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WEEKLY REPORT

Pedestrian Fatalities — Cobb, DeKalb, Fulton, and Gwinnett Counties, Georgia, 1994–1998

In 1997, a total of 5307 pedestrian fatalities occurred in the United States, accounting for 13% of motor-vehicle–related deaths (*1*). The Atlanta metropolitan statistical area (MSA) is reported to be the third most dangerous large metropolitan area for walking, behind Fort Lauderdale and Miami, Florida (*2*). This report summarizes an investigation of pedestrian fatalities in four central metropolitan Atlanta counties; the findings indicate that the annual pedestrian fatality rate* for these counties combined has been consistently higher than the national rate, and from 1994 to 1998 the four-county area pedestrian fatality rate increased 13%.

A pedestrian fatality was defined as a death of a person on foot within 30 days after being struck on a public roadway by a motor vehicle during 1994–1998 in the Georgia counties of Cobb, DeKalb, Fulton, and Gwinnett. The four counties constitute 65% of the 20-county Atlanta MSA population. These are the only counties in the Atlanta MSA with medical examiners (MEs), and MEs were the only source identified with a complete record of pedestrian deaths through the end of 1998. Cases identified in ME databases were confirmed using police crash reports from the Georgia Department of Public Safety. Both ME data and police crash report data were used in the analysis. MEs assigned each person who died a race/ethnicity in the mutually exclusive categories of black, white, and Hispanic. The corresponding census groups used in calculating the rates were non-Hispanic black, non-Hispanic white, and Hispanic, respectively. Other races/ethnicities were not included in the analysis. Population estimates from the Bureau of the Census were used to calculate rates. However, because estimates of the 1998 population by age, race, and sex were not available for the counties, the 1996 population was used to calculate average annual rates for these variables. Pedestrian fatality rates for the United States were obtained from the National Highway Traffic Safety Administration, Fatality Analysis Reporting System.

A total of 309 pedestrian fatalities occurred in the four-county area during 1994–1998. The pedestrian fatality rate (per 100,000 population) increased from 2.53 in 1994

*Dividing the number of pedestrian deaths from collisions in a county by the population of the county is not a rate because some of those who died may not have been county residents. For simplicity and consistency with reporting of national crash data, the term "rate" instead of "ratio" was used.

Pedestrian Fatalities — Continued

to 2.85 in 1998 (Figure 1). In comparison, the U.S. pedestrian fatality rate decreased from 2.19 in 1993 to 1.98 in 1997.

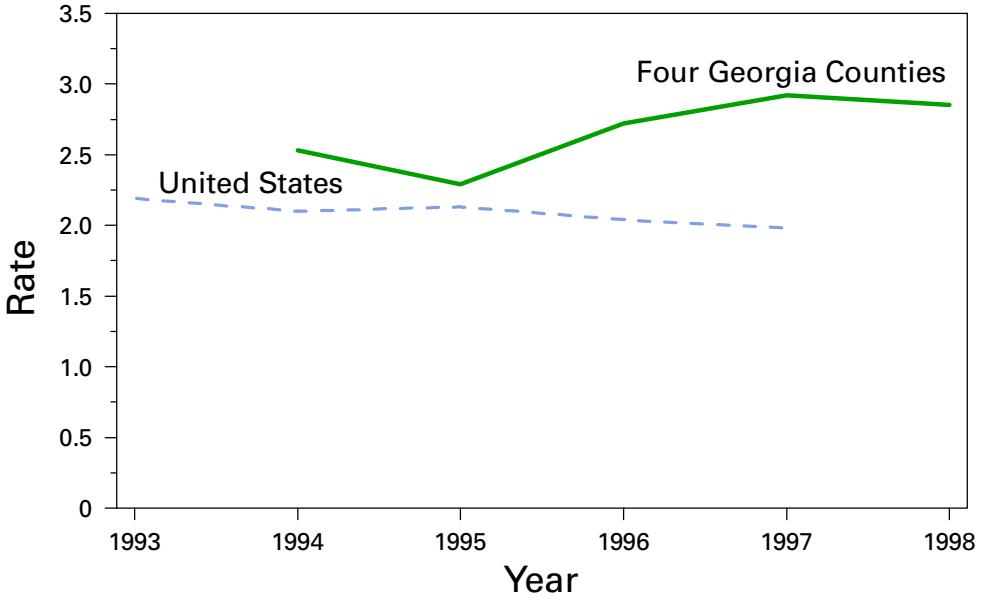
The pedestrian fatality rates for the two most central counties in the Atlanta MSA (DeKalb and Fulton) were higher than the rates for the other two counties studied (Cobb and Gwinnett) (Table 1). The pedestrian fatality rate for males was three times that for females. Rates for non-Hispanic blacks and Hispanics were two and six times greater, respectively, than for non-Hispanic whites. All rates for pedestrians aged ≥20 years were higher than for those aged <20 years; the highest rate was for pedestrians aged 45–54 years. Of the 266 pedestrians aged ≥15 years who died, alcohol test results were available for 219 (82%). Of these, 74 (34%) had a blood alcohol concentration (BAC) of ≥0.10 g/dL.

Sixty-seven (22%) pedestrians died after being struck on interstate highways, 96 (31%) on state highways, 62 (20%) on county roads, and 84 (27%) on city streets. Thirty-three (11%) pedestrian deaths occurred after a person exited a privately owned vehicle in traffic; of these, 24 (73%) were on interstate highways. One hundred ninety-three (63%) pedestrians involved in fatal collisions were attempting to cross a street at the time they were struck; 28 (9%) were at crosswalks.

The monthly number of pedestrian deaths varied considerably (mean: 5.1 deaths per month; range: 0–12). More pedestrian fatalities occurred on Saturday (64 [21%]) than any other day of the week. The number of fatal pedestrian incidents peaked from 6 p.m. through midnight, when 138 (45%) of the incidents occurred. According to police crash reports, 87 (44%) of 198 pedestrians struck after dark were on unlighted roads. Street surface conditions were wet at the time 64 (21%) pedestrians were struck.

Multiple motor vehicles were involved in 38 (12%) of pedestrian fatalities. Of the 363 drivers involved in the 309 pedestrian fatalities, information was available on

FIGURE 1. Pedestrian fatality rates*, by year — Cobb, DeKalb, Fulton, and Gwinnett counties, Georgia, and the United States,† 1993–1998



*Per 100,000 population.
†Data for the United States are from the Fatality Analysis Reporting System, National Highway Traffic Safety Administration, U.S. Department of Transportation.

Pedestrian Fatalities — Continued

TABLE 1. Distribution and rate* of pedestrian fatalities, by selected characteristics† — Cobb, DeKalb, Fulton, and Gwinnett counties, Georgia, 1994–1998§

Characteristic	Deaths No.	Deaths (%)	Rate
Year			
1994	56	(18)	2.53
1995	52	(17)	2.29
1996	63	(20)	2.72
1997	69	(22)	2.92
1998	69	(22)	2.85
County			
Cobb	34	(11)	1.26
DeKalb	104	(34)	3.55
Fulton	140	(45)	3.92
Gwinnett	31	(10)	1.30
Sex			
Female	81	(26)	1.36
Male	228	(74)	4.04
Age group (yrs)¶			
0– 4	16	(5)	1.84
5– 9	13	(4)	1.59
10–14	12	(4)	1.58
15–19	12	(4)	1.58
20–24	28	(9)	3.32
25–34	56	(18)	2.53
35–44	58	(19)	2.61
45–54	55	(18)	3.78
55–64	28	(9)	3.71
65–74	15	(5)	2.96
≥75	14	(5)	3.74
Race/Ethnicity**			
Black, non-Hispanic	140	(45)	3.85
White, non-Hispanic	117	(38)	1.64
Hispanic	40	(13)	9.74

*Per 100,000 population.
†Age-, race/ethnicity-, and sex-specific average annual rates were calculated using the 1996 population as the denominator.
§n=309.
¶Age was unknown for two pedestrians.
**Ten persons were of "other" races/ethnicities, and race/ethnicity was unknown for two.

312 (86%); 217 (70%) were men; median age was 33 years (range: 17–90 years). Fifteen (5%) drivers were cited for driving under the influence of alcohol. Forty-eight (16%) pedestrian fatalities involved a driver who fled or attempted to flee the scene.

