

# MNWR

MORBIDITY AND MORTALITY WEEKLY REPORT

- 153 Injuries Associated with Soccer Goalposts — United States, 1979–1993
- 155 Heterosexually Acquired AIDS — United States, 1993
- 160 Update: Impact of the Expanded AIDS Surveillance Case Definition for Adolescents and Adults on Case Reporting — United States, 1993
- 171 Measles — Puerto Rico, 1993, and the Measles Elimination Program
- 173 Notices to Readers

## *Epidemiologic Notes and Reports*

### **Injuries Associated with Soccer Goalposts — United States, 1979–1993**

Injuries associated with sports can be related to a variety of factors, including participant's level of conditioning or training, failure to use safety equipment, contact, overexertion, difficulty in conducting the task required, mismatch in skill or size between players, and adverse environmental conditions. A rare but often fatal event is a blow caused by a falling soccer goalpost resulting from improper installation or use. From 1979 through 1993, 27 persons were injured or killed from falling soccer goalposts. This report describes three (two fatal) injuries associated with soccer goalposts and summarizes an analysis of all fatal and nonfatal soccer goalpost-related injuries reported in the United States to the Consumer Product Safety Commission (CPSC) during 1979–1993.

#### **Case 1**

A 16-year-old boy and two friends at a high school soccer field without adult supervision climbed the mobile soccer goalpost. As one person climbed on the horizontal header of the 600-pound steel goalpost, the goalpost tipped forward and struck the head of the 16-year-old, who was hanging from the header, and rendered him unconscious. Cardiopulmonary resuscitation at the scene and at the local emergency department was unsuccessful. He was pronounced dead 1 hour after the incident. An autopsy revealed severe blunt head trauma with multiple skull fractures and cerebral edema. Analysis of blood samples was negative for alcohol and drugs. The goalpost, which was commercially made and had been in service without incident for 6 years, was not anchored to the ground at the time of the incident.

#### **Case 2**

A 3-year-old boy was playing in front of a metal goalpost after a soccer game. As his father and brother were lifting one of the goalpost's corners to remove the net for storage, the goalpost fell, striking the boy's head and pinning him to the ground; he was rendered unconscious immediately. Cardiopulmonary resuscitation was unsuccessful, and the boy was pronounced dead approximately 1 hour later. The goalpost had not been anchored.

*Soccer Goalposts — Continued***Case 3**

A 9-year-old boy was playing goalie during a team practice when a wind gust blew over the unstaked steel soccer goalpost. The child tried to stop the fall of the goalpost when it struck his upper leg and fractured his femur. He was hospitalized for 6 weeks and disabled for 4 months before regaining useful leg function. The goalpost had been moved before the beginning of practice, and the seven steel stakes that secured it to the ground had been left behind.

**Analysis of National Morbidity and Mortality Data**

Data about persons injured or killed by falling soccer goalposts in the United States during 1979–1993 were identified by CPSC from 1) the National Electronic Injury Surveillance System (1.) 2) newspaper clippings, 3) medical examiner reports, and 4) personal contacts made by soccer coaches or equipment manufacturers to CPSC. Each case was investigated through site inspections and interviews with the injured patient, a parent or other family member, a witness, and/or authorities responsible for purchase or maintenance of the soccer goalposts.

During 1979–1993, 27 injuries related to falling soccer goalposts were investigated by CPSC, of which 18 were fatal. Most (23) injuries occurred among males; the mean age of injured persons was 10 years. Head trauma was the principal cause of death in 14 of the fatal injuries and was diagnosed in two of the nonfatal ones.

Of the 27 goalposts involved, 26 were made of metal, usually steel or galvanized pipe; 23 of the goalposts were mobile, one was permanently installed, and three were of unknown type. Twenty-five injuries occurred when a goalpost fell forward, with the top crossbar striking the victim. Eighteen goalposts were not anchored, one was anchored poorly, and three were anchored properly; for five, the status could not be determined. Fifteen of the incidents occurred on a school field; 11, at a local or private field; and one, at an unspecified site. Four events occurred during a soccer game and four during practice; the remaining events occurred during times not involving games or practice. All 27 events were witnessed: in six cases, an adult was directly supervising and in visual contact with the victim; in eight, an adult supervisor was in the general vicinity, although not in visual contact. Four injuries were associated with a person climbing; seven, with a person swinging or doing chin-ups; six, with lifting the soccer goalpost; and four, with wind gusts. In 12 (nine fatal) incidents, the injured persons caused the goalposts to fall.

*Reported by: J DeMarco, C Reeves, US Consumer Product Safety Commission. Div of Unintentional Injuries Prevention, National Center for Injury Prevention and Control, CDC.*

**Editorial Note:** The findings in this report indicate the potential for serious injuries associated with improperly installed or used soccer goalposts. Regulation soccer goalposts can be manufactured from steel, aluminum, or metal pipe; measure approximately 8 feet by 24 feet; and weigh 250–800 pounds. Because the mouth of the goalpost is completely open to the playing field, only three sides are available for stabilizing the goalpost from forward falls. The reports to CPSC indicate that injuries typically result from climbing on goalposts, swinging or hanging from crossbars, or doing chin-ups on crossbars.

In the United States, soccer goalposts are manufactured by seven companies, and an undetermined number are produced by local machine shops without strict specifications. In 1990, CPSC issued a voluntary labeling standard for use of warning labels

*Soccer Goalposts — Continued*

on the front and back of the crossbar and the front of the goalposts. Because of concerns about the inability of young children to read such warnings and the likelihood that older children would ignore these warnings, voluntary standards were adopted in 1992 by manufacturers; these standards specify the need to anchor or counterweight the goalposts using driving stakes, auger stakes, vertical pipe sleeves, or sandbags. If stakes are used, four are recommended—two on the rear and one on either side. Goalposts not in use should be chained to a fence or other permanent structure, placed goal-face down on the ground, or disassembled for storage. Additional information concerning these or other methods of anchoring is available from the Coalition to Promote Soccer Goal Safety, telephone (800) 527-7510 or (800) 531-4252.

The findings in this report demonstrate the potential benefit of using a national surveillance system to collect data on rare injury events. Accurately assessing the extent of such events and targeting prevention efforts requires calculating an injury rate through improved collection of numerator and denominator data and collecting exposure risk data (i.e., age and sex of injured person and level of competition). In addition, schools, park districts, and soccer associations should report injuries associated with falling soccer goalposts to the CPSC hotline, telephone (800) 638-2772. For injuries involving goalposts that were properly installed and used, specific information should be collected about the materials and method used to anchor these structures and soil and weather conditions on the day of the incident.

*Reference*

1. US Consumer Product Safety Commission. The NEISS sample: design and implementation. Washington, DC: US Consumer Product Safety Commission, March 1986.

*Current Trends***Heterosexually Acquired AIDS — United States, 1993**

From 1991 through 1992, persons with acquired immunodeficiency syndrome (AIDS) who were infected with human immunodeficiency virus (HIV) through heterosexual transmission accounted for the largest proportionate increase in reported AIDS cases in the United States (1). During 1993, a total of 103,500 persons aged  $\geq 13$  years with AIDS were reported to CDC. This report summarizes the characteristics of persons reported with AIDS in the United States in 1993 attributed to heterosexual contact, compares data with those for 1992, and presents trends in heterosexual exposure categories.\*

From 1985 through 1993, the proportion of persons with AIDS who reported heterosexual contact with a partner at risk for or with documented HIV infection increased from 1.9% to 9.0%, respectively (Figure 1). During the same period, the proportion of cases attributed to male-to-male sexual contact decreased from 66.5% to 46.6%, while the proportion attributed to injecting-drug use among women and heterosexual men increased from 17.4% to 27.7%. In 1993, AIDS cases attributed to heterosexual contact (n=9288) increased 130% over 1992 (n=4045). Cases in all

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\*Single copies of this report will be available free until March 11, 1995, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

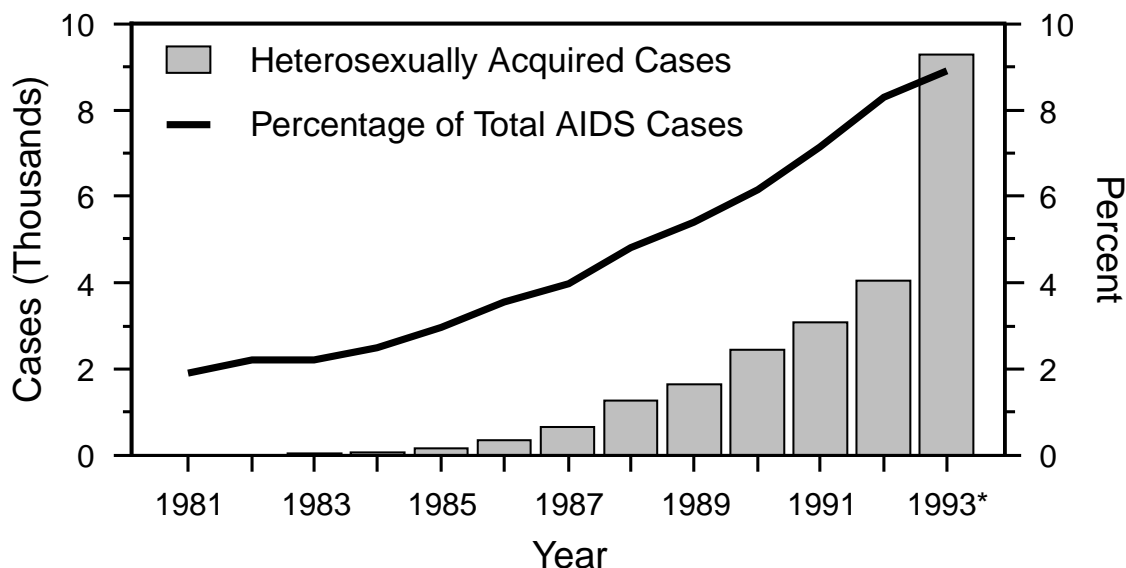
*AIDS — Continued*

other exposure categories combined increased 109% in 1993, when the expanded AIDS surveillance case definition resulted in substantial increases in reported cases in all demographic and exposure categories (2,3). These reports include present AIDS cases diagnosed in 1993 and in earlier years.

