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World Health Day — April 7, 1994

The theme for World Health Day (April 7, 1994), "Oral Health for a Healthy Life," will be used throughout 1994, the "Year of Oral Health." Worldwide, oral health problems affect persons of all ages; dental caries and gingival infections represent the most common chronic health problems in many countries. For example, in the United States, 84% of persons aged 17 years have evidence of present or past tooth decay; one third of persons aged >65 years are edentulous; approximately half the population has gingival infections; and approximately 30,000 cases of and nearly 8000 deaths from cancers of the oral cavity and pharynx occur each year (*1*).

World Health Day is cosponsored by 24 health-related organizations including the World Health Organization, the Pan American Health Organization, the American Association for World Health, and the U.S. Department of Health and Human Services. In the United States, examples of scheduled events include presentation of World Health Day awards; a panel discussion featuring leaders in dental research, education, and services delivery; and presentation of a videotape highlighting World Health Day events. Throughout the year, 50,000 resource kits and posters printed in English and Spanish will be distributed in the United States (*2*), and additional activities are planned by federal agencies, businesses, and professional organizations.

This issue of *MMWR* focuses on oral health and comprises reports about examinations for oral cancer, use of the core functions of public health to improve oral health, and self-reported tuberculin skin testing among Indian Health Service and Federal Bureau of Prisons dentists. Additional information and resource material about World Health Day are available from the American Association for World Health, 1129 20th Street, NW, Suite 400, Washington, DC 20036; telephone (202) 466-5883.

Reported by: Div of Oral Health, National Center for Prevention Svcs, CDC.

References

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Current Trends

Examinations for Oral Cancer — United States, 1992

During 1992, oral cancer (i.e., cancers of the oral cavity and pharynx) was diagnosed in approximately 30,000 persons in the United States and caused nearly 8000 deaths (*1*); approximately 70% of deaths from oral cancer are associated with smoking (*2*) and other forms of tobacco use (*3*). Although the 5-year survival rate (53%) for persons with oral cancer remains low, survival varies by stage at diagnosis (*4*). Detection of oral cancers by oral examination can reduce morbidity and death associated with this problem (*5*). To characterize examinations for oral cancer among U.S. adults, CDC analyzed data from the 1992 National Health Interview Survey–Cancer Control (NHIS-CC) supplement. This report summarizes findings from that analysis.

The NHIS-CC supplement collected self-reported information from a representative sample (n=12,035) of the U.S. civilian, noninstitutionalized population aged ≥18 years regarding cancer screening and cancer-risk behaviors. The response rate was 87.0%. Participants were asked, "Have you ever had a test for oral cancer," and were provided a description of the examination (i.e., "in which the doctor or dentist pulls on your tongue, sometimes with gauze wrapped around it, and feels under the tongue and inside the cheeks?") and were asked about cigarette smoking and other tobacco use. Persons reporting that they had had an examination were asked the length of time since the most recent one and the reason for and the type of health professional who performed the examination. Data were weighted to adjust for nonresponse and sample design to provide national estimates. Confidence intervals (CIs) were calculated using standard errors generated by SUDAAN (*6*).

Overall, 14.3% (95% CI=±0.8%) of respondents reported that they had ever been examined for oral cancer. Having ever received an oral cancer examination varied by demographic characteristics, education, and smoking status (Table 1). Blacks were less likely than whites and Hispanics were less likely than non-Hispanics to report an oral cancer examination. The percentage of adults reporting an examination for oral cancer increased with level of education and with age but was lower for persons aged ≥65 years. Current smokers were less likely to report an examination than were former smokers.

Of persons ever examined for oral cancer, 48.7% (95% CI=±3.0%) reported their most recent examination had occurred during the preceding year (Table 1). More than half (54.4%; 95% CI=±3.3%) of respondents who had received oral cancer examinations reported that the most recent one was part of a routine dental examination and more than one third (35.0%; 95% CI=±3.2%) as part of a routine physical examination; small proportions reported that the primary reason was because of a specific oral problem (6.3%; 95% CI=±1.5%) or for other reasons (4.3%; 95% CI=±1.3%).

Among respondents who reported examinations, 67.4% (95% CI=±3.1%) reported that the most recent one had been performed by a dentist, followed by a physician (23.5%; 95% CI=±2.9%), a dental hygienist (6.6%; 95% CI=±1.5%), and another health-care provider (2.5%; 95% CI=±0.8%).

Oral Cancer — Continued

Reported by: Office on Smoking and Health, Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion; Div of Oral Health, National Center for Prevention Svcs, CDC.

Editorial Note: More than three fourths of oral cancers occur in sites that can be readily visualized or palpated (e.g., tongue, 20% of oral cancers; lip, 12%; oropharynx or

TABLE 1. Percentage of respondents who reported having had an oral cancer examination ever and during the preceding year, by selected characteristics — United States, National Health Interview Survey–Cancer Control Supplement, 1992

	Ever had examination for oral cancer		Had most recent oral cancer examination within preceding year	
Characteristic	**%**	**(95% CI*)**	**%**	**(95% CI)**
Sex				
Female	13.9	(±1.0)	50.5	(± 3.8)
Male	14.8	(±1.2)	46.8	(± 4.5)
Age group (yrs)				
18–24	9.0	(±2.0)	37.2	(±10.7)
25–44	14.4	(±1.1)	50.4	(± 4.4)
45–64	17.5	(±1.8)	48.6	(± 5.4)
≥65	13.3	(±1.6)	50.1	(± 7.2)
Race				
White	15.2	(±0.9)	49.8	(± 3.2)
Black	9.0	(±1.8)	29.9	(± 9.0)
Other†	10.7	(±4.2)	§	
Hispanic origin				
Hispanic	9.3	(±1.9)	§	
Non-Hispanic	14.7	(±0.9)	49.5	(± 3.1)
Education (yrs)				
<12	8.5	(±1.3)	39.4	(± 7.6)
12	11.4	(±1.1)	45.0	(± 5.2)
13–15	17.3	(±1.8)	50.4	(± 5.7)
≥16	22.7	(±2.0)	54.2	(± 4.9)
Smoking status				
Current¶	13.0	(±1.5)	46.4	(± 6.0)
Former**	16.7	(±1.6)	47.9	(± 5.4)
Never	13.9	(±1.1)	50.5	(± 4.3)
Smokeless tobacco use status				
Current††	11.2	(±4.1)	§	
Former§§	13.8	(±3.4)	§	
Never	14.5	(±0.9)	48.9	(± 3.1)
Total	**14.3**	**(±0.8)**	**48.7**	**(± 3.0)**

*Confidence interval.
†Includes American Indians/Alaskan Natives and Asians/Pacific Islanders.
§Number too small for meaningful analysis.
¶Respondents who reported having smoked at least 100 cigarettes and who were currently smoking every day or some days at the time of the interview.
**Respondents who reported having smoked at least 100 cigarettes but were not smoking at the time of the interview.
††Respondents who reported using snuff and/or chewing tobacco at least 20 times and who were using these products at the time of the interview.
§§Respondents who reported using snuff and/or chewing tobacco at least 20 times and who were not using these products at the time of the interview.

