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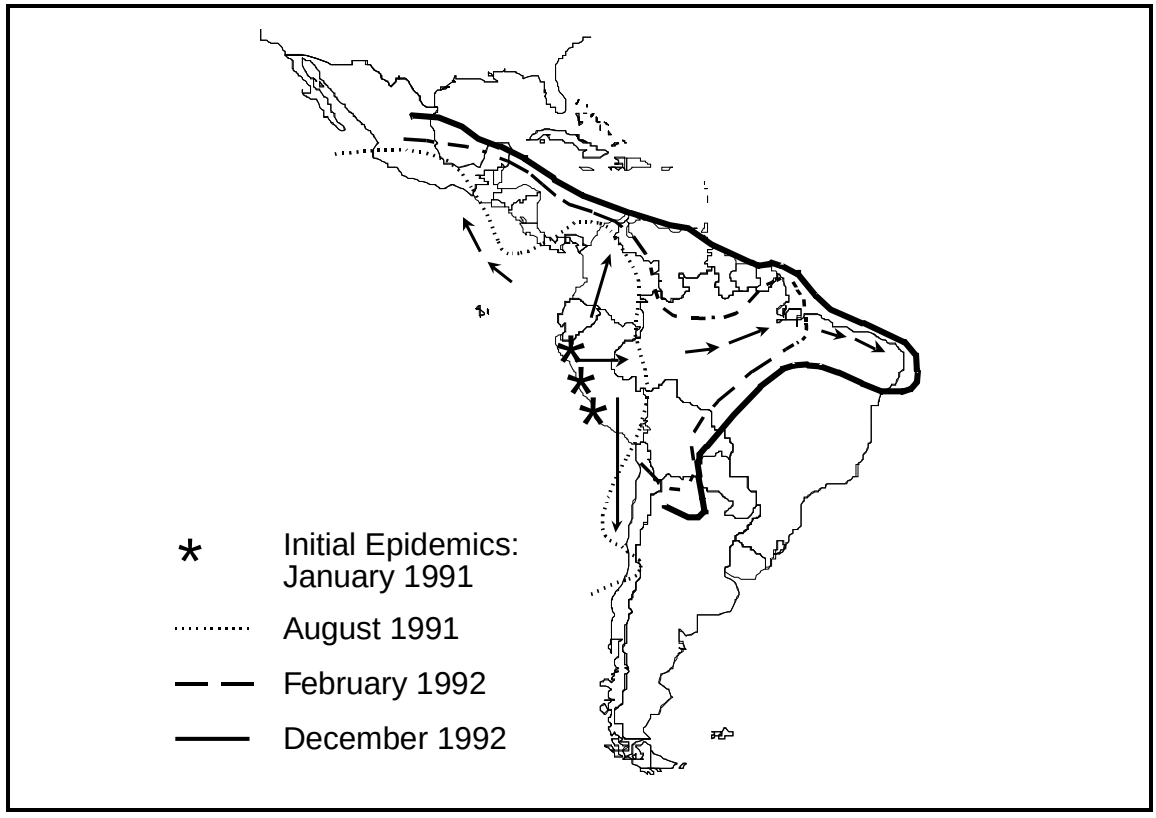
International Notes

Update: Cholera — Western Hemisphere, 1992

Epidemic cholera continues to spread throughout Central and South America (Figure 1) (*1*). This report updates the surveillance of this problem during 1992.

In 1992, 339,561 cholera cases and 2321 cholera-related deaths were reported from 21 countries in the Western Hemisphere, bringing to 731,312 cases and 6323 deaths the total numbers reported since the beginning of the epidemic in January 1991 (Table 1).

FIGURE 1. Spread of epidemic cholera — Latin America, 1991–1992



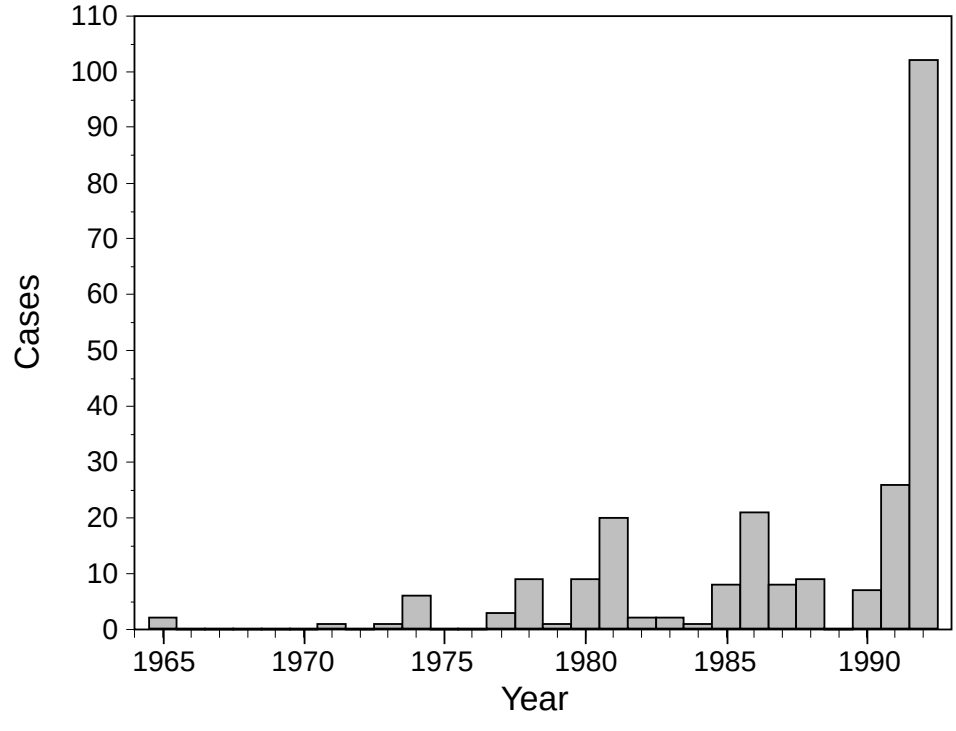
Update: Cholera — Continued

TABLE 1. Cholera cases reported to the Pan American Health Organization — Western Hemisphere, 1991–1992

Country	1992 Cases	1992 Deaths	1991 Cases*
Peru	206,565	709	322,562
Ecuador	31,870	208	46,320
Brazil	24,039	312	2,101
Bolivia	21,324	383	206
Guatemala	15,178	207	3,674
Colombia†	15,129	158	11,979
El Salvador	8,109	45	947
Mexico	7,814	99	2,690
Nicaragua	3,067	46	1
Venezuela	2,456	62	13
Panama	2,416	49	1,178
Argentina	553	15	0
Honduras	384	17	11
Guyana	290	4	0
Belize	154	4	0
United States	102	1	26
Chile	71	1	41
French Guyana	16	0	1
Surinam	12	1	0
Costa Rica	12	0	0
Canada	0	0	1
Total	**339,561**	**2,321**	**391,751**

*1991 deaths=4002.
† Data for 1992 are preliminary.

FIGURE 2. Reported cholera cases, by year — United States, 1965–1992



Update: Cholera — Continued

In 1992, 102 cases of cholera were reported in the United States—more than in any year since CDC began cholera surveillance in 1961 (Figure 2). Cases were reported from 12 states: California (64 cases), Nevada (15), Texas (four), Maryland (three), New York (three), Arizona (two), Connecticut (two), Florida (two), Hawaii (two), Louisiana (two), Washington (two), and New Jersey (one). Seventy-five cases occurred among passengers who had been served contaminated seafood salad on an airplane arriving in Los Angeles from South America in February 1992; one person died (*2*).

Reported by: Div of Communicable Disease Prevention and Control, Pan American Health Organization, Washington, DC. Enteric Diseases Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: During the current Latin American epidemic, no cases of cholera have been reported from countries in the Caribbean; however, because all adjacent Latin American countries have been affected, spread to the Caribbean is likely to occur as the epidemic continues.

