury to measure the impact of this health problem in Louisiana. Effective January 1, 1995, the definition of a reportable traumatic brain injury in this system will be changed.

A case of severe traumatic brain injury must include one or more of the following conditions in an injured person:

1. observed or self-reported loss of consciousness
2. observed or self-reported retrograde amnesia
3. skull fracture
4. objective neurologic abnormalities (determined from neurologic examination or neuropsychological evaluation) or
5. diagnosed intracranial lesion(s) (determined from radiological examination or other neurodiagnostic procedures)
6. Death as a result of trauma with head injury listed on the death certificate, autopsy report, or medical examiner report.

For more information use of ICD-9 CM diagnosis codes, clarification of definition, or reporting procedures, contact the Disability Prevention/Injury Control Section at 504-568-2509.

AIDS Case Trends



Louisiana's Improved Immunization Levels

Since 1992, Louisiana has been participating in a national initiative to improve immunization coverage of infants. The program in Louisiana, called Shots for Tots, has resulted in increases in immunization coverage that, if maintained, will succeed in reaching the goal of complete coverage of 90% of 2-year-olds for all vaccines by the year 2000 and 90% coverage for each individual vaccine by 1996.

The Shots for Tots program tries to improve immunization in a variety of ways, including expanding clinic hours, making clinics operate more efficiently, tracking infants who are behind schedule, and educating parents about the importance of timely immunizations. In many areas of the state, public health officials have worked closely with community groups to improve public awareness about immunizations.

To follow the progress of the program, in 1992 two surveys were devised to measure the immunization status of children as they reached their second birthdays. A school-enterer retrospective survey studies the immunization status of kindergarten students when they were two years old; this survey has the advantage of being representative of all children in the state but the disadvantage that it reflects immunization coverage that is approximately four years old. A public clinic survey studies the immunization coverage of two-year-olds in public clinics; this survey is timely, but it only provides information on the 70% of children who receive immunizations in Louisiana's public clinics.

In each year between 1992 and 1994 the kindergarten retrospective survey has found that 56%-58% of children had received four DTP, three OPV and one MMR vaccine before their second birthdays; this shows that there was no change in the coverage of infants turning two between 1988

and 1991 - before Shots for Tots began. However, the public clinic survey has shown an increase in immunization coverage of two-year-olds from 56% in 1992 to 64% in 1994 (Figure 1). The increase occurred in most regions in the state, but was particularly pronounced in Region 2 (Baton Rouge) and Region 7 (Shreveport; Figure 2).

Infant immunization coverage has always been lower in larger clinics (generally in urban areas), but the increase in coverage between 1992 and 1994 was seen in clinics of all sizes (Figure 3).

There are still pockets in the state in which infant immunization coverage is low enough that a measles outbreak could occur, so more needs to be done to improve coverage rates. However, if current trends continue, by the year 2000 infant immunization coverage should be at the national goal of 90%, and the state should be well protected against outbreaks of measles and other vaccine-preventable diseases.

