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GOVERNOR

Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section
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SECRETARY

January-February 1998

Volume 9 Number 1

STD Treatment as HIV Prevention

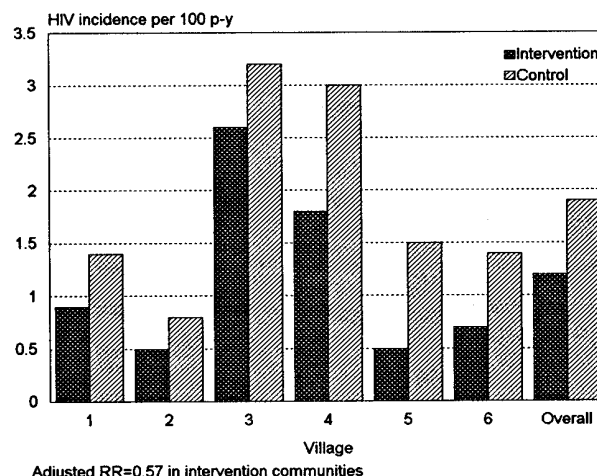
Increasing evidence demonstrates that STD treatment can significantly reduce the spread of HIV. This evidence is in the form of laboratory studies, epidemiology studies and one community-level controlled prospective trial. The intervention trial, conducted in the Mwanza District of Tanzania, found that provision of effective drugs for STDs and training of health care providers to treat symptomatic STDs resulted in a 40% decline in HIV incidence in six intervention communities compared to six controlled communities (Figure). This decline in HIV infection was not associated with any changes in sexual behavior or condom use.

STDs facilitate both the transmission and the acquisition of HIV. If an HIV infected individual has a concurrent STD, the increased shedding of the HIV virus in either the ulcerative STD (syphilis, herpes, chancroid) or inflammatory genital secretions STDs (chlamydia, gonorrhea, trichomoniasis) increases the transmission of HIV. Likewise, an HIV-noninfected individual with an STD increases his/her chance of acquiring HIV since STD genital ulcers and inflammatory secretions are an efficient portal of entry for HIV.

Any strategy which decreases the prevalence of STDs in a population will also decrease HIV transmission and acquisition. Thus, the HIV prevention benefit can be achieved not just through treating STDs in persons with HIV infection, but also through treating STDs in any person at risk for these STDs.

The CDC Advisory Committee on HIV and STD Prevention is currently developing recommendations which state that early detection and treatment of STDs should be a central and explicit component of national, state, and local strategies to prevent HIV infection and AIDS. It is unclear how specific these recommendations will be regarding screening and treatment for STDs. Because the rates of STDs and HIV are very high in Louisiana, the Louisiana Office of Public Health STD/HIV Programs recommend the following steps to expand STD detection and treatment as HIV prevention:

Figure: HIV incidence in intervention and control villages after establishment of basic STD clinical services, Mwanza, Tanzania



1. Improve access to and quality of STD clinical services

Basic clinical services (i.e. STD diagnosis and treatment) should be readily available to every sexually active adult and adolescent in the United States who believes he/she has symptoms of a sexually transmitted disease. These services should be accessible without fees or with only nominal fees, opened for services at least five days per week, and provided the day on which care is sought (i.e. without advanced appointments).

(Continued on next page)

Contents

Epidemiology Video Teleconferences	2
Salmonellosis at a Fund-Raising Event	3
Childhood Lead Screening Results	4
Bulletin: Influenza A	4
AIDS Update	5
Annual Summary: Shigellosis, 1996	7

STD Treatment as HIV Prevention (Cont.)

2. Expand screening for STDs in medical and non-medical settings.

(1) All sexually active male and female adolescents and adults under the age of 25 who are visiting health care providers for any reason should be screened for gonorrhea and chlamydia at least once per year.

(2) High-risk males and females over the age of 25 who are visiting health care providers for any reason should be screened for gonorrhea and chlamydia at least once per year.

(3) All HIV-infected persons should be screened regularly for curable STDs including gonorrhea, chlamydial infection and trichomoniasis. The frequency of such screening should depend on their risk behavior and the incidence of STDs in the local setting, but should be at least twice per year.

(4) All males and all females entering correctional facilities should be screened for syphilis, gonorrhea and chlamydia.

