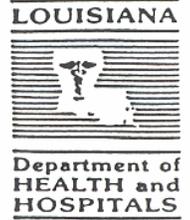




# Louisiana Morbidity Report

Louisiana Office of Public Health - Epidemiology Section  
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Volume 7 Number 6

## Teenage Pregnancy in Louisiana

In 1995 in Louisiana 13,274 girls aged 15-19 became pregnant and 12,351 gave birth, constituting 20% of all babies born in Louisiana. Approximately 9,300 of these youth were unmarried. In 1994 the birth rate among girls age 15-19 in Louisiana was 27% higher than in the U.S. as a whole (75 vs. 59 per 1,000), and the birth rate among girls age 15-17 was 34% higher (51 vs. 38 per 1,000). In this year Louisiana was 3rd among states in birth rate for girls age 15-17. After declining between the 1960s to 1980, teen birth rates in Louisiana have remained stable at this high rate since 1980 (Figure 1).

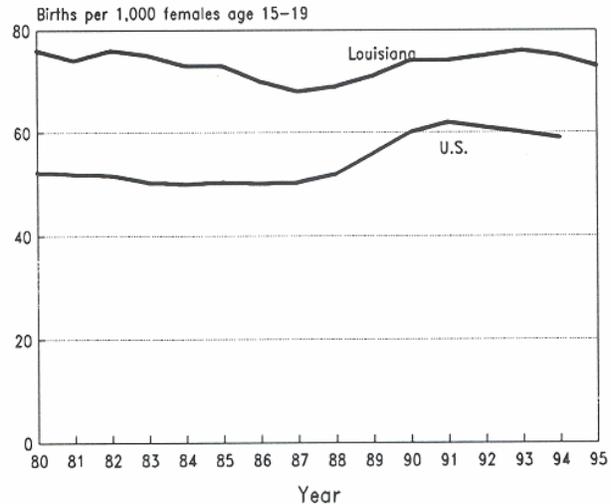
Of these births to 15 - 19 year olds, 12.3% were premature, 11.9% were of low birth rate and 184 died during their first year of life. These adverse outcomes are approximately 30% more frequent than the state average.

In 1994, 27 parishes have percent of births to 15-19 year olds above the state average of 20% (Figure 2). Concordia was the highest (33%), followed by Morehouse and Tensas (31%), and Washington (30%).

Sexually active and pregnant adolescents face many challenges and are at a higher risk to experience negative health outcomes than women 20 years of age and older. They receive less prenatal care. In 1995 only 57% of Louisiana's 15-19 year old pregnant teens received adequate prenatal

care, compared to a 74% of all mothers in the state and 81% of mothers in the nation. Of all adolescent mothers 68% have been sexually abused at some time between the ages of 12 and 17. They are also twice as likely to suffer physical abuse by a partner during pregnancy. Adolescents who are married are four times as likely to become divorced than older women. Adolescent mothers are three times as likely not to complete high school as adolescents who do not have children. Of all

Figure 1: Birth rate among females age 15-19 in Louisiana and U.S. 1980-1995



adolescent mothers in the United States 49% receive public assistance. In Louisiana over 40% of adolescent mothers are living below the poverty level.

The Louisiana Reproductive Health and Maternal & Child Health Programs at the Office of Public Health have identified prevention of adolescent pregnancy as a top priority. Principles of successful programs serve as guidelines for present efforts:

- A holistic approach. Inclusion of public and private sectors, community centered, sustainable, collaborative, and adolescent focused.
- Age-appropriate sex and family life education by parents and in the schools focusing on abstinence, delay of sexual activity, and access to information on safe sex practices and contraceptives

(Continued on page two)

