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LOUISIANA MORBIDITY REPORT

EPIDEMIOLOGY

RECEIVED

OCT 29 1990

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September/October 1990

Volume 1, Number 5

INFLUENZA 1990-91

The 1990-91 influenza season is rapidly approaching, so physicians should see to it that high-risk patients under their care are vaccinated as soon as possible. Patients that are at high risk for complications from influenza are elderly persons and persons with underlying cardiac, pulmonary, or other chronic medical problems. This year's influenza vaccine will be available in parish health units by November 1, 1990.

Influenza epidemics occur nearly every year, with the peak activity falling between the months of December and March. During the influenza season, the virus is a major cause of morbidity and mortality. The severity of an influenza season is judged nationally by the number of excess deaths attributed to "pneumonia and influenza" on death certificates. At least 10,000 excess deaths have been documented in each of the 19 recognized epidemics in the United States from 1957 to 1986.

The 1989-90 influenza season was primarily caused by strains similar to type A(H2N3)/Shanghai/11/87. Nationally, the 1989-90 season was reported to be more severe than usual. However, in Louisiana, sentinel physicians and hospitals reported in 1989-90 seeing fewer cases of influenza-like illness than in previous years. Nearly all isolates of influenza virus from the state were type A(H3N2).

Two antigenic types of influenza cause epidemic disease: type A and type B. Influenza A viruses are classified on the basis of two antigens: hemagglutinin (H) and neuraminidase (N). Immunity to these antigens

reduces the likelihood of infection and lessens the severity of disease if infection occurs. However, infection from one subtype confers little or no protection against viruses of another subtype.

Influenza viruses also show rapid "antigenic drift". New strains are named for the location and date in which they were first isolated (for example A/Shanghai/11/87). Laboratories worldwide track the number of isolates of various antigenic types, and each spring the World Health Organization uses this information to determine the viral antigens that will be included in the upcoming season's vaccine. In recent years, influenza vaccines have included one strain each of influenza subtypes A(H1N1), A(H3N2), and B. The trivalent influenza vaccine for the 1990-91 season will include antigens of the following types:

- A(H1N1)/Taiwan/1/86
- A(H3N2)/Shanghai/16/89
- B/Yamagata/16/88

The two measures that can reduce the impact of influenza are vaccination and chemoprophylaxis with the antiviral drug amantadine. Vaccination of high risk persons is the most effective measure to reduce the impact of influenza. When vaccine and epidemic strains of influenza are well matched (as they were in 1989), achieving high vaccination rates among closed populations (eg. in nursing homes) can reduce the risk of outbreaks by inducing herd immunity. The vaccine efficacy during the past two years has been estimated at 65-80%.

Target groups for vaccination include:

High risk persons: 1) Persons >65 years of age. 2) Residents of nursing homes and other chronic-care facilities 3) Adults and children with chronic disorders of the pulmonary and cardiovascular systems, including children with asthma 4) Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, or immunosuppression 5) Children and teenagers receiving long-term aspirin therapy, who therefore may be at risk of developing Reye syndrome after influenza.

Groups that can transmit influenza to high risk groups: 1) Health care personnel in both hospital and outpatient-care settings 2) Employees of nursing homes and chronic-care facilities who have contact with patients or residents. 3) Providers of home care to high-risk persons. 4) Household members of high-risk persons.

Recent reports suggest that symptoms of influenza may be prolonged and the risk of complications increased for persons with HIV infection. Vaccination of HIV-infected persons is therefore a prudent precaution. In many recipients protective antibody levels will develop. However, the antibody response to vaccine may be low in persons with advanced HIV-related illnesses; a booster dose has not improved the immune response for these individuals.

Physicians should also administer vaccine to any person who wishes to reduce the chance of acquiring influenza.

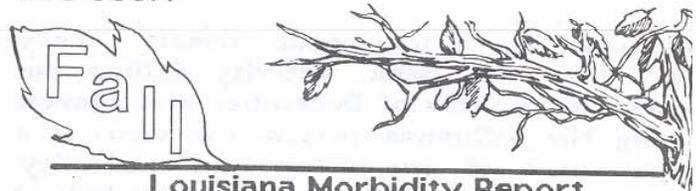
Inactivated influenza vaccine should not be given to persons known to have anaphylactic hypersensitivity to eggs. Persons with acute febrile illnesses usually should not be vaccinated until their symptoms have abated. Recommended doses for the vaccine are listed below.