Oral Cancer — Continued

tonsils, 13%; floor of mouth, 11%; and other sites within the oral cavity, 26% [*7*]) during an oral examination. One of the national health objectives for the year 2000 is to increase to at least 40% the proportion of persons aged ≥50 years who have received an oral examination while visiting a primary-care provider during the preceding year (objective 16.14) (*5*).

The findings in this report indicate that a low proportion of persons reported having had an examination for oral cancer, ever or during the preceding year. At least two explanations may account for these findings. First, clinical health-care providers may not conduct oral examinations routinely or when patients' medical histories indicate the need for an examination. In addition, some clinical health-care providers may not have received appropriate training beyond that needed to conduct a simple oral inspection and thus do not examine or palpate for early clinical signs of oral cancer. Second, the prevalence of oral cancer examinations may be underestimated because some persons made primary-care visits for reasons unlikely to prompt an examination for oral cancer and because some patients may not recall receiving an oral cancer examination, despite a prompting question.

Routine examinations by primary-care providers offer opportunities for primary and secondary prevention. The U.S. Preventive Services Task Force has recommended that clinical health-care providers perform oral examinations for cancerous lesions in patients who use tobacco or excessive amounts of alcohol (*8*). Persons who may be at risk for oral cancer should be identified and counseled about risk behaviors (e.g., tobacco use) and encouraged to have regular oral examinations. The findings in this report may be used to target efforts to increase oral examinations in underserved groups and others (e.g., racial/ethnic minorities and persons with <12 years of education) and groups at increased risk for oral cancer (e.g., persons who smoke cigarettes or use other tobacco products).

References

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8. US Preventive Services Task Force. Guide to clinical preventive services: an assessment of the effectiveness of 169 interventions—report of the U.S. Preventive Services Task Force. Baltimore: Williams and Wilkins, 1989.

Current Trends

Core Public Health Functions and State Efforts to Improve Oral Health — United States, 1993

Since the 1988 Institute of Medicine report on the future of public health (*1*), state health agencies (SHAs) have focused on the role of the core functions of public health (i.e., assessment, policy development, and assurance) in improving health in the United States. Oral diseases and conditions are among the most prevalent and preventable chronic health problems in the United States (*2*). Through use of the core functions as a guideline to identify basic public health practices integral to oral health, SHAs can improve oral health in the United States. To assess the level of involvement among SHAs with core public health functions related to oral health, in January 1994 the Association of State and Territorial Dental Directors (ASTDD) conducted a survey of SHAs in the 50 states and the District of Columbia. This report summarizes the survey findings.

ASTDD mailed a 10-question survey about the three core functions related to oral health to the public health official known by ASTDD to have overall responsibility for oral health activities within the SHA. SHAs that did not respond were contacted by telephone. The response rate for the survey was 100%. Respondents were asked about their involvement in oral health-related assessment activities (i.e., use of prevalence data for oral diseases, conditions, treatment needs, or risk factors and methods of collecting such data) since January 1, 1990, and in policy-development and assurance (i.e., primary and secondary prevention services) activities.

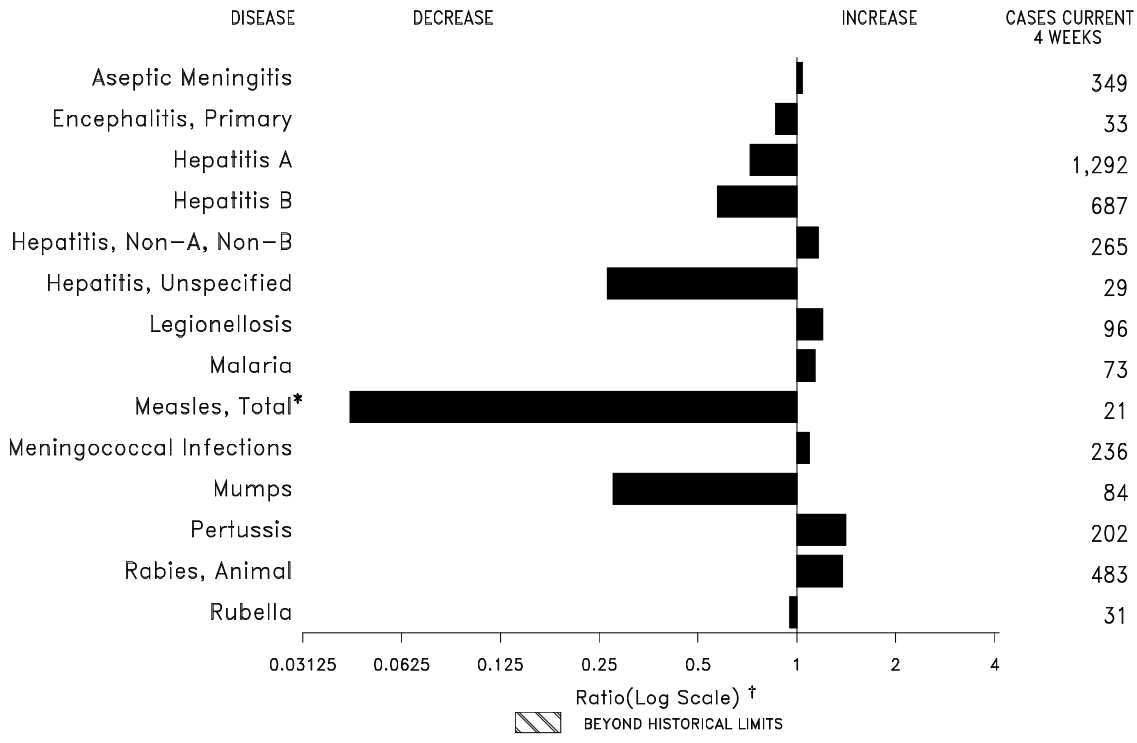
Of the 51 SHAs, 35 (69%) had full-time (minimum of 40 hours worked per week) dental directors, and 16 (31%) had either part-time (mean: 11 hours worked per week; range: 4–20 hours) (n=5) or no directors (n=11). Of the 11 SHAs with no directors, four reported having vacant director positions, and seven reported having no dental program. Of the 44 states with programs, 20 were mandated by specific legislation or authorized by SHAs.

