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GOVERNOR

# Louisiana Morbidity Report

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## Community Exposure to Nitrogen Tetroxide, Bogalusa

On October 23, 1995 a railroad tank car containing nitrogen tetroxide ruptured, releasing the chemical into the town of Bogalusa. Three thousand people were evacuated for up to two nights. The Office of Public Health investigated the health effects of this chemical release.

Nitrogen tetroxide, (N<sub>2</sub>O<sub>4</sub>) degrades to nitrogen dioxide, (NO<sub>2</sub>) when released into the atmosphere. When combined with water, it forms nitric acid. High level exposure to NO<sub>2</sub> in the range of 50-100 parts per million (ppm), causes burns, pulmonary edema, and death. Low level exposure (10-13 ppm) causes eye, nose, throat, and bronchial irritation.

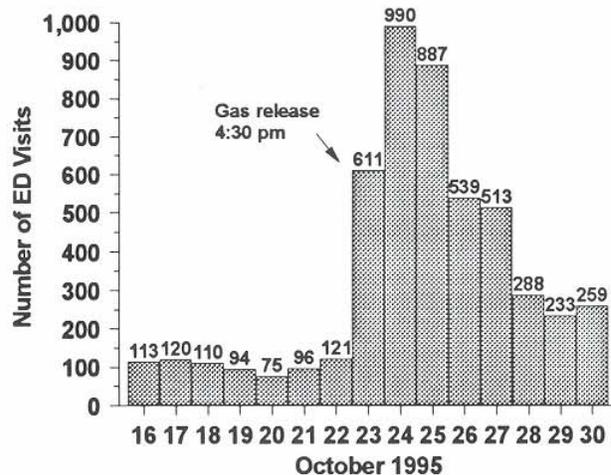
Following the gas release, the number of emergency department (ED) visits to three local hospitals increased five-fold (Figure 1). The most common symptoms seen among a sample of 528 visits in the first 30 hours after the release were headache (31%), burning eyes (30%), sore throat (24%), nausea (22%), and shortness of breath (18%). In 6% of visits, the patient left without being seen, and in 5% of visits, the patient had no complaint. Objective pulmonary findings were recorded in 165 visits in the week after the release, compared to 41 visits in the week prior, a four-fold increase (Figure 2). Objective pulmonary findings consisted of: an abnormal lung exam (150, 91%), either an O<sub>2</sub> saturation of less than 90% or a PaO<sub>2</sub> less than 90 mm. Hg (46, 28%), or an abnormal chest X-ray (36, 22%). There were no cases of

pulmonary edema and no deaths associated with the release.

OPH conducted a case control study to measure the association between acute exposure to NO<sub>2</sub> and pulmonary symptoms. A person was included as a case if he or she had one of the objective pulmonary findings described above, had onset of symptoms and visited the ED in the week after the release, and was within the city limits at the time of the release. Controls were community residents or plant or emergency workers who responded to a health department survey, were within the city limits at the time of the release and denied symptoms in the week after the release. Three controls per case, or 201 controls, were entered into the study.

Figure 3 shows the unadjusted odds ratio (OR) for case

Figure 1: Emergency department visits, October 16-30, 1995, Bogalusa



status at the site of the release and at each quarter mile increment in distance from the site relative to those who were more than one mile away (but within the city limits). In both this unadjusted data and in a multivariate model, cases were significantly more likely than controls to have been closer to the site. The odds of being a case increased by 40% for each quarter mile increment in proximity to the site (OR=1.4, 95% confidence limits (CL)=1.1, 1.8). In addition, cases were 4 times as likely as controls to have been on site (OR=4.1, CL=0.6, 26.0), 3.5 times as likely to have been southeast of the site (OR=3.5, (Continued on page two)

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Community Exposure to Nitrogen Tetroxide, Bogalusa (Cont.)

CL=1.2, 10.9); and 2.7 times as likely to have been northwest (OR=2.7, CL=0.9, 8.4), all relative to the low risk southwesterly direction. Cases were 2.4 times as likely as controls to have been outside at the time of the release (OR=2.4, CL=1.2, 4.9), 5 times as likely to have a pre-existing pulmonary condition (OR=5, CL=2.4, 10.6) and 5.6 times as likely to have no health insurance or to have Medicaid (OR=5.6, CL=2.5, 12.6). There were no differences between cases and controls with regard to age, sex, and smoking status.