TABLE 1. Influenza vaccine* dosage, by patient age—United States, 1990-1991 season

Age group	Product†	Dosage	No. doses	Route
6-35 mos.	Split virus	0.25 mL	1 or 2	IM
3-8 yrs.	Split virus	0.50 mL	1 or 2	IM
>9 yrs.	Whole or split virus	0.50 mL	1	IM

Full recommendations regarding influenza vaccine use are provided in *Prevention and Control of influenza. MMWR Recommendations and Reports 1990;39(RR-7):1-15*. Amantadine is effective only against influenza A, and for maximum effectiveness must be used throughout the period of risk. Amantadine prophylaxis is not a substitute for vaccination. Use of amantadine may be considered as a control measure when outbreaks occur in institutions housing high risk persons, or as short-term prophylaxis after late vaccination of high-risk individuals, or as seasonal prophylaxis for individuals for whom vaccine is contraindicated or who are immunocompromised and may not develop a significant antibody response. In addition, prophylaxis may be considered for unvaccinated health care workers who care for high-risk individuals either for the duration of influenza activity in the community or until immunity develops after vaccination.

Questions concerning the influenza program may be directed to your parish health unit or to the Immunization Section at (504) 568-5007.



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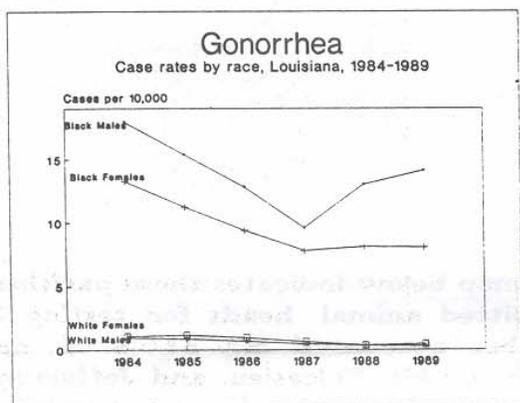
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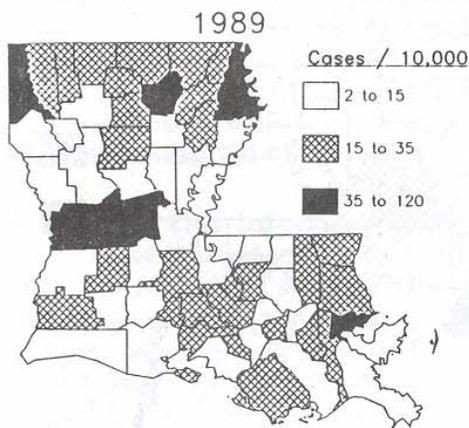
Annual Summary - Gonorrhea

Gonorrhea is the most frequently reported communicable disease in Louisiana. In 1989, there were 15,392 cases of gonorrhea reported in the state, for a case rate of 35 cases per 10,000 population. Annual reports of gonorrhea fell from 1984 to 1987 and then increased in 1988 and 1989. The decrease in case rates from 1984 to 1987 occurred in both whites and blacks; however, from 1987 to 1989 rates in whites continued to decline while rates in blacks increased. In all recent years, rates of reported gonorrhea were more than ten times as high for blacks as they were for whites.



Gonorrhea rates varied widely by parish. The highest rate was in Orleans Parish (117 cases/10,000), followed by Caddo (74/10,000), Madison (59/10,000) and East Carroll (51/10,000) Parishes.

Gonorrhea



Penicillinase-producing *Neisseria gonorrhoea* (PPNG) was an increasing problem in Louisiana in 1989. Statewide, 3.1% of isolates were PPNG in 1989, compared to 3

1.0% of isolates in 1988 and 1.1% of isolates in 1987.

Comment: Despite statewide and local efforts to control gonorrhea, case rates for this disease continue to be very high. Factors that may contribute to these high rates are the high degree of communicability of the agent and the presence of asymptomatic infection in females. Incomplete identification or referral of sexual contacts also allows the infection to be transmitted widely. The high rates nevertheless indicate that a large number of persons in Louisiana are practicing unprotected sexual intercourse (and putting themselves at risk for HIV infection) in spite of wide publicity about the risks involved.

