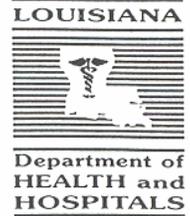




Edwin W. Edwards  
GOVERNOR

# 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

September-October 1994

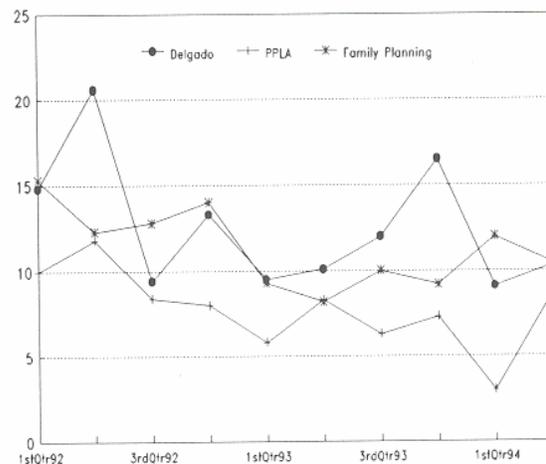
Volume 5 Number 5

## Chlamydia Rates Decrease in New Orleans

Chlamydia prevalence rates in New Orleans public health clinics have shown a decrease since 1992. A representative sample of DNA probe laboratory results obtained from attendees at the Delgado STD Clinic, the Family Planning Clinic, and the New Orleans Planned Parenthood Clinics show a steady reduction in the number of GenProbe tests positive for *Chlamydia trachomatis* in females. Rates at the Delgado Clinic have decreased from 15% to about 11%, at the Family Planning Clinic from 13.5% to about 11%, and at the Planned Parenthood Clinics from 10% to about 6.5%. *Neisseria gonorrhoea* rates have remained steady, at about 20% at the Delgado Clinic and about 3% at the Family Planning and Planned Parenthood Clinics. Coinfection rates with both organisms largely parallel the decrease in chlamydial infections. Both gonorrhea and chlamydia rates in males at the Delgado STD Clinic have remained stable at about 32% and 13%, respectively.

The populations sampled by these clinics varies. The Delgado STD Clinic is utilized primarily by individuals with a physical complaint consistent with a venereal disease, though some users come simply wanting to be "checked out." The standard practice at the clinic is to obtain the GenProbe sample from all patients, including those who come for treatment because of notification of an

Figure: Rates of chlamydia by quarter, Orleans Parish, 1992-1994



infected partner. The other two clinics obtain the GenProbe sample not only when a patient complains of symptoms consistent with a STD, but on all initial and annual examinations that are performed as a part of routine contraceptive care.

Reasons for this decline in chlamydia are unclear. This could indicate that sexual behaviors are changing as individuals learn of the risks associated with AIDS. The decline may also be a reflection of the benefits of the practice of dual antibiotic therapy for both gonorrhea and chlamydia when symptoms of either are present.

The 6-10% rate of chlamydia in the Planned Parenthood and Family Planning Clinics probably represents primarily asymptomatic disease. Even though the prevalence is decreasing, asymptomatic disease continues to be a significant problem, and the long term sequelae of pelvic inflammatory disease and ectopic pregnancy still cause considerable suffering. Clinicians are reminded of the importance of screening for these infections in asymptomatic women of child-bearing age. Dual antibiotic therapy for both gonorrhea and chlamydia is still recommended for cases of suspect gonorrhea unless chlamydia is ruled out by laboratory tests. Currently recommended drugs for treatment are doxycycline or tetracycline for 7 days or azithromycin 1 gram once AND a single dose of ceftriaxone 125mg IM or oral cefixime, ofloxacin, or ciprofloxacin.

### Contents

Early Prenatal Care and Infant Mortality.....	2
St. Louis Encephalitis Outbreak, 1994.....	3
Influenza Immunization Program 1994-95.....	3
Louisiana's Physical Activity Profile.....	4
AIDS Update.....	5
Annual Summary: Salmonellosis, 1993.....	7

