



## Epidemiologic Notes & Reports

Volume 35 Number 9

September 2000

### Kentucky Influenza 2000 – 2001 Peggy Dixon, RN, CIC

#### Surveillance

The Kentucky influenza surveillance network is comprised of three essential components:

- **Sentinel physicians**, who report directly to the Centers for Disease Control and Prevention (CDC) with information which pertains to the number of patients (age grouped) that have been seen for a specified week with flu-like symptoms.
- **Sentinel Local Health Departments**, who have agreed to participate in Kentucky's influenza network report flu-like illness information obtained from a specific local nursing home and their school district absenteeism for a specified day each week. In addition, local health departments in the surveillance network located in larger populated areas of the state obtain information of flu-like illnesses from a doctor's office and/or a hospital. This information is reported to the State Influenza Surveillance Coordinator.
- **Laboratories**, report isolate/culture confirmed influenza cases to the Division of Epidemiology and Health Planning in Kentucky's Department for Public Health (KDPH). **All** laboratories are required by law to participate by reporting isolates/cultures, of influenza on a weekly basis to the KDPH.

Information from all three reporting areas is used to determine weekly flu activity statewide. Surveillance for the current influenza

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season will begin the **First Week in October**.

This season, the Communicable Diseases Branch urges every local health department to obtain influenza viral culture kits and distribute them to local physicians. Strains of influenza can only be determined from cultures. Strain identification is necessary to detect epidemic or pandemic strains of influenza, to make informed decisions regarding the components of the next season's vaccine, and to determine whether strains of influenza are similar in all areas of the state. All local health departments are requested to participate in this activity whether or not the health department is participating in the surveillance network. All physicians are requested to keep the kits on hand and collect specimens on patients with flu-like symptoms. The only cost involved is postage to mail the specimen back to the state lab. Local health departments may choose to pick up the specimens and mail them to the laboratory, relieving the medical professional of this expense.



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## KENTUCKY INFLUENZA

(Continued from page 1)

CDC's case definition for a flu-like illness is: Fever greater than 100 degrees Fahrenheit, and cough or sore throat. And while rapid diagnostic tests can be useful to the practitioner for the purpose of treatment decisions, the CDC does not consider these tests as confirmation of a case of influenza. CDC only considers influenza viral isolate/cultures as confirmation of an influenza case. Rapid diagnostic test results may only be used in determining surveillance activity if accompanied by a Kentucky Reportable Disease Form with complete information regarding signs and symptoms and submitted to the KDPH. The information can then be used for counting flu-like illnesses for determining influenza activity. CDC's definitions for influenza activity are defined as:

- **No activity** is no flu-like illnesses or culture confirmed cases;
- **Sporadic activity** is flu-like illnesses or culture confirmed cases with no outbreaks;
- **Regional activity** is an outbreak of either flu-like illnesses or culture confirmed cases in less than 50% of the state's population;
- **Widespread activity** is an outbreak of either flu-like illnesses or culture confirmed cases in greater than 50% of the state's population.

**Information regarding surveillance, statistics, pandemic planning and recommendations for vaccine and antiviral drug use may be directed to:**

Peggy Dixon, Communicable Diseases Branch, 502/564-3261, extension 4037.

**To request flu collection kits, please contact:**

Diane Young, Division of Laboratory Services, 502/564-4446, extension 4483.

**For information regarding ordering and distribution of Vaccines For Children influenza vaccine:**

The Immunization Program at 502/564-4478. During the Kentucky 1999 – 2000 Influenza

season, the Kentucky Division of Laboratory Services, Virology/FA Section reported the following formation on isolates/cultures submitted for testing as seen in Table 1.