Figure 1: Public clinics progress toward 90% coverage of infants by 2000

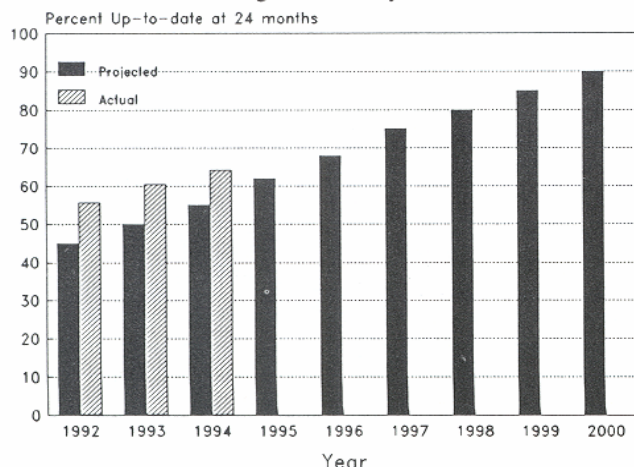


Figure 2: Immunization coverage by region, 1992-1994

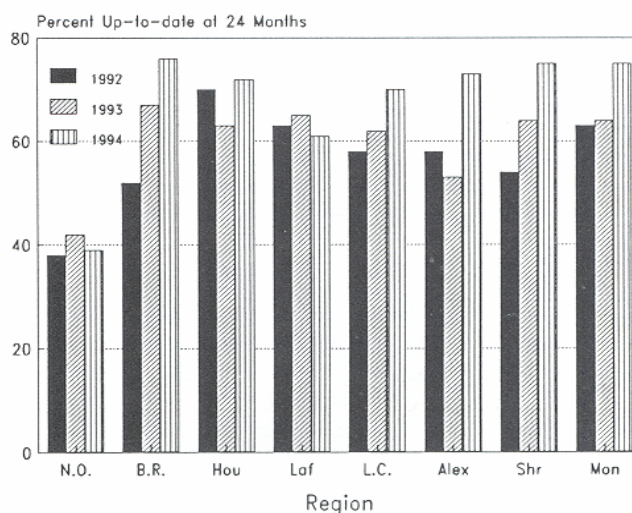
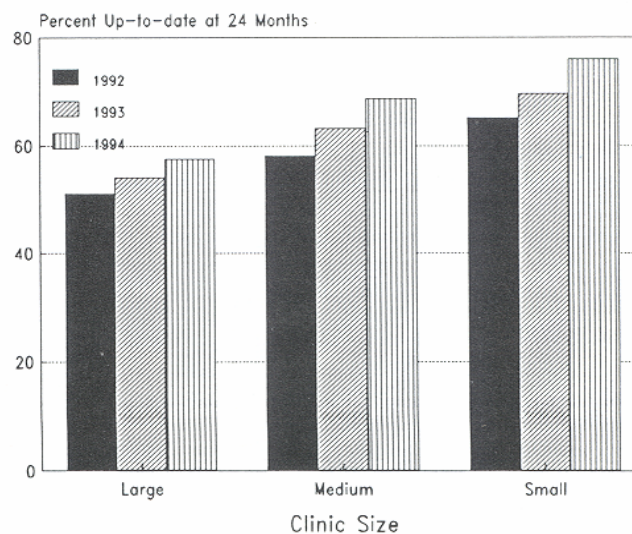


Figure 3: Immunization coverage by clinic size, 1992-1994



AIDS UPDATE

Prevalence of HIV among Clients Attending the New Orleans STD Clinic

In October 1987, the Centers for Disease Control and Prevention (CDC) instituted a sentinel surveillance system for HIV-1 infection in a variety of clinical settings serving persons at increased risk of infection and groups of public health importance. The survey is used to target HIV prevention, evaluate HIV prevention efforts and to estimate the prevalence of HIV in groups at risk for HIV infection. Some of the demographic variables collected in this survey include sex, race, age group and risk factors for HIV infection. Louisiana began participating in the survey during 1988. This blinded survey is conducted in the STD clinic located in Orleans parish (North Rampart Street Health Clinic, formerly known as Delgado). The clinic diagnoses and treats approximately 40% of gonorrhea and 21% of syphilis cases in Louisiana.

The following analysis includes only clients from Orleans parish (219 whites and 9852 blacks). The infection rate is the highest in the age group of 35-44 years, with a seropositivity rate of 5.1%, followed by 25-34 years with a positivity of 3.5% (table 1). Males and females had seropositivity rates of 3.1% and 1.3%, respectively. Gay/Bisexual, IDU and Gay/Bisexual/IDU risk groups together accounted for 3.9% of all tests with a seropositivity rate of 20.8%. These risk groups had 31.6% of all HIV infection cases. Persons with sex contact of unknown risk accounted for 88% of the clients with a seropositivity rate of 1.6%. This group contributed for 54.7% of all HIV infection cases. The positivity rate for this group between 1988 to 1993 is increasing (Figure 1).