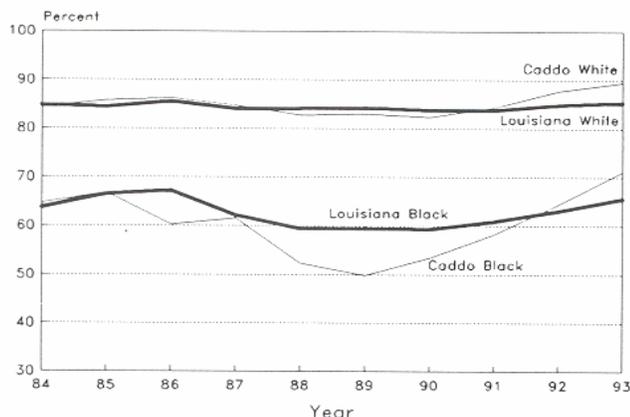
## Early Prenatal Care and Infant Mortality

Efforts in the past few years to increase the number of pregnant women receiving early prenatal care have apparently succeeded, but this success has not translated into decreases in infant mortality. This conclusion can be drawn from newly-available vital statistics data from 1993.

Overall, approximately 75% of women in Louisiana begin prenatal care in the first trimester, with the percentage being greater in whites than blacks. However, between 1989 and 1993, there were increases in the percentage of women with first-trimester prenatal care (Figure 1). The increase in the state as a whole was greater in black women (from 60% to 66%) than in white women (from 84% to 85%). In Caddo Parish the increase was particularly pronounced; there black women increased from 50% to 71% and white women from 83% to 90%.

The increase in early prenatal care may have been

**Figure 1:** Percent of pregnant women beginning prenatal care in the first trimester, Louisiana and Caddo Parish, 1984-1993



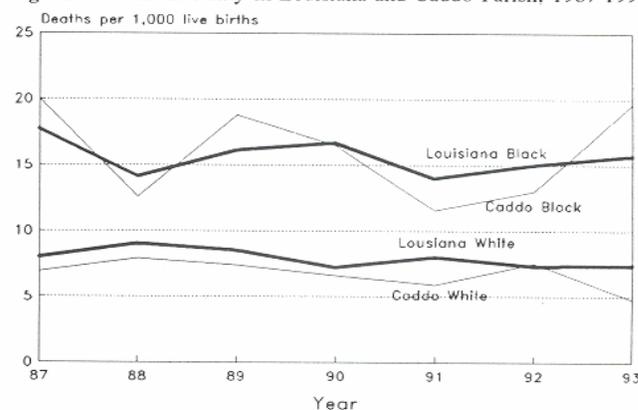
caused by a number of programmatic changes. Under the SOBRA law, which began in 1989, many more low-income women were eligible for Medicaid-funded prenatal care than had been eligible previously. In 1992 and 1993, there was a major public relations effort in the Shreveport area called "Baby Your Baby," spearheaded by KSLA TV station, with the goal to increase prenatal care and decrease infant mortality rate. And in 1993, the Office of Public Health began a statewide media campaign focusing on prenatal care called "Partners for Healthy Babies." Other changes in the economy or health access may have also contributed to the increase.

Unfortunately, this increase in early prenatal care has not been matched by parallel decreases in infant mortality. From 1989 to 1991 infant mortality in the state decreased from 11.5 to 10.5 per 1,000 births, but between 1991 and 1993 (when early prenatal care increased the most), infant mortality increased from 10.5 to 10.8. This increase in infant mortality was greater in those groups who had the greatest increases in

prenatal care: black women statewide (from 14.0 to 15.7) and in Caddo Parish (from 11.6 to 19.6; Figure 2).

It is unclear why early prenatal care has not caused a decrease in infant mortality. It is possible that while those women accessing prenatal care may have decreased their risk, another group of women who still are not receiving prenatal care (such as crack cocaine users) have greatly increased their risk. It is also possible that prenatal care by itself is insufficient to eliminate some of the factors that cause prematurity and infant death. A recent study of the content of prenatal care found that counseling carried out during prenatal visits was more protective than the medical procedures. (Continued on page three)

**Figure 2:** Infant mortality in Louisiana and Caddo Parish, 1987-1993



**Louisiana Morbidity Report**  
**Volume 5 Number 5**  
**September-October 1994**

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.

<i>Assistant Secretary, OPH</i>	Eric Baumgartner, MD MPH
<i>State Epidemiologist</i>	Louise McFarland, DrPH
<i>Editors</i>	Thomas Farley, MD MPH Karen Kelso, RNC MS
<i>Production Manager</i>	Ethel Davis, CST
<i>Contributors</i>	Susan Wilson, BSN Donald Thompson, MD Girma Michael, MSPH ScD Edward Roubal

Early Prenatal Care and Infant Mortality (Cont.)