(5) Screening for gonorrhea and chlamydia should be conducted, whenever feasible, in institutions that serve adolescents, including schools, employment programs (e.g. Job Corps), sports programs and summer youth programs. Newer screening tests such as those done on urine samples or self-obtained swabs make screening in non-medical settings feasible.

3. Provide presumptive antibiotic treatment.

(1) All sexually active males with urethral discharge and all sexually active females with mucopurulent cervical discharge should be treated presumptively with antibiotics to treat gonorrhea and chlamydial infections immediately upon identification by medical provider of these clinical signs without waiting for laboratory test results.

(2) Sex partners of person treated presumptively for gonorrhea and/or chlamydial infection should be examined and treated presumptively for both of these diseases as well.

These practical steps to STD treatment and prevention listed above are an important and effective biomedical tool to prevent HIV infection. Although this particular strategy is currently underappreciated as an HIV prevention strategy, the recognition and use of this strategy is likely to increase in the future. The potential impact of enhanced STD detection and treatment on prevention of sexually transmitted HIV in Louisiana, where STD and HIV rates are very high, is likely to be significant.

Reminder

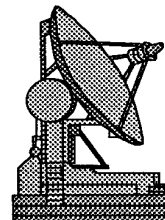
In the fall of 1998 a complete series of hepatitis B vaccination will be required for school and day care center registration. For additional information/assistance please call the Immunization Program at 504-483-1900.

Epidemiology Video Teleconferences

The Epidemiology Section will begin offering a series of specific communicable disease presentations and trainings over the course of this year, utilizing the LSU videoconferencing system. The following is a list of seminars being offered at six sites throughout Louisiana:

1. "Rabies in Louisiana" - 2/10/98, 3:00 P.M.-4:00 P.M.
2. "Emerging Infectious Disease Threats" - 4/8/98, 1:00 P.M.-3:00 P.M.
3. "How to Use and Interpret Epidemiologic Data" - date to be determined.

Seminar sites include: UNO-New Orleans, LSU-Baton Rouge, LSU-Eunice, LSU-Alexandria, LSU-Shreveport, and NLU-Monroe. Registration forms will be sent to OPH offices, laboratories, hospital ICP staff, physicians, and others. For additional information/registration forms, please contact the Epidemiology Section at (504) 568-5005.

**Louisiana Morbidity Report**

Volume 9 Number 1

January-February 1998

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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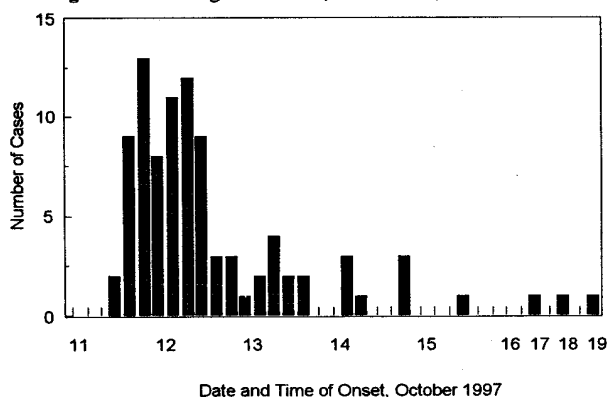
Salmonellosis at a Fund-Raising Event

On October 14, 1997 the Epidemiology Section was notified by a sanitarian about two patients with similar symptoms of gastroenteritis who participated in a school fund-raising event. The school event took place on October 11, 1997 and included servings of spaghetti meals prepared by mothers of eighth graders.

Telephone interviews were conducted with a parent (caretaker) of each of the 37 eighth graders and with participants who ate a spaghetti meal regarding participation in the event and the development of gastroenteritis.

Thirteen of the 36 caretakers had eaten a spaghetti meal. Four (31%) of these 13 caretakers and none of the 21 caretakers who did not participate in the event developed gastroenteritis ($P=0.007$). Among the 162 persons who ate the meal and were interviewed, 93 (57%) became ill (Figure 1). The most frequent symptoms (Table 1) were diarrhea (100%), cramps (91%), fever (85%), headache (75%), nausea (73%) and vomiting (45%). The attack rate was highest for participants who purchased a meal before 11:30 a.m. (AR=88%) and declined gradually every half hour of serving (Figure 2).

