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Effectiveness in Disease and Injury Prevention

Zidovudine for the Prevention of HIV Transmission from Mother to Infant

Worldwide, perinatal (i.e., mother to infant) transmission accounts for most human immunodeficiency virus (HIV) infections among children; in the United States, of the approximately 7000 infants born to HIV-infected mothers each year, 1000–2000 are HIV-infected (*1*). Strategies for reducing perinatally acquired HIV infection have included preventing HIV infection among women and, for HIV-infected women, avoiding pregnancy or refraining from breastfeeding their infants (*2*). On February 21, 1994, the National Institutes of Health's National Institute of Allergy and Infectious Diseases (NIAID) and National Institute of Child Health and Human Development (NICHD) announced preliminary results from a randomized, multicenter, double-blinded clinical trial of zidovudine (ZDV) to prevent HIV transmission from mothers to their infants (AIDS Clinical Trials Group [ACTG] protocol 076). This report summarizes the interim results of that trial, which indicate effectiveness of ZDV for prevention of perinatal transmission.*

The study was initiated in April 1991 by the Pediatric ACTG of NIAID in collaboration with NICHD and the National Institute of Health and Medical Research (INSERM) and the National Agency of Research on AIDS (ANRS), France. Eligible participants were HIV-infected pregnant women who had received no antiretroviral treatment during their current pregnancy, had no clinical indications for maternal antepartum antiretroviral therapy in the judgment of their health-care provider, and who had a CD4+ T-lymphocyte count >200/μL at time of entry into the study. Enrolled women were randomized to receive either a ZDV or placebo regimen. The ZDV regimen included antepartum ZDV (100 mg given orally five times daily) initiated at 14–34 weeks' gestation and continued for the remainder of the pregnancy; intravenous ZDV during labor (administered intravenously as a loading dose of 2 mg per kg body weight given over 1 hour, followed by continuous infusion of 1 mg per kg body weight per hour until delivery); and oral administration of ZDV to the newborn (ZDV syrup at 2 mg per kg

*Single copies of this report will be available free until April 29, 1995, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

Zidovudine — Continued

body weight per dose given every 6 hours) for the first 6 weeks of life, beginning 8–12 hours after birth (see box). The placebo regimen was given on the same schedule. Blood specimens were obtained for HIV culture from all infants at birth and at ages 12, 24, and 78 weeks. A positive viral culture was considered indicative of HIV infection. Infants also were tested for HIV antibody at ages 15 and 18 months.

Based on analysis of data for 364 births through December 1993, ZDV therapy was associated with a 67.5% reduction in the risk for HIV transmission; the estimated rates of transmission were 25.5% (95% confidence interval [CI]=18.3%–33.7%) among the 184 children in the group receiving the placebo regimen compared with 8.3% (95% CI=3.8%–13.8%) among the 180 children in the group receiving ZDV (Kaplan-Meier estimate at age 18 months; p=0.00006). Although the ZDV regimen was well tolerated by mothers and infants, hemoglobin levels were lower for infants in the ZDV group (mean decrease in hemoglobin was <1 g/dL); however, this problem resolved without therapy following completion of ZDV treatment. The incidence of reported side effects was similar among mothers and infants between the two randomized groups.

Based on these interim findings, NIAID accepted the recommendation of an independent data and safety monitoring board to terminate enrollment into the trial and to offer ZDV to women in the group who had received the placebo but had not yet delivered and to their infants aged <6 weeks. An NIAID Clinical Trials Alert summarizing the trial is available by calling (800) 874-2572.

Reported by: Div of AIDS, National Institute of Allergy and Infectious Diseases; Center for Research for Mothers and Children, National Institute of Child Health and Human Development; National Institutes of Health.

Eligibility Criteria and Zidovudine Regimen for HIV-Infected Pregnant Women and Their Infants Participating in AIDS Clinical Trials Group Protocol 076

Patient Eligibility:

- Has not received antiretroviral treatment during current pregnancy
- Has no clinical indications for maternal antepartum antiretroviral therapy in the judgment of her health-care provider
- Has a CD4+ T-lymphocyte count >200/μL at initial assessment

Zidovudine Regimen:

- Oral administration of 100 mg zidovudine (ZDV) five times daily, initiated at 14–34 weeks' gestation and continued for the remainder of the pregnancy
- During labor, intravenous administration of ZDV in a loading dose of 2 mg per kg body weight given over 1 hour, followed by continuous infusion of 1 mg per kg body weight per hour until delivery
- Oral administration of ZDV to the newborn (ZDV syrup at 2 mg per kg body weight per dose given every 6 hours) for the first 6 weeks of life, beginning 8–12 hours after birth

Zidovudine — Continued

Editorial Note: This clinical trial demonstrated efficacy of ZDV in reducing perinatal HIV transmission when administered to HIV-infected women meeting the study's eligibility criteria (see box). However, these findings are subject to at least four limitations. First, the study did not assess the efficacy of ZDV among women with CD4+ T-lymphocyte counts ≤200 cells/μL or among women who had previously used ZDV for extended periods and who may be infected with ZDV-resistant strains of HIV. Second, this trial could not assess the relative or independent contributions of the antepartum treatment, intrapartum treatment, or treatment of the infant; therefore, the efficacy and side effects of ZDV regimens restricted to only one or two of these treatment periods is unknown. Third, the study did not evaluate the risk or benefit of ZDV use in the first trimester. Finally, the study has not yet provided information about long-term side effects for infants and mothers treated with ZDV, including infants who did not become infected with HIV; however, long-term follow-up of infants and mothers is being conducted to monitor for possible late side effects.

Based on the findings of ACTG protocol 076, the Public Health Service (PHS) provides the following interim recommendations[†]: 1) all health-care workers providing care to pregnant women and women of childbearing age should be informed of the results of ACTG protocol 076; 2) HIV-infected pregnant women meeting the protocol eligibility criteria should be informed of the potential benefits but unknown long-term risks of ZDV therapy as administered in ACTG protocol 076, and decisions to use ZDV for prevention of perinatal transmission should be made in consultation with their health-care providers (see box); 3) health-care providers should inform their patients that this ZDV regimen substantially reduced, but did not eliminate, the risk for HIV infection among the infants; and 4) until the potential risk for teratogenicity and other complications from ZDV therapy given in the first trimester can be assessed, ZDV therapy only for the purpose of reducing the risk for perinatal transmission should not be instituted earlier than the 14th week of gestation. PHS is developing further recommendations for the uses of ZDV for HIV-infected pregnant women whose clinical indications differ from the ACTG protocol 076 eligibility criteria and for counseling and HIV-antibody testing for women of childbearing age.