Since the beginning of the epidemic, cholera cases have been reported in 14 states in the United States, representing all regions of the country. Because persons who have returned from travel in cholera-affected countries may seek medical care in areas throughout the United States, health-care providers should consider cholera as a possible diagnosis in any patient with watery diarrhea who has recently returned from a cholera-affected country. Stool specimens from patients with suspected cholera should be cultured on thiosulfate citrate bile salts sucrose agar, and suspected cases should be reported to local and state health departments. Effective treatment of cholera requires rapid and appropriate replacement of fluid and electrolytes (*3,4*).

References

1. CDC. Update: cholera—Western Hemisphere, 1992. MMWR 1992;41:667–8.
2. CDC. Cholera associated with an international airline flight, 1992. MMWR 1992;41:134–5.
3. CDC. Update: cholera—Western Hemisphere, and recommendations for treatment of cholera. MMWR 1991;40:562–5.
4. Swerdlow DL, Ries AA. Cholera in the Americas: guidelines for the clinician. JAMA 1992;267:1495–9.

Epidemiologic Notes and Reports

Isolation of *Vibrio cholerae* O1 from Oysters — Mobile Bay, 1991–1992

On July 2, 1991, during routine monitoring, the Food and Drug Administration (FDA) isolated toxigenic *Vibrio cholerae* O1, serotype Inaba, biotype El Tor from oysters and intestinal contents of an oyster-eating fish taken from closed oyster beds in Mobile Bay (*1*). This isolate was indistinguishable from the Latin American epidemic strain and differed from the strain of *V. cholerae* O1 that is endemic to the Gulf Coast. This report summarizes the public health response to this isolation of *V. cholerae* O1.

On July 18, Gulf Coast residents were advised by the Mobile County Health Department and the Alabama Department of Public Health (ADPH) to wash their hands after handling raw seafood and to eat seafood well cooked. FDA and ADPH initiated biweekly sampling of oysters from Mobile Bay, and on July 22 and September 16, 1991,

Cholera—Mobile Bay — Continued

the Latin American strain was again isolated from oysters. The Mobile Bay oyster beds, initially closed on May 31, 1991, remained closed to harvesting until November 4, 1991. On June 15, 1992, toxigenic *V. cholerae* O1 was again isolated from a sample of oysters from a restricted shellfish-growing area, and the adjacent growing areas were closed to harvesting. On August 19, 1992, the oyster beds were reopened after samples were repeatedly negative. No toxigenic vibrios have been isolated since June 1992.

Toxigenic vibrios have not been isolated from Moore swabs that were placed in effluent from sewage treatment plants in the Mobile Bay area after each isolation of *V. cholerae* O1 from oysters. FDA and ADPH continue monitoring of shellfish obtained or harvested from the Mobile Bay area, and ADPH maintains surveillance for cases of cholera.

Reported by: BH Eichold, II, MD, JR Williamson, MPH, Mobile County Health Dept, Mobile; CH Woernle, MD, State Epidemiologist, Alabama Dept of Public Health. RM McPhearson, ScD, Food and Drug Administration. Enteric Diseases Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: No cases of cholera have been identified in Alabama in recent decades. Surveillance for clinical cases has increased since the beginning of the Latin American outbreak in 1991, and many clinical laboratories now routinely culture diarrheal stool specimens on culture media appropriate for isolation of *V. cholerae*. The strain responsible for the epidemic in Latin America can be distinguished in the laboratory from the endemic *V. cholerae* O1 strain that is unique to the U.S. Gulf Coast (*2*).

The isolation of the Latin American strain of *V. cholerae* O1 from Gulf Coast oysters during two successive summers illustrates the potential for this organism to be repeatedly introduced or to persist in the environment at least transiently after a single introduction. However, there have been no recognized cases of cholera in the United States caused by the Latin American strain as a result of consumption of seafood harvested from the Gulf of Mexico. It is unknown how the Latin American strain was introduced into Mobile Bay. Surveillance using Moore swabs would have detected clinical cases and asymptomatically infected shedders of *V. cholerae* O1 (*3*). However, repeatedly negative Moore swabs indicate that municipal sewage was probably not the source of the strain.

Introduction of toxigenic vibrios into Mobile Bay may have resulted from discharge of contaminated ballast water from freighter vessels. To control buoyancy, ships take on large volumes of ballast water in a harbor and discharge it in other locations. This process may have been responsible for the introduction of other harmful species such as the zebra mussel in the Great Lakes (*4*). In 1991, the FDA isolated toxigenic *V. cholerae* O1 from the ballast tanks of ships that had originated from Latin American ports and arrived at Mobile Bay (*5*). To reduce the risk of introducing harmful organisms through contaminated freighter ballast water, the International Maritime Organization has recommended that freighters empty and refill their ballast water tanks twice on each voyage while in international waters (*6*). The efficacy of ballast water exchanges in reducing the level of contamination of ballast water has not been assessed. Although ballast water exchanges may decrease the risk of introduction of *V. cholerae* O1 from other ports into U.S. harbors, this approach would not eliminate the strain already endemic in U.S. Gulf Coast waters.

Cholera—Mobile Bay — Continued

Since 1973, 91 cases of cholera have occurred in the United States that were unrelated to international travel. Most of these followed consumption of raw or undercooked seafood harvested from the U.S. Gulf Coast contaminated with the Gulf Coast strain of *V. cholerae* O1. The risk for transmission of cholera can be reduced by avoiding consumption of raw or undercooked seafood.

References

1. DePaola A, Capers GM, Motes ML, et al. Isolation of Latin American epidemic strain of *Vibrio cholerae* O1 from U.S. Gulf Coast [Letter]. Lancet 1992;339:624.
2. Wachsmuth IK, Bopp CA, Fields PA. Difference between toxigenic *Vibrio cholerae* O1 from South America and U.S. Gulf Coast [Letter]. Lancet 1991;337:1097–8.
3. Barrett TJ, Blake PA, Morris GA, et al. Use of Moore swabs for isolating *Vibrio cholerae* from sewage. J Clin Microbiol 1980;11:385–8.
4. Roberts L. Zebra mussel invasion threatens U.S. waters. Science 1990;249:1370–2.
5. McCarthy SA, McPhearson RM, Guarino AM, Gaines JL. Toxigenic *Vibrio cholerae* O1 and cargo ships entering Gulf of Mexico [Letter]. Lancet 1992;339:624–5.
6. Coast Guard, US Department of Transportation. International Maritime Organization ballast water control guidelines. Federal Register 1991;56:6483.

International Notes

Update: Dracunculiasis Eradication — Ghana, 1992

The reported incidence of dracunculiasis (i.e., Guinea worm disease) in Ghana declined substantially during 1992—the third consecutive year in which reports of known cases declined. This report summarizes 1992 surveillance data for Ghana that are being used to monitor progress toward eradication of this disease (*1*).

During 1992, 33,464 cases of dracunculiasis were reported in 3185 villages, compared with 66,697 in 3718 villages in 1991 (a decline of 49.6%) and 179,556 in 6873 villages (a decline of 81.4%) in 1989 (*1*). In addition, when compared with 1991, the percentage reduction in cases reported by month increased from 20.1% in January to 34% in March, 59.9% in June, 81% in September, and 55.6% in December (Figure 1).

During 1992, at least 84% of the known affected villages reported surveillance findings to national authorities on time each month (i.e., within 20–30 days after the end of the reporting month), compared with 61% during 1991. In seven of 12 months during 1992, more than 90% of the villages reported on time. Data from villages reporting late are included in the subsequent month's report.

Data for 1991 and 1992 were based on monthly reports from trained village-based health workers in villages where the disease is endemic. These workers used visual aids (e.g., flip charts and posters) to provide health education in all villages where the disease is endemic. School teachers in areas where the disease is endemic were provided 10,000 teacher's manuals; in addition, they were provided one million pamphlets about prevention of dracunculiasis for distribution to schoolchildren beginning in December 1992.

By October 31, 1992, approximately 456,720 (66%) of the 692,000 households in villages where the disease is endemic had received cloth filters, and villagers had been instructed on use of these for filtering unsafe drinking water. A collaborative effort has been initiated to provide rehabilitated sources of safe water in 2024 villages

Dracunculiasis Eradication — Continued

where dracunculiasis is endemic. Unsafe water sources in 266 of the villages were being treated with temephos (Abate®*).