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Pedestrian Fatalities — Continued

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Editorial Note: The findings in this report document that the pedestrian fatality rate of the four most populous Atlanta MSA counties combined has remained higher than the national rate since at least 1994. Moreover, the rate in these four counties has increased while the overall U.S. rate has declined. Characteristics of pedestrian fatalities in the four counties were similar to those of pedestrian fatalities nationwide (*1,3,4*). For example, higher pedestrian fatality rates have been reported for certain minority populations (*5,6*). Rate differences by race/ethnicity probably result, in part, from differences in walking patterns; the 1995 Nationwide Personal Transportation Survey showed that blacks walk 82% more than whites, and Hispanics walk 58% more than non-Hispanics (*7*). In other reports, one third of fatally injured pedestrians aged ≥15 years had BACs of ≥0.10 g/dL (*4*). In the United States during 1982–1992, the proportion of fatally injured pedestrians with BACs of ≥0.10 g/dL declined from 39% to 36%, compared with a decrease from 20% to 12% among drivers in such collisions (*4*). Also, the finding that pedestrian death rates were higher in the two most central counties is consistent with previous reports of higher rates in more urban areas of the United States (*3*).

Half of all pedestrian fatalities in the four counties occurred on state or county roads. Generally, these roads have posted speed limits of 30–45 miles per hour (mph) and often do not provide physical separation between pedestrians and traffic. The risk for pedestrians dying from collisions increases rapidly as speeds exceed 25 mph (*8*).

Fatalities typically represent only a small proportion of pedestrian injuries (*1*). Data from police crash reports show that pedestrian injuries also have increased in the four-county area. During 1994–1997, the rate of pedestrian injuries (fatal and nonfatal) increased 21% from 50.6 to 61.2 per 100,000 population in these counties (Georgia Department of Public Safety, unpublished data, 1999).

The findings in this report have at least five limitations. First, limited information was available about pedestrian characteristics (e.g., color of clothing), driver behavior, environmental factors (e.g., availability of crosswalks and crossing signals), and pedestrian exposure information (e.g., prevalence of walking). Second, only pedestrian fatalities were studied, and nonfatal incidents may have different modifiable risk factors. Third, if census estimates underestimated the four-county area's rapidly growing populations, pedestrian fatality rates reported here would be inflated. Fourth, BAC reports were not obtained for drivers; therefore, the reported proportion of drivers cited for "driving under the influence" probably underestimates the true prevalence of alcohol use. Finally, race/ethnicity misclassifications may have occurred.

The findings described in this and other reports suggest potential engineering, education, and enforcement measures to protect pedestrians (*9*). Engineering interventions should include methods to separate pedestrians from traffic (e.g., sidewalks); "traffic-calming" measures (e.g., speed bumps and lower posted speed limits) (*10*); safer ways to cross streets (*9*); and improved street lighting.

On the basis of the data in this report, three educational interventions were identified. First, drivers and passengers need to know about the dangers of exiting a vehicle in traffic. In 1995, the Georgia Department of Transportation instituted the Highway

Pedestrian Fatalities — Continued

Emergency Response Operators (HERO) program to assist stranded motorists, primarily on Atlanta's interstate highways. During 1994–1998, 25 pedestrians died after exiting a vehicle on roads now covered by the HERO program. Increased awareness of the availability of this service has the potential to prevent pedestrian deaths and injuries. Second, messages to increase awareness of the risk for injury to pedestrians who have been drinking alcohol should be developed for both the public and establishments that serve alcohol (*4*). Third, pedestrians should be made aware of the dangers of being struck even while crossing at crosswalks. Stricter enforcement of driving laws (e.g., speeding, running a red light, and yielding to pedestrians) and pedestrian regulations (e.g., jaywalking) also may help protect pedestrians. The success of public health measures will require involvement of local community groups, evaluation to identify effective interventions, and ongoing surveillance.

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Deaths Among Children Aged ≤5 Years from Farm Machinery Runovers — Iowa, Kentucky, and Wisconsin, 1995–1998, and United States, 1990–1995

Children who reside on family farms are exposed to unique hazards. Young children may be present where work is being done and may wander into areas where machines are operating or may be passengers on these machines. This report describes four fatal incidents in Iowa, Kentucky, and Wisconsin in which young children were run over by farm machinery, summarizes national mortality data to characterize this problem, and provides recommendations for expanded prevention efforts.

Case information was collected and reported to CDC's National Institute for Occupational Safety and Health (NIOSH), Division of Safety Research (DSR), by state health departments in Iowa, Kentucky, and Wisconsin. Data were obtained through on-site

Farm Machinery Runovers — Continued

investigations, telephone interviews, official law and medical examiners' reports, and news reports.*

Case Reports

Case 1. In July 1998, a 5-year-old boy in Wisconsin and his two brothers, aged 8 and 12 years, were riding in the front bucket of a skid-steer loader (a compact loader that is steered by skidding the wheels) operated by their 9-year-old brother. The loader hit a bump, causing the 5-year-old to lose his balance and fall out of the bucket. He was run over by the loader and died instantly from massive head trauma. His brothers remained in the bucket and were not injured.

Case 2. In April 1998, a 1-year-old girl in Kentucky was run over by a farm tractor driven by her father, who was spreading mulch around trees lining a farm road. He drove the tractor along the road, stopping every few feet to apply mulch. In the late afternoon, he took a break with his wife and three children who had come to visit with him. As he prepared to resume work, his wife and children walked to a nearby creek. He saw his wife and two of the children and, assuming the third child was also with his wife, he engaged the tractor. His daughter was run over by the right rear tractor tire and died instantly from blunt impact to the head, trunk, and extremities and crushing head injuries.

Case 3. In May 1997, a 2-year-old girl in Iowa was killed on the family hog farm when she was run over by a tractor driven by her father. As the father was loading hogs into a livestock trailer attached to the tractor, his wife was assisting and the child was playing nearby. When he drove the tractor forward, the right front wheel ran over the child's lower torso. The child remained conscious and crying after the incident and was airlifted to a regional children's hospital where she died 4 hours after the incident from internal bleeding.

Case 4. In October 1995, a 4-year-old boy in Kentucky died after being run over by a tractor driven by his 10-year-old uncle. Five children, aged 4–12 years, were taking turns driving the tractor in the field. The 10-year-old occupied the driver's seat. The other children sat on two flat fenders, two on each side. The victim was held by an 8-year-old girl. The tractor hit a bump on the dirt farm road, and the victim fell beneath the rear tractor tire. The child sustained a skull fracture and died at the scene.

National Mortality Data, 1990–1995

Following receipt of these reports, DSR reviewed CDC's National Center for Health Statistics (NCHS) mortality data for 1990–1995 and identified 167 deaths among children aged ≤5 years caused by agricultural machinery (*International Classification of Diseases, Ninth Revision* code E919.0†). These data included all farm machinery-related cases, but excluded agricultural machines using public roadways (NIOSH, unpublished data, 1998). The average age of decedents was 3 years (range: 4 months–5 years); 73% were male. Approximately half the deaths occurred from April through

* Information was collected using the NIOSH Fatality Assessment and Control Evaluation model, which evaluates the relations among agent, host, and environment during pre-event, event, and postevent phases of work-related fatalities. Cases in Kentucky were collected in collaboration with a NIOSH-sponsored Community Partners for Healthy Farming cooperative agreement.

† In addition to tractors, agricultural machinery includes animal-powered agricultural machines, combines, derricks (hay), harvesters, hay mowers or rakes, reapers, threshers, and farm machinery not otherwise specified.

Farm Machinery Runovers — Continued

July, with the largest proportions occurring in April (16.2%), June (12.6%), and July (12.6%); 27% occurred from August through October. One third (33%) of deaths occurred in hospital emergency departments, and 19% of the children died at the scene.

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Editorial Note: From 1979–1981 to 1991–1993, the rate of farm-related fatalities for persons aged <20 years decreased by 39%, but the rate for children aged <5 years declined 29% (*1*). During 1991–1993 in the United States, machinery was involved in 36% of farming-related fatalities of children aged <5 years (*1*). An earlier study of U.S. agricultural equipment fatalities indicated that the rate for fatal tractor runovers of farm residents was highest among children aged <5 years (*2*), and during 1979–1985, a study of farm-related deaths among children aged 1–9 years in Wisconsin and Illinois indicated that moving machinery was the most common source of injury (63% and 53%, respectively) (*3*).