The international Antiretroviral Pregnancy Registry, sponsored by Burroughs Wellcome Co. (Research Triangle Park, North Carolina)[§] and Hoffmann-LaRoche Foundation, Inc. (Nutley, New Jersey)[§], is collecting observational, nonexperimental data on exposure to ZDV and dideoxycytidine (ddC) during pregnancy. Women who have been treated with either of these drugs at any time during pregnancy for any duration are eligible for registry enrollment. Patients can be enrolled by contacting the registry, telephone (800) 722-9292, extension 8465; fax (919) 315-8981.

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[†]These recommendations do not reflect current Food and Drug Administration-approved labeling for ZDV.

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

Topics in Minority Health

Differences in Infant Mortality Between Blacks and Whites — United States, 1980–1991

National health objectives for the year 2000 include reducing the overall infant mortality rate (i.e., deaths at age <1 year per 1000 live births) to no more than 7.0 per 1000 live births (objective 14.1) and the infant mortality rate for blacks to no more than 11.0 (objective 14.1a) (*1*). Achieving this goal will require reducing the race-specific differences in infant mortality. During 1979–1981, infant mortality was the second leading cause of excess deaths among blacks aged <45 years, accounting for approximately 6000 more deaths among black infants than among white infants (*2*). Since 1960, rates for infant mortality and low birthweight (LBW) (<2500 g [<5 lbs, 8 oz]) for blacks were twice those for whites; these ratios remained stable through the early 1980s. To characterize current trends in the ratios of race-specific infant mortality, LBW, and very low birthweight (VLBW) (<1500 g [<3 lbs, 4 oz]) rates among blacks and whites, data were analyzed from published reports of final birth and mortality statistics from 1980 through 1991* (*3,4*). This report summarizes the results of that analysis.

From 1980 to 1991, the overall infant mortality rate in the United States declined 29.4% (from 12.6 to 8.9). Infant mortality among whites declined 33% (from 10.9 to 7.3), while infant mortality among blacks declined 20.7% (from 22.2 to 17.6). The ratio of infant mortality rates for blacks compared with whites increased 20% (from 2.0 to 2.4), while the ratio of LBW infants among black infants compared with that among white infants increased 4.0% (from 2.2 to 2.3), and the ratio of VLBW infants increased 11.2% (from 2.8 to 3.1) (Figure 1).

Reported by: Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report indicate that, despite overall declines in infant mortality during the 1980s, the differences in race-specific rates for infant mortality, LBW, and VLBW between blacks and whites have steadily increased. Based on current trends, the differences are expected to be threefold by the year 2000.

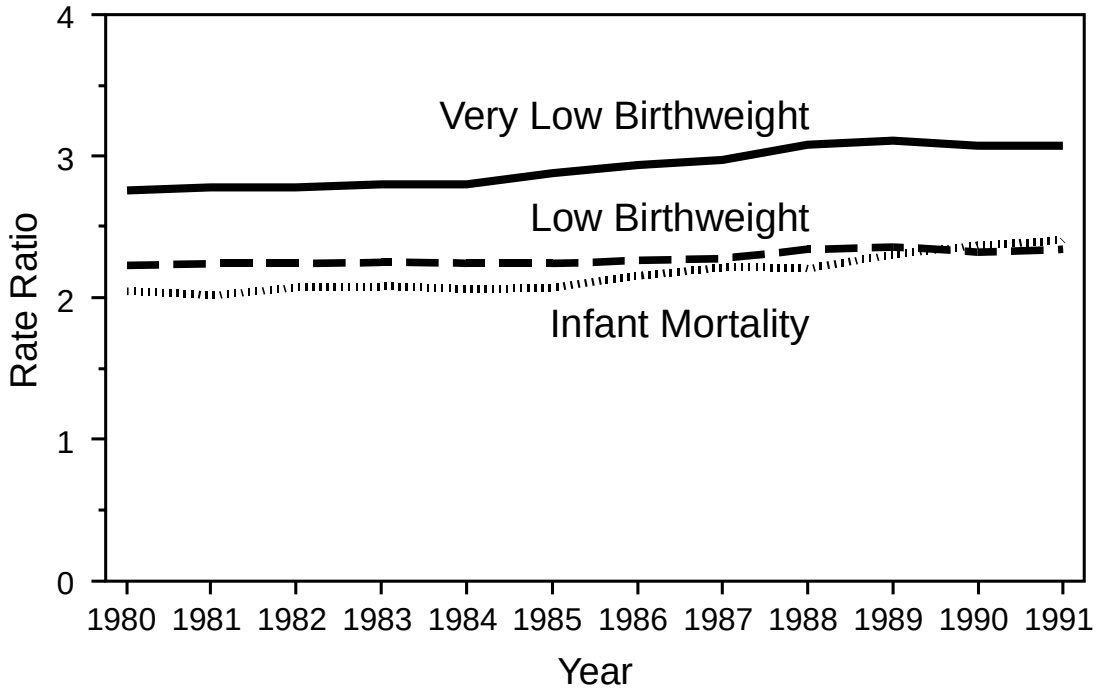
A substantial portion of the race-specific difference reflects the high rate of VLBW among black infants (*5*). However, known risk factors for LBW and infant mortality (i.e., medical complications during pregnancy [*6*] and lack of prenatal care [*7*]) account for only a small proportion of this difference. For example, the difference persists when race-specific rates are controlled for educational level of mother (*8*).

Efforts to narrow the race-specific difference in infant mortality should be aimed at reducing known risk factors; however, reducing the unexplained differences will require the identification of protective and risk factors not yet clearly elucidated and the subsequent development and evaluation of prevention strategies. Efforts to identify new potential risk factors include assessment of psychosocial factors (i.e., stress, social support, and coping mechanisms), environmental factors (i.e., housing, lead exposure, and violence), and access to health care (*9*).

* Most recent year for which published data were available.

Infant Mortality — Continued

FIGURE 1. Black–white ratios in infant mortality*, low birthweight (LBW)†, and very low birthweight (VLBW)§ rates¶ — United States, 1980–1991



*Deaths at age <1 year.
†LBW=weight of <2500 g (<5 lbs, 8 oz) at birth.
§VLBW=weight <1500 g (<3 lbs, 4 oz) at birth.
¶Per 1000 live births.

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Clean Air Month — May 1994

Since 1972, the American Lung Association (ALA) has sponsored Clean Air Week each May to educate the public about the relation between clean air and respiratory health. This year Clean Air Week has been expanded to Clean Air Month; its theme, "Clean Air Is Up To You!" emphasizes the role of each person in promoting clean air.

Through local Clean Air Month activities, ALA will emphasize approaches—such as driving less, conserving energy, keeping indoor air clean, and supporting clean air regulations—to reduce air pollution. Local ALA chapters will sponsor environmental health fairs, school presentations, and other community events. Approximately 50 communities in the United States also will participate in the Clean Air Challenge, a pledge-based event to raise funds for local clean air programs and other efforts aimed at preventing lung disease. In addition, many local ALA offices will implement Clean Commute Day(s) to encourage motorists to try alternative forms of transportation (e.g., carpools, mass transit, or bicycles). This issue of *MMWR* includes a report that provides estimates of the number of persons potentially exposed to particulate air pollution.