In conclusion, this release of nitrogen tetroxide was associated with objective health problems. Persons with a pre-existing pulmonary disease appeared to be more susceptible. Symptoms seen in the emergency departments were consistent with low level exposure.

Figure 2: Emergency department visits with objective pulmonary findings October 16-30, 1995, Bogalusa

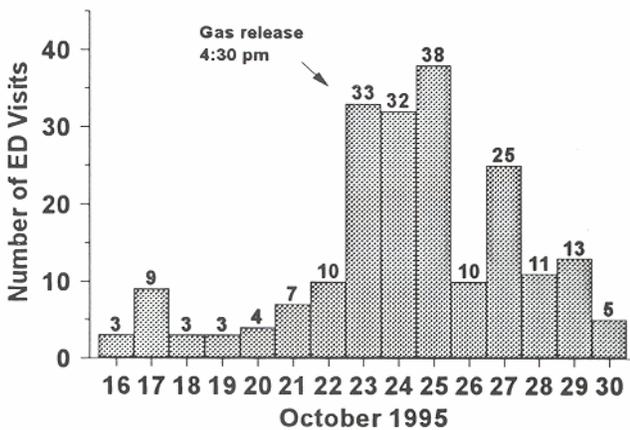
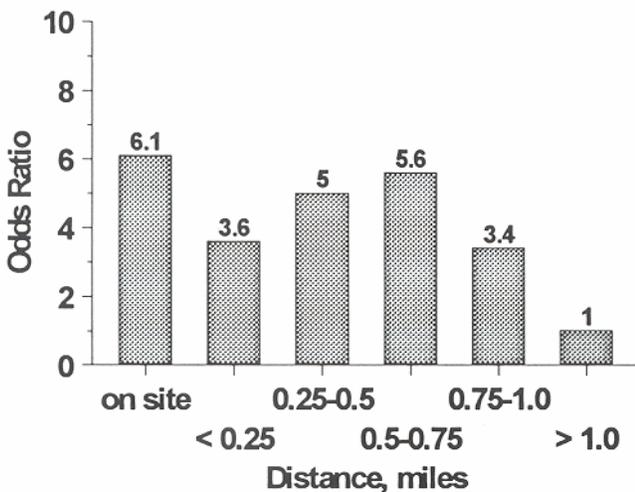


Figure 3: Unadjusted odds ratios for case status by distance from the site of the release



$\chi^2$ , trend = 13.0,  $p=0.0003$

## Prevention of Group B Streptococcal Infection

Last year the Epidemiology Section published in the Louisiana Morbidity Report a summary of draft guidelines developed by the Centers for Disease Control and Prevention (CDC) for prevention of Group B Streptococcal (GBS) infection in infants. Although Group B Streptococcal infection in infants is not regularly reported in Louisiana, it is known nationally to be the major infectious cause of severe illness and death among newborns, occurring at a rate of 1.8 infections per 1,000 live births. The case fatality rate for GBS infection is estimated to be 5-20%, and many survivors develop permanent neurologic damage. Studies in recent years have found that most GBS infections in infants can be prevented if mothers who are carriers of GBS during the last trimester and who have certain risk factors are given antibiotics during labor and delivery. Because of these findings, the CDC guidelines called for routine screening of pregnant women by vaginal and rectal cultures for GBS carriage at 26-28 weeks of gestation and treatment of women carrying GBS with intrapartum antibiotics if they had intrapartum fever, prolonged rupture of membranes (> 12 hours) or premature labor (< 37 weeks gestation). Nationally, health care providers have commented on these guidelines, but the final version of the guidelines has not yet been published. To understand what are the current practices in Louisiana, the Epidemiology

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Section conducted a survey of obstetricians and hospital labor and delivery staff in August of 1995.