**Table 1:**

COUNTY	FLU TYPE A	H3N2 SYDNEY STRAIN	H1N1 BEIJING STRAIN
1 Adair	4	3	
2 Allen	2	2	
3 Anderson	1		
4 Barren	6	3	
5 Boone	2	1	
6 Bourbon	1	1	
7 Boyd	5	5	
8 Boyle	1		
9 Calloway	3	2	
10 Campbell	5	3	
11 Carter	1	1	
12 Christian	4		
13 Clark	3	2	
14 Daviess	7	1	6
15 Elliott	1	1	
16 Fayette	17	7	
17 Franklin	5	3	1
18 Hancock	1	1	
19 Harlan	1		
20 Jefferson	19	2	2
21 Jessamine	2		
22 Kenton	4		
23 Leslie	1		
24 Letcher	1		
25 Madison	4	1	
26 Marion	1		
27 Mason	1		
28 McCracken	5	4	
29 Meade	3	1	2
30 Menifee	1	1	
31 Metcalfe	3	3	
32 Montgomery	1		
33 Nelson	1	1	
34 Perry	3		
35 Pike	4	2	
36 Powell	3		
37 Pulaski	1		
38 Simpson	2		2
39 Warren	9	4	5
40 Washington	2	1	1
<b>TOTAL</b>	141	56	19

Note: The article, "Kentucky Influenza Surveillance", November, 1999, edition of the *Kentucky Epidemiologic Notes and Reports* indicates that the first two "confirmed" isolates for the 1999-2000 season from Clark and Rowan counties were type B. Because these rapid antigen test results were not confirmed by culture, the status for both was changed to "probable" cases.

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## KENTUCKY INFLUENZA

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### Influenza Vaccine Recommendations

The CDC Advisory Committee on Immunization Practices (ACIP), published recommendations for the use of influenza vaccine in April, 2000. Vaccination is recommended for the following groups who are placed at increased risk for complications of influenza due to age or underlying medical conditions, or who have a higher prevalence of chronic medical conditions; vaccination is also recommended for the health-care workers and others in close contact with persons in these groups:

- Anyone greater than 50 years of age;
- Nursing home and other chronic-care residents;
- Anyone who has chronic pulmonary or cardiovascular disorders;
- Anyone required to have regular medical follow-up or hospitalization because of chronic metabolic diseases during the preceding year;
- Children, beginning at age 6 months, and teenagers up to 18 years of age, receiving long-term aspirin therapy; and
- Pregnant women who will be in the second or third trimester of pregnancy during the influenza season.

In July, 2000, the Adult Vaccine Preventable Diseases Branch, National Immunization Program at CDC announced that delays are expected in the distribution of influenza vaccine for the current season. In addition, it is also possible there will be significantly fewer doses of vaccine available than last season. In response to these expected delays and possible shortages, the CDC and ACIP recommend that:

- **Organized, mass influenza vaccine campaigns should be delayed until early to mid-November** until further information regarding vaccine availability is known to minimize cancellations of vaccine campaigns and wastage of vaccine doses re-

sulting from delays in vaccine delivery. Providers and health departments can work together to develop local networks to help re-distribute unused influenza vaccine or direct persons desiring vaccination to providers with available vaccine. To minimize the amount of unused vaccine, purchasers should refrain from placing duplicate orders with multiple companies.

- **High risk individuals and their close contacts should proceed to be vaccinated during regular health care visits.** Vaccination of residents of nursing homes and other health care facilities with residents who are at high risk, and health care workers and others caring for high risk persons, should proceed with vaccination plans with available vaccine.
- **Providers should develop contingency plans for the possibility of a vaccine shortage** to maximize vaccination of high-risk persons and health care workers. Providers should continue to administer influenza vaccine to unvaccinated high-risk persons after mid-November and throughout the influenza season as vaccine is available. Contingency plans for 50-64 year old persons should focus on vaccinating those at high risk, rather than the entire group. There are four antiviral drugs approved by the FDA for use in the U.S. The approved treatment or chemoprophylaxis, age groups, dosages, routes of administration, routes of metabolism, adverse reactions, and costs vary among these medications; all require a physician's prescription. Vaccination is the best way to prevent influenza virus infection. The use of antiviral drugs is not a substitute for influenza vaccination.

**To obtain announcements regarding vaccine availability:** please refer to the National Immunization website at [www.cdc.gov/nip](http://www.cdc.gov/nip).

**For information regarding ordering and distribution of Vaccines For Children influenza vaccine:** please contact the Immunization Program at 502/564-4478.

**Questions regarding recommendations for influenza vaccine and antiviral drug use may be directed to:** Peggy Dixon at 502/564-3261.