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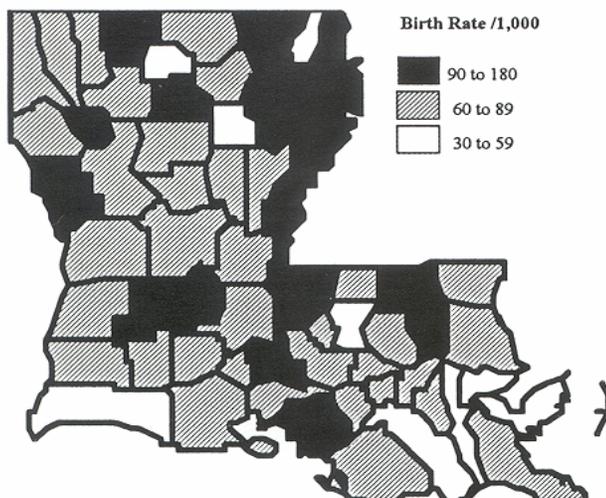
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## Teenage Pregnancy in Louisiana (Cont.)

- Comprehensive adolescent health clinics: community based, school based, and/or school linked.
- Culturally appropriate, intensive, developmental, long term programs that recognize family and community values.
- A multidisciplinary approach, including adult mentors, peers, and community members that have similar experiences.
- Multimessaged programs which include drop out prevention, real life options, job exploration, training, placement, and individual and family counseling when necessary.
- Youth involvement in program design, implementation, and evaluation.
- Coordinated, consistent messages to men and women.

Persons who are interested in joining statewide efforts or who would like to learn more about adolescent pregnancy prevention programs should call 1-504-568-5330.

Figure 2: Birth rate to females age 15-19 by parish, 1994



*Happy Holidays*



## Inpatient Tuberculosis Treatment Unit Available

A 15-bed unit for inpatient treatment of patients with tuberculosis has opened at Villa Feliciana Chronic Disease Hospital in East Feliciana Parish. This unit is intended for the treatment of patients with proven tuberculosis who require extended inpatient treatment because of problems with drug-resistance, drug intolerance, compliance with treatment, or homelessness. This unit is not meant to replace routine outpatient treatment using Directly-Observed Therapy, which is the standard of medical care in Louisiana. For those patients for whom inpatient care is necessary, however, the TB Unit at Villa Feliciana provides skilled nursing care and appropriate infection control measures to prevent the spread of tuberculosis to others. Medical care is provided by Dr. Bill Brown, an infectious disease physician with many years experience in the treatment of tuberculosis at the previous inpatient facility at Greenwell Springs.

Bed space is available at the TB Unit. Admissions are required to be approved by the Tuberculosis Control Program of the Office of Public Health. If you have a patient who would be appropriate for this facility, please contact your regional TB Supervisor through your nearest public health unit.

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## Acellular Pertussis Vaccine Approved For Infants

The FDA has approved a combination vaccine including an acellular pertussis component (DTaP) for use in place of DTP vaccine for children at 2, 4, and 6 months. The approved vaccine, Tripedia, is marketed by Lederle. It contains diphtheria toxoid and tetanus toxoid as well as the acellular pertussis component and it has previously been approved for use for the fourth and fifth doses in older children.

Studies in Europe showed excellent efficacy of this vaccine in comparison to whole-cell pertussis vaccine. In addition, the incidence of side effects was significantly less in children receiving the acellular combination rather than the whole-cell combinations. Redness, pain, and fever were all significantly less common in infants given DTaP, rather than whole-cell DTP. The severe side effect, encephalopathy, has not yet been reported in any child receiving DTaP.

Another manufacturer's acellular combination is expected to be approved shortly. In addition, several combinations of DTaP with other vaccines are already in the process of review by the FDA. These include DTaP-Hib, DTaP-HepB, and DTaP-IPV. For more information, contact the Immunization Program at 504-483-1900.

## Survey on Needle Sales

The HIV/AIDS section estimates that approximately one-third of AIDS cases in men in Louisiana and two-thirds of AIDS cases in women in Louisiana are directly or indirectly related to injecting drug use. These cases occur in drug users themselves as a result of needle sharing or in sex partners of drug users. Many of these cases can be prevented if drug users who are not willing or not able to enter drug treatment have access to sterile needles. A study in Baltimore found that injecting drug users who were diabetics (and therefore were able to purchase needles without legal restrictions) were less than half as likely to be infected with HIV than other injecting drug users.