A total of 167 randomly selected obstetricians (including all rural obstetricians and a 25% sample of urban obstetricians) were mailed surveys and 140 (84%) returned them. Of those returning surveys, only 27% (38) reported routinely screening for GBS with rectal and vaginal cultures at 26-28 weeks gestation. Three others marked on the questionnaire that they screened at a different gestational age and three reported that they screened using vaginal cultures only. The large majority of obstetricians reported that they routinely treated women with intrapartum antibiotics if they were known to be GBS culture-positive and had intrapartum fever (96%), rupture of membranes of longer than 12 hours (92%), or onset of labor before 37 weeks gestation (86%). A smaller percentage (79%) of obstetricians reported treatment with intrapartum antibiotics if any of these risk factors were present and the GBS status was unknown. There were no significant differences in these practices between urban and rural obstetricians.

Of the 68 hospitals with labor and delivery areas surveyed, 66 (97%) provided information about GBS practices. Only 21% (14) of hospitals reported that they routinely performed GBS cultures at the time of delivery if the GBS status of the mother was unknown at that time. Eighty percent of hospitals reported that women with positive GBS cultures and risk factors listed above were routinely treated with antibiotics. Fifty-five percent reported routinely treating infants with prophylactic antibiotics if GBS culture-positive women with risk factors delivered before antibiotics were given.

In summary, the CDC guidelines under consideration are similar to current practices in Louisiana with regard to treatment of women known to be carrying GBS in the third trimester, but differ substantially with regard to practices of screening of women and treatment of infants. The Epidemiology Section will circulate or publish a summary of the CDC guidelines when they are finalized; in the meantime, obstetricians and hospital staff may want to review the draft guidelines and establish routine screening for GBS in the third trimester, with screening at delivery for women who were missed at that time.

## Fish Consumption Advisories

Because of chemical contamination in the fish from Sibley Lake in Natchitoches Parish, and Henderson Lake in St. Martin Parish, [Fish Consumption Advisories](#) have been issued which provide restrictions on the ingestion of fish from these waters.

The Henderson Lake Advisory is new; and the Sibley Lake Advisory is an update from a previous, more restrictive advisory which was issued in 1989, (Table).

Location	Parish	Fish Consumption Advisory	Pollutant
Sibley Lake	Natchitoches	Select one of the two options largemouth bass or crappie - 1 meal*/week; or channel cat, striped bass - 1 meal/month. Do Not eat shad, gar, or carp.	PCB
Henderson Lake	St. Mary	Fish consumption by pregnant women, breastfeeding women, and children less than 7 years of age - no more than 1 meal per month of largemouth bass, crappie, and freshwater drum.	Mercury

\* 1 meal = approximately 1/2 lb. of fish.

**This advisory does not imply that persons have to stop eating fish.** Fish are a nutritious food source, which are high in protein and other nutrients, and low in fat. But to prevent an increased health risk from eating contaminated fish, it is advised that people adhere to the restrictions from the [Fish Consumption Advisories](#).

Certain chemicals, such as PCB's, are stored in body fat areas of humans and animals. For this reason, it is important to cut away, or "Trim" the fat from fish, because it will decrease the amount of chemicals in the fish.

- Remove all organs and skin. Organs and skin can be high in fat and organic chemicals.
- Trim off the fatty areas. This includes the belly fat, side fat, and back fat. Organic contaminants concentrate in the fat.
- Bake or broil skinned, trimmed fish on a rack or grill so fat drips off. Throw away the drippings.

The Fish Consumption Advisories have been issued by the Louisiana Office of Public Health Section of Environmental Epidemiology, in collaboration with the Department of Environmental Quality and the Department of Wildlife and Fisheries. Such advisories are issued when it is found that unacceptable levels of chemical contaminants are present in the fish; and certain activities and practices, such as fishing and fish consumption, may pose a threat to the public's health. This is particularly important for children and pregnant women, who are more vulnerable to chemical contamination, and subsistence fisherman, who are at greater risk of chemical toxicity.

Health effects from ingesting contaminated fish are not likely to occur from one meal. The levels of contamination will not cause harm after a single, or a few meals. The health risk, and the possibility of a health effect, arises from frequently eating contaminated fish, or eating fish over a long period of time.