In 1993, most heterosexually acquired AIDS cases were attributed to heterosexual contact with an injecting-drug user (IDU) (42.3%) or with a partner with HIV infection or AIDS whose risk was unreported or unknown (49.7%) (Figure 2). Men were more likely than women to report contact with a partner with HIV infection or AIDS whose risk was unreported or unknown (60% versus 44%); this group may include persons whose sex partners were IDUs or bisexual men for whom risk was not known or reported and persons whose sex partners were themselves infected heterosexually. Compared with 1992, during 1993 the number of cases associated with heterosexual contact with an IDU (n=3916) increased 79%, and the number of cases associated with heterosexual contact with a partner with HIV infection or AIDS whose risk was unknown or unreported (n=4617) increased 195%. Increases also occurred in the number of cases associated with heterosexual contact with a bisexual man (171%), a person with hemophilia or other coagulation disorder (200%), or a transfusion or transplant recipient (132%). However, the number of cases in these latter three categories is small, and they represent a decreasing proportion of all heterosexual-contact cases (Figure 2).

In 1993, heterosexual HIV transmission accounted for 6056 AIDS cases reported among women (median age: 33 years) and 3232 cases among men (median age: 38 years). In addition, 55% of men and 50% of women were non-Hispanic black, and 23% of men and 24% of women were Hispanic (Table 1). Rates were highest for non-Hispanic blacks (20 per 100,000 population) and Hispanics (10 per 100,000) than for non-Hispanic whites (1 per 100,000), Asians/Pacific Islanders (1 per 100,000), and American Indians/Alaskan Natives (2 per 100,000). During 1992 and 1993, persons

**FIGURE 1. Number of AIDS cases attributed to heterosexual HIV transmission and percentage of total AIDS cases — United States, 1981–1993**



\*Expanded AIDS surveillance case definition implemented (2).

## AIDS — Continued

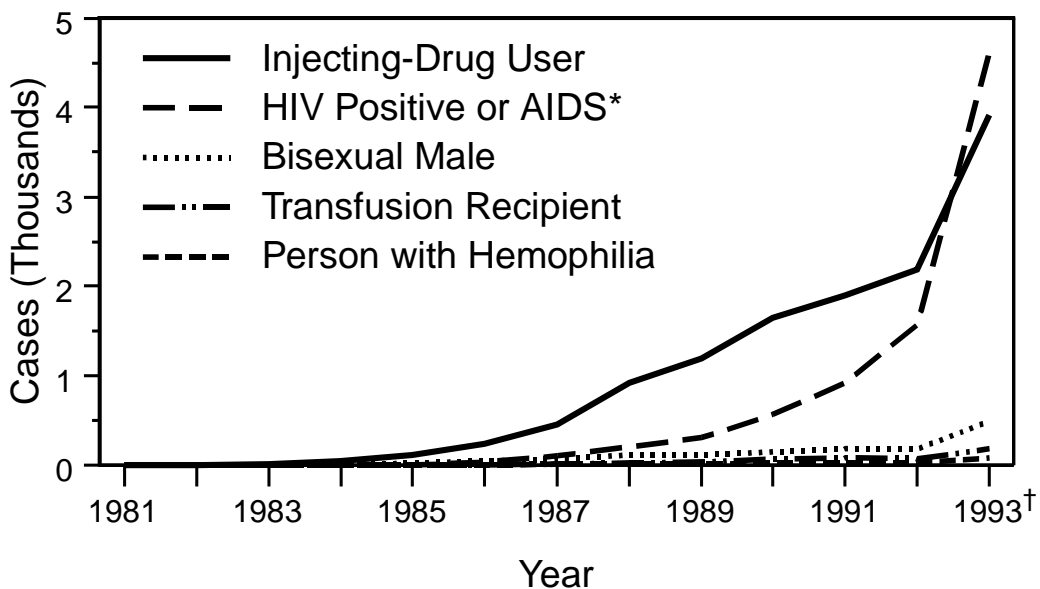
aged 13–29 years accounted for 25% and 27%, respectively, of heterosexual-contact cases, while representing 18% of total adolescent and adult AIDS cases each year.

The highest proportions of cases associated with heterosexual contact during 1993 were in the South<sup>†</sup> (42%) and Northeast<sup>§</sup> (31%); these areas also accounted for 24% and 53%, respectively, of cases reported among heterosexual IDUs (n=28,687). States

<sup>†</sup>South Atlantic, East South Central, and West South Central regions.

<sup>§</sup>New England and Middle Atlantic regions.

**FIGURE 2. Number of AIDS cases attributed to heterosexual HIV transmission, by partner's risk factor — United States, 1981–1993**



\*Partner's risk unknown or not reported.

<sup>†</sup>Expanded AIDS surveillance case definition implemented (2).

**TABLE 1. Number and percentage of adolescents and adults with heterosexually acquired AIDS, by race/ethnicity and percentage increase — United States, 1992–1993**

Race/Ethnicity	Males			Females						
	1992		% Increase from 1992 to 1993	1992		% Increase from 1992 to 1993				
	No.	(%)		No.	(%)					
White, non-Hispanic	331	( 22)	681	( 21)	106	616	( 24)	1510	( 25)	145
Black, non-Hispanic	845	( 56)	1789	( 55)	112	1308	( 52)	3022	( 50)	131
Hispanic	325	( 22)	736	( 23)	126	584	( 23)	1444	( 24)	147
Asian/Pacific Islander	3	(<1)	16	(<1)	*	20	(<1)	52	(<1)	*
American Indian/ Alaskan Native	1	(<1)	6	(<1)	*	5	(<1)	23	(<1)	*
<b>Total<sup>†</sup></b>	<b>1509</b>	<b>(100)</b>	<b>3232</b>	<b>(100)</b>	<b>114</b>	<b>2536</b>	<b>(100)</b>	<b>6056</b>	<b>(100)</b>	<b>139</b>

\*Estimate of percentage change is unreliable because of small numbers of cases.

<sup>†</sup>Includes eight men and eight women for whom race/ethnicity was unknown.

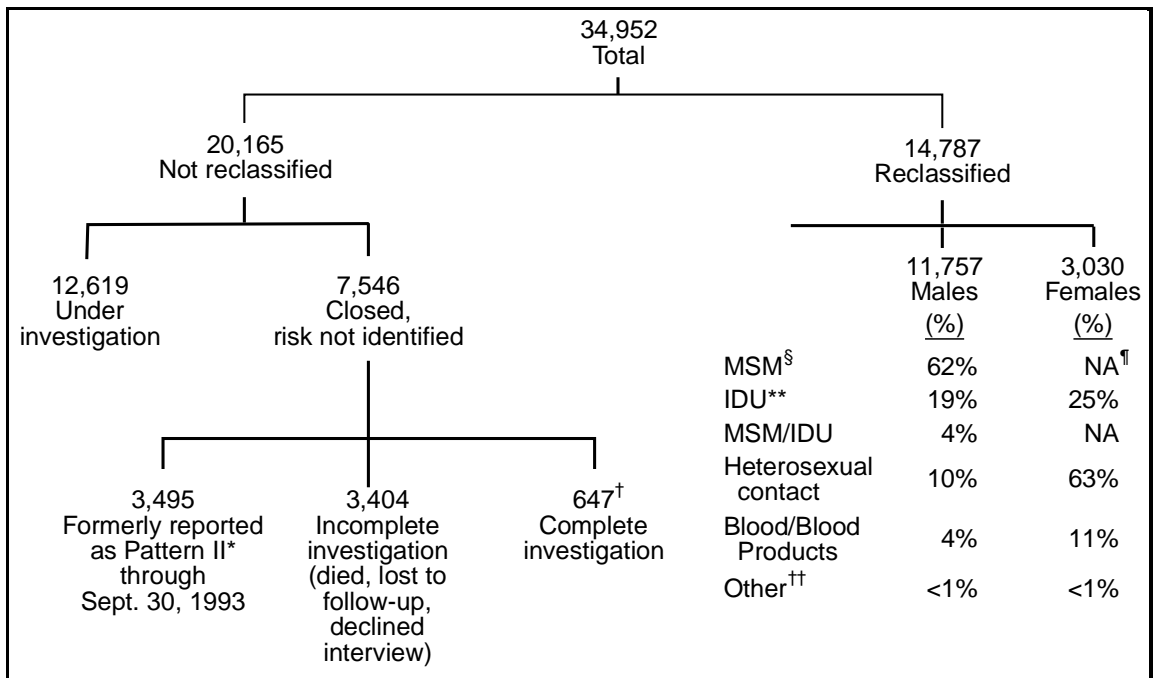
## AIDS — Continued

reporting the largest number of heterosexually acquired AIDS cases in 1993 were Florida (1772 cases), New York (1336), and New Jersey (855).