Additional information about Clean Air Month and related activities is available from local ALA offices (telephone [800] 586-4872) or from the national office (1740 Broadway, New York, NY 10019-4374; telephone [212] 315-8700).

Health Objectives for the Nation

Populations at Risk from Particulate Air Pollution — United States, 1992

Despite improvements in air quality since the 1970s, air pollution remains an important environmental risk to human health. A national health objective for the year 2000 is to reduce exposure to air pollutants so that at least 85% of persons live in counties that meet U.S. Environmental Protection Agency (EPA) standards (objective 11.5) (*1*). This report provides estimates from the American Lung Association (ALA) of populations potentially at risk from exposure to particulate air pollution in the United States during 1992.

The National Ambient Air Quality Standard for particulate matter <10 μm in diameter (PM_{10}) is 150 μg/m^3, averaged over 24 hours (*2*). The federal standard is met if this value is not exceeded more than once per calendar year, and the annual arithmetic mean is ≤50 μg/m^3. Information in this report is based on the second highest maximum 24-hour PM_{10} concentrations recorded by at least one monitor in 1992 (EPA, unpublished data, 1993). Both the federal "exceedance" definition (≥155 μg/m^3) and a similar approach applied to the California standard* (≥55 μg/m^3) were used as cutoff values. Estimates of the numbers of persons potentially exposed to levels of PM_{10}

*California's particulate matter air quality standard of 50 μg/m^3 averaged over 24 hours (*3*) is the most stringent standard in the United States.

Particulate Air Pollution — Continued

above these cutoff values were derived from 1991 census figures for each county (U.S. Bureau of the Census, unpublished data, 1992).

For this report, a population at risk was defined as persons who have a "significantly higher probability of developing a condition, illness, or other abnormal status," as described by EPA (*4*). Five at-risk populations were included: preadolescent children (aged ≤13 years), the elderly (aged ≥65 years), persons aged <18 years with asthma, adults (aged ≥18 years) with asthma, and persons with chronic obstructive pulmonary disease (COPD) (e.g., chronic bronchitis and emphysema). Age-specific county populations for 1991 were estimated by applying the population age distribution of each state (U.S. Bureau of the Census, unpublished data, 1992) to the counties within that state. The number of persons with asthma or COPD in each county was estimated by applying age-specific prevalences from CDC's National Health Interview Survey (*5*) to age-specific population estimates for each county. Although PM_{10} levels are presented on a county basis, they do not indicate that all areas of the county were subject to that level or that all persons in the county were exposed to the recorded concentration.

During 1992, PM_{10} levels were ≥155 μg/m^3 in 16 counties; an estimated 23 million persons (9.1% of the total U.S. population) resided in these counties (Table 1). Approximately 92 million additional persons (36% of the U.S. population) resided in counties in which PM_{10} levels were 55 μg/m^3–154 μg/m^3. Overall, an estimated 115 million persons (45% of the U.S. population) resided in counties with PM_{10} levels ≥55 μg/m^3 (Table 1). In the United States during 1992, 46% of persons with asthma lived in communities with levels of particulate air pollution higher than the California standard.

TABLE 1. Estimated number and percentage of the total population and at-risk* subgroups residing in counties with particulate air pollution with a diameter of <10 μm (PM_{10}) at levels ≥155 μg/m^3 and ≥55 μg/m^3† — United States, 1992§

	PM_{10} levels ≥155 μg/m^3		PM_{10} levels ≥55 μg/m^3	
Population at risk	**No.**	**(%)¶**	**No.**	**(%)¶**
Total population	**22,894,856**	**(9.1)**	**114,671,632**	**(45.5)**
Preadolescent children (aged ≤13 yrs)	4,931,408	(9.5)	23,794,139	(46.0)
Elderly (aged ≥65 yrs)	2,649,477	(8.3)	14,010,297	(44.1)
Persons (aged <18 yrs) with asthma	387,220	(9.5)	1,878,848	(45.9)
Persons (aged ≥18 yrs) with asthma	697,444	(9.1)	3,528,475	(46.2)
Persons with chronic obstructive pulmonary disease**	1,243,407	(9.1)	6,263,409	(46.0)

*Population-at-risk estimates should not be added to form totals. These categories are not mutually exclusive.

†PM_{10} ≥155 μg/m^3 is the federal "exceedance" definition; PM_{10} ≥55 μg/m^3 is the California "exceedance" standard.

§The PM_{10} level of the county does not imply responsibility for the disease status of its population.

¶Of the total population in the category, the proportion of each population subgroup potentially exposed.

**Includes chronic bronchitis and emphysema.

Particulate Air Pollution — Continued

Reported by: P Vigliarolo, Communications Div; S Rappaport, MPH, K Lieber, MPH, A Gorman, Epidemiology and Statistics Div; R White, MST, National Programs Div, American Lung Association, New York. Air Pollution and Respiratory Health Br, Div of Environmental Hazards and Health Effects, National Center for Environmental Health, CDC.

Editorial Note: Particulate matter (e.g., dust, dirt, and smoke) is a complex and varying mixture of substances. Sources include motor-vehicle emissions, factory and utility smokestacks, residential wood burning, construction activity, mining, agricultural tilling, open burning, wind-blown dust, and fire. Some particles are formed in the atmosphere through the condensation or transformation of other chemical substances. Particles with diameters <10 μm pose a greater health risk than larger particles because particles of this size are easily inhaled deep into the lungs.

Increased risks for illness and death have been associated with particulate air pollution at levels comparable to those presented in this report (*6–8*). Acute effects on the respiratory system are well established and include exacerbations of chronic respiratory disease, restrictions in activity, and increases in emergency department visits and hospitalizations for respiratory illness (*8*). Persons with asthma are particularly sensitive to the effects of particulate air pollution (*8*). A national health objective for the year 2000 is to reduce asthma morbidity, measured by a reduction in asthma hospitalizations, from 188 per 100,000 in 1987 to no more than 160 per 100,000 (objective 11.1) (*1*).

The estimates presented in this report underscore the potential public health importance of particulate air pollution. Although levels of airborne particulate pollution declined substantially from 1988 to 1992 (emissions of PM_{10} decreased 8% and air concentrations of PM_{10} decreased 17%) (*9*), continued efforts are required to reduce health risks associated with particulate air pollution. EPA is reviewing technical and scientific information to determine whether the federal ambient air quality standard for particulate matter, established in 1987, should be revised.

ALA recently issued *The Perils of Particulates* (*10*), which includes national and county estimates of populations at potential risk for exposure to particulate air pollution. Copies are available from local offices of the ALA, telephone (800) 586-4872.