Assessment. The reported level of involvement of SHAs in oral health assessment activities varied substantially (Table 1, page 207). The proportion of states that used selected types of oral health prevalence data ranged from 55% (levels of dental caries among children) to 26% (dental fluorosis). The proportion of states that used selected methods of collecting oral health data ranged from 53% (screenings to assess the dental treatment needs of children) to 31% (statewide dental surveys) (Table 1, page 207). Compared with states with part-time or no dental director, states with full-time directors reported substantially greater involvement in assessment related activities. The difference was greatest for use of prevalence data about dental sealants (Table 1, page 207).

Policy development. Seventy-five percent of states reported either "active" or "some" involvement in nine of 12 selected policy-development activities (Figure 1, page 208). The highest levels of active involvement were reported for oral health policies related to fluoride mouthrinsing (67%), water fluoridation (61%), maternal and child health programs for prevention of oral disease (57%), and dental care for low-income persons (53%); the lowest levels were reported for policies related to dental care for underserved populations (i.e., persons who are elderly, human immunodefi-

(Continued on page 207)

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending March 19, 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 19, 1994 (11th Week)

	Cum. 1994		Cum. 1994
AIDS*	10,369	Measles: imported	6
Anthrax	-	indigenous	52
Botulism: Foodborne	6	Plague	-
Infant	15	Poliomyelitis, Paralytic§	-
Other	4	Psittacosis	6
Brucellosis	9	Rabies, human	-
Cholera	1	Syphilis, primary & secondary	3,992
Congenital rubella syndrome	3	Syphilis, congenital, age < 1 year	-
Diphtheria	-	Tetanus	5
Encephalitis, post-infectious	20	Toxic shock syndrome	46
Gonorrhea	71,858	Trichinosis	15
Haemophilus influenzae (invasive disease)†	227	Tuberculosis	2,960
Hansen Disease	18	Tularemia	2
Leptospirosis	6	Typhoid fever	52
Lyme Disease	514	Typhus fever, tickborne (RMSF)	21

*Updated monthly; last update February 22, 1994.
†Of 214 cases of known age, 70 (33%) 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 19, 1994, and March 20, 1993 (11th Week)