Reported by: Ministry of Health, Ghana. Global 2000, Inc, The Carter Center, Atlanta. WHO Collaborating Center for Research, Training, and Eradication of Dracunculiasis, Div of Parasitic Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: Because of the rapid reduction in endemicity of dracunculiasis, Ghana has declined from the second to the third most highly endemic country for this problem. The number of prevalent cases is less than in Nigeria and Uganda (*2*).

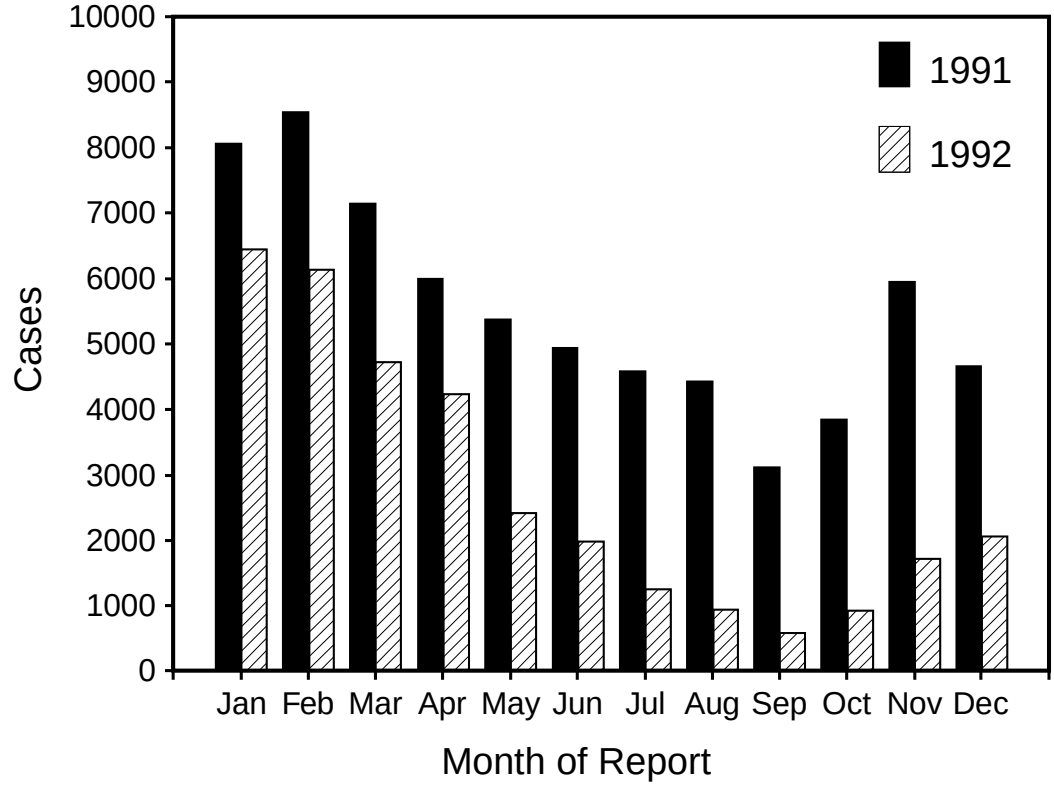
During 1992, more than 33,000 cases of dracunculiasis were prevented as a result of control interventions in 1991. As part of the goal to interrupt transmission of dracunculiasis completely by the end of 1993, Ghana has begun implementing intensive case-containment measures in all remaining areas with endemic disease.

References

1. CDC. Update: dracunculiasis eradication—Ghana and Nigeria, 1991. MMWR 1992;41:397–9.
2. World Health Organization. Dracunculiasis—global surveillance summary, 1991. Wkly Epidemiol Rec 1992;67:121–7.

*Use of trade names and commercial sources is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

FIGURE 1. Dracunculiasis cases, by month and year — Ghana, 1991–1992



Effectiveness in Disease and Injury Prevention

Business Responds to AIDS Program — December 1992–February 1993

Of all acquired immunodeficiency syndrome (AIDS) cases reported through 1991 in the United States, 76% occurred among persons aged 25–44 years (*1*); persons aged 15–44 years comprise approximately 50% of the United States workforce (*2*). On December 1, 1992, CDC introduced "Business Responds to AIDS" (BRTA)—a new program for the primary prevention of human immunodeficiency virus (HIV)/AIDS. BRTA, which was introduced by satellite teleconference, encourages business and labor leaders in U.S. communities to develop comprehensive workplace HIV-prevention education programs (*3*). This report describes BRTA and summarizes the response—from December 1, 1992, through February 5, 1993—to the launch of the national program.

BRTA is a public and private collaboration (involving business, labor, health, and AIDS service organizations) comprised of five components: 1) policy development; 2) training for supervisors and union leaders; 3) HIV education for employees; 4) HIV education for employees' families; and 5) community service and employee volunteerism. In addition, the BRTA Resource Service was established at the CDC National AIDS Clearinghouse to provide a toll-free reference and referral system to assist in implementing HIV workplace education programs. Materials in separate kits for managers and labor leaders, other resources, and local referrals are available from the Resource Service.*

In October and November 1992, advance information on the BRTA teleconference was sent to 35,000 corporations with communication systems that could receive the broadcast. In addition, the broadcast was carried by the American Red Cross Crosslinks Satellite System (84 chapters); the U.S. Department of Agriculture (1200 locations equipped to receive the broadcast); the Health and Science Television Network (1000 hospital receiving sites); the Scola Education Network (approximately 1200 colleges and universities, government organizations, and the World Bank) and many commercial television networks and local and regional cable television systems (Ogilvy Adams & Rinehart, unpublished data, 1993). Following the broadcast, the BRTA teleconference was reported on stations in 64 of the nation's largest 75 television markets and in major newspapers.

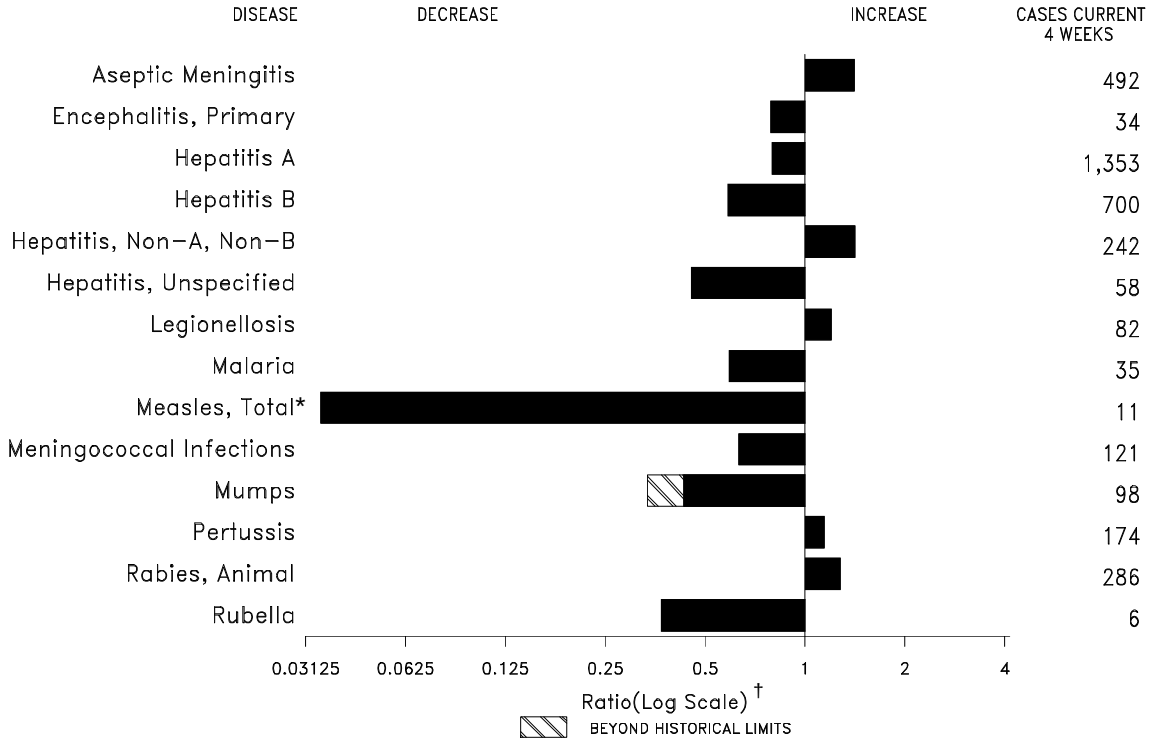
The total number of persons who watched the broadcast cannot be determined; however, many local events were conducted in conjunction with the teleconference (Ogilvy Adams & Rinehart, unpublished data, 1993), including the following:

- Communities in approximately 33 states and the District of Columbia used the BRTA teleconference as an event to involve local business leaders with public health and AIDS service organizations to promote HIV workplace education.
- Approximately 1500 managers from a national insurance company viewed the broadcast at 165 sites through an in-house corporate television network.