In Louisiana, persons can legally purchase needles without prescriptions, but not all pharmacists choose to sell needles if no prescription is provided. To better understand practices regarding needle sales in pharmacies, the Office of Public Health collaborated with the Xavier University School of Pharmacy to conduct a survey of pharmacy managers.

Of the 451 pharmacy managers sent questionnaires, 271 (60%) returned them, of whom 201 managed pharmacies with direct over-the-counter sales. Of these pharmacies, in 159 (80%) the decision regarding selling needles to an individual customer without a prescription was left up to discretion of the

pharmacist working at the time. Sixty-one percent of pharmacy managers answered that pharmacists in their stores sometimes sell needles without prescriptions to persons who were not diabetics, and 23% answered that they sometimes sell needles to persons who they know or suspect are injecting drug users. Pharmacies associated with store chains were slightly more likely to sell needles to drug users than independent pharmacies (27% vs. 21%), and pharmacies located in neighborhoods where the respondent felt there were "many" injecting drug users were more likely to sell needles than those in other neighborhoods (35% versus 20%). Among pharmacies that sold to drug users the frequency of such sales was most commonly reported as 5-9 times in the previous 30 days. Among pharmacies that did not sell needles to drug users, the concerns expressed by respondents most frequently were: the sales of needles might increase drug use (47%), drug users might scare away other customers (42%) or endanger staff (42%), and legal liability (40%).

Pharmacy managers were asked if they would personally be willing to sell needles to persons in certain categories (Table). These pharmacists were more likely to sell needles to a customer whom they knew than to a customer they did not know (24% vs. 16%), and they were particularly willing to sell needles to a drug user with a referral card from an agency or a clinic (47%).

This survey indicates that although the sale of needles to drug users is not routine practice in Louisiana, a substantial number of pharmacies in the state currently are selling needles to persons who are suspected to be drug users. Furthermore, a greater proportion of pharmacy managers are supportive of selling needles to specific drug users if they are referred from an agency or clinic for that purpose.

Because of the large number of AIDS cases in Louisiana caused by needle sharing, provision of sterile needles to drug users who are not in treatment is an important HIV prevention strategy. The HIV/AIDS section has been working with the Xavier University School of Pharmacy to educate pharmacists about the prevention opportunity provided by needle sales, and will continue to look for ways to promote needle availability in the state.

**Table.** Willingness of pharmacists (n=201) to sell needles without a prescription to specific categories of customers.

Customer	Willing (%)
HIV-negative injection drug user	58 (29%)
HIV-positive injection drug user	67 (33%)
Drug user referred from agency or clinic	94 (47%)
Drug user you know/regular customer	48 (23%)
Drug user you do not know	33 (16%)

## Fish Kills in Louisiana

A fish kill is an unusual or noticeable amount of dead fish in a water body. These fish are seen floating in a body of water or on shore.

Regardless of the cause of the fish kill, it is very important that people do not take or eat dead fish. Eating dead fish collected from a fish kill may result in food poisoning.

People should also NOT catch and eat fish that are dying. Dying fish can be seen swimming abnormally, in strange patterns, or very slowly. Consumption of dying fish may also cause Scombroid Poisoning since parts of the fish begin to die before the fish dies.

Aside from the health risk, collecting dead or dying fish with the use of a dip net is illegal for many species of gamefish in the State of Louisiana.

Fish kills can occur either from natural causes or from man's influence upon the environment. In Louisiana, the primary cause of fish kills is low dissolved oxygen (DO) in the water. Fish breathe by filtering DO from the water through their gills. When the amount of dissolved oxygen is too low, fish suffocate. These low DO (hypoxic) conditions can be a result of many factors.

- Usually hot weather.
- Plankton and algae overgrowth, which may result in low DO, especially at night and in extended periods of cloud cover when there is little or no sunlight.
- High amounts of decaying matter in the water. Heavy rainfalls contribute to this effect by washing decaying matter from the banks into the water.
- Temperature changes in the fall and spring which cause churning of the different layers of water.