As of December 31, 1993, of 34,952 persons with AIDS ever reported without a behavioral risk factor, 14,787 (42%) had been reclassified; of these, 10% of men and 63% of women were reclassified as having acquired AIDS through heterosexual transmission of HIV (Figure 3). By comparison, in 1993, 4% of men and 37% of women with AIDS were reported as having HIV infection associated with heterosexual transmission.

Reported by: Local, state, and territorial health depts. Div of HIV/AIDS, National Center for Infectious Diseases, CDC.

**FIGURE 3. Results of investigations of adolescents and adults with AIDS classified as "risk not reported" — United States, December 1993**



\*Persons whose origin is a country where heterosexual transmission was presumed to be the predominant mode of HIV transmission or who had sex with a person whose origin is such a country.

<sup>†</sup> Investigations on these persons included patient interviews. These persons could not be reclassified into an exposure category. This group includes persons possibly infected through heterosexual contact; persons who may choose not to disclose high-risk information; persons with possible occupational exposure to blood; and persons who report heterosexual contact, sexually transmitted disease infections, noninjecting-drug use, and hepatitis infections.

<sup>§</sup> Men who have sex with men.

<sup>¶</sup> Not applicable.

\*\*Injecting-drug user.

<sup>††</sup> Includes health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; patients who developed AIDS after exposure to HIV within the health-care setting, as documented by epidemiologic and laboratory studies; persons who acquired HIV infection perinatally but did not have AIDS diagnosed until after age 13 years; and one person who acquired HIV infection through intentional self-inoculation of blood from an HIV-infected person.

*AIDS — Continued*

**Editorial Note:** This report documents the continued increase in the number and proportion of AIDS cases attributed to heterosexual HIV transmission. Persons at highest risk for heterosexually transmitted HIV infection include adolescents and adults with multiple sex partners, those with sexually transmitted diseases (STDs), and heterosexually active persons residing in areas with a high prevalence of HIV infection among IDUs (4). In addition, a disproportionate number of persons with AIDS who acquired HIV infection through heterosexual contact are black or Hispanic; monitoring HIV prevalence and AIDS incidence in different racial/ethnic populations can assist in developing culturally and linguistically appropriate HIV-prevention messages.

Among heterosexuals at high risk for HIV infection (e.g., heterosexually active clients at STD clinics and drug-treatment centers), the seroprevalence of HIV infection is higher among men than women (5). However, serosurveillance findings indicate that rates of HIV infection are increasing among women in some populations and geographic areas. For example, among disadvantaged young women who enter the Job Corps and among childbearing women in the South, seroprevalence rates were higher during 1991–1992 than during earlier years (5). Therefore, to understand the extent of heterosexual transmission and to develop targeted prevention programs, health officials must account for local variations in population characteristics and behaviors that may affect the risk for HIV transmission.

Although some persons classified as having acquired HIV infection through heterosexual contact may have other unreported risk factors (6), the proportions of AIDS cases attributed to heterosexual contact (9% and 6%, respectively, of persons reported in 1993 and cumulatively) probably are a conservative estimate of heterosexual contact AIDS cases. The classification for heterosexual transmission requires a history of heterosexual contact with a partner who has HIV infection, AIDS, or risk factors for HIV infection (i.e., male-to-male sexual contact, injecting-drug use, or receipt of HIV-contaminated blood or blood products). In addition, persons whose origin is a country where heterosexual transmission was presumed to be the predominant mode of HIV transmission (i.e., formerly classified by the World Health Organization as Pattern II countries [7]) and persons who had sex with a person whose origin is such a country are no longer automatically classified as having acquired AIDS through heterosexual contact. To promote more consistent risk ascertainment among persons reported with AIDS, all persons who have no specific risks for HIV infection are classified as “no risk reported.”

Other persons with AIDS also may have become infected through heterosexual contact. For example, of the 86,961 persons cumulatively classified as IDUs, approximately 12,600 also reported heterosexual contact with a person at risk. In addition, after follow-up investigations are completed, some persons currently classified as “risk not reported” will be found to have risks for heterosexual transmission. To develop more accurate estimates of the proportion of AIDS cases resulting from heterosexual transmission, CDC is collaborating with six local and state health departments to evaluate the validity and accuracy of heterosexual risk information reported to surveillance programs.

Compared with persons who acquired HIV infection through other modes of transmission, the number of persons infected through heterosexual transmission is increasing rapidly. Increased awareness of these trends and concerns about STDs and unintended pregnancies among adolescents and young adults should result in

*AIDS — Continued*

enhanced efforts to promote safer-sex behaviors. These behaviors include postponing sexual activity among youths, restricting sexual contact to a mutually monogamous relationship with an uninfected partner, and consistently and correctly using latex condoms during intercourse (8). Because promotion of such behavior change is influenced by community norms (9), CDC has expanded efforts to assist local and state health departments in planning HIV-prevention programs at the community level.

*References*

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4. CDC. Update: heterosexual transmission of acquired immunodeficiency syndrome and human immunodeficiency virus infection—United States. *MMWR* 1989;38:423–4,429–34.
5. CDC. National HIV serosurveillance summary: results through 1992. Vol 3. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1993:29–30.
6. Nwanyanwu OC, Conti L, Ciesielski CA, et al. Increasing frequency of heterosexually transmitted AIDS in southern Florida: artifact or reality? *Am J Public Health* 1993;83:571–3.
7. Mertens TE, Burton T, Stoneburner R, et al. Global estimates and epidemiology of HIV infection and AIDS. *AIDS: A Year in Review, 1993–1994* (in press).
8. CDC. Update: barrier protection against HIV infection and other sexually transmitted diseases. *MMWR* 1993;42:589–91,597.
9. National Commission on AIDS. Behavioral and social sciences and the HIV/AIDS epidemic. Washington, DC: National Commission on AIDS, July 1993:44–9.

*Current Trends***Update: Impact of the Expanded AIDS Surveillance Case Definition for Adolescents and Adults on Case Reporting — United States, 1993**

During 1993, local, state, and territorial health departments reported 103,500 acquired immunodeficiency syndrome (AIDS) cases among persons aged  $\geq 13$  years in the United States, an increase of 111% over the 49,016 reported in 1992 (Figure 1). This increase resulted from the expansion of the AIDS surveillance case definition in 1993\*; in comparison, the number of cases based on the preexisting case definition decreased slightly. This report summarizes characteristics of persons reported with AIDS in 1993, compares these findings with data from 1992, and describes the impact of the change in the AIDS surveillance definition on AIDS case reporting.<sup>†</sup>

Of cases in 1993, 55,432 (54%) were reported based on conditions added to the definition in 1993; and 48,068 (46%) were reported based on pre-1993 defined conditions—a 2% decrease from the number of cases reported in 1992 (Figure 1). Of the

\*On January 1, 1993, the AIDS surveillance case definition for adolescents and adults was expanded beyond the definition published in 1987 to include all human immunodeficiency virus-infected persons with severe immunosuppression ( $<200$  CD4+ T-lymphocytes/ $\mu$ L or a CD4+ T-lymphocyte percentage of total lymphocytes of  $<14$ ), pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer (1).

<sup>†</sup>Single copies of this report will be available free until March 11, 1995, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.



*AIDS Surveillance Case Definition — Continued*

55,432 cases reported based on 1993-added conditions, 50,061 persons (91%) had severe human immunodeficiency virus (HIV)-related immunosuppression only; 3988 (7%), pulmonary tuberculosis (TB); 1251 (2%), recurrent pneumonia; and 151 (<1%), invasive cervical cancer (19 persons were reported with more than one of these opportunistic illnesses).