Reporting Area	AIDS*	Aseptic Menin-gitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionel-losis	Lyme Disease
			Primary	Post-in-fectious			A	B	NA,NB	Unspeci-fied		
	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1993	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994
UNITED STATES	10,369	954	114	20	71,858	83,714	3,682	2,165	892	74	289	514
NEW ENGLAND	483	40	5	1	1,742	1,829	60	84	21	12	12	64
Maine	21	4	1	-	11	16	8	2	-	-	-	-
N.H.	18	1	-	1	-	15	2	4	5	-	-	3
Vt.	6	3	-	-	6	11	-	-	-	-	-	1
Mass.	246	14	3	-	625	682	27	76	9	12	9	40
R.I.	66	18	1	-	90	88	11	2	7	-	3	14
Conn.	126	-	-	-	1,010	1,017	12	-	-	-	-	6
MID. ATLANTIC	3,752	76	12	6	6,734	8,869	149	171	108	2	34	317
Upstate N.Y.	167	35	6	1	1,868	1,412	72	65	53	-	11	170
N.Y. City	2,881	-	-	-	1,595	3,355	-	-	-	-	-	-
N.J.	451	-	-	-	881	1,352	44	67	45	-	6	49
Pa.	253	41	6	5	2,390	2,750	33	39	10	2	17	98
E.N. CENTRAL	785	186	35	7	13,766	17,348	334	208	58	2	82	6
Ohio	137	53	12	-	5,618	5,326	123	46	2	-	46	6
Ind.	41	46	2	-	1,762	1,707	74	43	2	-	11	-
Ill.	490	21	7	1	2,492	5,508	51	11	-	1	4	-
Mich.	102	65	14	6	3,697	3,422	59	80	54	1	19	-
Wis.	15	1	-	-	197	1,385	27	28	-	-	2	-
W.N. CENTRAL	132	65	4	1	4,100	4,586	154	94	49	2	38	3
Minn.	27	2	1	-	750	588	21	8	1	-	-	1
Iowa	13	25	-	-	277	366	7	7	2	1	14	1
Mo.	36	14	-	-	2,245	2,561	88	71	44	1	17	-
N. Dak.	1	1	1	-	-	13	1	-	-	-	-	-
S. Dak.	3	-	-	-	28	35	9	-	-	-	-	-
Nebr.	12	1	1	1	-	169	17	2	-	-	6	-
Kans.	40	22	1	-	800	854	11	6	2	-	1	1
S. ATLANTIC	2,213	244	18	3	21,757	21,565	267	628	236	9	60	102
Del.	35	1	-	-	360	300	3	9	19	-	1	40
Md.	163	30	4	-	3,958	3,444	34	61	11	2	15	13
D.C.	166	6	-	-	1,827	1,222	6	11	-	-	-	-
Va.	94	35	8	1	3,045	1,366	26	21	9	2	2	11
W. Va.	4	5	-	-	162	154	3	6	8	-	1	3
N.C.	187	43	6	-	5,342	4,969	23	75	17	-	6	17
S.C.	90	5	-	-	2,443	2,024	7	10	-	-	1	-
Ga.	291	9	-	-	-	3,053	32	326	129	-	22	17
Fla.	1,183	110	-	2	4,620	5,033	133	109	43	5	12	1
E.S. CENTRAL	177	67	10	1	9,198	8,101	98	256	190	-	16	3
Ky.	44	29	4	1	946	1,043	43	11	4	-	1	1
Tenn.	53	19	5	-	2,602	1,748	29	228	184	-	9	1
Ala.	50	15	1	-	3,462	3,233	12	17	2	-	4	1
Miss.	30	4	-	-	2,188	2,077	14	-	-	-	2	-
W.S. CENTRAL	1,255	41	4	-	8,226	10,829	523	219	58	15	8	2
Ark.	23	4	-	-	1,471	2,022	8	5	1	-	1	-
La.	122	1	1	-	3,001	2,184	18	26	15	-	-	-
Okla.	19	-	-	-	494	643	48	73	38	-	7	2
Tex.	1,091	36	3	-	3,260	5,980	449	115	4	15	-	-
MOUNTAIN	184	21	2	-	1,636	2,430	684	102	73	5	21	4
Mont.	4	-	-	-	27	13	8	6	-	-	9	-
Idaho	1	-	-	-	16	25	65	20	30	1	-	1
Wyo.	-	-	-	-	24	15	5	5	18	-	1	-
Colo.	62	6	-	-	494	880	32	3	6	2	1	-
N. Mex.	21	3	-	-	216	227	227	42	4	2	1	3
Ariz.	45	6	-	-	351	765	226	14	4	-	1	-
Utah	11	2	-	-	72	65	80	5	7	-	-	-
Nev.	40	4	2	-	436	440	41	7	4	-	8	-
PACIFIC	1,388	214	24	1	4,699	8,157	1,413	403	99	27	18	13
Wash.	157	-	-	-	680	855	75	18	15	-	4	-
Oreg.	63	-	-	-	253	299	73	12	2	1	-	-
Calif.	1,111	171	23	-	3,413	6,808	1,202	355	78	24	13	13
Alaska	8	4	1	-	179	112	53	2	-	-	-	-
Hawaii	49	39	-	1	174	83	10	16	4	2	1	-
Guam	-	-	-	-	19	20	-	-	-	-	-	-
P.R.	209	4	-	-	117	110	8	56	13	2	-	-
V.I.	5	-	-	-	8	20	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	7	7	2	-	-	-	-	-
C.N.M.I.	1	-	-	-	14	12	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 19, 1994, and March 20, 1993 (11th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1994	1994	Cum. 1994	1994	Cum. 1994	Cum. 1993	Cum. 1994	1994	Cum. 1994	1994	Cum. 1994	Cum. 1993	1994	Cum. 1994	Cum. 1993
UNITED STATES	194	4	52	-	6	76	711	14	248	37	673	661	3	61	36
NEW ENGLAND	20	1	4	-	-	41	44	-	8	5	54	180	3	43	1
Maine	1	-	-	-	-	-	6	-	3	-	2	3	-	-	1
N.H.	3	-	-	-	-	-	1	-	2	3	17	86	-	-	-
Vt.	1	-	-	-	-	23	1	-	-	-	7	27	-	-	-
Mass.	6	-	1	-	-	10	20	-	-	1	22	58	3	43	-
R.I.	4	1	3	-	-	-	-	-	1	-	2	1	-	-	-
Conn.	5	-	-	-	-	8	16	-	2	1	4	5	-	-	-
MID. ATLANTIC	24	-	3	-	1	6	59	1	24	20	167	104	-	4	15
Upstate N.Y.	8	-	2	-	-	1	27	1	3	12	58	35	-	4	1
N.Y. City	-	-	1	-	-	1	-	-	-	8	32	2	-	-	7
N.J.	12	-	-	-	-	4	15	-	-	-	-	25	-	-	6
Pa.	4	U	-	U	1	-	17	U	21	U	77	42	U	-	1
E.N. CENTRAL	19	-	3	-	1	-	105	3	44	3	107	151	-	2	1
Ohio	2	-	-	-	-	-	26	-	8	1	55	60	-	-	-
Ind.	5	-	1	-	-	-	22	-	2	1	15	8	-	-	-
Ill.	3	-	-	-	-	-	35	-	20	-	11	19	-	2	-
Mich.	8	-	-	-	-	-	11	3	14	1	21	8	-	-	-
Wis.	1	-	2	-	1	-	11	-	-	-	5	56	-	-	1
W.N. CENTRAL	6	-	-	-	-	-	49	-	9	-	21	25	-	-	1
Minn.	3	-	-	-	-	-	5	-	-	-	8	-	-	-	-
Iowa	1	-	-	-	-	-	5	-	3	-	1	-	-	-	-
Mo.	2	-	-	-	-	-	25	-	5	-	5	11	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	1	-	-	1	-	-	-
S. Dak.	-	-	-	-	-	-	4	-	-	-	-	1	-	-	-
Nebr.	-	U	-	U	-	-	1	U	-	U	1	4	U	-	-
Kans.	-	-	-	-	-	-	9	-	-	-	6	8	-	-	-
S. ATLANTIC	54	-	6	-	-	13	127	3	48	5	101	40	-	5	3
Del.	2	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Md.	20	-	-	-	-	1	8	1	8	4	33	16	-	-	1
D.C.	7	-	-	-	-	-	1	-	-	-	2	-	-	-	-
Va.	8	-	1	-	-	1	18	-	10	-	12	2	-	-	-
W. Va.	-	-	-	-	-	-	6	-	2	-	1	1	-	-	-
N.C.	1	-	-	-	-	-	24	-	16	1	31	8	-	-	-
S.C.	1	-	-	-	-	-	4	-	5	-	7	2	-	-	-
Ga.	7	-	-	-	-	-	18	1	2	-	6	8	-	-	-
Fla.	8	-	5	-	-	11	48	1	5	-	9	3	-	5	1
E.S. CENTRAL	5	1	22	-	-	-	54	1	4	-	22	25	-	-	-
Ky.	-	-	-	-	-	-	14	-	-	-	2	7	-	-	-
Tenn.	3	1	22	-	-	-	13	-	-	-	13	9	-	-	-
Ala.	1	-	-	-	-	-	21	-	-	-	7	7	-	-	-
Miss.	1	-	-	-	-	-	6	1	4	-	-	2	-	-	-
W.S. CENTRAL	5	2	5	-	1	1	89	2	56	-	24	8	-	-	1
Ark.	-	-	-	-	-	-	10	-	-	-	-	-	-	-	-
La.	-	-	-	-	-	1	10	1	4	-	1	1	-	-	-
Okla.	1	-	-	-	-	-	8	-	14	-	20	7	-	-	1
Tex.	4	2	5	-	1	-	61	1	38	-	3	-	-	-	-
MOUNTAIN	4	-	1	-	-	2	49	1	7	3	35	38	-	-	4
Mont.	-	-	-	-	-	-	2	-	-	2	2	-	-	-	-
Idaho	2	-	1	-	-	-	10	1	3	-	16	6	-	-	1
Wyo.	-	-	-	-	-	-	2	-	-	-	-	1	-	-	-
Colo.	-	-	-	-	-	2	2	-	-	-	5	12	-	-	-
N. Mex.	1	-	-	-	-	-	4	N	N	-	3	12	-	-	-
Ariz.	-	-	-	-	-	-	17	-	-	-	6	3	-	-	-
Utah	1	-	-	-	-	-	8	-	1	1	3	4	-	-	2
Nev.	-	-	-	-	-	-	4	-	3	-	-	-	-	-	1
PACIFIC	57	-	8	-	3	13	135	3	48	1	142	90	-	7	10
Wash.	1	-	-	-	-	-	11	-	2	-	11	6	-	-	-
Oreg.	2	-	-	-	-	-	15	N	N	-	16	-	-	-	1
Calif.	45	-	8	-	3	3	104	3	41	-	109	79	-	7	5
Alaska	-	-	-	-	-	-	1	-	2	-	-	1	-	-	1
Hawaii	9	-	-	-	-	10	4	-	3	1	6	4	-	-	3
Guam	-	U	1	U	-	-	-	U	-	U	-	-	U	-	-
P.R.	-	-	5	-	-	80	2	-	2	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	1	-	-	1	-	1	2	-	-	-
C.N.M.I.	1	1	23	-	-	-	-	-	-	-	-	-	-	-	-