Machine runover fatalities among children aged 1–4 years often were associated with playing near machinery, and runover fatalities in children aged 5–9 years often were associated with falling from and being run over by machinery (*3*). Peaks in unintentional farm-related childhood injury deaths from all causes occur at age 2 years and ages 13–15 years (*4*); fatalities among very young children are related to accompanying their parents as they perform their work duties, and fatalities among older children are related to the children's increased time spent working on the farm. Most fatalities occurred in the spring and fall (i.e., times of planting and harvesting), when parents are busy with farm work and may have less time to supervise children (*1,3,4*).

Prevention efforts can be improved to reduce and eliminate childhood fatalities caused by agricultural machines. Pediatricians, family practitioners, and health departments providing health care to farm families and agricultural safety specialists, farm machinery manufacturers, and organizations serving farm families should warn parents that young children are at high risk for runover by farm machinery and encourage parents to make changes that will make their farms safer. The following recommendations to parents for child safety on farms are summarized from the National Safety Council (NSC) recommendations (*5*):

- Design a fenced, safe play area that is near the house and away from work activities.
- Inspect the farm on a regular basis for potential hazards, and correct such hazards immediately.
- Equip all barns and the farm shop with latches that can be locked or secured so children cannot enter.
- Always lower hydraulics, turn off agricultural machines, and remove ignition keys before leaving machines unattended.
- Never carry children on tractors or permit them into areas where agricultural machines are used or stored, and never allow additional riders, especially children, on any agricultural machinery.

Farm Machinery Runovers — Continued

In addition, NIOSH encourages parents to

- Ensure that agricultural machines are in safe operating condition.
- Carefully inspect the area around the machines before use to make sure no children are present.
- After any work interruption (e.g., lunch with the family), clarify who is to supervise children and confirm their location before work is resumed.
- Restrict operation of machinery to older adolescents and adults who possess the knowledge, skills, and physical capacity necessary for safe operation of these machines.

Additional information about child safety and farm equipment is available from the National Children's Center for Rural and Agricultural Health and Safety, telephone (888) 924-7233 or (715) 389-4999, and on the World-Wide Web[§] at http://research.marshfieldclinic.org/children; NSC, (800) 621-7615 (extension 2087) or (630) 775-2023, or at http://www.nsc.org/farmsafe.htm; Farm Safety 4 Just Kids, (800) 423-5437 or (515) 758-2827, or at http://www.fs4jk.org; NIOSH, (800) 356-4674 or http://www.cdc.gov/niosh/homepage.html; or NIOSH Centers for Agricultural Disease and Injury Research, Education, and Prevention, (304) 285-5711.

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[§]References to sites of nonfederal organizations on the World-Wide Web are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages found at these sites.

Ascertainment of Secondary Cases of Hepatitis A — Kansas, 1996–1997

Each year, 25,000–30,000 cases of hepatitis A are reported in the United States. The most common infection source (22%–26%) is household or sexual contact with a person already infected with hepatitis A virus (HAV) (i.e., the source-patient) (*1*). In Kansas during 1992–1997, contact with a source-patient was reported by 39% of persons with hepatitis A (*2*). Cases reported in 1996 and 1997 were studied retrospectively to determine the reasons for the apparently high proportion of secondary cases and to evaluate missed opportunities for prevention (i.e., postexposure prophylaxis with immune globulin [IG]) (*3,4*). Results of this investigation indicate that persons with hepatitis A often were classified incorrectly as secondary cases and that some correctly identified secondary cases represented missed opportunities for prevention.

Hepatitis A Virus — Continued

For this investigation, the hepatitis A cases included were those the Kansas Department of Health and Environment determined as being secondary and were among the residents of one of the five Kansas counties reporting the highest number of secondary cases each year during 1996–1997. Kansas counties collected information using CDC's Viral Hepatitis Surveillance Program form, which includes whether case-patients reported "sexual, household, or other contact with a suspected or confirmed hepatitis A case within the 2–6 weeks before onset of their illness." Persons who responded affirmatively to this question were classified as having a secondary case for the Kansas Annual Summary of Reportable Diseases (*2*).

As part of this investigation, the definition of a secondary case was expanded to include persons reporting any contact with a source-patient and with an illness onset of either 15–65 days after onset of illness in the source-patient or, in the case of a single exposure to the source-patient, 15–50 days after that exposure date. Persons with an illness onset date within 15 days of illness onset in the source-patient were presumed to be co-infections and classified as concurrent primary cases. When the interval between the onset dates of source and presumed secondary case was >65 days, they were considered unrelated. Information on each case-patient was obtained from data recorded on the surveillance form and from on-site review of local health department records.

During 1996–1997, the state recorded 655 persons with hepatitis A; 443 (68%) were from the selected counties. Of these 443 cases, 210 (47%) had been classified as secondary cases: 16 (8%) reported sexual contact, 66 (34%) reported household contact, 104 (54%) reported "other" contact, and 24 (4%) had no type of contact recorded.

Of the 210 patients originally classified as having secondary cases, 119 (57%) had illnesses that met the investigation definition of a secondary case, 53 (25%) were reclassified as having co-primary cases, and seven (3%) were reclassified as having unrelated cases. For 27 (13%) patients, information was insufficient to determine when contact had occurred, and information for four (2%) had been entered incorrectly in the database.

According to recommendations for postexposure prophylaxis used in Kansas, 53 (45%) of the 119 secondary case-patients should have been offered IG. Of these, 18 (34%) received IG, seven (13%) were offered IG but refused, and 26 (49%) were identified too late to provide effective postexposure prophylaxis: 15 (28%) had not been reported as contacts by the source-patient, and for 11 (21%) a source-patient either was not reported or was reported after the secondary case was diagnosed. For two (4%) patients, the reason for not being offered or receiving IG was unknown.

Among the 18 patients who developed a secondary case of hepatitis A, the median interval between source-patient diagnosis and receipt of IG by the secondary case-patient was 7 days (range: 0–15 days), within the recommended interval of 2 weeks from last exposure. However, the median interval between receipt of IG by the secondary case-patients and the subsequent onset of illness was 11 days (range: 3–34 days), suggesting that the patients were late in their incubation period when they received IG. Twelve (67%) of these patients were household contacts and three (17%) were day-care contacts, all of whom had multiple exposures to their source-patients over days or weeks during the infectious period.

Sixty-six (55%) of the 119 secondary case-patients did not meet criteria for receiving IG; among them likely sources of infection could be identified for 44 (67%): seven

Hepatitis A Virus — Continued

(11%) occurred during a school-associated outbreak, and 37 (56%) reported close personal contact with a source-patient. Circumstances of these contacts, which had not been reported during the original investigation, included 15 (23%) secondary case-patients who had used illegal drugs and 22 (33%) secondary case-patients who had participated in activities (such as playing; sharing drinks, ice, or meals; or providing care for a person) with hepatitis A.

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Editorial Note: This investigation illustrates that assessing specific aspects of surveillance data, such as case investigations, data collection, and analysis can identify areas in need of modification or improvement. Accurate and understandable case definitions are needed to classify primary and secondary cases of hepatitis A; also, timely and complete case reporting and investigations are necessary to avoid missing opportunities for prevention.

In Kansas, the high proportion of reported secondary cases occurred because some of these cases should have been classified as co-primary or unrelated cases. The proportion of reported cases that met the definition used in this investigation (27%) is consistent with that reported nationwide (*1*). To improve the accuracy of surveillance data, health department personnel should verify that both the presumed source and presumed secondary case-patient meet the hepatitis A case definition, that close personal contact has occurred, and that the interval between illness onset in the source and in the secondary case-patient was 15–50 days, the hepatitis A incubation period.