Figure 1: Sex partner of unknown risk



The major STD diagnosis in Orleans parish are syphilis and gonorrhea. Of those tested 8% were diagnosed with syphilis and had a seropositivity rate of 5.5% (accounting for 17.2% of all HIV infection cases).

HIV prevalence rate in the survey from 1988 through 1993 were applied to all syphilis and gonorrhea cases diagnosed in Orleans parish to estimate HIV infection among those diagnosed with these sexually transmitted diseases. The estimated number of HIV cases among clients diagnosed with syphilis for each year varied between 19-90 (an average of 56 HIV cases a year) and for those diagnosed with gonorrhea the range was 71-134 (an average of 112 HIV cases a year; table 2). The results above cannot be extrapolated for the population of Orleans parish. However, it may well apply to those involved in high risk behaviors. The results suggest the need for controlling sexually transmitted diseases through prevention, intervention and education efforts as one of the strategies for combating the spread of HIV in Orleans Parish.

Table 1: Demographic characteristics and risk behaviors of clients at New Orleans STD clinic

Variables	Categories	No. Tested	No. Positive	% Positive
Race/sex	Black male	6935	197	2.8
	Black female	2901	37	1.3
	White male	161	20	12.1
	White female	58	1	1.7
Age Group	15-24	5372	80	1.5
	25-34	3064	107	3.5
	35-44	1225	62	5.1
	45+	467	9	1.9
Risk Group	Homo/Bx	154	57	37.0
	IDU	204	18	8.8
	Homo/Bx/IDU	42	8	19.0
	Sex contact			
	Unknown risk	8909	142	1.6
	Non-identified risk	661	30	4.5
	Other	198	30	1.9

Table 2: Estimated HIV cases among syphilis and gonorrhea cases in Orleans Parish

Year of Survey	GC	Syphilis	HIV among GC %	HIV among syphilis %	Est HIV/ GC	Est HIV/ syphilis
1988	6435	854	1.9	5.4	122	46
1989	6261	1303	2.1	6.0	131	78
1990	5616	1595	2.3	5.6	129	90
1991	6136	1444	1.2	5.0	67	72
1992	5176	559	2.6	3.5	135	19
1993	4890	347	1.7	8.6	83	30
Total	34,514	6102	1.9	5.5	557	335

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE,
SEPT - OCT, 1994
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	Sept-Oct 1994	Sept-Oct 1993	Cum 1994	Cum 1993	% Chg
<u>Vaccine-preventable</u>														
Measles	0	0	0	0	0	0	0	0	0	0	0	0	1	-
Mumps	2	0	1	1	1	0	1	0	1	7	2	29	17	+71
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	1	-
Pertussis	0	0	0	0	0	0	0	0	0	0	3	10	12	-17
<u>Sexually-transmitted</u>														
AIDS Cases	33	19	6	3	2	4	3	7	1	78	176	682	455	-29
AIDS Rate ¹	3.0	3.4	1.6	0.6	0.8	1.3	0.6	2.3	0.3	1.8	4.1	15.8	22.1	
Gonorrhea Cases	776	173	82	161	80	94	276	151	102	1895	2007	10233	10926	-6
Gonorrhea Rate ²	7.5	3.2	2.3	3.2	3.1	3.0	5.5	4.4	2.9	4.5	4.7	24.3	25.9	
Syphilis(P&S) Cases	57	55	16	33	4	4	34	35	16	254	474	1461	2241	-34
Syphilis(P&S) Rate ²	0.6	1.0	0.5	0.7	0.2	0.1	0.7	1.0	0.5	0.6	1.1	3.5	5.3	
<u>Enteric</u>														
Campylobacter	4	3	11	4	1	5	0	0	1	29	22	117	136	-14
Hepatitis A Cases	10	0	2	0	0	1	1	1	3	18	15	138	72	+92
Hepatitis A Rate ¹	1.4	-	0.7	-	-	0.3	0.2	0.3	0.7	0.4	0.4	3.2	1.7	
Salmonella Cases	7	18	9	24	3	4	3	2	3	73	74	398	370	+7
Salmonella Rate ¹	1.0	2.4	3.0	4.3	1.2	1.3	0.5	0.7	0.7	1.7	1.8	9.4	8.8	
Shigella Cases	33	2	1	14	9	33	11	2	34	142	66	425	369	+1
Shigella Rate ¹	4.5	0.3	0.3	2.5	3.5	10.6	2.0	0.7	7.6	3.4	1.6	10.1	8.8	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	0	1	-
Vibrio, other	3	2	1	0	1	0	0	0	1	9	9	42	32	+31
<u>Other</u>														
Hepatitis B Cases	3	12	0	2	2	2	2	2	1	26	26	153	184	-17
Hepatitis B Rate ¹	0.4	1.6	-	0.4	0.8	0.6	0.4	0.7	0.2	0.6	0.6	3.6	4.4	
Meningitis/Bacteremia														
H. influenzae	0	0	0	1	0	0	0	0	0	1	1	5	4	+25
N. meningitidis	4	0	0	3	0	0	0	0	0	7	5	35	35	0
Tuberculosis Cases	0	0	0	0	0	0	0	0	0	0	-	-	-	-
Tuberculosis Rate ¹	-	-	-	-	-	-	-	-	-	-	-	-	-	