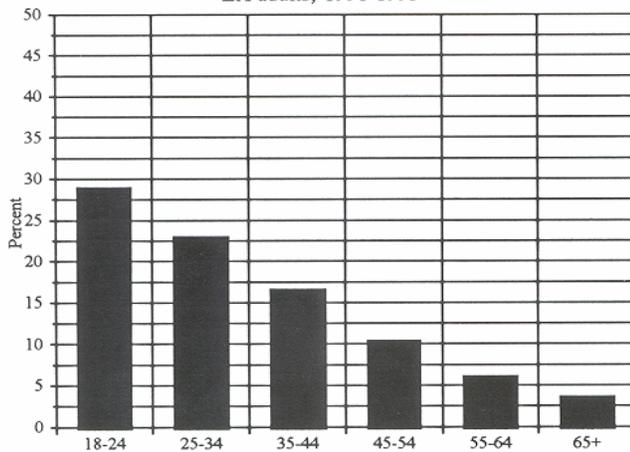
If you would like more information about [Fish Consumption Advisories](#), or if you have any questions about this information, call the Environmental Epidemiology Section at (504) 568-8537.

## Alcohol Abuse in Louisiana, 1991-1993

Since 1991, the Office of Public Health with assistance from Northeast Louisiana University, Center for Business and Economic Research annually has conducted a randomized phone survey (Behavior Risk Factor Surveillance System-BRFSS) of Louisiana adults 18 and older regarding a variety of health behaviors. Part of the survey centers on the use of alcohol.

Approximately one in seven Louisianans drank five or more drinks on one or more than one occasion (binge drinking) within the past month. Males (26%) were approximately 3.5 ( $p < 0.01$ ) times as likely to report binge drinking than females (7%). Whites (18%) reported binge drinking significantly ( $p < 0.01$ ) more frequently than African Americans (11.9%). Young adults (age 18-34) reported binge drinking at three times the rate of persons 35 years and older (26% vs 9%,  $p < .01$ ; Figure 1).

Figure 1: Five or more drinks on an occasion, LA adults, 1991-1993



Three percent (3%) of Louisiana adults admitted to drinking an average of two or more alcoholic drinks per day (heavy drinking) within the last month. Males were eight times as likely to drink excessively on a daily basis than females (6.5% vs 0.8%,  $p < 0.01$ ). A similar proportion of whites (3.7%) and African Americans (2.6%) reported heavy daily drinking. Persons ages 18-34 were twice as likely ( $p < 0.025$ ) to drink heavily as persons 35 years of age and older (5.0% vs 2.3%), Figure 2.

Heavy and binge drinking rates did not change significantly ( $p < 0.2$ ) from 1991 to 1993, Figure 3. Moderate drinking (less than two drinks per day) may actually improve health, but heavier drinking (two or more drinks per day), binge drinking (five or more drinks on an occasion), and driving after drinking are dangerous.

The national Healthy People 2000 objective for alcohol usage is to reduce the consumption by people aged 14 and older to an average of no more than 0.7 oz of ethanol (12 oz of beer, 5 oz of wine, or 1.5 oz of hard liquor) per person per day. Trends suggest that the 18-24 year old group have a high incidence of alcohol use. Further studies are indicated and increased efforts to decrease heavy alcohol use in Louisiana need to be targeted toward this younger male population.

Figure 2: Average of 60 or more drinks a month, LA adults, 1991-1993

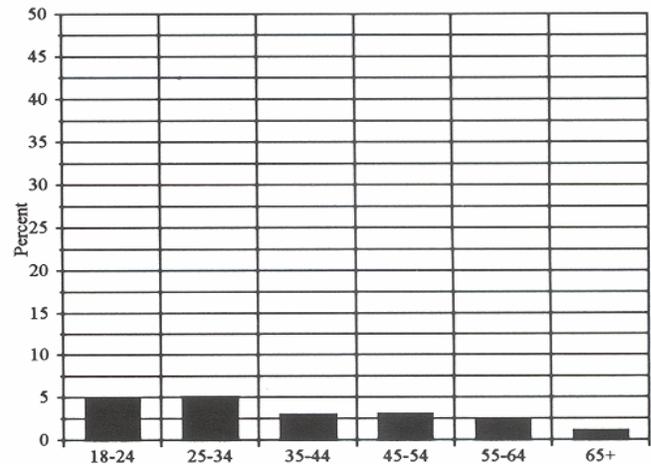
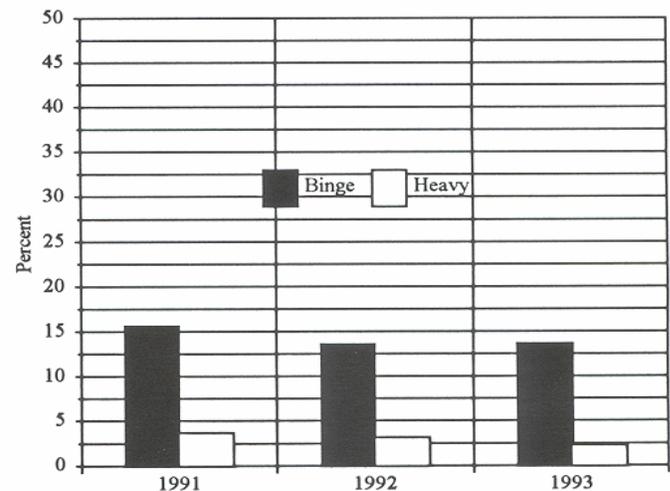