**IMPLEMENTATION OF ICD-10  
FOR MORTALITY**  
George Robertson, MA

**Beginning with deaths occurring in January 1999, the Kentucky Department for Public Health Vital Statistics Branch, along with the rest of the U.S. and most other countries, began coding cause-of-death by the Tenth Revision of the International Classification of Diseases (ICD-10). Consequently, mortality statistics reported by the Department from 1999 forward will be reported according to the new ICD-10 categories.**

**International classification of diseases (ICD):** The ICD is a system developed collaboratively between the World Health Organization (WHO) and ten international centers, one of which is housed at the U. S. National Center for Health Statistics (NCHS). The purpose of the ICD and of WHO sponsorship is to promote international comparability in the collection, classification, processing and presentation of mortality and morbidity statistics. The ICD was first adopted in 1900, and has been revised infrequently, usually once every ten years, except for the twenty year interval between the last two revisions, ICD-9 and ICD-10. The periodic revisions have been necessary to reflect medical advances in terms of disease nomenclature and etiology.

**ICD-10 compared to ICD-9:** ICD-10 differs from ICD-9 in a number of respects: 1) ICD-10 is far more detailed than ICD-9, with about 8,000 disease and injury categories compared to 4,000. 2) ICD-10 uses 4-character alphanumeric codes compared with 4-digit numeric codes in ICD-9. The basic ICD is a single coded list of three-character categories, each of which can be further divided into up to ten four-character subcategories. The fourth character follows a decimal point. Possible code numbers therefore range from A00.0 to Z99.9.

3) Three additional chapters have been added, and some chapters rearranged. Some cause-of-death titles have been changed, and conditions have been regrouped. 4) Some coding rules have been changed.

The first two points above can be illustrated by the example of ICD-9 code 162\*, malignant neoplasm of trachea, bronchus and lung. Under ICD-10 this condition would be coded as either C33, malignant neoplasm of trachea, or C34, malignant neoplasm of bronchus and lung. \*Only the first 3 characters are shown for purposes of this illustration.

**Tabulation lists:** Mortality data released for 1999 will have to reflect the new ICD changes, which include alphanumeric codes, new titles, and reorganized cause-of-death categories. To address these needs, NCHS, working with other Federal agencies and the states, has designed eight new tabulation lists which, for various purposes, group the individual cause-of-death codes into disease categories, e.g., codes E10-E14 are grouped under diabetes mellitus. The lists have been developed with three general principles in mind: 1) to separately identify causes of death specified by the WHO in its recommended mortality tabulation lists; 2) to maintain continuity with past lists for historic continuity and to facilitate trend analysis, to the extent possible; and 3) to separately identify causes of death that are of public health and medical importance. The list that will be most widely used by most Federal agencies and the states is the *113 Selected Causes of Death* (which replaces the ICD-9 list of *72 Selected Causes of Death*). This is the list that will be used to identify and rank the leading causes of death in the United States. The lists are included in *NCHS Instruction Manual Part 9*, and can be downloaded from the NCHS web site at <http://www.cdc.gov/nchswww/about/major/dvs/im.htm>.

**Statistical impact and comparability:** The introduction of a new revision of the ICD can create major discontinuities in trend data. This happens because changes in the codes and

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## ICD-10 FOR MORTALITY

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coding rules may cause certain classes of deaths to move from one cause grouping in the current revision to a different grouping in the new revision. For example, a large discontinuity occurred between 1978 and 1979 in the 11<sup>th</sup> leading cause of death, nephritis, nephrotic syndrome, and nephrosis. The rate for this cause in 1979 was 74 percent higher than in the previous year because of the introduction of ICD-9.

The extent of the discontinuity is measured through a "comparability ratio," obtained by coding a large sample of death records by both the old and new revisions. The results are expressed as a ratio of deaths from a given cause as coded by the later revision divided by deaths from the same cause as classified by the earlier revision. The ratios can thus be used to measure the proportion of the change in a death rate which occurred strictly as a result of the change in the ICD classification, and they can be multiplied by rates from earlier years to obtain "ICD-adjusted" rates for more accurate trend analysis. NCHS is currently conducting an ICD-10 comparability study using a large sample of records from the 1996 national mortality file. The final set of comparability ratios is expected to be published in the fall of this year.