1 = Cases per 100,000

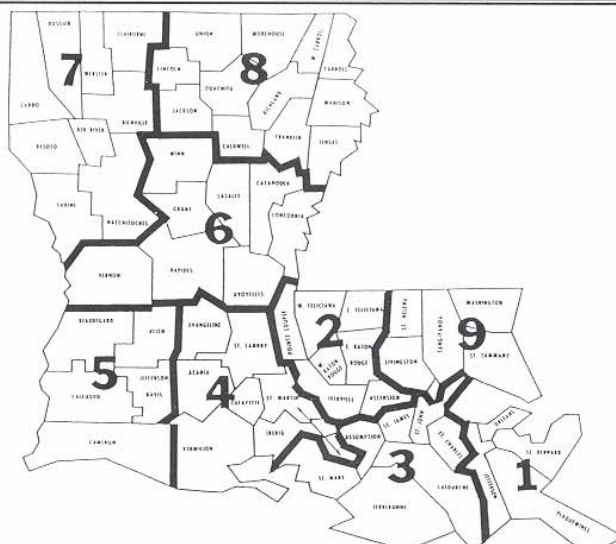
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	2
Brucellosis	2
Histoplasmosis	1
Lead Toxicity	63
Legionellosis	13
Lyme Disease	2
Malaria	9
Typhoid	4

Table 3. Animal Rabies (Sept-Oct 1994)

Parish	No. Cases	Species
St. Landry	2	Skunks
Vernon	1	Bat
Lafayette	1	Skunk



Annual Summary

Meningococcal Infections, 1993

In 1993, a total of 46 cases of meningococcal infections were reported, an overall case rate of 1.1 per 100,000. Total cases for this year has increased by 20% from 1992 and 36% from 1991 reported cases. Case rates were similar for both males and females, while race-specific rates were higher for blacks than whites (1.4 vs 0.9 per 100,000). Seventy-six percent of the cases occurred in agegroups 0 - 15 years of age (Figure 1). Fifty-four percent of the reported cases occurred during the four winter months (December through February) most commonly associated with the influenza season. Twenty-five parishes reported cases on meningococcal infections with the highest case rates reported from Jefferson Davis, St. Helena, and St. James Parishes (Figure 2). Of the 24 isolates that were serotyped, 11 were group C, 7 were group B, 5 were group Y, and one was group A.