The increase in reports of PPNG has prompted a change in the recommended antibiotic treatment for gonorrhea from ampicillin to ceftriaxone (Rocephin). For more details, see below.

Change in Recommended Treatment for Gonococcal Infections

Current CDC sexually transmitted disease guidelines have replaced penicillin or ampicillin and tetracycline with ceftriaxone and doxycycline as recommended therapy for uncomplicated gonococcal infections, including those resistant to penicillin, tetracycline and other antibiotics. There, Office of Public Health facilities treating patients diagnosed with uncomplicated gonorrhea in men and non-pregnant women will now routinely use the following regimen:

Ceftriaxone 250 mg IM once *plus*
Doxycycline 100 mg orally twice/day for 7 days

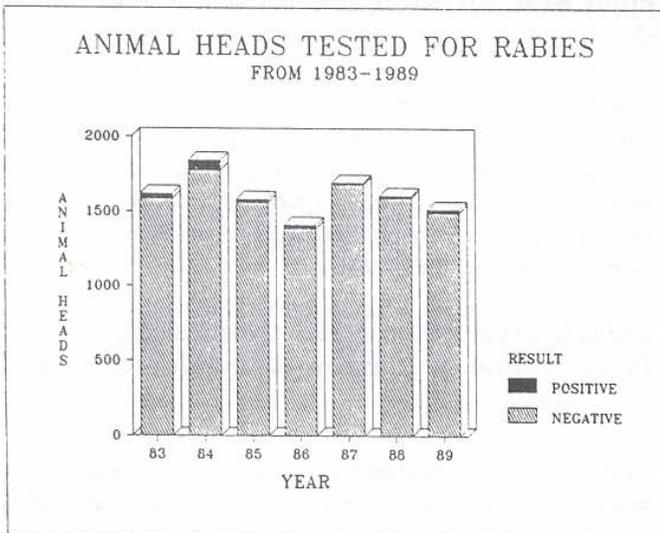
For those patients who cannot take ceftriaxone, the preferred alternative is spectinomycin 2 g IM once plus doxycycline 100 mg orally 2 times a day for 7 days.

Intramuscular administration of ceftriaxone is generally well-tolerated. During the treatment of uncomplicated gonorrhea with ceftriaxone, the following adverse events were noted (all <1%): swelling and pain at the injection sites, muscle soreness due to injection, nausea and dizziness. As with any cephalosporin, there exists the possibility of hypersensitivity reactions.

Rabies Testing Comes to a Head

Rabies has been decreasing in occurrence over recent years. The last case of human rabies occurred in Louisiana in 1953. The number of cases of rabies in animals, both domestic and wild, have decreased dramatically as well. In 1953 there were 5,688 cases in domestic animals and 319 cases in wild carnivores and bats. By 1979, domestic cases dropped to 198 but cases in wild animals increased to 3,031. For the years 1983-89 only 13 positive domestic animals and 177 wild animals were identified. Because of this change in the pattern of rabies in the state and the cost to the state for rabies testing, we have reviewed rabies test results in recent years and evaluated our rabies program.

The Louisiana State Public Health Laboratory tested a total of 11,267 animals for rabies for the seven years from 1983-89. Of those tested, only 190 (1.7%) were positive. The highest number of positive tests occurred in 1984 with 64 cases, followed by 1983 with 35 cases.