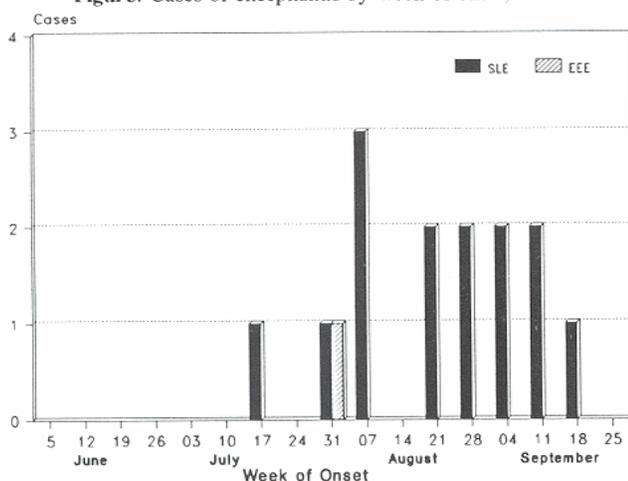
Further study needs to be done to understand this increase in infant mortality. In the meantime, it is clear that infant mortality is still a problem in Louisiana, and that efforts must still be made to improve access to prenatal care and to take full advantage of prenatal visits that do take place to prevent prematurity and infant death.

## St. Louis Encephalitis Outbreak, 1994

As of the end of September 1994, 15 cases of arboviral encephalitis were reported in Louisiana. Fourteen cases were identified as St. Louis encephalitis (SLE) and one case as Eastern Equine encephalitis (EEE). The last SLE encephalitis outbreak occurred in 1980 and since then very few sporadic cases have been reported. Aggressive mosquito control activities were instituted as soon as the initial cases were identified.

The EEE case was reported in a 67 year old white male from Iberville parish with onset of illness on August 4th. Of the 14 SLE cases, 13 lived throughout the metropolitan New Orleans area and one case lived in Washington parish. Onset of illness ranged from July 22 to September 21 with ages ranging from 12 to 81 years (Figure 1). Eight of the cases were males. Nine (64%) of the cases were black and 5 (36%) were white. Three ill persons died.

Figure: Cases of encephalitis by week of onset, 1994



SLE was first recognized during an outbreak in St. Louis in 1933 and is the most frequently reported arboviral encephalitis in the U.S. It occurs sporadically and in outbreaks during the late summer and fall. The illness is usually benign, consisting of fever and headache, and most ill persons recover completely. Severe disease is occasionally seen in young children and is more common in adults over 40 years of age. The incubation period for SLE is up to two weeks. 10 - 25% of adults die from complications of this disease. No specific vaccine is available and

treatment is purely supportive. Surveillance of seasonal mosquito-avian activity as an ongoing process can help guide control measures. Further studies by the Office of Public Health to estimate the prevalence of SLE in the greater New Orleans area are being pursued.

## Influenza Immunization Program 1994-95

Beginning the week of 10/31/94-11/4/94, parish health unit clinics throughout the state will begin to administer influenza immunizations to individuals who are at high risk of serious illness or death from influenza infection. High risk persons include:

Persons 65 years of age or older; residents of nursing homes and other extended-care facilities; adults and children with chronic disorders of the pulmonary or cardiovascular systems, including children with asthma; 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 (such as persons with AIDS and cancer patients receiving chemotherapy); children and teenagers (6 months - 18 years of age) who are receiving long-term aspirin therapy and therefore may be at risk of developing Reye syndrome after influenza.

Physicians, nurses and other personnel capable of nosocomial transmission of influenza to high risk individuals are encouraged to see their own physicians or to organize their own immunization programs.

This year's trivalent influenza vaccine will contain A/Texas/36/91-like (H1N1), A/Shangdong/9/93-like (H3N2), and B/Panama/45/90-like viruses. Because the 1994-95 vaccine differs from the 1993-94 vaccine and because immunity for a person declines in the year following vaccination, annual vaccination using the current vaccine is necessary. Any remaining supplies of the 93-94 influenza vaccine should be discarded.

Previously unvaccinated children 6 months to 9 years who are in risk groups should receive two doses of split virus vaccine administered at least one month apart. The dosage of split virus vaccine for children is 0.25ml for those 6 to 35 months of age, 0.5ml for those 3 through 8 years of age, and 0.5ml for those 9 to 12 years of age. Persons older than 12 years of age may receive 0.5ml of either split or whole virus vaccine.

