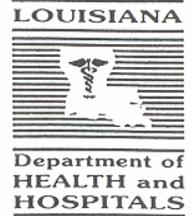




Edwin W. Edwards
GOVERNOR

Louisiana Morbidity Report

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



Rose V. Forrest
SECRETARY

January-February 1995

Volume 6 Number 1

Update: Syphilis Emergency

In December 1993, DHH Secretary Rose Forrest declared syphilis to be a "public health emergency" and announced a Department-wide Action Plan to control it. The Action Plan included improvements in clinical services, partner notification, screening, and public education. In the 12 months since that plan was announced syphilis rates have decreased sharply.

Evaluation and treatment of sexually transmitted diseases (STDs) are now available five days per week in 52 of the 64 parishes, as compared to 31 parishes in July 1993. In an annual clinic survey, there was a decrease in the average delay between onset of symptoms and treatment from 9.0 days to 7.6 days. Much of this expansion has been accomplished by nurse-practitioners and nurses working under standing orders. The number of sex partners identified and treated through the partner notification program has increased by 12% or more.

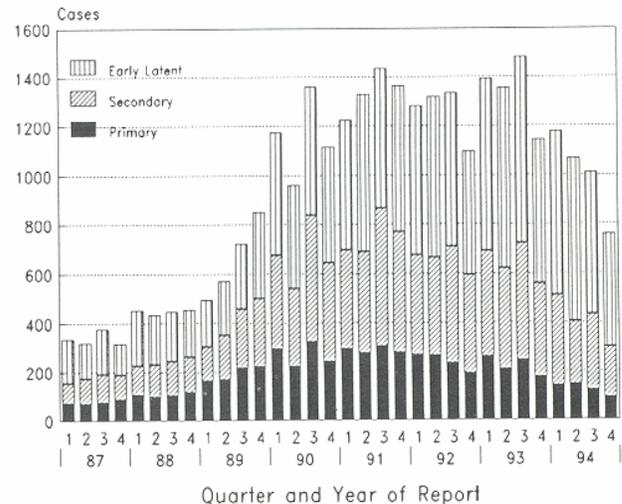
Routine screening for syphilis is now occurring in public family planning clinics. Routine screening of arrestees is taking place in six jails and routine screening of inmates who enter the general jail population is occurring in an additional three jails. Overall, more than 2,500 arrestees are tested every month, and approximately 6% have positive VDRL or RPR tests. Screening is also taking place in some drug treatment centers, in inpatients at the Louisiana Health Care Authority Hospitals, and in two

Emergency Rooms (where VDRL positivity rates are approximately 6-7%). OPH is trying to expand these screening programs.

The STD program has also been working with the HIV program, other offices within DHH, and community-based organizations to promote condom use for the prevention of syphilis, HIV, and other STDs ("Operation Protect"). Over the first 9 months of 1994, over 8 million condoms were distributed through this program. One survey of STD patients indicates that the distribution has led to increased use of condoms.

The rate of early syphilis decreased by 25%, from 5373 cases (127 per 100,000) in 1993 to 4,014 cases (95 per 100,000; Figure 1) in 1994. Moreover, the rate of primary and secondary syphilis, a more accurate measure of new disease, decreased by 37%, from 2,593 cases (61 per 100,000) to 1,645 cases (39 per 100,000). Syphilis rates decreased in all race-sex groups and in every region of the state. Interestingly, syphilis rates in rural areas were higher than rates in urban areas for the first time in 1994 (Figure 2).

