

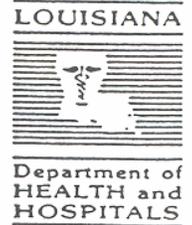


Buddy Roemer  
GOVERNOR



# Louisiana Morbidity Report

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



J. Christopher Pilley  
SECRETARY

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Volume 2 Number 6

## Cancer Incidence in South Louisiana 1983-1986

*Editor's note: In recent years there has been a great deal of concern and publicity about cancer in Louisiana, with particular interest in the relationship between cancer and exposure to man-made chemicals in the environment. The Louisiana Tumor Registry has recently published a report entitled **Cancer Incidence in South Louisiana 1983-1986**. This report is the first user-friendly monograph to compare cancer incidence rates by region in South Louisiana and with the national rates. The data cover a four-year period, 1983 - 1986, and include 35 parishes, representing the most heavily industrialized area of the state and 72% of the state's population. To provide information to physicians about the epidemiology of cancer in the state, we have reprinted below the Executive Summary of this report.*

For more information about this report, contact the Louisiana Tumor Registry at (504) 568-2616.

### Major Findings

In general, the high cancer death rates observed in South Louisiana are not due to high incidence rates. With the exception of lung cancer, the major problem appears to be a lack of early detection and limited access to needed health care. The high incidence and death rates of lung cancer among males are primarily due to smoking.

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●Incidence rates for cancers combined in South Louisiana are either the same as, or lower than, the national rates. This is in contrast to the high death rates in South Louisiana which up to now have been the only available data.

●Both nationally and in South Louisiana, cancer is more common in men than women and more common in Blacks than Whites. Of the four sex-race groups, Black males in South Louisiana experience the highest age-adjusted rate (459/100,000), followed by White men (428/100,000), Black females (304/100,000) and White females (294/100,000).

●With the exception of lung cancer, residents in South Louisiana have a lower risk of developing the most common cancers.

●White men in South Louisiana have 30% more lung cancer than White men elsewhere in the nation. This excess in White men is seen in every South Louisiana region.

●Incidence rates of colon and rectal (large intestine) cancer in South Louisiana are below national rates.

●Incidence rates for cancers of the breast, ovary and uterus (except cervix) are significantly lower among White women in South Louisiana than the rest of the nation.

●Cancer of the prostate, the most common cancer in U.S. men, occurs significantly less frequently in both White and Black men residing in South Louisiana. Nationally, prostate cancer has surpassed lung cancer as the number one cancer in men. In South Louisiana, it remains second to lung cancer.

●Both Blacks and Whites in South Louisiana have substantially lower rates of melanoma of the skin.

●Cancers of the mouth (oral cavity), throat (pharynx) and esophagus are significantly less common in Black males in South Louisiana than Black males in the national data.

●Black men in South Louisiana have higher rates of stomach cancer than those nationwide.

(Continued on page 2)

*Cancer in South Louisiana (Cont.)*

•High overall rates of pancreatic cancer are observed in the Lafayette region. In other South Louisiana regions, the excess is limited to White men.

•New Orleans shows very high rates of lung cancer for White men, White women and Black men, higher than any other region in South Louisiana.

•Cancer rates for the Lake Charles region fluctuate greatly. The unstable rates are the results of the small population in this region.

**Discussion**

Cancer is the second leading cause of death in both the U.S. and in South Louisiana; one out of five deaths is due to cancer. Approximately one out of three Americans will experience cancer some time in his or her lifetime. Therefore, it is not unusual to find clusters of cancers. The American Cancer Society estimates that in 1991 there will be 19,000 new cancer cases and 9,000 cancer deaths in the state of Louisiana.

Cancer is a term that applies to more than 100 diseases. Each form of cancer is caused by a different set of factors, some well-established, some uncertain and some unknown. The most frequent cancer in South Louisiana is lung cancer, accounting for 20% of all newly diagnosed cases. Other common cancers in this area are colorectal (13%), breast (12%) and prostate (9%).

