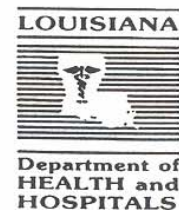




Murphy J. "Mike" Foster, Jr.
GOVERNOR

Louisiana Morbidity Report

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



David Hood
SECRETARY

November-December 1998

Volume 9 Number 6

Salmonellosis From a Commercially Distributed Product

In August, 1998, the Epidemiology Section was notified about an outbreak of gastroenteritis among guests who attended a wedding. Of 114 interviewed wedding guests, 63 (55%) reported diarrhea with a median duration of 3 days (Figure 1). Twenty-seven ill guests sought medical care for their symptoms, and 14 ill persons required intravenous rehydration.

The foods served included cochon du lait, barbeque chicken, pork and beans and cajun rice dressing. Sixty-two percent of the guests who ate the rice dressing became ill compared to 3% who did not recall eating the dressing (relative risk 3.3, p-value 0.001). None of the other food items served were associated with illness.

The basis of the rice dressing was a commercially distributed rice dressing mix product, which was mixed with cooked rice, cooked chicken gizzards and pork livers during preparation. The finished rice dressing was brought to the reception hall on the morning of the wedding, and serving lasted until around 7:30 p.m. The rice dressing was neither cooled nor reheated during the entire day before being served.

Nineteen of 23 ill persons who submitted stool cultures tested positive for *Salmonella infantis*, a rare serotype of *Salmonella*. All 19 specimens showed an identical pattern by pulsed-field gel electrophoreses (PFGE). Six randomly

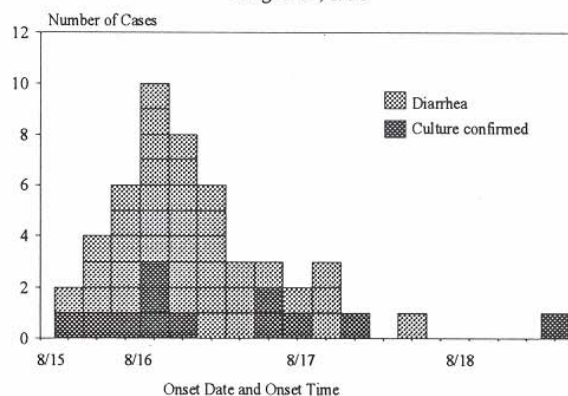
purchased rice dressing mix containers from local grocery stores and from the production plant, and left over rice dressing from the wedding tested positive for *Salmonella infantis* with an identical PFGE pattern as the stool specimens.

At the production plant, rice dressing mix was cooked in a cooking vat and then pumped through a packing machine, from which it was filled into the containers sold in grocery stores. The entire production line was cleaned every day and temperatures were checked properly and regularly. Of 19 environmental samples taken from the different steps in the production line on September 17, two tested positive for *Salmonella infantis*, again with an identical PFGE pattern as the previous samples. One sample was the finished product before it was filled into the commercial containers and the other sample came from part of a pump, which pumped the cooked product out of the cooking vat. This pump contained a deteriorated rubber gasket.

Based on this information, the U.S. Department of Agriculture issued a recall of the product on September 22. After this investigation, the plant changed its procedures to include a complete disassembly and cleaning of all parts daily.

However, without the time and temperature violations during the preparation and storage of the finished rice dressing itself, bacteria would likely not have survived and been allowed to grow to high enough quantities to cause illness. Thus, recommendations were made to the food preparers of the wedding regarding proper food handling procedures, particularly storing food at proper hot and cold temperatures.

Figure: Cases of diarrhea at a wedding reception, Opelousas, August 15, 1998



Contents

Childhood Injury	2
St. Louis Encephalitis Outbreak, 1998.....	3
Epidemiology Training Activity	4
Change in HBV Vaccine Dose	4
Emerging Pathogens Surveillance	4
HIV/AIDS Update	5
Annual Summary: Salmonellosis 1997	7

Childhood Injury

Unintentional ("accidental") injuries are the leading killer of children in the United States. Each year, more children ages 1-14 die from unintentional injuries than from all childhood diseases combined. Each year in the United States, 7,300 children ages 14 and under are killed and 50,000 are permanently disabled. This year, one child in four (approximately 13 million) will be hurt seriously enough to require medical attention.