Figure 1: Cases of early syphilis by quarter, 1987-1994

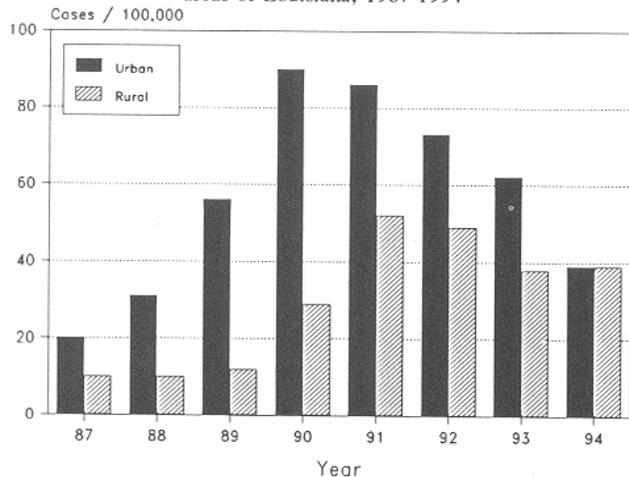


Syphilis has a historical pattern of showing periodic epidemics. This most recent epidemic has demonstrated the pressing need for increased rapid identification and treatment of persons with syphilis. Although the epidemic may be (Continued on page two)

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Update: Syphilis Emergency (Cont.)

Figure 2: Rates of primary and secondary syphilis in urban and rural areas of Louisiana, 1987-1994

subsiding, the need for this access to clinical services continues. Private physicians are urged to: 1) test patient for syphilis if they have other sexually transmitted diseases, have multiple sex partners, use cocaine, or have symptoms at all suggestive of syphilis, and 2) notify patients of the high rates of syphilis in the state and the need to use condoms in non-monogamous relationships.

Fish Consumption and Mercury Poisoning

In recent years, concern has been raised about the potential health effects of high levels of mercury in fish. Because high levels of mercury were found in fish taken from parts of the Ouachita River, the Department of Health and Hospitals (DHH) and the Department of Environmental Quality (DEQ) have issued an Advisory recommending limiting consumption of fish from this area. In addition, during the past year, one case of definite mercury poisoning and three cases of possible mercury poisonings have been reported to the Office of Public Health (OPH). All four of the cases are in adults and are being investigated by the Section of Environmental Epidemiology, because of their relation to consumption of mercury contaminated fish caught in Louisiana waters.

Mercury released into the environment is organified to methylmercury, which accumulates in fish and other organisms. The methylmercury concentration in predator fish at the top of the food chain is typically biomagnified up to 100,000 times the concentration in surrounding waters. Humans eliminate mercury over months or years; if the dose exceeds the elimination rate, methylmercury may reach toxic levels. The effects of mercury poisoning include tremor, paresthesias, and personality changes including loss of concentration, depression, irritability, and fatigue. Increased levels may result in ataxia, blurred vision, and

constricted visual field. The most severe effects of methylmercury are on the fetus, causing microcephaly and mental retardation.

Mercury is unlike many other chemicals in that it attaches to protein (the filet) of fish and cannot be removed by cooking or cleaning the fish. General precautions to keep mercury intake low include: eating younger, smaller fish, which have less mercury than larger, older fish; and avoiding predator fish, such as bass or gar, which can have more than 50 times the average mercury concentration found in most other fish.

The Advisory mentioned above was prompted by the finding of unacceptable levels of mercury in samples of fish taken from the Ouachita River between the Louisiana / Arkansas border and the lock and dam at Columbia, Louisiana. The Advisory made the following recommendations: Pregnant and lactating women, women who are trying to become pregnant, and children less than 7 years old should eat no bass, and eat only two, 1/2 pound meals each month of other species from these waters. Non-pregnant women, men and children over 7 years old should eat only two 1/2 pound meals of bass each month, and can eat unlimited amounts of other species from these waters.

For more information on the fish consumption Advisories in Louisiana refer to the July - August, 1994 issue of Louisiana Morbidity report, or contact Environmental Epidemiology at (504) 568-8537 or (800) 256-4609.

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The Christmas Staph Party

On Friday December 23, 1994, the Epidemiology Section was notified about an outbreak of gastroenteritis that was later shown to be caused by *Staphylococcus aureus*. Twenty-four of seventy people attending an office party on December 22 reported being ill with diarrhea (n=23) or vomiting (n=20). The incubation period ranged from one to six hours with the majority of cases reporting three to four hours (16; figure). The illness lasted less than forty-eight hours. Eight sought medical attention and sixteen stool samples were collected.