*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 19, 1994, and March 20, 1993 (11th 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	3,992	6,000	46	2,960	3,267	2	52	21	1,010
NEW ENGLAND	40	99	1	70	34	-	8	1	341
Maine	-	2	-	-	3	-	-	-	-
N.H.	-	11	-	2	2	-	-	-	44
Vt.	-	-	-	-	-	-	-	-	30
Mass.	11	45	1	30	8	-	4	1	135
R.I.	5	2	-	8	-	-	1	-	5
Conn.	24	39	-	30	21	-	3	-	127
MID. ATLANTIC	268	472	8	424	690	-	4	-	107
Upstate N.Y.	25	54	5	42	97	-	2	-	-
N.Y. City	147	325	-	238	427	-	-	-	-
N.J.	40	74	-	96	84	-	2	-	67
Pa.	56	19	3	48	82	-	-	-	40
E.N. CENTRAL	464	961	16	310	404	-	9	2	2
Ohio	211	258	6	49	51	-	1	1	-
Ind.	62	88	1	29	34	-	1	-	-
Ill.	109	359	3	179	233	-	4	-	-
Mich.	65	142	6	43	73	-	3	1	-
Wis.	17	114	-	10	13	-	-	-	2
W.N. CENTRAL	266	390	7	69	57	2	-	1	29
Minn.	11	24	-	11	-	-	-	-	-
Iowa	11	22	5	7	5	-	-	1	13
Mo.	228	316	1	38	34	2	-	-	4
N. Dak.	-	-	-	1	3	-	-	-	-
S. Dak.	-	-	-	6	4	-	-	-	1
Nebr.	-	3	1	-	4	-	-	-	-
Kans.	16	25	-	6	7	-	-	-	11
S. ATLANTIC	1,225	1,581	1	525	536	-	13	14	362
Del.	6	25	-	-	9	-	-	-	2
Md.	54	85	-	55	73	-	2	-	123
D.C.	55	84	-	27	23	-	1	-	1
Va.	151	127	-	66	112	-	-	-	75
W. Va.	5	1	-	17	16	-	-	-	13
N.C.	414	405	-	70	73	-	-	7	32
S.C.	132	274	-	71	78	-	-	-	31
Ga.	200	286	-	197	152	-	-	7	77
Fla.	208	294	1	22	-	-	10	-	8
E.S. CENTRAL	852	653	1	176	191	-	-	1	33
Ky.	57	62	-	60	58	-	-	-	-
Tenn.	200	124	1	1	-	-	-	-	9
Ala.	148	186	-	85	99	-	-	-	24
Miss.	447	281	-	30	34	-	-	1	-
W.S. CENTRAL	826	1,437	-	240	223	-	2	1	71
Ark.	117	256	-	51	22	-	-	-	5
La.	447	501	-	-	-	-	1	-	14
Okla.	10	79	-	18	23	-	-	1	15
Tex.	252	601	-	171	178	-	1	-	37
MOUNTAIN	42	54	2	95	78	-	5	-	14
Mont.	-	-	-	-	-	-	-	-	-
Idaho	1	-	1	6	1	-	-	-	-
Wyo.	-	1	-	3	-	-	-	-	4
Colo.	25	20	1	1	-	-	2	-	-
N. Mex.	1	10	-	15	-	-	-	-	-
Ariz.	10	21	-	50	50	-	-	-	10
Utah	5	1	-	-	8	-	1	-	-
Nev.	-	1	-	20	19	-	2	-	-
PACIFIC	9	353	10	1,051	1,054	-	11	1	51
Wash.	6	11	-	41	44	-	1	-	-
Oreg.	2	18	-	18	10	-	-	-	-
Calif.	-	322	9	935	935	-	9	1	34
Alaska	-	1	-	9	8	-	-	-	17
Hawaii	1	1	1	48	57	-	1	-	-
Guam	-	-	-	7	16	-	-	-	-
P.R.	73	118	-	-	24	-	-	-	17
V.I.	4	11	-	-	2	-	-	-	-
Amer. Samoa	-	-	-	-	1	-	1	-	-
C.N.M.I.	1	-	-	13	5	-	-	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending March 19, 1994 (11th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	641	446	107	63	15	9	71
Boston, Mass.	190	115	34	27	9	4	23
Bridgeport, Conn.	38	29	6	2	-	1	3
Cambridge, Mass.	28	20	6	2	-	-	2
Fall River, Mass.	23	15	6	2	-	-	1
Hartford, Conn.	55	36	12	6	1	-	1
Lowell, Mass.	19	16	3	-	-	-	3
Lynn, Mass.	12	9	1	1	-	1	2
New Bedford, Mass.	28	22	2	4	-	-	1
New Haven, Conn.	42	28	8	3	2	1	5
Providence, R.I.	45	34	8	1	2	-	7
Somerville, Mass.	7	5	2	-	-	-	1
Springfield, Mass.	48	39	4	5	-	-	5
Waterbury, Conn.	42	32	4	4	-	2	2
Worcester, Mass.	64	46	11	6	1	-	15
MID. ATLANTIC	2,889	1,871	564	327	63	64	152
Albany, N.Y.	50	31	11	5	1	2	2
Allentown, Pa.	24	18	5	1	-	-	-
Buffalo, N.Y.	100	54	20	18	5	3	3
Camden, N.J.	45	33	7	3	2	-	2
Elizabeth, N.J.	25	18	3	3	1	-	-
Erie, Pa.§	40	33	4	2	1	-	5
Jersey City, N.J.	56	38	6	9	1	2	-
New York City, N.Y.	1,387	860	285	186	28	28	53
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	34	18	6	2	1	7	1
Philadelphia, Pa.	683	436	145	67	20	15	51
Pittsburgh, Pa.§	108	68	24	12	1	3	12
Reading, Pa.	10	5	2	2	1	-	2
Rochester, N.Y.	126	99	15	9	1	2	6
Schenectady, N.Y.	31	25	5	1	-	-	1
Scranton, Pa.§	30	26	3	-	-	1	2
Syracuse, N.Y.	77	60	11	5	-	1	8