Figure 1: Cases of gastroenteritis, school event, October 1997



The meal served consisted of spaghetti with meat sauce, salad, bread and muffins or cake. Ground beef for the meat sauce was bought in two different batches two and three days before the event, refrigerated and prepared separately by each of the four volunteers the night before the event. After preparation, seven pots of meat sauce were refrigerated until being reheated the next morning. Serving began around 11:00 a.m. and ended around 2:00 p.m. Remaining meat sauce of the first pot served was poured into the second pot.

All interviewed participants ate meat sauce. None of the other food items was statistically associated with illness. *Salmonella newport* was grown from left-over meat sauce from a plate purchased around 11:30 a.m. and from 13 stool samples tested from 20 ill participants.

Table: Characteristics of Illness in Cases (N=93)

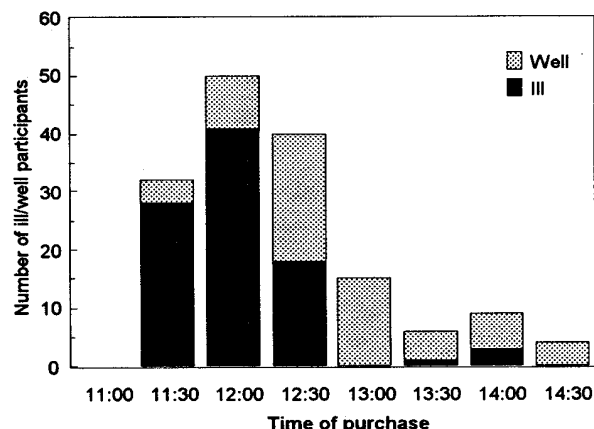
Symptoms	Number (%)
Diarrhea	93 (100%)
Median days (range)	5 (1-11)
Median stools/day (range)	12 (1-30)
Blood in stool	15 (16%)
Cramps	84 (91%)
Fever	79 (85%)
Headache	70 (75%)
Nausea	68 (73%)
Vomiting	42 (45%)
Incubation period	
Median hours (range)	21 (2-76)
Duration of illness	
Median days (range)	6 (1-11)
Medical care	
Physician consultation	5 (5%)
Hospitalization	8 (9%)
Rehydration (i.v.)	15 (16%)
Antibiotics	32 (34%)

Raw ground beef is frequently contaminated with *Salmonella*. It is likely that volunteers inexperienced in preparing food in large quantities cooked the meat sauce at temperatures that allowed the organisms to grow and cause an outbreak. Recommendations were made regarding food preparation and storage at proper temperatures with particular focus on rapid cooling of cooked food in shallow pans.

The Louisiana State University Extension Service offers food safety instructions and can be contacted by any group, including school volunteers, planning food preparation in larger quantities (contact information for East Baton Rouge Parish: 805 St. Louis St, phone (504) 389-3056).

Irradiation of beef (as previously of poultry) was recently approved by the FDA. While irradiation cannot prevent outbreaks that are caused by contamination after cooking, it would drastically reduce the frequency of contamination of raw meat products and should reduce illness due to improper handling and/or improper cooking of these raw products.

Figure 2: Attack rate of gastroenteritis, by time of purchase



Childhood Lead Screening Results

Childhood lead poisoning is a common public health problem, which is often unrecognized due to the fact that most poisoned children have no obvious symptoms. Lead is ubiquitous in the environment as a result of industrialization. However, enough is now known about the sources and pathways of lead exposure and about ways of preventing this exposure to begin efforts to eradicate this disease. Part of these efforts includes screening of children for lead poisoning.

In 1991 the Centers for Disease Control and Prevention (CDC) lowered the level of lead defined as elevated to 10 micrograms/dl because of the recognized toxic effects of low level lead on the developing brain. CDC recommended lead screening of all children to determine communities and children at risk for lead toxicity. If a large proportion of children within a community have blood lead levels above 10 micrograms/dl, there should be a community-wide childhood lead poisoning prevention program, and all children whose blood lead levels are in this range should be rescreened more than once per year. Intervention to reduce environmental contamination should also be conducted for individual children with lead levels above 15 micrograms/dl.

Lead screening has been part of the Louisiana KIDMED program since the early 1990s. The Environmental Epidemiology Section reviewed the results of lead screening among children seen in parish health units in 1996. The analysis was an unduplicated count based on the first test on a child in the year. The standard screening protocol utilizes a capillary blood sample, followed by a venous blood sample if the level is elevated; elevated capillary samples are confirmed in only about 40% of cases. Because the results analyzed were primarily capillary samples, the results represent a "worst case" scenario of the prevalence of lead poisoning in these children.