Fish kills should be reported to the Louisiana Department of Environmental Quality (LDEQ) 24-Hour Hotline 504-342-1234 or 504-765-0671. For fish kills, LDEQ's main concern is the determination of the water quality. Depending upon the severity and cause of the fish kill, LDEQ will contact either the Louisiana Department of Wildlife and Fisheries and/or the Louisiana Department of Agriculture and Forestry. For additional information, contact the Environmental Epidemiology Section at (504) 568-8537.

## Global Measles Eradication Summary

According to World Health Report, before a measles vaccine became available in the 1960s, each year measles killed between seven and eight million children and caused an estimated 135 million cases worldwide. Today, approximately one million children still die annually from measles

and countless others have permanent sequelae. However, progress has been made in measles control/elimination during the past 3-5 years (Figure).

Global measles eradication is technically possible and is targeted for the next 10-15 years. Vaccination would not need to be continued following eradication. Elimination refers to the interruption of transmission in a sizable geographic area, such as a country or a region. However, because of the continued threat of re-introduction of the virus, vaccination would need to be continued. Global eradication will basically represent the sum of successful elimination efforts in all regions.

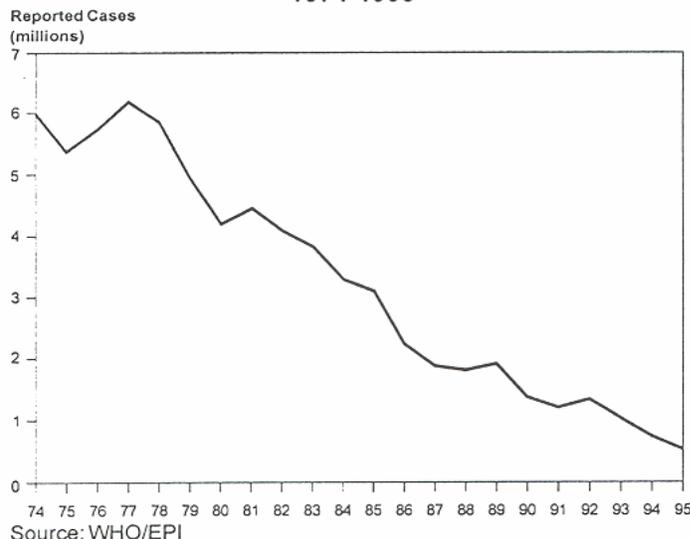
The initiative to eradicate measles worldwide is based upon the expected success of polio eradication by the year 2000; the success to date of measles elimination in the Americas and United Kingdom; the urgency of measles eradication because of expected epidemiologic changes resulting from routine measles vaccination (i.e., the accumulation of a growing population of susceptible adults; the high benefit:cost ratio to developed countries; and the recognition of measles as a major public health problem in many developing countries.

Existing vaccines and strategies are sufficient to eradicate measles but alternative methods of delivery, particularly jet injectors, and alternative preparation of the vaccine will continue to be explored. The most pressing research need is a rapid field diagnostic test.

Although measles eradication may seem costly in the short-run, measles eradication will quickly pay for itself in vaccinations and hospitalizations forgone and deaths prevented. Documenting the health burden of measles in more countries, especially in the developed world, will be important in gaining support for global eradication.

For the complete article on this topic, contact the Epidemiology Section.

Global Annual Reported Measles Cases  
1974-1995



## AIDS UPDATE

### AIDS Cases in Men Who Have Sex with Men

Nationwide, AIDS is the leading cause of death among 25-44 year old men. There is a similar trend in Louisiana (Figure 1). The largest exposure category of persons with AIDS is men who have sex with men (MSM, Figure 2). Of men who report gay/bisexual behavior in Louisiana and are tested for HIV, approximately 5-10% test positive.