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Particulate Air Pollution — Continued

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International Notes

Update: Dracunculiasis Eradication — Ghana and Nigeria, 1993

In 1989, Ghana and Nigeria, countries in west Africa, ranked first and second in the number of reported cases of dracunculiasis (i.e., Guinea worm disease) with 179,556 cases and 640,008 cases respectively (*1*). During 1987–1988, Global 2000 and the World Health Organization (WHO) Collaborating Center for Research, Training, and Eradication of Dracunculiasis at CDC initiated direct, onsite assistance for the eradication of dracunculiasis in Ghana and Nigeria. This report summarizes surveillance data for the two countries during 1993 and describes efforts toward eradication of dracunculiasis.

Ghana

In 1993, Ghana (1991 population: 16 million) reported to WHO 17,918 cases of dracunculiasis from 2306 villages, representing substantial declines in the numbers of cases (46.5%) and villages with endemic disease (25.6%) from 1992 (*2*). The number of villages included 520 that did not report any cases in 1992 but had at least one case in 1993. Since initiation of active surveillance in 1989, the numbers of cases and villages with endemic disease have decreased by 90.0% (Figure 1) and 64.6%, respectively. During 1993, the Northern Region reported 69.0% of all cases in the country, compared with 51.2% of all cases in 1992.

By the end of 1993, health education and nylon filters had been provided to all known villages with endemic disease, 40% of villages had at least one safe source of drinking water, and temephos (Abate®*) was being used in 20% of such villages. Emerging Guinea worms were removed surgically in 8% of persons with detected cases in Ghana in 1993.

Nigeria

In 1993, Nigeria (1992 population: 90 million) reported to WHO 75,752 cases of dracunculiasis from 3614 villages with endemic disease, representing substantial declines in the numbers of cases (58.6%) and known villages with endemic disease (21.0%) from 1992 (*3*). From January 1993 to December 1993, the number of villages reporting some or no cases increased from 2485 to 4159. From the epidemiolgic year July 1987–June 1988 to December 1993, the numbers of cases and villages with endemic disease declined 88.4% (Figure 2) and 38.5%, respectively. Of all cases reported in 1993, 65.5% occurred in five of the 30 states and the Federal Capital Territory:

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

Dracunculiasis — Continued

FIGURE 1. Number of reported cases of dracunculiasis, by year — Ghana Guinea Worm Eradication Program, 1989–1993

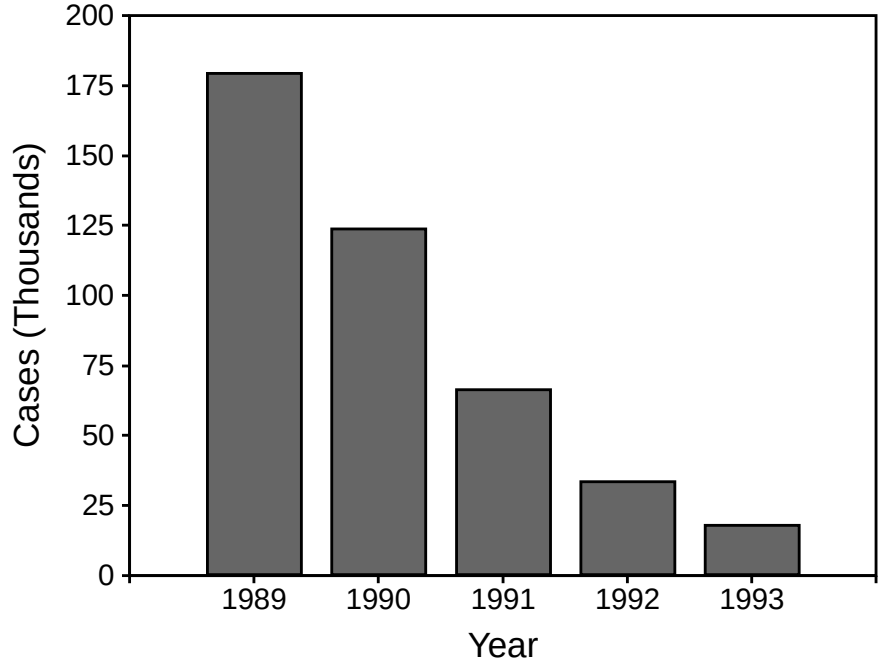
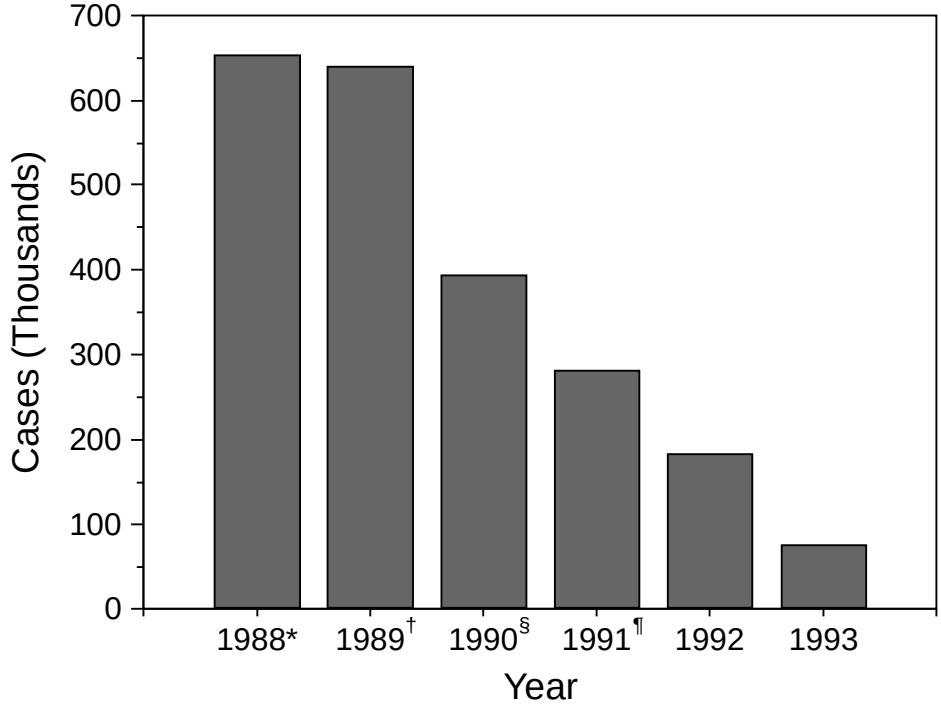


FIGURE 2. Number of reported cases of dracunculiasis, by year — Nigeria Guinea Worm Eradication Program, 1988–1993



* July 1, 1987–June 30, 1988.
† July 1, 1988–June 30, 1989.
§ July 1, 1989–June 30, 1990.
¶ July 1, 1990–June 30, 1991; data for July–December 1991 not included.

Dracunculiasis — Continued

Sokoto (17.0%), Ondo (17.0%), Enugu (16.8%), Katsina (11.3%), and Benue (11.1%). Three states (Akwa Ibom, Anambra, and Kaduna) reported no cases. Four states (Abuja, Imo, Kogi, and Rivers) reported 10 or fewer cases; all of the eight cases reported in Lagos state were imported from other parts of Nigeria.