(Continued on page 101)

*Additional information on BRTA and kits (cost: $25 per kit) are available from the CDC Business Responds to AIDS Resource Service, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending February 6, 1993, with historical data — United States



*The large apparent decrease in reported cases of measles(total) reflects dramatic fluctuations in the historical baseline.

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where thehatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending February 6, 1993 (5th Week)

	Cum. 1993		Cum. 1993
AIDS*	4,278	Measles: imported	3
Anthrax	-	indigenous	12
Botulism: Foodborne	-	Plague	-
Infant	4	Poliomyelitis, Paralytic§	-
Other	1	Psittacosis	10
Brucellosis	4	Rabies, human	-
Cholera	-	Syphilis, primary & secondary	2,683
Congenital rubella syndrome	1	Syphilis, congenital, age < 1 year	-
Diphtheria	-	Tetanus	1
Encephalitis, post-infectious	10	Toxic shock syndrome	17
Gonorrhea	35,223	Trichinosis	2
Haemophilus influenzae (invasive disease)†	93	Tuberculosis	1,249
Hansen Disease	10	Tularemia	6
Leptospirosis	-	Typhoid fever	43
Lyme Disease	180	Typhus fever, tickborne (RMSF)	10

*Updated monthly; last update January 30, 1993.
†Of 84 cases of known age, 38 (45%) were reported among children less than 5 years of age.
§No cases of suspected poliomyelitis have been reported in 1993; 4 cases of suspected poliomyelitis were reported in 1992; 6 of the 9 suspected cases with onset in 1991 were confirmed; all were vaccine associated.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending February 6, 1993, and February 1, 1992 (5th Week)

Reporting Area	AIDS*	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1993	Cum. 1993	Cum. 1993	Cum. 1993	Cum. 1993	Cum. 1992	Cum. 1993	Cum. 1993	Cum. 1993	Cum. 1993	Cum. 1993	Cum. 1993
UNITED STATES	4,278	597	49	10	35,223	44,969	1,956	830	295	62	107	180
NEW ENGLAND	195	13	2	-	792	1,034	76	43	1	1	3	23
Maine	8	2	-	-	10	10	3	-	-	-	1	-
N.H.	8	1	-	-	5	-	2	9	-	-	-	5
Vt.	3	1	-	-	5	1	1	-	-	-	-	-
Mass.	102	7	2	-	354	413	45	29	1	1	2	9
R.I.	4	2	-	-	41	76	20	5	-	-	-	7
Conn.	70	-	-	-	377	534	5	-	-	-	-	2
MID. ATLANTIC	948	47	1	2	3,391	3,529	95	75	19	2	17	127
Upstate N.Y.	160	18	-	1	479	12	34	14	7	1	2	58
N.Y. City	677	5	-	-	925	1,867	10	1	-	-	-	-
N.J.	100	-	-	-	717	704	34	28	9	-	4	5
Pa.	11	24	1	1	1,270	946	17	32	3	1	11	64
E.N. CENTRAL	333	104	15	2	5,978	8,668	307	120	74	-	35	2
Ohio	85	49	9	-	2,045	2,787	59	29	1	-	17	2
Ind.	59	13	2	-	710	859	201	38	3	-	8	-
Ill.	118	7	1	-	1,617	3,434	20	5	-	-	-	-
Mich.	51	33	2	2	1,311	1,243	25	47	70	-	10	-
Wis.	20	2	1	-	295	345	2	1	-	-	-	-
W.N. CENTRAL	86	22	2	-	2,072	2,377	367	49	14	-	7	7
Minn.	19	2	2	-	276	288	23	2	-	-	-	-
Iowa	13	4	-	-	148	140	1	1	1	-	-	-
Mo.	39	7	-	-	1,184	1,540	259	38	11	-	2	-
N. Dak.	-	-	-	-	5	8	4	-	-	-	-	-
S. Dak.	1	-	-	-	18	17	3	-	-	-	-	-
Nebr.	3	1	-	-	-	8	54	-	2	-	4	-
Kans.	11	8	-	-	441	376	23	8	-	-	1	7
S. ATLANTIC	977	128	5	2	10,646	16,907	81	98	21	8	16	9
Del.	15	1	-	-	136	142	1	4	14	-	2	6
Md.	142	13	4	-	1,607	1,647	18	33	1	1	9	-
D.C.	106	1	-	-	765	764	-	3	-	-	3	1
Va.	13	8	-	-	573	2,017	4	3	-	1	-	-
W. Va.	3	2	1	-	79	105	-	2	-	3	-	1
N.C.	60	6	-	-	2,531	1,120	1	13	-	-	-	-
S.C.	55	1	-	-	1,138	1,285	2	6	-	-	-	-
Ga.	131	9	-	-	1,383	7,036	14	3	3	-	2	-
Fla.	452	87	-	2	2,434	2,791	41	31	3	3	-	1
E.S. CENTRAL	195	52	1	-	3,874	3,501	30	94	46	-	9	-
Ky.	16	26	-	-	477	472	19	7	-	-	2	-
Tenn.	107	10	1	-	1,256	1,263	7	77	45	-	5	-
Ala.	57	13	-	-	1,171	799	2	8	1	-	-	-
Miss.	15	3	-	-	970	967	2	2	-	-	2	-
W.S. CENTRAL	603	13	1	-	4,811	3,669	57	20	3	4	3	1
Ark.	16	4	-	-	643	186	6	3	-	-	-	-
La.	140	-	-	-	1,182	853	3	6	-	-	-	-
Okla.	38	-	-	-	314	426	6	-	3	1	3	1
Tex.	409	9	1	-	2,672	2,204	42	11	-	3	-	-
MOUNTAIN	103	22	3	2	765	1,191	346	54	23	16	9	-
Mont.	-	-	-	-	10	6	13	-	-	-	-	-
Idaho	2	2	-	-	9	8	25	3	-	-	1	-
Wyo.	1	-	-	-	5	2	1	-	3	-	2	-
Colo.	4	7	1	-	242	375	116	3	7	13	-	-
N. Mex.	10	8	1	2	90	79	31	27	9	-	-	-
Ariz.	31	3	1	-	249	508	106	12	2	2	2	-
Utah	17	-	-	-	4	17	51	2	1	1	-	-
Nev.	38	2	-	-	156	196	3	7	1	-	4	-
PACIFIC	838	196	19	2	2,894	4,093	597	277	94	31	8	11
Wash.	26	-	-	-	396	380	35	10	7	-	-	-
Oreg.	23	-	-	-	148	103	19	11	3	-	-	-
Calif.	776	188	18	2	2,268	3,476	460	256	82	30	8	11
Alaska	3	1	1	-	46	90	71	-	-	-	-	-
Hawaii	10	7	-	-	36	44	12	-	2	1	-	-
Guam	-	-	-	-	-	10	-	-	-	-	-	-
P.R.	127	2	-	-	28	1	-	14	1	-	-	-
V.I.	30	-	-	-	11	5	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	4	5	2	-	-	-	-	-
C.N.M.I.	-	2	-	-	7	5	-	-	-	-	-	-