For both white men and African-American men, the primary risk category is male-to-male sex; in 1995, 77% of cases in white men and 44% of cases in African-American men were in MSM (Table 1). Although the number of MSM cases recently diagnosed in African-Americans is similar to that in white MSM, the trends are different for the two groups. Among white MSM, over the last several years the number of new cases is level. However, among African-American MSM, the trend is sharply increasing (Figures 3 and 4).

The trend toward increasing numbers of AIDS cases in African-American men who have sex with men is part of a larger trend toward an increasing proportion of AIDS cases in persons in minority groups. However, it is often not recognized that male-to-male sex is an extremely important mode of transmission in these minority groups. Because African-American men who have sex with men often do not self-identify as gay or bisexual, they may have to be reached through approaches which are different from those used to reach white gay men. Since the 1997 state HIV prevention plan identifies African-American MSM as the highest priority group to reach, intervention programs will increasingly focus on this important seropopulation.

Table: AIDS cases in men by ethnicity and major risk group

	White Men		African-American Men	
	Cum (%)	1995 (%)	Cum (%)	1995 (%)
MSM	3698 (85)	269 (77)	1800 (55)	207 (44)
IDU	237 (5)	32 (9)	792 (24)	131 (28)
Hetero	83 (2)	11 (3)	191 (6)	42 (9)
Total*	4378	348	3301	471

\* Totals include all other exposure group

Definitions:

*MSM*: Men who have sex with men (homosexual/bisexual)

*IDU*: Injection Drug Users (non-MSM)

*Hetero*: High risk heterosexual exposure

*Adjustments* incorporate observed cases with estimates for reporting delay, redistribution of unidentified risks, and expected year of first opportunistic infection.

Figure 1: Leading causes of death in men age 25-44, Louisiana, 1984-1994

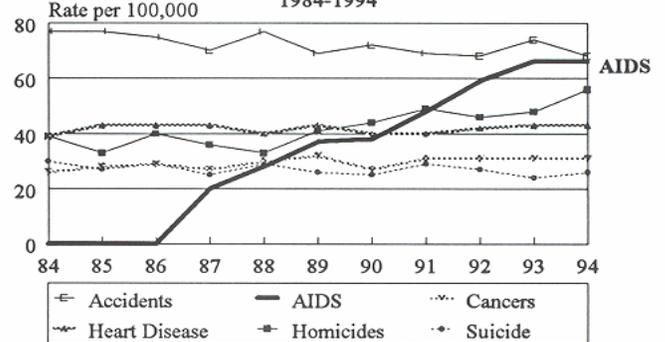


Figure 2: AIDS cases by risk category, Louisiana 1986-1995

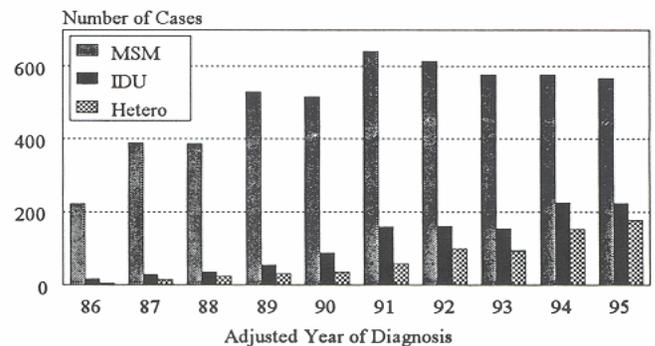


Figure 3: AIDS cases (diagnosed and adjusted for reporting) in white men who have sex with men, Louisiana, 1986-1995