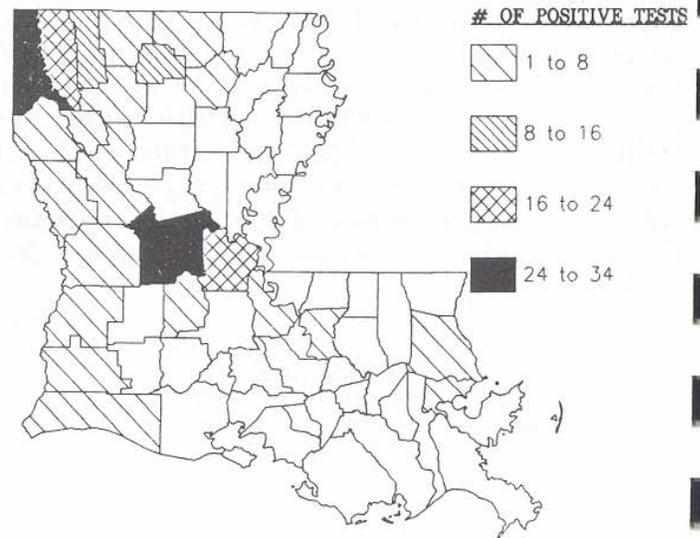


The decision of whether to administer rabies prophylaxis to individuals who have been exposed to potentially rabid animals should be based in part on the geographic prevalence of animal rabies. The parish distribution of laboratory-confirmed cases of animal rabies in Louisiana from 1983 through 1989 is shown below. Four parishes accounted for 55% of the positive cases: Caddo-34, Rapides-33, Bossier-20, and Avoyelles-18. Only nine cases were identi-

fied in southern Louisiana, only one of which was in a terrestrial animal.

RABIES

POSITIVE ANIMALS TESTED 1983-1989



The map below indicates those parishes that submitted animal heads for testing. Seven parishes accounted for 31.6% of animals tested. Caddo, Calcasieu, and Jefferson parishes submitted the largest number; 966, 515, and 491 respectively. These were followed by Bossier, E. Baton Rouge, Orleans and Rapides parishes.

RABIES

ANIMALS TESTED 1983-1989

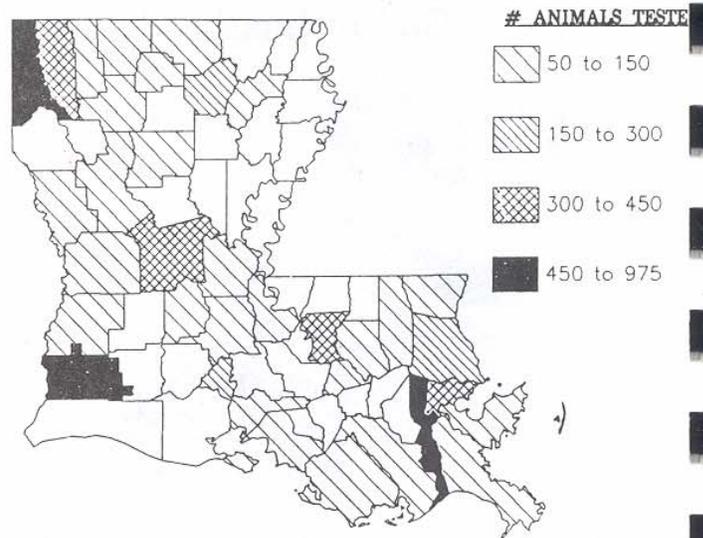
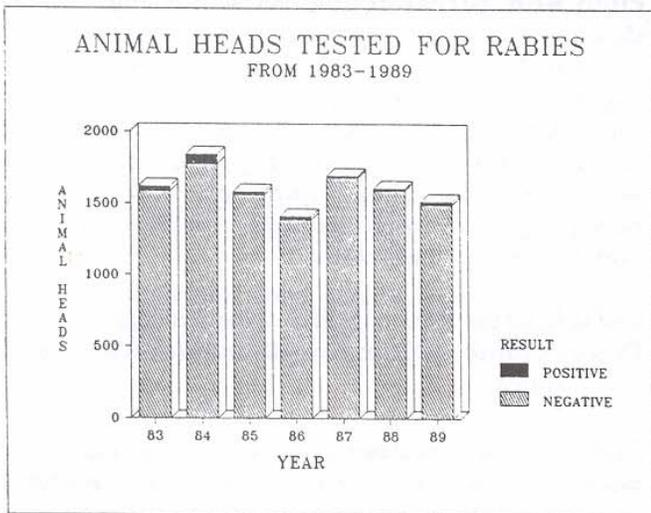


Table 1 indicates the 7 most frequently tested species. Cats, dogs and rats repre-