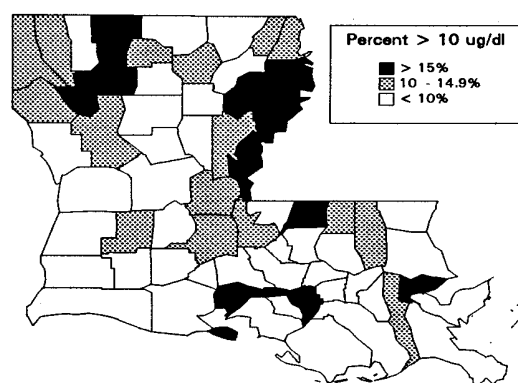
Results were available for 32,259 children, of whom 4,205 (13%) had levels above 10 micrograms/dl. The positivity rate was nearly three times as high for black as for white children (16.7% vs. 5.7%) and tended to increase with age (Table). Positivity rates by parish are shown in the Figure. In general, the parishes with the highest positivity rates were in the northeastern and northwestern areas of the state.

The goal of lead poisoning prevention activities is to reduce children's blood lead levels below 10 micrograms/dl. The results of this screening program can be used to help target these lead prevention activities to populations with high rates of lead toxicity.

Table. Results of lead screening in parish health units, 1996

Demographic Group	Positive	Tested	% >10 ug/dl
Sex			
Male	2,377	16,065	14.8
Female	1,826	15,904	11.5
Race			
Black	3,554	21,291	16.7
White	596	10,452	5.7
Other	55	516	10.7
Age			
< 1 year	95	2,645	3.6
1 yr	1,155	13,613	8.5
2 yrs	1,199	8,194	14.6
3 yrs	867	4,226	20.5
4 yrs	571	2,871	19.9
> 5 yrs	197	710	27.7
Total	4,205	32,259	13.0

Figure: Percent of tested children with lead levels above 10 micrograms/dl, by parish, 1996



BULLETIN

In late November, 1997, CDC reported the isolation of influenza A(H3N2) viruses from nursing home residents in Hawaii and persons on a cruise ship sailing between New York and Montreal. These influenza isolates were characterized as A/Sydney/05/97 (H3N2), which is a variant of the A/Wuhan /359/95-like virus contained in the 1997-98 influenza vaccine. A/Sydney is closely related but antigenically different from A/Wuhan. However, antibodies to A/Wuhan do cross react with A/Sydney and vaccination with 1997-98 vaccine will provide some protection. Because of this, we should expect to see more cases of type A illness in those persons who received vaccine as compared to previous years. The Office of Public Health Immunization Section was notified by CDC in January that some of the isolates submitted in December typed as A/Sydney.

AIDS UPDATE

Estimated Perinatal Transmission Rates

One of the significant advances in prevention of HIV has been the discovery that treatment of HIV-infected pregnant women with zidovudine (AZT) during pregnancy and delivery combined with treatment of their infants with AZT during the neonatal period decreases the transmission of HIV infection to these infants from 26% to 8%. This makes it important for pregnant women to be counseled and tested for HIV infection, and for those who are HIV-infected to be followed closely and treated during pregnancy. The HIV/AIDS Program analyzed data from several sources to estimate how successful the state's medical care system was in identifying and treating these women, and to project how many cases of HIV infection in infants may have been prevented.

Between 1990 and 1995, the percentage of women giving birth who were HIV infected rose, particularly among African-American women, as estimated by data from the Survey of Childbearing Women (SCBW), a blinded state-wide survey of HIV antibodies in women giving birth (Figure 1). However, during the same time period the number of infants who became infected with HIV has dropped. The transmission rates each year were estimated using the reported cases of perinatal HIV infection in infants and estimates of the number of HIV positive women giving birth (projected from the SCBW results). These estimates show the rate of perinatal HIV transmission decreased from 1990 to 1995 (Figure 2), which is consistent with the increase in reported use of AZT by these women and children.

The CDC has developed a method for testing blood samples for AZT to determine whether neonates tested had received this medication in the previous 48 hours. The HIV positive blood samples from the blinded Survey of Childbearing Women were analyzed for AZT for years 1994-95. Between these two years, the percent of blood samples testing positive for AZT doubled to 71% (Table 1).