Figure 1: Cases of meningococcal disease by age and sex, 1993

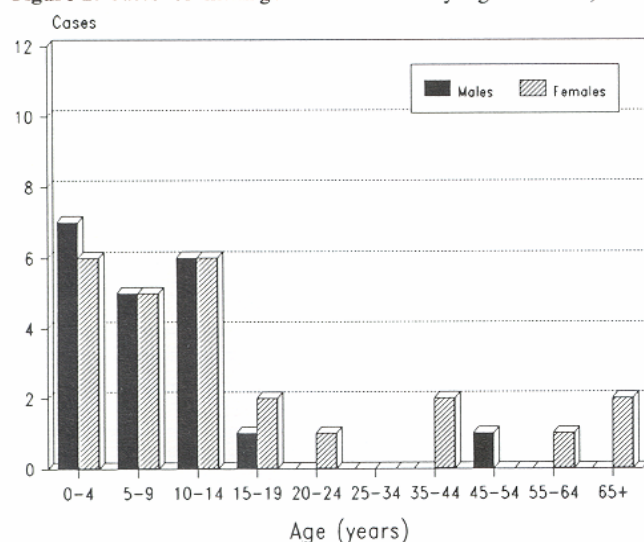


Figure 2: Cases of meningococcal infection by parish, 1993



Comment:

Meningococci may be carried asymptotically in the nasopharynx. Meningococcemia may occur without infection of the meninges and should be suspected in cases of otherwise unexplained acute febrile illness associated with petechial rash. Susceptibility to the clinical disease is low and decreases with age. One formulation of meningococcal polysaccharide vaccine is currently available in the U.S. (quadrivalent for serogroups A, C, Y, and W-135). The vaccine is available in single dose vials. No vaccine is yet available to offer protection against serogroup B. Vaccine against meningococcal disease is rarely used in the U.S. due to the delay in laboratory identification of serogroup, the lack of vaccine for group B, and low efficacy against groups A and C in small children.

Since the rapid decline in reported cases of *Haemophilus influenzae* type b infections, meningococcal infections has become the most frequently reported cause of bacterial meningitis. The United States reported a 12% increase in reported cases of meningococcal infections in 1993.

LOUISIANA FACTS

Most Commonly Reported Causes of Death City of New Orleans, 1872

Consumption	784
Pneumonia	317
Trismus nascentium	231
Convulsions, infantile	227
Marasmus, infantile	204
Congestion of the brain	186
Heart, disease of	169
Fever, congestive	165
Inflammation of the bowels	150
Debility, infantile	127
Diarrhea, chronic	107
Meningitis	106
Bronchitis	99
Old age	91
Teething	90
Dropsy	88
Apoplexy	85
Debility, adult	85
Gastro-Enteritis	77
Dysentery	71

Taken from Reports, Louisiana Board of Health. 1872-1875, Vol. I

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Granuloma Inguinale**	Cancer
Amebiasis	Hepatitis (Specify type)	Complications of abortion
Anthrax	Herpes (genitalis/ neonatal)**	Congenital hypothyroidism
Aseptic meningitis	Human Immuno-deficiency Virus (HIV)	Lead poisoning
Blastomycosis	Legionellosis	Phenylketonuria
Botulism*	Leprosy	Reye Syndrome
Brucellosis	Leptospirosis	Severe Traumatic Head Injuries+
Campylobacteriosis	Lyme Disease	Severe undernutrition
Chancroid**	Lymphogranuloma venereum**	severe anemia, failure to thrive
Chlamydial infection**	Malaria	Sickle cell disease (newborns)
Diphtheria*	Measles (rubeola)*	Spinal cord injury+
Encephalitis (Specify primary or post-infectious)	Meningitis, Haemophilus	Sudden infant death syndrome (SIDS)
Erythema infectiosum (Fifth Disease)	Meningococcal Infection (including meningitis)*	
Foodborne illness*	Mumps	
Genital warts**	Mycobacteriosis, atypical***	
Gonorrhea**	Ophthalmia neonatorum*	
	Pertussis (whooping cough)	
	Plague*	
	Poliomyelitis	
	Psittacosis	
	Rabies (animal & man)	
	Rocky Mountain Spotted Fever	
	Rubella (German measles)*	
	Rubella (Congenital syndrome)	
	Salmonellosis	
	Shigellosis	
	Syphilis**	
	Tetanus	
	Trichinosis	
	Tuberculosis***	
	Tularemia	
	Typhoid fever	
	Typhus fever, murine (fleaborne endemic)	
	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 FAX # 504-568-3206

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