Trenton, N.J.	45	33	10	2	-	-	4
Utica, N.Y.	18	16	2	-	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,203	1,378	387	243	125	70	155
Akron, Ohio	39	27	8	1	1	2	-
Canton, Ohio	40	28	5	4	1	2	5
Chicago, Ill.	528	221	86	119	77	25	38
Cincinnati, Ohio	156	106	27	9	6	8	26
Cleveland, Ohio	153	103	27	14	6	3	1
Columbus, Ohio	126	76	29	12	4	5	5
Dayton, Ohio	116	82	26	5	2	1	5
Detroit, Mich.	222	130	49	25	10	8	6
Evansville, Ind.	39	28	6	4	-	1	2
Fort Wayne, Ind.	66	49	9	2	3	3	3
Gary, Ind.	16	6	7	3	-	-	1
Grand Rapids, Mich.	42	35	4	1	1	1	12
Indianapolis, Ind.	180	125	33	13	6	3	9
Madison, Wis.	48	41	-	5	2	-	11
Milwaukee, Wis.	146	104	29	9	-	4	9
Peoria, Ill.	35	28	5	-	2	-	4
Rockford, Ill.	43	28	8	5	2	-	5
South Bend, Ind.	45	37	5	2	-	1	-
Toledo, Ohio	94	72	12	8	1	1	9
Youngstown, Ohio	69	52	12	2	1	2	4
W.N. CENTRAL	722	494	148	37	20	23	41
Des Moines, Iowa	77	57	16	2	1	1	5
Duluth, Minn.	31	19	8	1	1	2	2
Kansas City, Kans.	34	22	7	1	3	1	2
Kansas City, Mo.	122	88	23	7	2	2	6
Lincoln, Nebr.	U	U	U	U	U	U	U
Minneapolis, Minn.	160	111	32	7	3	7	11
Omaha, Nebr.	71	43	19	5	3	1	2
St. Louis, Mo.	121	83	23	7	3	5	6
St. Paul, Minn.	44	31	9	2	2	-	6
Wichita, Kans.	62	40	11	5	2	4	1
S. ATLANTIC	1,362	828	263	185	48	35	77
Atlanta, Ga.	193	102	45	28	7	11	5
Baltimore, Md.	294	170	55	49	14	6	19
Charlotte, N.C.	85	39	14	28	3	1	5
Jacksonville, Fla.	123	87	20	10	3	1	10
Miami, Fla.	115	56	29	21	7	2	2
Norfolk, Va.	53	29	14	6	-	4	3
Richmond, Va.	93	60	23	7	2	1	3
Savannah, Ga.	49	38	8	1	-	2	9
St. Petersburg, Fla.	73	58	8	3	2	2	3
Tampa, Fla.	167	115	29	18	2	2	17
Washington, D.C.	93	54	15	13	8	3	1
Wilmington, Del.	24	20	3	1	-	-	-
E.S. CENTRAL	845	575	145	90	18	17	76
Birmingham, Ala.	133	85	29	12	3	4	6
Chattanooga, Tenn.	78	55	6	13	2	2	8
Knoxville, Tenn.	82	57	13	9	2	1	9
Lexington, Ky.	119	92	15	6	1	5	15
Memphis, Tenn.	173	117	35	14	7	-	22
Mobile, Ala.	84	57	13	13	1	-	2
Montgomery, Ala.	59	38	12	8	1	-	1
Nashville, Tenn.	117	74	22	15	1	5	13
W.S. CENTRAL	1,449	889	307	156	49	48	90
Austin, Tex.	64	42	8	9	1	4	6
Baton Rouge, La.	50	26	9	8	6	1	1
Corpus Christi, Tex.	49	36	6	3	2	2	3
Dallas, Tex.	189	109	49	20	6	5	4
El Paso, Tex.	65	41	15	5	1	3	5
Ft. Worth, Tex.	68	43	12	7	3	3	5
Houston, Tex.	404	219	101	54	19	11	28
Little Rock, Ark.	69	40	15	5	6	3	5
New Orleans, La.	91	56	20	9	2	4	-
San Antonio, Tex.	217	136	46	27	3	5	18
Shreveport, La.	75	58	11	3	-	3	5
Tulsa, Okla.	108	83	15	6	-	4	10
MOUNTAIN	925	627	167	76	30	23	90
Albuquerque, N.M.	98	67	12	11	4	4	5
Colo. Springs, Colo.	49	34	7	7	1	-	5
Denver, Colo.	126	75	31	11	2	6	9
Las Vegas, Nev.	162	105	42	7	6	1	11
Ogden, Utah	25	18	4	2	1	-	4
Phoenix, Ariz.	190	122	31	21	8	8	23
Pueblo, Colo.	27	23	1	3	-	-	1
Salt Lake City, Utah	92	67	18	4	1	2	23
Tucson, Ariz.	156	116	21	10	7	2	9
PACIFIC	1,849	1,308	274	184	49	33	136
Berkeley, Calif.	12	7	5	-	-	-	-
Fresno, Calif.	96	62	14	9	6	5	11
Glendale, Calif.	27	20	6	1	-	-	1
Honolulu, Hawaii	72	55	6	8	2	1	10
Long Beach, Calif.	107	80	13	5	4	5	7
Los Angeles, Calif.	398	273	59	45	17	3	18
Pasadena, Calif.	26	23	3	-	-	-	1
Portland, Oreg.	139	98	20	17	2	2	6
Sacramento, Calif.	151	111	24	11	2	3	16
San Diego, Calif.	211	142	31	26	6	6	23
San Francisco, Calif.	135	91	24	17	1	2	4
San Jose, Calif.	180	126	33	18	2	1	18
Santa Cruz, Calif.	23	18	3	1	-	1	4
Seattle, Wash.	148	111	15	16	4	2	7
Spokane, Wash.	43	32	6	4	1	-	3
Tacoma, Wash.	81	59	12	6	2	2	7
TOTAL	12,885¶	8,416	2,362	1,361	417	322	888