Figure: Cases of gastroenteritis among attendees



The office party was the only common meal reported. The food was prepared by the people attending the office party. The menu consisted of 31 different food items. The majority of the people ate between 11:30 am and 12:30 pm on December 22, 1994.

Attack rates were calculated on the foods served (Table). Elevated attack rates were observed for the cornbread dressing (59%, 23/39 vs. 10%, 1/10, RR=5.90), sweet potatoes (67%, 14/21 vs. 36%, 10/28, RR=1.87), and green bean casserole (65%, 15/23 vs. 35%, 9/26, RR=1.88). Samples of cornbread dressing, rice dressing, and turkey were sent to the state lab to be tested for pathogens.

The food was prepared in the private homes of the attendees. According to the sanitarian's report, the cornbread dressing was prepared with cornbread, giblets, green onions, celery, and bell pepper that were purchased pre-packaged from a local grocery store. These ingredients were sauteed. Water, salt, pepper, and bread crumbs were added. In order to achieve the desired consistency, the hands and

arms, up to the elbows, of the preparer were used as mixing utensils. The dressing was refrigerated overnight in one large-sized roasting pan. It was transported to work and put back into the refrigerator. The food was removed mid-morning to be warmed. It was put on the serving table at 11:30 am.

Based on the symptoms (diarrhea and vomiting for the majority of the cases) and the incubation period (one to six hours) and the possibility of contamination during preparation (cornbread dressing), *Staphylococcus aureus* intoxication was the most likely causative agent.

The lab investigation revealed *S. aureus* in both the cornbread dressing (250,000,000 organisms per gram of dressing) and the rice dressing (17,000,000 organisms per gram of dressing). The turkey did not grow *S. aureus* in sufficient quantities to cause illness (600 organisms per gram of turkey). Three of the stool samples also grew *S. aureus*.

In conclusion, our investigation indicated a food-related outbreak of gastroenteritis. *Staphylococcus aureus* was identified as the causative organism and the cornbread dressing and the rice dressing were the likely vehicles of transmission. Our recommendations were to store large amounts of one food stuff in multiple, small sized pans instead of one large pan, to practice good hygiene when preparing food at all times by avoiding food and human skin contact, and store and reheat food at temperatures that prohibit the growth of pathogens (<45 F or >140 F).

The Epidemiology Section would like to commend those at the parish health unit who did a thorough investigation in a timely manner despite the approaching holiday weekend.

Table: Food specific attack rates among attendees

Food Items	Ate				Did not eat				
	Ill	Not Ill	Total	% Ill	Ill	Not Ill	Total	% Ill	RR
Cornbread dressing	23	16	39	59	1	9	10	10	5.90
German choc cake	5	1	6	83	19	24	43	44	1.89
Sweet potatoes	14	7	21	67	10	18	28	36	1.87
Green bean casserole	15	8	23	65	9	17	26	35	1.88
Rice dressing	11	8	19	58	13	17	30	43	1.34
Broc & rice casserole	16	13	29	55	8	12	20	40	1.38
Artichoke casserole	7	5	12	58	17	20	37	46	1.27
Cranberry sauce	3	2	5	60	21	23	44	48	1.15
Turkey	21	25	46	46	3	0	3	100	.46

Update: St. Louis Encephalitis Outbreak, 1994

In the September-October issue of the Louisiana Morbidity Report we reported an outbreak of 15 cases of St. Louis Encephalitis (SLE) in the New Orleans area. Although SLE is usually benign, three (20%) of the ill persons in this outbreak died; all three were older than 40 (a known risk factor for more severe disease), and two of those three persons had underlying medical conditions which may have predisposed them to more severe illness. Illness onset in this outbreak ranged from July 22 to October 8. Aggressive mosquito control activities were instituted as soon as the initial cases were identified, and these may have helped control the spread of the outbreak.

In order to specify the vector involved in this outbreak, trapping and testing of mosquitos for SLE virus was done by the Centers for Disease Control, in collaboration with New Orleans Mosquito Control. None of the mosquitos tested were positive for SLE virus. Although *Culex p. quinquefasciatus* had been assumed to be the vector for SLE in this outbreak (and indeed large populations of *quinquefasciatus* mosquitos were found near some of the initial cases), the finding of a higher than expected prevalence of *Culex nigripalpus*, the primary SLE virus vector in Florida, raises the possibility of transmission by *nigripalpus* mosquitos in this outbreak.