**Tobacco**

Studies carried out in South Louisiana, nationally, and internationally consistently show cigarette smoking to be the major cause of lung cancer. Cigarette smoking is responsible for 35% of all cancers and at least 83% of lung cancer cases in the U.S. Ninety percent of lung cancer in South Louisiana could be prevented if cigarette smoking were eliminated. A study of cancer of the pancreas shows that the excess of this cancer in South Louisiana is linked primarily to smoking. Cigarette smoking also increases the risk of cancers of the mouth, throat, larynx, esophagus, bladder, kidney, cervix and liver.

A survey conducted in Louisiana shows that the proportion of smokers, the preference for high tar and unfiltered cigarettes, and the early age at which smoking begins, are excessive in South Louisiana when compared with North Louisiana. There is no doubt that smoking is the most important cause of cancer in Louisiana.

**Diet/Nutrition**

Another major factor associated with cancer in Louisiana is diet/nutrition. Based on epidemiologic studies carried out in South Louisiana, improving diet by eating more fresh fruits and vegetables daily could reduce lung cancer cases by about 15%. Higher intake of fresh fruits and vegetables could also reduce risk of cancers of the stomach, pancreas and colon. High fat diet is linked to breast and colon cancer and inadequate fiber intake to colorectal cancer. In addition, excessive salt in the diet is linked to stomach cancer and high intake of pork products to pancreas cancer in South Louisiana.

**Occupation and Environment**

National estimates suggest that occupation accounts for approximately 4-6% of all cancer deaths. Pollution accounts for less than 2%. Epidemiologic studies done to date in South Louisiana suggest that the same is true here. Cancers classically linked to occupational exposures account for 4-6% of lung cancer cases in South Louisiana. No excess risk has been detected for either brain tumors or leukemia in South Louisiana residents. Non-Hodgkins lymphomas occur slightly more frequently in Whites compared to the national figures, but not in Blacks.

Some individuals are at high risk of certain types of cancer because of occupational exposures. Examples include asbestos and mesothelioma, aniline dyes and bladder cancer, benzene and leukemia.

*(Continued on page 3)*

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*Cancer in South Louisiana (cont.)*

Air, water and land pollution have been suggested as major causes of cancer in South Louisiana. The data in this monograph and the many cancer studies conducted to date in South Louisiana do not support this belief.

### Access to Health Care

The risk of developing cancer in South Louisiana is at or below the national average, but the risk of death from cancer is higher. This seems to be due to a larger proportion of late (advanced) stage disease at the time of diagnosis. Inadequate screening with mammograms and Pap smears has resulted in fewer cancer cases diagnosed early in the course of the disease. Cervical cancer diagnosed as carcinoma in-situ is 99% curable. Breast cancer patients with localized disease have a 5-year survival rate greater than 85%. An on-going study funded by the National Cancer Institute shows that women in New Orleans have poorer access to medical care than women in Atlanta or San Francisco. They are less likely to have a usual source of care or medical insurance. Programs to increase the accessibility of screening mammograms, Pap smears and other cancer screening tests are greatly needed.

### RECOMMENDATIONS

1. Do not smoke or chew tobacco.
2. Eat a variety of fresh fruits and vegetables daily and reduce fat intake
3. Avoid excessive exposure to the sun.
4. Have mammograms and Pap smears regularly.
5. Do not delay needed medical care.



## Influenza Arrives Early

Louisiana's first culture-confirmed case of influenza in the 1991-92 season occurred on September 22. As of November 21, 1991, 113 culture-confirmed cases of influenza have been reported in the state. All cases are influenza A, and all that have been studied further are subtype A(H3N2) Beijing-like, one of the strains included in this year's vaccine. In the same period, physicians in all regions of the state have been reporting widespread activity of influenza-like illness.

As far as anyone we spoke to can recall, this is the earliest arrival of influenza in Louisiana in the last 30 years. Ordinarily, the influenza season in the state runs from January to March. The fact that the flu season began early does not necessarily mean that it will be prolonged or severe. We will continue to monitor the progress of the disease in the state through the use of sentinel physicians. In the meantime, we encourage physicians to immunize their high-risk patients with the influenza vaccine as soon as possible.