By the end of 1993, health education had been initiated in all villages with endemic disease, nylon filters had been distributed in 89%, at least one safe source of drinking water already existed or was targeted to be placed by 1996 in 37%, and temephos (Abate®) was being used in 9% of such villages. Health workers from seven states had been trained in case-containment measures to be implemented in all areas with endemic disease by 1995.

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

Editorial Note: The reductions in the incidence of reported dracunculiasis of at least 90% in Ghana and Nigeria since 1989 are important achievements in the global campaign to eradicate dracunculiasis. Despite the known underreporting in Nigeria in 1993, the findings in this report indicate that both programs have substantially reduced the occurrence of dracunculiasis. Continued reduction of dracunculiasis will require implementation of intensive case-containment measures, health-education efforts, and campaigns to increase public awareness of dracunculiasis prevention.

References

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Addendum: Vol. 43, No. 14

In the box, "Workers' Memorial Day—April 28, 1994," the following sentence should be added to the end of the first paragraph (page 262): "Workers' Memorial Day was initiated by the American Federation of Labor–Congress of Industrial Organizations (AFL-CIO) and designated by Congress in 1989."

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending April 23, 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

TABLE II. Cases of selected notifiable diseases, United States, weeks ending April 23, 1994, and April 24, 1993 (16th 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	20,445	1,444	160	37	111,295	119,434	5,792	3,374	1,328	117	436	907
NEW ENGLAND	697	52	5	2	2,482	2,357	100	152	39	13	15	112
Maine	28	6	1	-	19	31	11	4	-	-	-	-
N.H.	22	2	-	1	-	19	2	7	6	-	-	4
Vt.	10	5	-	-	8	11	-	-	-	-	-	1
Mass.	337	18	3	-	918	908	48	138	26	13	11	56
R.I.	83	21	1	1	132	118	12	3	7	-	4	17
Conn.	217	-	-	-	1,405	1,270	27	-	-	-	-	34
MID. ATLANTIC	5,899	145	21	11	14,642	11,881	316	315	170	4	59	572
Upstate N.Y.	537	53	8	1	2,717	2,463	140	111	80	-	14	375
N.Y. City	3,661	3	1	-	4,459	3,595	21	12	-	-	-	-
N.J.	1,203	-	-	-	1,511	1,984	82	102	69	-	7	83
Pa.	498	89	12	10	5,955	3,839	73	90	21	4	38	114
E.N. CENTRAL	1,670	266	45	8	20,035	23,969	528	345	92	2	114	9
Ohio	296	72	15	-	7,302	7,043	173	65	3	-	65	8
Ind.	286	55	2	-	2,502	2,370	108	62	2	-	14	-
Ill.	767	36	13	2	4,372	7,854	123	53	7	1	4	-
Mich.	230	99	15	6	5,182	4,708	83	114	78	1	26	1
Wis.	91	4	-	-	677	1,994	41	51	2	-	5	-
W.N. CENTRAL	426	97	7	1	5,988	6,123	255	182	68	3	57	18
Minn.	106	6	1	-	992	803	61	18	5	-	-	7
Iowa	13	34	-	-	409	546	8	11	6	2	20	1
Mo.	163	28	-	-	3,453	3,289	128	131	50	1	26	8
N. Dak.	27	1	2	-	7	17	1	-	-	-	2	-
S. Dak.	4	-	1	-	45	64	11	-	-	-	-	-
Nebr.	29	5	2	1	-	182	27	9	3	-	8	-
Kans.	84	23	1	-	1,082	1,222	19	13	4	-	1	2
S. ATLANTIC	4,056	337	27	12	30,871	32,751	402	844	305	13	109	158
Del.	53	1	-	-	555	415	7	11	19	-	1	40
Md.	298	50	6	1	5,799	5,390	47	106	11	4	27	42
D.C.	304	12	-	-	2,047	1,665	9	14	-	-	-	1
Va.	249	50	10	5	4,147	3,219	39	28	14	1	2	12
W. Va.	7	7	-	-	225	192	3	7	10	-	1	3
N.C.	384	50	10	-	7,357	7,358	29	94	22	-	7	19
S.C.	325	9	-	-	3,863	2,815	9	12	1	-	1	-
Ga.	547	12	1	-	-	4,395	34	369	150	-	52	37
Fla.	1,889	146	-	6	6,878	7,302	225	203	78	8	18	4
E.S. CENTRAL	549	91	17	1	13,706	12,278	144	369	265	1	21	4
Ky.	105	37	6	1	1,356	1,426	65	24	7	-	1	2
Tenn.	154	22	7	-	4,040	2,988	44	321	256	1	13	1
Ala.	155	23	4	-	5,105	4,833	18	24	2	-	5	1
Miss.	135	9	-	-	3,205	3,031	17	-	-	-	2	-
W.S. CENTRAL	2,674	99	6	-	12,669	14,620	849	353	107	27	11	10
Ark.	65	6	-	-	2,256	2,843	13	7	2	-	4	-
La.	304	4	1	-	4,004	3,385	31	42	26	1	-	-
Okla.	57	-	-	-	494	1,048	69	107	57	-	7	8
Tex.	2,248	89	5	-	5,915	7,344	736	197	22	26	-	2
MOUNTAIN	609	47	2	-	2,687	3,507	1,206	157	116	8	24	4
Mont.	8	-	-	-	29	13	9	7	2	-	10	-
Idaho	15	1	-	-	21	40	99	26	36	1	-	1
Wyo.	5	-	-	-	29	24	6	6	35	-	1	-
Colo.	292	7	-	-	790	1,181	72	8	7	3	1	-
N. Mex.	43	6	-	-	325	304	336	67	18	3	1	3
Ariz.	124	18	-	-	860	1,228	483	17	4	-	1	-
Utah	33	4	-	-	105	97	137	11	10	-	1	-
Nev.	89	11	2	-	528	620	64	15	4	1	9	-
PACIFIC	3,865	310	30	2	8,215	11,948	1,992	657	166	46	26	20
Wash.	209	-	-	-	934	1,164	124	27	23	-	5	-
Oreg.	103	-	-	-	314	462	94	14	2	1	-	-
Calif.	3,477	249	29	1	6,466	10,019	1,691	591	137	43	19	20
Alaska	10	12	1	-	267	147	70	5	-	-	-	-
Hawaii	66	49	-	1	234	156	13	20	4	2	2	-
Guam	-	-	-	-	31	38	1	-	-	4	-	-
P.R.	608	9	-	-	139	163	19	94	19	3	-	-
V.I.	24	-	-	-	8	25	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	7	7	4	-	-	-	-	-
C.N.M.I.	1	-	-	-	17	22	2	-	-	-	-	-