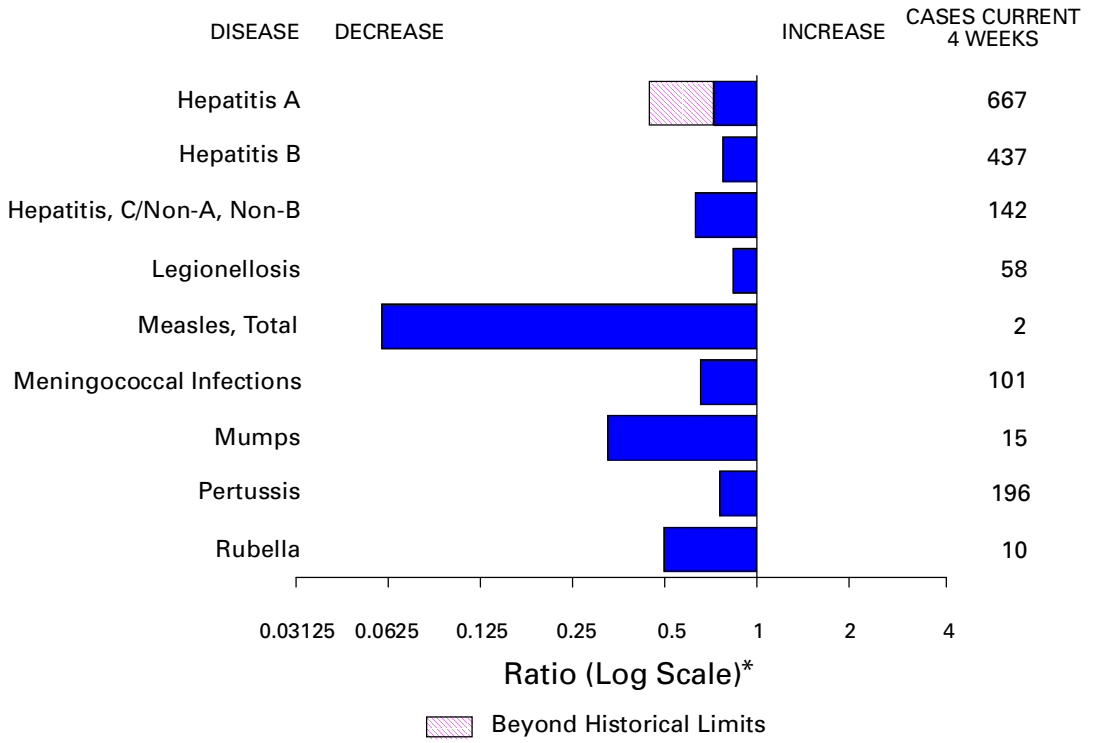
The limitations of this investigation relate to its retrospective design. The data used had been previously collected for surveillance purposes and not specifically for this investigation. Because the patients were not reinterviewed, additional information about the type of contact with the potential source-patients was not collected systematically and sometimes was not available.

The Advisory Committee on Immunization Practices recommends IG for persons who have been exposed to HAV and have not been vaccinated (*5*). IG should be given as quickly as possible after exposure, but not longer than 2 weeks after the last exposure. Situations in which IG is recommended include close personal contact with a person with hepatitis A, including household and sexual contacts; contact with HAV-infected persons in day-care centers, and sometimes following exposure to a food-handler with hepatitis A (*5*). Hepatitis A vaccination is recommended for pre-exposure prophylaxis in certain populations and settings, but is not approved for postexposure prophylaxis (*5*).

Approximately 25% of persons who had had household or sexual contact with a source-patient were identified too long after exposure to benefit from IG. Health departments should encourage rapid laboratory reporting of positive serologic test results and should educate health-care providers about the importance of complete and timely reporting. Local health department personnel also should be encouraged to

(Continued on page 619)

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending July 17, 1999, with historical data — United States



*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 the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending July 17, 1999 (28th Week)

	Cum. 1999		Cum. 1999
Anthrax	-	HIV infection, pediatric*§	81
Brucellosis*	20	Plague	2
Cholera	2	Poliomyelitis, paralytic	-
Congenital rubella syndrome	3	Psittacosis*	14
Cyclosporiasis*	12	Rabies, human	-
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	198
Encephalitis: California*	2	Streptococcal disease, invasive Group A	1,224
eastern equine*	2	Streptococcal toxic-shock syndrome*	26
St. Louis*	-	Syphilis, congenital¶	94
western equine*	1	Tetanus	13
Ehrlichiosis human granulocytic (HGE)*	65	Toxic-shock syndrome	68
human monocytic (HME)*	12	Trichinosis	5
Hansen Disease*	41	Typhoid fever	150
Hantavirus pulmonary syndrome*†	7	Yellow fever	-
Hemolytic uremic syndrome, post-diarrheal*	26		

-:no reported cases
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly from reports to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP), last update June 27, 1999.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 1999, and July 18, 1998 (28th Week)

Reporting Area	AIDS		Chlamydia		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 1999†	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998
UNITED STATES	23,194	23,725	306,823	309,501	724	1,055	949	1,044	528	884
NEW ENGLAND	1,120	810	10,070	10,936	36	79	125	143	85	128
Maine	29	18	193	552	12	18	12	17	-	-
N.H.	26	15	497	518	6	6	18	21	11	24
Vt.	6	10	254	215	6	12	14	6	7	5
Mass.	716	372	4,886	4,456	12	39	48	73	39	73
R.I.	61	69	1,259	1,310	-	4	9	5	6	1
Conn.	282	326	2,981	3,885	-	-	24	21	22	25
MID. ATLANTIC	5,913	6,918	37,452	32,427	104	311	54	107	14	41
Upstate N.Y.	725	856	N	N	63	190	46	70	-	-
N.Y. City	3,003	3,888	19,678	14,212	22	109	2	7	4	7
N.J.	1,158	1,215	5,882	6,193	9	12	6	30	10	26
Pa.	1,027	959	11,892	12,022	10	-	N	N	-	8
E.N. CENTRAL	1,502	1,760	44,353	52,941	69	113	165	200	105	159
Ohio	241	339	12,425	14,366	20	44	64	48	38	25
Ind.	191	323	5,486	5,778	13	20	19	54	16	27
Ill.	682	693	14,940	13,982	12	33	50	54	18	34
Mich.	308	305	11,502	11,612	24	16	32	44	15	30
Wis.	80	100	U	7,203	-	-	N	N	18	43
W.N. CENTRAL	537	441	17,039	18,180	55	136	199	136	85	128
Minn.	82	64	3,264	3,720	14	46	68	47	47	58
Iowa	50	49	1,334	2,071	13	28	30	37	10	25
Mo.	261	210	7,420	6,448	11	11	23	16	22	23
N. Dak.	4	4	325	528	4	14	3	2	1	8
S. Dak.	11	9	832	864	3	17	12	8	4	10
Nebr.	39	37	1,273	1,538	9	17	53	16	-	-
Kans.	90	68	2,591	3,011	1	3	10	10	1	4
S. ATLANTIC	6,366	5,825	70,564	58,680	174	103	125	64	64	75
Del.	80	75	1,474	1,349	-	-	2	-	-	1
Md.	720	717	6,397	4,538	9	10	7	13	-	8
D.C.	242	480	N	N	7	4	-	-	-	-
Va.	340	424	7,623	5,887	10	1	31	-	20	29
W. Va.	31	51	1,011	1,291	-	1	4	3	1	3
N.C.	390	389	12,249	11,509	5	-	24	14	25	22
S.C.	588	381	8,635	9,970	-	-	12	3	9	2
Ga.	958	618	17,159	12,667	87	30	8	24	-	-
Fla.	3,017	2,690	16,016	11,469	56	57	37	7	9	10
E.S. CENTRAL	1,034	933	21,004	21,236	11	15	62	59	24	38
Ky.	152	126	3,333	3,311	2	5	15	18	-	-
Tenn.	405	330	7,294	6,902	4	6	27	24	17	25
Ala.	257	274	5,676	5,476	3	-	16	14	6	12
Miss.	220	203	4,701	5,547	2	4	4	3	1	1
W.S. CENTRAL	2,491	2,889	44,718	46,340	33	18	31	41	42	53
Ark.	90	104	3,257	1,952	-	3	5	4	5	6
La.	463	507	7,726	7,513	21	8	3	3	6	2
Okla.	70	170	4,258	5,263	2	3	7	9	5	4
Tex.	1,868	2,108	29,477	31,612	10	4	16	25	26	41
MOUNTAIN	860	816	16,863	17,259	43	74	81	146	37	119
Mont.	4	15	697	655	8	6	4	6	-	2
Idaho	12	15	665	1,051	3	14	4	11	2	7
Wyo.	3	1	397	357	-	-	3	46	5	49
Colo.	172	146	3,833	4,244	4	5	29	28	13	24
N. Mex.	46	130	1,731	2,075	17	31	6	12	1	7
Ariz.	427	327	6,965	5,861	8	10	14	17	6	13
Utah	80	65	1,026	1,223	-	1	17	19	8	10
Nev.	116	117	1,549	1,793	3	7	4	7	2	7
PACIFIC	3,371	3,333	44,760	51,502	199	206	107	148	72	143
Wash.	188	230	6,303	5,903	-	-	34	28	26	41
Oreg.	88	94	3,175	2,788	78	22	27	36	21	36
Calif.	3,036	2,930	32,673	40,542	121	181	46	82	22	60
Alaska	13	12	1,003	1,005	-	-	-	2	-	-
Hawaii	46	67	1,606	1,264	-	3	-	-	3	6
Guam	5	-	149	203	-	-	N	N	-	-
P.R.	734	995	U	U	-	-	5	-	U	U
V.I.	15	17	N	N	-	-	N	N	U	U
Amer. Samoa	-	-	U	U	-	-	N	N	U	U
C.N.M.I.	-	-	N	N	-	-	N	N	U	U