## Update - Cholera in Louisiana and South America

In response to concern about the spread of cholera from South America to the United States, the Office of Public Health has carried out extensive culturing for *Vibrio cholera* in sewers in Louisiana. So far none of these cultures have grown *V. cholera*.

The U.S. had been free of cholera since the early part of this century until Louisiana experienced an outbreak of 11 cases in the fall of 1978. This outbreak was caused by *Vibrio cholerae* O1 serotype Inaba, biotype El Tor, the same bacteria that apparently caused a single case of cholera in a Texas resident in 1973. Since that time the Office of Public Health has investigated additional outbreaks of cholera (in 1981 and 1986) along with isolated cases occurring almost every year.

In January 1991, an epidemic of cholera was reported in Peru. Since then, this epidemic has spread to other South American and Central American countries. In July, 1991, the FDA Fisheries Research Laboratory on Dauphin Island, Alabama, and the Alabama Department of Public Health announced the isolation of *Vibrio cholerae* O1 Inaba from oysters and other specimens from Mobile Bay. The oysters were from closed commercial oyster beds and were sampled as part of other studies. Repeat samples collected at four sites in Mobile Bay were tested in duplicate in two laboratories and two of the four sites were positive for *V. cholerae* O1 Inaba. The Mobile Bay isolates were not the endemic Gulf Coast strain of *V. cholerae* O1 but appeared to be similar to the Latin American strains.

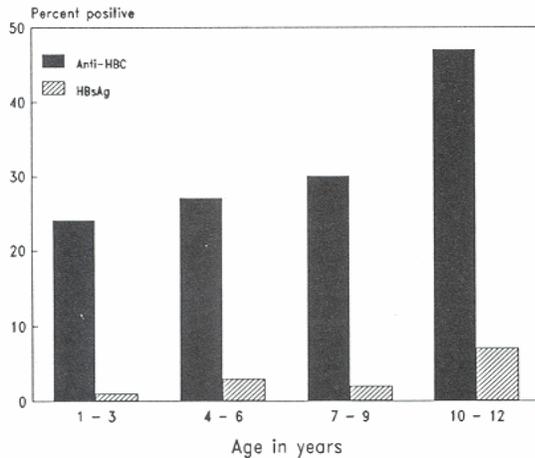
The identification of these isolates suggested that the South American strain of *V. cholera* had arrived in the United States and might be causing disease. However, no known associated human illness has been identified in Alabama or any other Gulf Coast state. The FDA is culturing oysters from other commercial harvest areas of the Gulf Coast to look for toxigenic *V. cholerae* but to date none has been found. The CDC has suggested that Gulf states may wish to begin laboratory surveillance to detect *V. cholerae* in the sewage systems of major coastline cities. This method of surveillance is sensitive enough to detect a single active infection in a city. In Louisiana, sewer swab surveillance was instituted August, 1991, in Calcasieu, Cameron, Iberia, Jefferson, Jeff. Davis, Lafayette, Lafourche, Orleans, Plaquemines, St. Bernard, St. Mary, St. Tammany, Terrebonne, and Vermilion Parishes. The surveillance of sewage systems continued through October, 1991, with no toxigenic *V. cholerae* O1 found. Thus, although the South American strain may have arrived in the Gulf of Mexico, there is no evidence that it has caused any human disease.

# Hepatitis B Program for Southeast Asians Begins

The Office of Public Health is now encouraging all physicians to vaccinate newborn infants of Southeast Asian mothers with hepatitis B vaccine. This program comes as a follow-up to a hepatitis B serosurvey conducted by OPH this summer.

In July and August 1991, a serosurvey was conducted in a Vietnamese community in Louisiana. Preliminary results of this survey show that among children born in this country to mothers who are not carriers of hepatitis B, nearly 50% of 10-12 year olds had evidence of past hepatitis B infection, and 7% had become carriers (Figure). The fact that infection began at an early age and continued to occur during early childhood suggests that transmission is taking place from person to person during routine personal contact (rather than through sex or needle use). The reason for the high rate of transmission in early childhood among Southeast Asians is unknown, but the fact that it is so high suggests that the only means to prevent the diseases is immunization of infants in this group.