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly; last update January 30, 1993.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending February 6, 1993, and February 1, 1992 (5th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1993	1993	Cum. 1993	1993	Cum. 1993	Cum. 1992	Cum. 1993	1993	Cum. 1993	1993	Cum. 1993	Cum. 1992	1993	Cum. 1993	Cum. 1992
UNITED STATES	56	5	12	-	3	49	187	25	126	65	216	84	2	11	17
NEW ENGLAND	7	4	8	-	-	2	16	-	1	1	50	-	1	1	4
Maine	-	-	-	-	-	-	2	-	-	-	3	-	1	1	-
N.H.	1	-	-	-	-	-	4	-	-	-	44	-	-	-	-
Vt.	-	4	5	-	-	-	2	-	-	-	1	-	-	-	-
Mass.	5	-	-	-	-	-	7	-	-	-	-	-	-	-	-
R.I.	1	-	-	-	-	-	-	-	1	-	1	-	-	-	4
Conn.	-	-	3	-	-	2	1	-	-	1	1	-	-	-	-
MID. ATLANTIC	7	-	-	-	-	11	23	3	14	16	43	26	-	1	1
Upstate N.Y.	4	-	-	-	-	1	9	2	4	7	13	6	-	-	1
N.Y. City	2	-	-	-	-	1	3	-	-	-	-	-	-	-	-
N.J.	1	-	-	-	-	9	6	-	1	-	11	14	-	1	-
Pa.	-	-	-	-	-	-	5	1	9	9	19	6	-	-	-
E.N. CENTRAL	7	-	-	-	-	1	40	6	31	14	29	12	-	-	4
Ohio	2	-	-	-	-	-	6	6	16	14	21	-	-	-	-
Ind.	2	-	-	-	-	-	22	-	-	-	2	5	-	-	-
Ill.	1	-	-	-	-	-	7	-	4	-	-	2	-	-	4
Mich.	2	-	-	-	-	-	4	-	11	-	5	1	-	-	-
Wis.	-	-	-	-	-	1	1	-	-	-	1	4	-	-	-
W.N. CENTRAL	-	-	-	-	-	-	4	-	6	2	8	10	-	1	1
Minn.	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Iowa	-	-	-	-	-	-	1	-	2	-	-	1	-	-	-
Mo.	-	-	-	-	-	-	-	-	3	2	6	5	-	1	-
N. Dak.	-	-	-	-	-	-	-	-	1	-	-	1	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	1	2	-	-	-
Kans.	-	-	-	-	-	-	3	-	-	-	-	-	-	-	1
S. ATLANTIC	7	1	2	-	2	7	37	2	16	4	7	10	1	1	1
Del.	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Md.	3	-	-	-	1	-	1	2	7	-	3	6	-	-	-
D.C.	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Va.	-	-	-	-	1	-	4	-	4	-	-	-	-	-	-
W. Va.	-	-	-	-	-	-	1	-	2	-	-	-	-	-	-
N.C.	-	-	-	-	-	-	4	-	-	-	-	4	-	-	-
S.C.	-	-	-	-	-	-	5	-	1	2	2	-	-	-	-
Ga.	1	-	-	-	-	-	14	-	-	-	-	-	-	-	-
Fla.	2	1	2	-	-	7	6	-	2	2	2	-	1	1	1
E.S. CENTRAL	2	-	-	-	-	23	14	-	4	-	4	1	-	-	-
Ky.	-	-	-	-	-	22	3	-	-	-	-	-	-	-	-
Tenn.	-	-	-	-	-	-	5	-	3	-	1	-	-	-	-
Ala.	1	-	-	-	-	-	3	-	1	-	3	1	-	-	-
Miss.	1	-	-	-	-	1	3	-	-	-	-	-	-	-	-
W.S. CENTRAL	1	-	-	-	-	-	1	8	19	3	6	4	-	-	-
Ark.	-	-	-	-	-	-	1	1	1	-	-	3	-	-	-
La.	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-
Okla.	1	-	-	-	-	-	-	-	2	3	6	1	-	-	-
Tex.	-	-	-	-	-	-	-	6	15	-	-	-	-	-	-
MOUNTAIN	1	-	-	-	-	-	12	-	10	4	10	9	-	1	-
Mont.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	1	-	2	-	-	4	-	-	-
Wyo.	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-
Colo.	1	-	-	-	-	-	-	-	1	-	-	3	-	-	-
N. Mex.	-	-	-	-	-	-	-	N	N	4	8	2	-	-	-
Ariz.	-	-	-	-	-	-	10	-	4	-	1	-	-	-	-
Utah	-	-	-	-	-	-	-	-	3	-	-	-	-	1	-
Nev.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
PACIFIC	24	-	2	-	1	5	40	6	25	21	59	12	-	6	6
Wash.	-	-	-	-	-	-	3	-	3	-	1	-	-	-	-
Oreg.	1	-	-	-	-	-	5	N	N	-	-	2	-	1	-
Calif.	23	-	1	-	-	4	30	5	20	21	55	10	-	3	6
Alaska	-	-	-	-	-	1	1	1	2	-	-	-	-	1	-
Hawaii	-	-	1	-	1	-	1	-	-	-	3	-	-	1	-
Guam	-	U	-	U	-	3	-	U	-	U	-	-	U	-	-
P.R.	-	18	18	-	-	4	-	-	-	-	-	1	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

*For measles only, imported cases include both out-of-state and international importations.
N: Not notifiable U: Unavailable † International § Out-of-state