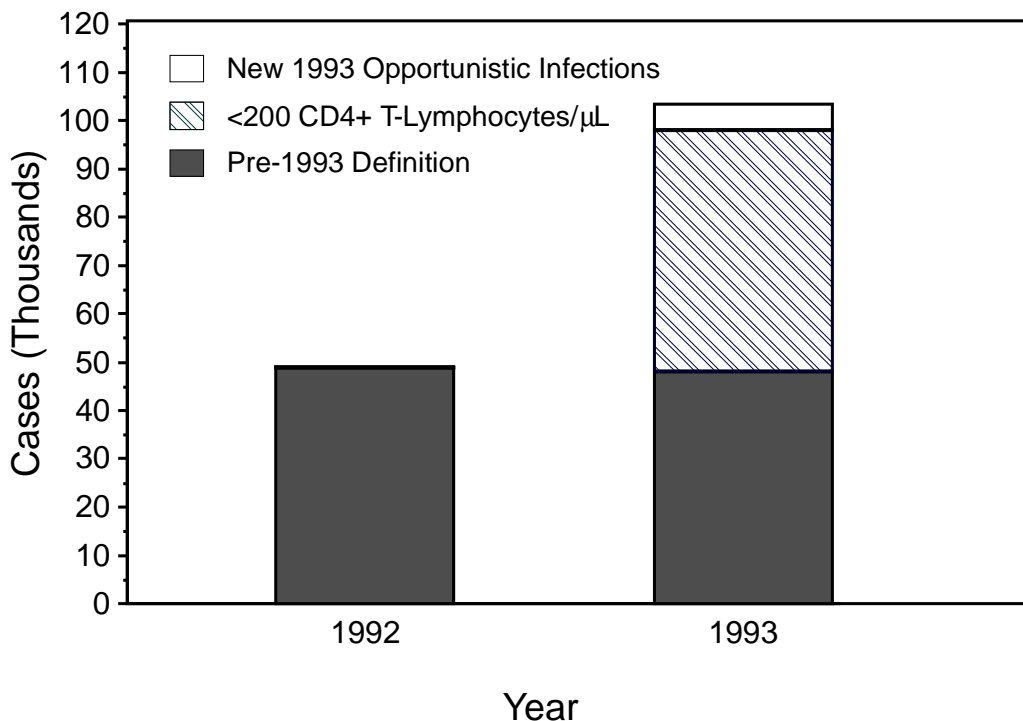
The number of case reports was highest during the first quarter of 1993 (n=33,875, a 178% increase over the same period in 1992) and declined throughout the year: 18,957 cases were reported during the fourth quarter, a 67% increase over the same period in 1992. Comparing the same quarters of 1993, the median interval between date of diagnosis and date of report declined from 9 months to 4 months among persons reported with the newly added criteria but remained stable for persons reported using pre-1993 criteria. Of the cases reported in 1993, 56% had been diagnosed in earlier years, compared with 42% of cases reported in 1992.

In 1993, substantial increases in the number of reported AIDS cases occurred in all regions of the United States (Table 1, page 168). Of areas reporting more than 250 cases, the proportion of cases based on the 1993-added criteria ranged from 35% in North Carolina (n=1353) to 71% in Colorado (n=1323).

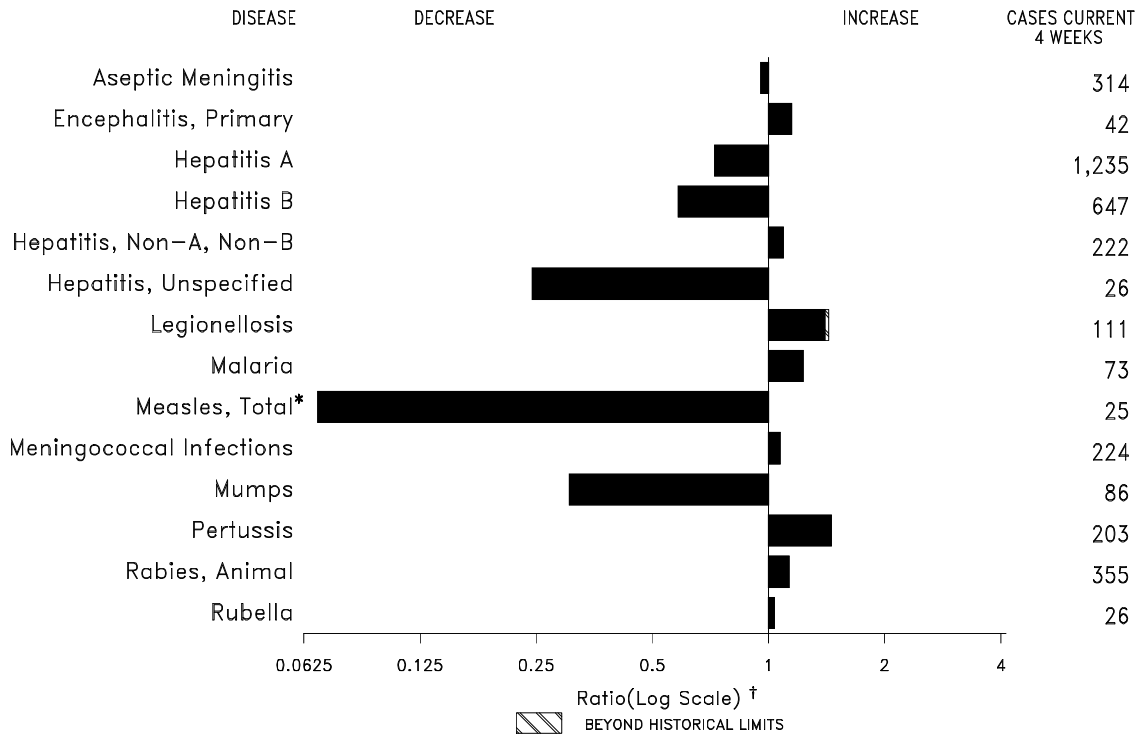
The increase in reported cases in 1993 was greater among females (151%) than among males (105%) (Table 1, page 168). Proportionate increases were greater among blacks and Hispanics than among whites. The largest increases in case reporting occurred among persons aged 13–19 years and 20–24 years; in these age groups, a greater proportion of cases were reported among women (35% and 29%, respectively) and were attributed to heterosexual transmission (22% and 18%, respectively).

*(Continued on page 167)*

**FIGURE 1. Number of adolescents and adults with AIDS — United States, 1992–1993**



**FIGURE I. Notifiable disease reports, comparison of 4-week totals ending March 5, 1994, 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 the hatched 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 March 5, 1994 (9th Week)**

	Cum. 1994		Cum. 1994
AIDS*	10,369	Measles: imported	6
Anthrax	-	indigenous	30
Botulism: Foodborne	6	Plague	-
Infant	12	Poliomyelitis, Paralytic <sup>§</sup>	-
Other	4	Psittacosis	3
Brucellosis	5	Rabies, human	-
Cholera	-	Syphilis, primary & secondary	2,998
Congenital rubella syndrome	3	Syphilis, congenital, age < 1 year	-
Diphtheria	-	Tetanus	4
Encephalitis, post-infectious	15	Toxic shock syndrome	39
Gonorrhea	55,816	Trichinosis	14
<i>Haemophilus influenzae</i> (invasive disease) <sup>†</sup>	181	Tuberculosis	2,255
Hansen Disease	15	Tularemia	1
Leptospirosis	5	Typhoid fever	42
Lyme Disease	391	Typhus fever, tickborne (RMSF)	15

\*Updated monthly; last update February 22, 1994.

†Of 168 cases of known age, 54 (32%) were reported among children less than 5 years of age.

§No cases of suspected poliomyelitis have been reported in 1994; 3 cases of suspected poliomyelitis have been reported in 1993; 4 of the 5 suspected cases with onset in 1992 were confirmed; the confirmed cases were vaccine associated.

**TABLE II. Cases of selected notifiable diseases, United States, weeks ending March 5, 1994, and March 6, 1993 (9th Week)**