Children at high risk for influenza-related complications may receive influenza vaccine at the same time as MMR, Hib, pertussis, pneumococcal, hepatitis B, and oral polio vaccines. Vaccines should be administered at different sites on the body.

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

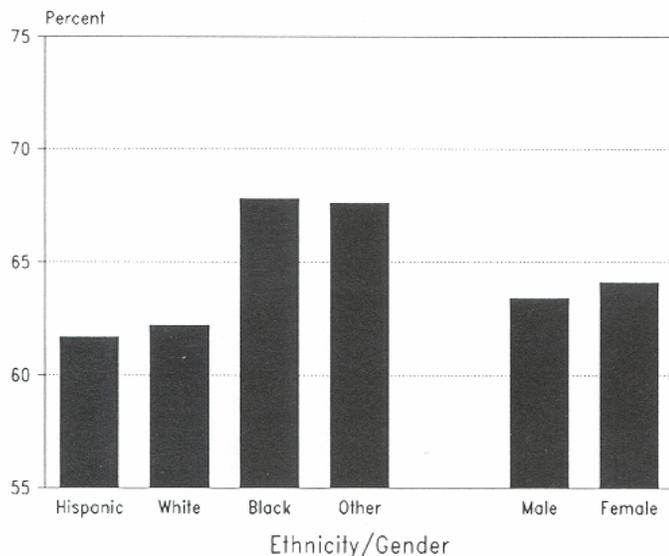
## Louisiana's Physical Activity Profile

Approximately 63.8% of adults surveyed in Louisiana aged 18 yrs. or older report that they exercise only irregularly or not at all outside of normal work duties. These surprisingly high rates of inactivity are documented by the Louisiana Behavioral Risk Factor Surveillance System (BRFSS), an ongoing annual telephone survey conducted by the Office of Public Health and the Centers for Disease Control. The survey assesses the prevalence and trends of health related risk factors for chronic diseases in the Louisiana population. Research has shown a sedentary lifestyle leads to obesity and increases risks for cardiovascular and other chronic diseases.

In the BRFSS, sedentary lifestyle is defined as physical activity for less than 20 minutes/or activity for less than three times per week during the last month. This information from Louisiana is combined with survey results from other states to present a behavioral risk picture for the entire country.

Overall percent of Hispanics and white non-Hispanics were slightly less likely (61.7% and 62.2% respectively) to

Figure 1: Sedentary Lifestyle by ethnicity/gender



be sedentary than black non-Hispanics and persons of other race/ethnicities (67.8% and 67.6% respectively). (Figure 1).

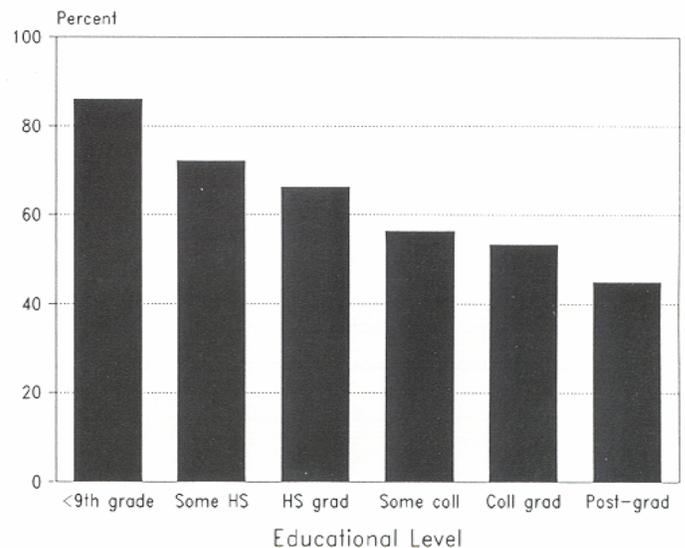
Sedentary lifestyle did not differ substantially by age or gender. However, sedentary lifestyle was more prevalent in persons with lower education. 86% of those who had less than a 9th grade education had a sedentary lifestyle, compared to 45% of those with a postgraduate degree (Figure 2).

In 1992, 49 states participated in the BRFSS survey. The median of sedentary lifestyle among participating states was 56.5%, ranging from 49.4% (Alabama) to 82.1% (South Dakota). There was a 7.3% increase in sedentary lifestyle nationwide from 1990 to 1992.