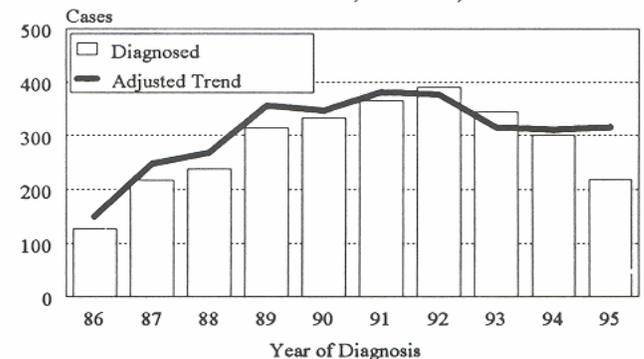
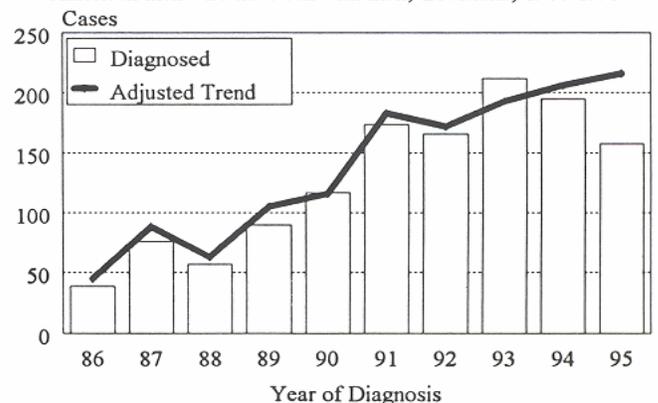


Figure 4: AIDS cases (diagnosed and adjusted for reporting) in African-American men who have sex with men, Louisiana, 1986-1995



**LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE**  
**September -October, 1996**  
**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	Sept-Oct 1996	Sept-Oct 1995	Cum 1996	Cum 1995	% Chg	
<b>Vaccine-preventable</b>															
Measles	0	0	0	0	0	0	0	0	0	0	0	0	18	-	
Mumps	0	1	0	0	0	0	0	0	0	1	3	17	12	+42	
Rubella	0	0	0	0	0	0	0	0	0	0	0	1	0	-	
Pertussis	0	0	0	1	0	0	0	0	0	1	3	9	17	-47	
<b>Sexually-transmitted</b>															
AIDS	Cases Rate <sup>1</sup>	42 3.9	19 3.5	4 1.1	3 0.8	4 1.5	1 0.3	3 0.6	4 1.2	3 0.8	83 1.9	183 4.2	848 19.5	831 19.3	+2
Gonorrhea	Cases Rate <sup>2</sup>	652 6.3	218 4.0	150 4.1	160 3.2	89 3.4	77 2.5	222 4.4	157 4.5	132 3.7	1857 4.4	1628 3.9	8063 19.1	9279 22.0	-13
Syphilis(P&S)	Cases Rate <sup>2</sup>	14 0.13	13 0.24	17 0.46	2 0.04	1 0.04	3 0.10	9 0.18	2 0.06	8 0.23	69 0.16	176 0.42	477 0.13	868 2.06	-45
<b>Enteric</b>															
<i>Campylobacter</i>		12	5	1	0	0	0	1	1	3	23	40	134	168	-20
Hepatitis A	Cases Rate <sup>1</sup>	8 0.8	0 -	1 0.3	0 -	1 0.4	0 -	11 2.2	21 6.0	1 0.3	43 1.0	32 0.7	183 4.2	124 2.9	+48
<i>Salmonella</i>	Cases Rate <sup>1</sup>	27 2.6	15 2.6	6 1.6	17 3.3	5 1.9	3 1.0	14 2.8	16 4.6	27 7.0	130 3.0	202 4.7	508 11.8	436 10.1	+17
<i>Shigella</i>	Cases Rate <sup>1</sup>	15 1.4	8 1.4	0 -	3 0.6	0 -	0 -	7 1.4	4 1.1	3 0.8	41 0.9	87 2.0	511 11.8	329 7.6	+55
Vibrio cholera		0	0	0	1	0	0	0	0	0	1	0	1	0	-
Vibrio, other		6	0	0	1	0	0	0	0	2	10	11	37	40	-99
<b>Other</b>															
Hepatitis B	Cases Rate <sup>1</sup>	6 0.6	2 0.4	1 0.3	3 0.6	4 1.5	0 -	7 1.4	9 2.6	7 1.8	42 1.0	31 0.7	142 3.3	195 4.5	-27
Meningitis/Bacteremia <i>H. influenzae</i>		0	0	1	0	0	0	0	0	0	1	0	5	1	+400
<i>N. meningitidis</i>		0	2	3	0	0	0	1	0	2	8	7	58	47	+23