Based on the decreased transmission rates observed, in 1995 HIV infection was prevented in 21 infants by AZT use. Additional cases can be prevented by ensuring that all HIV-infected pregnant women are identified and receive appropriate treatment during pregnancy, delivery, and the neonatal period.

Table: Estimated use of AZT by pregnant women and children, 1993-1996

Year of Birth	% AZT use Reported to OPH During:			% Blood ADV in Blinded Survey
	Pregnancy	Labor & Del	Preg or Labor & Del	
1993	23.1%	6.6%	24.2%	n/a
1994	53.2%	31.5%	53.2%	33.3%
1995	56.1%	48.0%	60.2%	70.7%
1996	65.7%	56.6%	70.6%	n/a

Figure 1: Percent of childbearing women infected with HIV by race, 1990-1995

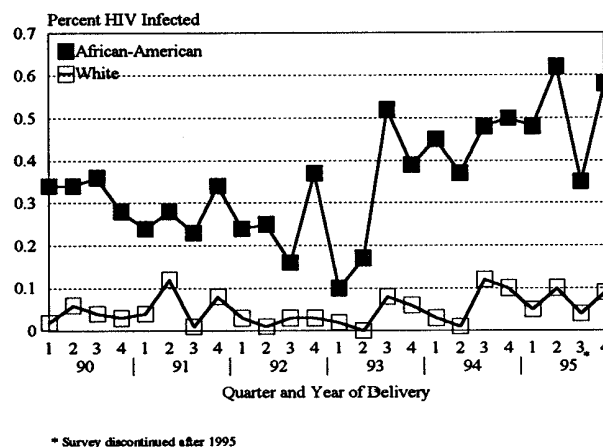
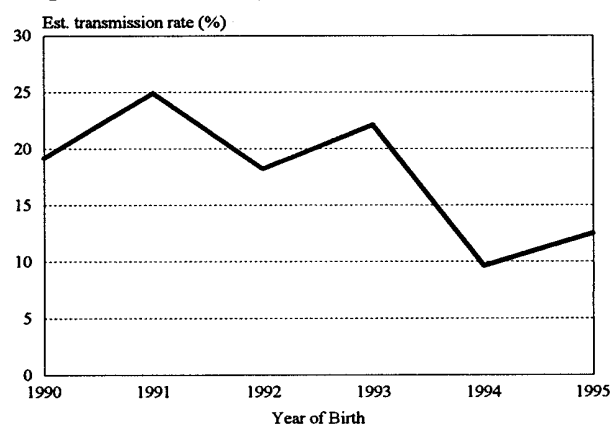
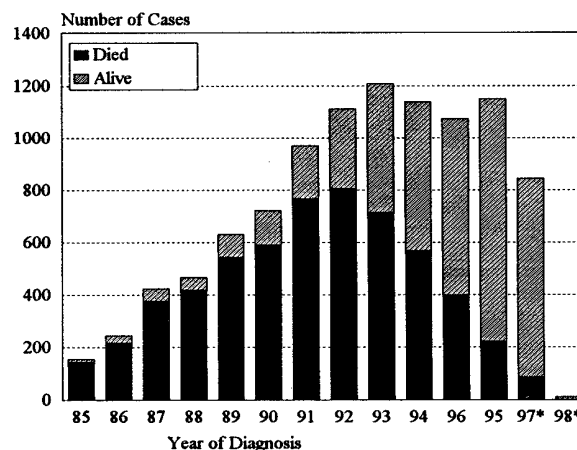