Reporting Area	AIDS*	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
			Cum. 1994	Cum. 1994			Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994		
UNITED STATES	10,369	760	98	15	55,816	69,364	2,922	1,611	679	60	240	391
NEW ENGLAND	483	38	5	1	1,445	1,535	50	61	17	8	12	50
Maine	21	4	1	-	8	13	3	-	-	-	1	-
N.H.	18	-	-	1	-	11	2	2	3	-	-	3
Vt.	6	3	-	-	7	11	-	-	-	-	-	1
Mass.	246	14	3	-	512	573	26	57	7	8	9	37
R.I.	66	17	1	-	74	83	10	2	7	-	2	9
Conn.	126	-	-	-	844	844	9	-	-	-	-	-
MID. ATLANTIC	3,752	57	8	6	5,224	7,275	131	146	91	2	30	224
Upstate N.Y.	167	22	2	1	914	1,267	56	46	38	-	9	83
N.Y. City	2,881	-	-	-	1,595	2,602	-	-	-	-	-	-
N.J.	451	-	-	-	591	1,097	44	62	43	-	6	46
Pa.	253	35	6	5	2,124	2,309	31	38	10	2	15	95
E.N. CENTRAL	785	151	29	5	11,362	13,919	284	153	45	2	71	5
Ohio	137	47	9	-	4,568	4,503	99	39	1	-	41	5
Ind.	41	41	2	-	1,430	1,385	69	35	2	-	10	-
Ill.	490	12	5	-	2,233	4,505	44	6	-	1	4	-
Mich.	102	51	13	5	3,040	2,371	52	61	42	1	14	-
Wis.	15	-	-	-	91	1,155	20	12	-	-	2	-
W.N. CENTRAL	132	47	3	1	2,745	3,593	121	77	45	1	31	3
Minn.	27	-	1	-	639	473	12	6	1	-	-	1
Iowa	13	21	-	-	174	274	6	5	-	-	13	1
Mo.	36	13	-	-	1,250	1,928	69	61	42	1	11	-
N. Dak.	1	-	1	-	-	11	1	-	-	-	-	-
S. Dak.	3	-	-	-	28	31	7	-	-	-	-	-
Nebr.	12	1	1	1	-	158	17	2	-	-	6	-
Kans.	40	12	-	-	654	718	9	3	2	-	1	1
S. ATLANTIC	2,213	188	15	-	18,246	18,139	203	399	142	8	46	89
Del.	35	1	-	-	276	247	3	9	19	-	1	40
Md.	163	22	3	-	3,384	2,883	30	40	9	2	9	8
D.C.	166	5	-	-	1,559	953	6	10	-	-	-	-
Va.	94	29	7	-	2,475	1,143	22	17	8	2	2	8
W. Va.	4	4	-	-	118	124	3	4	4	-	1	3
N.C.	187	38	5	-	4,754	4,312	18	64	13	-	5	14
S.C.	90	5	-	-	1,970	1,729	6	7	-	-	1	-
Ga.	291	6	-	-	-	2,512	23	168	59	-	18	15
Fla.	1,183	78	-	-	3,710	4,236	92	80	30	4	9	1
E.S. CENTRAL	177	58	9	1	7,528	6,459	75	218	165	-	15	2
Ky.	44	26	4	1	761	842	31	4	2	-	1	1
Tenn.	53	16	5	-	1,958	1,262	24	201	162	-	9	-
Ala.	50	12	-	-	2,971	2,634	10	13	1	-	3	1
Miss.	30	4	-	-	1,838	1,721	10	-	-	-	2	-
W.S. CENTRAL	1,255	31	4	-	4,212	9,351	343	155	40	14	6	2
Ark.	23	3	-	-	1,196	1,834	8	5	1	-	1	-
La.	122	1	1	-	2,619	1,884	12	17	4	-	-	-
Okla.	19	-	-	-	397	448	43	62	34	-	5	2
Tex.	1,091	27	3	-	-	5,185	280	71	1	14	-	-
MOUNTAIN	184	17	2	-	1,307	2,047	594	84	59	4	17	4
Mont.	4	-	-	-	20	13	7	2	-	-	7	-
Idaho	1	-	-	-	11	21	56	14	20	1	-	1
Wyo.	-	-	-	-	20	10	3	5	17	-	1	-
Colo.	62	6	-	-	346	732	26	2	4	2	1	-
N. Mex.	21	2	-	-	174	184	183	36	4	1	1	3
Ariz.	45	6	-	-	351	669	226	14	4	-	1	-
Utah	11	2	-	-	59	53	61	4	6	-	-	-
Nev.	40	1	2	-	326	365	32	7	4	-	6	-
PACIFIC	1,388	173	23	1	3,747	7,046	1,121	318	75	21	12	12
Wash.	157	-	-	-	546	711	67	14	13	-	2	-
Oreg.	63	-	-	-	200	236	52	11	2	1	-	-
Calif.	1,111	138	22	-	2,764	5,936	955	278	56	19	9	12
Alaska	8	3	1	-	138	96	39	1	-	-	-	-
Hawaii	49	32	-	1	99	67	8	14	4	1	1	-
Guam	-	-	-	-	19	16	-	-	-	-	-	-
P.R.	209	2	-	-	92	73	6	39	10	2	-	-
V.I.	5	-	-	-	4	18	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	4	5	2	-	-	-	-	-
C.N.M.I.	1	-	-	-	13	9	1	-	-	-	-	-

N: Not notifiable

U: Unavailable

C.N.M.I.: Commonwealth of Northern Mariana Islands

\*Updated monthly; last update February 22, 1994.

**TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending March 5, 1994, and March 6, 1993 (9th Week)**

Reporting Area	Measles (Rubeola)						Men- gococcal infections	Mumps		Pertussis			Rubella		
	Malaria	Indigenous		Imported*		Total									
		Cum. 1994	1994	Cum. 1994	1994	Cum. 1994		Cum. 1993	Cum. 1994	1994	1994	Cum. 1994	Cum. 1993	1994	Cum. 1994
UNITED STATES	145	7	30	1	6	61	575	26	193	45	531	520	6	39	28
NEW ENGLAND	14	-	1	-	-	38	36	-	6	6	39	123	3	26	1
Maine	1	-	-	-	-	-	6	-	3	-	2	3	-	-	1
N.H.	-	-	-	-	-	-	1	-	1	1	9	38	-	-	-
Vt.	-	-	-	-	-	20	1	-	-	-	7	21	-	-	-
Mass.	5	-	1	-	-	10	16	-	-	5	17	58	3	26	-
R.I.	4	-	-	-	-	-	-	-	-	-	2	1	-	-	-
Conn.	4	-	-	-	-	8	12	-	2	-	2	2	-	-	-
MID. ATLANTIC	22	1	2	-	1	5	45	4	21	21	117	89	2	4	11
Upstate N.Y.	7	1	1	-	-	-	16	-	2	16	41	26	2	4	-
N.Y. City	-	-	1	-	-	1	-	-	-	-	8	-	-	-	6
N.J.	12	-	-	-	-	4	15	-	-	-	-	25	-	-	4
Pa.	3	-	-	-	1	-	14	4	19	5	68	38	-	-	1
E.N. CENTRAL	13	-	-	-	1	-	87	1	31	4	91	126	-	1	1
Ohio	2	-	-	-	-	-	23	-	8	1	52	48	-	-	-
Ind.	4	-	-	-	-	-	16	-	2	-	12	6	-	-	-
Ill.	2	-	-	-	-	-	29	-	10	-	8	15	-	1	-
Mich.	5	-	-	-	-	-	9	1	11	3	14	5	-	-	-
Wis.	-	-	-	-	1	-	10	-	-	-	5	52	-	-	1
W.N. CENTRAL	3	-	-	-	-	-	38	1	7	-	10	21	-	-	1
Minn.	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Iowa	1	-	-	-	-	-	4	1	2	-	-	-	-	-	-
Mo.	2	-	-	-	-	-	23	-	4	-	3	10	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	1	-	-	1	-	-	-
S. Dak.	-	-	-	-	-	-	3	-	-	-	-	1	-	-	-
Nebr.	-	-	-	-	-	-	1	-	-	-	1	4	-	-	-
Kans.	-	-	-	-	-	-	6	-	-	-	6	5	-	-	-
S. ATLANTIC	38	-	3	-	-	10	110	6	40	10	91	29	-	3	2
Del.	2	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Md.	7	-	-	-	-	1	8	1	5	2	28	15	-	-	-
D.C.	6	-	-	-	-	-	1	-	-	-	1	-	-	-	-
Va.	8	-	1	-	-	1	12	5	9	3	12	1	-	-	-
W. Va.	-	-	-	-	-	-	6	-	2	-	1	1	-	-	-
N.C.	1	-	-	-	-	-	19	-	16	1	27	-	-	-	-
S.C.	1	-	-	-	-	-	4	-	4	2	7	2	-	-	-
Ga.	5	-	-	-	-	-	18	-	1	-	6	8	-	-	-
Fla.	8	-	2	-	-	8	42	-	3	2	9	2	-	3	1
E.S. CENTRAL	5	5	19	-	-	-	48	-	3	1	22	17	-	-	-
Ky.	-	-	-	-	-	-	12	-	-	-	2	6	-	-	-
Tenn.	3	5	19	-	-	-	13	-	-	-	13	5	-	-	-
Ala.	1	-	-	-	-	-	17	-	-	1	7	5	-	-	-
Miss.	1	-	-	-	-	-	6	-	3	-	-	1	-	-	-
W.S. CENTRAL	4	-	-	-	1	1	70	11	46	-	16	7	-	-	1
Ark.	-	-	-	-	-	-	6	-	-	-	-	-	-	-	-
La.	-	-	-	-	-	1	4	-	1	-	1	-	-	-	-
Okla.	-	-	-	-	-	-	7	8	13	-	12	7	-	-	1
Tex.	4	-	-	-	1	-	53	3	32	-	3	-	-	-	-
MOUNTAIN	2	-	1	-	-	2	41	-	6	2	27	29	-	-	4
Mont.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
Idaho	-	-	1	-	-	-	4	-	2	-	15	4	-	-	1
Wyo.	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-
Colo.	-	-	-	-	-	2	2	-	-	-	2	11	-	-	-
N. Mex.	1	-	-	-	-	-	4	N	N	-	2	11	-	-	-
Ariz.	-	-	-	-	-	-	17	-	-	1	6	2	-	-	-
Utah	1	-	-	-	-	-	8	-	1	1	2	-	-	-	2
Nev.	-	-	-	-	-	-	3	-	3	-	-	-	-	-	1
PACIFIC	44	1	4	1	3	5	100	3	33	1	118	79	1	5	7
Wash.	1	-	-	-	-	-	8	1	2	-	10	5	-	-	-
Oreg.	1	-	-	-	-	-	10	N	N	-	10	-	-	-	1
Calif.	36	1	4	1 <sup>§</sup>	3	1	78	1	27	1	93	69	1	5	3
Alaska	-	-	-	-	-	-	1	-	2	-	-	1	-	-	1
Hawaii	6	-	-	-	-	4	3	1	2	-	5	4	-	-	2
Guam	-	U	1	U	-	-	-	U	-	U	-	-	U	-	-
P.R.	-	-	5	-	-	69	2	-	1	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	1	-	1	1	1	1	-	-	-	-
C.N.M.I.	1	U	22	U	-	-	-	U	-	U	-	-	U	-	-