To ensure that all cases of SLE presenting to area hospitals were identified and reported, the Office of Public Health instituted active surveillance for SLE beginning on October 3 at five New Orleans hospitals: Medical Center of Louisiana at New Orleans, Mercy-Baptist, Touro, Oschner, and Methodist Hospitals. A total of 65 CSF samples were submitted through November 18, and none were positive for IgM antibody to SLE.

Because 33% of the cases reported for July and August occurred in homeless people, and because of the great deal of time spent outside by homeless people, there was concern that this group might be at particularly high risk for SLE. In order to estimate the rate of SLE exposure in the homeless population and in the general population, in October serosurveys were conducted of two groups: persons attending the city's Health Care for the Homeless clinic, and persons attending the city's sexually transmitted disease clinic. The samples from the sexually transmitted disease clinic were screened in a blinded fashion; the homeless clinic samples were obtained with voluntary consent.

None of the samples from 128 homeless people were positive for SLE antibodies, and only 1/505 (0.2%) of the samples from the sexually transmitted disease clinic were positive for SLE antibodies. Based on these data we are 95% sure that the true prevalence of SLE infection in the general

population was less than 0.9%. The prevalence among the homeless is likely to be in this same range, although it may be as high as 2.3%.

Studies from other SLE outbreaks have estimated that for every known SLE case there are approximately 350 other exposed persons. Extrapolating from the numbers of known cases in this outbreak to the New Orleans area in general, we estimate that there were a total of approximately 5250 people infected with SLE during this outbreak — a prevalence of approximately 0.5% (and a prevalence within the range in our serosurvey).

New Medical Director For Chronic Disease Section

Dr. Rebecca Meriwether received her MD degree from Medical College of Georgia, her MPH from University of North Carolina, School of Public Health and is Board Certified in Family Practice. For the past nine years she has served as Branch Head, Section Chief and Deputy Section Chief of Communicable Disease Control for the North Carolina Department of Health where her responsibilities included clinical and epidemiologic direction for a variety of infectious disease surveillance and control programs. She will be a valuable asset to the Louisiana's Office of Public Health and can be reached at 504-568-7210.

BULLETIN

New Typhoid Vaccine Licensed

As of November 28, 1994, the FDA has approved a new injectable typhoid vaccine. The newly licensed capsular polysaccharide vaccine for parenteral use (ViCPS) is manufactured by Pasteur Merieux and will be distributed by Connaught Laboratories Inc. This vaccine should be available in the United States sometime in February.

Each of the three vaccines approved by FDA has a different lower age limit for use among children. In addition, the time required for primary vaccination differs for each vaccine. The parenteral inactivated vaccine causes substantially more adverse reactions but is no more effective than Ty21 or ViCPS. Therefore, when not contraindicated, the Centers for Disease Control recommends either oral Ty21 or parenteral ViCPS.

Routine typhoid vaccinations are not recommended in the United States. Vaccination is indicated for travelers to areas with a recognized risk of exposure, persons with intimate exposure (e.g., household contact) to a documented *S. typhi* carrier, and microbiology laboratory workers who work frequently with *S. typhi*.

For more information, refer to MMWR, Vol. 43, No. RR-14 dated December 9, 1994 or contact the Epidemiology Section at 504-568-5005.

AIDS UPDATE AIDS in the Elderly

Currently there are 299 reported AIDS cases in persons over age 60 in Louisiana, representing 4.7% of all cases. Patterns of demographic characteristics within this group of elderly are comparable to those of the total population with exception of location of diagnosis. Specifically, 83% are male; 67% are white, 30% are African American. Forty-seven percent of elderly AIDS cases were diagnosed in the New Orleans metro area, compared to almost 60% in cases under 60 years of age.