Figure 3: Alcohol abuse among LA adults, 1991-1993



## AIDS UPDATE Pediatric HIV Cases

To date, there have been 157 children reported with HIV infection in Louisiana; of these, 102 have progressed to AIDS. The majority (83%) of cases were infected through perinatal transmission, 8% were hemophiliacs, 5% received blood transfusions, and in 4% of cases the mode of transmission was unknown. Eighty percent of cases are in African Americans, and 19% are in Caucasians; less than 1% are in Hispanics. Regionally, the New Orleans area, the Baton Rouge area, and the Shreveport area represent the highest number of cases with 50%, 17% and 11% of the total cases respectively. Thus far, 52 children are known to have died.

In addition to the 157 cases of HIV infection, reporting data shows 173 babies have been born to HIV infected mothers in this state since HIV reporting began in 1993. Sixty-two (36%) of these exposed babies have been found to be not infected; the HIV infection status of the others is as yet undetermined.

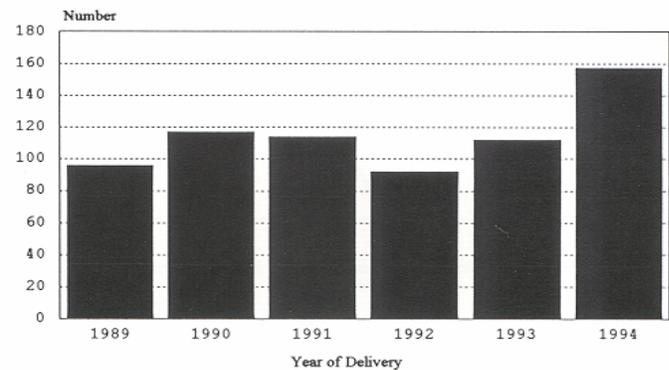
Cases related to transmission via blood and blood products are on the decline. However, as the number of HIV infected women increase so will the risk of perinatal transmission. A survey which monitors the prevalence of HIV infection in childbearing women shows an increase from 988 through 1994 (0.10 to 0.24% respectively). Louisiana is one of the few states in which infection rates are increasing; most other state's rates in women have stabilized or declined. Figure 1 shows the number of HIV infected women giving birth per year; approximately 25% of these babies could be infected with HIV. Prevention guidelines (i.e., AZT therapy for pregnant women) recommended in 1994 may reduce transmission to 8%.

Figure 2 demonstrates the known HIV/AIDS cases among children exposed perinatally in Louisiana. There is a decrease in infected cases since 1993. The decrease in cases of HIV infection - both overall and as a proportion of the number of HIV-infected women giving birth - may reflect decreased reporting or may reflect actual decreases in transmission due