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending February 6, 1993, and February 1, 1992 (5th Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic-Shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1993	Cum. 1992	Cum. 1993	Cum. 1993	Cum. 1992	Cum. 1993	Cum. 1993	Cum. 1993	Cum. 1993
UNITED STATES	2,683	2,786	17	1,249	1,467	6	43	10	450
NEW ENGLAND	51	56	3	68	6	-	2	2	99
Maine	-	-	-	3	-	-	-	-	-
N.H.	-	4	-	-	-	-	-	-	2
Vt.	-	-	-	-	-	-	-	-	2
Mass.	32	20	3	1	3	-	2	2	24
R.I.	1	3	-	54	-	-	-	-	-
Conn.	18	29	-	10	3	-	-	-	71
MID. ATLANTIC	208	379	2	218	332	-	17	1	160
Upstate N.Y.	9	35	1	33	41	-	-	-	113
N.Y. City	163	199	-	125	210	-	2	-	-
N.J.	29	59	-	31	40	-	-	1	47
Pa.	7	86	1	29	41	-	15	-	-
E.N. CENTRAL	343	518	7	108	124	2	2	-	3
Ohio	117	62	4	16	25	-	2	-	-
Ind.	26	19	1	6	12	1	-	-	-
Ill.	114	263	-	67	51	-	-	-	-
Mich.	64	94	2	14	31	1	-	-	-
Wis.	22	80	-	5	5	-	-	-	3
W.N. CENTRAL	173	69	2	17	41	-	-	-	24
Minn.	10	7	1	-	24	-	-	-	7
Iowa	12	1	-	2	3	-	-	-	-
Mo.	151	60	-	8	13	-	-	-	1
N. Dak.	-	-	-	-	1	-	-	-	4
S. Dak.	-	-	-	2	-	-	-	-	-
Nebr.	-	1	-	2	-	-	-	-	-
Kans.	-	-	1	3	-	-	-	-	12
S. ATLANTIC	815	883	1	161	230	-	4	2	143
Del.	12	14	-	-	1	-	-	-	12
Md.	41	76	-	24	41	-	2	-	33
D.C.	55	66	-	8	7	-	-	-	3
Va.	53	69	-	-	8	-	-	-	40
W. Va.	4	1	-	5	9	-	-	-	4
N.C.	249	171	-	49	26	-	-	2	4
S.C.	131	135	-	24	22	-	-	-	8
Ga.	134	199	-	51	22	-	-	-	39
Fla.	136	152	1	-	94	-	2	-	-
E.S. CENTRAL	346	369	-	55	77	2	-	2	9
Ky.	38	13	-	17	23	-	-	1	-
Tenn.	99	74	-	-	-	1	-	-	-
Ala.	83	176	-	33	29	1	-	-	9
Miss.	126	106	-	5	25	-	-	1	-
W.S. CENTRAL	635	262	-	9	4	-	-	3	4
Ark.	61	-	-	9	3	-	-	-	2
La.	218	152	-	-	-	-	-	-	-
Okla.	59	18	-	-	1	-	-	3	2
Tex.	297	92	-	-	-	-	-	-	-
MOUNTAIN	7	71	-	21	20	-	-	-	5
Mont.	-	2	-	-	-	-	-	-	-
Idaho	-	1	-	-	4	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-	2
Colo.	3	11	-	-	-	-	-	-	-
N. Mex.	1	7	-	-	6	-	-	-	1
Ariz.	3	28	-	17	7	-	-	-	2
Utah	-	1	-	-	-	-	-	-	-
Nev.	-	21	-	4	3	-	-	-	-
PACIFIC	105	179	2	592	633	2	18	-	3
Wash.	-	9	-	19	19	-	-	-	-
Oreg.	7	5	-	6	2	-	-	-	-
Calif.	97	164	2	550	585	2	18	-	-
Alaska	-	-	-	-	7	-	-	-	3
Hawaii	1	1	-	17	20	-	-	-	-
Guam	-	1	-	-	10	-	-	-	-
P.R.	36	2	-	-	-	-	-	-	2
V.I.	10	6	-	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	3	-	-	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending February 6, 1993 (5th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	675	472	112	62	12	17	65
Boston, Mass.	197	127	34	23	6	7	18
Bridgeport, Conn.	U	U	U	U	U	U	U
Cambridge, Mass.	28	24	4	-	-	-	1
Fall River, Mass.	34	23	8	3	-	-	2
Hartford, Conn.	67	43	10	9	4	1	1
Lowell, Mass.	22	20	1	1	-	-	2
Lynn, Mass.	17	12	4	1	-	-	1
New Bedford, Mass.	26	17	8	-	-	1	-
New Haven, Conn.	61	41	10	7	-	3	6
Providence, R.I.	51	40	7	3	1	-	12
Somerville, Mass.	9	6	1	2	-	-	1
Springfield, Mass.	52	41	7	2	-	2	6
Waterbury, Conn.	29	22	4	2	1	-	2
Worcester, Mass.	82	56	14	9	-	3	13
MID. ATLANTIC	2,675	1,795	477	270	57	76	134
Albany, N.Y.	63	48	7	6	1	1	2
Allentown, Pa.	29	22	4	3	-	-	2
Buffalo, N.Y.	120	77	26	12	3	2	5
Camden, N.J.	36	20	9	3	2	2	2
Elizabeth, N.J.	36	27	6	3	-	-	3
Erie, Pa.§	41	35	4	1	1	-	2
Jersey City, N.J.	76	51	9	8	3	5	1
New York City, N.Y.	1,428	923	267	178	31	29	57
Newark, N.J.	75	40	15	10	4	6	11
Paterson, N.J.	23	16	2	4	-	1	1
Philadelphia, Pa.	306	189	65	23	6	23	18
Pittsburgh, Pa.§	81	59	15	4	2	1	4
Reading, Pa.	16	11	3	2	-	-	1
Rochester, N.Y.	143	123	12	5	1	2	8
Schenectady, N.Y.	17	14	3	-	-	-	-
Scranton, Pa.§	25	22	3	-	-	-	2
Syracuse, N.Y.	102	77	17	3	2	3	8
Trenton, N.J.	36	23	7	5	-	1	5
Utica, N.Y.	22	18	3	-	1	-	2
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,340	1,474	443	222	121	80	128
Akron, Ohio	58	42	11	1	-	4	-
Canton, Ohio	44	37	5	1	1	-	6
Chicago, Ill.	510	231	100	91	74	14	14
Cincinnati, Ohio	176	118	36	13	5	4	12
Cleveland, Ohio	147	97	33	5	4	8	5
Columbus, Ohio	189	125	32	15	7	10	14
Dayton, Ohio	112	69	33	6	2	2	7
Detroit, Mich.	259	145	55	35	14	10	8
Evansville, Ind.	44	32	6	3	1	2	3
Fort Wayne, Ind.	60	39	12	4	2	3	2
Gary, Ind.	16	11	2	-	3	-	2
Grand Rapids, Mich.	60	44	9	4	-	3	6
Indianapolis, Ind.	171	101	42	18	3	7	6
Madison, Wis.	41	27	8	4	1	1	7
Milwaukee, Wis.	152	123	19	5	2	3	12
Peoria, Ill.	40	26	9	2	-	3	9
Rockford, Ill.	46	35	6	3	-	2	3
South Bend, Ind.	47	36	6	4	-	1	2
Toledo, Ohio	103	82	12	4	2	3	9
Youngstown, Ohio	65	54	7	4	-	-	1
W.N. CENTRAL	797	565	144	47	19	22	51
Des Moines, Iowa	82	64	10	5	3	-	2
Duluth, Minn.	18	13	3	1	-	1	1
Kansas City, Kans.	17	13	3	-	1	-	1
Kansas City, Mo.	104	78	20	6	-	-	9
Lincoln, Nebr.	42	31	9	1	-	1	2
Minneapolis, Minn.	195	139	32	15	4	5	14
Omaha, Nebr.	74	53	16	3	1	1	5
St. Louis, Mo.	139	84	33	8	7	7	8
St. Paul, Minn.	69	52	10	4	1	2	6
Wichita, Kans.	57	38	8	4	2	5	3

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,361	876	275	148	33	27	73
Atlanta, Ga.	172	101	41	24	5	1	4
Baltimore, Md.	241	151	48	34	4	3	27
Charlotte, N.C.	93	58	22	8	2	3	4
Jacksonville, Fla.	128	83	29	10	3	3	4
Miami, Fla.	102	66	22	9	5	-	1
Norfolk, Va.	56	39	10	4	1	2	5
Richmond, Va.	87	57	15	11	1	2	9
Savannah, Ga.	49	34	12	2	-	1	5
St. Petersburg, Fla.	52	40	5	5	-	2	-
Tampa, Fla.	170	120	36	11	1	2	10
Washington, D.C.	176	102	31	27	9	7	4
Wilmington, Del.	35	25	4	3	2	1	-
E.S. CENTRAL	822	522	178	68	27	27	65
Birmingham, Ala.	129	79	32	9	5	4	9
Chattanooga, Tenn.	65	39	16	7	2	1	1
Knoxville, Tenn.	123	86	26	7	4	-	14
Lexington, Ky.	70	45	17	3	2	3	7
Memphis, Tenn.	205	135	36	15	8	11	22
Mobile, Ala.	71	37	15	11	2	6	6
Montgomery, Ala.	42	23	9	8	1	1	1
Nashville, Tenn.	117	78	27	8	3	1	5
W.S. CENTRAL	1,540	962	323	164	53	38	87
Austin, Tex.	68	46	9	8	3	2	6
Baton Rouge, La.	59	32	15	5	2	5	4
Corpus Christi, Tex.	56	40	8	6	1	1	1
Dallas, Tex.	211	126	46	23	11	5	3
El Paso, Tex.	67	42	10	9	6	-	7
Ft. Worth, Tex.	112	75	15	15	3	4	4
Houston, Tex.	385	233	96	42	9	5	33
Little Rock, Ark.	76	48	13	8	2	5	4
New Orleans, La.	126	68	29	21	6	2	-
San Antonio, Tex.	235	159	48	21	4	3	15
Shreveport, La.	62	34	17	4	3	4	5
Tulsa, Okla.	83	59	17	2	3	2	5
MOUNTAIN	849	583	158	65	26	15	77
Albuquerque, N.M.	78	56	11	7	3	1	7
Colo. Springs, Colo.	47	36	8	1	-	2	9
Denver, Colo.	118	82	19	12	3	2	3
Las Vegas, Nev.	147	85	38	16	4	2	9
Ogden, Utah	17	17	-	-	-	-	3
Phoenix, Ariz.	202	128	44	16	9	5	23
Pueblo, Colo.	24	19	3	2	-	-	-
Salt Lake City, Utah	84	61	14	6	2	1	8
Tucson, Ariz.	132	99	21	5	5	2	15
PACIFIC	2,160	1,457	353	215	83	40	173
Berkeley, Calif.	19	15	3	1	-	-	2
Fresno, Calif.	106	67	21	4	6	8	9
Glendale, Calif.	24	14	6	2	2	-	-
Honolulu, Hawaii	77	56	11	9	-	1	6
Long Beach, Calif.	83	52	17	4	3	7	13
Los Angeles, Calif.	583	351	95	92	30	4	36
Pasadena, Calif.	37	31	5	-	1	-	5
Portland, Oreg.	167	128	22	9	4	4	7
Sacramento, Calif.	159	103	27	18	8	3	14
San Diego, Calif.	196	127	36	14	13	6	22
San Francisco, Calif.	184	115	35	27	3	3	5
San Jose, Calif.	169	118	32	11	8	-	25
Santa Cruz, Calif.	27	24	2	1	-	-	4
Seattle, Wash.	193	149	23	15	4	2	12
Spokane, Wash.	51	40	7	2	1	1	4
Tacoma, Wash.	85	67	11	6	-	1	9
TOTAL	13,219¶	8,706	2,463	1,261	431	342	853

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

U: Unavailable.