For every child who dies from a preventable injury, over 40 others are hospitalized and 1,120 are treated in emergency rooms. These injuries result in enormous financial, emotional and social effects on not only the child and his/her family, but the community and society as a whole.

Unintentional injuries disproportionately affect poor children and result in more fatalities compared to children with greater economic resources.

Injury is the leading cause of medical spending for children 5 to 14 years of age. The annual lifetime cost of unintentional injury among children ages 14 and under is nearly \$180 billion, which includes more than \$10.5 billion in direct medical costs, \$17.5 billion in future earnings and \$151 billion in reduced quality of life. For every child injured, total costs are nearly \$12,000, including \$730 in medical costs, more than \$1,200 in future earnings and nearly \$10,500 in quality of life.

Figure 1 depicts types of unintentional injury deaths of children 14 years old and under in Louisiana, 1997. Motor vehicle deaths account for 48% of these injury deaths, with drowning next (15%) followed by "other" deaths (14%) and fire (11%).

Figure 1: Unintentional injury deaths of children 14 and under by type, Louisiana, 1997

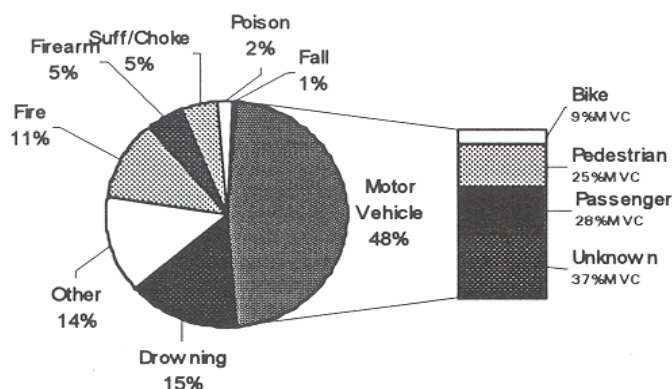
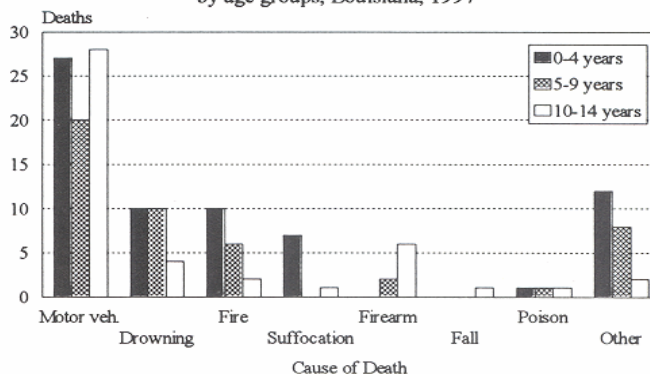


Figure 2 depicts unintentional injury deaths of children by age groups. All three age groups are highest for injury deaths by motor vehicle. The 0-4 age group is the next highest in the "other" category, and again is the highest for drowning (along with the 5-9 age group) and for fire.

Figure 2: Unintentional injury deaths of children 14 and under by age groups, Louisiana, 1997



The Louisiana SAFE KIDS Coalition, a project of the Louisiana Office of Public Health and Children's Hospital, is working to reduce childhood injuries. Call 504-568-2508 or 504-896-3986 for more information on children's safety.



Louisiana Morbidity Report

Volume 9 Number 6

November-December 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.