Figure: Seropositivity for hepatitis B markers among US-born infants of non-carrier Vietnamese women, New Orleans, 1991



All infants of mothers who were born in Vietnam, Cambodia, Laos, Thailand, the Philippines, Korea, China, and the Western Pacific Islands are eligible for this program. The hepatitis B vaccine is to be given at birth, 1-2 months of age, and 6 months of age. Hospitals and physicians are encouraged to vaccinate newborns before discharge from the nursery; follow-up doses will be available in parish health units and the New Orleans City Health Department clinics. Although the vaccine schedule is the same as that for infants whose mothers are hepatitis B carriers, the dose of hepatitis B vaccine is lower for infants of mothers who are not carriers when Recombivax is used (Table). In addition, infants of Southeast Asian women who are not carriers do not need to receive Hepatitis B Immune Globulin (HBIG). Questions about this program should be directed to the Immunization Section at (504) 568-5007.

Table: Dose schedule for hepatitis B vaccination of Southeast Asian infants

Group	HBIG*	Recombivax-HB**		Engerix-B**	
	ml	ug	ml	ug	ml
Infants of carriers mothers	0.5	5	0.5	10	0.5
Southeast Asian infants of non-carrier mothers	-	2.5	0.25	10	0.5

\* Hepatitis B Immune Globulin is given as a single dose immediately after birth.

\*\*Hepatitis B vaccines are given in three doses: at birth, 1-2 months, and six months of age.



## BULLETINS

### Severe Head Injuries Now Reportable

Reporting of severe traumatic head injuries became mandatory with the passage of Act 215 of the Louisiana Legislature in 1990 and the publication of the reporting rule in the Louisiana Register on February 20, 1991. Each licensed hospital and physician in the course of his or her medical practice shall report these injuries to the Disability Prevention Program (DPP) of the Office of Public Health. In developing the brain injury clinical case definition and the reporting form, the DPP consulted neuroscience clinicians and conducted a pilot study at three major hospitals in Louisiana. Following a suggestion of the Louisiana Hospital Association, the necessary information for head injury reporting was combined with the already existing form for the reporting of traumatic spinal cord injuries. For more information contact the Disability Prevention Program (504) 568-2509.



### DNA Probe for Diagnosis of Gonorrhea and Chlamydia Infections

Beginning January 2, 1992, OPH will change to a DNA probe test for diagnosis of gonorrhea and chlamydia in maternity, family planning, and sexually transmitted disease clinics. This test uses a DNA probe that hybridizes with ribosomal RNA of gonorrhea and chlamydia cells. Studies have demonstrated a sensitivity of 95% and specificity of 98% for infection with *Neisseria gonorrhoeae*, and a sensitivity of 75-95% and specificity of 98% for infection with *chlamydia trachomatis*, when compared to confirmatory tests in research laboratories. These sensitivities are higher than those of the culture tests currently used, so we expect a substantial increase in the number of identified cases of gonorrhea and chlamydia infection.

## AIDS Update

### Cases with No Identified Risk

Approximately 5% of all AIDS cases in Louisiana have no identified risk factor (NIR) at the time of initial report. All cases without risk factors are investigated by questioning physicians or other health care professionals involved in them, reviewing additional medical records, or interviewing the patients. These investigations may take up to six months to complete.

Since 1988, 397 NIR cases have been reported. Sixty percent of these have been reclassified into a specific risk category (Figure 1); 15% of cases have been closed because the patient died, refused an interview, or was lost to follow-up, and 25% are still open for investigation.

NIR cases are of concern because of the need to accurately monitor the epidemic in subpopulations. The demographics of NIR cases are compared to other major risk groups in Table 1. NIR cases are predominantly white and male. Overall, the table suggests that the risk factors of these NIR cases may be a mixture of those of homosexuals/bisexuals and other groups. To date no differences in NIR cases have been found between the various regions of the state.