**ICD-10 statistics for Kentucky:** The State Center for Health Statistics is currently in the process of making the conversion to ICD-10 for future tabulation and presentation of mortality statistics in Kentucky. The first published statistics using ICD-10 will appear in the *Kentucky Annual Vital Statistics Report 1999*, scheduled for publication early in 2001. Following receipt of the necessary information from NCHS, the State Center also plans to publish "ICD-adjusted" rates for leading causes of death for 1980-1999, probably in the summer of 2001.

**Additional information concerning conversion to ICD-10 in Kentucky may be obtained**

**by contacting the:** Surveillance & Health Data Branch by phone: 502-564-2757, fax: 502-564-6533, or e-mail: [healthdata@mail.state.ky.us](mailto:healthdata@mail.state.ky.us).

**Additional information concerning ICD-10 in general may be obtained from:** NCHS web site at <http://www.cdc.gov/nchswww/about/major/dvs/icd10des.htm>, or by phone at 301-458-4636.



### The Non-Public Health Clinical Microbiology Laboratory First Responder to Bioterrorism Workshop

#### TIME

October 13, 2000, 8 AM – 4 PM

#### LOCATION

Health Services Auditorium, 275 East Main Street,  
Frankfort KY

#### AGENDA

- Reality of the Threat: Are we prepared as a state and as a community? KD Lane, FBI, Louisville, KY
- Planning a Medical Response to Bioterrorism. William S, Smock, MD, University of Louisville, Louisville, KY
- Clinical Syndromes Associated with likely Biological Warfare Agents. Paul McKinney, MD, University of Louisville, Louisville, KY
- Laboratory Preparedness for Bioterrorism. Meloney Russell, BSMT, Kentucky Department for Public Health, Frankfort, KY
- Laboratory Detection, Recovery, and Identification of "Targeted Agents" of Bioterrorism, James W Snyder, PhD, University of Louisville, Louisville, KY

#### REGISTRATION FEE

**Members: \$30, Non-members: \$45**

(Includes 2001 SCACM membership, breaks & lunch)

#### PRESENTED BY

The South Central Association for  
Clinical Microbiology  
and

The Kentucky Public Health Laboratory

#### For more information contact:

Timothy L. Overman, Ph.D, (859)381-5938,

e-mail: [toverma@pop.uky.edu](mailto:toverma@pop.uky.edu)

Chuck Johnson, (502)562-3299,

email: [huk57@aol.com](mailto:huk57@aol.com)

# Head Lice

## What are head lice?

Head lice are small parasitic insects found on the heads of people. Head lice (*pediculus capitis*) is very common in preschool and elementary-age children. Head lice derive nutrients by biting and eating blood several times each day, and cannot survive for more than a day or so at room temperature without ready access to a blood meal.

## There are three forms of lice:

- **Nits:** They are head lice eggs that are attached to the hair shaft. They are difficult to see and are white or yellow. They can be mistaken for dandruff. Nits take about 1 week to hatch.
- **Nymph:** The nymph is a baby louse and it is much smaller than an adult louse. The nymph state lasts about 7 days
- **Adult:** The adult louse is tan to grayish-white and has 6 legs. It is the size of a sesame seed. An adult louse can live 30 days on a person's head.



Adult female (left) and adult male head lice.

## How You Get Head Lice:

- By physical contact with a person that has head lice (head to head, sharing hats, clothing, combs, brushes or towels).
- Head lice do not jump from one person to another.
- By lying on a bed, couch, pillow, carpet, or stuffed animal that has been used by an infested person.

## The Symptoms of Head Lice Infestation:

- Itching
- Tickling feeling of something moving in the hair.
- Sores can develop from scratching the scalp.
- The louse's saliva and feces may sensitize people to their bites, thereby exacerbating the irritation and increasing the chance of secondary infection from excessive scratching.

## How Head Lice Infestation Is Diagnosed:

- Observation of nits, nymphs, or adult lice on the head of an individual.
- If nits are observed ¼ inch from the scalp, the infestation is probably an old one and does not need treating.