Contrary to the common perception that elderly persons with AIDS usually contract the virus through blood transfusions, recent data indicate that transfusions as the mode of transmission is rapidly declining (see Figure 1). In fact, the primary modes of transmission in recent AIDS cases

resemble those of the whole population: homo- or bisexual sex accounts for transmission in 60% of elderly male AIDS cases, and heterosexual sex for 41% of elderly female cases (see Figure 2). As seen in Figure 3, homo- or bisexual sex remains the leading mode of transmission irrespective of race, albeit considerable differences between races exist with respect to modes of transmission. Interestingly however, the decrease in overall elderly case rates between 1991 and 1994 (see Figure 1) is attributable primarily to a drop in the numbers of cases related to homosexual transmissions.

Since the transmission of HIV through blood transfusions has dropped substantially over the last decade, ascertainment of the correct risk exposure in the elderly yields important information for preventive efforts disease. As well, prompt detection of serostatus in older persons with recurrent or unusual infections will facilitate appropriate and timely treatment.

Figure 1: Transmission by transfusion (excluding hemophiliacs) vs other in elderly (age 60+)

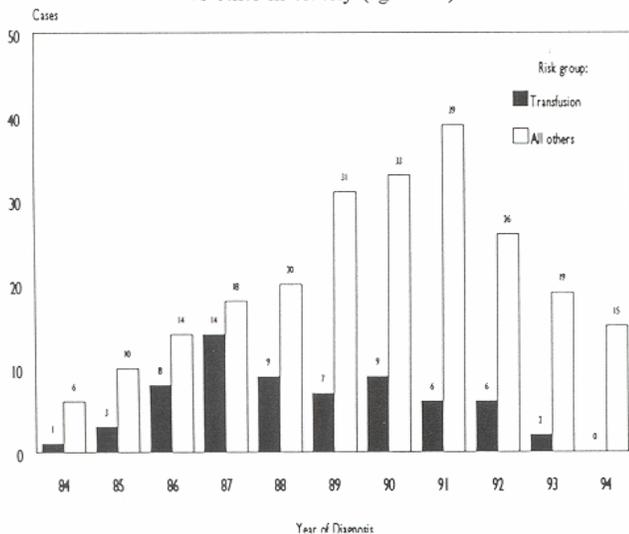


Figure 2: Modes of risk exposure in elderly by gender, AIDS cases since 1990

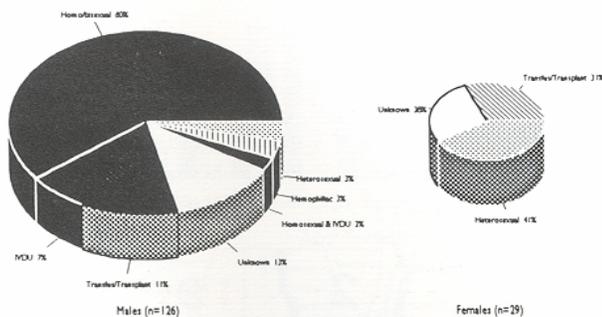
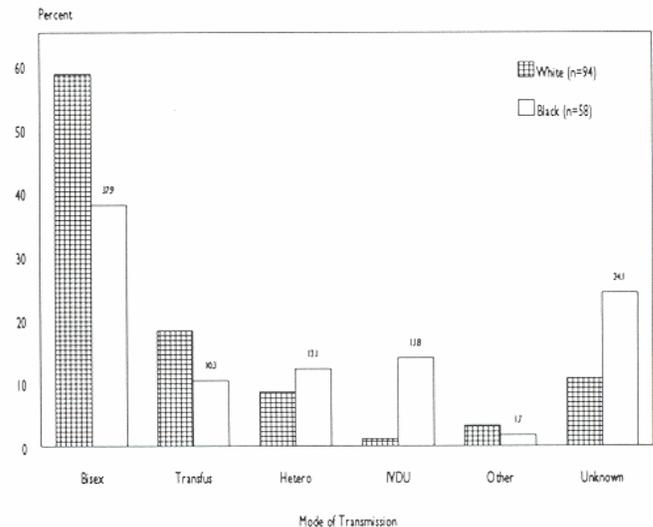
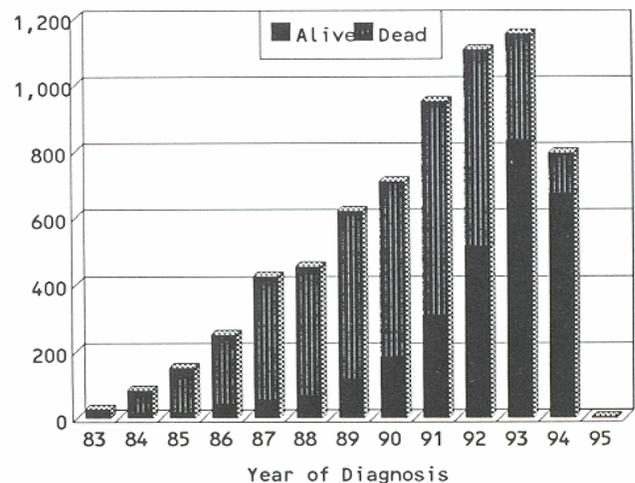