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

*Updated monthly; last update March 29, 1994.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending April 23, 1994, and April 24, 1993 (16th 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	282	29	234	4	15	94	1,012	27	379	38	894	909	4	113	60
NEW ENGLAND	25	-	11	-	-	47	61	-	10	8	88	171	-	76	1
Maine	1	-	-	-	-	-	8	-	3	-	2	5	-	-	1
N.H.	3	-	-	-	-	-	1	-	4	4	29	45	-	-	-
Vt.	1	-	-	-	-	28	1	-	-	1	10	37	-	-	-
Mass.	8	-	3	-	-	10	28	-	-	-	38	73	-	76	-
R.I.	4	-	5	-	-	1	-	-	1	-	2	3	-	-	-
Conn.	8	-	3	-	-	8	23	-	2	3	7	8	-	-	-
MID. ATLANTIC	37	-	22	-	2	9	100	2	36	7	220	147	-	6	15
Upstate N.Y.	12	-	3	-	-	1	32	2	7	5	87	51	-	6	1
N.Y. City	2	-	1	-	-	2	3	-	-	1	50	5	-	-	8
N.J.	13	-	18	-	1	6	21	-	-	-	-	26	-	-	5
Pa.	10	-	-	-	1	-	44	-	29	1	83	65	-	-	1
E.N. CENTRAL	29	1	9	-	3	4	157	3	66	1	143	212	-	7	2
Ohio	5	-	6	-	-	-	38	-	8	-	59	77	-	-	1
Ind.	6	-	-	-	1	-	40	1	5	1	31	12	-	-	-
Ill.	8	-	-	-	-	4	49	-	30	-	20	36	-	2	-
Mich.	9	1	1	-	1	-	14	2	20	-	21	14	-	5	-
Wis.	1	-	2	-	1	-	16	-	3	-	12	73	-	-	1
W.N. CENTRAL	16	-	-	-	1	2	73	4	17	11	39	53	-	-	1
Minn.	4	-	-	-	-	-	7	4	4	8	16	20	-	-	-
Iowa	3	-	-	-	-	-	6	-	4	1	3	1	-	-	-
Mo.	7	-	-	-	-	1	38	-	7	1	11	16	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	1	-	1	2	-	-	-
S. Dak.	-	-	-	-	-	-	5	-	-	-	-	1	-	-	-
Nebr.	1	-	-	-	1	-	6	-	1	1	2	4	-	-	-
Kans.	1	-	-	-	-	1	11	-	-	-	6	9	-	-	-
S. ATLANTIC	67	-	9	-	-	14	169	7	73	4	126	71	-	5	5
Del.	2	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Md.	30	-	-	-	-	1	13	2	17	2	42	28	-	-	1
D.C.	7	-	-	-	-	-	1	-	-	-	3	-	-	-	-
Va.	8	-	1	-	-	1	25	1	17	-	13	6	-	-	-
W. Va.	-	-	-	-	-	-	8	-	3	-	2	2	-	-	-
N.C.	2	-	-	-	-	-	32	4	24	1	35	11	-	-	-
S.C.	2	-	-	-	-	-	5	-	5	-	8	5	-	-	-
Ga.	7	-	-	-	-	-	30	-	2	1	7	9	-	-	-
Fla.	9	-	8	-	-	12	55	-	5	-	16	10	-	5	2
E.S. CENTRAL	8	-	27	-	1	-	72	-	4	-	24	41	-	-	-
Ky.	2	-	-	-	-	-	15	-	-	-	3	8	-	-	-
Tenn.	4	-	27	-	1	-	20	-	-	-	13	20	-	-	-
Ala.	1	-	-	-	-	-	31	-	-	-	7	9	-	-	-
Miss.	1	-	-	-	-	-	6	-	4	-	1	4	-	-	-
W.S. CENTRAL	8	2	7	2	4	1	131	8	89	5	31	15	3	7	8
Ark.	-	-	-	-	-	-	18	-	-	-	-	1	-	-	-
La.	-	-	-	-	1	1	20	1	8	1	4	4	-	-	-
Okla.	3	-	-	-	-	-	11	-	21	-	20	10	-	4	1
Tex.	5	2	7	2[§]	3	-	82	7	60	4	7	-	3	3	7
MOUNTAIN	9	26	143	1	1	2	68	2	10	2	52	58	-	1	4
Mont.	-	-	-	-	-	-	2	-	-	-	2	-	-	-	-
Idaho	2	-	-	-	-	-	10	-	3	2	22	11	-	1	1
Wyo.	-	-	-	-	-	-	2	-	-	-	-	1	-	-	-
Colo.	1	10	10	1[†]	1	2	6	-	-	-	9	21	-	-	-
N. Mex.	2	-	-	-	-	-	5	N	N	-	6	14	-	-	-
Ariz.	1	-	-	-	-	-	29	-	-	-	9	7	-	-	-
Utah	3	16	133	-	-	-	10	1	3	-	4	4	-	-	2
Nev.	-	-	-	-	-	-	4	-	3	-	-	-	-	-	1
PACIFIC	83	-	6	1	3	15	181	1	74	-	171	141	1	11	24
Wash.	2	-	-	-	-	-	15	-	2	-	11	8	-	-	-
Oreg.	5	-	-	-	-	-	27	N	N	-	20	-	-	-	1
Calif.	66	-	6	-	2	4	133	-	63	-	136	126	1	10	15
Alaska	-	-	-	-	-	-	1	-	2	-	-	1	-	-	1
Hawaii	10	-	-	1[†]	1	11	5	1	7	-	4	6	-	1	7
Guam	-	U	1	U	-	-	-	U	2	U	-	-	U	-	-
P.R.	-	-	13	-	-	145	3	-	2	-	1	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	U	-	U	-	1	-	U	1	U	1	2	U	-	-
C.N.M.I.	1	-	26	-	-	-	-	-	-	-	-	-	-	-	-