Assistant Secretary, OPH

Jimmy Guidry, MD

State Epidemiologist

Louise McFarland, DrPH

Editors

Thomas Farley, MD MPH
Karen Kelso, RNC MS

Associate Editor

Barbara Trahan, MPH

Layout & Design

Ethel Davis, CST

Contributors

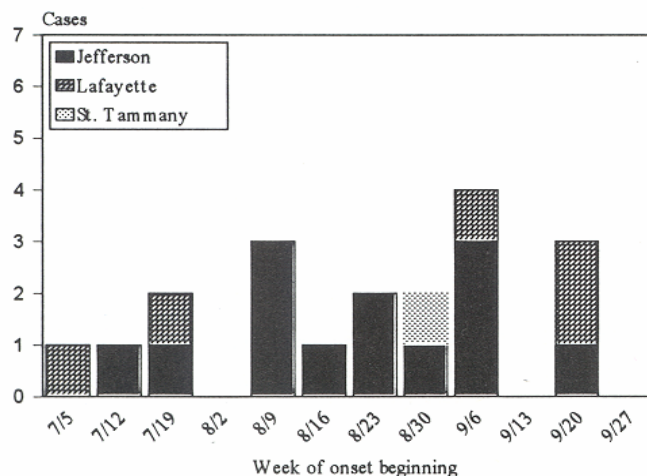
Susan Wilson, BSN
Katrin Kohl, MD MPH
Ruben Tapia, MPH
Diane Praytor-Cartwright, MPH
Stephanie Broyles, MS
Kerry Chausmer, MSW MPH

St. Louis Encephalitis Outbreak, 1998

Between July and October, 19 cases of St. Louis encephalitis (SLE) were reported from three parishes in southern Louisiana. In comparison, the last outbreak of SLE occurred in 1994 within the same time period as this year's outbreak (however, SLE cases were reported primarily from Orleans parish).

Of the SLE cases reported this year, five were reported from Lafayette parish, one from St. Tammany parish and the remaining cases were reported from Jefferson parish [13, (see map)]. Onsets of illness ranged from July 5 to September 27 (Figure) with ages ranging from 6 to 72 years. Ten of the cases (53%) were females. Fifteen (79%) of the cases were white and 4 (21%) were African-Americans. One death was reported from this outbreak compared to three SLE-associated deaths in 1994.

Figure: St. Louis Encephalitis cases, Louisiana, 1998



Notification to the media to solicit their assistance in getting information to the citizens on how to protect themselves from this mosquito-borne virus occurred as soon as the first cases of SLE were confirmed. At the same time, hospital Infection Control Officers were notified to alert Emergency Room and Infectious Disease physicians and staff regarding the SLE problem.

SLE is the most common mosquito-transmitted human

pathogen in the U.S. As soon as initial cases are identified, aggressive mosquito control activities are instituted such as aerial spraying or to areas of virus activity.

Less than 1% of SLE viral infections are clinically apparent. The vast majority of human infections are asymptomatic or undiagnosed. The incubation period for SLE is up to two weeks. Illness ranges in severity with nonspecific flu-like symptoms. Onset may be insidious or sudden with fever, headache, myalgia, malaise and occasionally prostration. The disease is generally milder in children than in adults, but in those children who do have disease, there is a high rate of encephalitis. No specific vaccine or antibiotic is available and treatment is mainly supportive. Arboviral encephalitis can be prevented by: a) personal protection measures such as reducing the time of outdoor exposure to mosquitoes; b) applying mosquito repellent to exposed skin areas; c) wearing protective clothing such as long sleeved shirts and pants; and d) eliminating mosquito breeding sites near residences by emptying containers which hold stagnant water.

St. Louis Encephalitis cases, Jefferson Parish, 1998



Happy Holidays

Epidemiology Training Activity

The Epidemiology Section has presented several training programs in 1998 utilizing a variety of communication methods. Videoconferencing through the LSU system allowed use of two-way audio and video, while in-service training workshops enabled the use of small group discussions/exercises. The latest training was conducted through audioconferencing, using two-way audio.

Over two hundred people from OPH clinics and hospitals statewide participated in the Hepatitis A - G audioconference, which was held December 10, 1998. Packs of materials were forwarded to facilitators for the participants. OPH Regional Offices received a slide set which can be used for additional training opportunities. Over 40 sites were involved. Staff from the Epidemiology Section conducted the conference which included time for questions and answers. Questions were faxed during the presentation, as well.

Nursing contact hours were offered for nursing participants. The conference was tape-recorded and will be available through the Epidemiology Section. The preparation for an audioconference is labor-intensive, however, the benefits are numerous: OPH and hospital staff can stay in their own facilities, saving time, and the costs of travel. More hospital staff registered for this course than for any other type of training program offered to date.

Epidemiologic training programs scheduled for the first half of 1999 will include basic epidemiologic principles, disease surveillance system development, infectious epidemiology for regional public health staff (nurses and sanitarians), disease specific seminars for OPH staff and ICPs, and program evaluation workshops, utilizing several methods of presentation/communications. Announcements for these will be sent to OPH offices, laboratories, hospital ICP staff, physicians, and others. For more information, please contact Barbara Trahan at (504) 568-5005.