Figure 3: Transmission and race in elderly AIDS cases since 1990



AIDS Case Trends



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE,
NOV - DEC, 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	Nov-Dec 1994	Nov-Dec 1993	Cum 1994	Cum 1993	% Chg
<u>Vaccine-preventable</u>														
Measles	0	0	0	0	0	0	0	0	0	0	0	1	1	0
Mumps	0	0	0	1	4	0	0	0	0	5	1	35	20	+75
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	1	-
Pertussis	0	1	0	0	0	0	0	0	2	3	1	14	13	+8
<u>Sexually-transmitted</u>														
AIDS Cases	23	6	0	4	0	3	5	4	1	46	161	784	1119	-30
AIDS Rate ¹	2.1	1.1	0	0.8	0	0.9	1.0	1.2	0.3	1.1	3.7	18.2	25.9	
Gonorrhea Cases	833	201	79	167	102	105	369	109	95	2060	2334	12288	13260	-7
Gonorrhea Rate ²	8.0	3.7	2.2	3.4	4.0	3.4	7.3	3.1	2.7	4.9	5.5	29.1	31.4	
Syphilis(P&S) Cases	33	39	10	26	3	4	16	23	31	185	352	1645	2593	-37
Syphilis(P&S) Rate ²	0.3	0.7	0.3	0.5	0.1	0.1	0.3	0.7	0.9	0.4	0.8	3.9	6.14	
<u>Enteric</u>														
<i>Campylobacter</i>	10	1	8	5	1	0	4	0	5	34	18	153	159	-4
Hepatitis A Cases	6	3	0	0	0	0	3	0	2	14	18	161	96	+68
Hepatitis A Rate ¹	0.6	0.6	-	-	-	-	0.6	-	0.6	0.3	0.4	3.8	2.3	
<i>Salmonella</i> Cases	40	9	7	39	7	7	15	7	12	145	122	548	492	+11
<i>Salmonella</i> Rate ¹	3.9	1.7	1.9	7.9	2.7	2.2	3.0	2.0	3.4	3.4	2.9	13.0	11.7	
<i>Shigella</i> Cases	11	1	3	5	1	0	0	1	1	25	55	458	418	
<i>Shigella</i> Rate ¹	1.1	0.2	0.8	1.0	0.4	-	-	0.3	0.3	0.6	1.3	10.9	9.9	
<i>Vibrio cholera</i>	0	0	0	0	0	0	0	0	0	0	0	0	1	-
<i>Vibrio, other</i>	2	0	4	0	0	0	0	0	1	7	6	50	38	+32
<u>Other</u>														
Hepatitis B Cases	9	1	1	2	0	1	1	1	2	18	42	188	241	-22
Hepatitis B Rate ¹	0.9	0.2	0.3	0.4	-	0.3	0.2	0.3	0.6	0.4	1.0	4.5	5.7	
<u>Meningitis/Bacteremia</u>														
<i>H. influenzae</i>	0	0	0	0	0	0	0	0	0	0	1	6	5	+20
<i>N. meningitidis</i>	3	0	0	1	1	0	0	1	0	6	4	41	40	+3
Tuberculosis Cases	-	-	-	-	-	-	-	-	-	-	-	433	368	+18
Tuberculosis Rate ¹	-	-	-	-	-	-	-	-	-	-	-	10.3	8.7	