*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 April 23, 1994, and April 24, 1993 (16th 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	6,071	8,616	78	5,129	6,004	3	91	38	1,762
NEW ENGLAND	60	145	2	98	95	-	10	2	569
Maine	1	2	-	-	7	-	-	-	-
N.H.	-	13	-	2	5	-	-	-	70
Vt.	-	-	-	-	1	-	-	-	56
Mass.	17	67	2	46	32	-	6	2	214
R.I.	5	3	-	11	18	-	1	-	5
Conn.	37	60	-	39	32	-	3	-	224
MID. ATLANTIC	434	749	13	866	1,222	-	17	-	180
Upstate N.Y.	54	71	7	65	176	-	3	-	-
N.Y. City	218	475	-	490	735	-	7	-	-
N.J.	39	142	-	182	113	-	7	-	100
Pa.	123	61	6	129	198	-	-	-	80
E.N. CENTRAL	722	1,376	19	554	631	-	22	4	8
Ohio	324	362	8	68	86	-	1	2	-
Ind.	78	124	1	45	59	-	1	-	-
Ill.	172	537	4	296	342	-	11	1	3
Mich.	98	198	6	131	121	-	3	1	2
Wis.	50	155	-	14	23	-	6	-	3
W.N. CENTRAL	385	570	10	129	105	3	-	1	48
Minn.	14	32	-	33	8	-	-	-	5
Iowa	15	32	6	9	8	-	-	1	21
Mo.	331	433	3	63	60	3	-	-	5
N. Dak.	-	-	-	1	4	-	-	-	-
S. Dak.	-	-	-	6	6	-	-	-	2
Nebr.	-	8	1	4	5	-	-	-	-
Kans.	25	65	-	13	14	-	-	-	15
S. ATLANTIC	1,805	2,264	5	784	1,267	-	17	26	597
Del.	7	41	-	-	9	-	1	-	6
Md.	82	114	-	96	121	-	3	-	189
D.C.	78	140	-	39	50	-	1	-	2
Va.	211	189	-	104	141	-	1	1	130
W. Va.	6	1	-	26	24	-	-	-	22
N.C.	581	610	1	108	131	-	-	10	60
S.C.	217	363	-	119	112	-	-	-	57
Ga.	335	397	-	270	235	-	-	15	123
Fla.	288	409	4	22	444	-	11	-	8
E.S. CENTRAL	1,218	994	1	277	377	-	-	2	31
Ky.	76	79	-	94	94	-	-	-	2
Tenn.	299	213	1	1	82	-	-	1	-
Ala.	229	262	-	124	133	-	-	-	29
Miss.	614	440	-	58	68	-	-	1	-
W.S. CENTRAL	1,217	1,947	-	594	471	-	4	2	233
Ark.	140	375	-	81	46	-	-	1	11
La.	595	754	-	-	-	-	2	-	30
Okla.	15	117	-	58	47	-	-	1	16
Tex.	467	701	-	455	378	-	2	-	176
MOUNTAIN	91	75	4	130	167	-	6	1	24
Mont.	-	-	-	-	5	-	-	-	-
Idaho	1	-	1	5	3	-	-	-	-
Wyo.	1	2	-	2	1	-	-	1	5
Colo.	49	23	1	1	28	-	2	-	-
N. Mex.	5	12	-	26	18	-	-	-	-
Ariz.	19	31	-	67	70	-	1	-	18
Utah	5	2	2	-	9	-	1	-	-
Nev.	11	5	-	29	33	-	2	-	1
PACIFIC	139	496	24	1,697	1,669	-	15	-	72
Wash.	10	18	-	63	78	-	1	-	-
Oreg.	2	26	-	41	27	-	-	-	-
Calif.	125	448	21	1,505	1,457	-	13	-	50
Alaska	1	2	-	21	15	-	-	-	22
Hawaii	1	2	3	67	92	-	1	-	-
Guam	1	-	-	7	24	-	-	-	-
P.R.	90	173	-	-	64	-	-	-	21
V.I.	9	16	-	-	2	-	-	-	-
Amer. Samoa	-	-	-	-	1	-	1	-	-
C.N.M.I.	1	-	-	14	7	-	1	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending April 23, 1994 (16th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	468	328	81	31	13	15	27
Boston, Mass.	60	42	12	2	2	2	5
Bridgeport, Conn.	25	17	5	2	-	1	2
Cambridge, Mass.	23	20	2	1	-	-	1
Fall River, Mass.	31	25	4	1	1	-	-
Hartford, Conn.	44	24	8	7	-	5	-
Lowell, Mass.	30	22	4	1	2	1	5
Lynn, Mass.	10	7	1	-	1	1	3
New Bedford, Mass.	23	16	3	3	1	-	1
New Haven, Conn.	47	28	13	3	2	1	2
Providence, R.I.	35	26	3	4	2	-	1
Somerville, Mass.	7	7	-	-	-	-	-
Springfield, Mass.	49	33	9	5	-	2	1
Waterbury, Conn.	24	19	5	-	-	-	1
Worcester, Mass.	60	42	12	2	2	2	5
MID. ATLANTIC	2,852	1,905	522	301	65	59	141
Albany, N.Y.	58	44	7	4	3	-	5
Allentown, Pa.	25	21	1	3	-	-	1
Buffalo, N.Y.	105	81	16	3	2	3	3
Camden, N.J.	33	22	6	2	-	3	2
Elizabeth, N.J.	19	12	3	2	2	-	-
Erie, Pa.§	47	34	11	1	-	1	1
Jersey City, N.J.	45	34	5	6	-	-	-
New York City, N.Y.	1,353	854	250	187	36	26	51
Newark, N.J.	68	28	20	11	5	4	6
Paterson, N.J.	34	22	8	3	1	-	1
Philadelphia, Pa.	621	427	116	53	10	15	39
Pittsburgh, Pa.§	53	38	11	2	2	-	9
Reading, Pa.	13	12	1	-	-	-	2
Rochester, N.Y.	136	103	25	5	2	1	12
Schenectady, N.Y.	29	23	3	3	-	-	-
Scranton, Pa.§	31	23	3	2	2	1	1
Syracuse, N.Y.	103	71	22	5	-	5	4
Trenton, N.J.	34	22	5	7	-	-	1
Utica, N.Y.	20	17	3	-	-	-	1
Yonkers, N.Y.	25	17	6	2	-	-	2
E.N. CENTRAL	2,428	1,478	431	286	142	91	162
Akron, Ohio	56	40	12	2	1	1	-
Canton, Ohio	29	24	5	-	-	-	4
Chicago, Ill.	699	298	124	139	93	45	50
Cincinnati, Ohio	109	73	22	6	3	5	8
Cleveland, Ohio	160	91	33	21	3	12	2
Columbus, Ohio	168	113	21	20	8	6	9
Dayton, Ohio	107	81	18	5	3	-	11
Detroit, Mich.	240	142	50	34	7	7	13
Evansville, Ind.	35	27	5	-	2	1	2
Fort Wayne, Ind.	64	46	8	6	2	2	4
Gary, Ind.	18	8	2	6	2	-	-
Grand Rapids, Mich.	30	26	2	2	-	-	7
Indianapolis, Ind.	192	141	37	11	1	2	11
Madison, Wis.	84	58	12	7	4	3	9
Milwaukee, Wis.	128	93	23	9	2	1	13
Peoria, Ill.	43	32	7	1	3	-	2
Rockford, Ill.	60	38	16	2	4	-	8
South Bend, Ind.	57	43	8	4	1	1	3
Toledo, Ohio	93	65	18	6	-	4	5
Youngstown, Ohio	56	39	8	5	3	1	1
W.N. CENTRAL	715	511	109	49	25	21	41
Des Moines, Iowa	56	42	9	3	2	-	5
Duluth, Minn.	23	21	-	-	-	2	-
Kansas City, Kans.	23	15	4	4	-	-	1
Kansas City, Mo.	97	75	14	6	-	2	5
Lincoln, Nebr.	32	28	2	1	1	-	6
Minneapolis, Minn.	158	113	22	8	9	6	10
Omaha, Nebr.	89	64	12	6	5	2	5
St. Louis, Mo.	109	66	23	9	5	6	5
St. Paul, Minn.	75	52	15	7	1	-	4
Wichita, Kans.	53	35	8	5	2	3	-