Change in HBV Vaccine Dose

Merck Vaccine Division has announced a change in the dosing regimen for RECOMBIVAX hepatitis B vaccine. The 5 mcg dose is now a standard dosing regimen for all new vaccinees from birth to 19 years of age, regardless of risk exposure.

Children who have been initiated with the 2.5 mcg dose may complete the vaccine series with either the 2.5 mcg or the 5 mcg dose. However, for the transition period, if the Health Unit has 2.5 mcg doses, they should continue to use these as appropriate until exhaustion of stock.

Please note that children who have been initiated and/or completed the hepatitis B vaccination series with the 2.5 mcg dose do not need to be revaccinated.

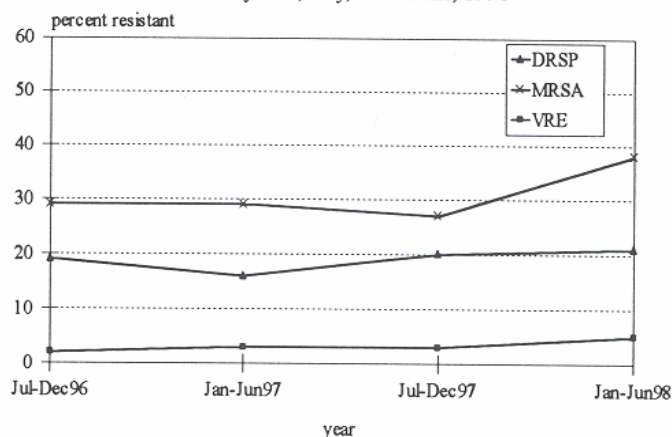
Any questions regarding the above can be directed to the Immunization Program at (504) 483-1900.

Emerging Pathogens Surveillance

State	Penicillin resistant <i>Streptococcus pneumoniae</i>	Methicillin resistant <i>Staphylococcus aureus</i>	Vancomycin resistant <i>Enterococcus</i> species
# Resistant isolates	145	1638	180
Total isolates	707	4364	3737
% Resistant	21%	38%	5%

The Figure below represents the trend of emerging pathogens data collected from the Emerging Pathogens Surveillance Program, July, 1996, through June, 1998, by six-month intervals. Vancomycin Resistant *Enterococcus* species (VRE) and Penicillin Resistant *Streptococcus pneumoniae* (DRSP) have remained relatively constant since the beginning of the surveillance program. Methicillin (Oxacillin) resistant *Staphylococcus aureus* (MRSA) has shown an increase in the last six months.

Figure: Louisiana Emerging Pathogens Surveillance Program, aggregate laboratory data, July, 1996-June, 1998



MERRY CHRISTMAS



HIV/AIDS UPDATE

HIV and Pregnancy in Teenage Females

Since 1993, about 50 new cases of HIV/AIDS have been identified in teenage (ages 13 – 19) females each year. In this time period, approximately 90% of these new cases have occurred in African-Americans, and about 80% of the new cases have occurred in teenage females who reside in either the New Orleans, Baton Rouge, or Monroe area (45%, 24%, and 12%, respectively).

In 1996, teenagers represented 6.9% of all prevalent cases of HIV/AIDS among women of childbearing age (13 – 44 years); for comparison, teenage females overall comprise 23.8% of all women of childbearing age. This is consistent with other data showing that HIV prevalence increases with age during the teens, twenties, and thirties. At the same time, 35% of HIV-infected teenage females who are reported to the Office of Public Health are detected with HIV during a pregnancy. In non-teens, 16% are detected via a pregnancy. Consequently, pregnancy may be serving as an important HIV screening tool in teenage females.

Although teenagers account for a small percentage of HIV-infected females, in 1996 they gave birth to 24% of all HIV-exposed babies. Additionally, the number of HIV-exposed babies born to HIV-infected teenage mothers has seen a 110% increase since 1993, whereas the number born to non-teen HIV-infected mothers has increased only 31% in the same time period. Among HIV-infected teenage mothers, the percent who knew that they were HIV+ before becoming pregnant has increased since 1993 (Table). Although this may indicate a trend towards earlier HIV screening in teen females, it also suggests that knowing of their HIV status does not deter these persons from continued risky sexual behavior and from becoming pregnant.