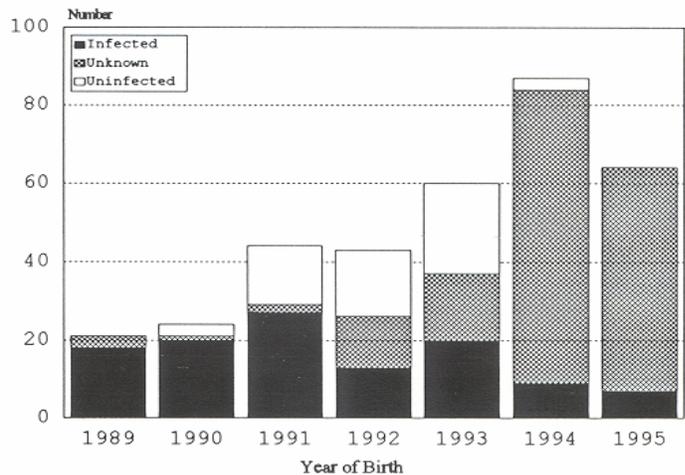
to AZT use during pregnancy and postpartum. In 1994 when reporting of all pediatric cases became more systematic, 45% of the cases were not reported (Fig. 3). Of concern is that cases may not be reported because they are not diagnosed.

The importance of reporting all cases of HIV infection or perinatal exposure in children must be emphasized. This data is used not only to monitor the epidemic, but also to evaluate compliance and effectiveness of prevention guidelines. Under current practices, pediatric HIV infection should be considered a preventable disease.

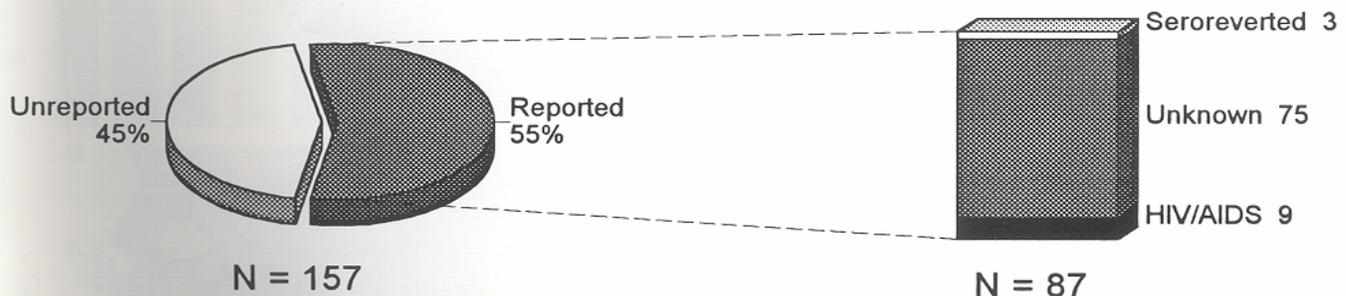
**Figure 1: Estimates of infants born to HIV-infected women**