\*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 March 5, 1994, and March 6, 1993 (9th Week)**

Reporting Area	Syphilis (Primary & Secondary)		Toxic- Shock Syndrome	Tuberculosis		Tula- remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1994	Cum. 1993	Cum. 1994	Cum. 1994	Cum. 1993	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994
UNITED STATES	2,998	5,187	39	2,255	2,455	1	42	15	740
NEW ENGLAND	30	87	1	51	25	-	8	-	221
Maine	-	2	-	-	3	-	-	-	-
N.H.	-	7	-	1	1	-	-	-	20
Vt.	-	-	-	-	-	-	-	-	14
Mass.	8	43	1	20	3	-	4	-	100
R.I.	5	2	-	6	-	-	1	-	-
Conn.	17	33	-	24	18	-	3	-	87
MID. ATLANTIC	227	414	6	298	494	-	4	-	89
Upstate N.Y.	15	54	3	18	73	-	2	-	-
N.Y. City	147	270	-	175	301	-	-	-	-
N.J.	17	74	-	69	58	-	2	-	49
Pa.	48	16	3	36	62	-	-	-	40
E.N. CENTRAL	390	807	11	237	308	-	5	2	2
Ohio	166	214	4	40	35	-	-	1	-
Ind.	55	63	1	21	26	-	1	-	-
Ill.	105	306	2	128	195	-	2	-	-
Mich.	59	129	4	40	40	-	2	1	-
Wis.	5	95	-	8	12	-	-	-	2
W.N. CENTRAL	182	320	7	48	47	1	-	-	21
Minn.	10	20	-	11	-	-	-	-	-
Iowa	11	15	5	6	5	-	-	-	12
Mo.	161	257	1	22	27	1	-	-	2
N. Dak.	-	-	-	1	3	-	-	-	-
S. Dak.	-	-	-	4	3	-	-	-	1
Nebr.	-	3	1	-	2	-	-	-	-
Kans.	-	25	-	4	7	-	-	-	6
S. ATLANTIC	993	1,362	1	404	336	-	10	10	280
Del.	3	23	-	-	6	-	-	-	2
Md.	50	71	-	45	55	-	2	-	97
D.C.	39	64	-	20	21	-	1	-	1
Va.	121	104	-	58	-	-	-	-	60
W. Va.	5	1	-	11	10	-	-	-	8
N.C.	343	368	-	14	63	-	-	5	24
S.C.	114	232	-	68	55	-	-	-	22
Ga.	152	240	-	166	126	-	-	5	58
Fla.	166	259	1	22	-	-	7	-	8
E.S. CENTRAL	686	550	1	126	144	-	-	1	28
Ky.	44	52	-	40	49	-	-	-	-
Tenn.	166	111	1	1	-	-	-	-	9
Ala.	116	162	-	63	68	-	-	-	19
Miss.	360	225	-	22	27	-	-	1	-
W.S. CENTRAL	459	1,258	-	151	176	-	1	1	49
Ark.	92	221	-	36	16	-	-	-	3
La.	362	441	-	-	-	-	-	-	-
Okla.	5	63	-	12	8	-	-	1	9
Tex.	-	533	-	103	152	-	1	-	37
MOUNTAIN	30	43	2	88	64	-	5	-	12
Mont.	-	-	-	-	-	-	-	-	-
Idaho	-	-	1	5	-	-	-	-	-
Wyo.	-	1	-	1	-	-	-	-	4
Colo.	15	18	1	1	-	-	2	-	-
N. Mex.	1	7	-	15	-	-	-	-	-
Ariz.	10	16	-	48	44	-	-	-	8
Utah	4	-	-	-	7	-	1	-	-
Nev.	-	1	-	18	13	-	2	-	-
PACIFIC	1	346	10	852	861	-	9	1	38
Wash.	1	10	-	34	37	-	1	-	-
Oreg.	-	13	-	17	9	-	-	-	-
Calif.	-	322	9	757	764	-	7	1	26
Alaska	-	-	-	9	5	-	-	-	12
Hawaii	-	1	1	35	46	-	1	-	-
Guam	-	-	-	7	9	-	-	-	-
P.R.	67	87	-	-	24	-	-	-	12
V.I.	1	11	-	-	2	-	-	-	-
Amer. Samoa	-	-	-	-	1	-	1	-	-
C.N.M.I.	-	-	-	12	1	-	-	-	-

U: Unavailable



*AIDS Surveillance Case Definition — Continued*

Compared with homosexual/bisexual men, proportionate increases in case reporting were greater among heterosexual injecting-drug users (IDUs) and among persons reportedly infected through heterosexual contact (Table 1). The largest proportionate increase in AIDS case reporting occurred among persons with hemophilia, although the total number of these cases was smaller than for the other HIV-exposure categories.

Females, blacks, heterosexual IDUs, and persons with hemophilia were more likely than others to be reported with 1993-added conditions (Table 2). Most of these differences were attributable to reports of the three opportunistic illnesses added in 1993; of 5371 persons reported with a 1993-added opportunistic illness, 26% were women, 48% were heterosexual IDUs, and 63% were black. The number of Hispanics reported under the 1993-added criteria reflected reports from Puerto Rico: 38% of the 3173 reports from Puerto Rico were based on the 1993-added criteria, compared with 54% of the 15,145 cases among Hispanics from other areas.

The pediatric AIDS surveillance case definition was not changed in 1993. During 1993, 968 children aged <13 years were reported with AIDS, an increase of 24% compared with the 783 cases reported in 1992. Of those 968 children, 50% were female, and most were either black (55%) or Hispanic (27%) and were infected through perinatal HIV transmission (93%). New York, Puerto Rico, and Florida reported 489 (51%) of the pediatric AIDS cases.

*Reported by: Local, state, and territorial health depts. Div of HIV/AIDS, National Center for Infectious Diseases, CDC.*

**Editorial Note:** The expansion of AIDS surveillance criteria in 1993 altered both the process of AIDS surveillance and the number of reported cases. The dramatic increase in the number of cases reported probably represents a one-time effect of the expanded reporting criteria that primarily results from reporting of persons who had newly added conditions diagnosed before 1993.

The increase in the number of cases reported in 1993 (111%) exceeded the projected increase (75%) (1,2), indicating the rapid and efficient implementation of the revised AIDS surveillance criteria by many local and state health departments. Because the initial impact of the expanded case definition is likely to wane, the number of AIDS cases reported in 1994 is expected to be less than the number reported in 1993.

During 1993, the number of reported cases meeting the pre-1993 AIDS surveillance definition decreased 2% from 1992. This reflects the rapid adoption of the CD4+ reporting criteria, which was used for 91% of AIDS case reports that were based on the 1993-added conditions. Therefore, the case count using pre-1993 criteria is not a precise measure of the number of cases that would have been reported if the definition had not been changed because the reporting of conditions meeting the pre-1993 criteria is affected by reporting using the CD4+ and other expanded criteria. For example, some cases reported under the expanded criteria may have had a concurrent or subsequent AIDS-defining condition in 1993 that was not reported; conversely, reporting of these pre-1993 conditions may have been enhanced by follow-up of cases initially reported with a newly added condition.

In addition to active surveillance in hospitals and outpatient clinics, local health departments have employed different methods and sources to implement the expanded reporting criteria; these include laboratory-initiated surveillance for HIV

## AIDS Surveillance Case Definition — Continued

**TABLE 1. Characteristics of persons with reported AIDS cases and percentage increase in the number of cases, by year of report — United States, 1992–1993**

Characteristic	1993 Reported cases		1992 Reported cases	% Increase 1992 to 1993
	No.	(%)		
<b>Sex</b>				
Male	86,986	( 84.0)	42,445	105
Female	16,514	( 16.0)	6,571	151
<b>Age group (yrs)</b>				
13–19	555	( 0.5)	177	214
20–24	3,722	( 3.6)	1,600	133
25–29	14,680	( 14.2)	7,021	109
30–39	47,415	( 45.8)	22,358	112
40–49	26,956	( 26.0)	12,609	114
50–59	7,514	( 7.3)	3,700	103
≥60	2,658	( 2.6)	1,551	71
<b>Race/Ethnicity*</b>				
White, non-Hispanic	47,003	( 45.4)	23,305	102
Black, non-Hispanic	36,951	( 35.7)	16,582	123
Hispanic	18,318	( 17.7)	8,541	114
Asian/Pacific Islander	741	( 0.7)	332	123
American Indian/ Alaskan Native	320	( 0.3)	114	181
<b>HIV-exposure category</b>				
Male homosexual/ bisexual contact	48,266	( 46.6)	25,864	87
History of injecting-drug use				
Women and heterosexual men	28,687	( 27.7)	12,163	136
Male homosexual/ bisexual contact	5,745	( 5.6)	3,028	90
Person with hemophilia	1,041	( 1.0)	360	189
Heterosexual contact†	9,288	( 9.0)	4,045	130
Transfusion recipients	1,219	( 1.2)	710	72
No risk reported	9,254	( 8.9)	2,846	—
<b>Region‡</b>				
Northeast	30,876	( 29.8)	13,243	133
Northcentral	10,755	( 10.4)	5,656	90
South	34,264	( 33.1)	16,588	107
West	24,372	( 23.5)	11,914	105
U.S. territories	3,233	( 3.1)	1,615	100
<b>Total</b>	<b>103,500</b>	<b>(100.0)</b>	<b>49,016</b>	<b>111</b>

\*Excludes persons with unspecified race/ethnicity (167 in 1993, 142 in 1992).