The BRFSS information is gathered via the telephone and is subject to bias. In particular, the data is self-reported and therefore cannot be substantiated. Also, the survey doesn't take into account how much physical activity is associated with job occupation.

One of the Healthy People 2000 Objectives is to achieve physical activity of at least 3 or more times per week, for at least 20 minutes per session. Health-care providers, we need to identify individual and social barriers that prevent physical activity and appropriate strategies to overcome these barriers.

Figure 3: Sedentary lifestyle by education



*HEALTHY PEOPLE 2000 Physical Activity Objectives are part of a national strategy developed by the public health service of the U.S. Department of Health and Human Services.*

*1.4a: Increase to at least 12% the proportion of lower-income people aged 18 and older (annual family income less than \$20,000) who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion.*

*1.5a: Reduce to no more than 22% the proportion of people aged 65 and older who engage in no leisure-time physical activity.*

*1.5b: Reduce to no more than 20% the proportion of people with disabilities who engage in no leisure-time physical activity.*

### AIDS UPDATE: HIV INFECTION IN WOMEN AND INFANTS

One of the objectives of the survey of childbearing women is to assess the impact of HIV infection in women and babies born in the state.

The survey of childbearing women is a statewide blinded survey of over 84% of babies born in the state. The survey was initiated in Louisiana in mid-1989. The study utilizes blood samples from the PKU testing of newborns to measure HIV antibodies. These antibodies indicate HIV infection in the mother, not the infant.

From 1989 through 1993 the overall seropositivity rate in the survey was 15 per 10,000 women (4 per 10,000 for white and 29 per 10,000 for black). To estimate the number of HIV infected women we applied the infection rates of women in the survey to the population census of women 15-44 years of age. The estimated number of HIV infected women increased from 1,105 in 1989 to 1,327 in 1993 (Figure 1). Estimates were also calculated for the geographic regions in the state for 1993 (Figure 2). The Baton Rouge area (Region 2) had the highest number of HIV infected women. The metro New Orleans area (Region 1) and the northern part of the state have had the most significant increases over the five year study period. The racial distribution of the prevalence of HIV infection was similar to that of AIDS case reports for women and children

Figure 1: Estimated prevalence of HIV infection in women, ages 15-44 by race

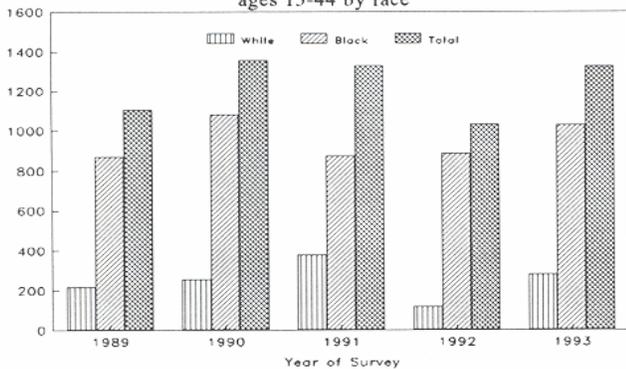
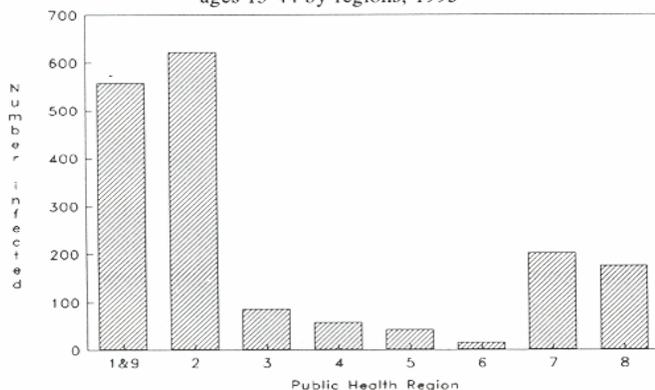


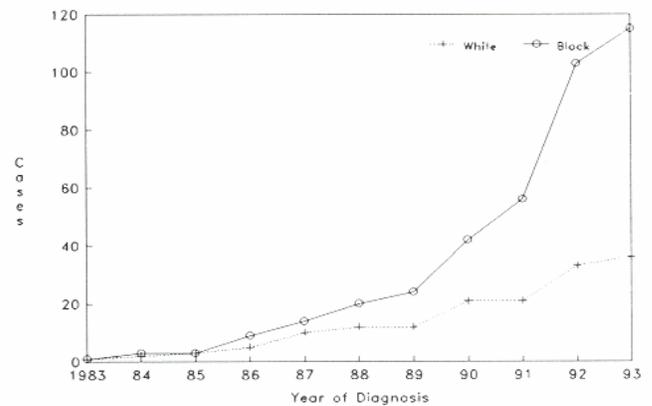
Figure 2: Estimated prevalence of HIV infection in women, ages 15-44 by regions, 1993



in that a higher proportion of cases occurred in the black population (Figure 3). However, the number of HIV-infected white women increased each year.