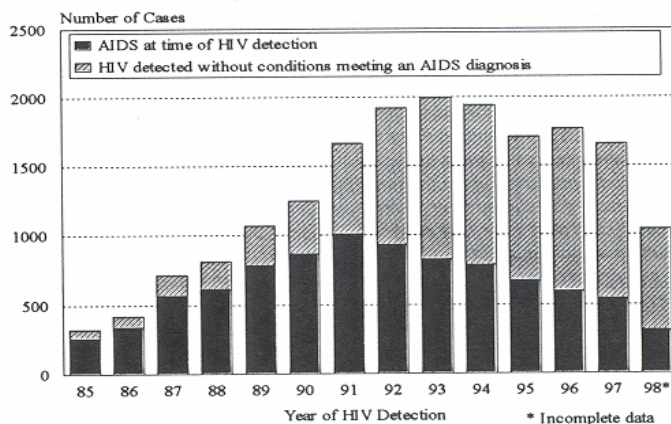
Among HIV+ teen mothers, the percentage of deliveries occurring in public facilities has increased from 1993 – 1996 (Table). For both teen and non-teen HIV-infected mothers, over 90% of deliveries occurred in public facilities in 1996. AZT use among both groups has also increased in this time period, with AZT use among both teens and non-teens being over 70% in 1996. The high rate of AZT use is encouraging; however, among both groups the percent using AZT was lower than the percent who were known, at some point during the pregnancy, to be HIV-infected. Consequently, some opportunities for treatment were missed.

Teenagers are at risk for HIV infection because they are physically mature yet often not capable of making wise decisions about sexual risk-taking. In teenage females this lack of maturity can also carry consequences for a baby as well. Given that teenage females are delivering a higher proportion of the HIV-exposed babies born in Louisiana, HIV prevention programs should promote increased HIV counseling and testing, as well as condom use, among sexually active teenagers.

Table: Characteristics of teenage and non-teen pregnant females reported with HIV infection

	TEENAGERS		NON-TEENS
	YEAR OF DELIVERY		
	1993 (n=17)	1996 (n=36)	1996 (n=115)
Characteristics			
African-American	94.1%	97.2%	88.7%
Resident of urban parish	94.1%	80.6%	92.2%
New Orleans	47.1%	38.9%	46.1%
Baton Rouge	29.4%	25.0%	26.1%
Exposure Group [†]			
Injecting Drug user	10.0%	0.0%	27.3%
High Risk	90.0%	100.0%	72.7%
Heterosexual			
Unspecified	41.2%	52.8%	42.6%
Knew HIV+ status prior to pregnancy	17.6%	27.8%	41.7%
Delivered in public facility [‡]	66.7%	91.4%	95.5%
Opportunity for treatment			
HIV+ status known before or during pregnancy, or at time of delivery	94.1%	94.4%	95.7%
AZT use during pregnancy or delivery	29.4%	83.3%	72.2%
[†] Total percent for Exposure Group does not include Unspecified Exposure.			
[‡] Percents do not include cases for which facility type was unknown.			