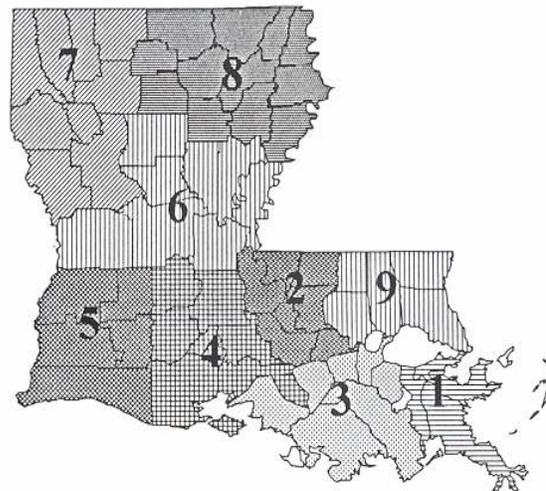
1 = Cases per 100,000  
 2 = Cases per 10,000

**Table 2. Diseases of Low Frequency**

Disease	Total to Date
Blastomycosis	5
Histoplasmosis	2
Lead Toxicity	101
Typhoid	1
Rocky Mountain Spotted Fever	2
Legionellosis	3
Lyme Disease	6
Malaria	7
Tetanus	1

**Table 3. Animal Rabies (Sept - Oct, 1996)**

Parish	No. Cases	Species
Calcasieu	1	Bat
Caddo	1	Dog
Bossier	1	Bat



## ANNUAL SUMMARY Hepatitis B - 1995

Hepatitis B cases reported for 1995 increased by 19% from 1994 (figure 1) after a large decline from 1987 to 1994. The overall case rate was 5.7 per 100,000. Race-specific rates for blacks (9.5 per 100,000) continued to be over four times higher than for whites (2.2). Sex-race specific rates per 100,000 were: black males (10.8), black females (8.4), white males (2.6) and white females [1.8, figure 2]. The age distribution remains unchanged from previous years in which the majority of cases occurred within the 15-44 year age range. Parishes with the highest case rate per 100,000 were: Morehouse (16), Orleans (13), Ouachita, Tangipahoa and Vermilion [12 each, figure 3].

**Comment:**

In the U.S., most persons infected with hepatitis B virus acquired their infection as young adults or adolescents. HBV is transmitted primarily through sexual contact, injecting drug use, regular household contact with a chronically infected person, or occupational exposure. However, the source of infection is unknown for approximately one third of persons who have acute hepatitis B. A comprehensive vaccination strategy to eliminate transmission of HBV for adolescents ages 11 - 12 years has been adopted. Routine vaccination of adolescents 11-12 years of age who have not been vaccinated previously is an effective strategy for more rapidly lowering the incidence of HBV infection and assisting in the elimination of HBV in the U.S. Adolescents should receive three age-appropriate doses of hepatitis B vaccine to be considered adequately immunized.