BRTA — Continued

- Public health representatives from 45 states and three territorial health departments viewed the teleconference as part of the Epidemiology by Satellite Training Conference at the University of Alabama at Birmingham.
- The Bureau of Public Health, West Virginia Department of Health and Human Resources, organized teleconference viewings at 23 sites where business professionals viewed the conference and received packets of information that included statistics on HIV/AIDS in West Virginia and a list of resources available to businesses.

From December 1, 1992, through February 5, 1993, the BRTA Resource Service received 3047 requests for assistance, compared with an average of 560 calls per month for workplace assistance during the 6 months before the BRTA teleconference. From December 1 through February 5, the Resource Service also received orders for 1844 manager's kits to be used in HIV education for employees; for example, a pharmaceutical company with 80,000 employees ordered kits and resource materials to use in developing programs for its employees.

Organizations contacting the Resource Service included small businesses, state and local health departments, large multinational and national corporations, and labor organizations. The largest percentage of requests for assistance (more than 65%) was received from the business sector.

Preliminary data indicate that the teleconference and its coverage by the media afterward were major sources of information about the BRTA Resource Service. During December, 26% of callers to the Resource Service indicated they learned of BRTA from the teleconference, 31% cited an article about the teleconference in a major newspaper, and 43% reported they learned of the service from national and local print media (CDC National AIDS Clearinghouse, unpublished data, 1993).

Reported by: National AIDS Information and Education Program, Office of HIV/AIDS, Office of the Director, CDC.

Editorial Note: Since the initiation of BRTA on December 1, business and labor organizations, the media, state and local health agencies, and AIDS community-based organizations have reported that the program provides useful background for development of HIV/AIDS workplace education. The types of organizations and individuals requesting information from the CDC National AIDS Clearinghouse BRTA Resource Service reflect a diversity of employers and include businesses with products and services for sale and health departments and other nonprofit organizations. The immediate subsequent steps for this long-term prevention program include aggressive marketing of the manager's kit, the labor leader's kit, and the CDC BRTA Resource Service and regional briefings for business and labor leaders to encourage comprehensive HIV workplace education across the nation.

References

1. CDC. HIV/AIDS surveillance report. Atlanta: US Department of Health and Human Services, Public Health Service, January 1992.
2. Fullerton HN Jr. New labor force projections, spanning 1988 to 2000. Monthly Labor Review 1989;112:3–12.
3. CDC. Business Responds to AIDS Program. MMWR 1992;41:879.

Surveillance Summaries

Publication of *CDC Surveillance Summaries*

Since 1983, CDC has published the *CDC Surveillance Summaries* under separate cover as part of the *MMWR* series. Each report published in the *CDC Surveillance Summaries* focuses on public health surveillance; surveillance findings are reported for a broad range of risk factors and health conditions.

Summaries for each of the reports published in the November 20, 1992, issue of the *CDC Surveillance Summaries* (*1*) are provided below. All subscribers to *MMWR* receive the *CDC Surveillance Summaries*, as well as the *MMWR Recommendations and Reports*, as part of their subscriptions.

MEASLES SURVEILLANCE — UNITED STATES, 1991

A total of 9643 measles cases was reported from the United States in 1991, a 65.3% decrease from the 27,786 cases reported in 1990. The overall incidence of measles was 3.9 cases per 100,000 population. The highest age-specific incidence was among children <12 months of age (46.9/100,000) and 1–4 years of age (19.6/100,000). Incidence rates among American Indian, Hispanic, and black children <5 years of age were 19, 6, and 4 times that for non-Hispanic white children, respectively. More than 61% of all cases were reported from seven large outbreaks, which involved predominantly unvaccinated preschool-aged children in large urban areas. Although reported measles cases decreased in 1991 compared with 1989–1990, only a sustained effort to provide age-appropriate vaccination will prevent another resurgence of measles.

Authors: William L. Atkinson, M.D., M.P.H., Stephen C. Hadler, M.D., Susan B. Redd, Walter A. Orenstein, M.D., Division of Immunization, National Center for Prevention Services, CDC.

YEARS OF POTENTIAL LIFE LOST BEFORE AGE 65, BY RACE, HISPANIC ORIGIN, AND SEX — UNITED STATES, 1986–1988

A substantial proportion of mortality among young persons is preventable. National vital statistics were used to establish a baseline for the surveillance of rates of years of potential life lost before age 65 (YPLL <65) in the United States. Rates of YPLL <65 were calculated for 1986 through 1988 for leading causes of preventable death, by race, Hispanic origin, and sex. U.S. racial and ethnic populations differed widely in YPLL <65. Among males, the rate (per 1000 population <65 years) of YPLL <65 was highest for non-Hispanic blacks (140.0), followed by American Indians/Alaskan Natives (100.9), Hispanics (74.3), non-Hispanic whites (68.3), and Asians/Pacific Islanders (38.2). Among females, it was highest for non-Hispanic blacks (73.7), followed by American Indians/Alaskan Natives (52.0), non-Hispanic whites (35.7), Hispanics (32.9), and Asians/Pacific Islanders (23.2). For non-Hispanic blacks, the high rate of YPLL <65 was due to increased rates for all causes of death considered, particularly homicide. The high rate for American Indians/Alaskan Natives was due principally to deaths from four causes: unintentional injuries, cirrhosis, suicide, and diabetes. Asians/Pacific Islanders had low rates for most causes of death. In setting health-care priorities and prevention strategies to reduce the large racial-ethnic gap in early deaths, it is essential to recognize the differences in causes of premature mortality among sex, racial, and ethnic populations. Periodic reassessment of YPLL <65 among these groups pro-

Surveillance Summaries — *Continued*

vides a simple, timely, and representative means of conducting surveillance to measure the impact of intervention strategies on a national basis.

Authors: Jean-Claude A. Desenclos, M.D., Hopital National de Saint-Maurice,European Centre for the Epidemiological Monitoring of AIDS. Robert A. Hahn, Ph.D., M.P.H., Division of Surveillance and Epidemiology, Epidemiology Program Office, CDC.

GROUP B STREPTOCOCCAL DISEASE IN THE UNITED STATES, 1990: REPORT FROM A MULTISTATE ACTIVE SURVEILLANCE SYSTEM

Group B streptococcal (GBS) disease is the most common cause of neonatal sepsis and meningitis in the United States. It is also an important cause of morbidity among pregnant women and adults with underlying medical conditions. Because most states have not designated GBS disease as a reportable condition, previous estimates of the incidence of GBS disease were based on studies from single hospitals or small geographic areas. This report summarizes the results of population-based active surveillance for invasive GBS disease in counties within four states that had an aggregate population of 10.1 million persons in 1990. A case of GBS disease was defined as isolation of group B streptococcus from a normally sterile anatomic site in a resident of one of the surveillance areas.

Age- and race-adjusted projections to the U.S. population suggest that >15,000 cases and >1300 deaths due to GBS disease occur each year. The projected age- and race-adjusted national incidence is 1.8/1000 live births for neonatal GBS disease and 4.0/100,000 population per year for adult GBS disease. Intrapartum chemoprophylaxis for pregnant women at risk for delivering infants with GBS disease is the most effective strategy available for prevention of neonatal disease. Development of effective GBS vaccines may prevent GBS disease in both infants and adults. Ongoing surveillance for GBS disease is important for targeting preventive measures and determining their effectiveness.