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

†Pneumonia and influenza.

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

¶Total includes unknown ages.

U: Unavailable.

Oral Health — Continued

TABLE 1. Reported use by state health agencies of oral health prevalence data and methods of collecting such data, by employment status of dental director — United States,* 1990–1993

	Employment status of dental director					
	States with full-time† dental director (n=35)		States with part-time§/no dental director¶ (n=16)		Total (n=51)	
Category	No.	(%)	No.	(%)	No.	(%)
Types of prevalence data used						
Dental caries among children	24	(69)	4	(25)	**28**	**(55)**
Tobacco use	20	(57)	6	(38)	**26**	**(51)**
Dental sealants	23	(66)	2	(13)	**25**	**(49)**
Baby bottle caries	13	(37)	3	(19)	**16**	**(31)**
Oral cancer	11	(31)	3	(19)	**14**	**(28)**
Dental fluorosis	12	(34)	1	(6)	**13**	**(26)**
Methods of collecting prevalence data						
Screenings to assess dental treatment needs of children	21	(60)	6	(38)	**27**	**(53)**
Clinical program data	17	(49)	5	(31)	**22**	**(43)**
Behavioral Risk Factor Surveillance System dental questions	17	(49)	3	(19)	**20**	**(39)**
Statewide dental survey	14	(40)	2	(13)	**16**	**(31)**

*The 50 states and the District of Columbia.
†Minimum of 40 hours worked per week.
§Mean hours worked per week=11 (range: 4–20 hours).
¶Of the 11 states with no dental director, four had vacant director positions, and seven had no dental program.

ciency virus-infected, or eligible for Medicaid). Compared with states with part-time or no dental director, states with full-time directors reported involvement in three times as many policy-development activities.

Assurance. Forty-three (84%) states reported that basic oral health education or fluoride-related prevention services were provided in schools; 12 (26%) of 47 states reported that they provided dental restorations (secondary prevention). Of 24 (47%) states that provided dental sealants to children through school-based programs, 20 (83%) had full-time dental directors.

Reported by: Association of State and Territorial Dental Directors. Div of Oral Health, National Center for Prevention Svcs, CDC.

Editorial Note: The findings in this report document the variable presence of activities related to core public health functions for oral health in the 50 states and the District of Columbia. The presence of all three core functions was greater in states with full-time dental directors than in those with part-time or no directors or no dental program.

Assessment activities provide decision makers with information for policy-development and assurance activities. However, only 56% of SHAs reported involvement in oral health assessment activities, while 82% have reported involvement in general health assessment activities (*3*). Cost-effective programs that address priority oral health needs are most appropriately based on information representative of

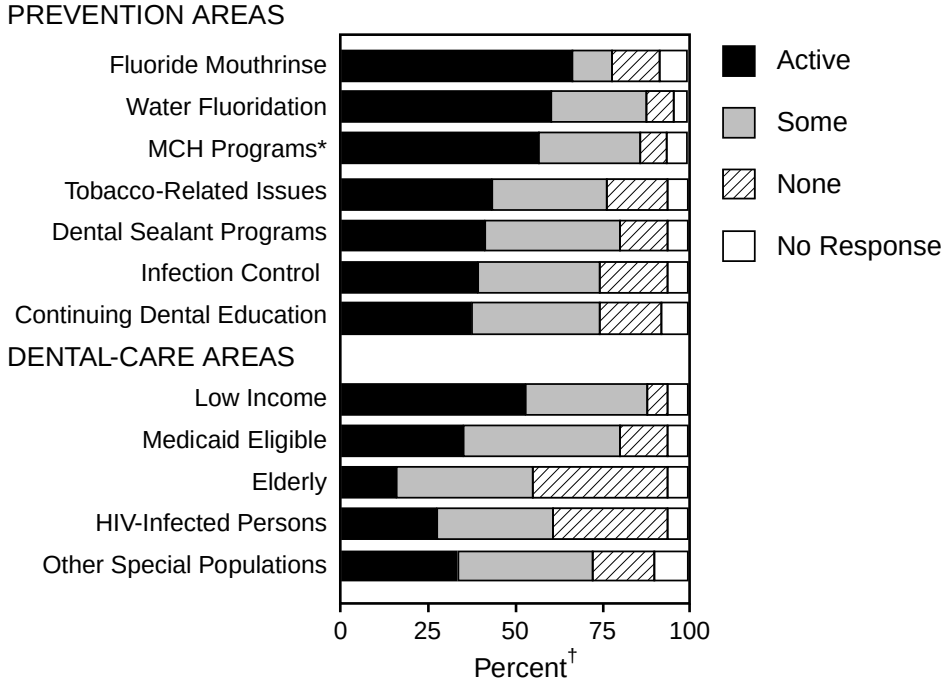
Oral Health — Continued

groups within a state. Although SHAs conduct surveillance for reportable diseases and conditions, no oral diseases are reportable. Some states have used screenings, surveys, and the Behavioral Risk Factor Surveillance System to estimate oral disease morbidity in defined populations. These assessments permit analysis of factors associated with particular oral health needs and assist in targeting prevention interventions to those at greatest risk for developing disease.

Oral health policy development emphasizes activities traditionally managed by dental programs (e.g., water fluoridation and fluoride mouthrinsing). However, state dental programs increasingly are becoming involved with other health issues (e.g., tobacco use, oral cancer, and infection control in the dental environment) that may provide opportunities to integrate oral health-related core function activities into other SHA programs.

Since 1971, dental sealants (a clinical oral-health measure used for both secondary and primary prevention) have been used to prevent the most common form of dental caries among children (*4*). The levels of involvement by SHAs in core function activities, especially those related to dental sealants, demonstrate the importance of full-time dental directors in state efforts to improve oral health. The findings in this report indicate that substantially more oral health-related assessment, policy-development, and assurance activities occurred in states with full-time directors. Such leadership is essential to meet the national oral health objectives for the year 2000 (objectives 13.1–13.16) (*5*)—including one for dental sealants (objective 13.8)—and assure that persons at greatest risk for oral disease are effectively targeted for prevention interventions.

FIGURE 1. Percentage of states reporting involvement in oral health policy-development activities, by level of involvement — United States, 1993



*Maternal and child health programs for prevention of oral disease.
†Percentage of 50 states and the District of Columbia.