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,273	780	261	157	44	30	83
Atlanta, Ga.	163	96	35	21	7	4	1
Baltimore, Md.	226	124	45	44	7	6	14
Charlotte, N.C.	91	45	29	11	4	2	17
Jacksonville, Fla.	96	59	20	14	2	1	6
Miami, Fla.	81	45	16	14	5	1	-
Norfolk, Va.	71	46	13	7	4	1	5
Richmond, Va.	89	57	19	9	4	-	11
Savannah, Ga.	64	41	12	7	2	2	7
St. Petersburg, Fla.	110	87	14	4	2	3	6
Tampa, Fla.	158	115	25	13	2	2	12
Washington, D.C.	118	61	32	12	5	8	4
Wilmington, Del.	6	4	1	1	-	-	-
E.S. CENTRAL	786	499	179	60	28	20	69
Birmingham, Ala.	128	63	37	11	8	9	1
Chattanooga, Tenn.	74	53	11	4	4	2	10
Knoxville, Tenn.	81	55	16	9	1	-	9
Lexington, Ky.	79	47	22	5	4	1	13
Memphis, Tenn.	151	101	32	12	4	2	12
Mobile, Ala.	85	57	23	4	1	-	14
Montgomery, Ala.	52	35	11	3	1	2	-
Nashville, Tenn.	136	88	27	12	5	4	10
W.S. CENTRAL	1,418	918	266	154	41	39	89
Austin, Tex.	61	40	13	5	1	2	5
Baton Rouge, La.	65	44	13	5	2	1	2
Corpus Christi, Tex.	61	44	10	3	1	3	2
Dallas, Tex.	209	126	41	28	9	5	5
El Paso, Tex.	46	28	11	4	1	2	5
Ft. Worth, Tex.	108	69	19	16	3	1	5
Houston, Tex.	385	250	83	39	7	6	35
Little Rock, Ark.	74	44	14	6	4	6	7
New Orleans, La.	77	52	13	5	3	4	-
San Antonio, Tex.	138	84	29	17	3	5	10
Shreveport, La.	103	62	16	18	4	3	13
Tulsa, Okla.	91	75	4	8	3	1	-
MOUNTAIN	887	612	168	71	23	13	83
Albuquerque, N.M.	85	54	19	6	6	-	5
Colo. Springs, Colo.	40	26	7	5	2	-	5
Denver, Colo.	124	83	20	14	4	3	16
Las Vegas, Nev.	184	120	43	15	6	-	10
Ogden, Utah	27	18	8	-	-	1	4
Phoenix, Ariz.	170	114	29	17	4	6	24
Pueblo, Colo.	23	18	3	2	-	-	-
Salt Lake City, Utah	88	64	16	6	-	2	8
Tucson, Ariz.	146	115	23	6	1	1	11
PACIFIC	1,667	1,123	271	182	46	36	123
Berkeley, Calif.	14	8	3	3	-	-	1
Fresno, Calif.	112	71	17	13	6	5	9
Glendale, Calif.	16	8	8	-	-	-	2
Honolulu, Hawaii	67	49	10	3	1	4	5
Long Beach, Calif.	75	48	12	9	4	2	10
Los Angeles, Calif.	421	275	71	55	9	2	19
Pasadena, Calif.	31	26	2	1	1	1	5
Portland, Oreg.	101	77	10	6	5	3	3
Sacramento, Calif.	188	127	34	18	4	5	14
San Diego, Calif.	167	95	34	29	7	2	9
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	180	124	36	12	1	7	22
Santa Cruz, Calif.	36	27	6	3	-	-	6
Seattle, Wash.	126	85	11	21	6	3	4
Spokane, Wash.	50	39	5	3	2	1	2
Tacoma, Wash.	83	64	12	6	-	1	12
TOTAL	12,494¶	8,154	2,288	1,291	427	324	818

*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.

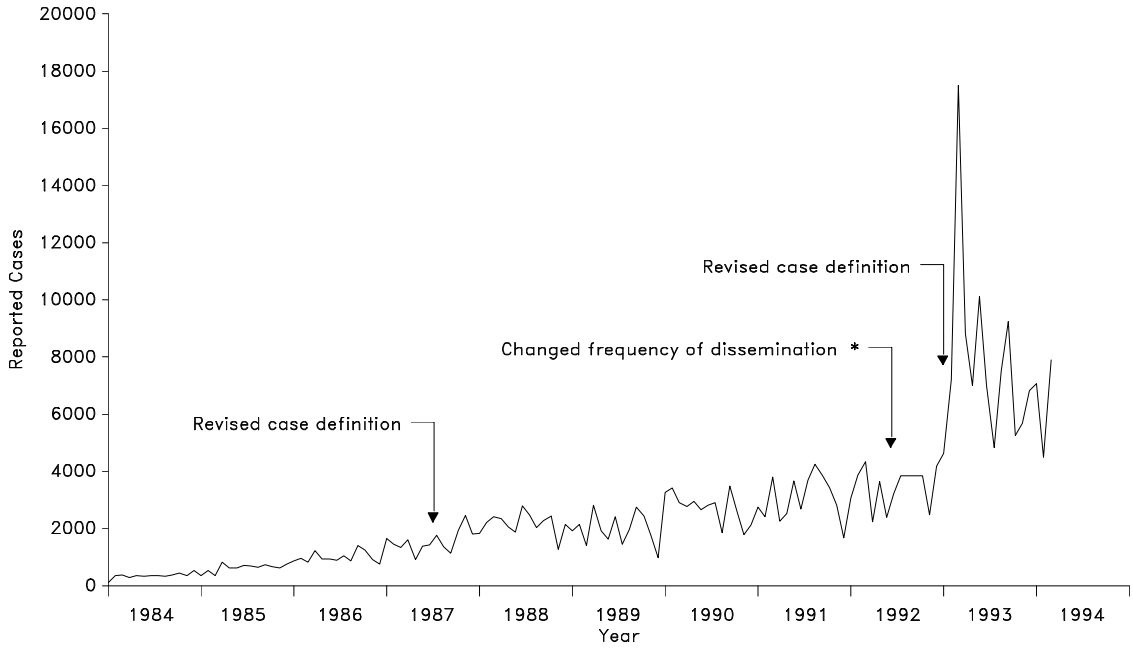
†Pneumonia and influenza.

§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.

FIGURE II. Acquired immuno



*Change to reflect Notice to Readers, Vol. 41, No. 18, pg. 325.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