The serosurvey data also enable us to estimate the number of children born each year to HIV-infected women, and the number who themselves are HIV infected. The number of infected children will increase with the number

Figure 3: AIDS case trends in women by race

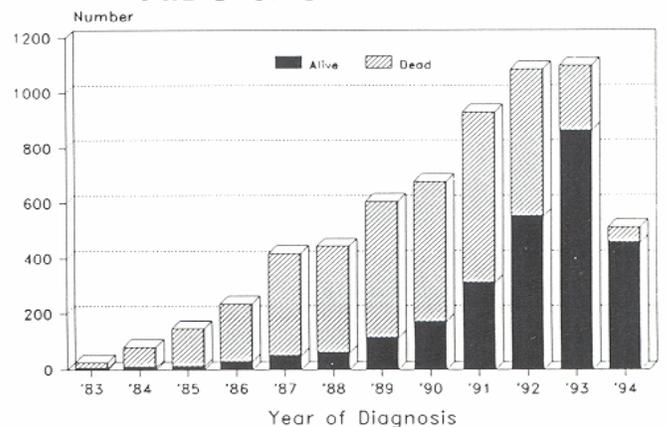


of infected women. An estimated 110 infected women delivered children in 1993. These infected children came from every region of the state. Assuming a mother to child transmission rate of 27%, approximately 30 of these children were HIV infected. If the transmission rate were decreased to 8% (that found in a recent study of the effect of AZT on perinatal transmission) then only 9 infants would be HIV infected. Thus routine use of AZT in all pregnant HIV-infected women could possibly save the lives of 21 infants each year.

Results from this analysis point to the need for routine HIV counseling and testing of pregnant women and referral of HIV infected women for AZT therapy.

**NOTE: In the last issue of *AIDS Update*, figures 3 & 4 were reversed.**

### AIDS CASE TRENDS



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE,  
JULY - AUGUST, 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	Jul-Aug 1994	Jul-Aug 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	1	0	0	0	1	1	0	1	0	4	4	22	15	+47
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	1	-
Pertussis	0	1	0	0	0	0	1	1	1	4	2	10	7	+43
<u>Sexually-transmitted</u>														
AIDS	Cases	38	6	4	2	2	4	5	6	69	173	512	771	-34
	Rate <sup>1</sup>	3.5	1.1	1.1	0.4	0.8	0.6	0.8	1.4	1.6	4.0	11.9	17.9	
Gonorrhea	Cases	952	198	119	142	94	352	131	106	2184	2288	8327	8919	-6.6
	Rate <sup>2</sup>	9.2	3.6	3.3	2.9	3.6	2.9	7.0	3.8	5.2	5.4	19.7	21.1	
Syphilis(P&S)	Cases	46	62	27	34	0	7	52	33	293	454	1208	1767	-31.0
	Rate <sup>2</sup>	0.4	1.1	0.8	0.7	0.0	0.2	1.0	0.9	0.7	1.1	2.9	4.2	
<u>Enteric</u>														
Campylobacter		5	6	10	5	2	0	0	6	34	35	87	112	-22
Hepatitis A	Cases	12	6	0	0	4	3	1	0	6	32	116	57	+104
	Rate <sup>1</sup>	1.6	0.8	-	-	1.5	1.0	0.2	-	1.3	0.8	2.8	1.4	
Salmonella	Cases	22	14	6	20	11	3	10	5	101	113	320	250	+28
	Rate <sup>1</sup>	3.0	1.9	2.0	3.6	4.2	1.0	1.8	1.6	2.4	2.7	7.6	5.9	
Shigella	Cases	21	6	1	7	9	6	5	3	88	113	279	272	+
	Rate <sup>1</sup>	2.9	0.8	0.3	1.3	3.5	1.9	0.9	1.0	2.1	2.7	6.6	6.5	
Vibrio cholera		0	0	0	0	0	0	0	0	0	1	0	1	-
Vibrio, other		5	1	3	2	1	0	0	3	15	8	33	22	+50
<u>Other</u>														
Hepatitis B	Cases	7	3	1	3	1	6	0	1	23	46	125	156	-20
	Rate <sup>1</sup>	1.0	0.4	0.3	0.5	0.4	0.3	1.1	--	0.2	0.5	3.0	3.7	
<u>Meningitis/Bacteremia</u>														
H. influenzae		0	1	0	0	0	0	0	0	1	0	4	3	+33
N. meningitidis		4	0	0	1	0	0	0	1	6	4	28	29	-3
Tuberculosis	Cases	0	0	0	1	1	0	0	0	2	-	116	-	-
	Rate <sup>1</sup>	-	-	-	0.2	0.4	-	-	-	0.5	-	2.8	-	