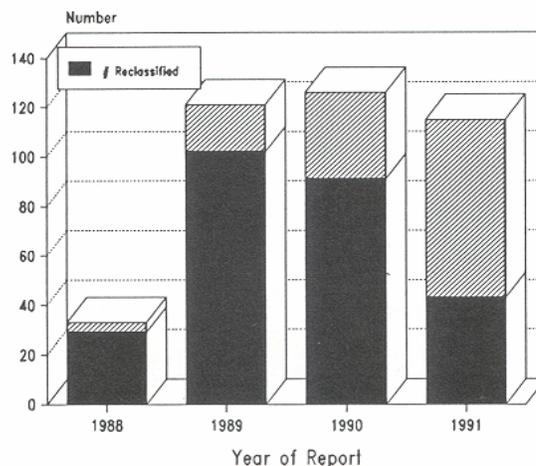
NIR cases appear to be increasing as a percentage of all AIDS cases, and it is suspected that this trend will continue (Figure 2). The percentage of 1991 cases will decrease as investigations are completed, however; it may still remain higher than that seen in 1990.

**Table 1.** Demographic comparison of AIDS patients with no identified risk to AIDS patients in selected risk categories.

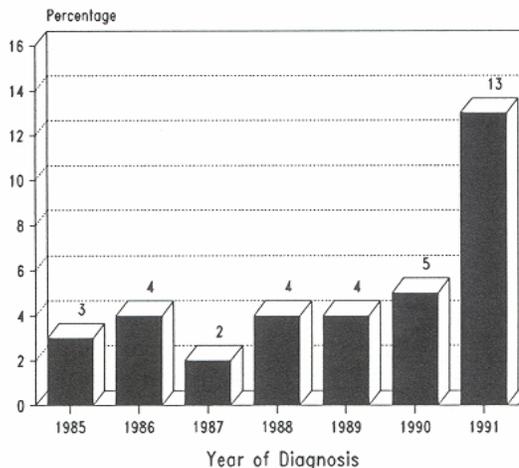
Risk Group:	<u>Homo/bisex</u>	<u>IVDU</u>	<u>Hetero</u>	<u>NIR</u>	<u>All Cases</u>
N	1935	271	107	160	2943
Sex:					
Male	100%	77%	41%	84%	93%
Female	NA	23%	59%	16%	7%
Race:					
White	74%	28%	25%	44%	65%
Black	23%	71%	68%	53%	33%
Age					
< 30	22%	27%	39%	22%	25%
30 - 39	47%	46%	37%	34%	44%
> 40	31%	27%	24%	45%	30%



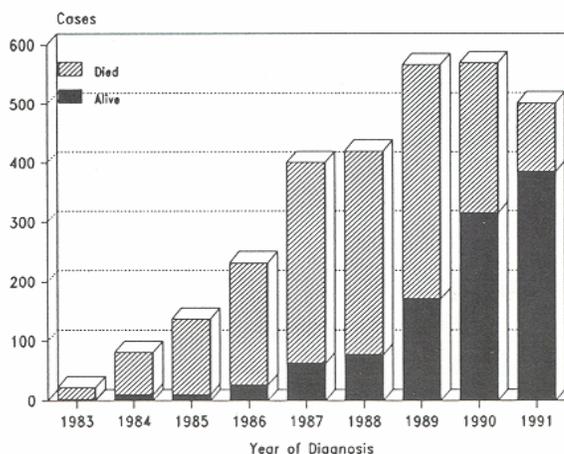
**Figure 1:** Cases of AIDS with no identified risk before and after reclassified, 1988-1991