HIV/AIDS Case Trends



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

Sept - Oct 1998

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	September October 1998	September October 1997	Cum 1998	Cum 1997	% Chg
Vaccine-preventable														
<i>H. influenzae</i> (type B)	0	0	0	0	0	0	0	0	0	0	-	0	-	-
Hepatitis B Cases	17	2	0	1	2	3	4	5	4	38	37	151	154	-2
Rate ¹	1.6	0.4	-	0.2	0.7	1.0	0.8	1.4	1.0	0.9	0.9	3.5	3.6	
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	3	8	15	-47
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	0	0	0	0	0	0	0	0	0	0	2	11	20	-45
Sexually-transmitted														
HIV/AIDS Cases ²	57	47	7	7	13	11	4	18	6	170	296	1095	1310	-17
Rate ¹	5.3	8.5	1.9	1.4	5.0	3.5	0.8	5.2	1.7	3.9	6.9	25.4	30.4	
Gonorrhea Cases	484	237	107	233	92	72	451	309	172	2157	2230	10431	8813	+18
Rate ¹	46.6	41.7	28.4	45.2	34.3	23.6	89.1	88.0	44.7	51.1	52.8	247.2	208.8	
Syphilis(P&S) Cases	17	7	29	23	4	4	2	4	1	91	61	369	313	+18
Rate ¹	1.6	1.2	7.7	4.5	1.5	1.3	0.4	1.1	0.3	2.2	1.4	8.7	7.4	
Enteric														
Campylobacter	7	5	0	1	0	1	1	1	4	20	23	100	141	-29
Hepatitis A Cases	11	2	0	2	1	4	0	3	0	23	48	107	219	-51
Rate ¹	1.1	0.4	-	0.4	0.4	1.3	-	0.9	-	0.5	1.1	2.5	5.1	
Salmonella Cases	29	19	23	16	11	16	16	17	24	175	140	567	477	+19
Rate ¹	2.8	3.3	6.1	3.1	4.1	5.2	3.2	4.8	6.2	4.1	3.2	13.1	11.1	
Shigella Cases	13	5	1	2	0	5	13	14	2	55	23	254	115	+121
Rate ¹	1.3	0.9	0.3	0.4	-	1.6	2.6	4.0	0.5	1.3	0.5	5.9	2.7	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	0	2	0	-
Vibrio, other	3	1	3	1	0	0	0	0	1	10	6	43	29	+48
Other														
<i>H. influenzae</i> (other)	1	0	0	0	0	0	0	0	0	1	1	23	13	+77
N. Meningitidis	0	1	0	0	1	0	0	0	2	4	1	58	47	+23
Tuberculosis	14	3	4	4	5	2	1	7	3	43	76	308	230	+34

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	4
E. coli 0157:H7	5
Histoplasmosis	1
Lead Toxicity	41
Varicella	173
Rocky Mountain Spotted Fever	2
Legionellosis	4
Lyme Disease	5
Malaria	13
Tetanus	1

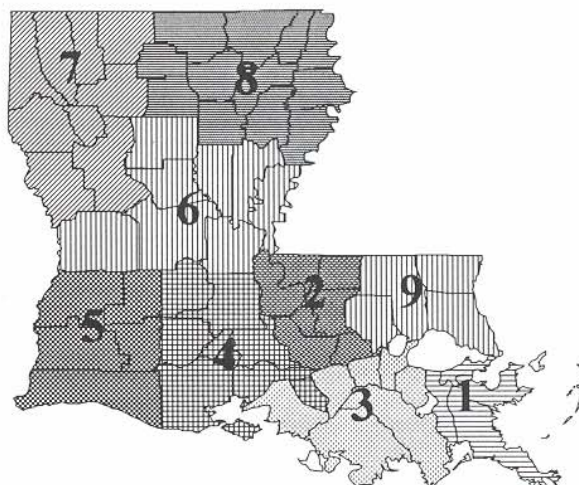


Table 3. Animal Rabies (September - October, 1998)

Parish No. Cases Species

No rabies reports for this quarter.

Annual Summary Salmonellosis - 1997

In 1997, six hundred and seventeen cases of salmonellosis were reported. This is almost identical to the number of cases reported in 1996 (616). Cases of salmonellosis per year have remained constant over the past few years. The Louisiana rate remains lower than the national rate (14.3/100,000 vs. 17.2/100,000). The sex-specific rate was higher for men than for women (15.5 vs. 12.6 respectively). The case rate for Black males (8.5/100,000) was higher than for Black females (6.3). The sex-specific rate for White females (7.6), however, was slightly more than for White males (7.2).

The 0-4 years age group represented fifty-three percent of the cases. The majority of the onset dates were reported between August and October, a seasonal trend consistent with previous years (Figure 1.) Terrebonne Parish had the highest case rate (32/100,000) followed by Lafayette Parish (30/100,000), Livingston Parish (25) and Ouachita Parish (22; Figure 2).