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands

*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

†Updated monthly from reports to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update June 27, 1999.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 1999, and July 18, 1998 (28th Week)

Reporting Area	Gonorrhea		Hepatitis C/NA,NB		Legionellosis		Lyme Disease	
	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998
UNITED STATES	165,661	179,996	1,966	1,613	492	624	3,683	5,177
NEW ENGLAND	3,038	3,031	57	47	30	40	932	1,856
Maine	15	33	2	-	4	1	-	26
N.H.	45	49	-	-	3	3	1	19
Vt.	31	15	3	2	5	3	3	5
Mass.	1,369	1,060	49	42	9	17	302	417
R.I.	323	185	3	3	3	8	115	119
Conn.	1,255	1,689	-	-	6	8	511	1,270
MID. ATLANTIC	20,684	19,499	87	119	98	144	2,103	2,516
Upstate N.Y.	3,157	3,574	52	59	28	38	1,253	1,279
N.Y. City	8,443	6,402	-	-	7	28	12	92
N.J.	3,361	3,930	-	-	5	7	124	474
Pa.	5,723	5,593	35	60	58	71	714	671
E.N. CENTRAL	29,365	35,272	1,056	301	134	218	67	296
Ohio	7,557	8,910	1	7	46	76	44	20
Ind.	3,162	3,300	1	4	41	40	20	12
Ill.	10,587	11,358	16	27	10	27	2	11
Mich.	8,059	8,620	456	263	34	39	1	11
Wis.	U	3,084	582	-	3	36	U	242
W.N. CENTRAL	7,054	9,027	71	21	27	32	41	41
Minn.	1,208	1,352	3	6	1	3	13	16
Iowa	331	666	-	5	12	4	11	12
Mo.	3,767	4,946	60	7	10	9	-	7
N. Dak.	31	47	-	-	-	-	1	-
S. Dak.	83	141	-	-	1	2	-	-
Nebr.	556	593	3	2	3	12	6	2
Kans.	1,078	1,282	5	1	-	2	10	4
S. ATLANTIC	51,238	48,189	129	59	61	68	371	357
Del.	890	733	-	-	6	8	13	27
Md.	5,625	5,205	30	5	10	16	260	263
D.C.	1,270	2,440	-	-	1	5	3	4
Va.	5,194	3,554	10	7	13	7	32	27
W. Va.	276	440	13	4	N	N	7	6
N.C.	10,540	9,812	26	14	10	6	38	19
S.C.	4,645	6,404	13	3	7	5	4	3
Ga.	11,398	10,409	1	9	-	2	-	2
Fla.	11,400	9,192	36	17	14	18	14	6
E.S. CENTRAL	16,731	20,024	150	86	60	36	56	40
Ky.	1,494	1,876	8	16	45	17	19	10
Tenn.	5,793	5,900	54	68	13	10	19	19
Ala.	5,008	6,896	1	2	2	3	11	11
Miss.	4,436	5,352	87	-	-	6	7	-
W.S. CENTRAL	24,457	27,915	132	288	2	11	10	8
Ark.	1,637	2,172	7	11	-	1	1	5
La.	6,054	6,174	100	15	1	2	-	-
Okla.	2,118	2,901	6	5	1	6	4	-
Tex.	14,648	16,668	19	257	-	2	5	3
MOUNTAIN	4,742	4,642	79	261	31	36	8	5
Mont.	22	25	4	5	-	1	-	-
Idaho	32	92	4	85	-	-	1	1
Wyo.	12	17	25	62	-	1	1	1
Colo.	1,160	1,105	15	14	9	7	1	-
N. Mex.	311	411	4	56	1	2	1	2
Ariz.	2,472	2,134	19	4	4	6	-	-
Utah	97	126	5	19	11	16	2	-
Nev.	636	732	3	16	6	3	2	1
PACIFIC	8,352	12,397	205	431	49	39	95	58
Wash.	1,096	1,023	9	11	9	6	2	2
Oreg.	441	396	14	10	N	N	6	8
Calif.	6,433	10,555	182	355	39	32	87	47
Alaska	165	166	-	1	1	-	-	1
Hawaii	217	257	-	54	-	1	-	-
Guam	22	25	-	-	-	2	-	-
P.R.	153	221	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	21	-	-	-	-	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 1999, and July 18, 1998 (28th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998
UNITED STATES	591	666	2,891	4,033	15,134	17,500	11,682	16,070
NEW ENGLAND	23	41	428	729	942	1,145	785	1,078
Maine	2	3	79	129	68	81	39	33
N.H.	2	3	27	41	54	85	47	108
Vt.	1	-	61	32	41	60	37	43
Mass.	8	15	92	231	501	645	407	641
R.I.	2	2	52	41	56	69	48	31
Conn.	8	18	117	255	222	205	207	222
MID. ATLANTIC	135	186	545	855	1,779	3,040	1,291	2,934
Upstate N.Y.	38	40	369	586	529	686	540	700
N.Y. City	47	108	U	U	391	1,005	442	857
N.J.	29	21	103	110	332	633	309	561
Pa.	21	17	73	159	527	716	-	816
E.N. CENTRAL	60	68	44	74	1,943	3,076	1,596	2,231
Ohio	12	3	14	40	505	706	363	630
Ind.	8	7	-	4	199	357	149	304
Ill.	19	28	2	7	724	948	399	542
Mich.	19	26	25	18	477	584	470	498
Wis.	2	4	3	5	38	481	215	257
W.N. CENTRAL	28	48	331	446	1,061	1,093	911	1,162
Minn.	5	24	62	76	283	270	308	315
Iowa	9	4	71	91	116	189	66	156
Mo.	10	11	9	21	350	305	418	425
N. Dak.	-	2	88	89	15	31	4	44
S. Dak.	-	-	44	103	50	41	26	61
Nebr.	-	1	2	3	111	94	-	22
Kans.	4	6	55	63	136	163	89	139
S. ATLANTIC	171	135	1,096	1,342	3,352	2,981	2,410	2,405
Del.	1	1	29	22	51	35	60	58
Md.	51	45	226	282	384	412	364	395
D.C.	11	10	-	-	50	45	-	-
Va.	38	26	282	351	564	492	421	423
W. Va.	1	-	62	48	43	67	64	75
N.C.	11	12	216	341	493	418	507	545
S.C.	2	4	84	86	205	193	154	176
Ga.	13	15	99	107	508	442	651	510
Fla.	43	22	98	105	1,054	877	189	223
E.S. CENTRAL	12	17	154	162	815	860	391	681
Ky.	3	2	24	20	176	192	-	91
Tenn.	5	9	56	90	228	255	199	349
Ala.	3	4	74	50	255	229	175	189
Miss.	1	2	-	2	156	184	17	52
W.S. CENTRAL	9	12	71	106	1,063	1,471	1,253	1,823
Ark.	-	1	14	19	203	160	76	110
La.	6	4	-	-	159	258	220	328
Okla.	2	1	57	87	159	176	107	58
Tex.	1	6	-	-	542	877	850	1,327
MOUNTAIN	24	32	110	102	1,485	1,049	982	1,018
Mont.	4	-	40	29	28	45	1	25
Idaho	1	3	-	-	48	54	35	48
Wyo.	1	-	30	42	15	33	22	28
Colo.	8	7	1	3	410	276	391	258
N. Mex.	2	11	4	2	182	111	110	105
Ariz.	5	5	30	23	464	275	370	329
Utah	2	1	4	3	241	163	-	119
Nev.	1	5	1	-	97	92	53	106
PACIFIC	129	127	112	217	2,694	2,785	2,063	2,738
Wash.	10	9	-	-	312	220	279	336
Oreg.	13	11	1	1	250	149	276	176
Calif.	99	104	104	196	1,897	2,286	1,342	2,092
Alaska	-	1	7	20	23	21	6	17
Hawaii	7	2	-	-	212	109	160	117
Guam	-	1	-	-	18	13	-	-
P.R.	-	-	42	29	207	344	-	-
V.I.	U	U	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	-	-
C.N.M.I.	-	-	-	-	-	13	-	-