**Figure 2:** Percentage of AIDS cases with no identified risk 1985-1991



### AIDS Case Trends



COMMUNICABLE DISEASE SURVEILLANCE, September-October 1991  
PROVISIONAL DATA

Table 1. Selected diseases by region

DISEASE	HEALTH DEPARTMENT REGION										Sept-Oct 1991	Sept-Oct 1990	Cum 1991	Cum 1990	%Change
	1	2	3	4	5	6	7	8	9						
<b>Vaccine-preventable</b>															
Measles	Cases	0	0	0	0	0	0	0	0	0	0	0	0	10	-
Mumps	Cases	1	1	1	2	0	1	1	0	0	7	10	27	101	-73
Rubella	Cases	0	0	0	0	0	0	0	0	0	0	0	0	-	
Pertussis	Cases	1	0	0	0	0	0	0	1	1	3	8	11	30	-63
<b>Sexually-transmitted</b>															
Gonorrhea	Cases	1046	339	126	220	137	82	416	262	269	2897	2217	13241	11443	+16
	Rate**	14.3	4.5	4.2	4.0	5.3	2.6	7.6	8.6	6.0	6.9	5.3	31.4	27.1	
Syphilis (P&S)	Cases	172	161	52	81	5	37	58	62	54	683	631	2620	2272	+15
	Rate**	2.3	2.1	1.7	1.5	0.2	1.2	1.1	1.1	1.2	1.6	1.5	6.2	5.4	
<b>Enteric</b>															
Campylobacter	Cases	3	4	1	5	0	1	3	0	2	19	26	73	113	-35
Hepatitis A	Cases	5	3	1	0	1	1	1	0	0	12	41	103	171	-40
	Rate*	0.6	0.4	0.3	0	0.4	0.3	0.2	0	0	0.3	0.9	2.4	3.9	
Salmonella	Cases	71	37	17	20	8	8	70	11	23	268	155	604	536	+13
	Rate*	9.1	4.8	5.5	3.5	3.0	2.5	12.0	3.5	4.9	6.1	3.5	13.8	12.2	
Shigella	Cases	5	0	2	12	2	0	16	2	1	40	52	164	247	-34
	Rate*	0.6	0	0.6	2.1	0.8	0	2.7	0.6	0.2	0.9	1.2	3.7	5.6	
Vibrio Cholera	Cases	0	0	0	0	0	0	0	0	0	0	1	0	2	-
Vibrio, other	Cases	1	0	2	0	0	0	0	0	1	4	4	37	25	+48
<b>Other</b>															
Hepatitis B	Cases	17	11	0	5	3	1	15	4	5	62	56	248	267	-7
	Rate*	2.2	1.4	0	0.9	1.1	0.3	2.6	1.3	1.1	1.4	1.3	5.7	6.1	
Meningitis/Bacteremia	Cases	0	0	0	0	0	0	0	1	0	1	5	19	57	-67
H. Influenza	Cases	0	0	0	0	0	0	0	1	0	1	5	19	57	-67
N. Mening.	Cases	2	4	1	1	0	0	0	0	0	8	4	28	31	-10
Tuberculosis	Cases	1	4	1	1	2	1	1	2	0	13	30	197	228	-14
	Rate*	0.1	0.5	0.3	0.2	0.8	0.3	0.2	0.6	0	0.3	0.7	4.5	5.2	

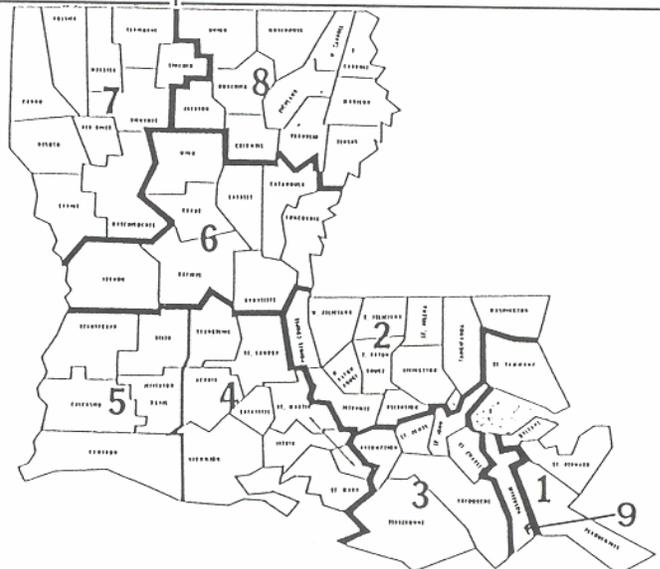
\* Cases per 100,000 population  
\*\* Cases per 10,000 population