1 = Cases per 100,000

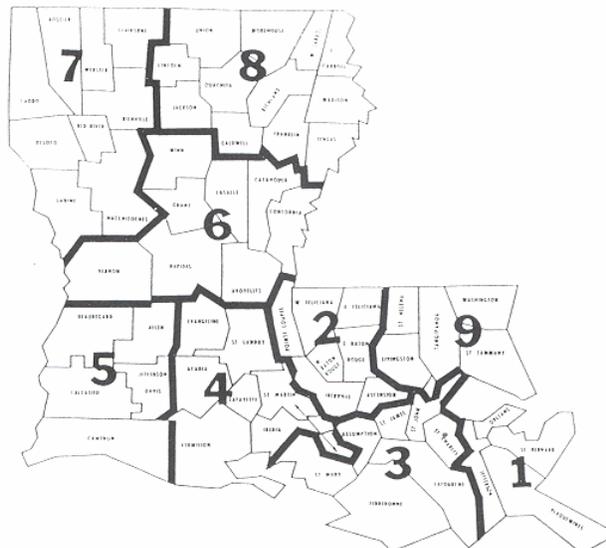
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Brucellosis	2
Histoplasmosis	1
Lead Toxicity	0
Legionellosis	10
Lyme Disease	2
Malaria	6
Tetanus	0
Typhoid	4

Table 3. Animal Rabies (Jul-Aug, 1994)

Parish	No. Cases	Species
Lafayette	1	Skunk
Vermilion	2	Skunks
Jefferson	1	Bat
Ouachita	1	Bat
Morehouse	1	Dog



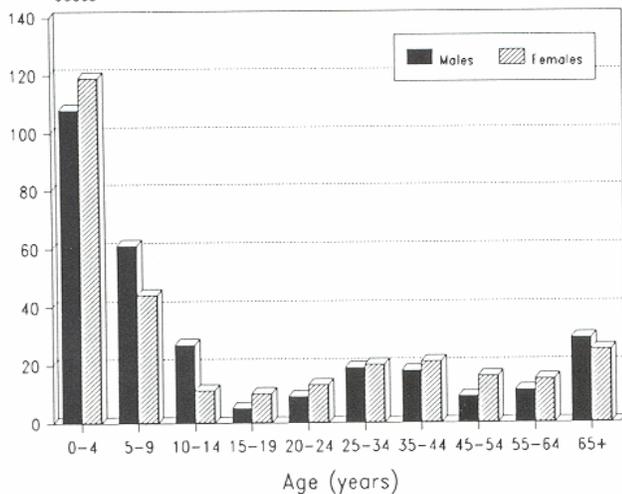
## Annual Summary Salmonellosis, 1993

Six hundred fifty cases of salmonellosis were reported for 1993, a case rate of 15 per 100,000. Sex-specific rates were similar among males vs females (16 vs 15 per 100,000) and race-specific rates did not differ between blacks vs whites (6.5 vs 6.9 per 100,000). Fifty six percent of the cases occurred in age groups less than 10 years of age which has been a consistent pattern of disease for salmonella infections (Figure 1). Two outbreaks of salmonellosis were identified during 1993 which include a church outing and a convention tour lunch. Of 27 salmonella serotypes isolated, the largest number were *S. typhimurium* (52), *S. newport* (46), *S. enteritidis* (34), *S. heidelberg* (33), *S. mississippi* (30) and *S. javiana* (20). Parishes with the highest case rates per 100,000 include: Allen (28), Lafayette (27), Terrebonne (25), Calcasieu, St. Tammany, Vermilion (24 each), Washington (23) and Evangeline [(21), Figure 2].