N: Not notifiable U: Unavailable -: no reported cases

*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 1999, and July 18, 1998 (28th Week)

Reporting Area	Shigellosis*				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS					
	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999†	Cum. 1998†
UNITED STATES	6,339	9,451	2,735	5,219	3,311	3,683	7,038	8,201
NEW ENGLAND	159	225	130	205	31	39	213	228
Maine	3	7	-	-	-	1	12	5
N.H.	7	10	6	11	-	1	4	6
Vt.	4	4	3	-	2	4	-	1
Mass.	97	140	82	136	20	23	122	119
R.I.	14	18	9	12	1	-	24	31
Conn.	34	46	30	46	8	10	51	66
MID. ATLANTIC	405	1,368	192	1,152	137	123	1,289	1,438
Upstate N.Y.	130	265	34	88	17	18	143	158
N.Y. City	100	437	81	471	59	31	717	730
N.J.	103	425	77	404	24	56	269	327
Pa.	72	241	-	189	37	18	160	223
E.N. CENTRAL	968	1,403	457	703	631	550	580	879
Ohio	274	307	54	66	55	81	100	142
Ind.	72	93	16	27	184	96	U	97
Ill.	399	735	269	581	279	227	287	393
Mich.	175	133	92	4	113	104	154	188
Wis.	48	135	26	25	U	42	39	59
W.N. CENTRAL	559	495	345	208	71	83	260	213
Minn.	94	85	90	89	5	5	95	71
Iowa	11	38	9	29	7	-	26	2
Mo.	388	60	225	42	50	65	97	87
N. Dak.	2	4	-	3	-	-	2	3
S. Dak.	9	22	4	19	-	1	9	14
Nebr.	32	267	-	15	4	4	12	8
Kans.	23	19	17	11	5	8	19	28
S. ATLANTIC	1,208	1,894	269	604	1,078	1,419	1,545	1,339
Del.	7	9	3	6	4	15	12	19
Md.	68	102	19	32	224	396	138	147
D.C.	32	11	-	-	26	42	28	62
Va.	47	79	15	39	89	91	121	144
W. Va.	5	7	2	5	2	2	23	24
N.C.	120	166	57	88	260	418	216	216
S.C.	67	83	32	32	125	170	124	174
Ga.	118	489	37	141	183	149	350	237
Fla.	744	948	104	261	165	136	533	316
E.S. CENTRAL	672	461	342	277	595	635	295	641
Ky.	129	77	-	36	46	63	82	99
Tenn.	436	77	310	107	339	306	U	214
Ala.	61	274	31	132	132	145	157	204
Miss.	46	33	1	2	78	121	56	124
W.S. CENTRAL	912	1,901	710	598	502	497	763	1,161
Ark.	52	109	21	25	40	70	85	62
La.	76	141	53	175	121	177	U	1
Okla.	289	126	82	30	119	22	69	93
Tex.	495	1,525	554	368	222	228	609	1,005
MOUNTAIN	392	578	182	347	113	135	204	288
Mont.	6	4	-	3	-	-	5	12
Idaho	9	12	3	8	1	-	-	8
Wyo.	2	1	1	-	-	1	1	2
Colo.	59	74	42	58	1	8	U	33
N. Mex.	50	148	17	66	-	18	29	31
Ariz.	211	299	113	191	103	95	124	110
Utah	29	20	-	14	2	3	26	33
Nev.	26	20	6	7	6	10	19	59
PACIFIC	1,064	1,126	108	1,125	153	202	1,889	2,014
Wash.	55	61	51	64	39	12	87	138
Oreg.	37	67	37	62	2	1	57	65
Calif.	948	973	-	973	109	188	1,624	1,689
Alaska	-	4	-	2	1	-	31	28
Hawaii	24	21	20	24	2	1	90	94
Guam	3	21	-	-	-	1	-	45
P.R.	29	30	-	-	87	116	41	80
V.I.	-	-	-	-	U	U	U	U
Amer. Samoa	-	-	-	-	U	U	U	U
C.N.M.I.	-	13	-	-	-	142	-	62

N: Not notifiable U: Unavailable -: no reported cases

*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

†Cumulative reports of provisional tuberculosis cases for 1998 and 1999 are unavailable ("U") for some areas using the Tuberculosis Information System (TIMS)

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending July 17, 1999, and July 18, 1998 (28th Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 1999†	Cum. 1998	Cum. 1999	Cum. 1998	Cum. 1999	Cum. 1998	1999	Cum. 1999	1999	Cum. 1999	Cum. 1999	Cum. 1998
UNITED STATES	669	653	8,238	12,084	3,418	4,844	-	30	-	15	45	42
NEW ENGLAND	48	42	102	160	61	109	-	5	-	4	9	3
Maine	5	2	4	13	1	2	-	-	-	-	-	-
N.H.	11	6	8	8	8	10	-	-	-	1	1	-
Vt.	4	2	3	13	1	4	-	-	-	-	-	1
Mass.	17	30	30	55	28	39	-	4	-	2	6	2
R.I.	1	2	10	9	23	35	-	-	-	-	-	-
Conn.	10	-	47	62	-	19	-	1	-	1	2	-
MID. ATLANTIC	99	99	543	936	402	691	-	-	-	2	2	11
Upstate N.Y.	52	31	137	185	110	135	-	-	-	2	2	2
N.Y. City	18	30	100	332	90	233	-	-	-	-	-	-
N.J.	28	31	57	188	40	121	-	-	-	-	-	8
Pa.	1	7	249	231	162	202	U	-	U	-	-	1
E.N. CENTRAL	95	109	1,614	1,694	343	536	-	1	-	1	2	15
Ohio	37	35	398	191	51	42	-	-	-	-	-	1
Ind.	14	27	98	93	27	62	-	1	-	-	1	3
Ill.	37	42	265	417	-	140	-	-	-	-	-	-
Mich.	7	-	827	859	264	239	-	-	-	1	1	10
Wis.	-	5	26	134	1	53	U	-	U	-	-	1
W.N. CENTRAL	53	58	423	935	262	229	-	-	-	-	-	-
Minn.	13	44	42	78	25	21	-	-	-	-	-	-
Iowa	14	1	80	357	104	35	-	-	-	-	-	-
Mo.	19	8	221	400	102	142	-	-	-	-	-	-
N. Dak.	-	-	1	3	-	4	-	-	-	-	-	-
S. Dak.	1	-	8	17	1	1	-	-	-	-	-	-
Nebr.	3	-	38	16	11	10	-	-	-	-	-	-
Kans.	3	5	33	64	19	16	-	-	-	-	-	-
S. ATLANTIC	157	119	1,044	912	618	506	-	1	-	3	4	6
Del.	-	-	2	3	-	-	-	-	-	-	-	1
Md.	40	41	203	187	86	97	-	-	-	-	-	1
D.C.	4	-	37	30	14	6	-	-	-	-	-	-
Va.	12	13	88	137	51	56	-	1	-	2	3	2
W. Va.	4	4	17	1	13	3	-	-	-	-	-	-
N.C.	23	18	67	59	125	114	-	-	-	-	-	-
S.C.	2	3	22	17	39	17	-	-	-	-	-	-
Ga.	41	22	267	258	72	94	-	-	-	-	-	1
Fla.	31	18	341	220	218	119	-	-	-	1	1	1
E.S. CENTRAL	47	39	246	239	255	215	-	-	-	-	-	2
Ky.	6	6	38	14	25	25	-	-	-	-	-	-
Tenn.	25	23	129	138	127	149	-	-	-	-	-	1
Ala.	14	8	37	47	51	41	-	-	-	-	-	1
Miss.	2	2	42	40	52	-	-	-	-	-	-	-
W.S. CENTRAL	37	33	1,469	2,111	312	1,105	-	1	-	2	3	-
Ark.	2	-	30	53	28	53	-	-	-	-	-	-
La.	7	16	59	44	72	54	U	-	U	-	-	-
Okla.	25	15	280	313	68	45	-	-	-	-	-	-
Tex.	3	2	1,100	1,701	144	953	-	1	-	2	3	-
MOUNTAIN	63	79	796	1,847	347	467	-	2	-	-	2	-
Mont.	1	-	12	63	16	3	-	-	-	-	-	-
Idaho	1	-	27	148	16	18	-	-	-	-	-	-
Wyo.	1	1	4	24	6	2	-	-	-	-	-	-
Colo.	9	15	138	143	46	58	-	-	-	-	-	-
N. Mex.	14	4	30	88	117	184	-	-	-	-	-	-
Ariz.	30	39	483	1,132	93	109	-	1	-	-	1	-
Utah	5	3	28	119	20	41	-	1	-	-	1	-
Nev.	2	17	74	130	33	52	-	-	-	-	-	-
PACIFIC	70	75	2,001	3,250	818	986	-	20	-	3	23	5
Wash.	2	5	170	626	35	55	-	-	-	-	-	1
Oreg.	27	31	145	248	51	101	-	8	-	-	8	-
Calif.	33	31	1,674	2,332	713	815	-	11	-	3	14	4
Alaska	5	1	3	14	12	7	-	-	-	-	-	-
Hawaii	3	7	9	30	7	8	-	1	-	-	1	-
Guam	-	-	2	-	2	2	U	1	U	-	1	-
P.R.	1	2	100	30	88	146	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	-	1	-	41	U	-	U	-	-	-