†Persons whose origin is or who had sex with a person whose origin is a country where heterosexual transmission was presumed to be the predominant mode of HIV transmission (i.e., formerly classified by the World Health Organization as Pattern II countries) are no longer automatically classified as having heterosexually acquired AIDS. These persons are classified as "no risk reported."

‡Northeast=New England and Middle Atlantic regions; Northcentral=East North Central and West North Central regions; South=South Atlantic, East South Central, and West South Central regions; West=Mountain and Pacific regions.



## AIDS Surveillance Case Definition — Continued

antibody and CD4+ measurements (in states that require such reporting) and for AIDS-defining opportunistic infections and information obtained from TB and cancer surveillance registries (3,4). Group-specific differences may exist in the incidence of 1993-added conditions and in access to and use of HIV testing and clinical-care services. For example, the large increase in AIDS reporting among persons with hemophilia may reflect high levels of HIV testing and immunologic monitoring in this population in which new HIV infections have been rare since 1985. Females, IDUs, and blacks were most likely to be reported with new AIDS-defining opportunistic illnesses. This difference largely reflects the population coinfecting with *Mycobacterium tuberculosis* and HIV (5).

**TABLE 2. Number and percentage of persons with AIDS meeting the 1993 surveillance case definition criteria, by pre-1993 and 1993-added definitions — United States**

Characteristic	Pre-1993 (n=48,068)		1993-Added (n=55,432)		Total (n=103,500)	
	No.	(%)	No.	(%)	No.	(%)
<b>Sex</b>						
Male	40,826	(84.9)	46,160	(83.3)	<b>86,986</b>	<b>(84.1)</b>
Female	7,242	(15.1)	9,272	(16.7)	<b>16,514</b>	<b>(15.9)</b>
<b>Race/Ethnicity<sup>†</sup></b>						
White, non-Hispanic	21,878	(45.5)	25,126	(45.3)	<b>47,003</b>	<b>(45.5)</b>
Black, non-Hispanic	16,630	(34.6)	20,321	(36.7)	<b>36,951</b>	<b>(35.8)</b>
Hispanic	8,958	(18.6)	9,360	(16.9)	<b>18,318</b>	<b>(17.7)</b>
Asian/Pacific Islander	348	( 0.7)	309	( 0.7)	<b>741</b>	<b>( 0.7)</b>
American Indian/ Alaskan Native	122	( 0.3)	198	( 0.4)	<b>320</b>	<b>( 0.3)</b>
<b>Risk exposure category</b>						
Male homosexual/ bisexual contact	23,355	(48.6)	24,911	(44.9)	<b>48,266</b>	<b>(46.6)</b>
History of injecting-drug use	12,410	(25.8)	16,277	(29.4)	<b>28,687</b>	<b>(27.7)</b>
Women and heterosexual men*	4,362	( 9.1)	4,926	( 8.9)	<b>9,288</b>	<b>( 9.0)</b>
Person with hemophilia	270	( 0.6)	689	( 1.2)	<b>959</b>	<b>( 1.0)</b>
<b>Region<sup>§</sup></b>						
Northeast	13,998	(29.1)	16,878	(30.4)	<b>30,876</b>	<b>(29.8)</b>
Northcentral	4,969	(10.3)	5,786	(10.4)	<b>10,755</b>	<b>(10.4)</b>
South	16,688	(34.7)	17,576	(31.7)	<b>34,264</b>	<b>(33.1)</b>
West	10,402	(21.6)	13,970	(25.2)	<b>24,372</b>	<b>(23.5)</b>
U.S. territories	2,011	( 4.3)	1,222	( 2.2)	<b>3,233</b>	<b>( 3.2)</b>
<b>Alive at report</b>	31,657	(65.9)	48,960	(88.3)	<b>80,617</b>	<b>(77.9)</b>
<b>No. with CD4+ T-lymphocyte counts</b>						
<200 cells/ $\mu$ L	28,563		51,130			
Median	44 cells/ $\mu$ L		121 cells/ $\mu$ L			

\*Persons whose origin is or who had sex with a person whose origin is a country where heterosexual transmission was presumed to be the predominant mode of HIV transmission (i.e., formerly classified by the World Health Organization as Pattern II countries) are no longer automatically classified as having heterosexually acquired AIDS. These persons are now classified as "no risk reported."

<sup>†</sup>Excludes 167 persons with unspecified race/ethnicity.

<sup>§</sup>Northeast=New England and Middle Atlantic regions; Northcentral=East North Central and West North Central regions; South=South Atlantic, East South Central, and West South Central regions; West=Mountain and Pacific regions.

*AIDS Surveillance Case Definition — Continued*

In 1993, the rate of increase in case reporting was greatest for women, racial/ethnic minorities, adolescents, IDUs, and persons infected through heterosexual contact. These trends in AIDS case reporting are similar to those observed in previous reporting years and suggest that changes in 1993 reflect, in part, underlying changes in the epidemic. Because race and ethnicity are not risk factors for HIV infection, an assessment of risk behaviors is necessary to properly target prevention efforts. The higher incidence of AIDS among non-Hispanic blacks and Hispanics than among non-Hispanic whites emphasizes the need for culturally sensitive and appropriate prevention messages. Although the pediatric case definition remained unchanged in 1993, the number of children reported with AIDS increased and paralleled the increase in AIDS among women.

The surveillance information available as a result of the expanded AIDS reporting criteria provides a representative and more complete estimate of the number and distribution of persons with severe HIV-related immunosuppression and three major HIV-related illnesses that are particularly important among groups in whom the growth of the AIDS epidemic has been greatest. In general, persons with 1993-added conditions had higher CD4+ counts than other persons with AIDS. The ability to conduct surveillance for persons in earlier stages of HIV infection should result in more prompt recognition of changes in the trends of HIV transmission and disease. The expanded reporting criteria also have made reporting more complete because persons with 1993-added conditions who had died would not have been reported if the AIDS surveillance definition had not been changed. The addition of the pulmonary TB reporting criteria has more than doubled the number of persons with AIDS reported with TB. Although the number of HIV-infected women reported with invasive cervical cancer is relatively small, the inclusion of this potentially preventable and life-threatening condition in AIDS surveillance efforts provides an opportunity to monitor gynecologic care for HIV-infected women. The expanded AIDS surveillance information should facilitate community efforts to plan, direct, and evaluate HIV-prevention and HIV-care programs.

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## Current Trends

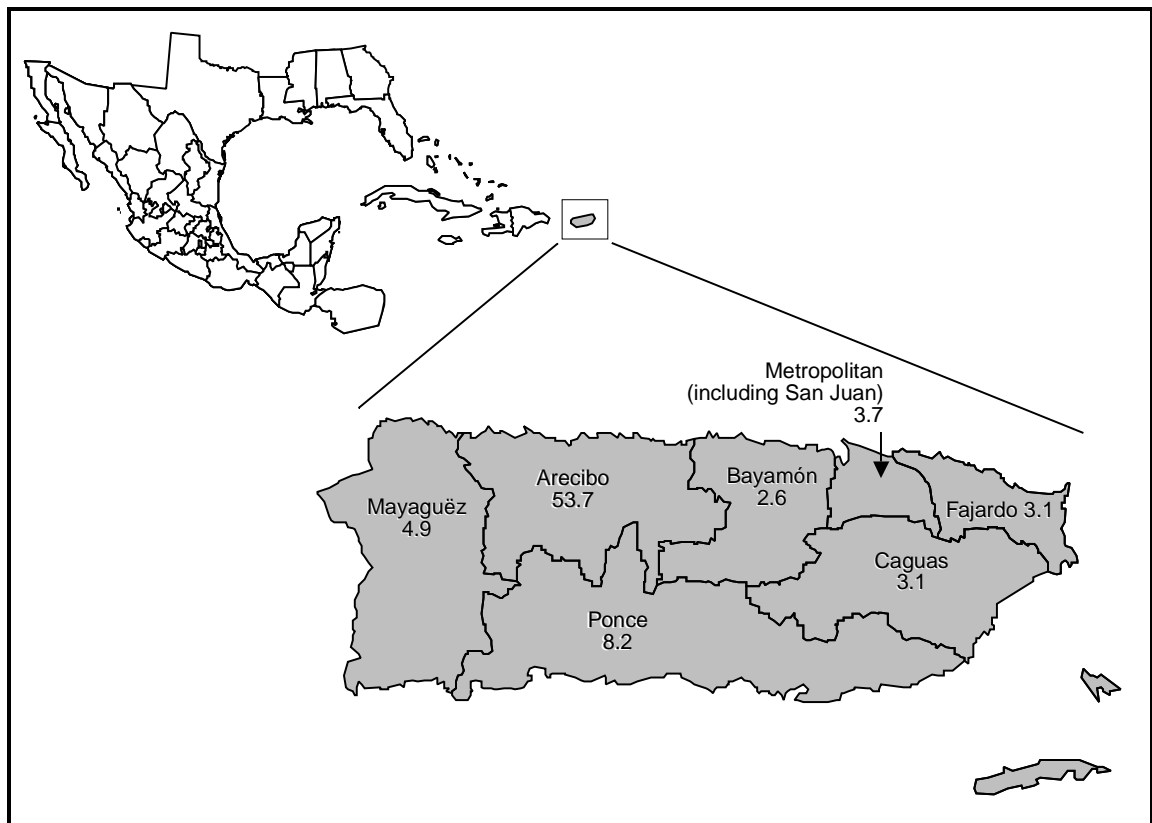
### **Measles — Puerto Rico, 1993, and the Measles Elimination Program**

In the Commonwealth of Puerto Rico, a resurgence of measles peaked in 1990 when 1805 cases (51.3 cases per 100,000 population) and 12 measles-related deaths were reported. This report summarizes the persistence of measles transmission in Puerto Rico in 1993 and describes the Puerto Rico Measles Elimination Program.