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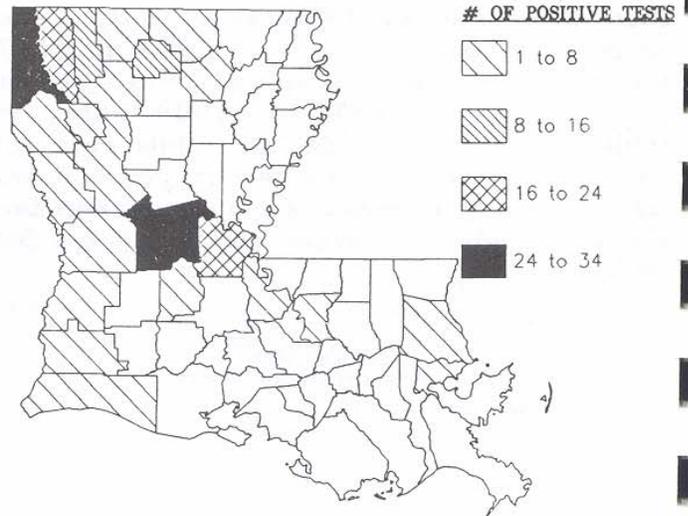


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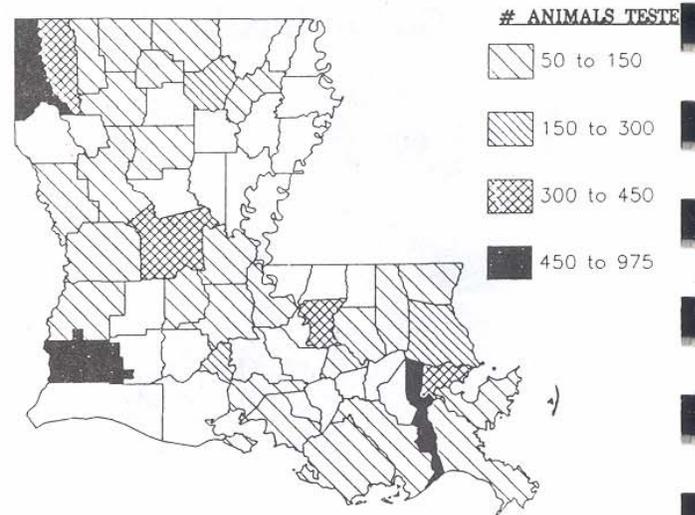


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abilities and disability prevention and have compiled a Resource Library Catalog with brief descriptions of over 300 items.

The program works to encourage and support the work of a variety of public and private agencies concerned with some aspect of disability prevention. Technical assistance is available for individuals and agencies interested in studying disabling conditions, developing preventive interventions, or addressing unmet needs of disabled persons in the community. The program provides staff support for the Louisiana Advisory Council on Disability Prevention. It is sponsoring a statewide conference hosted by the Southeast Louisiana Coalition for the Prevention of Head and Spinal Cord Injuries this fall. In November it will also help to host a conference on substance abuse and teenage pregnancy co-sponsored by the Advisory Council's Committee on the Prevention of Developmental Disabilities and the Louisiana Coalition for Maternal and Infant Health. A new program activity is beginning to establish car safety seat loaner programs for infants and toddlers in public health clinics. In a pilot project beginning this fall the Disability Prevention Program, in collaboration with Children's Hospital and Jefferson Parish Public Schools, will do population-based identification, evaluation, service referral, and tracking of infants and toddlers at high risk for developmental disabilities.

For more information about this program, write to the Disability Prevention Program, 325 Loyola Ave., Rm. 307, New Orleans, LA 70112, or call (504)-568-2509.

No Smoking Policy at OPH

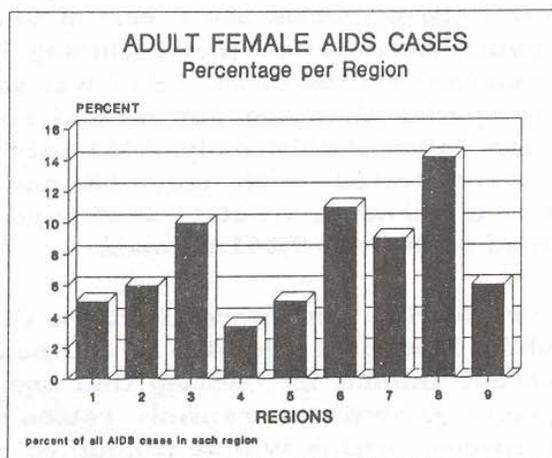
The Office of Public Health will institute a NO SMOKING policy in all its facilities effective January 1, 1991. The agency feels it is important to provide a good example in how to protect the health of employees and clients from the effects of tobacco smoke. The agency will share the cost of smoking cessation clinics with employees wishing to quit. OPH hopes that this initiative will encourage other government and private organizations to establish similar policies.