N: Not notifiable U: Unavailable -: no reported cases

*For imported measles, cases include only those resulting from importation from other countries.

†Of 138 cases among children aged <5 years, serotype was reported for 63 and of those, 15 were type b.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending July 17, 1999, and July 18, 1998 (28th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 1999	Cum. 1998	1999	Cum. 1999	Cum. 1998	1999	Cum. 1999	Cum. 1998	1999	Cum. 1999	Cum. 1998
UNITED STATES	1,416	1,651	4	194	426	59	2,751	2,706	2	151	310
NEW ENGLAND	78	76	-	3	1	11	280	510	-	6	38
Maine	5	5	-	-	-	-	-	5	-	-	-
N.H.	10	9	-	1	-	-	53	39	-	-	-
Vt.	4	1	-	-	-	-	9	45	-	-	-
Mass.	47	33	-	2	1	6	197	395	-	6	8
R.I.	2	3	-	-	-	5	13	5	-	-	1
Conn.	10	25	-	-	-	-	8	21	-	-	29
MID. ATLANTIC	134	169	1	25	169	4	592	312	2	21	136
Upstate N.Y.	37	44	1	6	2	4	506	154	2	17	111
N.Y. City	31	21	-	3	153	-	10	14	-	-	11
N.J.	33	41	-	-	6	-	12	9	-	1	13
Pa.	33	63	U	16	8	U	64	135	U	3	1
E.N. CENTRAL	226	259	1	24	50	7	229	250	-	2	-
Ohio	100	87	1	8	19	6	120	76	-	-	-
Ind.	37	46	-	3	5	-	14	68	-	1	-
Ill.	58	72	-	6	9	-	42	30	-	1	-
Mich.	30	29	-	7	17	1	26	38	-	-	-
Wis.	1	25	U	-	-	U	27	38	U	-	-
W.N. CENTRAL	154	143	-	9	20	4	109	202	-	77	31
Minn.	30	24	-	1	10	2	35	115	-	-	-
Iowa	29	22	-	4	6	1	26	46	-	27	-
Mo.	61	55	-	1	3	-	23	16	-	2	2
N. Dak.	3	2	-	-	1	-	-	3	-	-	-
S. Dak.	8	6	-	-	-	1	5	5	-	-	-
Nebr.	9	10	-	-	-	-	1	6	-	48	-
Kans.	14	24	-	3	-	-	19	11	-	-	29
S. ATLANTIC	244	268	2	37	27	8	160	135	-	20	8
Del.	3	1	-	-	-	-	-	2	-	-	-
Md.	37	23	1	4	-	1	43	28	-	1	-
D.C.	1	-	-	2	-	-	-	1	-	-	-
Va.	28	23	-	8	5	-	13	7	-	-	-
W. Va.	4	9	-	-	-	-	1	1	-	-	-
N.C.	28	41	-	8	9	-	42	50	-	19	5
S.C.	31	41	-	3	4	-	8	16	-	-	-
Ga.	43	59	-	2	1	-	16	6	-	-	-
Fla.	69	71	1	10	8	7	37	24	-	-	3
E.S. CENTRAL	115	114	-	4	10	-	45	59	-	1	-
Ky.	29	17	-	-	-	-	3	25	-	-	-
Tenn.	42	42	-	-	1	-	27	17	-	-	-
Ala.	26	35	-	4	5	-	11	15	-	1	-
Miss.	18	20	-	-	4	-	4	2	-	-	-
W.S. CENTRAL	101	194	-	23	40	1	69	188	-	5	79
Ark.	25	24	-	-	-	1	9	23	-	-	-
La.	34	38	U	3	8	U	3	2	U	-	-
Okla.	20	28	-	1	-	-	7	20	-	-	-
Tex.	22	104	-	19	32	-	50	143	-	5	79
MOUNTAIN	94	89	-	12	25	16	278	534	-	15	5
Mont.	2	3	-	-	-	-	2	3	-	-	-
Idaho	8	4	-	1	3	-	93	166	-	-	-
Wyo.	3	4	-	-	1	-	2	7	-	-	-
Colo.	24	17	-	3	4	3	63	128	-	-	-
N. Mex.	12	16	N	N	N	8	48	67	-	-	1
Ariz.	29	31	-	-	5	-	29	116	-	13	1
Utah	11	9	-	5	3	5	39	28	-	1	2
Nev.	5	5	-	3	9	-	2	19	-	1	1
PACIFIC	270	339	-	57	84	8	989	516	-	4	13
Wash.	40	47	-	2	6	3	509	153	-	-	9
Oreg.	46	55	N	N	N	-	22	34	-	-	-
Calif.	175	232	-	47	60	5	448	316	-	4	2
Alaska	5	1	-	1	2	-	3	3	-	-	-
Hawaii	4	4	-	7	16	-	7	10	-	-	2
Guam	-	2	U	1	2	U	1	-	U	-	-
P.R.	5	6	-	-	2	-	13	3	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	-	2	U	-	1	U	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE IV. Deaths in 122 U.S. cities,* week ending July 17, 1999 (28th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	542	367	115	38	16	6	52
Boston, Mass.	133	82	33	13	5	-	12
Bridgeport, Conn.	34	20	8	4	1	1	4
Cambridge, Mass.	16	13	1	2	-	-	1
Fall River, Mass.	19	15	4	-	-	-	-
Hartford, Conn.	57	37	11	5	3	1	4
Lowell, Mass.	19	11	5	3	-	-	-
Lynn, Mass.	11	9	1	1	-	-	3
New Bedford, Mass.	19	12	5	2	-	-	1
New Haven, Conn.	36	26	6	2	1	1	2
Providence, R.I.	53	40	10	2	-	1	-
Somerville, Mass.	8	6	2	-	-	-	1
Springfield, Mass.	58	38	12	2	5	1	10
Waterbury, Conn.	27	20	6	-	1	-	6
Worcester, Mass.	52	38	11	2	-	1	8
MID. ATLANTIC	2,351	1,627	481	177	39	27	62
Albany, N.Y.	44	33	7	3	-	1	2
Allentown, Pa.	U	U	U	U	U	U	U
Buffalo, N.Y.	82	59	14	6	1	2	-
Camden, N.J.	24	15	3	3	-	3	3
Elizabeth, N.J.	16	10	5	1	-	-	-
Erie, Pa.	50	37	9	2	2	-	3
Jersey City, N.J.	49	36	11	2	-	-	-
New York City, N.Y.	1,363	944	282	107	20	10	16
Newark, N.J.	30	17	9	3	-	1	-
Paterson, N.J.	25	18	3	1	2	1	2
Philadelphia, Pa.	299	182	75	33	6	3	11
Pittsburgh, Pa.§	40	29	8	3	-	-	4
Reading, Pa.	26	22	4	-	-	-	2
Rochester, N.Y.	118	82	23	8	2	3	8
Schenectady, N.Y.	24	20	3	1	-	-	2
Scranton, Pa.	31	26	4	-	-	1	-
Syracuse, N.Y.	98	72	17	2	5	2	8
Trenton, N.J.	15	10	2	2	1	-	1
Utica, N.Y.	17	15	2	-	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,934	1,295	390	140	60	48	106
Akron, Ohio	47	38	6	1	-	2	1
Canton, Ohio	27	21	4	2	-	-	2
Chicago, Ill.	322	192	79	37	5	8	22
Cincinnati, Ohio	117	91	19	3	3	1	9
Cleveland, Ohio	168	104	38	14	8	4	5
Columbus, Ohio	163	112	31	6	7	7	12
Dayton, Ohio	125	89	21	10	4	1	7
Detroit, Mich.	211	124	50	20	9	8	9
Evansville, Ind.	37	30	5	1	1	-	3
Fort Wayne, Ind.	76	56	8	6	4	2	3
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	63	38	15	3	2	5	5
Indianapolis, Ind.	169	105	41	11	7	5	5
Lansing, Mich.	35	26	9	-	-	-	2
Milwaukee, Wis.	136	96	24	12	1	3	2
Peoria, Ill.	40	26	11	1	2	-	3
Rockford, Ill.	43	30	10	2	1	-	8