Figure 1: Cases of salmonellosis by month of onset, 1997

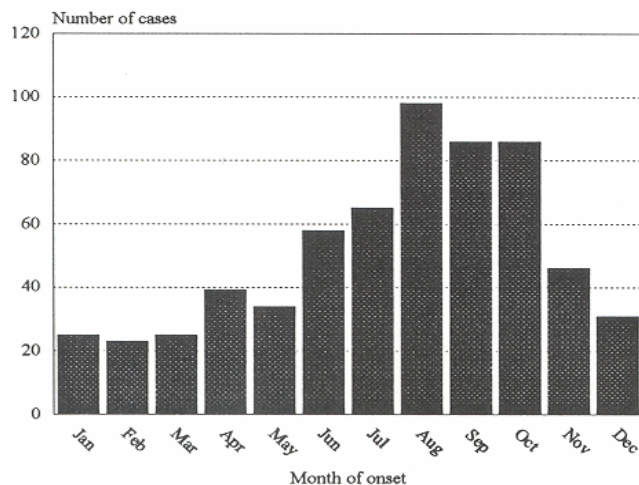
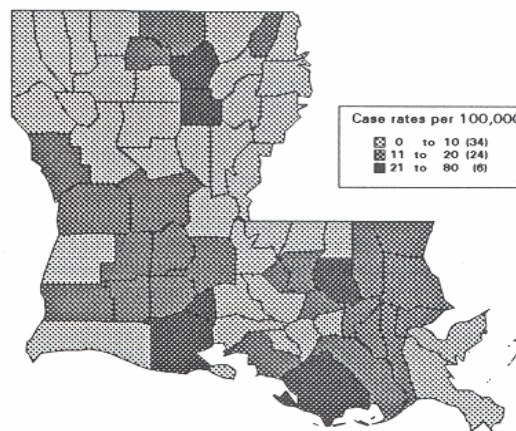


Table: Frequency of salmonella serotypes, 1995-1997

Serotype	1995			1996			1997		
	Cases	Rank	%	Cases	Rank	%	Cases	Rank	%
<i>newport</i>	93	1	26	71	2	14	95	1	21
<i>typhimurium</i>	66	2	18	105	1	21	92	2	20
<i>mississippi</i>	42	3	12	46	3	9	42	3	9
<i>enteritidis</i>	28	4	8	16	6	3	25	4	6
<i>javiana</i>	26	5	7	43	4	8	24	5	5
<i>heidelberg</i>	17	6	5	20	5	4	18	6	4

Of the 27 identified serotypes for Salmonella, the three most frequently isolated were *S. newport* (20.8%), *S. typhimurium* (20.2%), and *S. mississippi* (9.2%; Table). The high number of cases identified with the serotype *S. newport* has been associated with an outbreak of salmonellosis that occurred in E. Baton Rouge Parish in October, 1997. Of the 327 cases within the 0-4 years age group, 225 (69%) had completed information on daycare association. Of these, 5.8% attended a daycare.

Figure 2: Rates of salmonellosis by parish, 1997



Louisiana Fact

As a continuation of last issue's Louisiana Fact on the establishment of local boards of health within the state, the following reflects the merit of local public health offices both during the early years, as well as, today.

"The merit of local public health organizations was more than amply demonstrated during the great flood of 1927. This flood, often considered the greatest natural disaster in American history, inundated some 200,000 square miles of land and directly affected the lives of a million and a half persons. Within ten days from the beginning of the emergency, fourteen Public Health Service officers, trained in emergency health work and familiar with the flooded localities, were in the field assisting state health authorities. Volunteer agencies, particularly the American Red Cross, were also quickly on the job. Much of the work necessarily had to be done by medical and auxiliary personnel living in or near the stricken areas. After the battle had been won, parish and municipal health officers and their assistants received abundant praise for having set up refugee camps, for providing thousands of typhoid fever and smallpox immunizations, and for sacrificing themselves physically and financially. The United States Public Health Service observed that whenever full-time parish or county health units were operating, emergency work proceeded promptly and efficiently."

Taken from the *Progressive Years* by Gordon Gillson (page 301).

LIST OF REPORTABLE DISEASES/CONDITIONS

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

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

This public health document was published at a total cost of \$1,140.00. Eight thousand copies of this document were published in this first printing at a cost of \$1,140.00. The total cost of all printings of this document, including reprints is \$1,140.00. This document was published by Moran Printing, Inc., 5425 Florida Blvd., Baton Rouge, Louisiana 70806, 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.

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
P.O. BOX 60630 NEW ORLEANS LA 70160

BULK RATE
U.S. POSTAGE
PAID
Baton Rouge, LA
Permit No. 1032