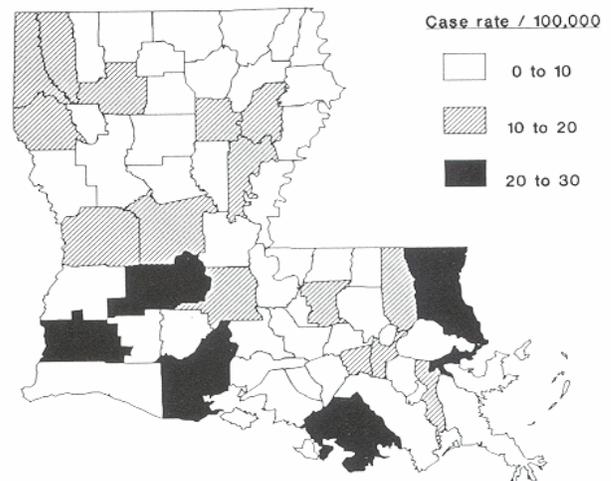
*Comment:*

Total case reports for salmonellosis did not differ significantly from 1992 (639 cases). Reported cases for this year is 10% below the five year mean of 724 cases. *Salmonella enteritidis* continues to rank within the top three serotypes most frequently identified, however, it has not become the predominant serotype as it has in other states in which eggs have been implicated. Children less than 5 years of age remain as the highest susceptible population, which has been a consistent trend over the last five years. Outbreaks of salmonella infection are unusual in child care programs. General measures for interrupting enteric transmission in child care centers are recommended.

**Figure 1:** Cases of salmonellosis by age and sex, 1993



**Figure 2:** Rates of salmonellosis by parish, 1993



### LOUISIANA FACTS

According to the "Report of the Health and Sanitary Survey of the City of New Orleans for 1918-1919," the crude tuberculosis of the lungs death rate per 100,000 in New Orleans during 1917 was 290.2, the rate for whites was 191.8 and for blacks was 570.0. This crude death rate was higher than any other city in the United States Bureau of the Census (1916) Registration Area. The table below compares New Orleans with several other cities which had an age distribution in their population comparable with the age distribution in New Orleans.

Comparison of Tuberculosis (All Forms) Death Rates Per 100,000 Population,  
In New Orleans With Other Cities 1906-1916

	1916	1915	1914	1913	1912	1911	Annual Average 1906-1910
<b>White</b>							
New Orleans, LA	172.9	176.6	196.1	159.3	182.2	173.3	206.3
Birmingham, AL	79.0	86.5	107.3	100.2	122.0	113.8	
Atlanta, GA	91.2	83.4	94.9	101.5	96.4	125.8	145.8
Richmond, VA	145.0	139.1	135.6	130.3	178.9	162.3	189.1
<b>Black</b>							
New Orleans, LA	627.3	660.1	565.3	516.3	498.1	503.8	528.1
Birmingham, AL	408.4	406.6	448.8	432.8	341.0	413.2	
Atlanta, GA	265.8	236.3	206.0	250.3	242.5	327.1	305.3
Richmond, VA	364.3	340.4	364.2	334.1	361.3	403.3	380.4

## LIST OF REPORTABLE DISEASES/CONDITIONS

	REPORTABLE DISEASES		OTHER REPORTABLE CONDITIONS
Acquired Immune Deficiency Syndrome (AIDS)	Granuloma Inguinale**	Plague*	Cancer
Amebiasis	Hepatitis (Specify type)	Poliomyelitis	Complications of abortion
Anthrax	Herpes (genitalis/ neonatal)**	Psittacosis	Congenital hypothyroidism
Aseptic meningitis	Human Immuno- deficiency Virus (HIV)	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)	
Gonorrhoea**	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 FAX # 504-568-3206

This public document was published at a total cost of \$1,388.09. Seven thousand copies of this public document were published in this first printing at a cost of \$1,388.09. The total cost of all printings of this document including reprints is \$1,388.09. This document was published by Moran Printing, Inc., 5425 Florida Blvd., Baton Rouge, LA 70806, to inform Physicians, hospitals, and the public of current Louisiana morbidity status under authority of R.S. 40:36. This material is printed in accordance with the standards for printing by state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with the provisions of Title 43 of the Louisiana Revised Statutes.