**Figure 2: Perinatally exposed infants - comparison by HIV infection status**



**Figure 3: Infants born to HIV-infected women vs reported cases, 1994**



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE

JANUARY - FEBRUARY, 1996

PROVISIONAL DATA

Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION									TIME PERIOD				% Chg
	1	2	3	4	5	6	7	8	9	Jan-Feb 1996	Jan-Feb 1995	Cum 1996	Cum 1995	
<u>Vaccine-preventable</u>														
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	2	1	0	0	0	1	0	0	2	6	1	6	1	+500
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	1	0	1	0	0	0	0	0	0	2	0	2	0	-
<u>Sexually-transmitted</u>														
AIDS Cases	48	15	4	4	2	2	1	4	6	86	142	86	142	-39
AIDS Rate <sup>1</sup>	4.4	2.7	1.1	0.8	0.8	0.6	0.2	1.2	1.7	2.0	3.3	2.0	3.3	
Gonorrhea Cases	835	167	68	166	66	109	261	96	102	1870	1953	1870	1953	-4
Gonorrhea Rate <sup>2</sup>	8.0	2.9	1.8	3.2	2.5	3.6	5.2	2.7	2.6	4.4	4.6	4.4	4.6	
Syphilis(P&S) Cases	41	18	0	5	1	11	19	19	7	111	174	111	174	-37
Syphilis(P&S) Rate <sup>2</sup>	0.4	0.3	-	0.1	0.04	0.4	0.4	0.4	0.2	0.3	0.4	0.3	0.4	
<u>Enteric</u>														
<i>Campylobacter</i>	3	2	0	0	0	0	0	1	2	19	14	19	14	+36
Hepatitis A Cases	0	2	0	1	0	0	2	7	0	12	9	12	11	+9
Hepatitis A Rate <sup>1</sup>	-	0.4	-	0.2	-	-	0.4	2.0	-	0.3	0.2	0.3	0.3	
<i>Salmonella</i> Cases	2	1	1	9	0	0	0	1	2	20	18	20	18	+11
<i>Salmonella</i> Rate <sup>1</sup>	0.2	0.2	0.3	1.7	-	-	-	0.3	0.5	0.5	0.4	0.5	0.4	
<i>Shigella</i> Cases	27	11	4	1	2	1	15	1	8	81	24	81	24	+238
<i>Shigella</i> Rate <sup>1</sup>	2.6	1.9	1.1	0.2	0.7	0.3	3.0	0.3	2.1	1.9	0.6	1.9	0.6	
<i>Vibrio cholera</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-
<i>Vibrio</i> , other	0	0	0	0	0	0	0	0	0	0	1	0	1	-
<u>Other</u>														
Hepatitis B Cases	1	3	1	0	1	0	1	3	2	12	18	12	18	-33
Hepatitis B Rate <sup>1</sup>	0.1	0.5	0.3	-	0.4	-	0.2	0.9	0.5	0.3	0.4	0.3	0.4	
Meningitis/Bacteremia														
<i>H. influenzae</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	-
<i>N. meningitidis</i>	10	3	0	3	0	1	0	0	1	18	11	18	11	+64
Tuberculosis <sup>3</sup> Cases	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A
Tuberculosis <sup>3</sup> Rate <sup>1</sup>	-	-	-	-	-	-	-	-	-	N/A	N/A	N/A	N/A	N/A

1 = Cases per 100,000

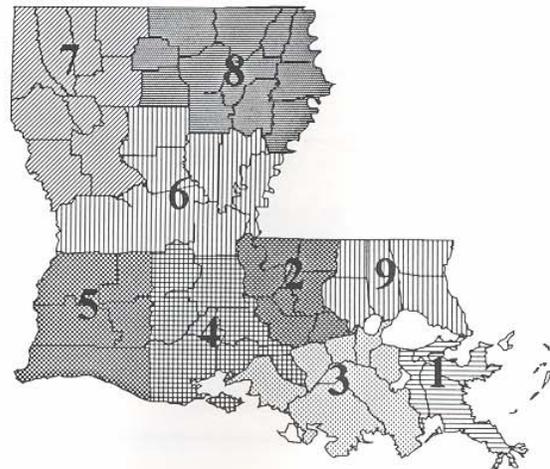
2 = Cases per 10,000

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	0
Histoplasmosis	0
Legionellosis	0
Lyme Disease	0
Malaria	0
Rocky Mountain Spotted Fever	0
Tetanus	0
Typhoid	0
Lead Toxicity	0

Table 3. Animal Rabies (Jan-Feb 1995)

Parish	No. Cases	Species
Acadia	1	Skunk
Lafayette	1	Skunks
St. Landry	2	Skunks



## Annual Summary Salmonellosis, 1995

In 1995, five hundred ninety cases of salmonella infections were reported to the Epidemiology Section, a 9% decrease from 1994 (Figure 1). The overall state case rate was 14 per 100,000. Sex-specific rates were higher for white males (7.5/100,000) than white females (6.1), black males and females (5.0, respectfully). Cases by age has been consistent with previous years in which 51% of the cases occurred in the age groups less than 15 years (Figure 2). The serotype was identified and reported for 62% of the cases. Of the twenty-six serotypes isolated, the most frequently reported isolates were: *S. newport* (93), *S. typhimurium* (66), *S. Mississipp*i (42) and *S. enteritidis* [28, Table]. Four parishes reported case rates double the overall state case rate. They include (per 100,000): Tensas (30), Lafayette (29), Caddo and St. James [28 each, Figure 3].