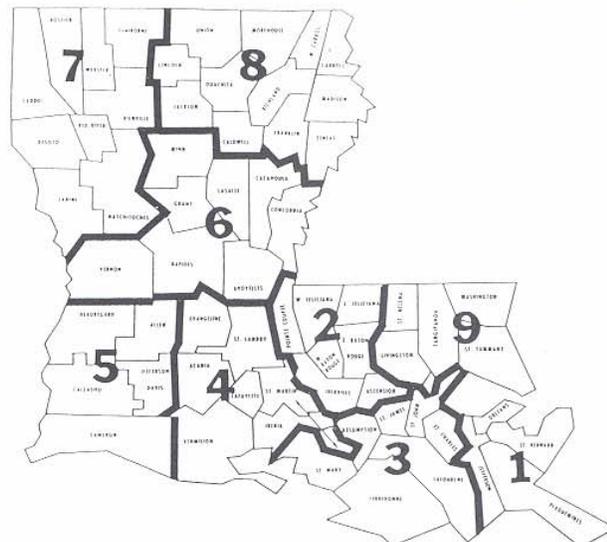
1 = Cases per 100,000
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	3
Brucellosis	2
Histoplasmosis	1
Lead Toxicity	85
Legionellosis	14
Lyme Disease	4
Malaria	11
Tetanus	1

Table 3. Animal Rabies (Nov-Dec 1994)

Parish	No. Cases	Species
St. Landry	2	Skunks
Lafayette	6	Skunks

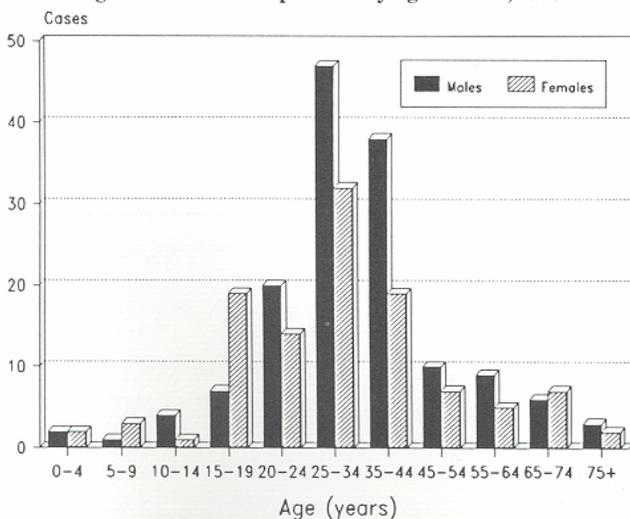


Annual Summary Hepatitis B, 1993

The number of hepatitis B cases reported was similar to last year's total but 26% lower than in 1991. Provisional data for the U.S., demonstrated a 25% decrease for 1993. Sex-specific rates were higher in males than females (7.6 vs 5.2 per 100,000) and race-specific rates were continually higher in blacks than whites (11 vs 3 per 100,000). The majority of the cases occurred within the 15-44 age groups, which has been a consistent pattern over the past several years (Figure 1). This data continues to demonstrate that the risk for HBV transmission is concentrated among adolescents and adult population. Parishes reporting the highest case rates include St. Helena (20), Orleans (16), Plaquemines (12), Caddo and Cameron [(11, respectively) Figure 2]. Of increasing importance to public health is chronic hepatitis B infection in pregnant women. In 1993, the Office of Public Health Central Laboratory tested 10,511 pregnant women for hepatitis B infection, and 122 (1.2%) were positive, a positivity rate that was similar to previous years. The positivity rate was higher in blacks than whites (1.3% vs. 0.8%). The rate did not vary with age. The highest rates across the state were in the Shreveport region (1.7%) and the Lafayette region (1.6%)

Infants born to women with chronic hepatitis B infection are tracked in an attempt to ensure vaccination against the virus. An evaluation of this program in 1993 found that 93% of children had records of having received the first dose of the hepatitis B vaccine, but only 65% had records of having received the third dose.