South Bend, Ind.	U	U	U	U	U	U	U
Toledo, Ohio	102	75	14	6	5	2	6
Youngstown, Ohio	53	42	5	5	1	-	2
W.N. CENTRAL	593	421	104	32	16	20	29
Des Moines, Iowa	49	41	5	1	1	1	5
Duluth, Minn.	U	U	U	U	U	U	U
Kansas City, Kans.	U	U	U	U	U	U	U
Kansas City, Mo.	74	45	15	3	5	6	4
Lincoln, Nebr.	29	23	4	1	1	-	2
Minneapolis, Minn.	162	116	30	10	3	3	6
Omaha, Nebr.	103	71	22	3	2	5	2
St. Louis, Mo.	95	56	22	9	4	4	7
St. Paul, Minn.	81	69	6	5	-	1	3
Wichita, Kans.	U	U	U	U	U	U	U
S. ATLANTIC	977	661	200	73	21	14	51
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	198	112	46	24	8	3	19
Charlotte, N.C.	101	74	21	5	1	-	10
Jacksonville, Fla.	140	96	32	8	3	1	1
Miami, Fla.	95	57	24	8	2	1	-
Norfolk, Va.	56	40	10	5	-	1	3
Richmond, Va.	67	33	19	11	3	1	3
Savannah, Ga.	58	45	9	1	-	3	2
St. Petersburg, Fla.	62	52	4	6	-	-	5
Tampa, Fla.	182	135	35	4	4	4	8
Washington, D.C.	U	U	U	U	U	U	U
Wilmington, Del.	18	17	-	1	-	-	-
E.S. CENTRAL	816	562	163	59	20	11	35
Birmingham, Ala.	192	129	41	18	2	1	8
Chattanooga, Tenn.	73	60	6	2	4	1	3
Knoxville, Tenn.	64	43	15	3	2	1	-
Lexington, Ky.	54	39	10	4	1	-	5
Memphis, Tenn.	164	99	43	13	4	5	16
Mobile, Ala.	68	48	10	7	2	1	-
Montgomery, Ala.	77	53	16	7	1	-	-
Nashville, Tenn.	124	91	22	5	4	2	3
W.S. CENTRAL	1,217	778	269	99	40	31	71
Austin, Tex.	82	56	18	7	1	-	6
Baton Rouge, La.	62	40	17	2	2	1	3
Corpus Christi, Tex.	51	38	10	2	-	1	2
Dallas, Tex.	187	114	38	19	11	5	2
El Paso, Tex.	U	U	U	U	U	U	U
Ft. Worth, Tex.	106	77	18	6	4	1	11
Houston, Tex.	423	260	108	36	10	9	30
Little Rock, Ark.	79	52	11	6	6	4	2
New Orleans, La.	62	30	19	9	2	2	9
San Antonio, Tex.	U	U	U	U	U	U	U
Shreveport, La.	47	27	9	5	3	3	3
Tulsa, Okla.	118	84	21	7	1	5	3
MOUNTAIN	896	572	197	77	29	20	61
Albuquerque, N.M.	109	75	23	5	4	2	10
Boise, Idaho	42	30	7	4	1	-	2
Colo. Springs, Colo.	56	30	15	9	1	1	3
Denver, Colo.	110	69	23	8	5	5	11
Las Vegas, Nev.	197	118	52	17	6	4	10
Ogden, Utah	36	21	7	6	2	-	-
Phoenix, Ariz.	71	46	13	5	3	4	2
Pueblo, Colo.	25	17	5	1	2	-	1
Salt Lake City, Utah	112	75	21	8	4	3	11
Tucson, Ariz.	138	91	31	14	1	1	11
PACIFIC	1,323	904	273	91	28	25	97
Berkeley, Calif.	13	9	3	1	-	-	-
Fresno, Calif.	119	77	27	9	4	2	7
Glendale, Calif.	18	14	4	-	-	-	1
Honolulu, Hawaii	67	49	13	4	-	1	4
Long Beach, Calif.	71	47	19	1	1	3	12
Los Angeles, Calif.	352	217	82	36	9	8	16
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	U	U	U	U	U	U	U
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	176	124	33	11	5	3	18
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	227	173	41	8	-	5	23
Santa Cruz, Calif.	30	24	6	-	-	-	3
Seattle, Wash.	115	67	24	15	6	3	2
Spokane, Wash.	50	38	9	1	2	-	6
Tacoma, Wash.	85	65	12	5	1	-	5
TOTAL	10,649¶	7,187	2,192	786	269	202	564

U: Unavailable -: no reported cases

*Mortality data in this table are voluntarily reported from 122 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 this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

Hepatitis A Virus — Continued

conduct prompt and thorough case investigations to identify contacts for whom IG might be indicated.

Another 30% of secondary cases occurred among persons who had no household or sexual contact with a person with hepatitis A but had reported other types of close personal contact that have been associated with transmission, such as contact with young children with unrecognized infection, and participating in the practices associated with illegal drug use (*6–10*). The risk for and the mode of transmission in these circumstances have not been established and are difficult to assess. An evaluation of the characteristics of each contact should be conducted to identify exposed persons who are not household or sexual contacts. Persons who report other types of close personal contact with a hepatitis A patient should be considered candidates for IG. Studies to characterize features of exposures associated with HAV transmission are needed to develop explicit criteria for IG administration in these settings.

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Notice to Readers

National Vaccine Advisory Committee Workshop on Thimerosal in Vaccines

The National Vaccine Advisory Committee will sponsor a workshop on thimerosal in vaccines on August 11–12, 1999. The workshop will be held at the Lister Hill Auditorium on the National Institutes of Health campus, Bethesda, Maryland, and will review use of thimerosal in vaccines and its reduction and elimination from vaccines. Additional information is available from the National Vaccine Program Office, CDC, Mailstop A-11, 1600 Clifton Rd, N.E., Atlanta, GA 30333; telephone (404) 639-4450; or from the World-Wide Web, http://www.cdc.gov/od/nvpo/calendar/htm.

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