AIDS UPDATE

Female AIDS Cases

Editorial Note: General AIDS statistics have been presented in the Louisiana Morbidity Report since October 1985. However, the AIDS epidemic does not affect the state uniformly. The diverse social, economic, racial, and behavioral characteristics in the state affect exposure to HIV and the AIDS case rates. A thorough understanding of the epidemiologic patterns of AIDS in Louisiana will help in the development of programs for education, prevention, early intervention, substance abuse, support services, and planning for health care resources. Therefore, in an effort to share this information about AIDS cases, we are starting a routine "AIDS Update" column. The topic for this column will be female AIDS cases. Future columns will address such topics as age, race, and risk factor distributions, survival analysis, and case projections.

Female cases account for 6.7% (123 adult cases) of the overall AIDS database for Louisiana. The percentage of persons with AIDS who are female varies among the different regions. Females are 5% of the cases in Region 1 (the New Orleans area). Ten percent of cases from Region 3 (Houma), 11% of cases from Region 6 (Alexandria), and 14.2% of cases from Region 8 (Monroe) are female. The number of cases in these areas are relatively small compared to the number of cases in metropolitan New Orleans.



Twenty-eight percent of female cases are IV drug users. Thirty-three percent acquired HIV through heterosexual transmission from a person known to be HIV infected or in a risk group for AIDS. Twenty-eight percent had received blood transfusions. For 11% the mode of transmission is unknown.

Thirty-six percent of female cases are white, 61% are black, and 3% are hispanic. Fifty-three percent of these cases are women of childbearing age (age 18-40 years). The HIV seroprevalence in women giving birth in Louisiana in 1.2 per thousand; and positive women were found in all regions of the state. Over one-half of children with AIDS (most of whom acquired HIV infection perinatally) reside outside the metropolitan New Orleans area.

- (1) Cultures of infectious agents
- (2) Tissue removed during surgery or autopsy.
- (3) Human blood, blood products, or blood collection bags, tubes and vials.
- (4) Sharps used or generated in health care or laboratories.
- (5) Bandages that have covered infected wounds

All potentially infectious biomedical wastes must be placed in leakproof containers "Sharps" must be placed in a break-resistant, rigid, puncture-resistant container with an opening that can be tightly closed for storage or transport. These wastes must be treated by incineration or other means in order to render them noninfectious and unrecognizable as potentially infectious biomedical waste. Large health care facilities may incinerate their own wastes on site or have a registered transporter remove them for proper treatment. Small health care facilities (such as physicians and dentists' offices) may transport untreated wastes to approved large health care facilities (such as hospitals) or to approved storage or treatment facilities.

Untreated wastes which leave a facility must be packaged in leakproof containers marked with the name and address of the facility and/or the transporter and labeled as "infectious waste."

A complete copy of the infectious waste regulations may be obtained by contacting Mr. Charles Anderson, Office of Public Health, P.O. Box 60630, New Orleans, LA 70160 or by calling (504) 568-5139.



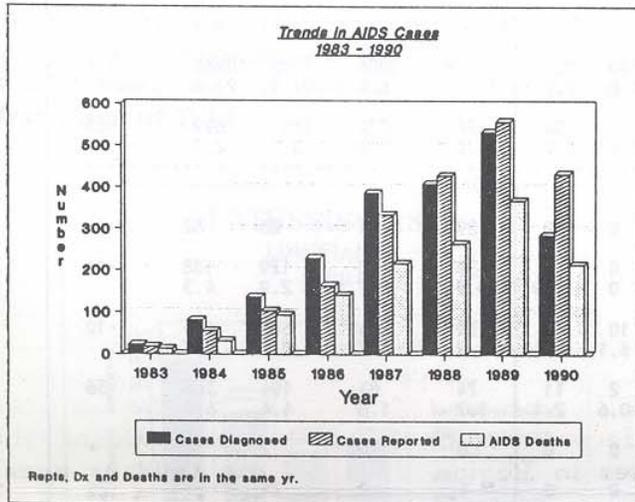
OOPS!

Change in 800 Number for Case Reporting

We were told in error that one of our telephone lines could be used as an 800 toll-free number for case reports, and we published that information in the last Morbidity Report. We have since then been informed that a new line (and a new number) has been established for this. The correct toll-free number for case reports is:

1-800-256-2748

Please accept our apologies for this error.