Oral Health — Continued

Strategies to improve oral health in the United States through use of the core public health functions related to oral health should include increasing the number of states with full-time dental directors, increasing the level of involvement among states in core function-related activities, and using assessment activities to target disease prevention and health promotion efforts to populations at greatest risk for oral disease.

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Current Trends

Self-Reported Tuberculin Skin Testing Among Indian Health Service and Federal Bureau of Prisons Dentists, 1993

Surveillance of health-care workers (HCWs) for tuberculosis (TB) and assessment of TB transmission through routine periodic screening with tuberculin skin tests (TSTs) are essential components of effective TB-control programs in health-care settings (*1*). Based on TST results, risk for acquiring new infections can be assessed and infection-control practices modified accordingly. In 1993, a self-administered mail survey was conducted to characterize the TST practices and results among dentists in the Indian Health Service (IHS) and the Federal Bureau of Prisons (FBoP). This report summarizes the findings of the survey.

In July 1993, a pretested questionnaire and a letter describing the purpose of the study were mailed to all dentists employed by IHS (n=389) and FBoP (n=120). IHS dentists provide clinical services in 200 dental clinics in IHS/tribal hospitals or ambulatory health centers in 33 states. Within the FBoP, inmates receive dental treatment at 107 dental clinics.

Of the 509 dentists who were mailed the questionnaire, 489 (96% [372 IHS and 117 FBoP]) responded. Of the 489, 194 (40%) dentists had practiced clinical dentistry in the IHS or FBoP for <3 years; 183 (37%), 3–9 years; and 112 (23%), ≥10 years. The mean years of clinical practice were similar for dentists in both groups (5.9 years for IHS and 5.6 years for FBoP dentists; p=0.7, two-tailed t-test); 438 (90%) reported that they were practicing clinical dentistry at the time of the survey (87% IHS and 97% FBoP), and the remainder were in nonclinical positions.

Almost all (474 [97%]) respondents reported ever having received a TST (365 [98%] IHS and 109 [93%] FBoP); 92% of those tested reported always having a negative test

Tuberculin Skin Testing — Continued

result (Table 1). Of 36 dentists who reported ever having a reactive TST, 17 (47%) reported the first reactive TST occurred after graduation from dental school. Of these 17 dentists, 14 (11 IHS and three FBoP) reported converting from a negative TST to a reactive TST.

Among respondents who reported ever being tested, the most frequent reason for testing was "as part of a TST program among health care personnel" (82%). In addition, 8% received a TST at the beginning of employment or during a routine physical examination; 6% received a TST as both part of a TST program and as a result of exposure; 1%, as the result of an exposure to TB; and 3%, for other reasons.

Almost half (46%) of respondents who were currently in clinical practice reported having ever been exposed to someone with active TB; of these dentists, 93% identified a dental patient as one of several possible sources of exposure; 6%, a co-worker; 3%, a personal acquaintance/friend; and 3%, a family member. The percentage of currently practicing dentists who reported ever having been exposed to a dental patient with active TB increased with years of clinical practice ($p<0.01$, chi-square test for linear trend). As a result of an exposure to a dental patient with active TB, 42% reported receiving a postexposure TST.

Among 425 respondents who were currently in clinical practice and reported having ever been tested, 80% received a TST within the 3 years preceding the survey. Of these 80%, 75% reported having a TST at routine intervals: annually (68%), semiannually (4%), and biannually (3%). The remaining 25% indicated they received TSTs at routine physical examinations, at the beginning of employment, or as the result of exposure to a person with active TB. The percentage of currently practicing dentists reportedly skin tested during the 3 years preceding the survey decreased with increasing years of clinical practice in the IHS or FBoP ($p<0.01$, chi-square test for linear trend); 90% practicing <3 years had been tested during the preceding 3 years, compared with 68% who had practiced ≥10 years.

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Editorial Note: The findings of this survey suggest that nearly all dentists employed by IHS and FBoP had received a TST. Although 80% of those currently practicing had been tested during the 3 years preceding the survey, less than 60% had been tested at least annually, in accordance with current recommendations (*1*). Even though these recommendations advise that HCWs be evaluated following exposure to TB, less than half of the dentists in this survey who reported exposure to a patient with active TB received a postexposure TST.

TABLE 1. Percentage of Indian Health Service and Federal Bureau of Prisons dentists reporting tuberculin skin test (TST) results, 1993

	Indian Health Service (n=365)		Federal Bureau of Prisons (n=109)	
TST results	**No.**	**(%)**	**No.**	**(%)**
Always negative	337	(92)	101	(93)
Reactive before dental school graduation*	14	(4)	5	(5)
Reactive after dental school graduation*	14	(4)	3	(3)

*Includes dentists who reported always having a reactive TST and dentists who reported changing from negative to reactive.

Tuberculin Skin Testing — Continued

Previous reports in other health-care settings suggest that transmission is most likely to occur from patients with unrecognized active TB (*2–5*). The dentists in this report may be at occupational risk for TB infection: almost half of currently practicing dentists reported previous exposure to a dental patient with active TB, and the dentists treat patients known to be at increased risk for TB (*1*). Despite this increased risk, the prevalence of reactive TSTs among the dentists in this survey is consistent with the estimated prevalence of TB in the general U.S. population (*6*) but lower than that reported among some groups of nondental HCWs (*7,8*). Neither the type or date of the TST nor the size of the TST reaction for those dentists who reported having a reactive TST could be verified.

Summary data of TSTs of dental workers and other HCWs should be periodically reviewed to evaluate the potential risk for transmission of TB among HCWs. Dental workers and other HCWs should be tested at the beginning of employment and at least annually thereafter (*1*). However, because the risk for exposure to TB may vary in relation to different factors (e.g., the prevalence of TB in the patient population), the frequency of retesting should be established according to the risk for acquiring new infection in a specific facility, particularly in settings where risk for TB transmission may be greater. The findings in this report are being used to assist efforts to increase awareness of and compliance with recommendations for TSTs within IHS and FBoP clinical dental programs.

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Erratum: Vol. 43, No. 9

In the article "Update: Impact of the Expanded AIDS Surveillance Case Definition for Adolescents and Adults on Case Reporting—United States, 1993" in Table 2 on page 169, for "Asian/Pacific Islander," the number in the 1993-Added column should be *393*. For "Person with hemophilia," the number in the Pre-1993 column should be *288*; in 1993-Added, *753*; and in the Total column, *1041*. The percentages are correct as published.

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