## How To Treat Head Lice:

- The drug of choice is permethrin 1% (e.g., Nix).
- Pyrethrin (Rid) is used if there appears to be a treatment failure with permethrin.

## How To Prevent Infestation of Head Lice:

- Do not share hats, combs or brushes.
- Avoid head to head contact with infected people.
- Do not lie on a bed, couch, pillow, carpet, or stuffed animal of an infested person.

## Clarification of Head Lice Myths:

- Head lice are not known to transmit infectious agents from person to person
- Shaving the head bald or cutting the hair short does not prevent head lice.
- Hair soaps, bleaches and dyes do not eliminate head lice.
- Pets do not give people head lice.
- You can not suffocate the head lice with oils or gels.
- Heat from a hair dryer will not kill head lice.
- Do not apply any application (i.e. mayonnaise, Vaseline, olive oil, etc.) to the head to repel lice. It will not work.
- Do not apply caustic agents (gasoline, kerosene, etc.) to the head to kill lice. They may be harmful to your health.

## Internet Links:

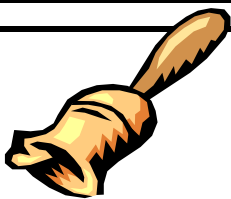
Informational site designed for children: [headlice.org](http://headlice.org)

Laboratory of Public Health Entomology, Harvard School of Public Health: <http://www.hsph.harvard.edu/headlice.html>

Kentucky Department for Public Health web page: [http://www.publichealth.state.ky.us/head\\_lice.htm](http://www.publichealth.state.ky.us/head_lice.htm)

## 10 Steps To Staying Ahead of Lice

- 1 Watch for signs of head lice, such as frequent head scratching. Anyone can get head lice... mainly by head-to-head contact but also from sharing hats, brushes and headrests. Lice do not jump or fly.
- 2 Check all family members for lice and nits (lice eggs) at least once a week. Only those infested should be treated. Lice are reddish-brown wingless insects, nits are grayish-white, always oval shaped, and are glued at an angle to the side of the hair shaft.
- 3 Be sure not to confuse nits with **hair debris** such as bright irregularly shaped clumps of dandruff stuck to the hair shaft or elongated segments of dandruff encircling the hair shaft and easily dislodged. Lice treatment is not appropriate for hair debris.
- 4 Consult your pharmacist or physician before applying or using lice treatment pesticides when the person involved is pregnant, nursing, has allergies, asthma, epilepsy, has pre-existing medical conditions, or has lice or nits in the eyebrows or eyelashes. Never use a pesticide on or near the eyes.
- 5 Remember, all lice-killing products are **pesticides**. If you choose to purchase an over-the-counter treatment, follow the directions carefully and use with caution. If the product fails, do not switch to other over-the-counter treatments or use any prescription products as a "last resort". This can be potentially harmful. Manual Removal is the safe alternative and a necessary component to any head lice treatment regimen.
- 6 Follow package directions carefully. Use the product over the sink, not in the tub or shower. Always keep the eyes covered.
- 7 **Remove all nits.** This assures total lice treatment. Separate hair in sections and remove all attached nits with an approved lice comb, baby safety scissors, or your fingernails. Wash bedding and recently worn clothing in hot water and dry in a hot dryer. Combs and brushes may be soaked in hot water (not boiling) for 10 minutes.
- 8 Wash bedding and recently worn clothing in hot water and dry in a hot dryer. Combs and brushes may be soaked in hot water (not boiling) for 10 minutes.
- 9 **Avoid lice sprays!** Vacuuming is the safest and best way to remove lice or fallen hairs with attached nits from upholstered furniture, rugs, stuffed animals and car seats.
- 10 Notify your child's school, camp, child care provider, neighborhood parents if your child develops head lice. Check for lice on a regular basis. This is the best way to protect your family and community.



## September is National Pediculosis (Head Lice) Prevention Month

This is to focus attention on the endemic state of head lice among children...that pediculosis is a common problem and to raise awareness for implementation of comprehensive prevention programs.

Back-to-School is an excellent time to educate parents, children and the community about head lice.