Infectious Waste Regulations Amended in Sanitary Code

On July 1, 1990 the Louisiana Sanitary Code was changed to include more extensive and more detailed regulation of the disposal of potentially infectious biomedical waste. Under the new regulations, hospitals, clinics, private physicians, and citizens who dispose of needles or other "sharps" will be required to use puncture-resistant containers and to dispose of them in a state-approved facility.

The AIDS epidemic has caused concerns about the potential transmission of HIV from discarded needles or other biomedical wastes. Previous regulations in the Louisiana Sanitary Code applied only to hospitals and were felt to be inadequate to address these concerns.

In the new regulations potentially infectious biomedical waste includes but is not limited to the following:

COMMUNICABLE DISEASE SURVEILLANCE, July-August 1990
PROVISIONAL DATA

Table 1. Selected diseases by region

DISEASE	HEALTH DEPARTMENT REGION									Jul-Aug 1990	Jul-Aug 1989	Cum 1990	Cum 1989	%Change	
	1	2	3	4	5	6	7	8	9						
Vaccine-preventable															
Measles	Cases	0	0	0	0	0	0	0	0	0	0	2	10	11	-9
Mumps	Cases	0	5	0	5	0	1	2	2	0	15	81	93	563	-83
	Rate*	0	0.6	0	0.9	0	0.3	0.3	0.6	0	0.3	1.8	2.1	12.9	
Rubella	Cases	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	Cases	3	1	2	0	0	0	1	0	4	11	11	22	16	+38
Sexually-transmitted															
Gonorrhea	Cases	841	104	56	85	57	41	212	120	126	1642	2806	9226	10265	-10
	Rate**	10.8	1.4	1.8	1.5	2.2	1.3	3.6	3.8	2.7	3.7	6.4	21.1	23.4	
Syphilis	Cases	162	84	4	23	3	36	54	28	34	428	274	1641	899	+83
	Rate**	2.1	1.1	0.1	0.4	0.1	1.1	0.9	0.9	0.7	1.0	0.6	3.7	2.1	
Enteric															
Campylobacter	Cases	4	6	2	1	3	2	1	0	10	29	31	86	62	+39
Hepatitis A	Cases	3	16	5	2	1	4	4	0	4	39	30	129	188	-31
	Rate*	0.4	2.1	1.6	0.4	0.4	1.2	0.7	0	0.9	0.9	0.7	2.9	4.3	
Salmonella	Cases	19	28	9	14	10	5	34	10	10	139	204	381	425	-10
	Rate*	2.4	3.6	2.9	2.5	3.8	1.5	5.8	3.1	2.1	3.2	4.7	8.7	9.7	
Shigella	Cases	44	5	0	2	1	2	7	2	11	74	81	194	303	-36
	Rate	5.7	0.6	0	0.4	0.4	0.6	1.2	0.6	2.4	1.7	1.8	4.4	6.9	
Vibrio Cholera	Cases	0	0	0	0	0	0	0	0	0	0	0	2	0	+
Vibrio, other	Cases	2	2	0	1	0	0	0	0	0	5	8	21	28	-25
Other															
Hepatitis B	Cases	17	12	2	12	0	3	9	0	7	62	67	205	267	-23
	Rate*	2.2	1.6	0.6	2.1	0	0.9	1.5	0	1.5	1.4	1.5	4.7	6.1	
Meningitis															
H. Influenza	Cases	2	2	2	0	1	2	1	1	3	14	17	52	61	-15
N. Mening.	Cases	0	0	0	0	2	0	0	0	0	2	10	27	34	-21
Tuberculosis	Cases	9	11	3	3	5	1	10	3	4	49	75	198	212	-7
	Rate*	1.2	1.4	1.0	0.5	1.9	0.3	1.7	0.9	0.9	1.1	1.7	4.5	4.8	