Figure 2: Estimated rate of perinatal HIV transmission, 1990-1995



AIDS CASE TRENDS



* Incomplete data

LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

Nov.-Dec., 1997

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	Nov. Dec. 1997	Nov. Dec. 1996	Cum 1997	Cum 1996	% Chg
Vaccine-preventable														
<i>H. influenzae</i>	1	0	0	0	0	0	0	0	1	2	0	16	6	+166.7
Hepatitis B	4	2	1	1	2	0	3	1	1	15	21	170	161	+5.6
	0.4	0.4	0.3	0.2	0.7	-	0.6	0.3	0.3	0.3	0.5	3.9	3.7	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	0	0	0	0	0	0	1	1	0	2	5	17	24	-29.2
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	1	-100
Pertussis	0	0	0	0	0	0	0	0	1	1	5	21	14	+50
Sexually-transmitted														
AIDS	59	24	1	20	6	6	4	4	8	132	114	1029	1446	-29
	5.4	4.4	0.3	4.0	2.3	1.9	0.8	1.2	2.2	3.1	2.6	23.9	33.5	
Gonorrhea	530	188	184	212	148	62	462	189	110	2085	1387	10621	9294	+14.3
	51.0	33.1	48.8	41.1	55.2	20.3	91.3	53.8	28.6	49.5	32.9	251.8	220.2	
Syphilis(P&S)	24	9	11	4	1	0	3	3	3	58	55	363	532	-31.7
	2.3	1.6	2.9	0.8	0.4	-	0.6	0.9	0.8	1.4	1.3	8.6	12.6	
Enteric														
<i>Campylobacter</i>	2	1	0	0	0	0	1	2	1	8	27	166	163	+1.8
Hepatitis A	4	2	0	4	0	2	15	5	1	33	57	258	241	+7.1
	0.4	0.4	-	0.8	-	0.7	3.0	1.4	0.3	0.8	1.3	6.0	5.6	
<i>Salmonella</i>	14	19	13	8	6	6	6	10	14	116	101	626	611	+2.5
	1.3	3.3	3.4	1.6	2.2	2.0	1.2	2.8	3.6	2.7	2.3	15.0	14.2	
<i>Shigella</i>	10	1	1	13	2	0	1	1	2	35	52	168	563	-70.2
	1.0	0.2	0.3	2.5	0.7	-	0.2	0.3	0.5	0.8	1.2	3.9	13.0	
<i>Vibrio cholera</i>	0	0	0	0	0	0	0	0	0	0	0	0	1	-100
<i>Vibrio, other</i>	2	0	0	0	1	0	0	0	0	3	1	35	40	-12.5
Other														
<i>N. Meningitidis</i>	0	0	0	0	0	0	0	0	0	0	8	49	66	-25.8
Tuberculosis	86	14	6	15	6	7	10	13	19	176	182	406	420	-3.3
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9.3	9.6	

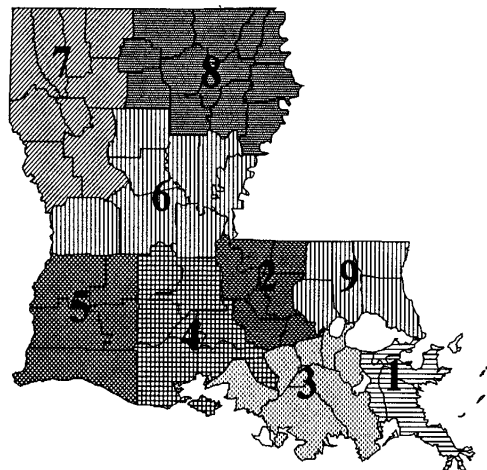
1 = Cases per 100,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	6
E. coli 0157:H7	0
Histoplasmosis	3
Lead Toxicity	99
Varicella	8
Rocky Mountain Spotted Fever	4
Legionellosis	20
Lyme Disease	5
Malaria	1
Tetanus	2

Table 3. Animal Rabies (Nov.-Dec., 1997)

Parish	No. Cases	Species
Sabine	1	Dog



Annual Summary Shigellosis - 1996

For 1996, 562 cases of shigellosis cases were reported, an increase of 16% from 1995 and 18% from 1994. Louisiana's case rate is 25% higher than the national rate (13 vs 9.8 per 100,000). Sex-race specific rates were highest among African-American males and females (9.6 vs 12.3 per 100,000, respectively) and over twice as high as for white males and females (4.7 vs 4.8, Figure 1). Sixty-nine percent of the cases occurred in age groups less than 15 years of age. Of the 54% of the cases for which this information was known, 5% were associated with a day care center. Cases were reported in all months of the year with a peak of cases reported between April and July (Figure 2). Parishes reporting the highest case rates per 100,000 include: Washington (48), Caddo (32), Ascension (31), E. Baton Rouge (30) and Bossier (27, Figure 3). Of 450 isolates reported, 96% of the cases were serotyped *S. sonnei*.