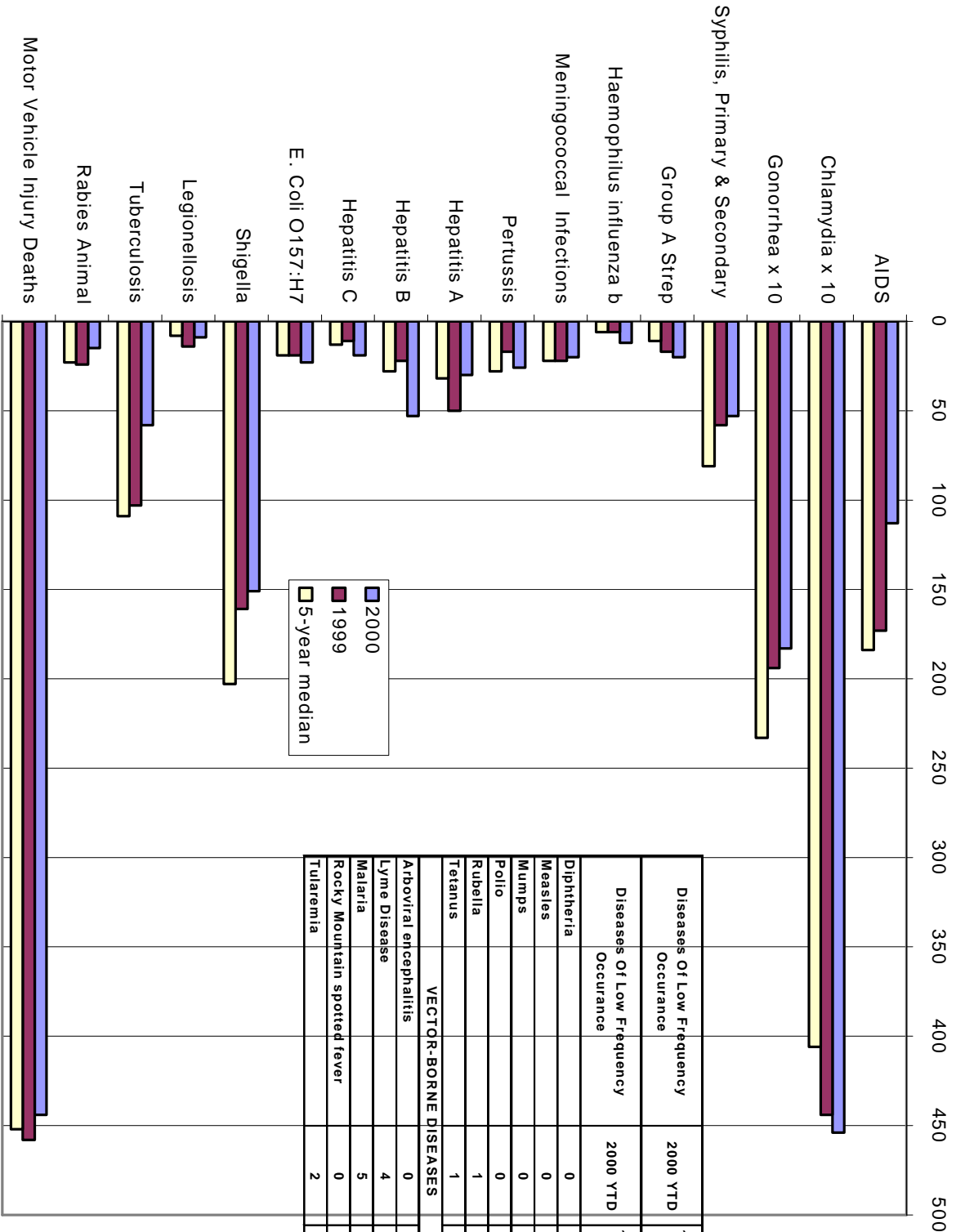


For more information contact your health care provider, local health department or the following pages:

[http://publichealth.state.ky.us/head\\_lice.htm](http://publichealth.state.ky.us/head_lice.htm)  
<http://www.headlice.org/publications/10steps.html>

web

**Cases of Selected Reportable Disease in Kentucky, Year to Date (YTD) Through July 2000**



Diseases Of Low Frequency Occurrence	2000 YTD	1999 Annual Totals
Diphtheria	0	0
Measles	0	2
Mumps	0	0
Polio	0	0
Rubella	1	0
Tetanus	1	0
<b>VECTOR-BORNE DISEASES</b>		
Arboviral encephalitis	0	1 LAC
Lyme Disease	4	19
Malaria	5	7
Rocky Mountain spotted fever	0	3
Tularemia	2	3

Disease numbers reflect only those cases which meet the CDC surveillance definition.  
 Contributed by: Patricia Beeler, Surveillance and Health Data Branch.



## Heptavalent Pneumococcal Polysaccharide (PREVNAR™) Vaccine

Prevnar™ is the Pneumococcal 7-valent Conjugate Vaccine, which will soon be available through The Vaccines for Children Program.

### Announcement For Upcoming Educational Offerings

Provided By:  
**Wyeth-Ayerst Laboratories**  
For more information please contact:  
**Chris Hurst of Wyeth-Lederle at (317) 431-5254**

#### EVERYONE IS WELCOME

Please review the following list of dates and locations:

September 6, 2000 10:00-12:00 noon Central Time	Barren River State Resort	1149 State Park Rd Lucas, KY 42156-9709
September 19, 2000 10:00-12:00 noon Central Time	Ken Lake State Resort	542 Ken Lake Road Hardin, KY 42048-9737
September 21, 2000 10:00-12:00 noon Central Time	Rough River Dam	450 Lodge Road Falls of Rough, KY 40119
September 25, 2000 10:00-12:00 noon Eastern Time	Cumberland Falls	735 Hwy 90 Corbin, KY 40701
September 27, 2000 10:00-12:00 noon Eastern Time	General Butler	PO Box 325 Carrollton, KY 41008
October 3, 2000 10:00-12:00 noon Eastern Time	Blue Licks	PO Box 66 Mt. Olivet, KY 41064
October 5, 2000 10:00-12:00 noon Eastern Time	Jenny Wiley	75 Theater Court Prestonsburg, KY 41653
October 13, 2000 10:00-12:00 noon Eastern Time	Environmental Health Services Bld	333 Waller Ave. Lexington, KY 40536

For information from the Kentucky Department for Public Health contact: Shirley Hearld, RN, Immunization Program (502) 564-4478.



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**Rice C. Leach, MD**, Commissioner,  
Department for Public Health

**Glyn G. Caldwell, MD**, State Epidemiologist, and Director,  
Division of Epidemiology & Health Planning

**Linda Fritz Vanorio, RN, BSN** Editor  
**Beverly Bevill**, Managing Editor

RETURN SERVICE REQUESTED

## Hepatitis C Advisory

On Thursday, July 27, 2000, the Surgeon General and representatives from congress issued a media advisory about hepatitis C. Specifically, the Surgeon General has joined with Congress to distribute a letter to all households to inform Americans about the need for persons at increased risk for HCV infection to go to their doctor to be tested. As we understand it, the groups for whom the letter recommends testing conform to the groups recommended by Centers for Disease Control and Prevention (CDC) for routine HCV testing in its October. 16, 1998 MMWR Recommendations and Reports (Vol. 47 No. RR-19), which include persons who had:

- a history of injecting drugs,
- a transfusion or transplant prior to July 1992,
- received a blood product for clotting problems produced before 1987,
- long-term kidney dialysis,
- a needlestick contaminated with HCV-infected blood;
- been borne to an HCV-positive mother.

We wanted to let you know about this advisory since it may result in an increase in calls from the public requesting information about testing related to Hepatitis C. The Kentucky Department for Public Health State Laboratory does not provide laboratory services for Hepatitis C testing. Additional information about Hepatitis C can be obtained from:

- CDC's website at [www.cdc.gov/hepatitis](http://www.cdc.gov/hepatitis) or their toll-free information line at 1-888-4HEPCDC (1-888-443-7232).
- Kentucky Department for Public Health website: [www.publichealth.state.ky.us](http://www.publichealth.state.ky.us) or by calling the state Hepatitis Coordinator at (502) 564-3261