Table 2. Diseases of low frequency, 1991

Disease	Total to date
Blastomycosis	4
Brucellosis	0
Histoplasmosis	3
Lead Toxicity	16
Legionellosis	7
Leprosy	1
Leptospirosis	1
Lyme Disease	3
Malaria	16
Rocky Mountain Spotted Fever	0
Tetanus	0
Typhoid	5

Table 3. Animal rabies - September - October, 1991

Parish	Species	No. Cases
No cases for this time period.		

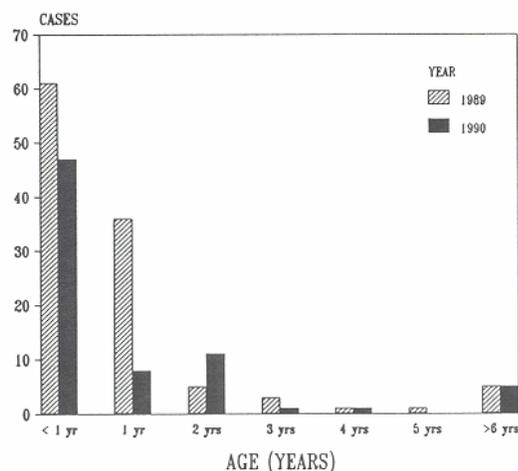


## Annual Summary

# H. Influenza Disease

Seventy three cases of invasive disease caused by *Haemophilus influenzae* were reported to the Epidemiology Section for 1990, a case rate of 1.7 per 100,000. Case rates have been gradually declining from 1988 to 1990 (from 3.0 to 1.7 per 100,000). Rates were not different for males vs females, but were over twice as high for blacks as for whites (2.9 vs 1.1 per 100,000). Age specific rates remain highest in the 0 - 4 year age group. Fifty-five cases (75%) occurred in children less than 2 years of age and 64% of the cases occurred in children below 12 months, ( none of whom had previously received the HIB vaccine). From 1989 to 1990, the number of cases in children less than age 2 decreased 43% (from 97 to 55) while the number of cases in age 2 to 5 increased from 10 to 13 (Figure 1).

**Figure 1:** Cases of H. influenzae disease by age 1989-1990



Ninety-five percent of the cases had bacterial meningitis and the other 5% had bacteremia or pneumonia. Type B was reported in 64% (47 of 73) of the cases.

Despite the availability of the currently licensed *Haemophilus conjugate vaccine*, invasive *Haemophilus* disease remains one of the single most important infectious diseases in Louisiana children. With widespread use of conjugate vaccine beginning at two months of age, it is anticipated that more than 90% of these cases can be prevented during the next several years. Despite the decline in case rates, the expected decrease in the target age groups may not yet be evident since vaccination of infants under one year of age has been implemented by OPH clinics only since March 1991.

**Figure 2:** Cases of H. influenzae disease by parish, 1990



*Ho! Ho! Ho!*  
*Merry Christmas!!*

### LOUISIANA FACTS

*The first Sanitary Code of the City of New Orleans was established in 1817. The 24 ordinances included requirements on the depth and maintenance of privies, prohibition of raising hogs or skinning cattle, and banning of the sale of oysters during the summer months.*

**Do you have an interesting fact about Louisiana that you would like to see published in the Louisiana Morbidity Report? Send facts and source to: Louisiana facts, DHH-OPH-Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160.**

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## LIST OF REPORTABLE DISEASES/CONDITIONS

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

Report cases on green EPI-2430 card unless indicated otherwise below.

\*Report suspected cases immediately by telephone. In addition, report all cases of rare or exotic communicable diseases and all outbreaks.

\*\*Report on STD-43 form. Report syphilis cases with active lesions by telephone.

\*\*\*Report on CDC 72.5 (f 5.2431) card

▪Report on DDP-3 form; preliminary phone report from ER encouraged (568-2509).

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

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