Figure 1: Rates of shigellosis by sex and race, 1994-1996

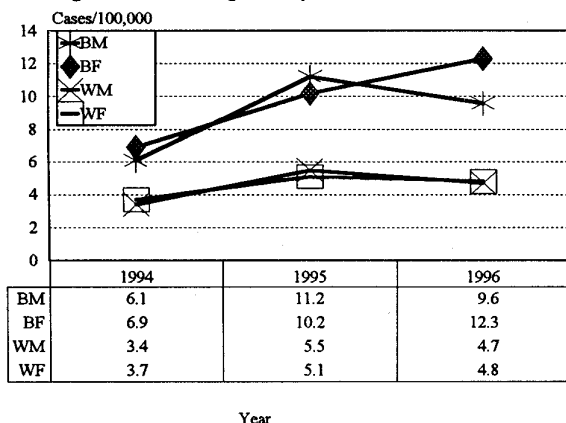


Figure 2: Cases of shigellosis by month of onset, 1996

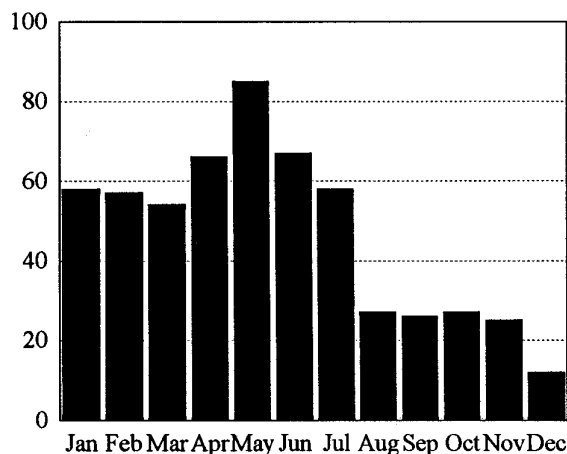
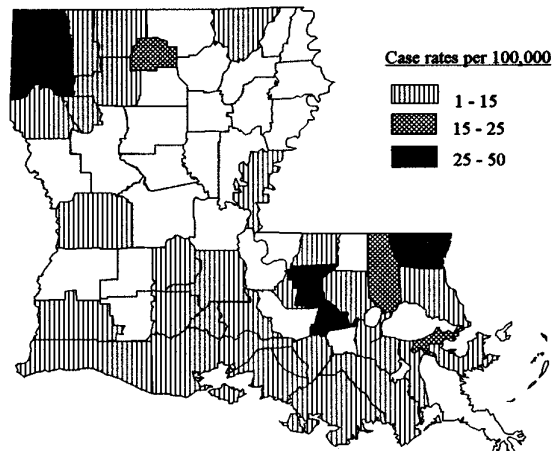


Figure 3: Rates of shigellosis by parish, 1996



Louisiana Fact

Did you know that an early pre-cursor of our current injury prevention efforts occurred in 1873 when the City of New Orleans passed an ordinance whereby "the proprietor or proprietors of every store, warehouse, or other building, wherein there shall be hatchways, staircases or other exposed openings in the floor, unprovided with trap doors, shall construct a strong and durable railing around said openings, the same to be movable, if so desired; said railings or trap-doors to be suitably adjusted each evening upon the closing of the building. For any violation of the foregoing provisions the occupant or occupants of the building shall be subjected to a fine not exceeding one hundred dollars, to be recovered before any court of competent jurisdiction; and for further protection to firemen while in the discharge of their duties, and to prevent the deplorable accidents resulting from staircases and hatchways left unprotected as aforesaid, the police of the city are hereby authorized and required to inspect, at suitable hours, all warehouses, etc, upon their respective beats, and to report all violations of this ordinance through the Superintendent of the Metropolitan Police to the Mayor, in order that the proper fines may be inflicted, and that this ordinance may be effectually enforced."

Taken from Health Ordinances of the City of New Orleans, State of Louisiana, 1880, p 70.

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	Galactosemia*
Botulism ¹	Legionellosis	Staphylococcus aureus (infection; resistant to methicillin/oxacillin or vancomycin)	Hemophilia*
Campylobacteriosis	Lyme Disease	Streptococcus pneumoniae (infection; resistant to penicillin)	Lead Poisoning
Chancroid ²	Lymphogranuloma venereum ²	Syphilis ²	Phenylketonuria*
Chlamydial infection ²	Malaria	Tetanus	Reye' Syndrome
Cholera ¹	Measles (rubeola) ¹	Tuberculosis ⁴	Severe traumatic head injury**
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)		

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.

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

** Report to Injury Research & Prevention Section (504-568-2509).

Numbers for reporting communicable diseases**1-800-256-2748****Local # 568-5005****FAX # 504-568-5006**

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