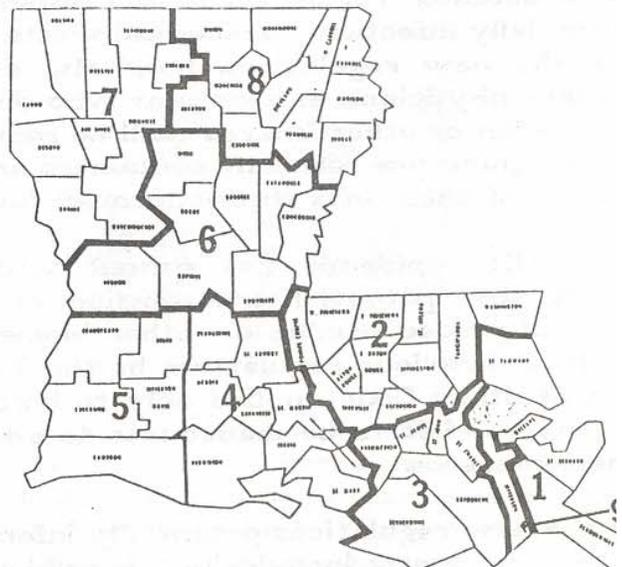
* Cases per 100,000 population
** Cases per 10,000 population

Table 2. Diseases of low frequency, 1990

Disease	Total to date
Blastomycosis	4
Brucellosis	2
Histoplasmosis	3
Lead Toxicity	6
Legionellosis	11
Leprosy	0
Lyme Disease	1
Malaria	2
Rocky Mountain Spotted Fever	2
Tetanus	2
Typhoid	0

Table 3. Animal rabies - July-August 1990

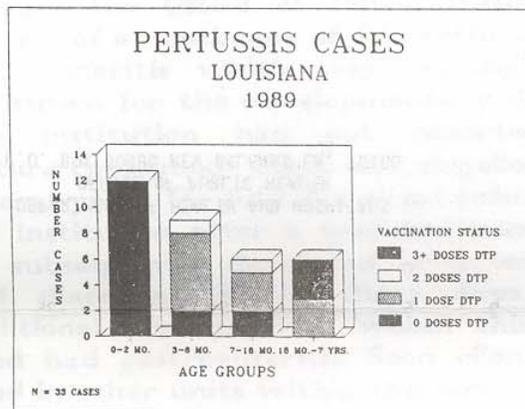
Parish	Species	No. Cases
Bossier	Skunk	2
Rapides	Bat	1



Annual Summary - Pertussis 1989

For the year 1989, 39 pertussis cases were reported to the Epidemiology Section, an increase from 21 cases in 1988. The case rate for 1989 was 0.09 per 10,000. Case rates showed no important differences by race or sex. All cases for which the age was known were under 7 years of age. The age distribution and immunization status of 33 case children are shown in the graph below. Approximately 73% (24 of 33) of cases with known immunization status had not been adequately immunized for age* and 18% (6 of 33) were not of age to have received the first dose of DTP.

PERTUSSIS LOUISIANA, 1989



Pertussis is predominantly a childhood disease with the incidence rates highest under 5 years of age. It is highly communicable and can cause severe disease, particularly among very young children. General use of pertussis vaccine has resulted in a substantial reduction in cases and deaths from pertussis disease.

Pertussis can be transmitted to infants by adults who may not be recognized as having the disease. The scattering of case throughout the state indicates that the organism is widespread in Louisiana and that further cases or clusters are likely to occur if immunization coverage levels fall.

* Adequate doses for age - one dose DTP by 2 months of age; two doses DTP by 4 months of age; three doses DTP by 6 months of age; > four doses DTP by 18 months of age through 7 years.

Cases were scattered over fifteen parishes with a clustering in Orleans and surrounding parishes. A cluster of pertussis cases in an institution was identified and investigated in 1989. (See La. Morbidity Report, Nov/Dec 1989).

LOUISIANA FACTS

Did you know that in 1929 Dr. W.W. Knipmeyer, Director of the Natchitoches Parish Health Unit, terminated a severe epidemic of pellagra by distributing large sacks of brewer's yeast?

DO YOU HAVE ANY INTERESTING FACTS ABOUT LOUISIANA THAT YOU WOULD LIKE TO SEE PUBLISHED IN THE LOUISIANA MORBIDITY REPORT? SEND FACTS AND SOURCE TO: LOUISIANA FACTS, DHH-OPH-EPIDEMIOLGY SECTION, P.O. BOX 60630, NEW ORLEANS, LA 70160.

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DEPARTMENT OF HEALTH AND HOSPITALS

**The new toll free number for reporting communicable diseases is
1-800-256-2748**

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