Because of similarities in clinical features of measles and dengue (which is endemic in Puerto Rico [1]), since 1991 only measles cases serologically confirmed by enzyme-linked immunosorbent assay have been reported to CDC. In 1993, 355 measles cases were reported (10.1 per 100,000). Cases were reported from each region of Puerto Rico (Figure 1); the largest outbreaks were reported from Arecibo (219 cases [53.7 per 100,000]), Ponce (46 [8.2]), and Metropolitan (including San Juan) (31 [3.7]). Confirmed cases were reported in each month; nearly half of all cases occurred during April (48 cases), May (77), and June (52); fewer than 10 cases occurred each month during October–December.

Most (254 [72%]) cases occurred among preschool-aged children (i.e., aged 0–5 years); 116 (33%) occurred among infants (i.e., aged <12 months). Among the 248 (70%) persons with measles for whom vaccination status was known, 149 (60%)

**FIGURE 1. Incidence rate\* of measles, by region — Commonwealth of Puerto Rico, 1993**



\*Per 100,000 population

*Measles — Continued*

were unvaccinated; these unvaccinated persons constituted 93% of infants, 56% of children aged 1–5 years, 2% of school-aged children, and 64% of adults (Table 1).

From 1983 to 1990, Puerto Rico required one dose of measles-mumps-rubella vaccine (MMR) for school entry, and annual audits during 1990–1992 indicated approximately 95% coverage among children in all grades. Since 1990, two doses of MMR have been required for school entry, and annual audits during 1991–1992 indicated approximately 90% coverage with two doses among children entering school. In 1990, Puerto Rico lowered the recommended age for routine vaccination with MMR to 12 months. Vaccination coverage with one dose of MMR by 24 months (estimated by retrospective studies of children entering school in 1992) was 69%.

To eliminate indigenous measles transmission in Puerto Rico by 1996, the Puerto Rico Department of Health (PRDH) is conducting the Puerto Rico Measles Elimination Program, an islandwide effort comprising a mass vaccination campaign, increased measles surveillance, and aggressive outbreak control.

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**Editorial Note:** Elimination of indigenous measles in the United States by 1996 is a goal of the Childhood Immunization Initiative (2). The approach adopted in Puerto Rico to meet this objective is based on a measles-elimination strategy advocated by the Pan American Health Organization (PAHO). This strategy, implemented by 14 Latin American countries and all 17 English-speaking Caribbean countries, supplements routine vaccination with mass vaccination campaigns for children aged <15 years regardless of previous vaccination status and enhances surveillance for febrile rash illness. Since September 1991, no confirmed indigenous measles cases have been reported from the English-speaking Caribbean countries or Cuba (Expanded Program on Immunization, PAHO, unpublished data, 1994).

Because effective school vaccination laws have resulted in high (>90%) MMR coverage among all school-aged children in Puerto Rico, PRDH will focus its mass vaccination campaign on preschool-aged children, among whom most (72%) of the recent cases have occurred. This campaign, scheduled for March 16–19, 1994, will target the approximately 353,000 children in Puerto Rico aged 6 months–5 years, regardless of previous measles vaccination history. In addition, health-care providers

**TABLE 1. Number and percentage of persons with reported measles for whom vaccination status was known, by age group and vaccination status\* — Puerto Rico, 1993†**

Age group (yrs)	Vaccinated		Unvaccinated		Total cases	
	No.	(%)	No.	(%)	No.	(%)
< 1	6	( 7)	82	(93)	88	( 35)
1– 5	40	(44)	50	(56)	90	( 36)
6–18	44	(98)	1	( 2)	45	( 18)
≥19	9	(36)	16	(64)	25	( 10)
<b>Total</b>	<b>99</b>	<b>(40)</b>	<b>149</b>	<b>(60)</b>	<b>248</b>	<b>(100)</b>

\*Excludes 107 persons with measles (28 were aged <1 year; 48, aged 1–5 years; 25, aged 6–18 years; and 6, aged ≥19 years) whose vaccination status was unknown.

†Data are provisional.

*Measles — Continued*

will assess vaccination status of children for whom records are available for oral poliovirus vaccine, diphtheria and tetanus toxoids and pertussis vaccine, and *Haemophilus influenzae* type b vaccine and will administer needed vaccines. Following the campaign, PRDH will conduct a population-based evaluation of the vaccination coverage achieved.

Other elements of the measles elimination program in Puerto Rico are to increase measles surveillance and to implement aggressive outbreak control. PRDH will establish a febrile rash illness reporting system. All health-care providers will be encouraged to promptly report to PRDH every case of febrile rash illness, which will be investigated within 24 hours of report. Measles surveillance will continue to be coordinated with the PRDH Community Hygiene Division (which conducts dengue surveillance) and CDC's Dengue Branch, Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases, in San Juan to provide additional laboratory diagnosis of cases of rash illness. Private laboratories will be requested to notify PRDH on receipt of any specimen submitted for measles serology. A case-response protocol will enable PRDH to implement outbreak-control measures as soon as a diagnosis of measles is considered likely—ideally within 3 days of rash onset. Control measures will include enhanced case investigation, contact tracing, and vaccination of contacts.

Because measles may circulate independently among older vaccinated persons (without a reservoir of susceptible preschool-aged children to sustain transmission), measles circulation in Puerto Rico could persist despite a successful mass vaccination campaign. Enhanced surveillance efforts will be needed to identify this trend and to stimulate development of additional strategies to interrupt transmission. In addition, continued efforts to improve timely vaccination of preschool-aged children will be necessary to maintain the high vaccination coverage level anticipated following the campaign.

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*Notice to Readers***International EIS Course**

CDC and Emory University will cosponsor a course designed for practicing health professionals in international public health. This course, "The International EIS [Epidemic Intelligence Service] Course," will be held at CDC October 3–28, 1994. It emphasizes the practical application of epidemiology to international public health problems and will consist of lectures, discussions, workshops, classroom exercises (including actual epidemiologic case studies), and an on-site community survey. The topics covered will include descriptive epidemiology and biostatistics, analytic epidemiology, epidemic investigations, public health surveillance, surveys and

*Notices to Readers — Continued*

sampling, computers and computer software, and discussions of selected prevalent diseases. There is a tuition charge.

Applications must be received by June 15. Additional information and applications are available from Department PSB, Emory University, School of Public Health, 1599 Clifton Road, NE, Atlanta, GA 30329; telephone (404) 727-3485 or 727-0199; fax (404) 727-4590.

*Notice to Readers***Availability of Computer-Based Epidemiologic Case Study**

CDC has developed a computer-based epidemiologic case study, "Investigating an Outbreak: Pharyngitis in Louisiana," to teach outbreak investigation skills to public health workers. The case study simulates a real outbreak investigation in which the student plays the role of the lead investigator. Through the case study, students learn to apply appropriate outbreak investigation practices, perform a variety of epidemiologic tasks (e.g., creating a line list, developing a case definition, and calculating attack rates), recognize the role of the laboratory in an outbreak investigation, and understand the applications of Epi Info computer software.

The case study can be used by individual students or in a classroom setting. It is designed to build on basic epidemiologic concepts learned in other courses such as CDC's "Principles of Epidemiology." The program must be run on an IBM\*-compatible computer running DOS 3.31 or higher with 3 megabytes of free disk space and a VGA monitor.

The case study is available at a cost of \$20 plus shipping and handling. Students can receive Continuing Education Units or Continuing Medical Education credits for completing the case study by enrolling with the CDC Distance Learning Program. Additional information is available by calling (800) 418-7246.

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

*Notice to Readers***Diabetes Translation Conference**

CDC will sponsor the 1994 Diabetes Translation Conference, "Diabetes Prevention and Control: Formula for the Future," May 15-18 in Atlanta. This conference is intended for representatives from state chronic disease programs, federal health agencies, the academic community, and voluntary health agencies to refine effective strategies for translating diabetes knowledge and technology into public health practice at community, state, and national levels.

Additional information is available from the Conference Coordinator, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC, Mailstop K-10, 4770 Buford Highway, NE, Atlanta, GA 30341-3724; telephone (404) 488-5004.



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