Figure 1: Cases of hepatitis B by year, 1986-1995

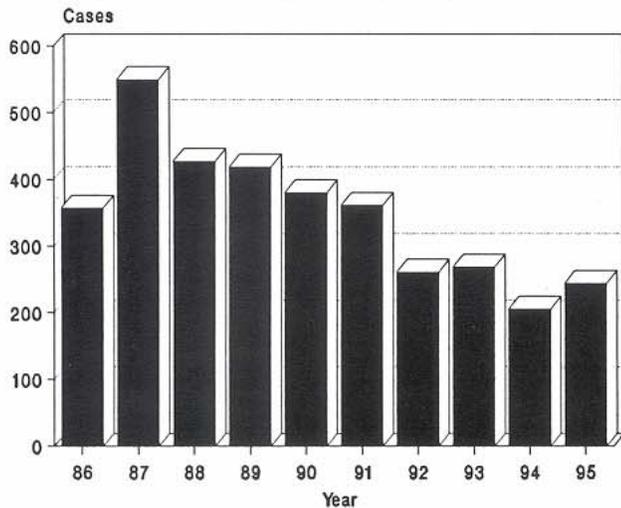


Figure 2: Cases of hepatitis B by race and sex, 1993-1995

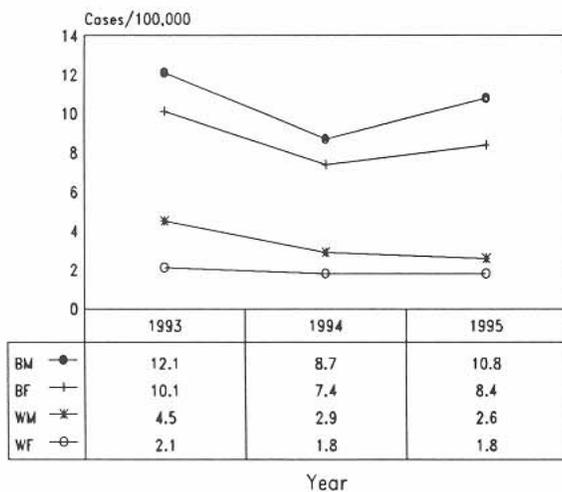
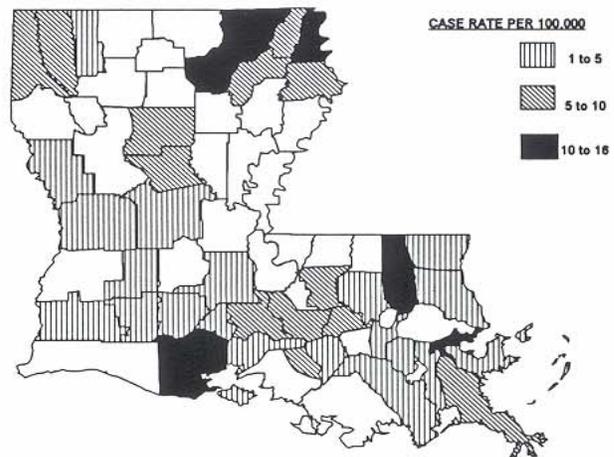


Figure 3: Rates of hepatitis B by parish, 1995



**LOUISIANA FACTS**

As far back as 1875, concern about the amount of ozone in the air was expressed. "It is to be regretted that no provision has yet been made toward determining the amount of ozone present in the atmosphere in and about New Orleans, as the subject is receiving attention in other cities, and is believed by many to have a controlling influence upon the public health." (Reports Louisiana Board of Health; 1872-1875 Vol 1)

# 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 +
Chlamydial infection**	Lymphogranuloma venereum**	Tetanus	Severe undernutrition
Diphtheria*	Malaria	Trichinosis	severe anemia,
Encephalitis (specify primary or post-infectious)	Measles (rubeola)*	Tuberculosis***	failure to thrive
Erythema infectiosum (Fifth Disease)	Meningitis, (Haemophilus)*	Tularemia	Sickle cell
Escherichia coli 0157:H7	Meningococcal infection (including meningitis)*	Typhoid fever	disease (newborns)
Foodborne illness*	Mumps	Typhus fever, murine (fleaborne, endemic)	Spinal cord injury +
Genital warts**	Mycobacteriosis, atypical***	Vibrio infections (excluding cholera)	Sudden infant death syndrome (SIDS)
Gonorrhea**	Ophthalmia neonatorum**	Yellow fever*	
Granuloma Inguinale**	Pertussis		
	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 DPP-3 form; preliminary phone report from ER encouraged (568-2509).

## Numbers for reporting communicable diseases

**1-800-256-2748**

**Local # 568-5005**

**FAX # 504-568-5006**

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