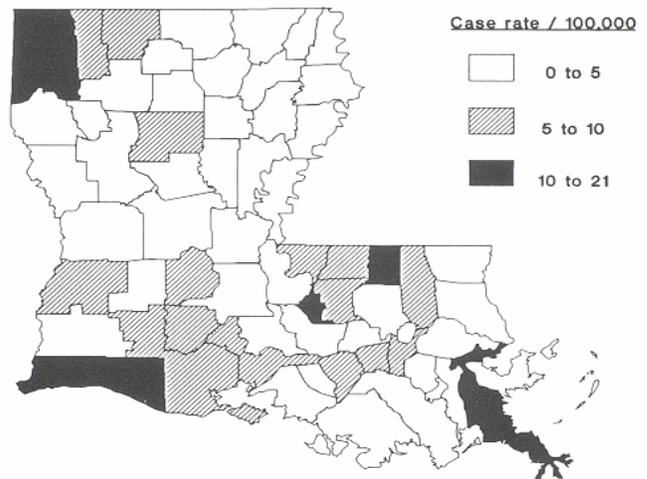
Figure 1: Cases of hepatitis B by age and sex, 1993



Comments:

Hepatitis B remains an important cause of preventable morbidity in Louisiana. The hepatitis B prevention program consists of vaccination of infants of carrier mothers with hepatitis B immune globulin and high-dose vaccine, vaccination of all other infants with standard dose vaccine, and pilot projects of vaccination of high-risk adolescents.

Figure 2: Cases of hepatitis B by parish, 1993



LOUISIANA FACTS

The Office of the Board of Health in its 1873 annual report made the following statement

"The Board recommends" —

The establishment and endowment of a Professorship of Hygiene in the University of Louisiana, to be independent of, and in addition to, that of Physiology. This action will secure to the young men of the medical profession proper knowledge of the subject as understood at the date of their studies, and a proper appreciation of preventive, as contrasted with curative medicine. Each physician will be to the community in which he practices his profession a source of information, a director of public sentiment, and an efficient supporter of all organizations and measures calculated to improve the public health, and prevent disease.

LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Granuloma Inguinale**	Pertussis	Cancer
Amebiasis	Hemolytic-Uremic Syndrome	Plague*	Complications of abortion
Anthrax	Hemophilia	Poliomyelitis	Congenital hypothyroidism
Aseptic meningitis	Hepatitis, Acute (A, B, C, Other)	Psittacosis	Lead poisoning
Blastomycosis	Hepatitis B in pregnancy	Rabies (animal & man)	Phenylketonuria
Botulism*	Herpes (genitalis/neonatal)**	Rocky Mountain Spotted Fever (RMSF)	reye Syndrome
Brucellosis	Human Immunodeficiency Virus (HIV) infection****	Rubella (German measles)	Severe Traumatic Head Injuries+
Campylobacteriosis	Legionellosis	Rubella (congenital syndrome)	Severe undernutrition
Chancroid**	Leptospirosis	Salmonellosis	severe anemia,
Cholera*	Leprosy	Shigellosis	failure to thrive
Chlamydial infection**	Leptospirosis	Syphilis**	sickle cell
Diphtheria*	Lyme disease	Tetanus	disease (newborns)
Encephalitis (specify primary or post-infectious)	Lymphogranuloma venereum**	Trichinosis	Spinal cord injury+
Erythema infectiosum (Fifth Disease)	Malaria	Tuberculosis***	sudden infant death
Escherichia coli 0157:H7	Measles (rubeola)*	Tularemia	syndrome (SIDS)
Foodborne illness*	Meningitis, (Haemophilus)*	Typhoid fever	
Galactosemia	Meningococcal infection (including meningitis)*	Typhus fever, murine (fleaborne, endemic)	
Genital warts**	Mumps	Vibrio infections (excluding cholera)	
Gonorrhea**	Mycobacteriosis, atypical***	Yellow fever*	
	Ophthalmia neonatorum**		

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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