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Summaries for each of the reports published in the November 27, 1992, issue of the *CDC Surveillance Summaries* (*2*) are provided below.

PEDIATRIC NUTRITION SURVEILLANCE SYSTEM — UNITED STATES, 1980–1991

The CDC Pediatric Nutrition Surveillance System (PedNSS) monitors the general health and nutritional characteristics of low-income U.S. children who participate in multiple public health programs. This system is intended to characterize trends and patterns in key indicators of nutritional status so that the information can be used for program planning and targeting. The indicators monitored by PedNSS are birth weight, childhood growth status, anemia, and breast-feeding patterns. From 1980 through 1991, the trends for low birth weight, low height-for-age (shortness), low weight-for-height (thinness), and high weight-for-height (overweight) were stable for all children monitored by the PedNSS, with the exception of Asian children, who were predominantly of Southeast Asian refugee background. In the early 1980s, the prevalence of low birth weight and shortness was higher among Asian children than among children of other racial or ethnic groups who were monitored by the PedNSS. However, these prevalences declined steadily from 1980 through 1991. By 1991, the

Surveillance Summaries — *Continued*

prevalences of low birth weight and shortness for Asian children were similar to those observed for children of other races/ethnic groups. Overall, low-income U.S. children had a slightly lower height-for-age than expected, indicating that some of these children were at a health and nutritional disadvantage. The prevalence of overweight varied among different racial/ethnic groups; Hispanic and Native American children had the highest prevalences of overweight. The 20%–30% prevalence of anemia among low-income children monitored by the PedNSS was higher than among the general population, reflecting in part the preferential enrollment and retention of anemic children by public health nutrition programs and also indicating that many children had inadequate iron nutrition. From 1980 through 1991, the prevalence of anemia declined >5% for most of the age- and race/ethnicity-specific groups monitored by PedNSS. That decline represents an improvement in iron nutritional status. PedNSS is a useful system for the monitoring and characterization of the nutrition status of low-income children at both state and national levels.

Authors: Ray Yip, M.D., M.P.H., Ibrahim Parvanta, M.S., Kelley Scanlon, Ph.D., R.D., Ellen W. Borland, Carl M. Russell, D.M.D., M.S., Frederick L. Trowbridge, M.D., M.Sc., Division of Nutrition, National Center for Chronic Disease Prevention and Health Promotion, CDC.

PREGNANCY NUTRITION SURVEILLANCE SYSTEM — UNITED STATES, 1979–1990

Since 1979, the CDC Pregnancy Nutrition Surveillance System (PNSS) has monitored behavior and nutritional risk factors among low-income pregnant women participating in public health programs. Although the states contributing to the system have varied over the period, the PNSS is able to characterize the behavior and health outcomes of pregnant women from diverse low-income populations. In 1990, 66.2% of the women in the system initiated prenatal care during the first trimester of pregnancy; 26.4% smoked during pregnancy. Since 1979, the prevalence of smoking remained relatively stable for white women, but declined for blacks and Hispanics. Prepregnancy body mass index (BMI, defined as kg/m^2) showed marked changes from 1979 through 1990; the prevalence of underweight (BMI <19.8) declined steadily and the prevalence of overweight (BMI >26) increased steadily. In 1990, 39.3% of the women had gestational weight gains below levels recommended by the National Academy of Sciences. Both prepregnancy underweight and inadequate gestational weight gain were associated with greater risk for low birth weight in the PNSS. The prevalence of anemia at each trimester has remained stable since 1979. In 1990, 9.8%, 13.8%, and 33% of the women reported by the PNSS were anemic in the first, second, and third trimesters, respectively. Anemia in the first trimester appeared to be strongly associated with a high risk of low birth weight; this association was attenuated in later trimesters. These findings indicate the need to improve iron nutrition among low-income women.

Authors: Insum Kim, Dr.P.H., Daniel W. Hungerford, Dr.P.H., Ray Yip, M.D., M.P.H., Sarah A. Kuester, M.S., R.D., Colette Zyrkowski, M.P.H., R.D., Frederick L. Trowbridge, M.D., M.Sc., Division of Nutrition, National Center for Chronic Disease Prevention and Health Promotion, CDC.

References

1. CDC. CDC surveillance summaries (November 20). MMWR 1992;41(no. SS-6).
2. CDC. CDC surveillance summaries (November 27). MMWR 1992;41(no. SS-7).

Notice to Readers

Update: Availability of Sulfadiazine — United States

Sulfadiazine is a sulfa drug commonly used in combination with pyrimethamine to treat toxoplasmosis in patients with acquired immunodeficiency syndrome (AIDS) and newborns with congenital infections. In December 1992, CDC reported that the domestic manufacturer of sulfadiazine had ceased production in October 1992 and that no large inventories of the drug were available from major distributors (*1*). On February 8, CDC obtained permission from the Food and Drug Administration (FDA) to proceed with an "Investigational New Drug" (IND) application protocol under which sulfadiazine may be imported and made available to physicians until a domestic commercial source is re-established.

The drug will be available from CDC beginning February 16 at no cost for the treatment of acute infection and for maintenance therapy of suspected or proven toxoplasmosis in persons with AIDS, persons with ocular disease, pregnant women who are infected, and congenitally infected infants. Pregnant women in the second and third trimester and infants must have an elevated *Toxoplasma* IgM titer before sulfadiazine can be released under this IND protocol. The drug will not be available under the CDC IND application protocol for primary prophylaxis of toxoplasmosis.

A 6-week supply of sulfadiazine will be provided for treatment of acute infection in persons with AIDS, ocular infection, and infection in pregnant women; a 2-month refillable supply will be provided for treatment of infection in congenitally infected infants and for maintenance therapy in persons with AIDS. Clinicians who would like to obtain sulfadiazine for patients must provide CDC with clinical and laboratory information about the patient, including *Toxoplasma* antibody titers, and a complete shipping address for their hospital or practice. CDC will not record patient names; instead, each patient will be assigned a computer-generated identification number that must be used to obtain additional drug supplies without having to re-enroll the patient. Having the patient's medical record available when contacting CDC will facilitate the initial drug release process. An IND information package will accompany the released drug.

Large hospitals or practices that wish to enroll several patients should consider designating one principal physician to serve as the clinical investigator for the facility. This person would ensure that all terms of the IND are adhered to by other physicians using the drug in the same facility. Requests should be directed to CDC's Division of Parasitic Diseases, National Center for Infectious Diseases, telephone (404) 488-4928.

Reported by: Div of Antiviral Drug Products, Center for Drug Evaluation and Research, Food and Drug Administration. Scientific Resources Program, and Div of Parasitic Diseases, National Center for Infectious Diseases, CDC.

Reference

1. CDC. Availability of sulfadiazine—United States. MMWR 1992;41:950–1.

Errata: Vol. 42, No. 2

In the article "Worksite Health Promotion—New Hampshire, 1992," on page 35, in Table 2, under the manufacturing industry heading, the percentage of worksites offering weight control activities should read *21.7 (±4.9)* and stress management should read *5.7*.

On page 37, the references should be renumbered as *3. Heimendinger . . ., 4. Eley . . ., 5. Public Health Service . . ., 6. Division of Public Health Services . . .,* and *7. National Resource Center on Worksite Health Promotion . . .* .

Errata: Vol. 41, No. 53

In Table I, Summary—Cases of specified notifiable diseases, United States, cumulative, week ending January 2, 1993 (53rd week), on page 979, the count for gonorrhea should be *484,133*, and for primary and secondary syphilis, *33,450*.

In Table II, Cases of selected notifiable diseases, United States, week ending January 2 . . ., on page 980, the cumulative number of gonorrhea cases reported in the United States for 1992 should be *484,133*; for the W.N. Central region, *24,379*; and for Missouri, *14,861*. On page 982, the cumulative number of primary and secondary syphilis cases reported in the United States for 1992 should be *33,450*; for the W.N. Central region, *1,553*; and for Missouri, *1,199*.

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The data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday. Inquiries about the *MMWR* Series, including material to be considered for publication, should be directed to: Editor, *MMWR* Series, Mailstop C-08, Centers for Disease Control and Prevention, Atlanta, GA 30333; telephone (404) 332-4555.

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