Figure 2: Cases of salmonellosis by age and sex, 1996

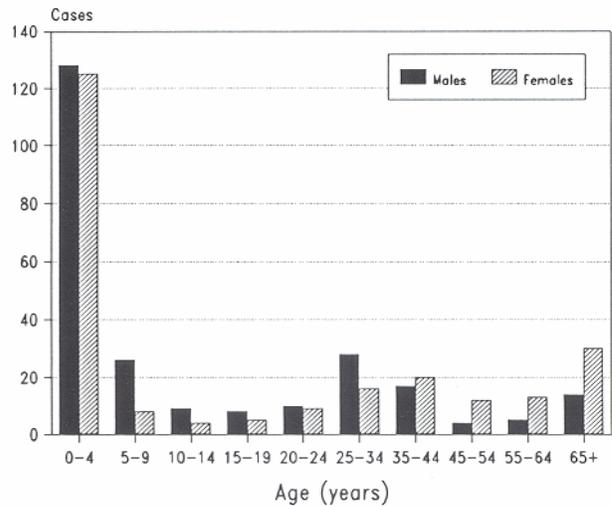


Table: Frequency of salmonella serotypes, 1993-1995

Serotype	1993			1994			1995		
	Cases	Rank	%	Cases	Rank	%	Cases	Rank	%
newport	46	2	13	73	2	12	93	1	26
typhimurium	52	1	14	87	1	15	66	2	18
mississippi	30	5	8	35	3	6	42	3	12
enteritidis	34	3	9	32	4	5	28	4	8
javiana	20	6	5	21	5	4	26	5	7
heidelberg	33	4	9	19	7	3	17	6	5

Figure 3: Rates of salmonellosis by parish, 1996

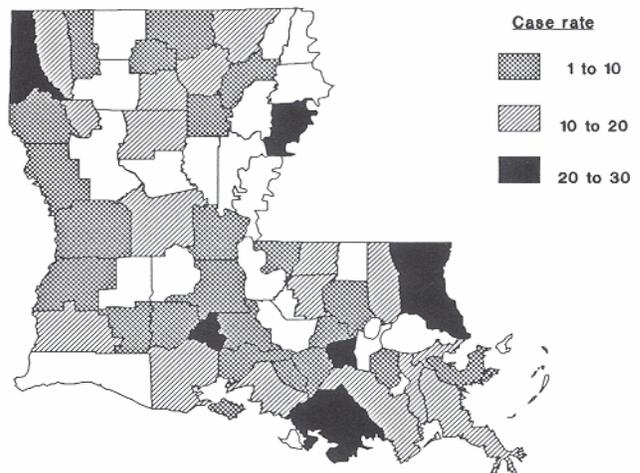
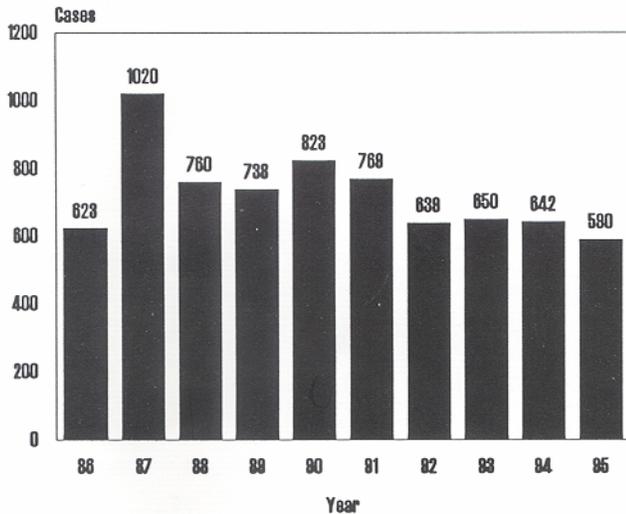


Figure 1: Cases of salmonellosis by year, 1986-1996



### LOUISIANA FACTS

*New Orleans' first effective Board of Health was established on July 9, 1804. Health issues confronted at that time included: requiring butchers to clean slaughterhouses of all accumulated filth, requiring that all garbage and filth be thrown into the river instead of being dumped near the Protestant cemetery; passing an ordinance necessitating "all Physicians, Surgeons, and Apothecaries pass an examination before the Faculty, when they could not produce their diplomas..."; burying the dead too close to the surface of the ground; and the failure to maintain sanitary conditions at Charity Hospital.*  
 Taken from *The Formative Years* by Gordon Gillson.

# LIST OF REPORTABLE DISEASES/CONDITIONS

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

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 Lab 94 form (Retrovirus). Name and street address are optional but city and ZIP code must be recorded.

+ 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 # 504-568-5006**

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